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DEPARTMENT OF DEFENSE APPROPRIATIONS FOR 2013

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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DEPARTMENT OF DEFENSE APPROPRIATIONS FOR 2013

WEDNESDAY, MARCH 7, 2012.

FY2013 ARMY BUDGET OVERVIEW

WITNESSES

HON. JOHN M. MCHUGH, SECRETARY OF THE ARMY
GENERAL RAYMOND T. ODIERNO, CHIEF OF STAFF, UNITED STATES ARMY

OPENING STATEMENT OF CHAIRMAN YOUNG

Mr. YOUNG. Good morning. The Committee will be in order. This morning the Committee is holding a hearing on the budget for the United States Army for fiscal year 2013. We will be discussing personnel matters, current operations and readiness, research and development and procurement, along with any other subject that our witnesses prefer to raise or that the members prefer to ask about.

And we are very happy to welcome our distinguished witnesses, the Honorable John McHugh, Secretary of the Army, and General Raymond T. Odierno, Chief of Staff of the Army. And of course John McHugh has been one of our colleagues for many, many years, former chairman of the Armed Services Committee, and a colleague that we are very proud of, Mr. Secretary. And General, we are very, very happy to have you here. Your biography will be placed in the record, which is an extremely, extremely impressive biography. It will be placed in our record.

Mr. Secretary, you have appeared several times before this subcommittee as Secretary of the Army. We welcome you back, as you are a veteran of the budget process and you bring to these proceedings a wealth of experience based on your service in the House of Representatives and your ongoing service as Secretary of the Army. Representing the people of New York's 23rd and 24th Districts, you served as ranking member on the House Armed Services Committee and you served on the Oversight and Government Reform Committee and the House Permanent Select Committee on Intelligence, and that is quite a background. You are highly respected in the area of military affairs, and we are pleased that you are here today to discuss the Army budget request for fiscal year 2013.

General, 38th Chief of Staff of the United States Army, welcome to you, sir. We note that you are a New Jersey native, as is one of our ranking members, who will be here shortly, that you are a West Point graduate and you are one of a very small company of officers who have commanded at division, corps and Army levels in

the same conflict. Quite a history and quite a record. And while serving in positions other than command, you were an assistant to the Chairman of the Joint Chiefs of Staff and military advisor to Secretary of State Rice. You bring with you experience gained in three tours in Iraq, initially as commanding general 4th Infantry Division and culminating as Commander of the Multi-National Force Iraq and senior U.S. Military commander in Iraq. Impressive. At present you are guiding the Army through a ramping down of actions in Afghanistan and a shifting focus to the Asia-Pacific. Your assessment of the status of personnel, equipment and training readiness will be of great assistance to this committee as we consider how to best allocate resources so that the Army might accomplish its mission in defense of our Nation.

OPERATIONS IN IRAQ AND AFGHANISTAN

Mr. Secretary and General, salute you and the men and women, officers and enlisted soldiers, family members and civilian employees that you represent. For the past decade the Army has carried a heavy load in Iraq and Afghanistan. Despite multiple extended combat tours many soldiers and their families have continued to serve in the Army. They are proud of what they have done, as they should be, and what they continue to do for the Nation.

ARMY END STRENGTH REDUCTION

Although operations are ramping down in Afghanistan, we hope that they will be successful. Deployments do continue. Meanwhile the Secretary of Defense has announced that while the United States will continue an active approach to countering the threat posed by violent extremists, the focus of national defense will be balanced toward the Asia-Pacific region. A significant reduction in Army end strength is planned, yet the Army is expected to maintain the capability to regenerate ground forces as necessary.

ARMY READINESS

Mr. Secretary, General, reversibility sounds great, but this committee will want to hear how you ensure the Army when called to action can provide the needed units fully manned, equipped and trained. The 32nd Chief of Staff of the Army, General Gordon Sullivan, frequently noted that hope is not a method. This Committee will continue to support an Army that is properly equipped, properly supplied, and fully trained. The Committee will guard against a hollow Army, and we would like to hear your assessment of where you propose to accept risk in soldier end strength, training, equipment, readiness and modernization.

SUICIDE AND SEXUAL HARASSMENT PREVENTION

We will be interested in your plan to downsize the Army and programs to prevent, important programs to prevent suicide and sexual harassment. Fiscal management and the frequency and magnitude of reprogramming requests are likely topics of discussion, as they were considerably last year. And we will be interested in your updates on key acquisition programs, including Joint Light Tactical Vehicle, Ground Combat Vehicle, Armed Aerial Scout, Abrams tank

and Paladin self-propelled Howitzer. We are interested as well in the performance of the Stryker vehicles that have the double V hull.

NETWORK INTEGRATION EVALUATIONS (NIE)

Finally, the Army has initiated a series of network integration evaluations at Fort Bliss in Texas. We will be interested to hear how that process is working and how the findings and recommendations are used to inform acquisition programs.

Mr. Secretary and General, we have an ambitious agenda this morning. We want to get started. But before we proceed I am going to complete my remarks. I should have just put them in the record, because what I said about all of you, you already know. Anyway, before we proceed I want to recognize Mr. Dicks, the former chairman of the subcommittee and ranking member on the Full Committee. Chairman Dicks.

REMARKS OF MR. DICKS

Mr. DICKS. Thank you, Mr. Chairman. In welcoming both Secretary McHugh and General Odierno before the Committee, we extend our sincere thanks to you both for your many years of service and dedication to our Nation. You are testifying before the Committee at a difficult time that places many often competing demands on the Army. We recognize that the Defense Department will begin to implement significant changes in its strategy to address both emerging global security realities and the obvious financial challenges.

FUNDING FOR THE DEPARTMENT OF DEFENSE

Regarding DOD funding, we understand that the Budget Control Act requires Department-wide savings of $487 billion over the coming decade. A significant portion of this will ultimately come from the Army budget. It is often said that soldiers are the strength of the Army. With this in mind, we realize that the Army faces many challenges managing its personnel. The Army bears a significant burden as our soldiers continue to engage in combat operations in Afghanistan over the next several years.

ARMY END STRENGTH REDUCTION IN AFGHANISTAN

Your written statement indicates that as of today over 63,000 soldiers are deployed to Afghanistan performing a variety of missions. As the Army continues to support deployments, we note that the largest share of the personnel drawdown will come from the Army. OSD figures show that the Army will draw down 72,000 active duty troops out of a total personnel reduction DOD wide of 124,000 over the FYDP. We also understand that the Army will reduce its force structure by eight brigades from the current 63 and will remove two brigades based in Europe. In addition, we understand the Army must tend to the needs of military families, post support to troops as they return from deployments and provide transition assistance as soldiers return to civilian life. And as the chairman mentioned, you are developing several new programs, the Ground Combat Vehicle, the Joint Light Tactical Vehicle, Soldier

Systems, including improved night vision, body armor, sensors and other individual equipment for soldiers, and the land warfare network, which includes Wind™ and the joint tactical radio system. And I know reset is very important to you, as we discussed earlier.

REQUIREMENTS DEFINITION

The Committee stands ready to help the Army field these programs. However, we need to hear what measures you have in place to ensure that requirements are clearly defined and technically achievable, that cost estimates to develop and field these programs are realistic and that these programs receive proper management and oversight. We look forward to working with you to meet the needs of our soldiers and their families to maintain the readiness of our forces and to field the next generation of combat equipment.

We look forward to your testimony. And Mr. Young and I have been here long enough that we remember when Shy Meyer was the Chief of Staff of the Army in the 1980s. And during that time we fielded the Bradley fighting vehicle, the M1 tank and the Apache helicopter. Now we know that General Odierno is as good as Shy Meyer was, and so we are expecting him to get these systems—he is going to crack the whip, have great oversight and get these things out and turn around the rather dismal record of the Army on procurement. And we are counting on you, General. Just like you did the surge over in Iraq, we are counting on you to turn around the Army acquisition and get them moving in the right direction.

Thank you, Mr. Chairman.

Mr. YOUNG. Well, thank you, Mr. Dicks. And I have mentioned in earlier hearings how much we regret Mr. Dicks has announced his retirement. And I should also say that Mr. Lewis, who Chaired this Committee for 6 years and chaired the Full Committee for 2 years, had also announced his retirement. And he leaves behind a real legacy of effective representation for the United States military and for our readiness and basically made the military accept some weapons that they did not want to accept and that are so widely used today.

Now, Mr. Secretary, we are going to place your entire statement totally in our record, as well as the General's, and so summarize it any way that you like, sir. I am happy to hear from you.

SUMMARY STATEMENT OF SECRETARY MCHUGH

Mr. MCHUGH. Thank you very much, Mr. Chairman. I will do that. I will try to abbreviate my comments so we can have more opportunity for discussion. First of all, on behalf of the 1.1 million soldiers, 270,000 civilians that make up this great Army, it is an honor for me to be here today to add my voice of admiration to what is without question the greatest land force the world has ever seen, the United States Army. And Mr. Chairman, Ranking Member Dicks and distinguished members of the committee, I truly appreciate both your kind comments, Mr. Chairman, but more importantly the incredible support year in and year out that this great subcommittee and ultimately the committee in Congress provide to our Army and to our great military at large.

I do not know if the Chief will—I do know the Chief will be every bit as effective as Mr. Dicks has challenged. And certainly he is bigger than Shy Meyer, I know that, by sitting next to him. So I am honored and feel very blessed to have as our 38th Chief of Staff someone on the caliber of Ray Odierno, who as you noted Mr. Dicks, has a career record throughout his military career, but I think for many of us who had the opportunity to visit him in Iraq, particularly in that very, very difficult theater of being someone who can come in and take a tough job and get it done. And we have got a few tough jobs ahead of us, and like you, Mr. Dicks, I look forward to working with him. I feel very fortunate, as I said.

ARMY DEPLOYMENTS

Mr. Chairman, I most of all want to assure you that the strategy that this administration, the Department of Defense, all the military services went through, the development of it and ultimately the adoption of the supporting budget, was one that took a great deal of analysis, a great deal of thought and I think fairly represents a reasonable way for all of us to go forward in these very, very difficult times. For your Army these challenges over the last 10 years in many ways continue, as I know you understand. But we are busier than that. We have soldiers on six of the seven continents of the world, some 150 nations across this great planet. And whether in the Pacific from Japan to Korea to the Philippines or through EUCOM and the Middle East and on and on and on, this Army remains fully engaged. And this budget that we are here to discuss today I think helps us to be prepared for today and, as was noted, to be postured for tomorrow.

This budget really does I think underpin an Army that is fully embracing the hard decisions, as I said, we have to make at this moment, and at the same time laying the right foundation for a new and better future. Under the new framework that we will talk about, which was developed collaboratively, as I said, I would argue the Army clearly remains adecisive arm of the combat power. And at the end we will have a balanced and transformed force that will continue to be the most capable and effective land force in the world. That is our standard, that is what the strategy requires, and that is what this budget supports.

KEY ARMY PRINCIPLES

I would also note that we are implementing a new paradigm under, as was mentioned, the significant cuts directed by the Budget Control Act. And we did have to make tough decisions. But I want you to know that we were guided by a number of key principles. First, we intend to fully support the ongoing fight and make sure the operational commanders in Afghanistan and other theaters have the best trained and ready land forces in the world. That is our top priority, and it was not in any way compromised through this budget.

Secondly, we intend not to sacrifice readiness for force structure. We must responsibly reduce our end strength in a manner that fully supports the new strategy, but also provides sufficient time to properly balance our training, equipment, infrastructure and soldier and family support programs with our mission requirements.

Third, we will be able to build force structure and capabilities to handle unforeseen changes to global security. The Army must be able to hedge risk through an efficient and effective force generation process and access to a strong operationalized reserve component.

Fourth, we will maintain and enhance the Army's extensive commitments as they exist today even further in the future as they exist in the Pacific.

IMPACT OF BUDGET CONTROL ACT

And lastly, we will not let the Budget Control Act cuts be taken on the backs of our soldiers or their families. Although we have and we will continue to, where appropriate, examine all of our programs we will fully fund those support systems that work with special emphasis on wounded warrior, suicide prevention, behavioral health and sexual assault programs. And based on these principles our budget, as you noted, Mr. Chairman, reduces end strength beginning in 2013 and 2014 to support the current fight, emphasizes continuing investments in vital modernization programs such as a network GCV and JLTV, and delays or eliminates programs which no longer meet urgent needs in support of our new strategy in transforming the force, and defers certain military construction programs.

At its core the Army is not programs, it is not systems, and it is people. And every time I have had the honor to appear before you, including this moment, I come not as just Secretary but as representative in a small way of those soldiers, civilians and their families. And no one on this great subcommittee needs to have me sing the praises of these incredible men and women who have endured so much over the past decade and who depend upon all of us to provide them with the tools that they need, the support they deserve, and the funding that is required to support them and our families.

We have remaining challenges. Suicide and substance abuse rates are unacceptably high. We are pursuing multiple avenues to provide our personnel with the best medical and behavioral health support available. We never, never must forget our success in Iraq and Afghanistan came at a heavy price to our Army families, and we are going to do everything we can to continue to provide for them.

Let me just finally close, Mr. Chairman, if I may, adding my words of great admiration to two great Americans who served in this Congress and with whom I had the great chance to serve with Ranking Member Dicks and my dear long friend Jerry Lewis. One of the sad things I have learned since leaving this building and looking across sometimes longingly at the Capitol from the fun side of the Potomac and the Pentagon is so often incredible work is not widely recognized. I think all of us understand that when we come here to serve, and in these areas it is probably not that important. But the good that these two gentlemen have done, the programs that they have initiated, sometimes over the objections of some, the support that they have provided to these brave men and women in the military and their families far extends the reputations, and their reputations are extensive. So to my good friends, thank you

both personally and as the Army secretary of what you have done. I wish you both every best in the future.

I will yield back, Mr. Chairman, and I look forward to our discussion.

Mr. YOUNG. Mr. Secretary, thank you very much. And you have given us a lot of thought for some thoughtful questions already in your very well thought out statement.

General Odierno, we are very happy to hear from you now, sir.

SUMMARY STATEMENT OF GENERAL ODIERNO

General ODIERNO. Well, thank you very much, Chairman Young, Ranking Member Dicks, and the rest of the distinguished members of the Committee. Thank you so much for allowing us to be here today. I want to first thank you for the continued support that you have given our soldiers, especially over the last 10 years, as we have been involved in two conflicts in Iraq and Afghanistan and other places around the world. Without your oversight and without your help we could not have accomplished what we have done, and your work has saved many, many, many lives as we have worked in these conflicts, so I thank you all for that.

I also appreciate your vote of confidence, I appreciate the confidence that Secretary McHugh has shown in me. I think we have an incredible civilian military team in the Army today. We are focused on continuing to have the best Army in the world, one that can satisfy the security requirements of this Nation, and there is no better person to do that than Secretary McHugh, and he is a great boss, and I appreciate the opportunity to work with him.

It is an honor for me to be representing the 1.1 million soldiers in our Army today, our 278,000 Army civilians and our 1.4 million family members who have contributed so much over the last 10 years to our Nation's security. And we owe them a debt of gratitude, but more importantly we owe them to provide an Army that is capable of moving forward and also capable of taking care of our families.

ARMY DEPLOYMENTS

As the Secretary said, we continue to be a truly globally engaged Army. We have 95,000 soldiers deployed today in a variety of places around the world and another 96,000 forward stationed today conducting a broad range of missions.

But the one thing I would like to point out is our Army's primary purpose is steadfast and resolute, and that is to fight and win our Nation's wars. As the Army continues its transition we will ensure the President's 2012 strategic defense priorities are implemented, first meeting our current commitments in Afghanistan and elsewhere by ensuring a highly trained, properly equipped, and well manned force.

Now that operations in Iraq are complete and we continue surge recovery in Afghanistan, we will begin to shape the regional environs in some of the other combatant commanders' areas of responsibilities in order to develop the strategic environment that allows us to sustain our own security. In the Asia-Pacific, which is home to seven out of the 10 largest armies in the world, we will provide

an array of tools through rotational forces, multi-lateral exercises and other innovative engagements with our allies and new partners. We currently have some 66,000 soldiers and almost 10,000 civilians in this region.

During a time of great uncertainty in the Middle East we remain committed and prepared to ensuring security and stability across the spectrum of conflict through our rotational presence and other available means. And in Europe as we inactivate two brigade combat teams, one in 2013 and one in 2014, we will compensate through a series of engagement tools to build and sustain relationships with our European and NATO allies and partners. And I believe in the long term this will serve as a model of how I see us doing business in the future, a combination of forward station and rotational forces using a tailored approach by regionally aligned forces and prepositioned stocks.

ARMY FOCUS AREAS

As we move forward we will build on the competency and experience that has been gained over the past 10 years by our National Guard, our Army Reserves, and our Active component in Iraq and Afghanistan through the resourcing of a progressive training model that will continue to sustain this expertise, specifically in our National Guard and Army Reserves.

As we look forward, the Secretary already touched on this a bit, there are several focus areas which will help us guide us in the future. Foremost, remain committed to our 67,000 warfighters in Afghanistan and continue to provide trained, equipped and ready soldiers to be successful in that current fight.

END STRENGTH REDUCTION

Next, as the Army becomes leaner we must continue to build on the key characteristics of our future force, adaptability, innovation, flexibility, agility, versatility and lethality. We have to prioritize our efforts as we integrate and synchronize our activities as part of a larger joint interagency and multi-national effort.

By the end of fiscal year 2017 we will decrease our end strength in the Active component from 570,000 to 490,000, from 358,000 to 353,500 in the National Guard, and from 206,000 to 205,000 in the Army Reserves. It is imperative for us to sustain a gradual ramp over the next 6 years that will allow us to take care of our soldiers, continue to provide forces for Afghanistan, and facilitate reversibility over the next several years, if necessary.

REDUCE NUMBER OF BRIGADE COMBAT TEAMS

Currently end strength of 490,000 is funded strictly through OCO and must be sustained to help mitigate risk as we continue current operations in Afghanistan and simultaneously reset for the future. We also reduce our end strength by a minimum of eight brigade combat teams. And I say minimum because we are looking at potential reorganization initiatives that will expand the capabilities of a brigade which could cause us to reduce some of the brigades while increasing the number of combat battalions available. And we can discuss that later if you would like.

ACQUISITION REFORM

Finally, we will be responsible government stewards through energy cost savings and institutional and acquisition reform. We are now taking a fundamentally different approach to how we do business with our acquisition reform, and I credit Secretary McHugh for his diligent efforts with this. We have really made some tremendous progress, and I will take the challenge that Congressman Dicks has given me as the Chief to continue to move forward with this.

Through a new affordable and incremental equipping strategy, we are making better business deals and better contracts, emphasizing competition and saving even more money as governmental stewards. Our expansion of multi-year contracts, firm fixed price contracts, and cost-plus incentive fee contracts have proven substantive cost savings already. By more closely linking the development of requirements with the acquisition cycle, we are building the flexibility to integrate new technologies incrementally. Additionally, we are looking to develop more efficient testing and evaluation strategies by eliminating redundancies. We will continue our equipment reset program to restore unit equipment to a level of capability that is commensurate with our future missions. There have been over 1.8 million pieces of equipment reset to date, which equates to approximately 31 brigade equivalents. Much of what the Army needs to do and much of what we hope to be able to do will be relying upon sustained OCO funding through our withdrawal in Afghanistan and for 2 to 3 years afterwards.

MODERNIZATION PRIORITIES

As we continue to transform our modernization practices to a holistic bottom up approach we have several priorities. First is a network, which is critical to our ability to manage information and command our forces at all levels, both home and abroad. We have made significant progress on this critical program due to the series of network integration evaluation exercises that field tested equipment and integrated the system using our soldiers.

Second, the Ground Combat Vehicle, a replacement for our Infantry Fighting Vehicle, that can accommodate an infantry squad, balance mobility and survivability and provide unmatched lethality. We have paid close attention to risk reduction in this development program by maximizing competition to stimulate innovation, support cost containment and schedule requirements, ensuring industry identifies potential pricing schedule versus performance tradeoffs and requiring industry to provide cost targets throughout the life cycle of this program.

Our third priority is the more mobile and survivable network integrated Joint Light Tactical Vehicle, which both myself and General Amos agree is necessary given the last 10 years of fighting and what future operations may entail. We carefully revised our acquisition strategy to reduce the schedule for the next developmental phase from 48 to 33 months while reducing the projected cost of the program by $400 million.

Next is lightening a soldier's load with a focus on the squad. This must be continued efforts to give our squad superiority on the bat-

tlefield with advanced soldier systems and weapons, communications and protection. There has been tremendous progress in the advancements to help lighten the load of our individual soldiers, so now we must turn to look at how the squad can carry the load smarter. We will continue to look at decreasing the weight of our body armor while increasing protection. But we can make more progress by studying how to better distribute the load across the squad.

The budget request for aviation modernization will continue to ensure our lift and close combat attack capabilities remain effective. These aircraft provide critical support to our joint ground forces, our special operations community, and also our international partners.

Finally, I would like to point out that in order to achieve these priorities within our modernization strategy we will need the help of this Committee to ensure timely appropriations to reduce production and scheduling delays.

In conclusion, the Secretary and I will continue to assess and make adjustments to our strategy while addressing any potential risk incurred as we adjust our force posture.

SEQUESTRATION CONCERNS

I would like to leave you with one last thought. Sequestration is not in the best interest of our national security. The Army share of the cut could be almost $134 billion through 2017. The impact to the Army could cause up to 100,000 in cuts to end strength, in addition to the 86,000 we were already programmed to take. This would result in severe reductions in the National Guard, the Army Reserves and also continued reductions in the Active component and will significantly decrease what the Army can do for the joint force. In my estimation, sequestration would require us to fundamentally relook at how we provide national security.

Mr. Chairman, members of the Committee, thank you again for the opportunity to speak here today. It is an honor to be here representing the Army, and I look forward to your questions.

[The statement of Secretary McHugh and General Odierno follows:]

RECORD VERSION

STATEMENT BY

THE HONORABLE JOHN M. MCHUGH
SECRETARY OF THE ARMY

AND

GENERAL RAYMOND T. ODIERNO
CHIEF OF STAFF
UNITED STATES ARMY

BEFORE THE

HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

SECOND SESSION, 112TH CONGRESS

ON THE POSTURE OF THE UNITED STATES ARMY

MARCH 7, 2012

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICE

STATEMENT BY
THE HONORABLE JOHN M. MCHUGH
SECRETARY OF THE ARMY
AND
GENERAL RAYMOND T. ODIERNO
CHIEF OF STAFF
UNITED STATES ARMY

The Strategic Context

Our Nation has weathered difficult circumstances since the attacks on 9/11, yet we have met every challenge. The mission in Iraq has ended responsibly, continued progress in Afghanistan is enabling a transition to Afghan security responsibility and targeted counterterrorism efforts have significantly weakened al Qaeda and degraded its leadership. In all these endeavors, the Army has played a leading role.

As President Barack Obama stated in introducing his new national defense priorities, the country is at a turning point after a decade of war and considerable increases in defense spending. Even as large-scale military campaigns recede, the Nation will still face a growing array of security challenges. These new priorities focus on the continuing threat of violent extremism, the proliferation of lethal weapons and materials, the destabilizing behavior of Iran and North Korea, the rise of new powers across Asia and an era of uncertainty in the Middle East.

On top of that, our Nation confronts a serious deficit and debt problem (in itself a national security risk) that will squeeze future Army budgets. However, declining defense budgets do not nullify our obligation to provide enough capacity and maintain a highly ready force that is sufficiently modernized to provide a leaner, adaptive, flexible and integrated force that offers the President a significant number of options along the spectrum of conflict.

Today the U.S. Army is the best-trained, best-equipped and best-led combat-tested force in the world. Today's Soldiers have achieved a level of professionalism, combat experience and civil and military expertise that is an invaluable national asset. Our warriors have accomplished every assigned task they have been given. But all we have accomplished in building this magnificent force can be squandered if we are not careful. We are an Army in transition, and we look to Congress to assist us in the difficult work to build the Army of 2020.

America's Army–The Nation's Force of Decisive Action Every day, America's Army is making a positive difference in the world during one of the most challenging times in our history. Although stressed and stretched, the United States Army remains the most agile, adaptable and capable force in the world. Ours is an Army that reflects America's diversity and represents the time-honored values that built our Nation: hard work, duty, selflessness, determination, honor and compassion.

Today, less than one-half of 1 percent of Americans serve in the Army. As members of one of our Nation's oldest and most enduring institutions, these volunteers play an indispensible role in guarding U.S. national interests at home and abroad. Young men and women who want to make a difference in this world want to be part of our Army, which is why even after a decade of conflict, we continue to fill our ranks with the best the Nation has to offer. They have earned the gratitude, trust and admiration of an appreciative people for their extraordinary accomplishments.

2011–The Army in Transition Over the past year, the Army has concluded its mission in Iraq and commenced the drawdown of surge forces in Afghanistan while transferring responsibility to Afghan forces. We are beginning reductions in end-strength to face budgetary realities. We are also undertaking efforts to rebalance force structure and make investment decisions that will shape the Army of 2020– all during a

time of war. These transformational efforts are both significant and unprecedented. As the President's new national defense priorities are implemented, the Army will continue its transition to a smaller yet capable force fully prepared to conduct the full range of operations worldwide.

Operation Enduring Freedom A decade into the war in Afghanistan, the Army continues to play a leading role in defending our national security interests in this vital theater. At the start of the war, following the attacks on 9/11, elements of Army Special Operations Forces led efforts on the ground to bring al Qaeda members to justice and remove the Taliban from power, thereby denying a safe haven to terrorists. With more than 70,000 Soldiers in Afghanistan at peak strength in 2011, the Army's brigade combat teams conducted operations ranging from stability to counterinsurgency.

Today, over 63,000 Army Soldiers in both general purpose and special operations units continue to conduct a wide range of missions across Afghanistan country to help Afghan citizens lay the foundation for lasting security. Simultaneously, the Army provided essential logistics capabilities to sustain the land-locked Afghan theater. In fact, only America's Army could provide the necessary theater logistics, transportation, medical and communications infrastructure capable of supporting Joint and Combined forces for an operation of this size and complexity.

Since the beginning of combat operations in Afghanistan, Soldiers have earned 5,437 valor awards, including 241 Silver Stars and 8 Distinguished Service Crosses. Four Soldiers have been awarded the Medal of Honor for their heroic actions: Sergeant First Class Jared C. Monti, Staff Sergeant Salvatore A. Giunta, Staff Sergeant Robert J. Miller and Staff Sergeant Leroy A. Petry. They exemplify the courage, commitment and sacrifice of all the men and women who have served in this conflict.

Operation New Dawn In December 2011, the Army concluded more than 8 years of combat and stability operations in Iraq. Initially, powerful and agile forces liberated Iraq and then adapted to the new demand of suppressing the post-invasion insurgencies. Indeed, when the Nation needed a sustained effort to achieve its strategic objectives, the Army answered the call, adjusting its deployment tours from 12 to 15 months to enable a decisive surge in forces. Army units trained and equipped Iraq Security Forces, and when the mission changed, the Army executed the extremely difficult tasks of redeploying people and retrograding equipment to ensure future readiness.

Over one million Soldiers and Department of the Army Civilians served courageously in Iraq. They were essential to freeing more than 25 million Iraqi people from the tyranny of a brutal dictator, putting Iraq's future in the hands of its people and removing a national security threat to the United States.

Success came at a great cost in blood and treasure. But even during the most dire times, our Soldiers never wavered. Their heroic actions earned 8,238 awards for valor, including 408 Silver Stars and 16 Distinguished Service Crosses. Two Medals of Honor were awarded posthumously to Sergeant First Class Paul R. Smith and Private First Class Ross A. McGinnis.

Other Global Commitments In addition to the Army's unprecedented contributions in Afghanistan and Iraq, we have continued to conduct operations across the globe to prevent conflict, shape the environment and win decisively. Nearly 20,000 Soldiers remain stationed on the Korean peninsula, providing a credible deterrent and investing in our partnership with the Republic of Korea Army. Simultaneously, Army Special Operations Soldiers in the Pacific region continue to provide advice and support to the Philippine Armed Forces, enhancing our robust alliance. Both are examples of

strategic investments in a region that is home to 7 of the world's 10 largest armies. (In fact, in most countries around the world, the army is the dominant defense force.) And U.S. Soldiers continue to serve in places such as the Sinai, Guantanamo Bay, Bosnia, Kosovo and the Horn of Africa, developing and maintaining relationships on six of the world's seven continents.

Defense Support of Civil Authorities Over the past year, the Army has continued to provide instrumental support to civil authorities. The Army's reserve component proved to be one of our great strengths for these missions, giving the force depth and flexibility. The National Guard provides a distinctive capability for the Nation. When floods, wildfires and tornados struck from the Midwest to the South over the span of a few days in spring 2011, more than 900 National Guard Soldiers supplied a coordinated response to address citizens' needs across the affected region. Similarly, when Hurricane Irene knocked out power and flooded towns across the Northeast in the summer of 2011, nearly 10,000 National Guard Soldiers and Airmen across 13 States delivered critical services to sustain the region through the crisis.

In addition to ongoing counterdrug operations, approximately 1,200 National Guard Soldiers and Airmen supported the U.S. Department of Homeland Security in 4 States along the southwest U.S. border by providing entry identification and analysis to disrupt criminal networks and activities.

Army Special Operations Forces To conduct unified land operations, the U.S. Army fields a suite of Special Operations capabilities that range from the world's finest precision strike and special warfare forces to the world's most lethal combined arms maneuver formations. The Army draws from across its broad set of capabilities to provide the Joint commander the blend of Army assets required to ensure mission accomplishment. True in Afghanistan today, Army Special Operations Forces are also

providing assistance in the Philippines, Yemen, the Arabian Gulf, Lebanon, Colombia, the African Trans-Sahel and across the Caribbean and Central America. As Army regular forces become available, they will increasingly integrate with Army Special Operations Forces to promote trust and interoperability with allies and build partner nation capacity where mutual interests are at risk from internal or external enemies.

Fiscal Environment

Challenges of Reduced Budget Today's global fiscal environment is driving defense budgets down for our partners and allies, as well as our Nation. Historically, defense spending has been cyclic with significant reductions following the end of major conflicts. The Army understands it cannot be immune to these fiscal realities and must be part of the solution. Our focus areas for the FY 13 budget demonstrate our concerted effort to establish clear priorities that give the Nation a ready and capable Army while being good stewards of all our resources.

Challenges of Continuing Resolutions Timely and predictable funding enables the Army to plan, resource and manage the programs that produce a trained and ready force. The Army very much appreciates that Congress approved the FY 12 budget earlier than had been the case in recent years when we were forced to operate for long stretches under continuing resolutions. Long-term continuing resolutions force the Army to slow its spending, freeze production rates and delay the start of new programs. Such delays pose a risk to the Army's operational readiness and investment strategy. We stand ready to help Congress once again pass defense bills in a timely manner.

Security Environment A series of powerful global trends continue to shape the current and future strategic environment: increased demand for dwindling resources,

persistent regional conflict, empowered non-state actors, the continuing proliferation of weapons of mass destruction and failed states. We anticipate a myriad of hybrid threats that incorporate regular and irregular warfare, terrorism and criminality. We also face cyber-threats to an increasingly critical and vulnerable information technology infrastructure and the destabilizing effect of global economic downturns. Together, these trends create a complex and unpredictable environment in all of the Army's operational domains: land, sea, air, space and cyberspace.

Implications for America's Army

Role of the Army: Prevent, Shape, Win In the uncertain environment our country faces, the Army remains central to our Nation's defense as part of the Joint Force. No major conflict has been won without boots on the ground. Listed below are the three essential roles the Army must play.

First, our Army must ***prevent*** conflict just as we did during the Cold War. Prevention is most effective when adversaries are convinced that conflict with your force would be imprudent. The Army's ability to win any fight across the full range of operations as part of a Joint Force must never be open to challenge. It must be clear that we will fight and win, which requires a force with sufficient capacity, readiness and modernization. That means quality Soldiers; agile, adaptive leaders; versatile units; realistic training and modern equipment. Prevention is achieved through credible readiness, sometimes requiring decisive action. Our Army must continue to be a credible force around the globe to prevent miscalculations by those who would test us.

Second, our Army must help ***shape*** the international environment to enable our Combatant Commanders to assure our friends and contain our enemies. We do that by engaging with our partners, fostering mutual understanding through military-to-military contacts and helping them build the capacity to defend themselves. These actions are

an investment in the future that the Nation cannot afford to forego. We must cultivate positive relationships before they are needed and be a reliable, consistent and respectful partner to others.

Finally, the Army must be ready to ***win*** decisively and dominantly. Nothing else approaches what is achieved by winning, and the consequences of losing at war are usually catastrophic. With so much at stake, the American people will expect what they have always expected of us—decisive victory. The Army must never enter into a terrible endeavor such as war unprepared. Although we may still win, it will be more expensive, cost more lives and require more time.

In addition to being trained, sized and equipped to win decisively in the more traditional operational domains, the Army also will require robust capability in cyberspace. As the past decade of conflict has demonstrated, the information environment has changed the way we fight. Military and cyberspace operations have converged, and protecting information in cyberspace is more essential than ever to how our Army fights. The advantage will go to those able to maintain the freedom to operate and able to gain, protect and exploit information in the contested cyberspace domain. The Army must be dominant in both the land and cyberspace domains.

Smaller but Reversible As our new national defense priorities drives us to a smaller Army, we must avoid the historical pattern of drawing down too fast or risk losing leadership and capabilities, making it much harder to expand again when needed. It is critical that the Army be able to rapidly expand to meet large unexpected contingencies, and four components are key to that ability. First, the Army must maintain a strong cadre of noncommissioned and mid-grade officers to form the core of new formations when needed. Second, we will make significant investments in Army Special Operations Forces to increase their capabilities and provide the President with

more options. Third, it will require ready and accessible Army National Guard and Army Reserve forces. The Army's reserve component has proven essential in contingency operations around the world. From Kosovo, the Sinai and Horn of Africa to Afghanistan and Iraq, homeland defense along America's southwest border, humanitarian assistance and disaster relief at home and abroad, the Army National Guard and Army Reserve have evolved into indispensible parts of our operational force and we will continue to rely on them to provide depth and versatility to meet the complex demands of the future. The fourth critical component of the Army's ability to expand is the Nation's industrial base. We rely on the industrial base to perform research and development and to design, produce and maintain our weapons systems, components and parts. It must be capable of rapidly expanding to meet a large demand. Reversibility is the *sine qua non* to ensuring that the Army can rapidly grow when our Nation calls.

The Army's Focus Areas

Support to Operations in Afghanistan

Our immediate focus remains on providing the best trained and most ready land forces in the world to win the current fight while maintaining responsiveness for unforeseen contingencies. The support of the American people is paramount to our success. We must fulfill our responsibilities to them without draining their goodwill and treasure.

Despite continued challenges and tough conditions, our forces are making measureable progress against an adaptive enemy. Army Security Force Assistance Teams continue to train both Afghan National Army forces (now almost 180,000 strong) and Afghan National Police forces (made up of nearly 144,000 men and women in uniform). The increased capability of Afghan Security Forces is allowing security of the

region to be turned back over to the government of Afghanistan district by district. During the coming year we must continue to provide trained and ready forces equipped to support operations. We remain focused on doing everything we can to ensure that we meet our national objectives and provide what our brave men and women in the field need to succeed.

In Afghanistan, the commitment and performance of our Soldiers and Civilians continues to be nothing short of extraordinary. Not only have they taken the fight to our enemies, but they have proven equally effective as emissaries. Our investment in leader development prepared them to operate in this demanding environment.

In the coming year we will continue to increase the Afghan lead of security responsibilities, target key insurgent leaders, retain and expand secure areas and help Afghan National Security Forces earn the support of the people through improved security capacity and capability. Because of its geography, distance, infrastructure and harsh environment, the difficulty and complexity of the drawdown in Afghanistan will exceed that in Iraq. The United States Army is the only organization in the world with the capability to plan and execute a logistical operation this complex and difficult.

The Army places great emphasis on properly maintaining its equipment to restore readiness to the force and ensure it is prepared to meet Combatant Commander requirements. The Army reset program reverses the effects of combat stress and restores equipment to a high level of combat capability to conduct future operations. Reset is a lengthy process, and even after the drawdown from Afghanistan is complete, the Army will require funding for 2 to 3 years to reset our equipment from the harsh demands of war.

Responsible Stewardship

Institutional Army Transformation The drive to reform the Institutional Army is about doing things better, smarter and faster while taking advantage of available technology, knowledge and experience. Our Institutional Army—the part of the Army that trains, educates and supports Army forces worldwide—will become more flexible by improving our ability to quickly adapt to changing environments, missions and priorities. The Institutional Army is also working to rapidly address the demands placed on the organization by the current and future operational environments. It performed magnificently to produce trained and ready forces, even while seeking to adapt institutional business processes.

Further, the Army is working to provide "readiness at best value" to help us live within the constraints imposed by the national and global economic situation. In short, the need to reform the Army's institutional management processes and develop an integrated management system has never been more urgent. To enhance organizational adaptive capacity while shepherding our resources, the Army initiated a number of efforts, such as the Army Financial Improvement Plan, which will enable the Army to achieve full auditability by FY17.

Acquisition Reform As a result of uncertain funding, insufficient contract oversight and an ineffective requirement determination process, the Army has initiated a significant reform of the way we develop and acquire our products and weapons. As part of this initiative, we have taken steps toward improvement through a series of capability portfolio reviews. These platforms serve to revalidate, modify or terminate programs based on the Army's need and the affordability of the program. We have also started to fix an inefficient procurement system that too often wastes precious resources and fails to provide needed systems in a timely manner. For example, the Army

commissioned a comprehensive review of our acquisition system that, based on the findings and recommendations, produced a blueprint for acquisition reform. These changes fall into four broad areas:

- realignment of acquisition requirements combined with a sharper focus on the needed competencies of acquisition professionals;

- expansion of stakeholder (acquisition professional and Soldier end-user) participation in developing requirements, planning and acquisition solicitation;

- reappraisal and streamlining of acquisition strategies and the attendant risk in such streamlining; and

- improvement in the selection, development and accountability of the people involved in the acquisition process.

We are implementing these recommendations as part of our broader effort to reform the Institutional Army.

Army Energy Security Supplying energy to our Army around the world is increasingly challenging, expensive and dangerous. The Army must consider energy in all activities to reduce demand, increase efficiency, obtain alternative sources and create a culture of energy accountability. Energy security is an imperative that can be described in two categories, operational and garrison.

Operational energy is the energy and associated systems, information and processes required to train, move and sustain forces and systems for military operations. The Army is developing new doctrine, policies, plans and technologies that will improve the management and use of operational energy to better support Soldiers' needs. Less energy efficient systems in an operational environment require more fuel, increasing the number of fuel convoys and thus risking more lives and limiting our flexibility.

Garrison energy is the energy required to power Army bases and conduct Soldier training. Dependence on fossil fuels and a vulnerable electric power grid jeopardize the security of Army operating bases and mission capabilities. The impact of increasing energy prices is a decrease in the quantity and quality of training the Army can conduct.

Initiatives such as cool roofs, solar power, stormwater management and water efficiency are positive steps toward addressing the challenges of energy security in the operational and garrison environments. Innovative and adaptive leaders, seeking ways to increase energy efficiency and implement renewable and alternate sources of energy, are key to saving lives and increasing the Army's flexibility by reducing costs.

A Leaner Army

The Army is committed to providing Combatant Commanders with the capabilities, capacity and diversity needed to be successful across a wide range of operations. With a leaner Army, we have to prioritize and also remain capable of meeting a wide range of security requirements. We will reduce in a manner that preserves our readiness and avoids any hollowing of the force. To satisfy this enduring requirement, we have three rheostats that must be continuously assessed and adjusted: end strength/force structure, readiness and modernization. We will balance these three foundational

imperatives throughout the next several years to provide Combatant Commanders trained and ready forces in support of Joint Force 2020.

Force Structure and Force Design The Army will maintain a versatile mix of tailorable and networked organizations, operating on a rotational cycle, to continue providing a sustained flow of trained and ready forces for the full range of military operations. This will give Combatant Commanders a hedge against unexpected contingencies and enable a sustainable tempo for our all-volunteer force. Over the next five years, the Army will decrease its end-strength from a peak authorized strength of about 570,000 to 490,000 Active Army, 358,000 to 353,500 Army National Guard and 206,000 to 205,000 Army Reserve Soldiers as directed. Reducing our end strength over a deliberate ramp through the end of fiscal year 2017 allows the Army to take care of Soldiers, Families, and Civilians; to continue meeting our commitments in Afghanistan; and to facilitate reversibility in an uncertain strategic environment.

An unpredictable and dynamic global security environment requires the Army, as a force in transition, to adjust and reduce its size while remaining flexible, capable and ready to meet the Nation's requirements and maintaining an ability to reverse course to readily expand if necessary. In accordance with the new defense priorities, the Army of 2020 must have a versatile mix of capabilities, formations and equipment that is lethal, agile, adaptable and responsive. As the Army transitions from the current force to a leaner force, it will do so while remaining engaged in the current conflicts. The Army will prioritize force structure and committed assets in the Pacific Region and the Middle East, and will shape the future force to support the Army's requirements as part of the Joint Force to fulfill the Nation's strategic and operational commitments. The Army will optimize force structure to maintain reversibility, and achieve maximum operational strategic flexibility. Today we plan on reducing at least 8 active component Brigade Combat Teams, however, we continue to assess the design and mix of these modular formations based upon the lessons from the last ten years of combat. This analysis

may lead to a decision to reorganize BCTs into more capable and robust formations, requiring further BCT reductions in order to increase overall versatility and agility for tomorrow's security challenges.

As the Army's active component reduces in size, the composition of combat support and combat service support enablers in the active and reserve components will be adjusted to give the Army the ability to conduct sustained operations, and to mitigate risk. The Army will continue to rely on the reserve components to provide key enablers and operational depth. An operational reserve comprised of a discrete set of capabilities with an enhanced level of readiness will be essential. This force will consist of three elements: select combat formations prepared to respond to crisis; combat support and combat service support enablers employed early in support of operational plans; and forces aligned to support steady-state Combatant Commander requirements. Ensured access to the reserve component is essential to providing the operational depth and flexibility Combatant Commanders require. During the transition, we must manage our people carefully to neither compromise readiness nor break faith with those who have served the Nation so well.

Readiness Army unit readiness is measured by the level of its manning, training and equipping. The current Army force generation model, known as ARFORGEN, has served us well in meeting the requirements for Iraq and Afghanistan; however, we will adapt it to ensure we meet future Combatant Commander requirements in the uncertain, complex strategic environment. We envision a progressive readiness model for most active and reserve component early deploying units which will align forces for Combatant Commanders. Because of their unique capabilities, our low density, high demand units do not lend themselves to a rotational pool like ARFORGEN. These units must be sustained in a constant readiness model.

The Strength of Our Army is Our Soldiers Soldiers and Families form the foundation of unit readiness. People are the Army, and our enduring priority is to preserve the high-quality, all-volunteer force —the essential element of our strength. The Army has gained the trust of the American public more than at any other time in recent history while developing a force that is very different from what it was a few short years ago. Our Army must maintain the public's trust while our Nation fulfills its responsibilities toward Soldiers and their Families. The United States Army is unique from other professions because our core attributes are derived from American values, the Constitution and law. Today's Army is building on a successful foundation with the trust, respect and support of the American people. This foundation, and our enduring commitment to strengthening our Army Profession, will improve our force as it adapts to meet the Nation's evolving needs.

The Army is the Nation's preeminent leadership experience. The all-volunteer force is our greatest strategic asset, providing depth, versatility and unmatched experience to the Joint Force. We must continue to train, develop and retain adaptive leaders and maintain this combat-seasoned, all-volunteer force of professionals. We will continue to adjust in order to prepare our leaders for more dynamic and complex future environments. Our leader development model is an adaptive, continuous and progressive process grounded in Army values. We grow Soldiers and Army Civilians into competent and confident leaders capable of decisive action. We must give our leaders broadening opportunities to better prepare them for the myriad challenges they will encounter. In addition, we must reinvigorate unit training, training management skills and leader development to build versatile units. By providing our leaders with the professional challenges they expect, we will retain them and nurture their adaptive spirit.

Our challenge in the coming years is not just about attracting and selecting the best available candidates to be Army professionals. We must also engage and develop our quality, combat experienced leaders so that we keep them, and they, in turn, train the

next generation of Army professionals. During the last decade of war, we have given our young leaders unprecedented flexibility and authority to operate effectively on the battlefield. We will prepare for tomorrow by building on that investment and ensuring that opportunities for creativity, leadership and advancement exist throughout the Army.

We must draw down wisely to avoid stifling the health of the force or breaking faith with our Soldiers, Civilians and Families. Excessive cuts would create high risk in our ability to sustain readiness. We must avoid our historical pattern of drawing down too much or too fast and risk losing the leadership, technical skills and combat experience that cannot be easily reclaimed. We must identify and safeguard key programs in education, leader development, health care, quality of life and retirement—programs critical to retaining our Soldiers.

The Strength of Our Soldiers is Our Families In order to ensure a relevant and ready all-volunteer force, the Army will continue to invest heavily in our Soldier and Family programs. The Army Family Covenant expresses the Army's commitment to care for Soldiers and their Families by providing a strong, supportive environment that enhances their strength and resilience and helps them to thrive. The Covenant focuses on programs, services and initiatives essential to preserving an all-volunteer force and institutionalizes the Army's commitment to provide Soldiers and their Families a quality of life commensurate with their service to the Nation. Through the Covenant, the Army is improving the delivery of Soldier and Family programs and services, sustaining accessibility to quality health care, and promoting education and employment opportunities for Family members. We are sustaining high-quality housing; ensuring excellence in school support, youth services and child care; and maintaining quality recreation services for Soldiers and Family members as they serve on the Nation's behalf around the world. We will not walk away from our commitment to our Families; however, a different fiscal reality requires us to review our investments and eliminate

redundant and poor performing programs while sustaining those that are high performing and most beneficial to our Families.

Honoring Service We must fulfill our moral obligation to the health, welfare and care of our Soldiers, Civilians and Families. The effects of more than 10 years of war and inadequate dwell time at home has resulted in a cumulative stress on Soldiers, Families and communities that has significant implications for the Army and our Nation. We have implemented an unprecedented number of personnel-focused programs, including Comprehensive Soldier Fitness; Wounded Warrior Program; and Health Promotion, Risk Reduction and Suicide Prevention, to ensure the continued care, support and services that sustain the high quality of our force.

Sexual harassment and sexual assault are inconsistent with the Army's values and our profession. It is imperative that we foster a climate where such misconduct is not tolerated and the dignity of our Soldiers, Civilians and Family members is respected and protected. Army Leaders are focused on the urgency of this issue and the level of commitment required to affect cultural change and combat this crime. We are aggressively implementing and expanding the Army's comprehensive Sexual Harassment/Assault Response and Prevention (SHARP) Program. The SHARP program is aimed at command prevention efforts at all levels, educating all members of our Army family, training our first responder professionals and supporting victims while reducing the stigma of reporting. One incident of this type of unwarranted and abusive behavior is one too many. The Army is committed to ensuring leadership at all levels is engaged in preventing sexual assault and harassment, and to appropriately holding offenders accountable.

The Army continues to invest heavily in better understanding traumatic brain injury and post-traumatic stress, the invisible signature wounds of our recent wars. We have

developed and implemented new prevention and treatment protocols, and we are in the third year of our 5-year partnership with the National Institute of Mental Health to identify the factors that help protect a Soldier's mental health and those that put it at risk.

We have also started to reduce the length of deployments to 9 months for many of our units at the division level and below, which we believe will alleviate significant pressure on our Soldiers and their Families. We are doubling our efforts to ensure that each of our more than 18,000 Soldiers currently enrolled in the Integrated Disability Evaluation System is carefully examined to determine whether he or she should return to civilian life or continue military service. A recent initiative between the Department of Defense and U.S. Department of Veterans Affairs – the Integrated Disability Evaluation System integrates formerly separate programs – resulting in a streamlined, more efficient process for servicemembers, which will reduce the backlog of Soldiers awaiting benefits.

As we draw down the Army, we must honor our veterans with the very best support, care and services they deserve as they make the transition from military service to civilian life. We are committed to our Soldiers and their Families, who are the strength of the Army. At the same time, the Army is focused on wisely managing our resources in the health care arena. The Army supports Defense Department proposals to further reduce the rate of growth in health care costs – proposals that are aligned with our priorities. TRICARE is a superb health benefit – one of the best in the country and appropriately so. Just as in all areas of the defense budget, we need to make decisions that preserve a strong benefit yet reflect the fiscal realities of the times. The proposals take care to exempt populations who have made the greatest sacrifices – those who are medically retired and those families who have lost their loved one while serving on active duty. The changes proposed are also adjusted to reflect lower adjustments for those retirees with lower retirement pay. And, most importantly, the Department

continues to provide resources that improve the overall health system for our soldiers and their families.

The Army is using the Health Promotion and Risk Reduction FY 11 Campaign Plan to holistically promote health and reduce risk. The Campaign Plan incorporates findings and recommendations from Department of Defense and Army reports regarding health promotion, risk reduction and suicide prevention. Health promotion and risk reduction activities are essential to sustain the force under the current operational tempo and reset our Army.

Modernization The Army has global responsibilities requiring large technological advantages to prevail decisively in combat. Just as pilots and sailors seek supremacy in the air and on the seas, Soldiers must dominate their enemies on land. Modernizing, especially as end-strength is reduced, is the key to ensuring that our dominance continues.

The Army is setting priorities and making prudent choices to provide the best possible force for the Nation within the resources available. We are developing and fielding a versatile and affordable mix of equipment to enable us to succeed in the full range of missions and maintain a decisive advantage over our enemies. To meet the challenges of an evolving strategic and fiscal environment, our strategy is based on three tenets: integrated capability portfolios, incremental modernization and leveraging the Army Force Generation cycle.

- Integrated capability portfolios align stakeholders to identify capability gaps and eliminate unnecessary redundancies.

- Incremental modernization enables us to deliver new and improved capabilities by leveraging mature technologies, shortening development times, planning growth potential and acquiring in quantities that give us the greatest advantage while hedging against uncertainty.

- Army Force Generation processes synchronize the distribution of equipment to units providing increased readiness over time and delivering a steady and predictable supply of trained and ready modular forces. The Army has consolidated its materiel management process under a single command and designated U.S. Army Materiel Command as the Army's Lead Materiel Integrator. Additionally, we consolidated all of our materiel data into a single authoritative repository called the Logistics Information Warehouse.

These emerging systems and processes represent a powerful new approach for implementing the Army's equipping priorities, policies and programs to the meet new security demands of the 21st century. The equipment requested in the President's FY 13 Budget strikes a balance between current and future needs, provides the basis for an affordable equipping strategy over time, and takes into account Army requirements and priorities. In developing this request, the Army made difficult decisions to shift funds previously programmed for future capabilities to current needs. The decisions came at the expense of promising and needed technologies with capabilities that did not fit within resource limitations. The Army's top four modernization priorities are the Network, Ground Combat Vehicle, Joint Light Tactical Vehicle and Soldier Systems.

Network Also known as LandWarNet, the Network remains the Army's top investment priority. With expectations of tighter budgets and a still very active threat

environment, the Army will have to produce a force that is smaller yet more capable. The Network is the core of that smaller, capable Army.

The Army is conducting a series of semiannual field exercises known as the Network Integration Evaluation to evaluate, integrate and mature the Army's tactical network. The exercises will assess network and non-network capabilities to determine implications across doctrine, organization, training, materiel, leadership and education, personnel and facilities. The process aligns several key Army network programs and advances the fusion of radio waveforms to form an integrated network baseline to which industry can build.

The foundation of the modernized Network is a Joint, secure and common architecture that will provide information from the cloud to enable leaders, units and the Institutional Army to function more effectively. The Army will extend this critical capability to its installations around the world. This capability will increase force effectiveness, facilitate transition for units and individuals from one phase of the Army Force Generation cycle to another and greatly improve network security.

The major programs that form the backbone of the tactical network are:

- the Warfighter Information Network-Tactical, which provides a real-time common operating picture down to the company level by extending satellite and line-of-sight communications, including telephone, data and video;

- the Joint Tactical Radio System, an advanced software-defined family of radios that will carry data and voice for dismounted troops and airborne and maritime platforms;

- the Distributed Common Ground System - Army, which provides intelligence, surveillance and reconnaissance data, as well as access to the entire Defense Intelligence Information Enterprise, to commanders from the company to Army service component command level;

- the Joint Battle Command Platform, which provides situational awareness data enhancing mission command to Army and Marine Corps tactical operations centers and combat vehicles; and

- Nett Warrior, which gives dismounted leaders integrated situational awareness and information sharing, helping them to avoid fratricide and increase combat effectiveness.

The Army Network must be dynamic to give Soldiers, Civilians and partners information and services when and where needed. Investment must be steady and wisely applied, while maintaining a strong partnership with industry.

Ground Combat Vehicle (GCV) The Infantry Fighting Vehicle is reaching the limit of its capacity to receive technology upgrades proven critical for Soldiers in combat operations. The GCV is the Army's replacement program for the Infantry Fighting Vehicle and the centerpiece of the Army's overall combat vehicle investment strategy. It will be designed to deliver a full nine-man squad with improved survivability, mobility

and network integration, considered crucial to our ability to conduct fire and maneuver in close quarters fighting in complex terrain. The vehicle will also provide the growth potential necessary to accommodate advances in protection, networking and space, weight, power and cooling technologies while reducing sustainment demands. No current vehicle can sufficiently meet all these requirements.

The GCV acquisition strategy implements affordability measures designed to ensure the long-term success of the program as the Army faces constrained resources in the future. To develop this acquisition strategy, the Army and the Office of the Secretary of Defense conducted a comprehensive review to make sure the program is both achievable and affordable within a 7-year timeframe. The model adopted for the GCV program incentivizes industry to use the best of mature technologies that are both affordable and support the 7-year timeframe. The Army has also paid close attention to risk reduction within the program by requiring industry to identify potential cost schedule and performance tradeoffs; provide cost targets throughout the GCV's life cycle; and maximize competition to support innovation, cost containment and schedule requirements.

Joint Light Tactical Vehicle (JLTV) As a Joint Service program between the Army and Marine Corps, the JLTV will replace approximately one-third of the Army's oldest unarmored High Mobility Multipurpose Wheeled Vehicles (HMMWV). The JLTV incorporates the strengths of the Mine-Resistant, Ambush Protected (MRAP) vehicles that the HMMWV family of vehicles does not provide. The HMMWV was not designed to be used as an armored combat vehicle, but it was often employed as one during the wars in Afghanistan and Iraq. In contrast, the JLTV will be designed for this role from the outset. It will be capable of operating across the range of military operations and physical environments providing, improved mobility and protection for Soldiers. The JLTV balances protection, payload, performance and improved fuel efficiency in one

affordable and sustainable vehicle. It will also be fully integrated into the Network to enhance the effectiveness of ground forces.

Soldier Systems The squad is the foundation of the decisive force; it is the cornerstone of all units. To ensure the success of combat operations in the future, the Army will invest in systems that consider the squad as a team rather than a collection of individuals. This approach will guarantee that the squad will not be in a fair fight but will have overmatch. The Army will continue to invest in Soldier systems that enable the lethality, protection, situational awareness and mobility of the individual Soldier in his or her squad. These systems include small arms, night vision, Soldier sensors, body armor and individual clothing and equipment.

Summary and Conclusion

The Army has been, and will continue to be, a critical part of the Joint Force because land power remains the politically decisive form of warfare and is essential to America's national security strategy. No major conflict has ever been won without "boots on the ground." By being tasked to seize, occupy and defend land areas, as well as to defeat enemy land forces, the Army is unique because it must not only deploy and defeat an adversary, but must be prepared to remain in the region until the Nation's long-term strategic objectives are secured. Indeed, the insertion of ground troops is the most tangible and durable measure of America's commitment to defend our interests, protect our friends and defeat our enemies.

With global trends pointing to further instability, our Army remains a key guardian of our national security. In the wake of the Cold War, it was said that we had reached the "end of history," and that liberal democracy had won the ideological competition. However, events since then make it clear that potential adversaries with competing ideologies still exist and are extremely dangerous.

As a result, we find ourselves in an increasingly uncertain world, with threats ranging from terrorist and cyberattacks to regional instability to the proliferation of weapons of mass destruction. For our Army that means we will likely have to deal with near peer competitors in niche areas and hybrid threats that mix regular, irregular and criminal activity—all while still facing the possibility of a conventional force-on-force conflict.

The danger extends from the homeland to the theater where combat operations might occur. Conflict is the norm; a stable peace the exception. In such a world, our adversaries will adapt to gain advantage, especially in the land domain. And it is on land, that our challenges will be the most complex because of dynamic human relationships and terrain variables.

While the Army's new end-strength numbers allow it to support current defense priorities, it is imperative that the Army draw down end-strength levels in a smart and responsible manner. We believe that our new end-strength provides us with the flexibility to retain the hard-won expertise it has gained over the last decade. To be sure, the Army has faced similar challenges before. After every major conflict since the Revolutionary War, the Army has faced pressure to decrease its end-strength. As recently as 2001 (pre-9/11), many believed a strategic shift was needed and that the future of modern warfare would be about missile defense, satellites and high-tech weaponry because no adversary would dare challenge America's conventional forces. But whenever we have rushed to radically diminish the position of the Army, the result has always been the same: an excessive decline in effectiveness at a cost of blood and treasure.

Decreases after World War I directly contributed to failures at Kasserine Pass. Decreases after World War II led to Task Force Smith's failure in Korea. More recently,

the end of the Cold War demonstrated our Nation's need for agile, adaptable and decisive ground forces to conduct a wide range of operations. These numerous missions include Operation Provide Comfort in Iraq, Joint Task Force Andrew in Florida, Operation Restore Hope in Somalia, Operation Uphold Democracy in Haiti, Operation Joint Endeavor in Bosnia-Herzegovina, and Operation Joint Guardian in Kosovo. What they have in common is that they were unforeseen, thus emphasizing our need to avoid the historical pattern of drawing down too fast.

America's leaders face difficult choices as they chart the way ahead for our Nation. Familiar external threats persist and complex new challenges will emerge. Concurrently, fiscal limitations create internal challenges for our leaders. America's Army is prepared to fulfill its role in keeping the Nation secure. The Army will ***prevent*** conflict by remaining a credible force with sufficient capacity to dissuade adversaries from challenging American interests. The Army will ***shape*** the environment, building positive relationships and capabilities that enable nations to effectively protect and govern their citizenry. Finally, when called, the Army will fight for the Nation and ***win*** decisively. We understand these responsibilities and resolve not to reduce the size of the Army in a manner that does not permit us to reverse the process should demand for forces increase dramatically.

As we look ahead, the Army is focusing on three areas. Our first priority remains supporting operations in Afghanistan. We will guard against becoming distracted by the future at the risk of our men and women who remain in harm's way.

Second, we will be the very best stewards we can, because America's resources are too precious to waste. Transforming the Institutional Army, reforming our acquisition process and ensuring energy security are essential for us to protect the resources provided by Congress and the American people.

Third, we will fight to incorporate principles and processes that preserve readiness and capability while reducing the size of the Army. We are adjusting our formations to build the right number of units with the right capability to meet the needs of the Joint Force. The past 10 years have taught us that an operational reserve force is essential to accomplish our missions and expand rapidly when required. We will invest deliberately and wisely in our Soldiers, Civilians and Families to make sure they are prepared and supported. We will treat those who have served in our ranks with respect and honor. Our wounded Soldiers will receive the very best care the Nation can provide, and our Soldiers who return to civilian life will be well prepared to do so.

Future threats will demand enhanced capabilities for our Soldiers, so we will modernize our equipment. The Army has identified four programs to highlight. The Network gives sight, sound and awareness to our Soldiers, Civilians and leaders to defeat our adversaries. The Ground Combat Vehicle and Joint Light Tactical Vehicle will incorporate hard won lessons in Iraq and Afghanistan to provide the mobility and protection our Soldiers require. Investments in Soldier Systems improve our Soldiers' ability to move, fight and survive on the battlefield.

The Army has chosen its focus areas carefully and deliberately because they will enable us to provide the what Nation needs. We owe it to America and to the American Soldier, the Nation's servant and warrior—the Strength of the Nation!

2012 Reserve Component Addendum to the Army Posture Statement

Sections 517 and 519 of the National Defense Authorization Act (NDAA) 1994 require the information in this addendum. Section 517 requires a report relating to implementation of the pilot Program for Active Component Support of the Reserves under Section 414 of the NDAA 1992 and 1993. Section 519 requires a detailed presentation concerning the Army National Guard (ARNG), including information relating to implementation of the ARNG Combat Readiness Reform Act of 1992 (Title XI of Public Law 102-484, referred to in this addendum as ANGCRRA). Section 704 of the NDAA amended Section 519 reporting. Included is the U.S. Army Reserve information using Section 519 reporting criteria. The data included in the report is information that was available 30 September 2011.

Section 517 (b) (2) (A). The promotion rate for officers considered for promotion from within the promotion zone who are serving as active component advisors to units of the Selected Reserve of the Ready Reserve (in accordance with that program) compared with the promotion rate for other officers considered for promotion from within the promotion zone in the same pay grade and the same competitive category, shown for all officers of the Army.

	AC in RC (%)*	Army Average (%) **
FY 2010		
Major	(57 of 67) 85.1%	92.1%
Lieutenant Colonel	(10 of 12) 83.3%	88.7%
FY 2011		
Major	(73 of 86) 84.9%	93.3 %
Lieutenant Colonel	(6 of 11) 54.5%	86.8 %

*Active component officers serving in reserve component assignments at time of consideration.

**Active component officers not serving in reserve component assignments at the time of consideration.

Section 517 (b) (2) (B). The promotion rate for officers considered for promotion from below the promotion zone who are serving as active component advisors to units of the Selected Reserve of the Ready Reserve (in accordance with that program) compared in the same manner as specified in subparagraph (A) (the paragraph above).

	AC in RC (%) *	Army Average (%) **
FY 2010		
Major	(6 of 123) 4.9%	5.7%
Lieutenant Colonel	(0 of 7) 0.0%	10.7%
FY 2011		
Major	(3 of 57) 5.3%	8.7 %
Lieutenant Colonel	(0 of 10) 0.0%	3.5 %

*Below the zone active component officers serving in reserve component assignments at time of consideration.

**Below-the-zone active component officers not serving in reserve component assignments at time of consideration.

Section 519(b)

1. **The number and percentage of officers with at least two years of active-duty before becoming a member of the Army National Guard or the US Army Reserve Selected Reserve units.**

ARNG officers: 21,425 or 49.2 percent of which 1,429 were FY 11 accessions

Army Reserve officers: 9,888 or 33 percent of which 389 were FY 11 accessions.

2. **The number and percentage of enlisted personnel with at least two years of active-duty before becoming a member of the Army National Guard or the U.S. Army Reserve Selected Reserve units.**

ARNG enlisted: 95,375 or 30 percent of which 7, 243 were FY 11 accessions.

Army Reserve enlisted: 35,796 or 21 percent of which 3,524 were FY 11 accessions.

3. The number of officers who are graduates of one of the service academies and were released from active duty before the completion of their active-duty service obligation and, of those officers:

a. The number who are serving the remaining period of their active-duty service obligation as a member of the Selected Reserve pursuant to section 1112(a)(1) of ANGCRRA:

In FY 11, there was one Service Academy graduate released from active duty before completing their obligation to serve in the Army Reserve.

b. The number for whom waivers were granted by the Secretary of the Army under section 1112(a)(2) of ANGCRRA, together with the reason for each waiver:

In FY 11, under section 1112(a) (2) of ANGCRRA the Secretary of the Amy granted no waivers to the Army National Guard.

In FY 11, under section 1112(a) (2) of ANGCRRA the Secretary of the Army granted one waiver to the Army Reserve. The waiver provided the Soldier an opportunity to play a professional sport and complete service obligation.

4. The number of officers who were commissioned as distinguished Reserve Officers' Training Corps graduates and were released from active duty before the completion of their active-duty service obligation and, of those officers:

a. **The number who are serving the remaining period of their active-duty service obligation as a member of the Selected Reserve pursuant to section 1112(a)(1) of ANGCRRA:**

In FY 11, there were no distinguished Reserve Officers Training Corps (ROTC) graduates serving the remaining period of their active-duty service obligation as a member of the Selected Reserve.

b. **The number for whom waivers were granted by the Secretary of the Army under section 1112(a)(2) of ANGCRRA, together with the reason for each waiver:**

In FY 11, the Secretary of the Army granted no waivers.

5. **The number of officers who are graduates of the Reserve Officers' Training Corps program and who are performing their minimum period of obligated service in accordance with section 1112(b) of ANGCRRA by a combination of (a) two years of active duty, and (b) such additional period of service as is necessary to complete the remainder of such obligation served in the National Guard and, of those officers, the number for whom permission to perform their minimum period of obligated service in accordance with that section was granted during the preceding fiscal year:**

In FY 11, there were no graduates released early from an active-duty obligation.

6. **The number of officers for whom recommendations were made during the preceding fiscal year for a unit vacancy promotion to a grade above First Lieutenant, and of those recommendations, the number and percentage that were concurred in by an active duty officer under section 1113(a) of ANGCRRA, shown separately for each of the three categories of officers set forth in section 1113(b) of ANGCRRA (with Army Reserve data also reported).**

There are no longer active and reserve component associations affiliated with ARNG vacancy promotion due to operational mission requirements and deployment tempo. Active component officers no longer concur or non-concur with unit vacancy promotion recommendations for officers in associated units according to section 1113(a). However, unit vacancy promotion boards have active component representation.

In FY 11, the ARNG recommended 4,286 Officers for a position-vacancy promotion and promoted 2,318.

In FY 11, the Army Reserve recommended 85 officers for a position-vacancy promotion and promoted 85.

7. **The number of waivers during the preceding fiscal year under section 1114(a) of ANGCRRA of any standard prescribed by the Secretary establishing a military education requirement for non-commissioned officers and the reason for each such waiver.**

In FY 11, the ARNG had a total of 44 Soldiers that received a military education waiver. The waivers were granted based on non-completion of the Warrior Leader Course (WLC) due to assignment to a Warrior Transition Unit (WTU) ("medical hold" or "medical hold-over" units); and non-completion of the Advanced Leader Course or Senior Leader Course due to deployment or training schedule constraints.

In FY 11, the Army Reserve had a total of 257 Soldiers who received a military education waiver. Of these, 89 were SGTs in need of a waiver for WLC as a result of being deployed or assigned to WTUs (medical hold or medical hold-over units) because of a medical condition incurred in direct support of Contingency Operations while otherwise eligible for promotion, if recommended. Furthermore, 155 waivers for Advanced Leaders Course (ALC) and 13 waivers for Senior Leader Course (SLC) were granted to Soldiers otherwise eligible for consideration but lacking the prerequisite level of Non Commissioned Officer Education System (NCOES) schooling as a direct result of operational deployment conflicts or inability of the Army to schedule the course.

The Secretary of the Army has delegated the authority for the waivers referred to in section 114(a) of ANGCRRA to the Director, ARNG and to the Commander, U.S Army Reserve Command. The National Guard Bureau and the U.S. Army Reserve Command maintain details for each waiver.

8. **The number and distribution by grade, shown for each State, of personnel in the initial entry training and non-deployability personnel accounting category established under section 1115 of ANGCRRA for members of the Army National Guard who have not completed the minimum training required for deployment or who are otherwise not available for deployment. (Included is a narrative summary of information pertaining to the Army Reserve.)**

In FY 11, the ARNG had 49,454 Soldiers considered non-deployable for reasons outlined in Army Regulation 220-1, Unit Status Reporting (e.g., initial entry training; medical issues; medical non-availability; pending administrative or legal discharge; separation; officer transition; non-participation or restrictions on the use or possession of weapons and ammunition under the Lautenberg Amendment). The National Guard Bureau (NGB) maintains the detailed information.

In FY 11, the Army Reserve had 34,180 Soldiers considered non-deployable for reasons outlined in Army Regulation 220-1, Unit Status Reporting (e.g., initial entry training; medical issues; medical non-availability; pending administrative or legal discharge; separation; officer transition; non-participation or restrictions on the use or possession of weapons and ammunition under the Lautenberg Amendment). The U.S. Army Reserve Command (USARC) maintains the detailed information.

9. **The number of members of the Army National Guard, shown for each State, that were discharged during the previous fiscal year pursuant to section 1115(c)(1) of ANGCRRA for not completing the minimum training required for deployment within 24 months after entering the National Guard. (Army Reserve data also reported.)**

A total of 445 ARNG Soldiers, with at least 24 months time in ARNG, were losses in FY 11 due to lack of minimum required military education. The breakdown is 265 enlisted and 180 officers.

The number of Army Reserve Soldiers discharged during FY11 for not completing the minimum training required for deployment within 24 months after entering the Army Reserve is 24 officers and five enlisted Soldiers. Under AR 135-175, Separation of Officers, separation actions are necessary for officers who have not completed a basic branch course within 36 months after commissioning. Under AR 135-178, Separation of Enlisted Personnel, separation actions are necessary for Soldiers who have not completed the required initial entry training within the first 24 months.

10. The number of waivers, shown for each State, that were granted by the Secretary of the Army during the previous fiscal year under section 1115(c)(2) of ANGCRRA of the requirement in section 1115(c)(1) of ANGCRRA described in paragraph (9), together with the reason for each waiver.

In FY 11, there were no waivers granted Secretary of the Army to the Army National Guard under section 1115(c)(2) of ANGCRRA of the requirement in section 1115(c)(1) of NGCRRA described in paragraph (9).

In FY 11, there were 210 waivers granted by the Chief, Army Reserve. The Army Reserve was delegated the authority to grant waivers for personnel who did not complete the minimum training required for deployment within 24 months after entering the Army Reserve. The reasons for waivers were categorized as Hardship, Medical or Administrative (i.e. Failed Height/Weight Standards, Failed to Obtain Driver License, Accepted ROTC Scholarship, Temporary Disqualified, and Failed to Complete High School).

11. The number of Army National Guard members, shown for each State, (and the number of AR members), who were screened during the preceding fiscal year to determine whether they meet minimum physical profile standards required for deployment and, of those members: (a) the number

and percentage who did not meet minimum physical profile standards for deployment; and (b) the number and percentage who were transferred pursuant to section 1116 of ANGCRRA to the personnel accounting category described in paragraph (8).

a. The number and percentage who did not meet minimum physical profile standards required for deployment:

In FY 11, 256, 696 ARNG Soldiers underwent a Periodic Health Assessment (PHA). There were 14, 305 (3.9 percent of the Soldiers who underwent PHA) personnel identified for review due to a profile-limiting condition or failure to meet retention standards.

In FY 11, 124,785 Army Reserve Soldiers underwent a Periodic Health Assessment (PHA). There were 14,948 (12 percent of the Soldiers who underwent PHA) personnel identified for review due to a profile limiting condition or failure to meet retention standards.

b. The number and percentage that transferred pursuant to section 1116 of ANGCRRA to the personnel accounting category described in paragraph (8).

In FY 11, the ARNG transferred all 14,305 Soldiers to a medically non-deployable status who were identified for a review due to a profile limiting condition or failure to meet retention standards.

In FY 11, the Army Reserve transferred 15,826 Soldiers to a medically non-deployable status who were identified for a review due to a profile limiting condition or failure to meet retention standards.

On 23 August 2010, Department of the Army implemented Medical Readiness Categories (MRC) per AR 40-501 which replaced Fully Medically Ready (FMR) as the metric for measuring Individual Medical Readiness (IMR) in the Army. This new way of measuring medical readiness by classifying Soldiers into MRC reduced the number of Soldiers considered medically not ready in the ARNG in FY 11. Soldiers previously listed as not "Fully Medically Ready" because they didn't have current immunizations, medical warning tags, DNA, and a current HIV test on file are now considered "Medically Ready" and identified as MRC 2 (which is correctable within

72 hours). The data is generated from MEDPROS, the medical readiness database of record for the Army.

12. The number of members and the percentage total membership of the Army National Guard shown for each State who underwent a medical screening during the previous fiscal year as provided in section 1117 of ANGCRRA.

Public Law 104-106 (NDAA 1996), Div A, Title VII, Section 704 (b), February 10, 1996, repealed Section 1117 of ANGCRRA.

13. The number of members and the percentage of the total membership of the Army National Guard shown for each State who underwent a dental screening during the previous fiscal year as provided in section 1117 of ANGCRRA.

Public Law 104-106 (NDAA 1996), Div A, Title VII, Section 704 (b), February 10, 1996, repealed Section 1117 of ANGCRRA.

14. The number of members and the percentage of the total membership of the Army National Guard shown for each State, over the age of 40 who underwent a full physical examination during the previous fiscal year for purposes of section 1117 of ANGCRRA.

Public Law 104-106 (NDAA 1996), Div A, Title VII, Section 704 (b), February 10, 1996, repealed Section 1117 of ANGCRRA.

15. The number of units of the Army National Guard that are scheduled for early deployment in the event of a mobilization, and of those units, the number that are dentally ready for deployment in accordance with section 1118 of ANGCRRA.

Public Law 104-106 (NDAA 1996), Div A, Title VII, Section 704 (b), February 10, 1996, repealed Section 1118 of ANGCRRA.

16. The estimated post-mobilization training time for each Army National Guard combat unit (and Army Reserve unit), and a description, displayed in broad categories and by State of what training would need to be accomplished for Army National Guard combat units (and Army Reserve units) in a post-mobilization period for purposes of section 1119 of ANGCRRA.

The January 19, 2007 Secretary of Defense Memorandum, "Utilization of the Total Force," limited reserve component unit mobilizations to 400-day periods, including 30-days post-mobilization leave, and five days out-processing. The most significant impact of this policy change to the Army National Guard is the inclusion of post-mobilization training time during the 400-day mobilization period.

Timely alert for mobilizations—at least one year prior—is crucial to the Army National Guard's mission success. Under the Army Force Generation (ARFORGEN) model, many training tasks previously conducted during the post-mobilization phase now occur in local training areas before mobilization. First Army, in CONUS, manages and directs post-mobilization training for reserve component conventional forces. First Army, in theater, conducts the theater-specified training required and confirms the readiness of mobilized units waiting to deploy.

Army National Guard training and Army Reserve training complies with the ARFORGEN model of progressive training over multi-year cycles and reflects the Army Training Strategy. Units move through the ARFORGEN cycle in three force pools (reset, train/ready, and available). Training progresses through these force pools with the initial focus on individual and leader training, migrating to low-level unit and battle staff, and finally culminating in multi-echelon, combined-arms exercises in the Ready year.

All ARNG units are "Combat Units." Forces Command Pre-Deployment Training, in support of Combatant Commands' guidance, identifies four categories of deploying units:

- Category (CAT) 1 includes units that would rarely, if ever, travel off a Contingency Operating Base/Forward Operating Base (COB/FOB)

- CAT 2 includes units that will, or potentially will, travel off a COB/FOB for short durations

- CAT 3 includes units that travel and conduct the majority of their missions off a COB/FOB

- CAT 4 consists of maneuver units with an Area of Operations (such as Brigade Combat Teams).

The pre-mobilization tasks increase by category, up to CAT 4. A unit's post-mobilization training time depends on the number of the pre-mobilization tasks completed during pre-mobilization. Army goals for post-mobilization training for reserve component headquarters and combat support/combat service support units range from 15 to 45 days, depending on the type and category of the unit (note: this time does not include administrative and travel days). Any pre-mobilization tasks not completed during the pre-mobilization phase must be completed at a mobilization station. The ARNG typically sends units to a mobilization station with a pre-mobilization task completion rate of 90-95 percent. Smaller ARNG units typically arrive at mobilization station 100 percent complete.

Post-mobilization training conducted by First Army typically consists of:

- theater orientation

- rules of engagement and escalation-of-force training

- counterinsurgency operations

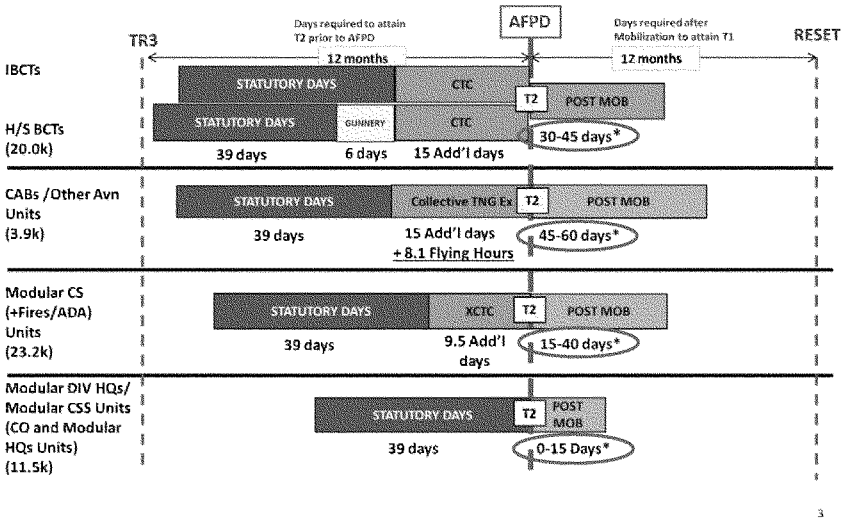
- counter-improvised-explosive-device training

- convoy live-fire exercises

- completion of any theater-specified training not completed during the pre-mobilization period

Post-mobilization training days for a CAT 4 unit range from 50-65 days training at mobilization station. This training supports a Combat Training Center culminating training event during post-mobilization that a CAT 4 unit is required to perform in order to be validated and deployed (National Training Center or Joint Readiness Training Center; 30 day training exercises).

Below is an outline depicting post-mobilization training day goals for various units:



The outline below depicts the actual number of post-mobilization training days for various units:*

	Post Mobilization Training Days		
	Current	Goal	Delta
I/H/S Brigade Combat Team	63	45	18
Combat Aviation Brigade	33	60	-27
Military Police (Internment/Resettlement)	27	40	-13
Engineer Battalion (Route Clearance)	37	40	-3
Military Police Company	30	40	-10
Quartermaster Company	23	15	8
Engineer Company (Construction)	29	40	-11
Transportation Company (Heavy Equip Trans)	37	40	-3

** from First Army-approved Post-Mobilization Training Plans.*

The Army Reserve (AR) Command in conjunction with First Army (1A), Forces Command (FORSCOM) and Headquarters Department of the Army (HQDA) are in the process of transitioning the business rules for pre and post mobilization training for AR formations deploying in support of Overseas Contingency Operations (OCO). This is motivated in order to meet the intent behind FRAGO 4 to HQDA EXORD 150-08 (RC Deployment Expeditionary Force (DEF) Pre and Post-Mobilization Training Strategy), the January 19, 2007 SECDEF Memorandum, "Utilization of the Total Force" and the August 04, 2011 Secretary of the Army Memorandum, "Army Deployment Period Policy."

Both the current and projected models are listed below, but both exclude all individual skills training, to include PME, MOSQ and functional training. The bulk of Individual skills training will remain a pre-mobilization requirement and would consist of 24 days of Inactive Duty Training, 15-29 days of Annual TrainingT for Collective Training, and, under the current model, 21 additional days of Active Duty Training individual training (Army Warrior Tasks (AWTs), Theater Specific Required Training (TSRT)). Under the

projected model, the 21 additional days would be eliminated. Some formations, under the current model, used up to 74 days pre-mobilization to obtain a T2 rating prior to mobilization and up to 60 days post-mobilization to achieve a T1 rating. Below is an average of current pre and post-mobilization training models which will expire September 30, 2012. To reduce the demand on soldiers in a pre-mobilization status, First Army will assume the training responsibility for many of the AWTs and TSRT on October 1, 2012. AR units will mobilize at no less than a T3 rating. The shift in training strategy is for DEF units only and will increase current post-mobilization days by a projected ten days.

Current Model

Category (CAT)*	AVG Pre-MOB	AVG Post-MOB TNG	AVG Total Post-MOB
1	65 days	17 days	30 days
2	60 days	22 days	34 days
3	56 days	33 days	46 days

Projected Model

Category (CAT)*	Average Pre-MOB	AVG Post-MOB TNG	AVG Total Post-MOB**
1	39-45	27 days	40 days
2	39-45	32 days	44 days
3	39-45	43 days	56 days

*No CAT 4 formations in the AR
**Some formations may require up to 70 days post-MOB to achieve T1 and satisfy COCOM requirements.

17. A description of the measures taken during the preceding fiscal year to comply with the requirement in section 1120 of ANGCRRA to expand the use of simulations, simulators, and advanced training devices and technologies for members and units of the Army National Guard (and the Army Reserve).

During FY 11, the ARNG continued to synchronize the use of existing and ongoing live, virtual, and constructive training aids, devices, simulations and simulators (TADSS) programs with the training requirements of the ARFORGEN training model. By

synchronizing the use of TADSS with ARFORGEN, the ARNG continues to improve unit training proficiency prior to mobilization.

To support the training requirements of M1A1 Abrams and M2A2 Bradley equipped Brigade Combat Teams (BCT's) the ARNG is continuing to field and train using the Conduct of Fire Trainer- Situation Awareness (COFT-SA) and the Mobile-Conduct of Fire Trainer Situation Awareness (M-COFT-SA). Due to the geographical dispersion of units, the ARNG has developed the M-COFT-SA trainer as a mobile solution to fulfill training gaps. The ARNG continued fielding Tabletop Full-Fidelity Trainers and is fielding the Bradley Advanced Training System (BATS) for the M2A2 units. When fully fielded, these devices, in addition to the Conduct of Fire Trainer Advanced Gunnery Trainer System (CAGTS) will be the primary simulation trainers to meet the virtual gunnery requirements of M1A1 and M2A2/A3 crews.

In order to train all ARNG units on the tactics, techniques, and procedures (TTPs) of convoy operations and meet unstabilized gunnery requirements, the ARNG has fielded the Virtual Convoy Operations Trainer (VCOT). The VCOT, through the use of software databases, provides commanders with a unique and critical mission rehearsal tool. In addition, the ARNG has added an Individual Gunnery Trainer (IGT) to train individual and crew drills for .50 caliber and MK19 unstabilized gunnery tasks listed in the HBCT gunnery manual. Currently, all 54 States and Territories have received the VCOT capability. The IGT is an initiative that is currently being fielded; to date 140 IGT systems have been fielded to ARNG units.

The ARNG is currently fielding the Operation Driver Simulator that trains transportation tasks in a family of vehicles, at both the unit and institutional levels.

The ARNG has just completed the Army Training Support Command directed upgrades to the Call For Fire Trainer II (CFFT II). The CFFT II trains Artillery Soldiers and observers of indirect fires on critical skills prior to live fire requirements.

To meet basic and advanced rifle marksmanship requirements, the ARNG is continuing to field the Engagement Skills Trainer (EST 2000). This system is the Army's approved marksmanship training device. The ARNG is also continuing the use of its previously

procured Fire Arms Training System (FATS) until EST 2000 fielding is completed. The EST 2000 and FATS also provides static unit collective gunnery and tactical training, and shoot/don't shoot training. The Army is currently rewriting the strategy for the EST 2000 to include the ARNG initiative of the mobile EST to accommodate the geographical troop dispersion of the ARNG. These systems also support units conducting vital homeland defense missions.

The ARNG supplements its marksmanship-training strategy with the Laser Marksmanship Training System (LMTS). The use of LMTS helps to develop and maintain basic marksmanship skills, diagnose and correct problems, and assess basic and advanced skills. The ARNG has over 900 systems fielded down to the company level. The LMTS is a laser-based training device that replicates the firing of the Soldier's weapon without live ammunition.

The Improvised Explosive Device Effects Simulator (IEDES) supports the training requirements for the detection, reaction, classification, prevention, and reporting of Improvised Explosive Devices. The IEDES kits consist of pyrotechnic and/or non-pyrotechnic training devices to achieve scalable signature effects. The ARNG is currently fielded 258 total IEDES kits, of which, 194 are non-pyrotechnic kits (A-kits) and 64 are pyrotechnic kits (B-kits). This distribution includes 53 ARNG training sites across 39 states and territories. They have received fielding, New Equipment Training (NET) and life cycle sustainment as of 3rd Quarter FY12. ARNG-TRS is continuing the effort to identify and fill requirements based on the recently completed (1st Quarter, 2012) Training Aids, Devices, Simulations, and Simulators (TADSS) Mission Essential Requirements (MER) review. The latest IEDES innovation is the fielding of the IEDES Transit Cases to support less than company size training scenarios.

The ARNG continues to develop its battle command training capability through the Mission Command Training Support Program (MCTSP). This program provides live, virtual, constructive, and gaming (LVC&G) training support at unit home stations via mobile training teams. Units can also train at Mission Training Complexes (MTC). The MCTSP consists of three MTCs at Camp Dodge, Iowa; Fort Indiantown Gap, Pennsylvania; and Fort Leavenworth, Kansas, and a regional Distributed Mission Support Team (DMST). The Army Campaign Plan 2011 requires the ARNG to train 172 units (Brigade equivalents and above). The MCTSP synchronizes ARNG mission command training capabilities to help units plan, prepare, and execute battle staff

training. The objective is to develop proficient battle command staffs and trained operators during pre- mobilization training.

In order to provide the critical culminating training event for the U.S. Army Forces Command (FORSCOM) ARFORGEN Cycle, the ARNG has implemented the Exportable Combat Training Capability (XCTC) Program. The ARNG XCTC program provides Battalion Battle Staff training to the level organized, coupled with a theater immersed, mission focused training event to certify company level proficiency prior to entering the ARFORGEN Available Force Pool defined as Certified Company Proficiency with demonstrated Battalion Battle Staff proficiency, competent leaders, and trained Soldiers prepared for success on the battlefield.

The Army Reserve continues to develop its ability to integrate live, virtual, constructive and gaming training aids, devices, simulations and simulators (TADSS) programs with the Army Reserve Training Strategy in order to meet established aim points in our ARFORGEN training model. TADSS play an essential role in our collective training exercises on our installations which help support our transition from a strategic to an operational Army Reserve and meet our ARGORGEN aim point of providing units at T2 readiness in the Available year. Just as critical, TADSS also support our individual Soldier training at home station, local training areas, and institutions. By synchronizing the use of TADSS with ARFORGEN, the Army Reserve continues to improve unit training proficiency and ensures we meet our requirement to provide the combatant commanders with trained units and proficient battle staffs.

The Warrior and Combat Support Training Exercises are the Army Reserve's major collective training exercises conducted on Army Reserve installations. These exercises integrate live and constructive environments to train senior battle staffs while lower echelon units conduct company and platoon lanes. The Army Reserve has made sizable investments in improving the facility infrastructure at Fort Hunter Liggett and Fort McCoy to support the use of TADSS in these and future exercises. The 75th Mission Command Training Division is utilizing the Entity-level Resolution Federation to provide a high resolution (e.g., individual Soldier-level fidelity aggregated to unit resolutions) joint constructive battle staff training simulation.

The Army Reserve also utilizes TADSS to assist individual Soldiers in maintaining their technical and tactical proficiency. These TADSS assist Soldiers in training on individual pieces of equipment and in sharpening their battlefield skills.

Low-density simulators continue to be employed to reduce expensive "live" time for unique combat service support equipment. For example, Army Reserve watercraft units train on the Maritime Integrated Training System (MITS), a bridge simulator that not only trains vessel captains but the entire crew of Army watercraft. Other simulators include locomotive simulators used by Army Reserve railroad units and a barge derrick simulator for transportation terminal units.

Use of the Laser Marksmanship Training System (LMTS) and Engagement Skills Trainer 2000 (EST 2000) remain essential elements of the Army Reserve marksmanship training strategy. During FY 11, the Army Reserve fielded more than 529 LMTS to 396 Army Reserve facilities to support home station basic marksmanship training for individual and crew served weapons. The system allows the Soldier to use their assigned weapon, as well as crew served weapons, in a simulation/training mode. In FY 11, the Army Reserve also fielded the EST 2000 to 21 Army Reserve facilities. The EST 2000 provides initial and sustainment marksmanship training, static unit collective gunnery and tactical training, and shoot/don't shoot training.

18. Summary tables of unit readiness, shown for each State, (and for the Army Reserve), and drawn from the unit readiness rating system as required by section 1121 of ANGCRRA, including the personnel readiness rating information and the equipment readiness assessment information required by that section, together with:

a. Explanations of the information:

Readiness tables are classified and can be provided upon request. The Department of the Army, G-3, maintains this information. The states do not capture this data. The information is maintained in the Defense Readiness Reporting System – Army.

b. Based on the information shown in the tables, the Secretary's overall assessment of the deployability of units of the ARNG (and Army Reserve), including a discussion of personnel deficiencies and equipment shortfalls in accordance with section 1121:

Summary tables and overall assessments are classified and can be provided upon request. The Department of the Army, G-3, maintains this information. The information is maintained in the Defense Readiness Reporting System – Army.

19. Summary tables, shown for each State (and Army Reserve), of the results of inspections of units of the Army National Guard (and Army Reserve) by inspectors general or other commissioned officers of the Regular Army under the provisions of Section 105 of Title 32, together with explanations of the information shown in the tables, and including display of:

a. The number of such inspections;

b. Identification of the entity conducting each inspection;

c. The number of units inspected; and

d. The overall results of such inspections, including the inspector's determination for each inspected unit of whether the unit met deployability standards and, for those units not meeting deployability standards, the reasons for such failure and the status of corrective actions.

During FY 11, Inspectors General and other commissioned officers of the Regular Army conducted 1,219 inspections of the Army National Guard. Regular Army Officers assigned to the respective States and Territories as Inspectors General executed the bulk of these inspections (959). Of the remaining 126 inspections, the U.S. Army Forces Command (FORSCOM), Communications-Electronics Command (CECOM),

and other external inspection agencies conducted 104. Because the inspections conducted by Inspectors General focused on findings and recommendations, the units involved in these inspections were not provided with a pass/fail rating. Results of these inspections may be requested for release through the Inspector General of the Army.

The Army Reserve Office of the Inspector General conducted two assessments within the last 12 months. The first was entitled Property Accountability within the Army Reserve (Directed by the Chief, Army Reserve (CAR)) on 25 January 2011 and final report approved on 11 August 2011). The second assessment entitled Special Assessment of Personnel Transition within the Army Reserve was directed by the CAR on 11 August 2011 and is ongoing (expected final report approval in March 2012). The Army Reserve Office of the Inspector General conducted both assessments. The Army Reserve Inspection General assessed 30 units for Property Accountability. As of 13 December 2011, 33 units have been assessed as part of the Personnel Transitions Assessment. The overall goal of both assessments was not to evaluate the unit's deployability status. However, out of the total 66 units assessed nothing was found that would cause a unit to be listed as non-deployable. Results of these inspections may be requested for release through the Inspector General of the Army.

20. A listing, for each ARNG combat unit (and US Army Reserve FSP units) of the active-duty combat units (and other units) associated with that ARNG (and US Army Reserve) unit in accordance with section 1131(a) of ANGCRRA, shown by State, for each such ARNG unit (and for the US Army Reserve) by: (A) the assessment of the commander of that associated active-duty unit of the manpower, equipment, and training resource requirements of that National Guard (and Army Reserve) unit in accordance with section 1131(b)(3) of the ANGCRRA; and (B) the results of the validation by the commander of that associated active-duty unit of the compatibility of that National Guard (or US Army Reserve) unit with active duty forces in accordance with section 1131(b)(4) of ANGCRRA.

While the methods employed by the Army to manage the active component (AC) support to reserve component (RC) readiness have changed during the last ten years of persistent conflict, we have met the intent of the Congress as outlined in Title XI of the National Defense Authorization Act of 1993, as amended. Every RC unit that deployed during FY 11 was properly manned, equipped, trained, and certified to meet Combatant Commander (CCDR) requirements prior to employment overseas and in the Continental

United States (CONUS) by supporting processes associated with the Army Force Generation (ARFORGEN) process.

The Army began its transformation from large, fixed organizations (divisions and corps) to a modular, brigade-centric organization in 2004. At the same time, and while engaged in persistent conflict, it began transforming the way it executes the training and readiness of modular units – both AC and RC – to meet CCDR requirements. As such, modular force transformation and the implementation of the ARFORGEN process precludes a response in the format directed by Title 10, U.S. Code, Section 10542.

The formal training relationships previously established by the AC/RC Association Program outlined in U.S. Army Forces Command (FORSCOM) Regulation 350-4, *Active Component (AC)/Reserve Component (RC) Partnerships*, were modified as the requirements of ongoing Overseas Contingency Operations kept AC units in frequent deployments and RC units in frequent mobilization. The deployment tempo problem was solved within the Army's Training Support XXI program by using designated, fully functional, AC-led multi-component organizations to provide the necessary contact with mobilizing RC units. Since FORSCOM Regulation 350-4 no longer reflected the way the AC partnered with RC units, FORSCOM discontinued its use on 21 July 2010. The legislated roles and responsibilities formerly given to the commanders of associated AC units listed in Appendices B and C of that regulation are now executed by the commanders of First Army (FORSCOM's executive agent for Active Army support for the training, readiness, and mobilization of conventional RC units in the Continental United States); the 196th Infantry Brigade (U.S. Army Pacific's executive agent for the training and readiness of conventional RC units located in the Pacific Command's area of responsibility); and the U.S. Army Europe (USAREUR) for the training and readiness of conventional RC units located in the European Command's area of responsibility.

In 2011, the Army published Army Regulation (AR) 525-29, *Army Force Generation*, which institutes the structured progression of unit readiness over time to produce trained, ready, and cohesive units prepared for operational deployment in support of CCDR and other Army requirements. This regulation was a collaborative effort between FORSCOM, U.S. Army Training and Doctrine Command, the Army National Guard, and the U.S. Army Reserve Command to meet the progressive readiness demands of an Army engaged in persistent conflict. Within ARFORGEN, all rotational active Army, Army National Guard, and Army Reserve units cycle through three ARFORGEN force pools – Reset, Train/Ready, and Available – and are designated either for deployment

to a validated CCDR operational requirement as a Deployment Expeditionary Force (DEF) or for the execution of a contingency mission, operational plan, or other validated Army requirement as a Contingency Expeditionary Force (CEF).

For the RC, this pertains to all modular division headquarters, brigade combat teams, multifunctional and functional support brigades (headquarters only), as well as modular units at the battalion to detachment level that comprise the critical enablers for operational missions. Assessments of the manpower, equipment, and training resource requirements of these RC units and validation of their compatibility with AC forces (as required by sections 1131(b)(3) and 1131(b)(4) of the Army National Guard Combat Readiness Reform Act of 1992) are executed and maintained by First Army, the 196th Infantry Brigade, and USAREUR as the RC unit progresses through the ARFORGEN process into the deployment window.

Fiscal Year 2011 also found the Army at an inflection point in which strategic conditions have signaled a future change in demand across the range of military operations (DEF to CEF). The RC will figure prominently in the Army's response to these changes. ARFORGEN is the process that will produce trained and ready RC units that are organized, manned, trained, and equipped, as integral members of the Total Force, compatible with their AC counterparts, to provide predictable, recurring and sustainable capabilities for the Nation's security requirements. The Army does not foresee a return to the legacy construct of associated units.

21. A specification of the active-duty personnel assigned to units of the

Selected Reserve pursuant to section 414(c) of the National Defense Authorization Act for Fiscal Years 1992 and 1993 (10 USC. 261 note), shown (a) by State for the Army National Guard (and for the US Army Reserve), (b) by rank of officers, warrant officers, and enlisted members assigned, and (c) by unit or other organizational entity of assignment.

Title XI (FY 11) Authorizations				
	OFF	ENL	WO	TOTAL
U.S. Army Reserve	97	110	8	215
TRADOC	50	3	0	53
FORSCOM	1033	2165	101	3299
USARPAC	30	49	1	80
TOTAL	1210	2327	110	3647

Title XI (FY 11) Assigned				
	OFF	ENL	WO	TOTAL
U.S. Army Reserve	12	18	0	30
TRADOC	36	3	0	39
FORSCOM	696	1925	102	2723
USARPAC	30	41	9	80
TOTAL	774	1987	111	2872

As of September 30, 2011, the Army had 2,872 active component Soldiers assigned to Title XI positions. In FY06, the Army began reducing authorizations in accordance with the National Defense Authorization Act 2005 (Public Laws 108-767, Section 515). Army G-1 and U.S. Army Human Resources Command carefully manages the authorizations and fill of Title XI positions. The data is not managed or captured by state – the chart above provides the best representation of how Title XI positions are dispersed and utilized.

Mr. YOUNG. Well, General, thank you very much. And Mr. Secretary, thank you very much.

I was not going to start with sequestration, but I have to tell you that all of the members that I know in this House of Representatives and many in the Senate are looking long and hard to find a solution to avoid sequestration. We understand sequestration would be a disaster for our national defense, for our military, and in fact for those who serve in the military. So believe me, we share that concern, and we are working ways to try to make sure that sequestration just does not happen. We cannot let it happen.

END STRENGTH REDUCTION

Now, let me ask about the end strength, because you mentioned great obligations that the United States Army has. You also mentioned that in the Pacific area you will be dealing with seven other armies. I believe you said it was seven. But we know, this Committee knows, that while our Army is by far the best Army of any of those we are not the biggest. We do not have the manpower that a lot of these other armies have. And then we are going to be reducing, and if I did the math properly, we are going to be reducing end strength by about 80,000, is that correct?

General ODIERNO. That is correct.

Mr. YOUNG. Over what time frame? What will be the time frame before you reach that 80,000 drawdown?

General ODIERNO. Mr. Chairman, the end of fiscal year 2017 is when we will meet that requirement. So it has begun in fiscal year 2012, so it is over a 6-year period from 2012 through 2017 that will impact that. And that is important because that ramp allows us to make sure we are taking care of our soldiers and families, it allows us to ensure we continue to meet our commitments in Afghanistan and other deployable places, and it also provides a hedge for a few years against uncertainty that can allow us to reverse if necessary.

Mr. MCHUGH. If I may, Mr. Chairman, there were some realities afoot. As you noted, armies are people. About 48 cents of every dollar currently we spend is on personnel cost. So to take the mandated reductions under the Budget Control Act, but also to look at the realities coming out of two theaters of war as planned by the end of 2014, we felt that that end strength reduction was first prudent, but also required so that we remained, as you noted, Mr. Chairman, balanced, that we did not hollow out. We spent a great deal of time ensuring through the process of constructing this budget that we had the sufficient resources behind that end strength to do the right things by them in family programs, modernization, all kinds of readiness, training availabilities, et cetera, et cetera. So when you look at this as a whole piece I think it represents a very prudent reaction to the realities of today, the likelihoods of tomorrow, and as I have said, the Budget Control Act that was passed by this Congress.

FEDERAL CIVILIAN EMPLOYEES

Mr. YOUNG. Mr. Secretary, we understand the difficulties in reaching the goals set by the President.

General, you mentioned when you talked about the size of the Army, I think you said 178,000 civilians also work for the Army. Was that the right number?

General ODIERNO. 278,000.

Mr. YOUNG. Will there be a reduction in that civilian force as well?

General ODIERNO. I think that we will see reductions in the civilian force. We are required to take some throughout this period. There will also be required reductions in the end force.

Mr. MCHUGH. That kind of falls over my side of the ledger. We had R&D by the Secretary that required us to reduce the end strength of civilian by 8,700. We are in the process of doing that. That will be completed by the end of this year. And thereafter we are right now trying to right size this civilian workforce. We are very mindful that all of the cuts cannot come just on the military side. We will in fact be announcing some steps forward in the very near future as to exactly how and where those civilian cuts will come. Some of your staff have already been briefed on the preliminary aspects of those drawdowns. But in short, civilian end strength will be coming down as well.

General ODIERNO. We grew about 30,000 civilians over the last 8 or 9 years as we increased the size of the Army during the mid-2000s. And in addition, because of some of the requirements, because of us being engaged in two theaters, we were using operational funds, hired overhires in order to provide support to deployed families and other things. So all of those things will be relooked as we come out of Iraq, as we begin to come out of Afghanistan, and those will all be things that we have to look at over the next several years as we right size the Army.

CONTRACT CIVILIAN EMPLOYEES

Mr. YOUNG. As you downsize, will it be necessary for you to hire contractors to fill in the void or will you just accept the void?

Mr. MCHUGH. We will always have a requirement for contractors. They provide specialized skills that it is just not cost beneficial for any military service to keep those internally. However, having said that, we are involved in just the opposite initiative at the moment, and that is trying to shed ourselves of the buildup of contractors that has happened principally because of the two theaters of war and begin to internalize those where they are absolutely essential and use military personnel wherever practicable.

Mr. YOUNG. I have a lot of other questions but we have a very good attendance today and so hopefully I will get a second chance to visit with you. But at this point I would like to yield to Mr. Dicks.

STRYKER RESET AND UPGRADE

Mr. DICKS. Thank you, Mr. Chairman. The Stryker program was initiated in 1999. The Stryker family of vehicles has 10 variants ranging from infantry carrier to reconnaissance vehicle to medical evacuation. The Stryker family was intended to serve as a bridge to the future fielding of the Future Combat System. FCS, as we know, was canceled in 2009, but the Stryker vehicles have performed well.

Now, let me ask you this. We are going have to go through reset on a number of these things. And what I am trying to figure out is, and we have had some discussion, General, about this, if there is a lack of mobility off the road why would not we consider increasing, putting a bigger engine in the Strykers, and at the same time going to the double V hull, which as I understand it has been very successful, and try to reset as many of those in that way in order to meet the requirement?

General ODIERNO. Congressman——

Mr. DICKS. Tell us what you think about the Stryker.

General ODIERNO. First, the Stryker has performed incredibly well both in Iraq and Afghanistan, and we are very proud of the legacy of the Stryker and the Stryker brigades and what they have been able to accomplish. What we have to do is one of the things we are doing with this downsizing, is we are reassessing the force mix. And a part of this force mix is how much light, medium, heavy airborne will we continue to have in the force. And once we make those decisions we will have to go back and relook at what systems do we want to have in these elements. I will tell you that right now the Stryker brigades are really not under consideration because they are found to be a very flexible capability that we want to sustain, at least into the future. Right now we are planning on purchasing two brigades with a double V hull Strykers. And I think in the future as we develop this force mix we will then make a decision do we have to purchase more of those or not. But before we make any decisions like that we have to ensure that we understand what our final force mix will be. And I suspect we will come to that answer in the next year or so as we continue to do our evaluations of what the final force will look like.

I would also add——

Mr. DICKS. Are you talking there about reset? I mean, about taking some of these that we are going to bring back and resetting them? I mean, I was intrigued by the idea of going to a slightly bigger engine. I think, what is it, 350 horsepower. You could go to 450 and maybe this would solve this off road issue that you raise.

General ODIERNO. What we are going to do is as we go through the Ground Combat Vehicle, which is an infantry fighting vehicle, as we go through that process, when we get to Milestone B one of things we are going to look at is alternatives, and one of the alternatives is the Stryker. And one would be improvements to the Stryker and would that be a better way to go once we see what the two competitors come up with in the Ground Combat Vehicle. So I think that is when we will take a look at that and decide is that a better way to go or not.

M1 TANK PRODUCTION

Mr. DICKS. You know, last year our committee felt very strongly on an almost unanimous basis that we ought to keep the tank line open, and so we added I think $255 million or whatever in order to do that.

Can you tell us kind of how the Army sees this now? And I understand that there is a possibility of foreign military sales that could help us keep the tank line open.

Mr. MCHUGH. Let me just start and then the Chief can, I am sure, fill in the substantial blanks I leave. I just approved the execution of the $225 million that you spoke about, Mr. Dicks. That will procedure between 42 and 44 tanks. In order to sustain the Abrams line at Lima you have to produce at least 70 tanks a year. So the money that we provided, while substantial, will not fill the production gaps. And in fact we would have to spend about $600 million to $800 million to close and later reopen the line versus nearly $3 billion to close it, and the cost analysis is that the closure costs far outweigh keeping an open, nearly $3 billion to keep it open.

The other thing I would tell you, the reality is——

Mr. DICKS. Mr. Secretary, does that include an analysis of industrial base? It just seems to me if you are going to reopen this thing in a couple of years the idea of shutting it down when we only have one tank for the country I think is something that is hard to accept up here.

Mr. MCHUGH. Well, you raise a good point. And we are very concerned about those high end jobs that are attendant not just at the Abrams line, but virtually any of our production lines. And we do have, as you noted, a strategy that is working its way that we think in concert with GDLS, General Dynamics Land Systems, we can fill in substantial gaps in that production gap to frankly hold the very high end, high technical jobs that are so critical and make reopening or a clean shutdown and a reopening so very, very difficult. So we are trying to fill those.

The other thing I would tell you is that the Department of Defense is conducting what they call a S2T2, a sector-by-sector, tier-by-tier analysis that the Army is participating in, to try to develop further strategies to protect this industrial base through these drawdown times. We simply do not feel, going back to the Abrams line, that this is one—we do know it is one of the most modernized platforms in our Army. The average Abrams tank is about 2½ years old. So we are trying to find the right way forward, we are sensitive to the industrial base, we think we have some means by which we can sustain those high end jobs but these are going to be tough challenges.

Chief.

TANK FLEET READINESS

General ODIERNO. And Congressman, the conundrum we have is that we do not need tanks. Our tank fleet is 2½ years old average now. It has been recapped, it has been reset, we are in good shape. And these are additional tanks that we do not need. So that is the other problem we have in keeping this line open. When we are done in 2014 we now have all the tanks we need, and we did not think we would have to start to reset or recapitalizing again until after 2017. So it is about a 3-year gap that we have. And in order to sustain it you got to purchase 70 tanks a year. That would be another 280 tanks that we simply do not need. And so that is part of the problem here as we assess this. So what we have done is we have—we believe there is, as I mentioned to you yesterday, there are several countries who are looking that they believe they have to do some work on their tank fleet. Saudi Arabia, Egypt and there

is a few others. And we think that this could be a solution to us keeping the line open if we are successful. But again, it is not a done deal yet, and so there is still a lot of work that we have to do in the foreign military sales area.

Mr. DICKS. What about the Guard and Reserve, do they have all the tanks they need?

General ODIERNO. Yes.

Mr. DICKS. Thank you, Mr. Chairman.

General ODIERNO. And the other piece, finally, is part of this force mix we also might, as we go through this force structure review, we actually might reduce the requirement for heavy capability. And that is the other thing we have to make sure we take into account as well.

Mr. DICKS. Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Dicks.

Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman. Secretary McHugh, General Odierno, a pleasure to be with you. Thank you very much for your service. I cannot help but reflect upon the chairman's mentioning that I had the privilege of chairing this Committee for a while. Emblazoned in my mind is a picture of a session I went to a couple of weeks after becoming chairman when they were swearing in a new Chief to the Army. I never had been exposed to this person before, but amazingly to me here was a guy who when he first became eligible for the Army was a foreign alien, born in Hawaii, World War II. And here some years later is this fellow Eric Shinseki being sworn in as the Chief of the U.S. Army, and amazing to me and amazing statement about this country.

SEXUAL HARASSMENT

I am a little uncomfortable beginning my questioning along these lines, but it is an important set of questions. Men and women who make up the U.S. Army, we do face a serious challenge oft time on the front line with a thing called sexual harassment within the force.

Could you please discuss for the committee those programs and policies in place that are designed to deal with this challenge and give us an idea of where you see us going regarding this challenge?

Mr. MCHUGH. Thank you very much, Mr. Lewis. That is a critically important issue, not just for the Army but for all of the services. And certainly from our perspective one of the most disturbing things about it other than the personal tragedy that it creates is that there are few things that are more contrary to the Army values. And it sadly tragically is not just on the front lines, it is through everywhere that we have men and women serving together, which is throughout all aspects of our United States Army.

What we have done is to try to take the most holistic approach we possibly can. And in fact we have supported what is called the SHAR program, sexual harassment and assaults response program, where we have literally increased the funding over the last 5 years by 500 percent to ensure that we bring on line better training programs so that today virtually every training level has it, not just as an hour or two, but something that is imbued through every aspect of our training modules. We have tried to enrich the per-

sonnel, to put out mobile training teams so that they can go out through all our camps, posts and stations training CID officers in the unique aspects of both investigating and forensically mining a crime scene. We have hired special prosecutors who are particularly adept at these kinds of cases to ensure that we are bringing the perpetrators to trial. We have hired new lab analysts to ensure that the forensic material that is collected is handled appropriately and that we are not falling behind the curve.

So from literally the first day that someone comes into the Army to the last day we are either providing the resources necessary or the training that is absolutely required. At the end of the day it is a commander's program. We have to rely upon leadership. And I will defer to the Chief to speak about that, but if we do not have our Army command and our NCO officers every day instilling this in our young soldiers, then I do not think we have really reached the place we need to be.

We see signs of it being better. The Army reporting rate for these incidents is about 33 percent, in the civilian sector is about 19 percent. We want crime victims to report. We want them to be assured that the Army will do right by them, that they will not be victimized again. So those increasing report rates I think are encouraging, and our conviction rates are going up as well. But as long as there is one case of this that still exists in our ranks that is one case too many, and we are working it each and every day.

General ODIERNO. Congressman, I would just say what I talk about all the time is that sexual harassment and sexual assault is inconsistent with our Army values. It is inconsistent with what we want our Army to be. We want to foster a climate of trust and respect. It is essential for us to have that. As we ask our soldiers to go into combat and do very many difficult missions, it is absolutely inherent that we have trust and respect for each other. And if we have sexual harassment and sexual assault going on within our force, we do not have that trust and respect of protecting each other to making sure we are taking care of each other no matter who you are.

And so there is a two-prong strategy, and actually the Secretary covered most of it. But one is institutional. And we have now embedded this from the time you come into basic training to the basic course in our military academies and ROTC programs all the way through our institutional training program to when you go through being a general officer. We have also now embedded it into all our command programs. We have programs that train battalion and brigade and company commanders. This is an integral part of this. And then we have our operational strategy, which the Secretary talked about, where we now go into operational units and continue to train them in there. It is about changing our culture. It is about changing the culture, and I call it the bystander culture, where you will not tolerate if you see something happen; you will not allow this to happen to a fellow soldier. And that is what our strategy is based on.

And we will continue to work this. As the Secretary said, we have increased our funding in this program. For me it is fundamental that we correct this problem. And I want you to know that we are totally dedicated and all in on this to ensure that we con-

tinue, because we still have problems and we will continue to go after this, Congressman.

NATIONAL TRAINING CENTER

Mr. LEWIS. Thank you very much for that, General and Secretary. General Odierno, we have a, you may or may not be aware of it, but the National Training Center for the Army, NTC, happens to be in San Bernardino County, which is in my district. No more fabulous training place in the world for the kinds of challenges we present to our soldiers. And what they do out there, the equipment we might place there, the testing of better, faster, stronger couldn't be done better than I see. I wish our entire Committee could go out and spend some time at the NTC to view the training aspects of this tremendous Army.

NATIONAL TRAINING CENTER EXPANSION

One piece of this that concerns me that I have not been able to successfully get a response to is the fact that beyond the NTC in this territory is also the 29 Palms training of the Marine Corps. There is space between these two great forces, and very, very important to our long-term success. There are some who are suggesting that it might be okay to let much of the remaining open space between the 29 Palms facility and the NTC to be taken up as an addition to our kind of park frontier. I am very, very concerned about what that might do to our future training capabilities by force, both in the air, but also on the ground.

Could you respond to that?

General ODIERNO. Well, first I will tell you I have spent many, many rotations, months, days out at the National Training Center, so I know it quite well. And it is in my opinion probably the finest combined arms training center in the world today. And as we have continued to increase its capabilities I think there is no other place where we can replicate the future environment as well. And I am very excited that this year we will conduct several rotations that really take us into the future and the threat that we might be challenged to see and we will start training our units to this threat as they return from Iraq and Afghanistan.

As I am sure you are aware, Congressman, the Marine Corps and the Army has in some cases different training requirements that we have to go through. And they do some at 29 Palms, we do ours at the National Training Center and the Joint Readiness Training Center. But as we become more joint it is important that we are able to bring some of these things together.

I will specifically look at the question you have asked. I do not have an answer for you on the area between 29 Palms and the National Training Center, but I will certainly look into that. And I just want you to know though that there is nothing more important to us, especially now that we are moving in reestablishing some of our basic capabilities that we have to reinstill in the Army and the importance of these training centers.

Mr. YOUNG. Mr. Lewis, thank you very much. And you have noticed the presence of our Full Committee chairman.

Mr. LEWIS. I noted his arrival. And I certainly want to defer to our chairman. But if I could just say in closing regarding that, the

NTC and the 29 Palms facility is so critical to our future, our ability to cross train. We have enough space out there to put four eastern States. We do not have to put the whole world into a big park. But indeed the future of our ability to extend our force, to exercise our force lies right there. And I would hope you give it very high priority, Mr. Secretary, as well as the General.

Mr. MCHUGH. I promise you we will take a look at that. And having been to NTC any number of times and been awed at places like Medina Wasl out there. It is an incredible resource and we cannot afford to lose it, I would fully agree. So we will get back to you on that.

Mr. YOUNG. I would like to yield now to Chairman Rogers.

PRESCRIPTION DRUG ABUSE

Mr. ROGERS. Thank you, Mr. Chairman, for yielding the time.

Welcome, Mr. Secretary. Back to your old stomping grounds here on the Hill. And General, welcome as well.

Last year, I discussed with you a problem that is a national problem but which also impacts our military, and that is prescription drug abuse. We had a good conversation about it last year, and I was happy to learn of efforts that you have undertaken and, over the last year, have enhanced. I don't need to repeat to you the problem that we have. In my home State, Kentucky, on the diversion of prescription drug medicine, we have more people dying of overdoses from prescription drug medicine than who die in car wrecks. The medicine cabinet is a bigger weapon than a car, and it is infecting the military as well. You are not immune from the problem.

According to a recent Army Times article, 21 percent of soldiers involved in illegal drug use in fiscal 2011 were abusing prescription drugs. In addition, between 2009 and 2011, 142 of the 197 drug-related undetermined or accidental deaths involved prescription drugs. Because of the mobility of soldiers and the different locales that they serve in during their tenure, it is difficult to keep tabs on what medicines have been prescribed along their path. I understand the complicated importance of that.

However, in 2009, the Army created a pain management task force to give us a standardized DOD vision and approach to pain management to optimize the care for warriors and their families, and I want to commend you for that and for the work that you have been doing. In February, you announced plans to expand drug testing to include hydrocodone and benzodiazepines, whatever that is. Varying press reports have told us about different drugs that are already being tested by the Army.

PRESCRIPTION DRUG TESTING

Are you testing for codeine, morphine, oxycodone, especially OxyContin?

Mr. MCHUGH. My understanding is, we have tested for oxycodone since 2009. We have expanded, as you noted, our testing particularly for the marker and indices in such drugs as Valium, Xanax, those kinds of prescription drugs that sadly are becoming widely used as recreational drugs. I think for the moment, our testing regimen and our protocols are such that we are covering many

of the drugs that are a problem. There are other drugs that we are told we are not able to effectively—no one is able to effectively test for yet. Some of these ever-emerging chemical concoctions, such things as spice and others that are more and more being used recreationally, provide a great deal of danger to the health of the force and to the individual but are extraordinarily hard to test for, and we are always working to try to find better ways to do that.

But it really is a two-part problem. Those who would purposefully abuse drugs, that is a legal challenge; and our random testing programs, I think, are becoming more and more effective as we root out those people who have a problem. And the others are who those who become inadvertent abusers. As you know, Mr. Chairman, the ability to track movement and migration of soldiers through the force and their medical records is a challenge, but it is one I think we are getting on top of. We are doing a far better job in tracking, through medical records, the kinds of prescriptions that are doled out by our military physicians, but therein lies another problem. These are American citizens. And while they may receive a set of prescription drugs for whatever challenges they face at the military health facility, they are free to go off base and receive perhaps another dose of the same medicines or other medicines that we simply can't track. So we need to do a better job working with the civilian sector and ensuring that we have a full range of understanding of what drugs are being prescribed to individual soldiers.

The other thing I will tell you is, we have become extraordinarily vigilant, particularly in our treatment centers and our wounded warrior care centers, for those who are in a polypharmacological situation, multiple drugs. If you have over four prescriptions, we have a single dispenser, a single person who has a responsibility for tracking those prescription drugs that are administered to you. We have instituted—I believe we talked last year—something called EMA, which is an electronic medicine disposal. You can only get so many drugs. We have limited the number of supplies of drugs that anyone can get for many of these types of prescriptions.

So we are trying to do what we can. But clearly the data show that this continues to be a big problem that we are fighting against each and every day.

Mr. ROGERS. Well, as you know, these drugs we are talking about are highly addictive and are extremely difficult to kick, especially OxyContin, which is a great pain reliever but is really subject to terrible abuse. What progress have you made in preventing addiction, and also helping those who admit to an addiction, particularly the implementation of the recommendations made in your pain management task force report from May of 2010?

PAIN MANAGEMENT CENTERS

General ODIERNO. Congressman, first we have now opened eight pain management clinics that talk about alternative means to address pain as you start to take yourself off of these drugs, especially our wounded warriors and other people who have done this. And we are finding those to be very, very successful, these alternative methods. We are testing codeine, morphine now starting this year. We expect to be about 20 percent in the next month or so, and that will continue to increase throughout the year. You

know, the electronic records have improved significantly in tracking this. One of the holes we have found was in drugs being prescribed in Iraq and Afghanistan that were not making it back into the medical records. We have now fixed that problem, so we now understand and have a system in place to track that. So I think through the pain management clinics, through the understanding of helping our soldiers who have been injured to begin to think about how you wean yourself off of the pain and how you have alternative methods to do this, I think we are finding some success in this.

But as the Secretary has stated, it is difficult sometimes to track what they do outside of the military medical system, and that is what we are trying to gain more awareness at the leader level so they understand the signs so they can identify this to us so we can get them the help necessary.

Mr. MCHUGH. If I could just add, Mr. Chairman, you mentioned a very important part. What are we doing to help these people directly? We have, as we discussed last year, the Army substance abuse program and it covers both alcohol and drug abuse. And what we are trying to do is encourage soldiers who understand they have a problem, the challenge of addiction, to come forward voluntarily before they are somehow discovered and that places them into the disciplinary process. And I think you look at the data and it is somewhat encouraging. We are having more and more soldiers self-report, self-identify, go get the help they need, whether it is relief from pain addiction, pain control addiction or alcohol addiction, and then return to their military service with no punitive action. But it is hard to convince someone that if they self-divulge something that not so many years ago was a complete career killer, that they are just going to receive help. But we are making progress there as well. And ultimately, I see that as a very important part of our response program.

Mr. ROGERS. Well, I appreciate your being on top of the problem. It is a problem not just for the military but, more importantly, I guess for the population at large. In bringing this up, I don't want to take away from the importance of pain medicine for those who are in need of it on the battle front.

So thank you for your work.

Mr. YOUNG. Mr. Chairman, thank you very much. And thank you for being here today. Now I have checked the clock and the very good attendance. So I think we are going to have to do the best we can to stick to the 5-minute rule for the balance of the hearing. And at this point I would yield to Mr. Moran.

REPROGRAMMING FUNDS

Mr. MORAN. Thanks very much, Mr. Chairman.

John, nice to see you. General.

I am concerned that the executive branch over the years on a bipartisan basis really has attempted to usurp the prerogatives of the legislative branch. It is our responsibility to determine how money is to be spent and yours to carry out those requirements that we put into law. We had this issue with the Air Force yesterday over Global Hawks, when we appropriated the money and they just decided not to use it. Now just over a 3-month period last year, you

reprogrammed $4.8 billion. Now is that an aberration or are we going to continue to see that kind of thing in the fiscal year 2012 budget?

Mr. MCHUGH. We had a very good conversation yesterday with a number of Senators who had that very same concern. I am somewhat conflicted. I have this dual vision on both sides.

Mr. MORAN. You are one of us, John. Don't forget, Mr. Secretary.

Mr. MCHUGH. The short answer to your question is: We are going to do better.

IMPACT OF SEQUESTRATION

Mr. MORAN. That is fair. All right. I wanted that to be the last word on the record.

In this budget, you have asked for money for involuntary separations from the Army because you have got to draw down by 80,000 people. But we also have a sequestration looming on the horizon this fiscal year. Now what would that mean to the Army if the sequestration was actually allowed to take effect?

Mr. MCHUGH. Well, the problem that you have just mentioned would be dramatically exacerbated. The Chief spoke to this in his opening comment. If you look at it mathematically—and I think in is a best-case scenario, sequestration would require us to find cuts of at least another $134 billion. You could translate that into a minimum of another five BCTs, probably more out of the Active component, and I think many on this Hill are concerned how we are going to manage the current eight.——

Mr. MORAN. So roughly, are we talking 200,000 Active plus Reserve and Guard?

General ODIERNO. We have 86,000 now. It would be another additional 100,000 at least.

Mr. MORAN. Sure. So it is about 200,000, roughly. And then on the Reserve and Guard, we actually have a retention rate of 110 percent. It is more than we had even anticipated. Now are you going to also ask for money for voluntary separations, like severance packages and that kind of thing, particularly with regard to what that may mean for morale? Obviously if it is voluntary it is a lot more of a morale booster than involuntary separation.

General ODIERNO. Well, I would just say, Congressman, if we do not go to sequestration, and we continue just to do the 80,000 that we are doing now—we went through voluntary incentives in the 1990s; and frankly, it didn't work out so well. Our assessment is the people we wanted to stay were leaving because they felt more confident about leaving and being able to do other things. And we want to have control somewhat over keeping our best people. So we would use that if we had to, but it would be something of a last resort to use something like that.

Mr. MCHUGH. Could I add to? Because I know some of your Northern Virginia concerns. This just isn't military. This is civilian as well. And those kinds of cuts would have to be equally weighed against civilian reductions, which are already a challenge for us, even under the current budget. So it would be a huge problem.

JOINT LIGHT TACTICAL VEHICLE

Mr. MORAN. Very good point. Thank you, Mr. Secretary. And lastly and very quickly, you have got about 150,000 high mobility wheeled vehicles. We are going to be sort of switching to the prototype, the Joint Light Tactical Vehicle. But we have got a problem in that we are requiring that we have the kind of MRAP protection underneath them for IEDs and so on. But the problem is that that weight is sinking them into light soil. And I see that, from the prototype testing and so on, that has been a real problem. How are you going to deal with that, General?

General ODIERNO. Are you asking about the Joint Light Tactical Vehicle?

Mr. MORAN. Yes.

General ODIERNO. We believe that the Joint Light Tactical Vehicle will actually be able to provide better protection based on the new technologies that we have. So that is one of the benefits we believe of the Joint Light Tactical Vehicle. So we think it will provide us better protection at less weight. We will see as we go forward with this. That is what we believe we will get. But we do have that problem with Humvees clearly right now because they are so heavy.

Mr. MORAN. Thank you.

Mr. MCHUGH. I would note, we worked very carefully with the Marine Corps to do the joint acquisition program, as you know, to reduce weight; in fact, 3 years shorter to acquisition and reduced the price by about 50 percent. So we feel pretty good about that program at this point.

Mr. MORAN. That is terrific. Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Moran, thank you very much. Mr. Frelinghuysen.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman. I apologize for my absence yesterday.

Mr. Secretary, thank you for being here. General Odierno, New Jersey is proud of you as a West Point graduate, your enormous success and your leadership of today's Army.

I have a general question and a specific question: There is a lot of talk of pivoting to the Pacific, the Asia Pacific. Representative Calvert and I had the privilege of visiting General Thurman on the Korean Peninsula. We also went and looked at some issues that related to our appropriations process and decisions here with the Navy in Japan. I hear a lot of talk about the Marines and the Navy and confrontations, you know, in the air; the Air Force has to meet challenges.

Where does the Army come into the picture here? You know, for some who read the newspaper, they feel, Well, maybe we can do everything with special operators. We can do things with drones. But when push comes to shove—and God only knows we hope it never happens—we need boots on the ground. Where do you see the Army getting into this picture? And how are you going to get today's Army into the fight to address issues of confrontation?

General ODIERNO. Well first, thank you, Congressman. While I remind everybody, if you go into the Pacific region, there are actually more Army soldiers there than sailors and airmen combined.

I will just continue to point that out to everyone, for those who believe there is not Army in the Pacific region.

The second thing is, though, as I mentioned earlier, seven out of 10 largest land armies. What I didn't say is, 22 out of the 27 chiefs of defense are Army. The most influential organizations within the Pacific region in each country is the Army itself. So it is important that we engage army-to-army. And both Admiral Willard and Admiral Locklear, the new PACOM commander, have said one of the issues they have had is they have not been able to engage with all of the armies because of the tension in the Middle East. So I think there is an opportunity for the Army here to build relationships, to do multilateral training. So we are relooking, prepositioned stocks in the Pacific. We are looking at how we can do that for both training and for if we need it for deployment. I believe the Army can help with gaining access for future conflicts, if necessary. And I believe in both Korea and outside of Korea, there is a need to have a joint combined arms capability which would require ground forces. And so we are working that very carefully as we move forward in the Asia Pacific.

So I think there is a big role for the Army. I think we are being aggressive at making sure everybody understands that I made my first trip over there and talked to both the chiefs of defense and the ministers of defense of both Japan and Korea. I recently had the head of the Australian Army here, and we are going to work very carefully with them as well as others. And I am going to go back there again this summer to some of the other nations to have these discussions and why it is important to have the Army involved there.

GROUND COMBAT VEHICLE

Mr. FRELINGHUYSEN. I must say, there seems to be a more of a public focus on Marines and Navy and the Air Force and we are for joint training with the Australians, who have always been supportive of us I guess since World War II. And I mean, you have worked and trained with the Australians. They are pretty good soldiers. They have been loyal to us. And obviously we have other allies.

One program question: Where do we stand with the Ground Combat Vehicle? How is that program going? A less pointed question than I had last year. Where do we stand?

General ODIERNO. We are in good shape. We had the protest. The protest was resolved. That delayed us a little bit, but we are on track. It is still a 7-year program. We are on track to get to Milestone B where in Milestone B, there will be two competitors that are developing a system. And then at that time, we will bring off-the-shelf capability to compete. Also at Milestone B, along with the new developmental capabilities to ensure that we are selecting the best infantry fighting vehicle——

Mr. FRELINGHUYSEN. It is still 7 years?

General ODIERNO. It is.

Mr. FRELINGHUYSEN. Whoa. Okay. Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Frelinghuysen.

Ms. Granger.

OH–58D KIOWA WARRIOR

Ms. GRANGER. General Odierno, thank you for your service and for being here. It is wonderful to be here. Thank you for speaking up about sequester and we have all got to be very specific about—this is what it is going to cost us in manpower and equipment, whatever, because we have got to stop it.

Secretary McHugh, thank you very much. I just have one question. It has to do with OH–58d Kiowa Warrior and you mentioned you are modernizing and replacing the existing commercial—the way I understand it, you are converting a commercial-off-the-shelf aircraft as a replacement for the Kiowa Warrior. And my question is, did you look at modernization and upgrading that? Because it is just the highest operational tempo and readiness and it has always just been a really magnificent vehicle.

Mr. MCHUGH. The Kiowa Warrior has been a terrific platform. There is no question about it. And it still remains one of the focal points of our planning for the way ahead. The current status is, we are in an AOA, an analysis of alternatives, to try to determine what kind of progress could be made were we to build the next generation of armed aerial scout. That analysis will be done somewhat later this year; and at that point, looking at the Kiowa Warrior, the costs and such of continuing to have the SLEP, the service life extension program, for that, where bringing in a new platform will be decided. So we really haven't finalized a way forward.

In the meantime, we do have what is called the CASUP program, which is the cockpit upgrade program for the Kiowa Warrior. We are implementing that. We are asking for funding to continue that. That brings that new capability set and modernization that you spoke about. If we go through to completion of that, that would keep the Kiowa Warrior in the fleet until about 2025. But we have got some important decisions to make probably by the latter part of this year.

Ms. GRANGER. But you are considering all your options?

Mr. MCHUGH. Yes, ma'am.

SEXUAL HARASSMENT AND ASSAULT RESPONSE PROGRAM

Ms. GRANGER. Thank you. Let me just say one more thing about what Jerry Lewis said, and that has to do with sexual assault. I was on the Air Force Academy board of visitors when they went through just a complete examination because of some situations there. I know it is Air Force. They did an amazing job. They brought in a new administration and they went through just an examination of everything. And it really was pretty amazing because I was brought on during that period of time. And of course not drug use but alcohol had a great deal to do with these assaults, and as you talk about drug and alcohol. And what they learned and the examination they went through would be beneficial. Other boards I served on, universities, I said, you need to look at this because it also happens in your university. But I would say that they really learned a lot and made a lot of changes. Some of them were situational. I mean, they went to women and said, All right, how could this be different? Because they looked at prevention really more

than criminal charges and what was happening after. I would just suggest that.

Mr. MCHUGH. I was on the West Point board when you were on the Air Force board, and we looked hard at what the academy out there did, and it did some darn good things. I think you would agree it is breathtaking, first of all, that we have this problem but that we have it at places such as West Point, Air Force Academy and, of course, at Annapolis, it makes it even more disturbing. And whether it is at the academies or just in the regular Army, alcohol abuse and the nexus between alcohol abuse and sexual abuse is disturbing. And we have got a real way by which we can control the latter by doing better on the former, and we are working that real hard.

Ms. GRANGER. Thank you.

Mr. YOUNG. Mr. Rothman.

MEDIUM EXTENDED AIR DEFENSE SYSTEM

Mr. ROTHMAN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. Good to see you. Thank you for your career in public service, which is continuing with extraordinary results for our country. Thank you, sir.

General Odierno, New Jersey is proud of you, sir, as a Jersey guy myself. I saw you at least once or twice in Iraq. And again, you have led an extraordinary career of military service. I hope your son is doing well. And God bless you, sir, for all you have done.

I have a limited amount of time, so I want to get right to my question. The overarching issue for me at this moment, for my limited time here, would be theater missile defense. Is that an issue for you? How do you address it? I know that some of the PATRIOT 3 missiles have been upgraded. I have been told that the Medium Extended Air Defense System, the MEADS, has been canceled; yet the budget request includes about $400 million for that system for fiscal year 2013. Can you talk a little bit about this?

Mr. MCHUGH. Yes. I will start with MEADS. This has been a 2-year excursion. And the reality is, the way forward is largely influenced by an agreement that was reached amongst the United States, Italian, and German Governments. The agreement stated that at the end of 2014, we would reach this magical place called "proof of concept." I can't really tell you what that means other than at the end of that year all financial obligations on the participating partners would be discharged. The agreement also calls for anyone who leaves unilaterally has to pay all the termination costs. So the judgment that the Department of Defense and the Army, as the executive agent for it, had to make last year was, would we spend approximately $800 million in termination costs, the estimate of what it would be to just walk away? Or would we spend roughly the same amount of money and get to the end of 2014, the proof of concept, and share in the technical capabilities package, whatever that might be?

PATRIOT 3

Mr. ROTHMAN. I just want to make sure I don't run out of time. The PATRIOT 3s, how effective are they, General?

General ODIERNO. Well, first, we are continuing to increase the effectiveness. They are one of the most wanted items around the world. 50 percent of our current fleet is either deployed or is preparing to deploy right now. We continue to procure PAC–3 missiles. We have 84 in 2013. Beyond that, we will try to do 56 a year. We are also improving the electronic launcher system, which upgrades its hit-to-kill capability. So we feel like we are investing appropriately there. It is a system that is wanted.

Mr. ROTHMAN. We have a joint U.S.-Israel missile defense program on the David's Sling, and we find that the President put in his budget last year $204 million for Iron Dome. Those are technologies that are being shared with the United States, obviously, and are being partly manufactured here. I am wondering if the Army is considering, rather than reinvent the wheel, so to speak, comparing those technologies, if we have got any lessons learned that we can make use of those investments we have already made?

Mr. MCHUGH. Well, we are always trying to do better. And the partnership on missile defense with the Israelis has been one of the more productive ones. We also have PAC–2s as part of that layered missile defense.

Mr. ROTHMAN. Could you just talk about—most Americans don't understand the need for theater missile defense. What is the threat that you are addressing with the theater missile defense?

General ODIERNO. It is an integrated system, and it has to do with short-range ballistic missiles, SCUDs, items like that that could be launched into a country, Israel is one example, from Iran.

Mr. ROTHMAN. But how about for our own forces?

General ODIERNO. Well, as our forward forces are deployed, it protects us from a ballistic missile attack as well as some other capabilities, short-range missile capabilities. And it defends our forces against that as they are deployed. So it is an incredibly important piece of our integrated missile defense system for tactical operation formations.

Mr. ROTHMAN. Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, sir.

Mr. Crenshaw.

M1 TANK PRODUCTION

Mr. CRENSHAW. Thank you, Mr. Chairman. Thank you all for your service and for being here today.

I was interested in Mr. Dicks' question about tank production because if you remember last year, we had kind of a conversation about that, about how the production lines were going to be shut down. And I wondered how much thought had been given at the time about the question of whether you spend money to shut down a production line or you keep it open and actually produce something. And I think that is why the Committee at the end of the day, under the leadership of Mr. Young and Mr. Dicks, said, Well, it would be $255 million to see what would happen and hopefully end up getting a tank, as opposed to just spending money, closing a production line.

So I was interested in hearing your comments. It sounds like there has been some study and documentation. I think the committee might like to see that, just to hear more about what went

into your decision to how that works. Because I think we all agree, we are in this thing. We have got to spend less money. But we also have got to spend money in a smart way. And we all agree that it would be better to spend money and get something than to spend money and get nothing. So let's continue that conversation. I think we would love to know more because I think at the end of the day the Bradleys are going to be in that same situation, as I understand it, in terms of production and what we are going to do there, so how we are going to deal with that.

And I guess one question: General, just in terms of saying we have got enough tanks, as I understand it, the active military has the SEP tanks and the National Guard has the A1. And I know you have got firsthand knowledge. Can you talk about a couple of the advantages of the SEP tank over the A1 tank?

General ODIERNO. Well, firstly, the National Guard has a combination of SEP and A1s. The active component has SEP tank. First, it is the integrated system between the commander's module and the gunner. The ability to—it is inside of the cockpit, for lack of a better term—the ability to coordinate and synchronize engagements and to be able to see longer distances at night is the major advantages of the SEP tank over the A1. The A1 AIM tank is a very good tank. And in fact there are some people who will tell you they like it because it is not as, for some people, technically confusing. It is much easier to operate. But they are both incredibly very good tanks that we are comfortable with, very, very comfortable with. And the reason they are important for the National Guard is, as you know, they have reduced training time. So in many ways, it is easier for them to have the AIM tank because it takes less training time to be able to operate and it is just as effective in terms of lethality as the SEP tank.

Mr. CRENSHAW. Sir, would there be any benefit of everyone having a SEP tank?

General ODIERNO. Yes. There could be. But the other thing I would like to point out is, again, we are in the process of reducing force structure. So as we look at reducing force structure, my guess is we will reduce some of our heavy requirements. So there will be tanks moving from the Active to the Reserve component probably as we move forward. So we have to continue to do that analysis and understand how many will be moving and how many will not be moving before we make a determination whether we need more SEP tanks or not.

Mr. MCHUGH. Just to give you some figures to think about: If we were going to pure fleet A1, A2, SEP2, D2, it would cost $600 million a year. That is the minimum sustained rate at Lima for 70 tanks a year for 6 years; so in other words, an additional $3.6 billion.

MI TANK ENGINE REVITALIZATION

Mr. CRENSHAW. And one last quick question about tanks, Mr. Secretary.

Last year you talked about the fact that the Abrams tanks, most of the maintenance issues relate to the engine in terms of fuel efficiency. And I think this Committee, in its report, encouraged you to pursue ways to deal with that fuel efficiency as well as mainte-

nance. And I wonder, is there any money in this year's budget to pursue those kinds of issues?

Mr. MCHUGH. We have continued money through I believe the end of 2014, as projected for the TIGER program, which is the Total InteGrated Engine Revitalization program, which brings in those kinds of capabilities. We are always looking to improve that as well. But the answer is yes.

Mr. CRENSHAW. Thank you. Thank you, Mr. Chairman.

Mr. YOUNG. Thank you Mr. Crenshaw.

Mr. Calvert.

Mr. CALVERT. Thank you, Mr. Chairman. And thank you both for coming. And John, I miss seeing you around here. General, thank you for your service.

Sorry I was late. I was representing the Appropriations Committee at the Budget Committee about the sequestration.

Mr. YOUNG. That is very, very important. And thank you very much.

GROUND COMBAT VEHICLE UNIT COST

Mr. CALVERT. Well, it is daily progress. And tomorrow Mr. Cole and myself will be at an interesting meeting.

But since—and maybe this question has already been asked, so I apologize if it has. This is regarding ground combat. I heard some comments about it, the Ground Combat Vehicle. Acquisition has been kind of a pet peeve of mine for years, the complexity of the acquisition process and the time that it takes to do these things. But since joining this subcommittee, I have taken a particular interest in that subject. And the current acquisition, as you know, is the Ground Combat Vehicle. As I understand it, the Army stated that the average unit production cost will be between $9 million and $10.5 million. And the average unit production cost will be between $11 million and $13 million. And the Pentagon's Office of Cost Assessment and Program Evaluation reportedly estimates that average unit production will be in the $16 to $17 million range.

So I guess I would ask: Why is there such a large difference between what the Army is saying it is going to cost and what the Pentagon's Cost Assessment and Program Evaluation office says it is going to cost?

Mr. MCHUGH. I don't want to speak for CAPE, and they don't want me to speak for them either, but I think you always have some differences in those estimates because they are, in fact, estimates. But part of the reason it is hard to pin down these costs precisely is the very fact that we have learned a lot of the lessons that people like you, Mr. Calvert, have been trying to teach us; and that is to take a more realistic approach.

We, as you know, first issued the RFP for the GCV. There were over 900 must-have requirements. That was a lot of the "here we go again" syndrome. And to the Army's credit, they withdrew that RFP, reconfigured it, rescoped it, and reduced those must-have requirements to under 200. The other thing that I think that is causing some differences of estimates is the fact that we are using competitive prototyping. And while we think that the effects of that may save a bit more than CAPE does, I think all of us can agree

that is a very smart way to go about this kind of acquisition program, this 7-year major acquisition program.

Number two, analysis of alternatives, looking at nondevelopmental alternatives from other nations, other platforms. The Chief has spoken earlier today about looking at the Stryker or a stretch Bradley or something as that instead of going to a GCV that causes cost estimates to become a little bit more uncertain as well. But for whatever differences we have with CAPE, OSD supports this initiative. They have given us the okay to go forward with it, and we think we are on a good track.

Mr. CALVERT. I appreciate that. But as you know, Mr. Secretary, unfortunately, CAPE in the past has been more accurate than the Army.

Mr. MCHUGH. It is a new Army and a new CAPE.

GLOBAL HAWK BLOCK 30 RETIREMENT

Mr. CALVERT. Hopefully that is the case. One thing, I just wanted to make a point. I was in Korea recently with Congressman Frelinghuysen and I met with General Thurman. We had a very candid conversation. And I imagine every combatant commander would love to have 24/7 persistent surveillance in their theater. And General Thurman is no exception. And I was wondering what kind of communication you had with your brothers in the Air Force when they determined to park the Global Hawk. Did you have quite a conversation about that versus being able to use that platform?

General ODIERNO. We did not have a specific conversation about Global Hawk between the Army and the Air Force. I think the combatant commanders in the Air Force had conversations about it. You know, it is not one of our programs, so we didn't have a specific discussion about that.

Mr. CALVERT. But obviously you are a big customer.

General ODIERNO. I am. Was.

Mr. CALVERT. And I would suspect that your people are the ones that are at risk here. And was there any candid conversation taking place between the Air Force and the Army?

General ODIERNO. It is about coming up with—you can't just take that capability away. You have to replace the capability. They believe they are going to replace the capability with some other fixed wing assets that they have. So they have worked very hard to explain to us why they will be able to replace those capabilities. And we would have to wait and see, have further discussion about that.

Mr. MCHUGH. If Secretary Donnelly were here, I am hopeful he would defend me as well. It is not all Global Hawk. It is just the Global Hawk Block 30.

General ODIERNO. That is right.

Mr. MCHUGH. So they have sustained the Global Hawk program. It is just a niche capability that is achieved that they feel they can cover with onboard available assets that they have at a cheaper price. That was their analysis. But again, we were not consulted.

Mr. CALVERT. Thank you. Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, sir.

Mr. Hinchey.

BATTERIES AND THE SOLDIERS LOAD

Mr. HINCHEY. Well, thank you very much, Mr. Chairman. Secretary, it is great to see you. Thank you very much. And I very much appreciate what you are doing. And it is a great pleasure to listen to you and understand all the things that you are doing. Of course we do understand a lot of things you are doing and how effective they are. We deeply appreciate it. And, General, thank you very much as well. We deeply appreciate you and all the things you are doing. And I appreciate the work both of you have done to bring attention to the Army's energy challenges and the need to improve energy security. A whole host of other things. Thanks for everything you are doing.

I just have a couple of simple little questions about the safety and security of these Army people. And one of them has to do with a report that soldier load can be as high now as 130 pounds. And that 130 pounds comes about as a result of a lot of things. But mostly apparently it is batteries. At least a big chunk of it is batteries. I know that this is something that you are paying attention to and something that you are trying to deal with effectively to try to make it more safe and secure. So I wonder if you could just talk a little bit about that and what is likely to happen and what things you are going to do to try to make it more safe and secure.

Mr. MCHUGH. I would be happy to. I will start with the battery part and the Chief can talk about the operational loads. He is far more conversant than I am. You are absolutely right. My favorite data point is to put a platoon on patrol for 72 hours, they have to take 400 pounds of batteries with them. So what we are trying to do is pretty simple, and that is replace those disposable batteries with rechargeable batteries. When the conflict started back in the early 2000s, only 2 percent of the battery supply of the United States Army was rechargeable. Today it is 52 percent. And we can reduce the individual soldier load by taking that 400-pound battery requirement away from that platoon by about six pounds per soldier, dispersed across the platoon. Now we still have 48 percent of those batteries to go, but that is something that we are working on very, very diligently, and making sure they have other recharge capability out on patrol. What you can really do is extend a foot patrol indefinitely. Whereas before batteries are as deadly—or lack of batteries can be as deadly as the enemy. If you don't have a sustainable electrical supply, you have to bring those soldiers back out of the field. So——

General ODIERNO. If I could, the 173rd Airborne Brigade and the 1st Brigade 82nd are getting ready to deploy to Afghanistan, and they are going to be the first brigades equipped with some of our newest energy systems. That should reduce the load of batteries.

I will just give you a couple of examples. The Rucksack Enhanced Portable Power System, which is solar panel charged batteries. They will be given 89 of those within the brigade. They will be down to squad platoon levels to help reduce loads. There is the Solar Stick, which is a solar module battery pack and charging system.

So these are some of the operational energy things that we are now employing and giving to the units getting ready to deploy that

will help reduce the load of batteries and also, frankly, increase our ability to use less batteries and more safe batteries as well. So we continue to work this very hard, but we are very understanding of this problem of weight on our soldiers.

ENERGY EFFICIENCY

Mr. HINCHEY. Well, thank you very much. I appreciate the attention to that and the positive effort that has being done.

One other simple little question about the safety and security of our people. And it is related to the battery issue. It is important to recognize that energy security efficiency projects being developed and deployed, you know, all of that has saved lives and that is something else that needs to be done to continue to do that. And I know that you are very much aware of the fact that over 3,000 American servicemembers and contractors were killed protecting fuel convoys between 2003 and 2007. And I am sure that number has increased since 2007. A lot can be done to cut down on the number of convoys and to try to do this more effectively and more safely.

I think it is important to educate and create a culture that considers energy efficiency a necessity. Soldiers should know that their greater efficiency is helping keep their fellow soldiers out of harm's way, implementing best practices at FOBs and take fuel trucks off the road and ultimately save American lives. So I know that this is something that is troubling you and something that you are paying a lot of attention to and dealing with, and I hope that maybe you can tell us some of the things that you are dealing with this and some of the things that you think might be more effective as time goes on.

Mr. MCHUGH. Excellent point. And you know we want to do this to save money. We want to do it for a lot of reasons. But at the end of the day, one of the most important is force protection. Convoys, for every 44 convoys we have approximately results in a casualty. So every time we have to put another convoy on the road we are putting our soldiers at risk and that is something we want to minimize. One of the key ways in which we are doing it, because about 70 to 80 percent of all of our convoy load is either water or fuel, what we are trying to do is lessen our requirements for water and fuel. We have installed shower reuse systems that can save about several thousand gallons, about 9,000 gallons of water per day per unit. Therefore, fewer convoys. One of the best things I think we are doing is what we are calling spot mini generators. They are going to save, when all installed, forward deployed, 50 million gallons of fuel a year. That is the equivalent of 55 trucks a day taken out of convoys each and every day, fewer casualties.

So these are the kinds of things we have to do, yes, because it makes environmental sense, yes, because if we do it smartly it saves us money, but most of all, it keeps our soldiers safe.

General ODIERNO. Can I just add, in Afghanistan we have 22 mini grids that have been established that have saved us about over 30 million gallons of fuel a year. We have 22 employees. We are adding six or eight more this year. So that is a significant savings in the amount of fuel that is being used. We are looking at a new turbine engine for our aircraft which will reduce fuel by 25

percent. So these are all keys things we will continue to work for. And it is about force protection, as you said, in the theater, and it is about us reducing our fuel costs as well. So it is dual purpose here. And it is very, very important.

Mr. HINCHEY. Well, thanks very much. I appreciate your response to this, and I seriously deeply appreciate all the attention and effectiveness that you deliver and the responsibilities that you have. Thank you very much for everything that you do.

Mr. MCHUGH. Mr. Chairman, would you allow me? Because I don't believe Mr. Hinchey was in the room and I have served with Maurice since our days in the State legislature and I know he is not running again either. As a fellow New Yorker, I want to thank him for his friendship and, more than that, for decades of leadership and concern. I wish you all the best.

Mr. HINCHEY. Thank you very much.

Mr. YOUNG. Mr. Secretary, thank you very much for that, because we love our colleague Mr. Hinchey, and we also wish him the very best. And thank you very much, Mr. Hinchey.

And now I will recognize Mr. Cole, who is also one of the representatives of this subcommittee to the Budget Committee as they try to protect our numbers when the budget funding comes out. Mr. Cole.

PALADIN INTEGRATED MANAGEMENT (PIM)

Mr. COLE. Thank you very much, Mr. Chairman. It is always great to see you, Mr. Secretary. I had the good fortune of being your vice chairman when you are a subcommittee chairman on HASC. I was there when you were ranking and now I am here when you are Secretary. So if you could tell me what you are doing next, I would have some idea the arc of my career is because I seem to kind of follow you around.

General, thank you for your extraordinary service and the sacrifice of your family. It is noted and appreciated greatly.

I am going to ask a parochial question and then I have a couple serious ones. The parochial one is this. A number of—as I know the Secretary knows and the General knows as well—Fort Sill is in my district. I have a lot of Indian tribes and when you guys canceled the Comanche I literally got a call from the Chief who said I can't imagine the U.S. going to war with Kiowas or Apaches and no Comanches. So the next time you name something, if you could just—I don't care what it is but if you could get the Comanches back in the mix, I would have 15,000 very happy constituents. He reminded me. He said, look, we fought against, with and for the United States Army more than anyone else. We ought to be a part of it.

More seriously, at Fort Sill in Lawton obviously we have lived through the cancelation of the Crusader, we have lived through the cancellation of the NLC. We are following the Paladin, the PIM program, with a great deal of interest. And so I would like to know from your standpoint what the status is, how the program is progressing and what you see for it going forward.

Mr. MCHUGH. PIM remains one of our critically important developmental and modernization programs. We have to have that capacity that can keep up with our formations, particularly as we

begin to develop JLTV, GCV and other components of both the tactical and nontactical vehicle fleet. We want a mobile artillery system. In Iraq I came across a figure the other day. We fired over 200,000 rounds of artillery. So I think we are pretty safe in assuring ourselves that we are going to need this capability in the future. So we remain dedicated to it. We have a way forward. And we are going to stick to that. Whether we can rename that or not, I am not sure.

General ODIERNO. I did not mention that as one of our key programs, but the PIM program is essential for us as we move forward. As an old artillery man, I can tell you how important it is not only to the ground force but in fact the joint integrated force. And it is about providing a system that is more capable, more survivable, and we need this improvement very badly as part of the combined arms maneuver team and we are moving forward with that. And we are very encouraged by the program and the progress it is making so far.

PRECISION MUNITIONS

Mr. COLE. You have actually already answered part of this in my question and maybe all of it. And it will be my last question, but since we are changing the nature and the structure of the force, and I know you are thinking in very long-term ways, if you could sketch out again sort of your view over time of where artillery will be. Are we going to eventually have another artillery piece? As you think through these problems, I think a lot of folks are interested in where that fits in the future Army.

General ODIERNO. Well, what we have learned—and the Secretary kind of mentioned it, over the last 10 years of warfare which is considered a counterinsurgency both in Afghanistan and Iraq, there has been significant use of indirect fire systems both by us and by the insurgents, frankly, and its value continues to be critical to us as we move forward in what we are considering to be a very complex hybrid environment that we are going to have to operate in, which could include conventional forces, irregular warfare, terrorism, and criminal activity, the need for us to be able to protect ourselves and also to provide fire as essential to that mission. So we don't see it being degraded. It will continue to be integrated within our maneuver formations both in the light, medium and heavy capacity. So we will continue to have to modernize our ability to provide accurate, longer-range capability in support of our infantrymen on the ground. And it will continue to be a key system that we move forward with.

Mr. MCHUGH. One of the things that assures that is the amazing development of precision munitions. And whereas in the past someone might have questioned the use of artillery in certain environments, with precision missions there is virtually no environment in which we can't use it very effectively.

General ODIERNO. Excuse me, Congressman. We talk about one of the characteristics. I was talking about lethality, but it is not just lethality, it is about discriminate lethality. And frankly ground forces can be the most discriminate lethality possible. And part of that is having an artillery system that is able to deliver at very

close range very accurately. So that is key to us as we move forward.

Mr. COLE. I appreciate that very much, and again thanks to both of you for your terrific service to our country. You have paralleled but very splendid careers in making sure all of us stay safe and the country stays free. Thank you very much.

I yield back, Mr. Chairman.

BUDGET REDUCTIONS AND READINESS

Mr. YOUNG. Mr. Secretary, General, thank you very much for a good hearing. I might change the tone just a little bit, but it is all in the interest of protecting our country.

Members of this subcommittee take very seriously the direct responsibility that we are given by Article I, Section 8 of the Constitution dealing with our national defense and dealing with appropriations. Last year we were required to reduce the fiscal year 2011 bill by $18 billion below the President's budget request and the fiscal year 2012 bill we were required to reduce it by some $20 billion below the President's budget request. It was not easy because we were committed and determined that we would not do anything to affect readiness or to affect the soldier. Now we have substantial reductions again this year, and we are going to do the same job. And we did it very carefully. We have a tremendously professional staff. We even went through line by line, item by item, contract by contract. We saved those billions of dollars and we did not affect readiness. And we have asked that question of all the services and they agreed. Those 2 years we did not affect readiness.

RISK

Now yesterday at our hearing, I heard the phrase "acceptable risk." You can imagine we had quite a conversation about what is the acceptable risk. Is it just a phrase? Or is it something that they really knew about? Today I heard the phrase "hedge risks." Mr. Secretary, what do you mean by that?

Mr. MCHUGH. As you know, Mr. Chairman, as the members of this committee know, you can never buy down to zero risk. We could spend every dollar in the Federal Treasury on defense and we would still have risks. We understand as we look toward the future we cannot in this budget and in this strategy foresee all unforeseen things. And when I speak of hedging against risk I am talking about the need to engage in some high-end, unforeseen, I don't think at this moment reasonably predicted conflict against our need to ensure that our end strength is balanced by the realm of requirements, readiness, making sure we have family programs, making sure we have modernization programs. So we are at a point under the budget dictates that we were handed, as you were over the last 2 years, where I think that when we hedged against risk we have accepted that we have a way by which we can accommodate today and the reasonably close in future but also in reversibility and in other ways meet that unforeseen risk that is always present.

Mr. YOUNG. And I understand that, sir. Let me just ask this, are you comfortable that when you consider risks, are you comfortable that this budget is adequate to face up to any risks that you might

know about today or that you think might be a potential risk tomorrow?

Mr. MCHUGH. The risks that are envisioned today—and this is not just John McHugh talking. If I may, I would like to defer to the Chief as well. He is required by law to tell you what he thinks, me not so much. But all of the combatant commanders were brought in on this development. All of the service secretaries, all of the service chiefs. We had an unprecedented meeting with the COCOMs, the chiefs, the secretaries, the national security staff, the principals of it, the President and Vice President of the White House everybody had their opportunity for their say. And I think in the context of this entire budget, this strategy makes sense, and I feel the Army has the necessary resources to do the duty that this Congress will assign to us in the future.

Mr. YOUNG. Well, you know I have much respect for your opinion. And General?

General ODIERNO. Thank you, Mr. Chairman. You know, as I have looked through this budget, there is three things that the Secretary and I constantly look at. It is end strength, it is modernization, it is readiness: Man, equip, train. And how do we balance those three things together in order to sustain the best Army in the world? And that is what we are going to be focused on. And so for me it is about mitigating the risk associated with less dollars and delivering an Army that can meet any of the spectrum of missions that we might be asked to do. So we talked about reprogramming before. There was a question about that. That is why as we continue to assess this we might have to come back to you next year or year after, and start talking about that we have found some risk in the program where we will have to adjust these three dials in order to get it right. But as it looks for the whole strategy, the risks that we are taking in the Army is if we get into two simultaneous sustained operations again. We realize we do not have the end strength to handle that. That does not mean we cannot do two simultaneous combat operations if they are of short duration. We can do that. But when they extend out for long periods of time and they are large capacity operations, we will then run into the same problems we ran into in the 2000s, is that we do not have the end strength to continue to support two of those operations at one time. And we understood that going in. That was the risk that we decided to take because we believe the chances of that happening are fairly low, having two simultaneous operations that would extend for a very long period of time. And so that is the risk we will look for as we move forward.

Mr. MCHUGH. But if I may, we also took steps to mitigate that should it become reality. We have taken 1,000 forces that generally major and senior NCOs, placed them into the generating force. Those are the people you can't grow overnight if for some reason you have to grow end strength quickly. So we tried to mitigate and hedge those risks where we can.

General ODIERNO. That is also why we are looking at the reorganization of the brigade because I think if we do this properly, that could also mitigate the risk of potential expansion in the future. And that is part of the analysis we are doing as we look at this.

Mr. YOUNG. Well, I understand that it is real challenging. It is challenging to me because I have this ingrained in my conscience for years of working on this Committee and having worked on the Armed Services Committee prior to that and the Intelligence Committee. But I believe that when it comes to defense we cannot just pick a number out of the air, and I do not think you have done that. But we cannot just make a political number, and I do not think you have done that. But we have got to base our investment in our national defense on what is the threat that we see today, that we know today, and what we see as a potential threat tomorrow, next week, next month.

So forgive me if I tend to be a little bit stronger on this issue of readiness and spending and making sure that your soldiers have whatever they need. I do not want one of your soldiers to be on patrol and reach out and need something and all of a sudden it is not there. I do not want that to happen, and I know that you do not want that to happen.

So anyway, that is my sermon for today on the issue of readiness. But we are here to be supportive. As you know, over the years we have been totally supportive of the administration, whichever the administration was, to make sure that our country was safe and secure and that the soldiers, the troops who keep it secure, that themselves are secure. And now I would yield to Mr. Dicks.

SEQUESTRATION

Mr. DICKS. Thank you. And just to follow with the chairman, I assume from all we have heard that if we have sequestration all of this is a completely different scenario. What were the numbers you have, General, of the reductions in personnel beyond what we are going to do now?

General ODIERNO. 100,000 is our estimate. And it will be a mixture of Active and Reserve component. We would have to, depending on the mix, it would depend on the specific number, we have to work our way through it, but it would be about 100,000 additional soldiers, so a total of about 186,000 reduction.

SYSTEMS ENGINEERS

Mr. DICKS. Just one other thing, our surveys and investigation staff looked at shortages of key engineering personnel such as systems engineers. Now, if you are going to beat Shy Meyer you have got to get some systems engineers. What has the Army tried to do about it? Is this a legitimate concern?

Mr. MCHUGH. The nomination the President sent to the Hill for the next Army ASAALT is a systems engineer. So we are trying to hire her at the highest level. But this has been one of the critical areas in which from our developmental perspective we have been challenged. Because at the end of the day as the systems get more complex you have to have someone who understands what you can and what you cannot put together. And we are trying very hard, and Congress has given us a mark on the wall to end source a great deal of those kinds of experts into our acquisition core. And we have come a long way, but we still have a ways to go. Like a

Major or a Captain you do not grow an acquisition expert, particularly a systems engineer overnight, but we are working it.

Mr. DICKS. Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Dicks. And Mr. Secretary and General, thank you very much. This has been a good hearing, you responded directly to our questions without any hedging, if I can borrow your word again, and we appreciate very much both of you and your service to our country.

And so the Committee will be adjourned until 10 a.m. tomorrow, at which time the three Surgeons General of our military will be here at 10:00.

[CLERK'S NOTE.—Questions submitted by Mr. Kingston and the answers thereto follow:]

DOWNSIZING THE MILITARY

Question. The Army proposes cutting 72,000 soldiers, per the budget proposal; Reserve strength is scheduled to be cut by an additional 5,000. Will these be specific targeted military skill sets or across the board cuts?

Answer. As part of the new DoD Strategic Guidance, the Army will downsize approximately 79,000 Soldiers to 490,000 in the Active Component, and will reduce its Reserve Components by 9,000 from 358,200 to 350,200 in the Army National Guard and from 206,000 to 205,000 in the United States Army Reserve by the end of the Future Years Defense Program. The Army's deliberate and responsible drawdown plans will take into consideration operational demands, unit readiness, and will proceed at a pace necessary to ensure mission success and retain flexibility to respond to unforeseen demands at a tempo that is predictable and sustainable for our all-volunteer force. The Army's plan will ensure that the force contains the required capability, capacity, and mix of skills to meet current and future operational requirements within authorized end strength. In general, we will see an increase in Army Aviation, Special Forces, Military Information Support Operations, Civil Affairs, Infantry and Armor skills. We will see a decrease in Field Artillery, Chemical and Signal skills. An announcement on specific force structure actions is expected sometime before, or in conjunction with, submission of the FY14 President's Budget in early February 2013.

Question. How will these personnel cuts impact Deployment/Dwell time ratio for those that don't get cut?

Answer. The Army will accomplish force reductions in a responsible and controlled manner in synchronization with units deploying or redeploying to and from Afghanistan. The Army will execute force reduction measures by following a drawdown ramp that allows us to take care of Soldiers and families, while maintaining a ready and capable force to meet any requirements, including our current operations in Afghanistan.

Question. There are some news reports beginning to circulate talking about the Army cutting as many as 13 BCTs. Would cutting 13 BCTs mean that we will be losing even more personnel than has already been announced?

Answer. The Army announced during the President's Budget 2013 release that a minimum of 8 BCTs and other force structure totaling 57,400 would have to be reduced over the course of the 2013–17 Future Years Defense Program (FYDP) to achieve the Active Component (AC) end state of 490,000 by the end of FY17. Additionally we have said that the Army continues to assess the design and mix of BCTs based upon the lessons from the last ten years of war. This analysis could lead to a decision to reorganize BCTs within the 490,000 AC end strength, into more capable and robust formations, requiring further BCT reductions in order to increase overall versatility and agility for tomorrow's security challenges. An announcement on specific force structure actions is expected sometime before, or in conjunction with, submission of the FY14 President's Budget in early February 2013.

C–27J

Question. It is my understanding that at least part of the rationale for divesting the C–23 (Sherpa) fleet was that we were going to acquire the C–27J. With the C–27J fleet now being divested, do we need to re-look at the original C–23 divestiture or can the requirements be met with other assets (like the C–130)?

Answer. The C–23 is an obsolete aircraft. It is limited on payload, range, speed, and "high/hot" performance. The time sensitive/mission critical cargo mission has been shifted to the United States Air Force. To continue with the C–23 would be cost prohibitive.

AFGHANISTAN

Question. Is the United States still on track to transfer Afghan forces to the lead security role, as we have planned with our NATO and ISAF allies? What impact does it have when nations (like France, most recently) announce that they are withdrawing early? Has this impacted our decision at all with respect to our withdrawal timing?

Answer. We are well into the process of transitioning security lead to the Afghan National Security Force (ANSF) as agreed to at the 2010 NATO Lisbon summit. Currently, approximately 50 percent of Afghans live in areas that are in the transition process and the ANSF are on track to assume lead for security for all of Afghanistan by the end of 2014.

Our coalition partners, including France, remain committed to the Lisbon-based transition process. The U.S. and members of the ISAF coalition realize that transition is critical to ensuring Afghanistan is safe and stable, not merely the way out. Over the next two years coalition forces will remain combat ready, but increasingly focused on security force assistance missions as we continue to move the Afghans into security lead. Both the U.S. and ISAF partners will continue to coordinate their drawdown plans to support overarching ISAF campaign plan objectives.

Question. What were some of the military & national security considerations that were taken into account when looking at the timing of withdrawal? What level have these discussions been occurring at?

Answer. The pace of force reduction is based on several factors including the recommendation of our military commanders as well as analysis of progress towards the core goals of the campaign of disrupting, dismantling, and defeating al-Qaeda, and preventing Afghanistan from ever again becoming a safe haven that could threaten the United States or our Allies and partners. In the process, the administration carefully looked at all input. The discussions regarding the pace of force reduction and the handling of security resulting has been discussed at all levels in the military chain of command, the U.S. government and the Government of Afghanistan.

Question. Is the withdrawal of surge forces this year in sync with the need for trainers at the Afghani police and Army unit levels?

Answer. Yes. We are shifting to a Security Force Assistance model that will enable ISAF to continue with ANSF development as we reduce U.S. Force levels.

Question. When will the "reset" of equipment used in Iraq and Afghanistan (estimate) be complete? Any idea of how much it will cost? (DoD comptroller, Mr. Hale said we have $9.3B planned for FY13 OCO reset at the 15 Feb HASC hearing).

Answer. The Army estimates that the Reset of equipment used in Iraq and Afghanistan will be completed 2–3 yrs after completion of operations in Afghanistan. We will require Reset funding for that period to complete the Reset effort and ensure equipment readiness for future contingencies. We estimate that if contingency operations ceased today, the Army would need $10–15B to complete Reset. There are many factors and assumptions that can affect the total future Reset requests, such as battle losses/washout of equipment, the condition of equipment at the time of retrograde and the final determination on what equipment we will retrograde from theater. The Army conducts an annual Reset Liability study in conjunction with the Office of Cost Assessment and Program Evaluation within the Office of the Secretary of Defense to revise and re-baseline our Reset estimates.

Question. What is the rationale behind refurbishing our legacy equipment versus deciding to buy new equipment? On what basis is the line drawn between buying new systems and repairing/refurbishing the legacy systems?

Answer. The rationale behind refurbishing legacy equipment rather than buying new equipment is to ensure the Army gets the capability required in the most cost effective way while getting maximum use out of the equipment. Refurbishing equipment is considerably less costly than buying new and allows for technology insertion, ensuring the legacy system is upgraded to the current production standard and required capability.

There is no firm line drawn between buying new systems and repairing/refurbishing legacy systems. Each case is evaluated separately using a Business Case Analysis (BCA) to evaluate the cost, schedule and performance of each course of action. In each case, the current Maintenance Expenditure Limit (MEL), which is a percentage of the new production cost, is taken into account. If the equipment can

be refurbished below the MEL, while still meeting the required capability, the Army will opt to refurbish the equipment. If the equipment cannot be refurbished below the MEL or the equipment can no longer meet the required capability, the Army will opt to buy new equipment.

INDIVIDUAL CARBINE REPLACEMENT

Question. The FY 13 Army base budget request contains approximately $21 M for Individual Carbine Replacement. How much progress can we expect to make this year with that level of funding? What are the goals—where would we like to be coming out of FY13 and into FY14 in this program?

Answer. The Fiscal Year 2013 (FY13) Carbine funding line, BLIN 24, containing $21 million, supports the procurement of 12,000 M4A1 configuration carbines to maintain an active production line during the Individual Carbine (IC) competition. The IC competition is not scheduled to be completed until the 1st Quarter of FY14.

FT. STEWART GROWTH IN UNMANNED AERIAL SYSTEMS

Question. With respect to the Army going to a concept of "consolidated stationing", where not all Combat Aviation Brigades will get a dedicated Grey Eagle UAS organization, we've been told that most will consist of 3 squadrons of 12 aircraft each, 6 ground control stations and 128 personnel per company. Is this accurate? How many contractor personnel will be associated with a typical organization? Is it true that these units will be attached to CABs that don't have Grey Eagles and will rotate with them for deployment/training?

Answer. U.S. Army Special Operations Command will receive two fully equipped Gray Eagle companies, each with 12 aircraft and 165 personnel. For the General Purpose Forces (GPF), the current plan is to collocate three Gray Eagle companies at five installations. One of the three companies will be fully equipped with 12 aircraft and 6 ground control stations (GCS), and will be deployed or available for deployment. The two remaining companies will each be equipped with 4 aircraft and 2 GCS in order to support training requirements. All GPF companies will have their full complement of 128 Soldiers and rotate through deployment cycles attached to deployed CABs. As the Gray Eagle is a complex system that is very early in its life cycle, a heavy contractor presence is required for sustainment—the first company deployed to Afghanistan with 28 contractors. Upon redeployment in FY13, this number will be reduced to approximately 12, and by FY15 will be further reduced to 5.

Question. How is the progress going in working with the FAA to get the agreements in place to operate the Grey Eagle UAS at those bases? Are there any problems getting the authorizations that you need to operate unmanned systems in our training airspaces?

Answer. Outside of the training base at Fort Huachuca, Arizona, the Army has not yet pursued a Certificate of Authorization or Waiver (COA) from the FAA to support Gray Eagle operations. Requests will be made after a detailed risk analysis is completed for each installation to ensure safe operations. We have a great deal of experience with the COA process, and do not anticipate any extraordinary problems gaining the required certifications.

Question. What are the advantages of this new approach? How much money will the Army save by doing this?

Answer. The consolidated stationing and reduced equipping of Gray Eagle companies enabled the Army to reduce costs while fielding additional force structure with a greater deployable capability. It enables continuous deployment of five companies while maintaining a trained rotational pool in the dwell force. This construct allowed the Army to procure 32 fewer aircraft at a savings of $76M and reduced associated military construction by $725M than if all companies were fielded with separate facilities.

CH–47 CHINOOK HELICOPTER

Question. (As part of this year's budget, the Army has submitted a request for approval to enter into a second multi-year contract for the CH–47 Chinook helicopter (five years & 155 aircraft). Coming off of our first five-year, multi-year contract for Chinooks, are there any lessons that we've learned—things that we need to do differently? What has the Army seen that led to this request authority for a second multi-year contract?

Answer. The first five-year, multi-year contract for Chinooks was exceptionally successful and there were no significant issues that would cause the Army to adjust the multiyear contracting approach. The primary reason for requesting a second

multi-year contract is the significant savings made possible. The first multi-year contract realized savings of $449 million (M) on the base contract for 181 CH–47F aircraft. In addition to the base contract savings, the program office procured 34 option aircraft for an additional $86M in savings. The current Chinook multi-year contract is a firm fixed price contract for Fiscal Year 2008–2012. The contract has executed on cost and delivered on schedule. The second requested multi-year contract is projected to yield a 10 percent savings or $373M.

ARMED SCOUT HELICOPTER (ASH)

Question. For FY 2011, this committee was a proponent of providing $15 million for a flight demonstration of a new Armed Scout Helicopter. I understand that the Army is going to issue a Request for Information (RFI) to industry, looking for technology solutions for the Armed Scout Program. What is the way ahead for an evaluation of the different capabilities available from industry? Is this program an Army priority? Is this program fully funded?

Answer. The Army has asked the Defense Acquisition Executive to authorize a Request for Information (RFI) and a voluntary flight demonstration to assess the current state of technology within industry. The voluntary flight demonstrations will help define the capabilities available from industry to fill the Armed Aerial Scout (AAS) requirement. After assessing the available data, the Army intends to make a capabilities decision that either conducts a service life extension of the Kiowa Warrior helicopter or pursues increased capability with a new helicopter through an achievable and affordable moderate risk program.

Funding for a new AAS helicopter program is yet to be determined. However, the Army is funded in Fiscal Year 2012 to release an RFI and execute the voluntary flight demonstration. Understanding the affordability of a new helicopter program will be a critical factor in the upcoming capabilities decision. The AAS capability remains a top equipping modernization priority for the Army.

ENHANCED MEDIUM ALTITUDE RECONNAISSANCE AND SURVEILLANCE SYSTEM (EMARSS)

Question. The Army and the Air Force have been engaged in airborne tactical Intelligence Reconnaissance (ISR) in both Iraq and Afghanistan. Have the Army resolved the division of responsibility for this function between the Army and the Air Force?

Answer. The deliberation of roles and missions is still ongoing, but the issue of direct support apportionment of manned medium-altitude Aerial Intelligence, Surveillance and Reconnaissance (AISR) assets was not discussed during the 15.7 FEB 12 Army—Air Force talks. That being said, this issue of EMARSS is really a larger issue within the Department as it pertains to redundancy. During the POM 13–17 build, CAPE analysis identified an existing shortfall of manned medium-level AISR. This identified shortfall is exacerbated by SOCOM's new requirement for an increased number of manned AISR orbits. The Chairman of the JS directed the J8 to conduct a review of all Services ISR assets to include SOCOM's request. The termination of the EMARSS due to affordability did not reduce the requirement for manned medium-altitude AISR support for Army BCTs. Joint interdependency would rely on AF providing manned medium-altitude requirement. While we continue to work towards a commitment to this higher level of support, the Army will assess additional options and other potential investment strategies to satisfy these JROC approved requirements. The lack of EMARSS multi-INT capability continues to be a major gap within the AISR layer.

Question. What is the role of the EMARSS program in support of the overall strategy in this area?

Answer. The initial Engineering and Manufacturing Development EMARSS systems will deploy in support of Operation Enduring Freedom. Though the affordability discussion impacted the EMARSS program decision, the requirement for manned medium-altitude Aerial Intelligence, Surveillance and Reconnaissance (AISR) still exists within the Army. The Army is committed to addressing these shortfalls by acquiring additional EMARRS platforms and/or recapitalizing existing Quick Reaction Capability AISR systems.

ARMY CORPS OF ENGINEERS PROJECTS IN AFGHANISTAN

Question. The U.S. Army Corps of Engineers (USACE) recently issued an RFI for a Detention Facility in Parwan, Afghanistan. A United States firm briefed the USACE prior to issuance of the formal RFP on the potential use of American-made, prefabricated steel detention cell modules for the project. The USACE completed the

design and advertised an RFP using an Afghanistan produced reinforced concrete, fully grouted contract masonry unit construction. Did the USACE consider "made in America" products like these prefabricated detention cell units? Would the USACE consider use of products like this in future requirements for detention and force protection?

Answer. The Detention Facility in Parwan (DFIP), Afghanistan, is being executed via two USACE-awarded construction contracts. The first of these contracts was awarded on August 25, 2011. The more recent Request for Proposal (RFP) was issued by USACE Middle East District on October 22, 2011. The proposals were received on November 22, 2011. The contract was awarded on January 30, 2012.

It is correct that the DFIP RFP specified reinforced concrete, fully grouted masonry unit construction. An extremely short construction schedule was mandated by the customer and end-user to meet critical detention space requirements. As a result, it was imperative that the contractor be allowed to use locally available materials and products that would allow for site fabrication and would not require the delivery of long lead items through unreliable border supply routes. However, the terms of the contract did not preclude the submission of alternate means and methods for Government approval. If the contractor had proposed prefabricated detention cell units as an alternate construction method, this method would have been reviewed for acceptability including impacts to the construction delivery date.

USACE would consider use of products like the prefabricated steel detention cell modules on future projects.

MILITARY TRENDS AND ISSUES FACING THE FORCE

Question. I have a large military community in the district (active and retired members) that I represent, and I also hear from some medical professionals involved in treatment of addiction and mental health problems in this population. I know the Army is attempting to deal with these problems, but could you address some specific actions that have been taken recently to address the following areas:

a. *Suicide*

- What is the Army doing to stem the tide of suicides in the force? From an article in Army Times, April, 2010:
- Eighteen veterans per day are committing suicide
- Although only 1% of Americans have served in the military, former service members represent 20% of suicides in the United States.

b. *Drug & Alcohol Dependency*

- I continue to hear that a lot of our soldiers returning from overseas are struggling with drug and alcohol dependency. (Article from NIH (National Institute of Health) and NIDA (National Institution on Drug Abuse), April, 2011)
- Prescription drug abuse doubled among U.S. military personnel from 2002 to 2005 and almost tripled between 2005 and 2008.
- Study of Army soldiers screened 3 to 4 months after returning from deployment to Iraq showed that 27 % met criteria for alcohol abuse (compared to a prevalence of alcohol abuse of 7.4% and of drug abuse of 1.5% in the general population).
- Drug or alcohol use frequently accompanies mental health problems and was involved in 30% of the Army's suicide deaths from 2003 to 2009 and in more than 45% of non-fatal suicide attempts from 2005 to 2009.

c. *PTSD (Posttraumatic Stress Disorder) & Depression*

- According to the Rand study conducted in 2008, nearly 20% of military service members (1 in 5) who have returned from Iraq and Afghanistan—300,000 in all-report symptoms of PTSD or major depression. This is compared to a lifetime prevalence rate for PTSD of 6.8% and for depression of 6% among the general population.
- Aggressive behavior or alcohol misuse was also present in about 50% of the soldiers who had PTSD or depression.

Answer. The Army is executing numerous initiatives that address drug testing, confidential alcohol treatment and education, counseling, prevention services to geographically-dispersed Soldiers, expeditionary treatment services, risk reduction, and stigma reduction.

Prescription Drug Abuse. The 2008 DoD Health Related Behavior Survey (HRBS) is used as a benchmark. The Army is aware that our Soldiers come from the civilian population where drug abuse is on the rise and is tracking prescription drug abuse. The HRBS rates cited in your question are self reports, and therefore different than the Army drug testing rates. The percentage of Soldiers on active duty that tested positive for illicit prescription drug abuse in FY02 was 0.13%, rising to 0.23% in FY11. The Army began testing for the "Oxy" family of painkillers in FY06 and has

led the charge to have DoD implement expanded testing for the hydrocodone family of painkillers and benzodiazepine (tranquilizer) testing for all Soldiers by the end of FY12.

The Army was actively involved in National Prescription Take Back Day and continues to develop a prescription substance abuse campaign for the force. Army policy was recently changed that limits the length of time to six months for prescription medication. With expanded prescription testing and campaign efforts, we believe the second order effects will be a disposal of unused medications and a decrease in prescription drug abuse.

To deter Soldiers from using emerging drugs, the Secretary of the Army issued a memorandum banning the use of Spice.

Alcohol and Drug Abuse of Returning Combat Veterans. The Army asks Soldiers about high-risk behaviors via the Re-integration Unit Risk Inventory (RURI). RURI data shows that, of the Soldiers serving in Iraqi Freedom, 24% (2116 of 8810) were screened as potential problem drinkers within six months of returning, and 2% (189 of 8810) of Soldiers admitted to illicit drug use. The DoD HRBS cites 16% alcohol abuse and 20% drug abuse for the comparable civilian (18–25 year) population, rather than use the general population statistics.

The Army is using an online prevention tool that allows Soldiers to self assess high-risk behaviors and attitudes and then prompts them to make lifestyle changes. This program is part of the new Expeditionary Substance Abuse Program (ESAP) for deployed and geo-dispersed Soldiers. Near future efforts include opening a call center for deployed troops and giving specialized substance abuse training for mental health specialists who will provide direct services in theater.

The Confidential Alcohol Treatment and Education Pilot (CATEP) was started in 2009 to provide confidential alcohol education and treatment to Soldiers. It is piloted at six installations and is currently being evaluated for Army-wide implementation.

The Army has focused on increasing the number of Army Substance Abuse Program (ASAP) counselors from 320 in October 2010 to a total of 493 as of April 2012.

Drug and Alcohol Use and Suicides. Army data reveals that, from Jan 2004 to June 2011, 21% of suicides involved alcohol while 9% involved drugs. From that same time period, 56% of suicide attempts were due to drug and alcohol overdose. To address suicides, the Army Health Promotion and Risk Reduction Task Force represents a portfolio of 60 + Soldier and Family programs that will be leveraged to reduce high risk behaviors that can culminate in suicide. Over 439 specific tasks have been developed and 135 implemented to address the issues. CATEP and limitation of drug prescriptions, both previously mentioned, are two example tasks from the Task Force.

To address stigma, the Army has developed a Stigma Reduction Campaign Plan with messages to help combat the negative perceptions of seeking help for substance abuse, behavioral health, and other challenges that Soldiers experience.

MINISTRY OF THE INTERIOR FUNDING

Question. The FY13 Army O&M budget cuts the Afghan National Security Force funds from $11.2B in FY12 to $5.7B. DoD has stated that this reflects the "front loading" of funds for equipment, facilities, etc, and does not reflect a decrease in commitment to the training mission. However, Ministry of the Interior forces (which include the Afghan police) is cut from $1.1B in FY12 to $570M in FY13, a decrease of almost 50%. This would appear to be a real blow to the Afghan police, who will be largely charged with maintaining stability and security, as well as bolstering confidence in the Afghan government's ability to care for its people just as the US military is pulling back.

Are there similar equipment and facilities costs associated with the Ministry of the Interior funding? If not, what is the rationale for such drastic cuts, which would appear to occur just as we are needing the Afghans to step up their roles?

Answer. The Afghan National Security Forces (ANSF), specifically the Afghan National Police (ANP), is growing in capability. This growth in capability is covered by two distinct phases: Build ANP capabilities and Sustain ANP capabilities. During FY 2012, the ANP will achieve their planned end strength of 157K. This fact passes the ANP into the Sustain phase in FY 2013 and subsequently reduces their requirement for initial entry training to only sustaining the force level. Another savings is projected based upon the Afghans assuming a greater role in overall training mission in FY 2013 and thus significantly reducing the reliance upon mentor and trainer contracts to meet these needs. The ANP is growing in overall strength and in capability. This capability will be reflected in both their operating and generating

forces. For clarification, the funding decrease for training and operations for the ANP is $1.1B in FY 2012 and $570M in FY 2013 for a reduction of 48%.

[CLERK'S NOTE.—End of questions submitted by Mr. Kingston. Questions submitted by Mr. Calvert and the answers thereto follow:]

GROUND COMBAT VEHICLE (DEFENSE ACQUISITION)

Question. Please explain why you believe the Army estimate for the ground combat vehicle (GCV) unit production costs is more accurate than the Pentagon's Office of Cost Assessment and Program Evaluation (CAPE) estimates.

Answer. The CAPE and the Army used two different approaches to the GCV cost estimates. The Army estimate is a detailed estimate directly driven by the GCV design concepts that take into account technical maturity, allowable trade space built into the GCV performance specification, and continued use of a detailed Cost Informed Trades process. It is based on the current planned schedule for delivering a production vehicle. The CAPE estimate is based on a conservative parametric estimate influenced by significant historical cost growth in various prior Army programs. As such, it is influenced by historical cost trends and is not directly driven by the GCV design concepts. For these reasons, we believe the Army estimate is a better reflection of anticipated GCV costs.

Question. is my understanding that three GCV development contracts were able to be awarded but only two actually were. Why wasn't the third contract awarded?

Answer. The GCV Technology Development (TD) phase Request for Proposals (RFP) specified that the Government would award up to three contracts for the TD effort. In response to the RFP, three offerors submitted their proposals. The Army conducted a thorough source selection and determined that the proposals submitted by British Aerospace Engineering (BAE) and General Dynamics Land Systems (GDLS) provided the best value to the U.S. Government. On August 29, 2012, Science Applications International Corporation (SAIC) filed a post-award Government Accountability Office (GAO) protest. On December 5, 2012, the GAO denied SAIC's protest and found that "With respect to SAIC, the Army found that, although the firm's Final Proposal Revision presented some strengths, it also had four significant weaknesses and numerous other weaknesses," and "In deciding not to award a third contract to SAIC, the Source Selection Authority concluded that there were clear and meaningful differences between the proposals and that the SAIC's proposal did not represent the best value to the U. S. Government."

JOINT LIGHT TACTICAL VEHICLE (DEFENSE ACQUISITION)

Question. Last year, the Joint Light Tactical Vehicle (JLTV) program appeared almost dead. Ford even declined an opportunity to bid on the project.

What makes it feasible now?

Answer. The JLTV is one of the Army's top three priorities. The Army and the United States Marine Corps (USMC) revised the Acquisition Strategy and Requirements to ensure that the MTV will be affordable while improving reliability and maintainability, providing commonality in design, and be procured competitively in order to reduce total ownership cost. The JLTV will fill the force protection and payload gaps not currently satisfied by the High Mobility Multipurpose Wheeled Vehicles. It also fills the mobility and transportability gaps in the Mine Resistant Ambush Protected Family of Vehicles.

Question. Why should Congress consider it to be a responsible acquisitions move now, when it arguably was not, last year?

Answer. Last year, the U.S. Congress expressed valid concerns about the program as it was structured prior to the efforts to align the program with the results of the Technology Demonstration phase. The Army and U.S. Marine Corps (USMC) have worked diligently to revise requirements, reduce the length of the program by more than 15 months, and reduce the development costs in the Engineering and Manufacturing Development (EMD) phase by nearly one half.

The U.S. Army and the USMC conducted trade and risk analysis through a Cost Informed Trade Assessment (CITA) to evaluate the Average Unit Manufacturing Cost of the base vehicle. The assessment yielded cost savings while only modestly affecting vehicle performance. The CITA process reduced the cost by 27.5 percent.

Question. Is the JTLV being offered as a lowest price/technically acceptable (LPTA) contract? If so, why was that contracting vehicle chosen?

Answer. No. The basis of the JLTV Engineering and Manufacturing Development (EMD) phase contract award(s) is not LPTA. The JLTV EMD Request for Proposal,

released to industry in Jan 2012, specifies that the U.S. Government will select the proposals that represent the best value to the U.S. Government according to a range of technical and other evaluation criteria.

The U.S. Government will award up to three contracts on a full and open competition basis for the JLTV EMD phase. The relative strengths, weaknesses, and risks of each proposal are considered when selecting the offer that represents the best overall value to the U.S. Government. Criteria for the EMD phase are focused on the maturity of the designs that are being bid, and the ability of those designs to meet at least threshold requirements. The solicitation also makes it clear that performance above threshold levels will be evaluated in the final selection for low rate initial production.

SEXUAL ASSAULT

Question. Some members of Congress have suggested that changes need to be made to the services prosecution of sexual assault. One proposal would establish a central body at the Pentagon to prosecute all sexual assaults in the Department of Defense.

In your opinion, would prosecuting sexual assaults separately from other criminal acts that occurred at the same time facilitate or delay prosecutions; cause any evidentiary issues; or have any potentially negative consequences for victims?

Answer. The separate prosecution of sexual assaults from other criminal acts occurring at the same time would delay prosecutions, cause evidentiary issues and unnecessarily subject victims to multiple investigations and trials. Many investigations arising from an allegation of sexual assault involve a variety of offenses (i.e. housebreaking, violations of regulations, alcohol offenses, false official statements). Bifurcation of these offenses for purposes of disposition and trial would be inefficient and contrary to basic principles of due process and equal protection by treating one class of offenses differently. Separate trials could raise complex issues regarding the admissibility of evidence, and create perceptions of potentially inconsistent findings, verdicts and unjust sentences. Separate trials would subject victims to additional interviews and cross examinations by defense counsel, forcing victims to recount the circumstances of the offense in a public forum on multiple occasions and delaying closure for the victim.

Question. Would removing the chain of command from the sexual assault prosecution process help avoid barriers to proper prosecution of allegations?

Answer. The Army's efforts to prevent, investigate and prosecute allegations of sexual assault are unprecedented. The result of 4 plus years of consistent focus and resourcing has made an enormous positive impact in culture change, in the quality of investigations, and in the way in which we hold offenders accountable. By any measure, our system of military justice is responsive, responsible and effective in dealing with this serious crime. Specifically, there are no barriers to the proper prosecution of sexual assault allegations under the Uniform Code of Military Justice in which Commanders, with the advice of Judge Advocates, are given the authority to dispose of allegations against members of their command. Commanders are appropriately trained, resourced and committed to reviewing all allegations of misconduct and holding offenders appropriately accountable. There is no evidence that removing the chain of command from the disposition of sexual assault allegations will improve decision-making or remove discretion from the process.

A Commander is responsible and accountable for all that goes on in a formation health, welfare, safety, morale discipline, and readiness to execute the mission. The adjudication of alleged offenses inside the unit must be efficient, visible, and just. Adjudication of sexual assault offenses by local commanders promotes these ends. Commanders are best-positioned to understand the impact of an offense on readiness and morale on his or her unit and the aggravating and mitigating factors of each unique offense. Transfer of the Commander's authority to an outside, centralized source does not ensure efficiency, reduces transparency, and undermines the credibility of dispositions of sexual assault cases. The military justice system, which utilizes the chain of command to adjudicate offenses, promotes loyalty to both superiors and subordinates, and is perceived by commanders, soldiers and the public as a just system.

Question. What has the Army done to disseminate the sexual assault programmatic changes that were included in the 2011 National Defense Authorization Act (NDAA) to the field? Do you have confirmation that the changes required by the 2011 NDAA have been implemented?

Answer. The FY11 NDAA required from the Army: Sec. 1602: Army Regulation 600–20, Appendix K (2) requires all Army Commands, Army Service Component Commands, and Direct Reporting Units to submit an annual report to Head-

quarters, Department of the Army (HQDA) which includes findings from any evaluation of the implementation of the Sexual Assault Prevention and Response (SAPR) program, actions and initiatives taken, recommendations for changes to SAPR policy, and any resource shortfalls.

Sec. 1611: Army Regulation 600–0, Appendix K (2) requires all Army Commands, Army Service Component Commands, and Direct Reporting Units include SAPR as part of their Command Inspection program, and conduct periodic evaluation of compliance. Additionally, The Department of the Army Inspector General (DAIG) conducts inspections at the direction of the Secretary of the Army. The Army Sexual Harassment/Assault Response and Prevention (SHARP) Program Office works closely with the DAIG to help the inspection team prepare for inspections of the SHARP Program, to include identifying subject matter experts to augment the team. The DAIG last inspected the SHARP Program from July 7, 2009 to November 6, 2009 and the report was approved on January 25, 2010. SHARP related inspections were not conducted in FY11 nor are planned for FY12 at either HQDA or Army Command-level, however SHARP related inspections were conducted at some TRADOC installations this past year. A look at SHARP may also occur incidental to other inspections. As an example, a recent inspection on Disciplined Leadership/Company Administration at numerous Army installations included a look at whether units were conducting SHARP training and the frequency of occurrence. Units are conducting SHARP training as required and in a timely manner. The topic will likely surface as an item of interest in future planned inspections as well.

The Army has a field grade officer/Major assigned to the DoD Sexual Assault Prevention and Response Office.

Sec. 1631: Army submitted its annual report for FY11 on March 12, 2012.

All other sections were not applicable to the Army.

[CLERK'S NOTE.—End of questions submitted by Mr. Calvert. Statements submitted by Mr. Visclosky.]

Mr. Secretary, General Odierno, I would like to express my support for the changes that have been made to the Joint Light Tactical Vehicle (JLTV) program. Last year, the Army and Marine Corps engaged in a thorough review of the program's schedule and requirements. By working closely with industry leaders, realistic determinations as to how to recalibrate this critical program were made, and the result is an accelerated, more cost effective program. I am pleased that the Army and Marine Corps leadership has taken these important steps on the JLTV program.

[CLERK'S NOTE.—End of statement submitted by Mr. Visclosky. Questions submitted Mr. Moran and the answers thereto follow:]

JOINT LIGHT TACTICAL VEHICLE (JLTV)

Question. The Joint Light Tactical Vehicle (JLTV) is a U.S. Army, U.S. Special Operations Command (USSOCOM), and U.S. Marine Corps collaborative program to replace the current High Mobility Multi-purpose Wheeled Vehicle (Hum-vee) with a fresh design to incorporate the survivability lessons learned from Iraq and Afghanistan.

General Odierno, the Army currently has about 150,000 HMMWVs. As the Army comes home from Iraq, and downsizes, how many light tactical vehicles will the Army maintain, and of that total number, how many will be JLTVs?

Answer. The Army will maintain approximately 136,000 light tactical vehicles, of which 49,099 will be JLTVs.

Question. General, during technology demonstration testing in March 2011, all three prototypes had difficulty navigating soft soil due to vehicle weight. The prototype's weight was driven by underbody protection equivalent to MRAPS. Is the JLTV's underbody protection requirement incompatible with the mobility requirements of the program?

Answer. The JLTV's underbody protection requirement is not incompatible with the mobility requirements. The adjustments that were made to the requirements preserved the key core capabilities that the MTV must satisfy by delivering significantly improved payload, protection and performance over our current light tactical vehicle fleet, without paying a premium in terms of either cost or schedule for marginally increased capabilities. Based on the Technology Development results, we have adjusted performance requirements so that the vehicle weight is reduced from approximately 24,000 lbs to approximately 19,500 lbs. This reduction in weight reduced the risk of meeting the mobility requirements.

Question. It is rumored that the testing period for the JLTV program will be reduced from 48 to 33 months. Is that true? What are the risks involved? What is driving an accelerated testing schedule?

Answer. The Joint Program Management Office revised the Acquisition Strategy, reducing the Engineering and Manufacturing Development (EMD) phase from 48 to 33 months. Out of those 33 months, the testing period for the JLTV program during the EMD phase is 14 months in length. Testing will include Contractor performance and U.S. Government reliability, performance, and blast testing.

The Department's program change from 48 to 33 months reduced program length and shifted from a traditional development phase where Industry would be paid with cost plus contracts for design to a program strategy that leverages and tests mature and production-ready industry designs. This adjusted schedule and strategy has reduced the total EMD cost by nearly $400 million.

TOUR NORMALIZATION IN KOREA

Question. Since the 1950s, soldiers assigned to Korea have served one year tours and family members are not supported or sponsored, With the exception of a few senior officers, the entire command in South Korea would rotate every year. In 2008, the Department announced "Tour Normalization" for Korea, which would normalize deployments to Korea by establishing two year tours for single service members and three year tours for married service members to include their family members.

How many soldiers do you estimate will take advantage of tour normalization?

Answer. Because tour normalization is currently on hold, the Army has not determined how many Soldiers will take advantage of tour normalization.

Question. Do you have an estimate of the additional cost per year for tour normalization?

Answer. If it is the decision to pursue full tour normalization the additional cost is estimated to be $481M per year, not including construction.

Question. Is adequate housing available for families that decide to accept a three year assignment in Korea?

Answer. Tour length is not a factor when determining the quantity of adequate family houses. The number of command sponsored families does not change with the increase in tour length.

COUNTERBOMBER SUICIDE BOMBER DETECTION SYSTEM

Question. The Congress has expressed concern over many years about the continued failure of the Army acquisition system to field systems to operational forces on a timely basis.

DOD has spent approximately $50 million developing and deploying the CounterBomber suicide bomber detection system. Over the last 5 years, the Departments of Army, Navy, and Air Force have expended millions of dollars testing the system and optimizing its performance against female bombers. Army ATEC formally tested the system at White Sands and Yuma Proving Grounds, where test reports indicate the CounterBomber system exceeded virtually all threshold and many objective thresholds from CENTCOM Joint Urgent Operational Needs Statement CC 315 for this kind of capability. The system has been continuously deployed by the Marines since 2008 and the Air Force since 2009 which includes 23 by the Army, 14 by the Marines, and 4 by the Air Force (total of 40). Unfortunately, only 6 Army systems are being operated, of which 2 are in Iraq and 4 are in Afghanistan, while others remain ready for deployment in transit boxes and some are in the manufacturer's warehouse undelivered due to lack of direction from the Army.

The Army has developed an innovative "Entry Control Point in a Box" for its soldiers, but has not yet included CounterBomber in that program while it conducts still more testing and evaluations and discusses which Army acquisition organization is responsible for it.

If the Army paid for CounterBomber systems, why haven't they been deployed?

Answer. The Joint Improvised Explosive Device Defeat Organization (JIEDDO), a joint services organization established to reduce or eliminate the effects of improvised explosive devices used against U.S. and Coalition Forces, funded 31 CounterBomber-3 (CB) systems for the Army. Of the Army's 31 CBs, 10 are in support of the Office of Security Cooperation-Iraq, 12 in Operation Enduring Freedom, and two in Kuwait. The remaining seven systems are located within the continental United States where they are used in support of the homeland defense mission.

Question. Why is CounterBomber not under the control of Army organizations responsible for the Entry Control Point in a Box program?

Answer. On April 3, 2012, Counter Bomber was assigned by the Assistant Secretary of the Army (Acquisition, Logistics and Technology) to the Joint Program Executive Office for Chemical and Biological Defense (JPEO CBD). The JPEO CBD is responsible for Non-Intrusive Inspection Systems (NIIS), and Entry Control Point in a Box.

Question. Question. Why is ownership of Counter Bomber still "stuck" internally in the Army between PEO Ammo and PEO CB Defense?

Answer. The Joint Program Executive Office for Chemical and Biological Defense (JPEO CBD) has been designated the Integrated Base Defense (IBD) lead, which provides the capability to present a holistic solution set, to include Counter Bomber 3 (CB–3). As of April 3, 2012, Counter Bomber was assigned to the JPEO CBD.

Question. What do U.S. forces use today to screen entry control points for personal-borne suicide bombers, and how close do potential bombers get to U.S. troops who inspect them? Why is this acceptable to the leadership of the Army?

Answer. The Joint Program Executive Office for Chemical and Biological Defense (JPEO CBD) was given the lead for the Integrated Base Defense (IBD) so integration of all applicable assets to screen at entry points are used in a system that can easily be accessed by the Base Commander. In addition to Counter Bomber (CB), the Army has procured other material solutions to screen personnel, to include Subtle Magnetic Anomaly Detection Networked Systems, Light Guard, Rapid Scan, Back Scatter Vans, walk-through metal detectors, Biometrics, and Random Antiterrorism Measures and the capabilities associated with Entrance Control Point in a Box. These systems provide protection against Vehicle Borne Improvised Explosive Device and Personnel Borne Improvised Explosive Device attacks. They allow the Army to generate a layered system of systems approach, a capability that is superior to CB, and capable of leveraging CB's ability to detect anomalies at a distance of up to 100 meters. This is acceptable to the leadership based on approved requirements from Commanders in the field.

Question. What systems is the Army fielding currently to meet the JUONS requirement for protection of U.S. forces against suicide bomber attacks?

Answer. The Army has fielded the following material solutions to meet the requirement for protection of U.S. Forces against suicide bomber attacks: Counter Bomber, Subtle Magnetic Anomaly Detection Networked Systems, Light Guard, Rapid Scan, Back Scatter Vans, walk-through metal detectors, Biometrics, Random Antiterrorism Measures and the capabilities associated with Entrance Control Point in a Box. These systems provide protection against Vehicle Borne Improvised Explosive Device and Personnel Borne Improvised Explosive Device attacks. The Joint Program Executive Office for Chemical and Biological Defense continues coordinating the integration of the systems to ensure a full solution that meets the requirements of the Combatant Commander.

[CLERK'S NOTE.—End of questions submited by Mr. Moran. Questions submitted by Mr. Hinchey and the answers thereto follow:]

SOLAR PANELS ON MILITARY BASES

Question. Mr. Secretary, I want to commend you on your efforts to stand up the Army Energy Investment Task Force and provide the leadership to ensure the Army meets its renewable energy goals.

The progress made by the Task Force is evident in its recently released draft RFP to develop $7 billion worth of renewable energy projects on bases via Power Purchase Agreements (PPAs), where third parties own and operate the system while leasing the power generated to the Army.

As you know, I am an ardent supporter of the military utilizing solar panels on these installations that comply with the Buy America Act. I am concerned this multi-year contract effort by the Army will allow solar panels from non-signatory WTO Government Procurement Agreement countries on sensitive U.S. bases.

How can the Army adjust the RFP to stop the circumvention of the Buy America Act for installation of solar panels on military bases?

Answer. The planned competitive Request for Proposals (RFP) for the Multiple Award Task Order Contract will include all provisions of the Buy American Act as required by Part 25 of the Federal Acquisition Regulation (FAR) and Part 225 of the Defense Federal Acquisition Supplement (DFARS), and the resulting award(s) will comply with the Buy American Act.

[Clerk's note.—End of questions submitted by Mr. Hinchey. Questions submitted by Mr. Young and the anwers thereto follow:]

ARMY FORCE REDUCTION

Question. As part of its fiscal year 2013 budget, the Army is proposing to reduce its end strength from 569,400 in fiscal year 2011 to 490,000, a reduction of over 80,000 troops.

General Odierno, the Committee is concerned that the proposed troop strength reduction is budget driven rather than based on military requirement. In your expert military opinion, will the Army have sufficient manpower based on the proposed end strength to meet its current obligations and respond to any future potential military needs?

Answer. The Army has sufficient end strength to meet current requirements and can implement the new defense strategy while affecting end strength reductions. By deliberately reducing end strength over a five-year period, the Army is able to take care of Soldiers, meet requirements in Afghanistan, and respond to unforeseen contingencies. We have planned a manpower reduction ramp that minimizes the number of Soldiers who will be involuntarily separated as well as reduces turbulence for recruiting and training requirements. Imposing arbitrary end strength floors would be detrimental to our deliberate manpower reduction plan. The Army will rely on Reserve Component (RC) forces to surge for major contingencies and maintain the proper deployed/home-station balance for the Total Army. We will also ensure the Army capitalizes on the investments of the past decade, such as Intelligence, Surveillance, and Reconnaissance (ISR) capabilities, Special Operations Forces (SOF), and leader development to support the new strategy as we decrease the Army's end strength. Investment in readiness, retention of high quality and combat experienced mid-grade officers and non-commissioned officers, and reliance on Reserve Component forces will allow the Army of 2020 to remain flexible to expand to meet requirements and to support long duration operations, if needed.

Question. Could the Army sustain additional reductions in end strength without overstressing the force or causing significant risk?

Answer. The reduction of the active Army to 490,000 Soldiers will enable the Army to meet both projected steady-state requirements and combatant commanders' timelines for warplans. Continued investment in readiness is required for this leaner stance, given the strategic environment of uncertainty and threat.

Question. As of the end of fiscal year 2011, the Army active and reserve components were operating at or near their authorized end strengths, and they were meeting or exceeding their recruiting and retention goals. In fact, the active component was at an average of 110% retention rate. For fiscal year 2013, the Army has requested increased funding for involuntary separation payments.

Given the high recruiting and retention rate, please describe how the Army plans to reduce the size of the force by 80,000 personnel.

Answer. The Army will use precision and care in determining who must leave our service, and will make every effort to keep faith with our All Volunteer Force and treat Soldiers and their Families fairly while continuing to meet the operational requirements of the Nation. First, the Army will minimize the number of induced (forced) losses needed to meet future end-strength requirements by lowering accessions without jeopardizing current and future operational requirements; thus allowing us to retain the greatest percentage of our seasoned force as possible. Second, the Army will use our proven centralized selection board processes to identify both Regularly Commissioned and Non-commissioned Officers with the greatest potential for continued service as we shape the force by grade and specialty. Finally, Commanders will be empowered to retain only the highest quality Soldiers. When feasible, fully qualified Soldiers identified as excess due to strength limitations will be afforded the option to volunteer for reclassification into a shortage skill. Additionally, in lieu of involuntary separation, voluntary options (when applicable) will be afforded to fully qualified Soldiers targeted to leave the service.

Question. Will reductions fall proportionately on officer and enlisted ranks?

Answer. Yes. While the number of enlisted inventory reductions will be greater in absolute terms, the proportionate reductions will be between 5.5% and 6% of the inventory for both enlisted and officers.

Question. The Army has already begun to request increased funding for involuntary separation payments—I understand that the Army plans to rely primarily on involuntary measures such as this to draw down. What impact will this have on the morale of the force? What is the rationale for using involuntary separation rather than incentives to encourage voluntary separations? Is the Army planning to use any voluntary separation payments in addition to the involuntary payments?

Answer. The Army seeks funding for several voluntary separation programs to ensure it retains flexibility as it continues to refine planning for inventory reductions. No final decisions have been made on specific programs or options at this time; how-

ever, a key precept of planning is that the Army will decide, to the greatest extent possible, who will remain and who will separate from service. These decisions will facilitate shaping the future force to requirements while retaining experienced Soldiers with the greatest potential for future contributions. Although DoD's force reduction objectives include guidance to maximize the use of voluntary separations, the Army's intent is to apply lessons learned from the 1990s drawdown when the magnitude of the voluntary separations made it difficult for the Army to control the quality of those service members choosing to separate. Post-drawdown analysis of the 90s reductions indicated that a large number of Soldiers accepting voluntary incentives would have separated without incentives.

In order to preserve this seasoned, All-Volunteer force, the Army will reduce accessions to the lowest level consistent with sustaining future mission capability, limit enlisted retention to support quantitative requirements based on a qualitative assessment, and employ proven and trusted centralized selection board processes to identify Soldiers, based on a qualitative review, who will leave our formations.

When forced separations are required, the Army will selectively target grades and specialties where excess capability exists, and will make maximum use of cross training and re-designation to fill critically short skills. The Army is an organization founded on an ethic of service to the nation. Soldiers understand that the Army must shrink or expand in response to the Nation's needs. Those who are identified to leave will be given the maximum amount of support in making the transition to retirement or other employment. Finally, the Army is evaluating use of voluntary separation incentives such as Temporary Early Retirement Authority as part of its overall strategy. Specific authorities and level of use will be determined as we finalize our planning and actively monitor execution in the future.

Question. Are you considering using new incentives, such as severance packages and early retirement packages, to encourage voluntary early separation as well?

Answer. As the Army finalizes our plans, we are analyzing the authorities provided by the Congress. We continue to evaluate the best methods to retain the best and brightest of our high-quality, experienced personnel as we shape our All-Volunteer force. Incorporating new incentives along with existing voluntary separation incentives will be determined as part of our final plan based on need and funding availability.

Question. Will forced separations or a Reduction in Force (RIF), be implemented to assist with the drawdown?

Answer. The normal losses we project through accession, retention and promotion processes will not achieve the end strength goals set for us. As a result, some combination of voluntary and involuntary separations will be necessary to achieve end strength goals. The Army will decide to the greatest extent possible which Soldiers will leave our service, and we will determine the most effective mix of all options for voluntary and involuntary separations as we finalize our planning.

Question. The Department's strategic guidance states that you will retain, to the extent possible, the ability to adjust or reverse force structure in case "unforeseen demands" arise in the future. Please explain how you plan to retain the ability to adjust or reverse changes in force structure should it be necessary.

Answer. The Army is examining strategies, policies and investments which posture the Army to slow down and reverse a planned drawdown of Army end strength and formations, and rapidly expand in response to a future crisis. Investment and Regeneration (I&R) will be attained through the adaptation of current manning, equipping, and training policies and procedures to enable the Army to reverse and expand by accessing additional soldiers annually to support regeneration of additional BCTs and enablers in response to any unforeseen requirements or changes in the defense strategy.

Additionally, the Army will identify military requirements resident in the Generating Force that can be concomitantly identified to support I&R.

Question. Under the new guidance, there will be an increased demand for certain military specialties even as the overall size of the force shrinks. While the size of the force is shrinking, are there certain occupations or skills that you would like to see grown? Please describe how you will reduce the size of the force while retaining or even increasing the number of personnel qualified for these high-demand specialties.

Answer. Although the overall force will be smaller, there are certain occupations or skills that the Army would like to see grown to both meet the new defense strategy and respond to lessons learned from current and recent operations. These include occupations such as those found in the Special Operations community, Cyber Operations and contracting specialists. The Army continues to carefully analyze personnel cohorts by skill and grade to determine where excess exists and alternatively where growth will be required. Our force shaping actions will be targeted and will

allow the Army to make the choice to keep our best qualified personnel with the highest potential for future contributions to the Nation's defense.

Question. General Odierno, many of our mid-level soldiers have only been in the military during war time. Concerns have been expressed about how to keep those soldiers used to the high op-tempo of the past ten years excited about staying in the Army. Are you concerned about how you will retain those soldiers, which will be the backbone of your smaller force, in this changing Army environment?

Answer. The Army remains committed to retaining the experienced, exceptionally capable mid-level Soldiers within our projected force structure. Soldiers at this level are remaining with the service for benefits, incentives, job satisfaction, security, and being part of a successful team. Army retention and promotion processes focus on the quality of the Soldier. Our goal is to keep Soldiers at all grades with the greatest potential to serve our Nation. This is accomplished for enlisted members by approving reenlistments based on a commander's review of the "Whole Soldier". Criteria for this review include meeting and exceeding Army standards, leadership potential, Soldier competencies, and overall military experience. Enlisted Soldiers with poor evaluations, no potential for future service, misconduct, and repetitive non-judicial punishments will not be retained as we shape our service to meet new fiscal realities. Officer career development and promotion policies ensure that only the best qualified and most experienced will be retained to advance to higher levels of responsibility.

Question. If we were attacked on two fronts, would we have the force strength and the resources necessary to respond?

Answer. The Army will carefully balance capability and risk as we size the force to meet national security demands. The Army uses a combination of factors when sizing the force: war plans, approved Defense Planning Scenarios developed in conjunction with the Joint Staff, and known and projected steady-state activities. These ranges of force demands are assessed in conjunction with force structure and end strength analysis to help the Army and senior leaders determine the risk associated with any course of action. Our ability to provide future forces is heavily dependent upon how we source units in accordance with Army priorities. Readiness will be a focus across all of our formations, emphasizing the need to maintain expertise and leader competencies, as well as the ability to expand the force to meet greater demands, if necessary.

DEPLOYMENT TO DWELL TIME

Question. The Army in particular has been experiencing very high rates of deployment over the past ten years. The mid-term deployment to dwell time ratio goal remains 1 to 2 for active duty units with a long term goal of 1 to 3 and 1 to 4 for reserve and National Guard troops. Achieving the dwell time goal is critical to restoring unit readiness and improving troop morale.

Please describe the specific measures the Army is implementing to reach its mid-term goal of 1 to 2 by the end of fiscal year 2013.

Answer. The objective for reaching 1:2 for the active Army is expected to occur in FY15. The Army implemented a 9 month Boots on the Ground (BOG) policy for units deploying in the second quarter of FY12 and later, which shortened tours to minimize stress on units and families.

To achieve these goals in the future, the Army is redesigning the Army Force Generation model to align with DoD strategic priorities and guidance while simultaneously providing for longer dwell time and appropriate readiness. Training time at home station will increase as commitments in Afghanistan diminish. The Army has a progressive readiness model for most units, but there are some high-demand, low-density units that may be better served by a constant readiness model. The Army will adjust the process where units advance through a reset phase, a training phase, and an available phase, by prioritizing their training and planning in support of a specific Combatant Command and mission sets.

Question. What is the Army doing to address dwell times of high demand units that are experiencing dwell time ratios below the average?

Answer. In the last decade the Army expanded low density, high demand capabilities such as aviation, civil affairs, intelligence, military police, psychological operations, engineers and special forces. We also mitigated shortages with in lieu of sourcing and re-missioning of units. The demand for these capabilities remains too high to realize a 1:2 Boots on the Ground (BOG):Dwell rotation prior to changes in the operational climate.

Question. What impact will the planned reduction in force have on future dwell time ratios?

Answer. In March 2012, the Army achieved the BOG:Dwell goal of 1:2 in the aggregate. The Army will sustain this goal even as we conduct the planned reduction in force in concert with the deliberate withdrawal from Afghanistan. Some low density, high demand capabilities have not yet achieved 1:2 BOG:Dwell. In the last decade the Army expanded many of these low density, high demand capabilities to include aviation, civil affairs, intelligence, military police, psychological operations, engineers and Special Forces. We also mitigated shortages with in lieu-of-sourcing and re-missioning of units. However, the demand for these capabilities remains too high to realize a 1:2 BOG:Dwell rotation prior to changes in the operational climate.

SUICIDE

Question. Suicide remains an issue of ongoing concern among the services. Anytime we lose a military member, it is a tragedy. It is even more of a tragedy when it is entirely preventable. The rate of suicides in the active Army has increased slightly from calendar year 2010 to calendar year 2011, from 159 to 165. The rate of suicide in the Army National Guard, in particular, remains extremely troubling with 103 suicides in 2010 and 80 in 2011.

Please describe the suicide prevention training and outreach programs currently in operation. What steps is the Army taking to identify potential at-risk personnel as well as to improve prevention and outreach efforts for them?

Answer. The Army currently provides suicide prevention training to Soldiers, leaders, Department of the Army (DA) civilians, and Family members through two main programs: the Ask, Care, Escort (ACE) Training Program and the Applied Suicide Intervention Skills Training (ASIST).

The Army's ACE Training Program is built around the actions to take to prevent suicide. The battle buddy should "Ask" a fellow Soldier or co-worker whether or not he/she is thinking about suicide, "Care" for the individual, and "Escort" the individual to the source of professional help. The ACE Training Program consists of two components: The Suicide Prevention Awareness, Education, and Training component (commonly referred to as ACE), and the Suicide Intervention (SI) Skills Training component.

The Suicide Prevention Awareness, Education, and Training component is the Army-approved suicide prevention and awareness training model for all Soldiers, leaders, and DA civilians, and is available to Family members. This training, approximately 1.0 to 1.5 hours in length, helps Soldiers, leaders, DA civilians, and Family members to avoid letting their fears of suicide govern their actions to prevent suicide. The ACE Training Program is supplemented by the "Shoulder to Shoulder" video series comprised of three installments ("No Soldier Stands Alone", "I Will Never Quit on Life" and "Finding Strength and Hope Together") as well as the interactive videos "Beyond the Front" and "Home Front." Army Regulation (AR) 600–63, Army Health Promotion, mandates annual ACE suicide prevention training for the Active Army, Army National Guard, Army Reserve, and DA civilians.

The ACE–SI Skills Training component is a 4-hour program that provides more in-depth suicide intervention training for leaders and first-line supervisors to empower them to be part of the solution. The ACE–SI training includes suicide awareness, warning signs of suicidal thinking and behavior, risk factors, protective factors/resilience, and intervention skills development. ACE–SI is a one-time training requirement for junior leaders and first-line supervisors that teaches the skills in active listening, increases the opportunity to secure early intervention before a suicidal crisis, and instructs individuals to take their battle buddy directly to a helping provider. In fiscal year 2012 (FY 2012), the Army will conduct ACE–SI train-the-trainer workshops Army-wide to provide the Army with the maximum number of ACE–SI trainers and support the requirement to train all junior leaders and first-line supervisors.

ASIST is the approved suicide intervention training for Gatekeepers. Gatekeepers are individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and DA civilians in need. ASIST is a one-time training requirement that helps Gatekeepers recognize and help individuals with suicide-related symptoms or issues. In FY 2012, the Army will provide funding to facilitate ten (10) ASIST Train-the-Trainer sessions and purchase 23,000 ASIST Kits to support the two-day workshops for Gatekeepers Army-wide. A Sole Source Indefinite Delivery, Indefinite Quantity (IDIQ) contract with Living Works Education is in the process of being approved to support this training requirement.

In addition to the ACE and ASIST training programs, the Army is currently developing curriculum for a new Company Commanders/First Sergeants Course that includes key information on health promotion, risk reduction and suicide prevention. This course will focus on the responsibility role of first-line leaders and peers. The

Army is also developing a new training course for Suicide Prevention Program Managers to assist them in organizing the many Army and community resources at their disposal to combat suicide.

In regards to outreach efforts, the Army continues to train Soldiers, leaders, DA civilians, and Family members to identify potential at-risk personnel and to have the confidence to intervene when someone is in need. The Army has also worked to increase access to and availability of behavioral health care to promote help-seeking behaviors, and has implemented in-theater mild Traumatic Brain Injury screening. Addressing the impact of substance abuse on suicides, the Army implemented the Pain Management Campaign to improve the appropriate use of narcotic pain medication and reduce medication adverse effects; launched the online alcohol and substance abuse risk self-assessment tool, "myPRIME"; expanded military drug testing of commonly abused prescription drugs, beginning with Hydrocodone and Hydromorphone; and initiated Army suicide prevention and substance abuse training at battalion and brigade pre-command courses to improve leader understanding. The Army has also worked to improve communication between law enforcement and unit leadership to ensure that Soldiers subject to investigative or legal actions are monitored for indicators of high-risk behavior or self-harm. Through collaboration with the Department of Veterans Affairs (VA), the Army has worked to promote the use of the free/confidential service (1–800–273–TALK (8255), press '1' for veterans) and to develop the Army Campaign theme.

Question. Secretary McHugh, does the fiscal year 2013 budget request adequate funding for suicide prevention training and outreach programs?

Answer. The Active Component Army Suicide Prevention Program is forecasted to receive $53.7 million in fiscal year 2013 (FY 2013). We assess this funding level will adequately address the program's requirements. However, this is not an enemy that can be defeated by a particular weapons system. It requires leader involvement from the top down and from the bottom up. Every Soldier must be aware and be prepared to intervene to stop a suicide. By and large this funding supports public awareness campaigns, suicide prevention support personnel, and training and education for Soldiers, leaders, Department of the Army (DA) Civilians, and Family members across the Active Army, Army National Guard (ARNG) and U.S. Army Reserve (USAR). Suicide prevention support personnel include Suicide Prevention Program Managers at installations, camps and stations worldwide for Installation Management Command (IMCOM), ARNG, and USAR. Army Suicide Prevention Program awareness training includes the Ask, Care, Escort (ACE) training; interactive and awareness training videos; suicide awareness training aids; execution of the Applied Suicide Intervention Skills Training (ASIST) Train-the-Trainer workshops and distribution of ASIST training materials; and health promotion, risk reduction, and suicide prevention training associated with Soldier and Family Ministry (Strong Bonds Training).

The foundation of the ARNG suicide prevention program is the ARNG Resilience, Risk Reduction and Suicide Prevention (R3SP) Campaign Plan. The R3SP Campaign Plan redefines suicide prevention as an integrated part of a broader based resilience and risk reduction framework. Although the ARNG engages in specific suicide prevention and intervention activities, the essence of prevention is accomplished by building resilient Soldiers and Families with well-developed coping skills, a strong support network, accessible and practical resources, and a supportive process for post-traumatic growth through times of crisis.

The ARNG FY 2013 funding is $5.3 million. If funding remains at this amount, the ARNG is capable of funding 54 Suicide Prevention Program Manager positions within each state and territory, providing five regional training classes for ASIST, and providing ASIST materials. The ARNG has made great strides in improving our support of Soldiers and Families. Additional funding would sustain FY 2013 capabilities for the ARNG Master Resilience Trainer Course.

Question. The Army recently released their "Gold Book", which serves as an update to the Army's "Red Book" and describes the health and discipline of the Force. Please discuss any new findings or new measures being taken based on the findings of the Gold Book.

Answer. The report entitled Army 2020, Generating Health and Discipline in the Force, otherwise known as the Army "Gold Book" looks at the current conditions across the Force. It examines the prevalence of behavioral health issues, incidents of crime and high-risk behavior, as well as relevant rates and trends over the last several years. It also reviews new policies and programs put in place since the Red Book to address identified gaps, and assesses their impact on improving Soldier health and readiness. Overall, the report tells us two things: we have made great progress in increasing health and discipline, and we have a lot of work still left to do.

One of the most important lessons that the Army has learned is that many health and disciplinary issues, ranging from post-traumatic stress to illicit drug use to suicide, are interrelated. As we move forward to address suicide, we must foster a culture that facilitates an awareness of the interactions of health and disciplinary issues on individual Soldiers, units and Army communities.

The 38 recommendations out of the Gold Book focus Army leaders on the actions required to close remaining gaps in Army health and disciplinary surveillance, detection and response systems. Additionally, the Health Promotion & Risk Reduction Council continues to implement and improve upon recommendations from the Red Book, while analyzing and incorporating those from the Gold Book.

Question. While soldiers serving on active duty return from deployments to military bases which provide more structured support networks, returning soldiers of the Army National Guard and the Army Reserve are frequently geographically isolated from their units and may not have regular interactions with their peers and chain of command. What are you are doing to help this vulnerable population?

Answer. Deployments place additional strain on our Soldiers and their Families. The Yellow Ribbon Reintegration Program serves service members from all Reserve Components and supports a safe, healthy, and successful reintegration of our Citizen-Soldiers and their Families following deployment. The Yellow Ribbon Reintegration program helps Soldiers and Families cope—and even thrive—in the face of life's challenges through information sharing, services, referrals, and proactive outreach opportunities coordinated at the state and territory level. This delivery structure ensures that attendees from all components are better prepared throughout the entire deployment cycle (pre-deployment, during a deployment, and post-deployment).

The National Guard Yellow Ribbon Reintegration program provides a robust, preventive, and proactive support program for Soldiers and Families, promoting preparedness through education, by conducting effective Family outreach, leveraging resources, and supporting the volunteer force. This provides the continuum of care needed to ensure successful Soldier and Family reintegration.

The Soldier and Family Support Division of National Guard Bureau assists and supports the Yellow Ribbon programs in the 54 states and territories. During fiscal year 2011 (FY 2011), 929 events were held with 89,524 service members and 91,151 designated individuals attending. To date in FY 2012, 550 events have been held with 38,397 service members and 41,172 designated individuals attending.

The U.S. Army Reserve (USAR) provides several behavioral health support networks initiatives for Soldiers who are geographically isolated from their units. Following return from a deployment, the USAR mandates personal contact with Soldiers and Family members between Battle Assemblies achieved through a variety of methods such as phone calls, Facebook, text messages, twitter, etc. The USAR has increased Suicide Prevention training opportunities and disseminated information to Family members in regard to risk factors, warning signs and contact assistance numbers. The USAR is strengthening Soldiers' and Families' support networks by ensuring that first-line supervisors, junior leaders, and unit Gatekeepers receive proper suicide intervention training. First-line supervisors and junior leaders receive the Ask, Care, and Escort (ACE) Skills Intervention (SI) training to help recognize suicidal behavior in fellow Soldiers and the warning signs that accompany it. Unit Gatekeepers receive the Applied Suicide Intervention Skills Training (ASIST), a standardized and customizable, two-trainer suicide prevention workshop designed for members of all care giving groups. The USAR also promotes Soldier and Family resiliency through a variety of programs, to include the Yellow Ribbon Reintegration Program, Strong Bonds, Army Strong Community Centers, the Army Reserve Fort Family hotline, Army Family Team Building training, virtual and real-world Family Readiness Groups, and Army Reserve Child and Youth Services. In addition to Army-specific programs, the USAR works to promote and advertise local resources to include Chaplains, Military and Family Life Consultants, Behavioral Health Providers, Off-Post Community Services, Churches, Medical Centers, Crisis Centers, Welcome Centers, and the National Suicide Prevention Lifeline 1–800–273–TALK (8255).

Question. Is there a particular demographic of personnel that are particularly vulnerable to suicide attempts? (i.e. age, race, gender, enlisted versus officer, frequently deployed versus never deployed) If so, please describe the measures being implemented by the Army to target this particularly vulnerable category?

Answer. It is important to first note that Soldiers who attempt suicide are a different demographic population than those who die by suicide. This response addresses those who attempt suicide, and thus, the below described demographic group does not represent the most vulnerable groups for death by suicide.

In reviewing suicide attempts from January 2004 to June 2011, the U.S. Army Public Health Command (USAPHC) Surveillance of Suicidal Behavior Report identifies the most vulnerable demographics to include: females, young Soldiers, and Soldiers of "other" race-ethnicity (non-White and non-Black). (Please note that each of these is a separate risk demographic, so it is not correct to say "young, female, non-white/non-black Soldiers.") Within these individual demographic characteristics, females were twice as likely as males to attempt suicide (attempt rates 128 per 100,000 and 60 per 100,000, respectively) and Soldiers age 24 or less were two to four times more likely to attempt suicide than older Soldiers.

The Army is targeting this demographic category by increasing Suicide Prevention training opportunities and disseminates information to Family members with regard to risk factors, warning signs and contact assistance numbers. The Army is also working to strengthen Soldiers' and Families' support networks by ensuring that first-line supervisors, junior leaders, and unit Gatekeepers receive proper suicide intervention training. First-line supervisors and junior leaders receive the Ask, Care, and Escort (ACE) Skills Intervention (SI) training to help recognize suicidal behavior in fellow Soldiers and the warning signs that accompany it. Unit Gatekeepers receive the Applied Suicide Intervention Skills Training (ASIST), a standardized and customizable, two-trainer suicide prevention workshop designed for members of all care giving groups. In addition to Army-specific programs, the Army works to promote and advertise local resources to include Chaplains, Military and Family Life Consultants, Behavioral Health Providers, Off-Post Community Services, Churches, Medical Centers, Crisis Centers, Welcome Centers, and the National Suicide Prevention Lifeline 1–800–273–TALK (8255).

Question. What mental health services are available to soldiers prior to deployment, while in theater, and then at home upon returning from deployment? What mental health services are available to their families?

Answer. The Army's Behavioral Health System of Care, under U.S. Army Medical Command, has an extensive array of behavioral health services and wellness resources available to address the strain on service members and their Families throughout the Army Force Generation Cycle. Soldiers and Family members have additional counseling options and other avenues to deal with stress through Army Chaplain services, Military One Source, in-theater combat and operational stress programs, psychological school programs, Army Community Service programs, and the Comprehensive Soldier Fitness program.

SEXUAL ASSAULT IN THE FORCE

Question. Sexual assault remains a significant problem in the military and in the Army specifically. While the Committee recognizes the steps the Department has taken to reduce the number of incidents, it remains a pervasive problem. The Army's Gold Book states that sex crimes in the active duty army have seen a 28% increase from fiscal year 2006 to fiscal year 2011.

In a recent press conference, Secretary of Defense Panetta stated that while 3,191 sexual assaults were reported last year in the military as a whole, the actual number of incidents was probably closer to 19,000. Both as a military and as a society, we must do more to change the stigma of sexual assault so that victims are not afraid to come forward and report the crime without worrying that their career or their personal reputation will be damaged and so that perpetrators know they will be held fully accountable for their crimes.

Please describe the policies and programs currently in place to combat sexual assault and provide immediate care and assistance to victims of sexual assault. What new programs are being implemented to combat this issue?

Answer. The behaviors of sexual assault and sexual harassment are unacceptable to the military profession, and the Army is taking strides to re-energize the standards and discipline long at the core of a professional, all-volunteer force.

Inasmuch as behavior such as sexual harassment sets a potential foundation for sexual violence, the Army is combining its SAPR Program with the Prevention of Sexual Harassment (POSH) efforts. The result is a new overarching program called Sexual Harassment/Assault Response and Prevention, or SHARP. SHARP addresses sexual misconduct at the earliest point of intervention, as Army survey data indicates approximately 40% of sexual assaults were preceded by sexual harassment.

The SHARP Program includes the Army's Sexual Harassment/Assault Prevention Strategy and Campaign, the intent of which is to prevent sexual assaults from occurring. Leaders at all echelons facilitate this prevention strategy by establishing positive command climates in which sexual assault rarely occurs, but when it does, victims can come forward with confidence that their leaders will take appropriate action.

The cornerstone of the prevention strategy is the "I. A.M. Strong" campaign where the letters I. A. M. stands for Intervene—Act—Motivate. The purpose of "I. A.M. Strong" is to encourage Soldiers to take action to prevent sexual assault and to actively foster respectful treatment of others. The Army's prevention strategy also strives to reduce the stigma of reporting, thus increasing a victim's propensity to report incidents for one of the nation's most unreported crimes.

To support commanders in implementing the SHARP Program and the "I. A.M. Strong" campaign, the Army established an 80-hour SHARP training course conducted by SHARP Mobile Training Teams (MTT). To date, MTTs have trained 12.8K command-selected SHARP personnel from major command down to the company level. These SHARP personnel are trained to help commanders establish and maintain positive command climates, and provide immediate and accessible support to victims of sexual assault.

Army Regulation (AR) 600–20 (Army Command Policy) formalizes the Army's Sexual Assault Prevention and Response (SAPR) Program. The Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA M&RA) has oversight of the Army's SAPR Program, while the Deputy Chief of Staff, G–1 is responsible for program implementation and assessment. As we combine the SAPR Program with the Prevention of Sexual Harassment (POSH) efforts, Army will combine Chapters 7 (POSH) and 8 (SAPR) of AR 600–20 into one chapter addressing SHARP.

The SHARP program is a command responsibility. Therefore, commanders are required to: establish a command climate that prevents the crime of sexual assault; treat all allegations of sexual assault seriously and ensure investigations occur; treat victims with dignity and respect; and take appropriate action against offenders. Significant elements of the current Army program include:

- Installation commanders and deployed senior commanders (or their representatives) have overall responsibility for SAPR Program implementation and 24/7 execution. As a critical element of program execution, these leaders conduct required monthly Sexual Assault Review Boards (SARB). The SARB provides executive oversight, procedural guidance and feedback concerning local program implementation and case management.
- Army-wide Victim Advocacy Program led by Sexual Assault Response Coordinators (SARCs) and supported by a cadre of professional Victim Advocates (VA). These SARCs and VAs are available 24 hours a day/7 days a week to interact directly with victims of sexual assault and other response agencies (medical, legal, law enforcement, investigative, and chaplain).
- Command Program Managers, Deployable Sexual Assault Response Coordinators (DSARCs) and Unit Victim Advocates (UVA) are Soldiers (or civilians assigned to military units) who assist their commanders in executing their SAPR Programs and coordinating sexual assault response efforts (legal, law enforcement, chaplaincy, and medical).
  - —DSARCs and UVAs provide/support advocacy services in deployed environments and for geographically dispersed units in CONUS and OCONUS not serviced by an installation. They also augment advocacy services in a garrison environment, as needed.
  - —Army policy requires each brigade level unit and higher echelon to have one trained DSARC. UVAs are Soldiers (or civilians assigned to military units) trained to provide victim advocacy as a collateral duty. Army policy requires two UVAs for each battalion sized unit. (Some units may require more than two due to geographical dispersion).
- All levels of Army institutional Professional Military Education (PME), from initial entry to senior service school, use a comprehensive set of training support packages to conduct required training. Annual unit level sexual assault awareness and pre- and post-deployment SHARP training is also mandatory per AR 350–1 (Army Training and Leader Development).

Question. Secretary McHugh, incidents of assault appear to be highest among the 18–24 year old, junior enlisted population. Females compose only 14% of the Army's force, but they make up 95% of all victims of violent sex crimes. What are we doing to teach our newest servicemembers about the military's no tolerance policy for sexual assault and the programs in place should they experience such an assault? What programs are in place for both our enlisted recruits and at West Point and ROTC to raise awareness of this issue? What programs are in place to train our commanders and senior non-commissioned officers how to handle such cases?

Answer. Army research and national data indicate sexual assault is a societal issue that affects male and female Soldiers. While female victims are more likely to report being sexually assaulted, the Army is addressing sexual assault prevention across the entire force. The SHARP Program includes the Army's Sexual Harassment/Assault Prevention Strategy and Campaign, the intent of which is to prevent

sexual assaults from occurring. The goal of phase II of this four-phased campaign was to achieve Army-wide synchronization, and included the task to aggressively indoctrinate pre-accession and first term Soldiers. Soldiers would become advocates for prevention and would participate in peer-to-peer intervention training, take action to stop harassment and assaults, and speak out against sexual harassment and sexual assault.

Since 2005, the Army has included sexual assault prevention and response training at all levels of Professional Military Education (PME), from Initial Entry Training (IET) through the Army War College. In 2011, the Army revised this PME training, starting with IET.

To educate new Soldiers in a more attention-getting and intriguing manner, the revised IET training includes a set of ten "Sex Rules" ("Sex Rules—Follow Them") which break down the elements of sexual harassment and sexual assault and defines them in simple, relatable terms. By linking each Sex Rule to an Army Value, the training helps establish the social behavior expected of all Soldiers. The revised curriculum challenges Soldiers to "Know the Rules—Live the Values" and includes a pocket guide for Drill Sergeants ("Sex Rules—Teach Them").

Most of the concepts in the new IET curriculum are also embedded in the upgraded ROTC training. In coordination with Cadet Command, the Army SHARP Program Office developed new ROTC training which incorporates "Sex Rules" messaging, an ROTC Cadre SHARP Guide, and a critical decision-making tool.

The IET curriculum also added the live, two-person, audience interactive "Sex Signals". This 90-minute program includes skits dealing with dating, consent, rape and other associated topics such as body language, alcohol use and intervention. Newly commissioned officers receive Sex Signals training in their Basic Officer Leadership Course. We are assessing the use of this program in other educational venues.

West Point conducts a myriad of sexual assault prevention and response training and education events which are above and beyond the requirements under DoD and Army policy. In addition to the required unit level training conducted by every Army unit, West Point conducts targeted Sexual Assault /Sexual Harassment education for each class of the Corps of Cadets. For example, during FY11, the Fourth Class (freshman) cadets received training from Ms. Veraunda Jackson, a renowned sexual assault survivor and lecturer. Third Class (sophomores) cadets received a cadet/staff facilitated class centered on a university-focused sexual assault training package, "Welcome to the Party". Second Class (Junior) cadets participated in audience interactive productions of "Sex Signals". First Class (Senior) cadets received additional instruction focused on the tenets of the Army SHARP campaign, "I. A.M. Strong", to prevent sexual assault and sexual harassment.

To ensure our commanders and senior non-commissioned officers know how to handle sexual assault cases, the Army's PME training is specifically tailored for junior, intermediate and senior leaders. This includes training at the Sergeants Major Academy, Army War College and Pre-Command Courses (PCC). The PCC curriculum for Brigade and Battalion Commanders includes instruction from the Army Judge Advocate General School and Legal Center on handling sexual assault cases.

Question. The Gold Book states that violent sex crimes are most likely to occur during periods of transition—during times when soldiers are transitioning into their new units and lack the formal chain of command and established social network. Young female soldiers are most vulnerable to assault. What is the Army specifically doing during these transition periods to prevent assaults?

Answer. The Army uses a battle buddy system for pairing Initial Entry Training (IET) Soldiers into teams to teach teamwork, develop a sense of responsibility and accountability for fellow Soldiers, improve safety, and reduce the likelihood and opportunity for sexual harassment, sexual assault, misconduct and suicidal gestures or attempts. Under the battle buddy concept, IET Soldiers are formed into two-person teams upon arrival at their initial training unit. Soldiers must have battle buddies at all times; the cadre will pair ad hoc buddy teams of the same gender for sick call, worship services, additional unit-specific training, or remedial training. Similarly, ad hoc buddy teams are formed on Family Day for Soldiers without family members attending. Soldiers must also utilize the battle buddy system during all passes except when accompanied by family members.

The Army takes sponsorship of Soldiers into their new units very seriously. Under the Army's formal Sponsorship Program, commanders are directed to assign same-gender sponsors for Soldiers and civilians, especially first-term Soldiers. Sponsors of first-term Soldiers act as battle buddies in order to orient inbound Soldiers to their new surroundings, in all aspects of Army life, and to provide support and assistance during the transition period. Sponsors of first-term Soldiers have a responsibility for their fellow Soldiers and are charged to monitor their safety and "reduce

the likelihood and opportunity for sexual assault" during the Soldier's first year in the unit.

The Army has sent training materials focused on the "I. A.M. Strong" Campaign down to the battalion level. These materials included posters, touch cards, brochures, and videos, including Amateur Night, a 12-minute video suitable for newcomer orientation training. Additionally, Annual unit level sexual assault awareness and pre- and post-deployment SHARP training are also mandatory per AR 350–1 (Army Training and Leader Development).

Question. The Gold Book states that 97% of victims at least casually knew their attackers and that most assaults occurred in the barracks in a situation in which alcohol was present. What is the Army doing to address the risk associated with high density housing? Does the presence of alcohol inhibit victims from coming forward for fear of being punished for violating rules regarding the use of alcohol?

Answer. The primary solution to these issues is positive and engaged leadership. That is why we are aggressively implementing and expanding the Army's comprehensive Sexual Harassment/Assault Response and Prevention (SHARP) Program. SHARP is a commander's program, committed to ensuring engaged leadership at all levels to foster a climate of trust that respects the dignity of our Soldiers and serves to prevent sexual assault.

To support commanders in this effort, the SHARP program is training SHARP Personnel at every echelon down to the company level. To date, the Army has trained over 9,000 unit SHARP personnel using mobile training teams delivering an 80-hour nationally certified curriculum.

Additionally, the Army fielded new mandatory annual unit training which includes leader and Soldier videos and an interactive video for all Soldiers. This self-study video ("Team Bound") is an interactive, multiple scenario product in which Soldiers become the lead character, making choices in situations dealing with sexual harassment and sexual assault. The revised unit and self-study training began in April 2011.

Finally, we know that one of the reasons Soldiers may not report they are a victim of sexual assault is because they were involved in some kind of misconduct themselves, including the unauthorized use of alcohol. Since March 2008, Army policy instructs Commanders to consider delaying disposition of any collateral misconduct on the part of a sexual assault victim so as to encourage reporting and cooperation.

Question. Does the fiscal year 2013 budget include sufficient funding for the Army Sexual Assault Prevention and Response Programs? Does the Army have a sufficient number of sexual assault response coordinators so that anywhere you might find a soldier, you will find a coordinator?

Answer. Senior Army leadership has always ensured adequate funding for all of the Army SHARP Program. Army currently has contract and collateral duty sexual assault response coordinators to provide services to the force regardless of location. Per FY12 NDAA requirement for full time brigade or like-sized unit Sexual Assault Response Coordinators (SARC) and Victim Advocates (VA), the Army is implementing an interim manning solution requiring trained, full time military personnel in the positions as we transition from contract and collateral duty program execution. Army uses Mobile Training Teams to train personnel to meet 17,000 Command program manning requirements at brigade and below command levels. Army is identifying costs based on the FY12 NDAA requirement and will request resources for these requirements through the normal programming and budgeting process.

STOP LOSS

Question. In 2009, Secretary Gates announced the phased suspension of the Stop Loss Program. Among the Services, the Army relied most heavily on Stop Loss to supplement their forces. This Committee established a new special pay, which provides up to a maximum of $500 per month for all service members extended under Stop Loss since September 11, 2001. This Committee believes it is important that every eligible service member that has earned the benefit have the opportunity to receive it.

How many soldiers have been provided with the benefit? How many are eligible to receive stop loss payments but have not yet collected their benefit?

Answer. The Army reviewed 108,946 claims to date. Of those, 82,707 have been paid; the remaining 26,239 claims did not meet the eligibility requirements established by the Department. There are 11,054 potential claimants remaining to be paid. However, they have not responded to the extensive outreach campaign the Army has conducted that included two certified mailing.

Question. In your opinion, have the outreach and education efforts adequately reached every service member who is eligible to receive these payments to ensure they are aware of the payments and understand the steps they must take to collect the benefit?

Answer. Yes, the Army has conducted a number of innovative outreach efforts to include a certified mail campaign advertising in every recruiting station, and communications with veteran service organizations. As a result, we know that some members have received as many as four notifications. We have received claims from every state and territory as well as 12 foreign countries. We have also received claims from Service Members who served during every major conflict going back to the Korean War.

Question. Is additional time needed to ensure that every soldier eligible for this special pay has een provided the opportunity to apply for it?

Answer. No, the Army does not believe additional time will measurably increase the number of Soldiers applying for the Special Pay. The program has had a number of extensions and the number of "new" claims that have been received since the October deadline is very small.

TOUR NORMALIZATION IN KOREA

Question. Since the 1950s, soldiers assigned to Korea have served one year tours and family members are not supported or sponsored. With the exception of a few senior officers, the entire command in South Korea would rotate every year. In 2008, the Department announced "Tour Normalization" for Korea, which would normalize deployments to Korea by establishing two year tours for single servicemembers and three year tours for married servicemembers to include their family members.

Mr. Secretary, do you have a timeline for implementation of Tour Normalization?

Answer. The Army does not have a timeline for the implementation of Tour Normalization. The Department's directions were to pursue Tour Normalization as affordable and feasible. After analysis the Department determined tour norm is not affordable because it would require additional housing, schools and require additional funding to support families.

Question. Will all of our soldiers that are bound for Korea be eligible for the longer, accompanied tours? If not, how will the Army determine which soldiers will be eligible for tour normalization?

Answer. All movement on Tour Normalization has been suspended as General Thurman, current commander of US Forces, Korea, reevaluates the strategic and financial environment on the Korean peninsula. Ultimately it is his military strategy that will drive the requirement for accompanied military members in Korea.

Question. How many soldiers do you estimate will take advantage of tour normalization? Do you have an estimate of the additional cost per year, not including the required military construction to support the additional families, for tour normalization?

Answer. The Army has not determined how many Soldiers would take advantage of command sponsorship if the Department of Defense was to authorize tour normalization. The estimated additional cost per year to implement tour normalization is $481 million annually, not including construction.

Question. General Odierno, how has Tour Normalization been received by our soldiers and then.FTily members who are bound for a tour of duty in Korea?

Answer. The Army currently does not have a matrix or a survey that identifies how Tour Normalization is received by Soldiers. However, anecdotal evidence from the chain of command indicates that Tour Normalization is well received by Soldiers. The total Army command sponsorship positions for the Army is 3740 out of 4645 total for all Services.

Question. Is adequate housing available for families that decide to accept a three year assignment to U. S. Forces Korea?

Answer. Tour length is not a factor when determining the quantity of adequate family houses. The number of command sponsored families does not change with the increase in tour length, therefore the quantity of housing remains adequate given existing limits on accompanied tours.

Question. What is the status of providing facilities such as schools, medical clinics, exchanges, commissaries, and other support activities that are needed to provide for a large increase in military families that are assigned to U.S. Forces Korea?

Answer. There are no plans to construct additional facilities to support tour normalization. The Fiscal Year 2012 NDAA section 2111 restricts the number of command sponsored tours at the current level of 4645.

Question. General Odierno, the Department of Defense recently released a report regarding women in combat, which stated that it is "committed to removing all barriers that would prevent Servicemembers from rising to the highest level of responsibility that their talents and capabilities warrant." The Army estimated that, in fiscal year 2011, 66% of Army active component positions were open to women.

What percentage of positions will be open to women in the Army once this guidance is implemented?

Answer. Approximately 67% of all authorized positions in the Active Army will be open to women based on the policy changes outlined in the DoD report.

Question. Please provide us with some examples of positions that would now be open to women. Are there concerns about the impact this guidance could have in the field? Does the Army expect it will have to adjust either its qualification requirements or it training or operations plans to accommodate this new guidance?

Answer. Example of positions that would become open based on the removal of collocation include: Bradley Fighting Vehicle System Maintainer, Field Artillery Radar Specialist, and M1 Abrams Tank System Repairer. These are positions that have never been available to women. Additionally, positions such Human Resources Specialist and Supply Specialist, though open to women, women will now have the opportunity to serve in units such as Multiple Launch Rocket Systems and Opposing Forces (OPFOR) Battalions. Examples of positions that would become open based on the exception to the Direct Ground Combat Assignment Rule include: Military Intelligence Officer, Human Resources Officer, and Physician's Assistants. Though currently held by women, this will be the first time they will be able to serve in these positions in Infantry, Armor, and Field Artillery Cannon Battalions. As outlined in the report released on 9 Feb, the openings of these particular positions are limited to only 37 battalions across the Army.

Yes, there is always some level of concern when doing something new or different. However, the Army is a highly disciplined, highly professional organization where women have fought side-by-side with their male counterparts since the inception of the All-Volunteer force. At this time the Army leadership believes this is the right step forward. We will not be adjusting any qualifications to accommodate this guidance. However, there are minimal billeting requirements that are currently working at the Fort Benning training base. The requirements entail reconfiguring barracks space that includes replacing urinals with toilets and constructing walls that completely separate male quarters from female quarters. These are requirements already in place at other installations impacted by the opening of these positions. Recruiting operations will be adjusted to include recruitment of women for positions that have never been available to them as we begin recruiting for FY 13.

Question. Please explain for the Committee any benefits or challenges that you envision will be a consequence of the new guidance will create for the Army and for the typical soldier, both male and female.

Answer. The greatest benefit under this new guidance is the opportunities created for both males and females to serve in a greater breadth of roles at varying levels of the force. It is a benefit to commanders as it adds flexibility in placing the best Soldiers, male or female, where they best fit. It is a benefit to the Army as it increases our opportunity to utilize the talents of our greatest assets, our Soldiers.

Question. For the past ten years the Department has focused nearly exclusively on counter insurgency, and as a result the military's readiness to address units "high end" warfighting missions has been compromised. Over the past few years the Army' "Status of Resources and Training System" readiness levels have hovered consistently at 20–25 percent, meaning only 25 percent of Army units can accomplish their assigned mission. The Army's operation and maintenance budget request includes additional training funds to support "Decisive Action", the effort to rebuild full spectrum readiness.

Secretary McHugh, the Department's quarterly readiness reports to the Congress state that 75 percent of the Army's military units are not able to accomplish their assigned mission. How did this impact your strategy review? How is this addressed in your budget request?

Answer. This issue pertains to the Army's readiness reporting (all units) of C-Level (Core mission) assessments and the A-level (Directed mission) assessments. In addition, readiness reporting is often confused with the Army's Force Generation (ARFORGEN) process for the rotational units in Operating force. The readiness reporting percentages cited in the question reflect readiness reporting C-level data aggregated for all Army units, to include units in the Reset and Train/Ready force pools.

The C-Level assessment reflects the ability of a unit to accomplish its core functions and to provide the capabilities for which it was designed (the core mission or designed mission). The A-Level assessment reflects the ability of a unit to accom-

plish the specific mission that has been directed for planning or formally assigned for execution (the directed or assigned mission).

Currently, the preponderance of deployed and next to deploy Army units report the highest levels of readiness for their directed missions (A-Levels), and a significant majority of these units report high C-Levels as well. In many cases, Army units are assigned and execute various missions and tasks that are significantly different from those for which they were designed (for example, a field artillery battalion assigned to execute a security force mission).

The ARFORGEN process is the structured progression of unit readiness over time to produce trained, ready, and cohesive units prepared for operational deployment in support of the Combatant Commander and other Army requirements. ARFORGEN utilizes aim points as a mechanism to establish benchmarks for manning, training and equipping criteria. Units entering into the "Train/Ready" force pool report degraded levels of readiness to accurately reflect their aim point for current resource and training status. Units in the "Available" pool are expected to be at the higher Core mission levels of readiness (C1/C2) for their directed or assigned missions (A-levels). The readiness percentages cited in this question reflect Core mission level data aggregated for all Army units, to include units in the "Reset" and "Train/Ready" force pools.

Question. General Odierno, could you explain the Army's training activity called "Decisive Action"?

Answer. Army Doctrine Publication 3–0 (ADP 3–0 published October 2011, provides a common operational concept for a future in which Army forces must be prepared for operations across the range of military operations, integrating their actions with joint, interagency, and multinational partners as part of a larger effort. As described in ADP 3–0, to achieve decisive action during operations, forces must be prepared to effectively execute some mix of offensive, defensive, and stability tasks (defense support to civilian agencies in the Contiguous United States). Army unit-level training strategies are designed to enable units for decisive action across a broad range of missions, that is, to perform the fundamental doctrinal tasks needed to conduct a combination of offense, defense, and stability operations (or defense support of civil authorities); by means of Army core competencies (combined arms maneuver / wide area security); as part of a joint, interagency, and frequently multinational coalition; against an adaptive hybrid threat (mix of conventional and unconventional forces, terrorists and criminals); at any point from stable peace to general war.

Question: Secretary McHugh, given the resources available, the Army has done a good job of supporting the effort to rebuild the Nation's readiness. Could you explain how a sequester would impact the Army's readiness budgets?

Answer. The magnitude of these cuts to both the military and civilian force structure, readiness, and modernization would be devastating. The indiscriminate nature of these large and arbitrary cuts does not provide the Army with the necessary flexibility to react to the uncertain security environment.

Such reductions would result in lower readiness levels of units and adversely impact our modernization efforts, as well as the defense industrial base. Moreover, we risk breaking faith with our Soldiers and their Families who have performed superbly over ten years of continuous conflict. Sustaining the all-volunteer force is absolutely essential for the Army's ability to support our Nation's defense.

THE HOLLOW FORCE

Question. In 1980, the term "Hollow Force" was coined by Army Chief of Staff General Meyer when only four of ten active divisions were capable of deploying overseas in an emergency. The term "hollow force" that was soon widely used to characterize a force was not capable of performing required missions. In the 1990s "hollowness" once again became a concern. The force structure following the victory in Operation Desert Storm/Desert Shield, the expected cold war "peace dividend," and a recession in the early 1990s resulted in a significantly reduced DoD top-line, a growing backlog of depot maintenance and degraded readiness. The Army's fiscal year 2013 budget request (base and OCO) includes $1 billion less (21 percent decrease) in equipment maintenance and reset funds from fiscal year 2012 planned levels and $1.8 billion less than was spent in fiscal year 2011. The impact of the Army's equipment repair budget after prolonged combat operations, or ten years of war on equipment is concerning. The continuous increase in operations has been unprecedented. Many types of military equipment have been used in operations at three to five times "peacetime" operational rates with a related increase in necessary maintenance. The need to "reset" equipment has been adequately funded

over the past five years, although these efforts will need to persist for several years after current operations end.

General Odierno, experts predict that it will take years to repair and reset equipment even after current operations end and yet the fiscal year 2013 request for equipment maintenance is 21 percent ($1 billion) less than will be spent this year. Can you assure the Committee that the budget request for equipment maintenance will keep it capable and will not put us on a path to a hollow force?

Answer. I can assure the committee that our FY13 request for equipment maintenance will adequately address our critical requirements and sustain our equipment readiness.

The Army is "right-sizing" its base depot maintenance budget to capture its post-war requirements in order to facilitate the transition of forces from Overseas Contingency Operations (OCO) to Base funding.

Depot Maintenance requirements are aligned with Army Force Generation (ARFORGEN) demands and resourced according to Army's priorities.

Depot maintenance base program sustains unit readiness by providing equipment availability and reliability and is balanced with other Army initiatives and priorities, i.e. force structure changes.

The FY 2013 budget request for Depot Maintenance is ~ $4.9B ($2.3B in Base Sub Activity Group (SAG) 123 and $2.6B in Reset SAG 137). The FY 2012 enacted budget for Depot Maintenance is ~ $5.3B ($3.0B in Base SAG 123 and $2.3B in Reset SAG 137).

I would also reiterate to the committee that reset is a lengthy process and even after the drawdown from Afghanistan is complete, the Army will require funding from OCO for 2 to 3 years to reset our equipment from the harsh demands of war.

Question. The proposed resource reductions to equipment maintenance are incremental, and the effects are not immediately apparent. General Odierno, can you assure the Committee that cuts to equipment maintenance budgets that you propose will not unintentionally reduce equipment capability and military readiness?

Answer. I can assure the committee that our reduction in equipment maintenance budget is tempered by the condition and readiness of our fleets and our ability to respond to unforeseen contingencies. FY13 request for equipment maintenance adequately addresses our critical requirements and sustains our equipment readiness.

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SECURITY CONTRACTORS IN AFGHANISTAN

Question. As of December 2011, the Department of Defense employed approximately 133,000 contractors in Afghanistan, 20,000 of which were security contractors with the majority of these being Afghan nationals. President Karzai has long expressed concern that private security firms skirt the law and are vulnerable to corruption. In 2009, President Karzai issued a decree to abolish the use of private security guards in Afghanistan. On March 21st the first tranche of private security guards, approximately 11,000 guards, now working for private security firms will become Afghan government employees as members of the Afghan Public Protection Force (APPF). The United States will finance future security requirements via an international security agreement with the APPF on a fee-for-service basis.

What impact has the recent killings of six U.S. soldiers had on the transition plan?

Answer. No combat operations are without risk. While the loss of any U.S. service member's life is tragic, these killings will not cause us to deviate from the current transition plan.

Question. Do you have confidence that the APPF has the capability and the resources to meet our security needs? If not, what is being done to mitigate risks?

Answer. The APPF has made notable progress over the past year, transforming itself from a government-run guard force, lacking advanced business functions, into a functioning State-Owned Enterprise, now capable of delivering commercial secu-

rity services to international organizations and commercial enterprises. As a State-Owned Enterprise (SOE), the APPF is working to develop modern business practices—providing effective security services while generating self-sustaining revenue. As of this date, the APPF has achieved an Initial Operating Capacity (IOC), sufficient to conduct business with and provide security to international organizations and commercial enterprises in Afghanistan—a significant achievement and a vast improvement from its operational capability a year ago. In some areas, however (e.g. contracting), the APPF has only been able to achieve IOC with assistance from ISAF advisors.

While the APPF did not fully meet the transition dates laid out in the Bridging Strategy, it was able to commence the transition of commercial and developmental contracts from Private Security Companies (PSC) to the APPF before the transition deadline. Toward that end, the APPF expanded its business and operations directorates, bringing in some talented Afghan experts from the business world and Afghan National Police (ANP), and expanded its operations from existing sites, previously contracted under substandard adhesion contracts, to include new sites, contracted under modernized contracts that approach international commercial standards. To date, the APPF has signed more than 50 contracts with domestic and international customers for security services, including 27 USAID projects. Four sites are fully transitioned to APPF control with another 33 in transition.

However, while it is an achievement that the APPF has reached IOC and begun the transition of security services in accordance with the Bridging Strategy, considerable work remains to be done before the APPF is ready to provide static security, convoy security and personal security detail (PSD) services nation-wide, independent of ISAF assistance. In particular, the APPF must mature and hone its business operations, implement its solution to overcome challenges associated with complex convoy operations, and strategically prepare to assume responsibility for ISAF/ANSF construction sites and ISAF bases. The APPF Advisory Group will continue to partner with the APPF over the next year to execute a smooth transition of security from private security companies to the APPF and to help build enduring capability for the APPF.

Question. Will you outline how the Army will contract with the APPF for security forces to ensure the security of our personnel?

Answer. All contracts for private security contractors used to guard personnel, sites, and convoys must be replaced by contracts with the Afghan Public Protection Force (APPF) in accordance with the following transition schedule: 1) by March 20, 2012, all development fixed site and all mobile security will transition to the APPF; 2) by March 20, 2013, all International Security Assistance Force bases and military construction sites will transition to the APPF. The transition of these security services to the APPF is part of an overall shift to Afghan-led security by 2014.

All development sites (non-military) and mobile security contracts, which currently rely on private security contractors (PSCs) must transition to the APPF by March 20, 2012. The National Afghan Trucking (NAT) contract will be impacted by the transition. Under NAT, the prime contractors provide transport services and issue subcontracts with PSCs when required. The U.S. Government will not contract directly with the APPF to provide PSC services. Instead, the NAT contractors will obtain PSC services from APPF and are all working their APPF agreements.

Once NAT contractors have their APPF agreements, the contracts will be modified to reflect the APPF rates. All contractors have been advised that it is their responsibility to ensure compliance with the Government of the Islamic Republic of Afghanistan law while performing services under the NAT contract.

Department of State (DoS) approved the content of an Acquisition Only Agreement (AOA) for direct contracts between the Department of Defense (DoD) and the APPF for all static security. United States Forces-Afghanistan has been delegated authority to negotiate the AOA with the APPF. Any changes to the terms of the Agreement are subject to approval by DoS. This Agreement will establish the basic terms, conditions, and procedures to facilitate the provision of logistic support, supplies, and services to U.S. forces personnel, DoD civilian employees, and DoD contractor personnel deployed to Afghanistan in support of Operation Enduring Freedom and International Security Assistance Force missions.

Question. What is the funding mechanism that will be used to hire APPF security guards? What protections will be in place to ensure there is no corruption?

Answer. Customers and users of APPF state-owned enterprise services will contract directly with the APPF to fund security services.

Although DoD contracts have not been established, current implementing partners have contracted with APPF for security services. An Acquisition Only Agreement has been established for DoD to negotiate contracts for security at fixed site lotations, ISAF bases and military construction sites. The negotiations for these con-

tracts will occur over the next year and will allow DoD representatives to work directly with the APPF to contract security services.

As DoD and DoS help build the capacity of numerous Afghan government entities, we are focused on anti-corruption efforts to ensure that these entities have credibility and transparency in their operations. We are working side by side with the Afghan Government to create mechanisms within the APPF that that will ensure transparent services for APPF customers. These include a robust quality control and quality assurance program and independent oversight.

FISCAL MANAGEMENT: GROWING RELIANCE ON REPROGRAMMINGS

Question. The Department of Defense's increased reliance on reprogramming of funds during the execution year has been extraordinary. There has been a 1,000 percent increase (10 fold) between fiscal year 2000 and 2011 in the magnitude of the annual omnibus reprogramming. In fiscal year 2011, $10 billion was transferred and used for different purposes than for which it was appropriated.

While an increased number of funding transfers would be expected in the early stages of a contingency operation, the war should not be the rationale for increasing funding transfers after ten years. While the chart above describes the overall DoD trend, Army's increasing reliance on reprogramming seems to mirror the overall Departments. For example, last June Army requested $2.3 billion be transferred for use in a manner differently than had been requested and appropriated and in September Army requested an additional (nearly) $2.5 billion be transferred.

Secretary McHugh, we are concerned that the Army has increasingly transferred and spent funding differently than the purposes for which the funding was justified and appropriated. For example in the last 3 months of fiscal year 2011, the Army proposed transfer of $4.8 billion to be spent in a manner differently than for which the funding was requested and appropriated.

What actions have you taken to enhance the discipline in the budget process?

Answer. The budget process has been improved with the increased emphasis and involvement of our senior leaders. They have directed that they be included in all decisions and realignments that are made at both an organizational and a strategic level. The process is very deliberative and disciplined.

Additionally, our leadership worked closely with the Secretary of Defense and the Chairman to ensure the Army's strategy was in concert with that of the Defense Department. The new strategic guidance was developed and provided before any final budget decisions were made to ensure that the budget choices reflected the new defense and Army strategies.

Internal to the Army process we have been "implementing a cost culture" using a Cost Benefit Analysis process that thoroughly reviews and costs out options—balancing between the most effective, efficient and least costly. Army leadership has taken a hands-on approach to conducting in-depth reviews of the programs and portfolios. These steps have ensured our budget is accurate and defendable.

Question. Are you confident in the Army's budget request that is before this Committee is fully executable as it is now arrayed? If not, will you work with us to adjust your request so that it can be appropriated in a manner in which you intend to expend it?

Answer. The Army's position is that the President's Budget requests what is required to meet our mission requirements. The Defense Department's new strategic guidance was developed before any final budget decisions were made to ensure that the budget choices reflected the new defense strategy. While shaping this strategy, the Department's leadership did not want to repeat the mistakes of the past. The goals were: to maintain the strongest ground force in the world, to not "hollow out" the force, to take a balanced approach to budget cuts, to put everything on the table, and to not break faith with troops and their families. As a result, the Army is strongly united behind the President's budget request for fiscal year 2013.

Since we developed the FY13 request we have identified several areas that could be realigned to better support emerging issues. We are working with the appropriators to make these adjustments for the upcoming marks and any adjustments made may reduce the number of reprogramming actions requested during the year of execution.

GROUND COMBAT VEHICLE

Question. The Ground Combat Vehicle (GCV) will replace the Bradley Fighting Vehicle. Add on armor kits have significantly improved Bradley survivability but sprint speed has been slowed thus increasing exposure to enemy fire. The fiscal year 2012 budget request for Ground Combat Vehicle development was $768,053,000. The conference agreement provided $449,387,000. The reduction was due to pro-

gram delays and a revised acquisition strategy. The fiscal year 2013 budget includes $640 million for GCV development.

General Odierno, please explain the changes made in the Ground Combat Vehicle program strategy and how those changes shaped the fiscal year 2013 budget request.

Answer. The Army awarded contracts to British Aerospace Engineering (BAE) and General Dynamics Land Systems for the Technology Development Phase on August 18, 2011. They were placed in a stop-work situation for 100 days due to a protest filed by Science Applications International Corporation (SAIC) on August 29, 2011. The U. S. General Accounting Office (GAO) denied the SAIC protest on December 5, 2011.

This stop-work period resulted in a 100-day schedule delay in the technology development phase of the program, which caused the Army to shift planned work into the next fiscal year. The Fiscal Year 13 President's Budget of $640 million for GCV accounts for this shift and associated planned contractor efforts.

Question. The Committee understands that the GCV program plans to review the infantry fighting vehicles that are in use currently in other countries, such as the Israeli Namer and the German Puma? What sort of trials will you put the vehicles through?

Answer. The Project Manager (PM) GCV Assessment of Non-Developmental Vehicles (NDV) consists of multiple technical and operational assessments.

The technical assessments include testing of armor survivability technologies, destructive testing of select vehicles, mobility testing of vehicles, a technical review of large remote weapons stations currently in service/production in the world (Rafeal, Elbit, and Kongsburg), and live-fire testing of select vehicle weapon systems to validate lethality performance. The technical assessments also include a bi-lateral data exchange with Germany on the PUMA.

The operational assessments will be conducted in two phases. Phase I, which is complete, included training on the CV–9035 at the Danish Infantry School and reviewing lessons learned from Denmark and Norway in Operation Enduring Freedom. Additionally, PM GCV sent a platoon of infantry Soldiers from Fort Benning to Israel to attend the Israeli Namer training course. Once trained, the platoon conducted two weeks of missions on the Namers. This effort was overseen by the Training and Doctrine Command Analysis Center and the Maneuver Center of Excellence. The focus was to validate the Namer impact on U.S. Army Tactics, Techniques, and Procedures while assessing vehicle performance.

During Phase II of the GCV Assessment of NDV, the Army will conduct an operational assessment of five NDV attributes across varying operational conditions. The platforms to be assessed include the: 1) M2A3 Bradley Infantry Fighting Vehicle; 2) Stryker Double V-Hull; 3) Israeli Namer; 4) Swedish CV–9035; and 5) M2 Turretless Bradley.

Key tasks during the assessment include: 1) Conducting a baseline assessment of vehicle capabilities against the draft GCV Capabilities Development Document (CDD); 2) creating operational conditions to highlight key discriminators among vehicle attributes; and 3) maximizing the number of vehicles the crews and dismounts utilize during the assessment to gather relevant Soldier feedback.

The assessment will be focused at the platform level using static assessments and situation training exercise (STX) lanes. The static assessments will benchmark vehicle attributes against draft GCV CDD requirements and complement STX lane observations. STX lanes will contain varied operational conditions, to include urban and open desert terrain, medium armored and dismounted threats, and operations during day time and hours of limited visibility.

The STX lanes will utilize three vignettes: 1) Security Patrol (Complex Ambush); 2) Movement to Contact (Far Ambush); and 3) Raid (Enter/Clear Building).

Question. The Army's goal is to transport a complete infantry squad in one vehicle. Is that a capability that is found in the infantry fighting vehicles of other countries? How important is this criteria?

Answer. As the Ground Combat Vehicle (GCV) Non-Developmental Vehicle Analysis is conducted (as well as other foreign vehicle and technology assessments) it has been determined that the capability to carry a complete infantry squad in one vehicle exists currently in the foreign vehicles under study by the US Army Training and Doctrine Command and the GCV Program Management office. Examples of this are the NAMER which carries a complete Israeli Squad and the CV–9035 which carries a complete Danish Infantry Squad.

The criterion to carry a complete infantry squad is one of the four most important capabilities in the GCV Program. The GCV facilitates the 9-man infantry squad to better deploy, gain, and maintain the initiative and tempo of small unit tasks. The GCV allows small sized units to seize, retain, and exploit the initiative by enabling

squads to deploy with unit integrity, providing immediate, coherent combat power on the ground. Transporting the entire 9-man Infantry squad supports decentralized operations and freedom of movement among other small units, enabling an agile and rapid deployment, re-deployment and task-organization of combat power across a distributed, ever-changing battlefield and missions. This capability provides increased leader presence, unity of command, and increased information dissemination reducing confusion and uncertainty. Lastly, this capability enables the deployment of complete infantry squads in close combat with the enemy under maximum armor protection.

Question. What is the expected date to begin fielding a new Ground Combat Vehicle?

Answer. The Army has consistently stated that it will be seven years from contract award to first production vehicle.

The Army awarded Technology Development (TD) contracts to British Aerospace Engineering (BAE) and General Dynamics Land Systems (GDLS) on August 18, 2011. Science Applications International Corporation (SAIC) filed a protest with the U.S. Government Accountability Office (GAO) on August 29, 2011. Both BAE and GDLS were placed in a stop-work situation for 100 days due to the protest. The GAO denied the protest on December 5, 2011 (Fiscal Year 2012) and work on the TD contracts officially began on December 6, 2011.

The Army's seven-year period must take into account the 100-day delay due to the GAO protest. The first production vehicle is scheduled for delivery in Fiscal Year (FY) 2019. Fielding to active Army units will begin in FY21.

Question. As funding is scarce, and trades must be made within and between programs, what is the possibility of continuing with the current fleet of Bradley Fighting vehicles with some limited upgrades and deferring the production of a new IFV?

Answer. The Bradley IFV has grown in weight and power demand above what it was designed for, exceeding its size, weight, and power-cooling (SWaP–C) margin and has minimal growth potential. Without significant and expensive turret and chassis redesign, the Bradley cannot incorporate latest and most effective vulnerability reduction principles, nor can it meet other identified critical gaps in lethality and capacity.

The Ground Combat Vehicle (GCV) will provide the protected mobility and fill capability gaps (Force Protection and Survivability, Network, Mobility, and Lethality) that currently exist in our heavy formations. The GCV will have growth capacity for SWaP–C to allow incremental improvements like the Abrams and be relevant for the next 40–50 years and will make our combined arms operations more effective by having the capability to carry a full squad in one Infantry Fighting Vehicle.

NETWORK

Question. The Network is the Army's top investment priority. The Army intends to have every soldier plugged into the tactical network; able to access and distribute information. Previously the Army fielded subsets of the network as the pieces became available. The new approach is to field capability sets when the necessary pieces are present, and with the receiving unit determined by the force generation process.

The budget request includes nearly $2 billion for the procurement of Network equipment:

$893 million for 2,166 items for Warfighter Information Network—Tactical (WIN–T) for seven brigade combat teams.

$556 million for Joint Tactical Radio System 11,059 radios

$274 million for Distributed Common Ground System

$103 million for Nett Warrior

$141 million for 1,032 systems of Joint Battle Command—Platform

How do you rate the status of the Network?

Answer. The Army Network could best be rated as emerging. Through more than 10 years of sustained combat, the Army made significant improvements to expeditionary communications capabilities to support our Soldiers in the fight. Although significant strides have been made to support the expeditionary portion of the Network, there has not been an equal focus on the strategic portion of the Network. The strategic portion includes the infrastructure on posts, camps and stations which enable home station training as well as business systems which enable medical, finance, logistics and personnel services for Soldiers and their Families. The Army's Network, Land WarNet, is an emerging fully integrated enterprise network. It is essential to planning and operating with Joint, coalition and interagency partners: It remains the Army's number one modernization effort. An enhanced, interoperable and fully modernized communications Network is central to the Army's efforts to

enable Mission Command, ensure our Soldiers always have the technological advantage and give the Army a decisive advantage across the range of military operations.

This Network is critical to enhanced decision making and enabling our Forces' missions, from the Commander to the Soldier. At the tactical level, the Army's modernization efforts remain on track. Beginning this fall, the Army will field the first fully integrated Network capability as part of Capability Set Fielding this fall. This approach is a fundamental change to the way we develop, evaluate, test and deliver Networked capabilities. Treating tactical Network capability as a cohesive portfolio, Capability Set Management evaluates the current operational environment and identifies a suite of systems and equipment to fulfill projected Army Force Generation (ARFORGEN) requirements.

Under this construct, each new Capability Set integrated and fielded reflects any changes or advances in technology. This incremental modernization allows the Army to buy fewer, more often, to help ensure that we leverage industry advancements and keep up with the pace of technology change. The Army completes two operational evaluations of the entire Capability Set prior to fielding.

Capability Set 13, the first to be fielded, provides Soldiers enhanced capability over current theater-provided Network equipment. We will establish the final integrated network baseline and integrate CS 13 in its entirety during the Network Integration Evaluation 12.2 to be conducted at Ft. Bliss, Texas; and White Sands Missile Range, New Mexico in May/June 2012. Key capabilities provided by CS 13 include Mission Command on the Move (allowing commanders to take the Network with them) and Network to the Soldier (providing capabilities through advanced radios and handheld devices down to the squad level).

We must focus our modernization efforts not only at the tactical portion of the Army's Network with Capability Set 13, but also on the enterprise infrastructure on posts, camps and stations. Modernization must address the entirety of the Army's Network to empower a CONUS based Army that projects Expeditionary Forces with little to no notice. The Army is addressing three major challenges as it modernizes the LandWarNet: (1) improving cyber security; (2) meeting operational needs in a dynamic threat environment; (3) while becoming more efficient.

Improving cyber security and Network operations is essential to build a single, secure, standards-based Network environment. Non-standard Network management tools, multiple access points, vulnerable perimeter defenses and inconsistent architectures (many of which were deployed quickly to support war efforts) make it harder to prevent, identify, isolate, and eliminate security risks. As cyber threats increase exponentially, it is imperative that we, as the Nation's premiere land force, address this challenge head on.

Second, balancing the Army's operational needs is a continuing challenge, both at the tactical edge and on posts, camps and stations. Army users have high operational expectations, and growing need for trusted access, assured connectivity, joint interoperability and collaboration with mission partners. The Soldiers and leaders expect the Network to be available wherever they are, whether they are training, preparing for deployment, en route or deployed.

Finally, as an Army, we are becoming more efficient through advanced technology and improved governance. The DoD mandate is to streamline, achieve efficiencies, and optimize return on investment. For a Networked Force, that translates into a need for enterprise systems and solutions, seamless data access, and robust, secure Network infrastructure to support every facet of Army, Joint and Multinational operations. LandWarNet is the key to retaining the Army's technological edge on the battlefield.

The Army is addressing these challenges through the combined resources requested in the President's Fiscal Year 2013 budget request.

Question. The RDT&E request includes $214 million for Network costs related to Network Integration Evaluations. Explain how the Network equipment is evaluated while concurrently supporting formal and informal evaluations of other items of equipment? What are some of the expenses that total $214 million?

Answer. The Network Integration Evaluation (NIE) process has allowed the Army to bring all elements of the Network together in one place for a holistic evaluation by an operational unit in an operational environment, and will allow for the validation of a network capability set that will be fielded to deploying Brigade Combat Teams starting in late 2012. The Army has also brought the materiel developers, combat developers, and testers together with industry, ensuring continuous coordination in providing the right capability to Soldiers. Most importantly, the Army has begun the difficult task of changing its processes to provide current network capabilities to the force faster and cheaper.

Treating tactical Network capability as a cohesive portfolio, Capability Set (CS) Management evaluates the current operational environment, and identifies a suite

of systems and equipment to answer projected requirements over a two-year period. The NIEs evaluate promising capabilities with the potential to close capability gaps identified by the Training and Doctrine Command, as well as Network capabilities in existing programs requiring formal tests, as part of the acquisition process. The CS13 Integrated Network Baseline will, upon approval, serve as the operational environment for future testing and evaluation.

The NIE 12.2 will focus on completing the formal evaluations of three Systems Under Test and 40 Systems Under Evaluation, establishing the initial integrated network baseline and evaluating its operational performance. The Army's key objectives for NIE 12.2 are to validate CS13/Software Block 11–12 architecture; establish the CS13 Integrated Network Baseline and finalize CS13 Mission Command On-The-Move/Soldier Connectivity configurations.

The NIE has established a strong foundation toward realizing the network of 2020 and has demonstrated its ability to pay off in operational and fiscal benefits. The key NIE expenses include engineering expenses, system under evaluation support, test/evaluation expenses, and infrastructure. Lessons learned from the NIE construct have helped the Army avoid approximately $6 billion in planned spending or re-allocate resources to other priorities—all while providing more capability, sooner, to our operational formations. This represents a considerable savings to a variety of recipients: Congress, the Office of the Secretary of Defense, and the U.S. Army. The benefits of the NIE construct far exceed testing and evaluation costs.

The FY13 President's Budget Request contains the following cost elements:

Cost Element	Project	Amount
Test Experimentation	DV1	58.9M
System of Systems (SoS) Integration Directorate	DV1	66.2M
Architecture Development and Systems Engineering	DV1	15.6M
Infrastructure	DV1	18.0M
Subtotal (Project DV1)		158.7M
Systems Under Evaluation Integrations	DU8	45.5M
SoS Engineering for Common Operating Environment (COE)	DU9	10.1M

*The $10.1 million (M) Budget Request in Project DU9 is not for the NIE, it will be distributed to support the Army's COE program.

JOINT TACTICAL RADIO SYSTEM

Question. The Joint Tactical Radio System (JTRS) dates from 1997. The program has been led by a Joint Program Manager since 2005. Program subsets include: Ground Mobile Radios; Handheld, Manpack and Small Form Fit; and Airborne Maritime and Fixed Station. The program Budget Request includes $556 million for 11,059 radios from the Joint Tactical Radio Family.

General Odierno, please give us an assessment of the radios in the JTRS family that will be used by the Army.

Answer. The Joint Tactical Radio System (JTRS) program has experienced success this year. The Army is over 80 percent complete in terms of development with two of the JTRS hardware programs, the Handheld/Manpack/Small (HMS) FormFit and Multifunctional Information Distribution System JTRS. Many of our capabilities, both hardware and software, were recently demonstrated in the field with other Army networking products and capabilities at the White Sands Missile Range during the Army's Network Integration Exercise (NIE). These exercises are a critical part of the Army's agile acquisition process designed to quickly field new capabilities in a synchronized manner for deploying Brigade Combat Teams. In addition to NIEs, we are developing the right mechanisms to encourage industry to leverage their own research and development funding and bring solutions to the table for assessment and potential inclusion as part of a larger interoperable tactical force.

In terms of the specific hardware programs, we are progressing toward production and delivery in many areas. The HMS program will be providing near term capabilities with both a Handheld version (Rifleman Radio) and a JTRS 2-channel Manpack. Both systems run the JTRS advanced networking Soldier Radio Waveform. The HMS program (Manpack and Rifleman Radio) completed a successful Milestone C, the point at which a production decision is authorized. The Manpack and Rifleman Radio have been thoroughly demonstrated and tested though the

Army's NIE process. For the Rifleman Radio in particular, over 100 radios were deployed with the 75th Ranger regiment to Afghanistan, with exceptional results. This program is meeting several successful milestones and driving toward full rate production and delivery this year.

Following the cancellation of the Ground Mobile Radio program, the Army is looking at a less expensive, mid-tier networking vehicular radio running the Wideband Networking Waveform. This capability will be an essential component of the Army's tactical network architecture, which will provide a critical link between Soldiers at the lowest tactical echelon and the Warfighter Information Network-Tactical. Accordingly, the Army is already looking at industry-provided alternatives that meet the intent of this low cost, reduced size, weight and power radios. Competitive production awards are targeted to meet the Army's Capability Set 13/14 requirements as part of our tactical network architecture.

The third program—Airborne, Maritime, Fixed (AMF)—is targeted to provide Link-16 capabilities to the Long Bow Apache program, and the program has delivered pre-production units to the Apache program for integration.

Question. We understand that the Rifleman Radio has been used by units in combat. What is the feedback from the field evaluation?

Answer. The United States Army's 75th Ranger Regiment in Afghanistan recently completed an operational assessment of the Rifleman Radio. The assessment highlighted the radio's ability to share combat-relevant information, voice and data across small units in real time. Results from the operational assessment indicate that the Rifleman Radio was effective, suitable, and reliable. Specifically, Soldiers found the radio easy to use and the appropriate size, weight, and power, with more than eight hours of battery life. They also experienced enhanced situational awareness via networked voice and data communications and effective, reliable communication inside buildings, through multiple walls, and to positions outside of compounds. Generally speaking, the Soldiers experience very few problems and found the Rifleman Radio outperformed current radios.

Question. Rifleman radios and Manpack radios were used in the Network Integration Evaluation at White Sands Missile Range in December 2011. Please describe how the radios were used, and how they performed.

Answer. The Rifleman Radio completed a successful Initial Operational Test & Evaluation (IOT&E) at the Army Network Integration Evaluation (NIE) 12.1 in December 2011. The Army Test Evaluation Command (ATEC) conducted the test with support from B Company, 1st Battalion, 35th Armored Regiment, 2nd Brigade Combat Team, 1st Armored Division (B Co, 1–35 AR, 2/1 AD) using 70 AN/PRC–154 Rifleman Radios. The independent evaluators used a variety of missions to test the radios. The Rifleman Radio was found to be effective by increasing the Soldier's situational awareness and providing useful capability to execute mission command. The radio was also found to be suitable. The radio met the size, weight and power requirements. Neither the size nor the weight posed any problems with the Soldiers, and the battery life either met or exceeded the eight hour requirement.

The United States Army Training and Doctrine Command Capability Manager for Tactical Radios (TCM–TR) conducted a Manpack operational assessment in conjunction with the Rifleman Radio IOT&E. The ATEC conducted the test with support from B Co, 1–35 AR, 2/1 AD using 18 AN/PRC–155 Manpack radios in both mounted, dismounted, and stationary command posts. In three weeks of operation using Soldier Radio Waveform (SRW), not a single Manpack was withdrawn from the test. The Operational Assessment noted good voice quality, reliable communications, and that it enhanced the Soldiers' ability to execute the mission. The TCM–TR evaluators reported that the Manpack enhanced voice and data communications to the tactical edge. The Soldiers were generally satisfied with the Manpack's overall design, form factor, and weight. The evaluators found that the Manpack clearly supports the Warfighting function of mission command. Combined with the Rifleman Radio, the Manpack increased every Soldier's situational awareness by extending voice and data between all echelons from Team to Company level.

The TCM–TR operational assessment further found that the SRW Platoon Network, consisting of both Manpacks and Rifleman Radios, provided voice and data down to the team leader level, increased staff awareness and provided leaders with valuable information.

Question. Over the past eight years billions of dollars have been provided to the Army to procure SINCGARs radios. Discuss the interoperability between SINCGARs and JTRS radios.

Answer. The Joint Tactical Radio System (JTRS) radios are designed to be fully interoperable with the Single Channel Ground and Airborne Radio System (SINCGARS) radios through JTRS support of the SINCGARS legacy waveform. The JTRS family of networking capability provides the Soldier with a software program-

mable and hardware configurable, scalable, Internet Protocol-based, wideband, networking radio to support Joint Forces requirements across the full range of military operations. JTRS uses both networking waveforms (Wideband Networking Waveform (WNW), Soldier Radio Waveform (SRW), etc.) and legacy waveforms (SINCGARS, waveformsLink 16, etc.). Specific wav ornis supported by capability are:

System	WNW	SRW	SINCGARS	Legacy SATCOM	Mobile User Objective System (SATCOM)	Link 16
Handheld/Manpacks/ Small Form Kit	.....	X	X	X	X	.....
Rifleman Radio	.....	X	.....	.....	.....	.....
Airborne Maritime Fixed	X	X	X	.....	.....	X
Mid-Tier Networking Vehicular Radio	X	X	X	.....	.....	.....

Use of the legacy waveforms ensures interoperability with current force systems, thereby capitalizing on the Services previous large investments while building capability for the future.

Question. After field testing, the Ground Mobile Radio and Network Integration Kit were cancelled. Have other items of equipment been selected to provide the services these two cancelled items were to provide?

Answer. Although the Ground Mobile Radio (GMR) program development was nearly complete, a recertification decision to formally restructure the current program required additional funding and, more importantly, delayed delivery of an advanced ground networking capability that the Army assessed as too expensive to procure in large quantities. Thus, in Fall 2011, the Department of Defense decided to terminate the program. However, the insight and knowledge obtained as a result of the GMR developmental efforts proved invaluable in establishing the foundation for a less expensive, mid-tier radio capability running the Wideband Networking Waveform. This capability will be an essential component of the Army's tactical network architecture, providing a critical link between Soldiers at the lowest tactical echelon and the Warfighter Information Network-Tactical. Accordingly, the Army is looking at Industry provided alternatives that meet the intent of this low cost reduced size, weight and power capability, particularly as part of the Network Integrated Evaluations. Competitive production awards are targeted to meet the Army's Capability Set 13/14 requirements.

JOINT LIGHT TACTICAL VEHICLE

Question. The Joint Light Tactical Vehicle (JLTV) is a U.S. Army, USSOCOM, and U.S. Marine Corps program to replace the current HMMWV with a fresh design, and with the advantage of lessons learned in Iraq and Afghanistan in HMMWVs and MATVs (MRAP All-Terrain Vehicle) the JLTV is expected to be more survivable, and able to carry a heavier load than an MATV.

General Odierno, the Army currently has about 150,000 HMMWVs. As the Army comes home from Iraq, and downsizes, how many light tactical vehicles will the Army maintain, and of that total number, how many will be JLTVs?

Answer. The Army will maintain approximately 136,000 light tactical vehicles, of which 49,099 will be JLTVs.

Question. When will JLTV fielding begin and when will it be complete?

Answer. The JLTV will begin fielding in Fiscal Year 2016 (FY16) for the U.S. Marine Corps (USMC) and FY18 for the Army. The LTV will be fielded in phases with Initial Operational Capability planned for the USMC in FY17 and for the Army in FY18. Fielding will be complete in FY22 for the USMC and in FY37 for the Army.

Question. Please describe the objective mix of unarmored HMMWVs, uparmored HMMWVs, MATVs, and JLTVs.

Answer. The objective mix of the Army's Light Tactical Fleet (LTV) will consist of High Mobility Multi-purpose Wheeled Vehicle (HMMWV) variants and the Joint light Tactical Vehicle (JLTV). In the near term, the Army will continue to divest and cross level its inventory of HMMWVs, retaining Up-Armored HMMWVs (UAH) and the most modern Non-Armored HMMWVs (NAH) to meet the LTV requirements. The Army has 53K UAHs and has recapitalized 47K NAHs. In the mid to

far term, the Army plans to procure approximately 49K JLTVs by FY37, which will displace un-armored legacy HMMWV variants over time. The Army intends to retain approximately 6K Mine Resistant Ambush Protected Vehicle-All Terrain Vehicles (M–ATV) for use in missions to mitigate Improvised Explosive Devices, Rocket Propelled Grenades, Explosively Formed Penetrators, underbody mines and small arms fire threats.

Question. How will the recently announced downsizing of the Army impact the requirement for JLTVs?

Answer. Based on current forecasted reduction of HMMWVs to 136,000 we expect the requirement for JLTVs to remain stable at 49,099.

Question. What is the plan to guard against requirements creep in the JLTV program?

Answer. The JLTV program will guard against requirements creep through the conduct of Configuration Steering Boards currently required on an annual basis for Acquisition Category I programs like JLTV. These boards serve as the principal mechanism for reviewing and evaluating the program to control cost and identify opportunities for revising requirements to meet program objectives.

Question. The Army and Marine Corps are said to be "joined at the hip" on JLTV. What compromises did the Army and the Marine Corps accept in order to agree on the requirement?

Answer. The Army and Marine Corps are "joined at the hip" on the JLTV program. The Marine Corps owns the Capabilities Development Document (CDD) which is the document that articulates both the Army and the Marine Corps requirements for the program. The CDD was approved in March 2012, by the Vice Chairman of the Joint Chiefs of Staff. The services have agreed on a common set of base requirements that allow for service unique flexibility such as scalable armor protection and external air transportability.

ABRAMS TANK

Question. The Consolidated Appropriations Act for fiscal year 2012 included an additional amount of $255,000,000 to procure 42 additional M1A2SEP tanks to support continuation of tank production. Also, it directed the Secretary of the Army to provide a report on the plan for the use of the additional funds and the plan to sustain tank production. In a letter to the chairmen of the congressional defense committees, dated February 15, 2012, Secretary McHugh advised that the Army will use the additional $255 million to procure 42 additional tanks and keep the production line going until June of 2014. The Army has been comparing the cost of continuing a sustaining level of production, to the cost of shutting down and later restarting when a new tank goes into production.

Secretary McHugh, the Committee appreciates your support, as announced in your letter of February 15, 2012 for keeping tank production going into mid-2014. We are aware that the Army has been studying various courses of action for the tank assembly line going forward. In the first option, the Army continues tank production at a minimum sustaining rate; in the second option the Army shuts down the line and restarts it when needed. The preliminary report of analysis compares the costs of the two options, but assigns no tactical or monetary value to the tanks that are produced under the minimum sustaining rate option.

Mr. Secretary, it would seem that the comparison of options should consider the value of the tanks that are produced under the minimum sustaining rate option. Do you agree?

Answer. The Army agrees that there is an operational value in the Abrams tank. The purpose of the RAND Arroyo study is to independently validate the Army's assessment of the costs and benefits of the planned production break. This study is focused on addressing whether it would be more beneficial from a cost perspective to stop or continue tank production. The ongoing RAND Arroyo study will not specifically assign a tactical or monetary value to continued Abrams tank production. The final results of the on-going RAND Arroyo cost refinement analysis will be available in the near term.

Question. When will you have a proposal for the way ahead for tank production?

Answer. From an Abrams fleet requirement perspective, the Army will meet its acquisition objective for M1A2/SEPv2 tanks when production is complete in June 2014. The Army currently plans to restart production in Fiscal Year 2017 in connection with future Abrams tank upgrades. The final results of the on-going RAND Arroyo cost refinement analysis will be available in the near term. The specific purpose of the RAND Arroyo study is to independently validate the Army's assessment of the costs and benefits of the planned production break. This study is focused on

addressing whether it would be more beneficial from a cost perspective to stop or continue tank production.

Currently the Army has a mix of models in the tank fleet. Active component units are equipped with M1A2SEP tanks and the Army National Guard has M1A1 tanks. The budget request proposes no funding to purchase tanks and provides funds only for contractor technical support, fielding, and training.

Question. Currently the Army has a mix of models in the tank fleet. Active component units are equipped with M1A2SEP tanks and the Army National Guard has M1A1 tanks. The budget request proposes no funding to purchase tanks and provides funds only for contractor technical support, fielding, and training.

General Odierno, how many additional new M1A2SEP tanks would be required to outfit all of our tank battalions, active, and national guard with the newest model, the M1A2SEPv2?

Answer. Under the current force structure and two-variant fleet requirement, all active component Armored Brigade Combat Teams (ABCTs) and Army Prepositioned Stocks (APS) will be fully equipped with M1A2SEPv2 tanks. The 116th Army National Guard ABCT is currently being fielded with 58 M1A2SEPv2 tanks. An additional 435 M1A2SEPv2 tanks would be needed to fully outfit the remaining six ABCTs and three Combined Arms Battalions in the Army National Guard.

Pending Active Duty force structure reductions will likely increase the number of M1A2SEPv2 tanks available to outfit more National Guard units.

Question. In the concept for the more lethal, high tech military, what would be the advantages of a pure M1A2SEP tank fleet?

Answer. The Army's two-variant fleet strategy equips all Armored Brigade Combat Teams (ABCTs) in Active Component, Army Prepositioned Stock (APS), and one ABCT in the Army National Guard (116th ABCT) with M1A2SEPv2 tanks. The remaining six ABCTs and three Combined Arms Battalions are equipped with M1A1AIM–SA tanks. This fleet mix is a result of refining the balance between affordable investment options over the last eight years and providing the right level of warfighting capability to Active and National Guard units. While there are advantages to the concept of a pure M1A2SEPv2 tank fleet, we must balance these with the substantial cost involved.

The Army's MlA1AIM–SA fleet is very new (2–3 years) and very capable. The benefits of replacing these tanks, many of which are still in the process of being fielded, with the M1A2SEPv2, do not outweigh the costs in our current fiscal environment. The principal operational difference between Abrams variants is the Commander's Independent Thermal Viewer (CITV) on the M1A2SEPv2 that provides the tank commander with a separate thermal sight and integrated digital fire control system. Despite the differences between the two variants, both Abrams variants offer similar lethality, protection and mobility capability. While a pure fleet would alleviate the training and logistic differences between the two variants, the benefits gained cannot be justified by the cost involved.

Question. What are the key advantages of the M1A2SEP over the M1A1?

Answer. The principal operational difference between Abrams variants is the Commander's Independent Thermal Viewer (CITV) on the M1A2SEPv2 that provides the tank commander with a separate thermal sight and integrated digital fire control system, which enables the Commander and gunner to engage the enemy using hunter/killer tactics—the Commander and gunner can search for targets independently from their protected positions using high quality optics.

Another difference between variants is the means of integrating the tank's on-board and mission command systems. The M1A2SEPv2 is a fully digitized tank with all on-board and mission command systems integrated into a single, embedded data bus, where data/output and processes are shared between on-board systems. The M1A1AIM–SA tank's mission command is appliqúe to the tank (hardware is attached to existing systems reducing room in the turret), and its on-board systems are not integrated into a single data bus.

However, both Abrams variants offer similar lethality, mobility, protection, and Mission Command capabilities.

Question. The Army has been working to have as many vehicles and systems as possible with digital capability. How important is digital capability in our tanks?

Answer. Today's complex battlefield environment places increasing demands on both individual Soldiers and leaders at every level, resulting in an unprecedented need to pass information both up and down the chain of command. Complex coalition efforts drive additional burdens on tactical formations to share common information and collaborate to achieve the desired battle field effects.

All command platforms, including tanks, must provide leaders at all levels the capabilities required to execute mission command, from the tactical operations center,

to the commander on the move, to the dismounted Soldier. Mission Command is the conduct of military operations through decentralized execution based on mission-type orders. Successful mission command demands that subordinate leaders at all echelons exercise disciplined initiative and act aggressively and independently to accomplish the mission.

The network remains essential to planning and operating with Joint, coalition and interagency partners: it remains the Army's number one modernization effort. Central to the Army's effort to enable Mission Command is a modernized, enhanced, and interoperable communications network that ensures our Soldiers always have the technological advantage and gives the Army a decisive advantage across the range of military operations.

Capability Set 13, the first Capability Set to be fielded, provides enhanced capability over current theater-provided network equipment. Key capabilities include Mission Command on the Move (allowing commanders to take the network with them) and Network to the Soldier (through advanced radios and handheld devices down to the squad level). Capability Set Management is geared toward our tactical forces, with initial sets going to infantry and Stryker formations. Efforts to integrate capability sets into armored formations are ongoing.

PALADIN INTEGRATED MANAGEMENT (PIM)

Question. The M109 self-propelled 155mm howitzer has served the Army well since the early 1960s. However the current model, the Paladin is showing its age. The British and a number of other North Atlantic armed forces have replaced their M109s with other howitzers. The Army is developing a new self-propelled 155mm howitzer and accompanying self-propelled ammunition carrier known as the "Paladin Integrated Management", or "Paladin PIM". To simplify logistics, the PIM has many components in common with the Bradley Fighting Vehicle, including the engine, transmission and track. It uses the gun elevating and traversing mechanisms from the cancelled Future Combat Systems program. The program experienced integration problems and schedule slips in fiscal year 2011, but seems to be on track after some key leadership changes.

General Odierno, the Paladin PIM 155mm self-propelled howitzer program seems to be on track to reach milestone C and begin low rate initial production at the end of the 3rd quarter of fiscal year 2013. What are the key improvements in the Paladin PIM as compared to the current M109 Howitzer?

Answer. The key improvements that Paladin Integrated Management (PIM) offers over the existing M109 Paladin Howitzer are increases in Force Protection and Survivability, mobility, responsiveness of fires, Space Weight and Power (SWaP) capacity, enhanced Network Capability, and commonality with the Bradley Fighting Vehicle.

PIM provides increases in Force Protection and Survivability through a new chassis, increased ground clearance, integration of a remote weapon station, more effective armor materials, improved crew seating and hull thickness. PIM can also accept add on armor modular kits.

PIM delivers increased mobility to provide the ability to maintain the tempo of the supported force and is able to support Full Spectrum Operations.

PIM improves the responsiveness of fires using electric drives to point the gun tube and pivot steer capability, allowing PIM to execute fire missions faster than the current M109A6 Paladin which utilizes a hydraulic system.

SWaP enhancements are critical enablers to provide growth margin for future requirements and technology insertion which the current M109 Howitzer cannot accommodate.

The new 600 volt system on PIM provides Enhanced Network Capability over the 28 volt system employed on the M109A6 Paladin. PIM accepts the Army's current and future networks and meets the need to remain network capable commensurate with supported forces.

The PIM chassis utilizes a Bradley common engine, transmission, suspension, and track. This commonality will reduce the logistics footprint of the Heavy Brigade Combat Team and is expected to reduce maintenance costs through common parts and maintenance tasks.

Question. The Paladin PIM shares a number of chassis components with the Bradley fighting vehicle, but much of the current M109 chassis remains the same. Please describe the improvements in mobility, lethality and survivability, plus the advantages in logistics of sharing parts and components with Bradley vehicles?

Answer. PIM has a new chassis/hull design that uses Bradley common power train and suspension components. The new hull provides increased structural integrity, more effective armor materials for greater force protection/survivability, and

provisions for add-on-armor to improve PIM's survivability over the current M109 Paladin. PIM uses an upgraded Bradley power train & suspension providing greater horsepower to improve PIM's mobility, enabling the platform to keep up with the maneuver force. The larger power train also provides margin for additional weight and power demands. Component commonality with Bradley reduces the logistics footprint of the Brigade Combat Team and reduces the number of unique parts in the Army supply chain. The use of Bradley common components leverages maintenance skill sets currently resident in the Army.

Question. At 79,600 pounds, the Paladin is 1,100 over its design weight. Is that a matter of concern?

Answer. The original M109 chassis and suspension fielded in 1963 was designed for a gross vehicle weight of 53,000 pounds. The current M109A6 Paladin gross vehicle weight is 67,200 pounds with no substantial changes to the original chassis and suspension, resulting in increased wear on suspension components and reduced ground clearance. The current M109A6 Paladin does not have the weight capacity to accommodate future howitzer related needs, to include Force Protection packages. The excess weight of the current M109A6 over its design weight is a matter of concern to the Army and is one reason for the Army's support for the Paladin Integrated Management system.

Question. Describe the countermine, counter IED and counter RPG protection on Paladin?

Answer. The Paladin's (M109A6) countermine, counter IED and counter RPG protection were appropriate to the threats to crew and platform at the time of its design in 1993. Counter Radio-Controlled Improvised Explosive Device Electronic Warfare (CREW) systems were added to the platform in 2004 to mitigate the increased IED threat in Operation Iraqi Freedom.

In developing Paladin Integrated Management (PIM), the M109A6's successor, the Army will increase countermine, counter IED and counter RPG protection by three levels of protection. The first level is improvements to the base vehicle by having a thicker hull and improved armor recipe, integrating a remote weapons system, increasing ground clearance, improved crew seating, and increasing electrical and mechanical power supply to accept future technology force protection insertions. Additional side armor to the base vehicle will provide the second level of protection against mine, IED and RPG threats. Finally, the third level of protection will be achieved by the ability to accept an underbody kit to increase force protection and survivability against underbelly mine and IED threats. These increases in countermine, counter IED and counter RPG protection will allow the PIM freedom of maneuver within the battlespace.

Question. Will the Paladin PIM howitzers have crash and blast tolerant fuel tanks?

Answer. The PIM howitzer design does not include crash and blast tolerant fuel tanks. The PIM sponson fuel cells incorporate fire suppression powder panels to mitigate potential fuel fires. Fuel subsystem vulnerability testing will be conducted using various threats.

STRYKER

Question. The Stryker Program was initiated in 1999. The Stryker family of vehicles has ten variants ranging from infantry carrier, to reconnaissance vehicle to medical evacuation. The Stryker family was intended to serve as a bridge to the fielding of the Future Combat Systems' vehicles. The FCS program was cancelled in 2009, but the Stryker vehicles have performed well. The Army plans to field 9 Stryker Brigade Combat Teams. Each of the brigades will have 340 Strykers. The Army will have 292 additional Strykers with double-vee hulls for duty in Afghanistan. All fielding is scheduled to be complete mid-2013.

Stryker vehicles have served well in Iraq and Afghanistan, and a high level of survivability has been maintained despite attacks by a determined and creative enemy. General Odierno, could you briefly describe the improvements that have been made to the Strykers to better counter IEDs, mines, and rocket propelled grenades.

Answer. The Army has continually improved the survivability of the Stryker vehicle to meet evolving threats. Examples of these additional survivability improvements include, SLAT and Stryker Reactive Armor Tiles to counter rocket propelled grenades, Driver's Enhancement Kit, Mine Roller Adapter Kit, Blast Mitigation Kit, Energy Attenuating (Blast) Seats, and Skydex (Energy Attenuating Floor Mat) to counter Improvised Explosive Devices and mines, Hull Protection Kit to counter Explosively Formed Projectiles and Common Ballistic Shield, Squad Leader Integrated

Protection Kit and Tire Fire Suppression Kit and Driver's Ballistic Shield to counter shrapnel and blast effects.

In 2010, the Army began integrating a unique, Double-V shaped hull onto the Stryker that mitigates the affects of underbelly blasts by deflecting the blast away from the vehicle. The Stryker Double-V Hull (DVH) has been extremely successful at providing additional survivability protection for our Soldiers. Currently, the Army has a requirement for a total of 742 Stryker DVHs of which 461 have been produced and 256 fielded in Afghanistan. The Army is completing the testing on Stryker Reactive Armor II (SRAT II), that provides protection against Rocket Propelled Grenade similar to SRAT, but at a reduced weight. The latest initiative being worked is a Targeting under Armor (TUA) effort that will allow Soldiers to conduct fire support mission tasks from under cover, allowing greater protection from the effects of IEDs, mines, and rocket propelled grenades.

Question. Has Stryker off-road mobility been reduced?

Answer. Continual application of survivability kits, to include integration of the Double V-Hull, have increased the weight of the Stryker vehicles. Testing conducted on the Stryker Double V-Hull (DVH) prior to fielding noted that mobility was affected to some extent in loose soil and on slopes; however, testing analysis also noted the differences between DVH and flat bottom Strykers were minor. Although these measures have reduced off-road mobility, it has not impacted operational use in Afghanistan.

Question. Does the Army plan to eventually convert all Strykers to the double-vee hull configuration?

Answer. Once the Army decides on the appropriate force structure, fleet mix and overall number of combat vehicles, the quantity of DVH Strykers and variants of Strykers will be finalized. The Army has a current procurement target of 2 Stryker Brigade Combat Teams (SBCT) with Double-V Hull (DVH), totaling 742 DVH Stryker vehicles, based on minimum operational and training needs to support Afghanistan. This plan currently maintains the nine garrison SBCTs with flat bottom hulls. Conversion of all Strykers to DVH configurations is unaffordable within our Combat Vehicle Modernization Portfolio and Strategy.

Question. The budget request includes funds for 58 Strykers, all of them chemical reconnaissance vehicles. Do you see a requirement for more Stryker brigades, beyond the nine being fielded now?

Answer. The Stryker brigades currently in the force are sufficient to meet current warplans and steady-state requirements.

HELICOPTER MODERNIZATION

Question. When Army units move on the battlefield, they would like to have tactical cover by armed helicopters. The strike on Osama bin Laden by special forces employed specially equipped helicopters to make the strike, and for subsequent extraction. In the recent hostage rescue in Somalia, the Navy SEALS parachuted into the action but were extracted by Army helicopters. However helicopter acquisition has not gone well in recent years. Comanche was cancelled. Armed Reconnaissance Helicopter—cancelled. And Army and DoD leaders have adopted a three to five year delay in helicopter modernization. Production of 24 Apache's will be deferred, the equivalent of a battalion. Development of a new armed scout helicopter has been deferred also.

General Odierno, what is your evaluation of the capabilities of the current Army helicopter fleets versus the requirements in the future force to be more agile, mobile, lethal and high tech?

Answer. We have been modernizing our current fleet of aircraft, UH–60M, CH–47F, AH–64D block III, and continuing to move forward for a replacement of the OH–58D Kiowa Warrior. These modernization efforts will keep our helicopter fleet relevant out to 2025/2030. 2030 and beyond the Army is heavily involved in the Future Vertical Lift effort which may prove to be our next generation of vertical lift aircraft.

Question. The Army will slow for five or six years the production of new Apache helicopters, essentially slipping one battalion of helicopters several years to the right. Is the cutback in Apache procurement driven by endstrength and structure downsizing or just to save money?

Answer. The reduction in Apache procurement was to save money in the near-term by deferring some Apache costs to the out years in order to support higher priorities within the Army. The reduction was not driven by end-strength and structure downsizing.

Question. Fiscal Year 13 production of UH–60M helicopters deceased from the planned 71 a year ago to 59 in the budget request. However, the Army has unfilled requirements of over 800 UH–60s. Why are you slowing production?

Answer. The reduction in UH–60M procurement was to save money in the near-term by deferring some UH–60M costs to the out years in order to support higher priorities within the Army. The Army still has a requirement for a total of 2,135 UH–60 L/M aircraft and will continue to procure UH–60M aircraft through the Five Year Defense Plan and beyond to meet those modernization requirements. The Army's planned procurement of the UH–60M will eventually displace its current non-modernized fleet of approximately 800 UH–60A aircraft.

Question. General Odierno, the Institute for Defense Analysis conducted a study on rotorcraft safety and survivability from 2001 to 2009. Of 375 rotorcraft losses with 496 fatalities, 81 percent were due to accidents—not the enemy. Accidents include flying into the ground, colliding with other aircraft, and crashing after loss of vision due to brown out.

This has been an item of concern for some time. What is the Army's plan to improve procedures, more training, or high tech solutions to address the accident problem? What progress has been made?

Answer. The Army is demonstrating significant improvement in reducing ClassA/B degraded visual environment (DVE) related incidents. The last compiled DVE statistics reflect a marked decrease in incidents per 100K flight hours from 1.47 in FY03–FY06 to .59 between FY07–FY10, a decrease of 60%. FY11 DVE rate remains at .54 per 100K hours. Reductions are attributable to the introduction of more modernized aircraft and DVE emphasis in pilot proficiency training.

Every aircraft currently under procurement has a fully modernized cockpit which includes flight symbology for all modes of flight, moving maps and enhanced flight controls to improve controllability. In addition, we are looking at focused solutions including active radar penetrating sensors to address DVE operations in the legacy platforms in support of current operations as well as a bridge to an end-state modernized fleet.

All aircrews practice the tactics, techniques, and procedures (TTPs) appropriate to their helicopter to ensure the best use of available power, aircraft systems and crew coordination as a part of regular crew training. Individual training includes sand and dust qualifications as well as unit training at the Combat Training Centers and during High Altitude Maneuver Environmental Training.

ARMED AERIAL SCOUT HELICOPTER AND UNMANNED AERIAL VEHICLE TEAMING

Question. Army initiated the Armed Reconnaissance Helicopter (ARH) program in December of 2004, about ten months after the cancellation of the RAH–66 Comanche helicopter program. The Comanche was over cost and the prospect for production was poor. The ARH was to be an economical alternative, based on commercial off-the-shelf aircraft technology. However by 2008 the ARH had also experienced significant cost growth. Following a Nunn-McCurdy review the ARH was not certified for continuation and in October 2008 the Army directed the program be terminated. The Committee anticipated, based on the sense of urgency and commitment in the Army for a new armed scout helicopter that a new program would be started promptly. That has not happened. The Committee understands that the Army will defer modernizing the scout helicopter fleet for three to five years and will continue to use OH–58D and F models with minor upgrades.

General Odierno, the Army has been searching for a replacement for the OH–58 series scout helicopter for nearly 30 years. However, with the submission of the fiscal year budget request, the Army delays helicopter modernization for three to five years, and will continue to rely on the OH–58D and F models.

General, what capability trades are you making to delay modernizing the scout helicopter fleet?

Answer. The Army is not delaying modernization or currently making any trades on the capabilities available to the scout helicopter fleet.

Modernization of the armed aerial scout capability is being addressed in the current Kiowa Warrior helicopter through the Cockpit and Sensor Upgrade Program (CASUP). This program addresses obsolescence and weight reduction on the current fleet of OH–58D helicopters and modernizes that platform to the OH–58F, but does not extend service life. The CASUP program is on schedule and continues to meet its program baseline requirements for completion. The first pre-production aircraft is scheduled for delivery in the 4th Quarter of FY12. The first unit equipped with the OH–58F is expected in FY16. However, the Army continues to pursue a potential replacement for the Kiowa Warrior.

The Armed Aerial Scout (AAS) Analysis of Alternatives was completed and submitted to the Office of the Secretary of Defense in January 2012. In order to make a more informed capabilities decision, the Army is requesting to conduct a Voluntary Flight Demonstration (VFD) of helicopters currently available from industry representatives. These flight demonstrations will help define the capabilities available from industry to fill the AAS helicopter role and perhaps better define the capability trades as they relate to the OH–58F helicopter. The Army is expected to make a capabilities decision once the data from the VFD is compiled and analyzed.

Question. Do you anticipate advances in technology in the next few years that will dramatically change rotorcraft capabilities?

Answer. The Army Science and Technology (S&T) community is actively engaged in developing next generation vertical lift technologies for the Future Vertical Lift family of aircraft. S&T is developing a technology demonstrator to provide a medium lift fleet (Blackhawk, Seahawk and Apache) replacement on or about 2030. We seek to achieve triple the un-refueled range, triple the operational persistence, or time on station, and double the speed of our current fleet aircraft, to meet the projected capabilities needed for the future. To achieve these operational capabilities, new technologies will be developed over the next five years, to include high speed rotors; multi-speed transmissions; low drag fuselages and embedded sensors; and internal weapons carriage. Upon successful development and flight demonstration, the Army anticipates integrating these technologies into advanced vehicle designs that provide increased cruise efficiencies, such as compound (auxiliary propulsion and wings) configurations (advanced tilt-rotor).

While this S&T effort is addressing the medium class fleet, these technologies are expected to support future light and heavy lift aircraft.

Question. Does teaming OH–58 series helicopters with unmanned aircraft deliver a significant boost in reconnaissance capability? Lethality?

Answer. Yes, Unmanned Aircraft Systems (UAS) complement existing OH–58Ds in many but not all of their reconnaissance tasks. UAS operate traditionally at higher altitude, with greater endurance and often unobserved by the enemy; this allows them to cue the OH–58s to additional targets, enhancing their missions. The UAS armed with laser designators also allows the OH–58 to engage targets with precision fire outside the range of the enemy, enhancing the survivability of the aircrew. The OH–58 in turn provides the needed lower viewing angle, and more detailed reconnaissance completing the overall reconnaissance picture. The ability of all aircraft to share Full Motion Video (FMV) with each other and the ground Commander provides greater situational awareness, and helps reduce the complexity of target acquisition and the number of steps between acquisition and engagement. This was demonstrated at a recent National Training Center rotation with our first Full Spectrum Attack Reconnaissance Squadron where teaming of manned and unmanned aircraft resulted in an increased tactical advantage.

Question. Which unmanned aerial vehicles will be teamed with the OH–58s?

Answer. The Attack Reconnaissance Squadron of the Full Spectrum Combat Aviation Brigade (CAB) teams the RQ–7B Shadow UAS with the OH–58Ds. All Army UAS will also be interoperable with the OH–58D, and thus teaming is enabled across the fleet.

Question. Does the pilot of the OH–58 essentially fly two aircraft at once?

Answer. No, the OH–58D copilot will take temporary control of only the sensor on the UAS, and then release control back to the UAS aircrew. This enables the OH–58D to survey the target area and communicate to the UAS operators how they can best support the helicopter's maneuver.

JOINT AIR-TO-GROUND MISSILE

Question. The Joint Air-to-Ground Missile (JAGM) provided greater range, insensitive munitions, and a tri-mode seeker with fire-and-forget capability. The JAGM was to provide precision engagement against stationary and moving targets. It was to be effective against armor, bunkers, vehicles, missile launchers, and command and control facilities. The very broad nature of the requirements also increased the complexity of integration and drove up cost. The fiscal year 2012 appropriation provides $127 million for JAGM development. The fiscal year 2013 request proposes only $10 million to continue development and the Secretary of Defense has announced that the Department will focus on low cost alternatives such as Hellfire.

General Odierno, describe for this Committee the significance of the capability that is lost by continuing with the older missiles rather than fielding JAGM.

Answer. The full JAGM capability provides the following improvements over the current HELLFIRE and Longbow missiles: 1) Improved Countermeasure/Adverse Weather capability; 2) More robust capability to engage Unmanned Aerial System

(UAS); 3) Improved Fire and Forget; 4) Improved operational flexibility through the use of the tri-mode seeker; 5) Increased lethality against moving/fleeting targets; and 6) Extended range (16 km for rotary-wing platforms versus the current 8 km for HELLFIRE).

The Army and Navy reviewed and prioritized JAGM's requirements for cost versus operational capability. The restructured program will take advantage of the tri-mode seeker we've already developed in this program and give it open system architecture. With this architecture we intend to incrementally improve its countermeasure and adverse weather capability as well as improve its Unmanned Aerial System lethality. This restructured approach leverages the development already completed and provides a more affordable solution.

Question. What is the unit cost of Hellfire versus JAGM?

Answer. The HELLFIRE Fiscal Year 2012 production costs, with government support, are $120,000 per missile, given a procurement rate of approximately 2,000 per year. Prior to program restructure, the JAGM certified costs were estimated by the Deputy Assistant Secretary of the Army (Cost and Economics) to be $169,000 per missile for a 16-year production program given a procurement rate of approximately 2,000 per year. The intent of the JAGM Extended Technology Development Phase is to address potential requirements tradeoff and affordability for future production; therefore, the JAGM actual production cost is expected to be reduced from the original program estimates when compared at the same production rate.

Question. What is the savings, year by year, of continuing with Hellfire rather than procuring JAGM?

Answer. During the period of Fiscal Years 2013–2017 (FY13–FY17), the Army projected savings would be $395.6 million (M).

	FY13	FY14	FY15	FY16	FY17	Total
RDT&E Funding	$159.4M	$145.8M	$37.7M	$26.7M	$26.0M	$395.6M

*For FY15 and out, the Army would continue to procure HELLFIRE Missiles to meet the Total Army Munitions Requirements at approximately $85M per year.

Question. What upgrades can be added to the Hellfire? At what cost?

Answer. The Army presently is not planning an upgrade to HELLFIRE. During the JAGM Extended Technology Development Phase, however, the Army will integrate a multimode seeker on existing qualified components of the HELLFIRE system in order to deliver a missile that has much greater capability than the current major HELLFIRE variants. The expected unit cost of this approach will ultimately be comparable to the current HELLFIRE.

PATRIOT PAC–3 AND MEDIUM EXTENDED AIR DEFENSE SYSTEM (MEADS)

Question. General Odierno, given the potential threat to U.S. and allied interests, especially the potential threat in the Pacific region posed by Chinese aircraft, cruise missiles, and ballistic missiles, there is a general consensus that more Patriot Missiles, and launchers may be needed. The budget request proposes 84 additional Patriot Advanced Capability 3 (PAC–3) missiles and 38 launchers, which completes the procurement.

General Odierno, please discuss the requirement for Patriot missiles, and the balance, or friction between assets available and the requests from the combatant commanders for Patriots to be forward deployed in their areas.

Answer. The Army requirement for Patriot missiles is currently well established at 2200. In conjunction with development and planned procurement of the next generation Patriot Advanced Capability—Phase 3 (PAC–3) missile and the Missile Segment Enhancement (MSE), the Army is working a revision to the current Army Acquisition Objective (AAO). As combatant commands submit their PAC–3 missile inventory requirements to the department, allocation of the PAC–3 missiles is then adjudicated by the Joint Staff and approved by the Secretary of Defense in the Patriot Missile Distribution Plan.

Question. The Committee understands that some Patriot units have a blended capability. That is, the units have a mix of earlier model missiles and PAC–3 missiles. General Odierno, please explain the strengths and limitations of Patriot units with a blended inventory of new and older model missiles.

Answer. All Patriot units fight with a mix of Patriot Advanced Capability—Phase 3 (PAC–3) and legacy missiles. This mix capitalizes on the strengths of our newest missile (PAC–3, soon to be Missile Segment Enhancement (MSE)), while utilizing

legacy missiles until they are expended. Commanders can select which missile variant to employ in response to their knowledge of the threat. Patriot is deliberately planned to have a mix of missiles for the next two decades, at minimum. The Patriot force is currently fielded with both newer PAC–3 Enhanced Launcher Electronic System (ELES) launchers, which can fire all missile variants and older launchers that can only fire legacy missiles. To increase commander flexibility, the Army is working to upgrade all launchers to the ELES configuration PAC–3 capability.

Question. The Medium Extended Air Defense System (MEADS) being jointly developed by the United States, Italy, and Germany was to replace the Patriot series air defense systems, but MEADS has been cancelled. Weighing threats versus Patriot capabilities, was MEADS termination the correct move?

Answer. The U.S. cannot afford to purchase the MEADS and make the required upgrades to Patriot concurrently over the next two decades. The estimated MEADS design and development program would have required at least $974 million additional U.S. investment on top of the Fiscal Year 2012 (FY12) and FY13 funding requirements. Additionally, three independent MEADS program studies concluded that the MEADS system design would not meet the U.S. requirements, and delays in the MEADS development would not have allowed the Army to replace the Patriot systems with the MEADS as originally planned. Consequently, the costs of completing the MEADS development and procuring it to eventually replace the Patriot would have required significant concurrent investment in the Patriot sustainment and modernization over the next two decades. Together, these costs are unaffordable in the current budget environment.

The Army has programmed significant Patriot modernization initiatives across FY13 through FY17. These investments provide critical capability upgrades and also help enable longer term sustainment of the force, while the U.S. plans to end participation in the MEADS. The Preplanned Patriot Product Improvement Program (P3I) provides for the upgrade of the Patriot System through individual materiel changes. The P3I sustains and modernizes the Patriot system to address operational lessons learned, enhance joint force interoperability, and make other system performance improvements to provide overmatch capability against emerging threats. The Army's Patriot modernization approach includes enhanced integration into the Integrated Air and Missile Defense architecture, the greater range and capability Missile Segment Enhancement missile, software upgrades to address specific emerging threats, net centric communication upgrades and new system processors with expanded capacity to accommodate current and future software evolution.

The Department will continue to refine the Patriot evolutionary development based on information gained from the MEADS Proof of Concept and results of the ongoing Army, Joint Staff, and the Office of the Secretary of Defense reviews and studies.

Question. The budget request includes $400,861,000 for MEADS in fiscal year 2013. For the current fiscal year, 2012, the program is funded at $389,630,000. What value is the United States receiving for the investment of approximately $800 million over fiscal years 2012 and 2013?

Answer. The Department of Defense and our MEADS partners seek the results of the final two years of the Proof of Concept (PoC) effort, the completed design and testing of the MEADS elements, the capability demonstrations and the data archival and performance reporting in order to fully assess which elements or technologies would be available to transition to existing air and missile defense architectures. Until this critical design and performance data is available, no final decisions can be made; but, we can say at this point, that multiple MEADS technologies, capabilities, and data could be harvested to potentially benefit the U.S. air and missile defense. The MEADS PoC facilitates demonstration on advanced, rotating Multifunction Fire Control Radar and lightweight/360 degree Launcher; and the design and limited demonstration of an advanced Surveillance Radar, all of which would be considered in follow-on efforts to enhance air and missile defense once the MEADS PoC is completed. The system demonstrations in 2012 and 2013 will demonstrate the maturity of design and be an enabler for potential European follow-on efforts and initial U.S. harvesting decisions. There is no U.S. MEADS funding planned beyond FY13.

Additionally, the PoC effort results in data archival and delivery for future use, potential options for harvesting, future consideration of MEADS Major End Items, and technologies to be assessed by the Department in determining future Air and Missile Defense capabilities.

The following MEADS technologies are candidates for U.S. harvesting:

- 360-Degree, Long Range UHF Surveillance Radar Demonstration Unit/Performance Data

- PAC–3 MSE Interceptor Data
- Performance Qualification Data From Three Flight Tests
- 360-Degree Engagement Solution Software Logic and Algorithms
- Band Fire Control Radar Exciter Design and Performance Data
- Lightweight Launcher With Improved Launcher Electronics and Near-Vertical Launch Design/Performance Data
- XM1160 FMTV 10-Ton Prime Mover With Armor
- Advanced Power and Cooling Technologies for Rotating Phased-array Radars
- Techniques and Algorithms for Track Fusion From Multi-spectral (UHF and X-band) Sensors
- Advanced Prognostic and Diagnostics Logistics Approaches
- Design for Reduced Personnel Requirements
- Data Link Processor From the BMC4I
- MEADS Intra-Communication System

More broadly, while the DoD understands the need to make difficult choices in the current fiscal environment concerning funding for all of our activities, we also note that failure to meet our MEADS Memorandum of Understanding funding obligations for FY13 could negatively affect our allies' implementation of current transatlantic projects and multinational cooperation, as well as their willingness to join future cooperative endeavors with the U.S. that are strongly supported by the Administration and Congress. Germany is a longstanding Partner in the Patriot system, and we are currently engaged in multiple cooperative efforts with Germany and/or Italy (e.g., Joint Strike Fighter). The ramification of failing to provide funds for this program, which is near completion, has already impacted relations with our Allies. Most recently, at the Three Nations Board of Directors meeting, our Allies expressed severe consternation that they had just formally ratified the U.S. recommended PoC, and insist on completing the PoC as agreed to in October 2011.

To remain flexible and adaptive for potential incorporation of any of the above technologies into the U.S. Army Air Defense structure, it is imperative to complete these final steps. Without this final MEADS investment, the U.S. use of these technologies would require reinvestment of additional development funds from near inception.

Question. What is the plan to enhance air defense capability going forward?

Answer. The characteristics of the future Air and Missile Defense (AMD) force are based on the new Defense Strategy and The Army Plan (TAP), which provide a framework for the modernization effort to keep pace with the evolving threat and remain lethal and discriminate. The Army's plan to enhance air defense capability entails:

- Integrated Battle Command System (IBCS) which will provide a single, modular, integrated architecture that will enable componentization of Joint AMD systems as well as the Patriot system by putting launchers and radars on the network.
- Sustain Patriot, to include planned product improvements through 2040.
- Institutionalize the current Counter-Rocket, Artillery and Mortar (C–RAM) system while seeking improved capability through the development of the Indirect Fire Protection Capability (IFPC) Increment 2.
- Investigate kinetic/non-kinetic integration to enhance cruise missile defense and counter Unmanned Aerial System (UAS) capability.
- Continue Doctrine, Organization, Training, Leadership, Material, Personnel and Facilities (DOTLMPF) integration with the Missile Defense Agency (MDA).
- The ability to defeat advanced countermeasures such as early release of sub-munitions and Digital Radio Frequency Memory (DRFM) electronic attack.
- The ability to provide relevant situational awareness and early warning across multiple joint operations areas simultaneously.
- In the far term, a 360 degree surveillance and fire control capability that enables the employment of advanced engagement concepts with other Joint AMD capabilities.

MODERNIZED EXPANDED CAPABILITY VEHICLE (MECV)

Question. The Modernized Expanded Capability Vehicle (MECV) was designed to build on the HMMWV (uparmored) Expanded Capability Vehicle. Though not as well armored as the MRAP series of vehicles, the MECV was intended to restore load carrying capability to the HMMWV while raising survivability to near MRAP levels. However the Army has terminated this program, and will focus on the MTV research and development effort.

General Odierno, the Army had planned to use a small number of MECVs, improved versions of the HMMWV Modernized Expanded Capability Vehicles, with improvements in survivability, availability and agility, but light enough for airmobile operations. That effort has been cancelled.

What light tactical wheeled vehicle will fill the void for the air mobile or airborne units until fielding of the JLTV?

Answer. The Up-Armored High Mobility Multipurpose Wheeled Vehicle (HMMWV) (UAH) is the current vehicle utilized for air mobile and airborne missions. The HMMWV UAH will continue to be utilized until fielding of the JLTV.

Question. How would you characterize the tradeoff made by focusing resources on JLTV and opting not to proceed with MECV?

Answer. The decision to not resource the MECV production in the FY13 President's Budget reflects the U.S. Army's and U.S. Marine Corps' commitment to the JLTV as our highest priority to close the capability gaps for Light Tactical Ground Mobility, which are to move mounted Combat, Combat Support and Combat Service Support Forces. The JLTV will support Air Assault operations in virtually all environments except in the most extreme conditions of altitude and heat where we accept minimal risk.

REVERSIBLE DOWNSIZING

Question. The Department of Defense paper entitled "Defense Budget Priorities and Choices", January 2012, addressed reversibility stating, "To the extent possible, structure major adjustments in a way that best allows for their reversal or for regeneration of capabilities in the future if circumstances change".

Reversibility or regeneration sounds good. What specifically are you proposing to do in the Army so that units can be rapidly regenerated if necessary?

Answer. Reversibility and Expansibility (R&E) will be attained through the adaptation of current manning, equipping, and training policies and procedures to enable the Army to reverse and expand by accessing additional soldiers annually to support regeneration of additional BCTs and enablers in response to any unforeseen requirements or changes in the defense strategy. The Army is examining strategies, policies and investments that would posture the Army to slow down and reverse a planned drawdown of Army end strength and formations, and rapidly expand in response to a future crisis.

Additionally, the Army is in the early stages of identifying billets in our Generating Force that can also support R&E.

Question. Is the capability to regenerate found mostly in the National Guard and the reserves?

Answer. A smaller Army requires a capable and ready Reserve Component; the Reserve Component is a vital element of the concept of reversibility embedded in the Department of Defense's strategic guidance. Combat experience and investment in the Army National Guard and the Army Reserve in Iraq and Afghanistan has significantly increased capabilities and readiness. Currently, we are making only small reductions in the Army Reserve and Army National Guard. The challenge is sustaining Reserve Component leader development and proficiency, given the biggest constraint, time to train. This requires us to carefully manage notification, mobilization, and deployment timelines and work closely with Reserve leaders to leverage their unique skill sets and advantages for certain missions. To this end, we will sustain the progressive readiness model for most National Guard and Reserve units in order to sustain increased readiness prior to mobilization.

Currently, the Reserve Components have manning challenges that will stress their ability to mobilize trained and cohesive units quickly in the event expansion is needed. A total force approach avoids over-reliance on one component and the Army will retain, to the extent possible, the ability to adjust or reverse active and reserve force structures and modernization changes being made today to preserve flexibility for tomorrow.

The Army is working to retain a more senior active force by retaining mid-grade NCOs and commissioned officers even as their overall end strength decreases. The Army is preserving the institutional structure and training force upon which it may build if required. In this way, the Army will have the structure and cadre of experienced leaders necessary to build upon if we have to re-grow the active force quickly.

Question. Can you provide examples of successful rapid regeneration of units in the Army?

Answer. The most recent example of successful expansion/regeneration of the Army is evident in the Grow the Army (GTA) Plan approved by the President in January 2007. This plan increased the size of the Army by 74,200 Soldiers to improve the balance of forces across all three components and better meet the Global

Force Demand in an era of persistent conflict. The decision to expand the size of the Army reflected the clear recognition by the President, the Secretary of Defense and the Congress of the importance of joint ground forces to meet strategic requirements and the need to reduce stress on Soldiers and Families related to the increasing and enduring operational demands. A complementary feature of the GTA Plan was Army leadership guidance to direct the implementation of a regeneration model that would serve to reconstitute and regenerate the force to increase unit readiness, improve preparation for deployment, and build strategic depth. The Army RESET imperative established a balanced six-month process that systematically restores deployed units to a level of personnel and equipment readiness that permits resumption of training for future missions. RESET encompasses those tasks required to reintegrate Soldiers and Families, then organize, man, equip, and train a unit. RESET is predicated on the concept of allowing Soldiers and Families the opportunity to recover in order to reverse the cumulative effects of sustained operational tempo.

Question. Secretary McHugh, how can the Army assist industry to sustain the capability to rapidly reverse cutbacks in the industrial base?

Answer. The Army can assist industry to sustain the capability to rapidly reverse cutbacks in the industrial base by identifying areas of risk to the preservation of critical capabilities. The Army continuously works with suppliers in the commercial industrial base to assess and sustain essential capabilities and to reduce the chances of single points of failure.

Related efforts include a Department of Defense Sector-by-Sector, Tier-by-Tier (S2T2) effort. The S2T2 effort seeks: (1) to establish early warning indicators of risk, particularly at lower-tiers; (2) to strengthen the supply chain and mitigate potential points of failure; and (3) to perform joint agency assessments providing the Army the ability to capture impacts on market sectors, manufacturers, and the Warfighter requirements across the U.S. Services. Another effort is the Industrial Base Baseline Assessment that seeks: (1) to conduct a sector/sub-sector assessment of programs identified as critical by Program Executive Offices and Life Cycle Management Commands; (2) to determine the impact of reductions in funding to program requirements; and (3) to develop recommendations which enable the industrial base to sustain current and future Warfighter requirements.

Question. General Odierno, is the concept of reversibility or rapid regeneration an example of relying on hope rather on proven capability?

Answer. As the new national defense priorities drives us to a smaller Army, we must avoid the historical pattern of drawing down too fast or risk losing leadership and capabilities, making it much harder to expand again when needed. The effort under way is a deliberate decision by the Army and DOD to understand how current manning, equipping and training strategies and policies will have to adapt in order to be able to expand to meet large unexpected contingencies in the future. The Army continues to conduct analysis that could lead to reorganizing our Brigade Combat Teams into more capable and robust formations.

C–27J SPARTAN

Question. The Army initiated the C–27J Spartan program in 2005, with the aircraft intended to replace the aging C–23 Sherpa, the C–12 Huron, and the C–26 Metroliner. The C–27J looks like a small C–130, but with two engines instead of four. The C–27J would provide frontline tactical airlift support to Army units and relieve some of the pressure on the CH–47 Chinook helicopter fleet. Also, the C–27J watended to serve as the airlift platform for the Army National Guard units that were losing C–130s. The Department of Defense changed the Army program to a joint program with the Air Force, and eventually made the program an Air Force program. The Department has received 38 of the C–27Js, but now the Air Force plans to end the program and divest of the 38 aircraft.

General Odierno, the Army and Air Force have barely begun fielding of the C–27J aircraft and yet the program is being cancelled.

What was the Army's requirement for C–27J aircraft?

Answer. The Army's requirement remains the intra-theater movement of time critical/mission essential cargo and personnel. The C–27J was a platform developed to meet or significantly mitigate this requirement gap. The Chief of Staff of the Army has co-signed an agreement with the Chief of Staff of the Air Force which will provide Air Force assets in Direct Support to Army ground commanders to mitigate the time critical/mission essential requirement.

Question. The Committee understands that the C–27J has served well in National Guard homeland missions, and the Ohio National Guard has flown the C–27J in Afghanistan. General Odierno, has the C–27J program had cost, schedule or performance problems which have led to the decision to end the program?

Answer. AF Response: No, the C–27J program divestiture did not result from cost, schedule, or performance issues. Force structure analysis informed by the new DoD Strategic Guidance revealed the Air Force had excess capacity in intra-theater airlift. A result of this force structure analysis, the Air Force made the difficult decision to retire 65 C–130s, terminate the C–27J procurement, and divest the delivered aircraft. These actions delivered a $2.1 billion budget reduction over the Future Years Defense Program and enabled the Air Force to focus on common configurations for key weapon systems to maximize operational flexibility and minimize sustainment costs.

Studies conducted by the Air Force and RAND have both shown the C–130 to be equally capable of performing the Direct Support airlift mission for the Army while offering increased capability to perform General Support airlift missions. The Air Force remains committed to meeting the Direct Support airlift requirements for the Army and has programmed sufficient C–130 force structure to fulfill this requirement.

Based on my experience in Iraq in 2009, when the Army and Air Force validated the direct support concept, I am confident the Air Force is fully committed to ensuring that this important mission will be accomplished.

Question. General Odierno, please explain the requirement for front line tactical airlift, and explain how some tactical airlift can be better performed by fixed wing aircraft than by a helicopter.

Answer. Fixed wing aircraft have a greater cargo, range, and speed capacity than tactical rotary wing aircraft. Fixed wing aircraft can operate at higher altitudes, reducing the risk to cargo and personnel in regards to threat and terrain. The Army's airlift requirement, time sensitive/mission critical cargo, requires both fixed wing and tactical rotary wing aircraft. Fixed wing aircraft is the preferred method to accomplish this mission when airfields are available. Tactical rotary wing aircraft are required to get the cargo/personnel to the point of need, often to locations where there is not an established airfield. The Army's airlift requirement demands a complementary fixed and rotary wing solution.

Question. General Odierno, The Committee understands that Army National Guard units are in the process of turning in their old aircraft, the Sherpas, Hurons, C–12s and Metroliners? Since the C–27J program has been cancelled and the Department of Defense plans to divest of the few that have been fielded, what is the plan to replace those older aircraft?

Answer. The C–27J program was conceived to mitigate a time sensitive/mission critical cargo mission for the Army. When the C–27J was transferred to the Air Force, they accepted the entire cargo mission for the Army. This negated the requirement for the Army to have cargo aircraft like the C–23 Sherpa. The agreement between the Chief of Staff of Army and the Chief of Staff of the Air Force continues to validate that Air Force will continue to support the Army's time sensitive/mission critical cargo mission requirement. The 26 Metroliners and 128 C–12s will be replaced with the Future Utility Aircraft.

Question. Mr. Secretary, the C–27J procurement plan at its peak was 127 aircraft for the Army. That number was reduced to 76 and later the program became an Air Force only program with an acquisition target of 38 aircraft. Now the Air Force plans to terminate the program and divest of the aircraft. Is this program another example of a lack of control in the Department of Defense regarding the establishment of requirements?

Answer. The Army's requirements have not changed. 127 Aircraft was a low risk acquisition strategy and 76 aircraft was a medium risk acquisition strategy. The program was transferred to the Air Force in 2008. The Memorandum of Understanding signed by the Army Chief of Staff and the Air Force Chief of Staff does not specify a specific aircraft or platform but does place Air Force assets in Direct Support of the Army Ground Commander.

Question. The Army's program exectitive officer has gone on record stating that the Army is considering whether to take the 21 C–27 Joint Cargo Aircraft that the Air Force is divesting. Is this accurate? Given that the Air Force plans on shutting down the C–27 program by the September 30 of this year, when will Army make a decision and inform the Committee?

Answer. The Army's fixed wing cargo mission and the C–27J aircraft were transferred to the Air Force. The Army's fixed wing cargo needs will be provided by the Air Force. The Army has no plans to take the C–27J into the service.

Question. If the Army is seriously considering this action, should the Committee be concerned that the Air Force cannot perform the direct support mission with C–130s alone?

Answer. The C–130 is capable of doing everything the C–27J can. It has greater load carrying capacity than a C–27J and will meet the Army's requirement for time

sensitive/mission critical cargo. The memorandum of understanding signed by the Army CSA and Air Force CSA places airlift (C–130s) in direct support of the ground commander to meet the time sensitive/mission critical cargo requirement.

BLAST TOLERANT FUEL CELLS

Question. Mr. Secretary a January 30, 2012 New York Times article, entitled "For Soldier Disfigured in War, a Way to Return to the World", described the medical treatment of Specialist Joey Paulk who was severely burned when his HMMWV struck a buried mine and the explosion ignited the fuel tank. The article details the medical treatment that Specialist Paulk received at Brooke Army Medical Center, and at U.C.L.A. Medical Center. The stories of Specialist Paulk and many other U.S. servicemembers who have suffered severe burns when their vehicles have been attacked by some form of conventional or home-made bomb call to question the commitment of the Army to employ state-of-the-art fuel cell technology to make ground vehicles more blast tolerant.

General Odierno, what is your assessment of the level of blast and fire survivability of combat vehicles and tactical trucks in Army units?

Answer. The Army is committed to providing the highest level of blast and fire survivability protection available in order to ensure the safety of our Soldiers. To that end, we have integrated a variety of technologies on our combat and tactical vehicles to mitigate the impact of conventional and home-made bomb blasts and enhance fire survivability of our vehicle crews. These technologies include V-hull designs, underbody Improvised Explosive Device improvement kits and Explosively Formed Penetrator Armor Kits. In addition to the blast mitigation measures, the Army also employs Fuel Tank Fire Suppression kits and Automatic Fire Extinguishing System systems on our combat and tactical vehicle fleets to enhance Soldier safety and survivability. While these measures have contributed immeasurably to saving the lives of countless Soldiers on the battlefield, the Army continues to investigate opportunities to improve blast and fire survivability of our combat and tactical vehicle fleets.

Question. What guidance has been established in the Army regarding the procurement of new vehicles to adopt advances in technology to make fuel cells less likely to explode and burn when the vehicle is struck by a mine or grenade, or when the vehicle is in an accident?

Answer. To lessen the likelihood of a vehicle exploding the Army has mandated that new tactical vehicle procurements meet the requirements of the Federal Motor Carrier Safety Regulation for liquid tanks. The fuel tanks on new tactical vehicle procurements will be self-sealing and all fixed fuel tanks will be mounted external to the crew compartment or compartmented away from the crew. Guidance concerning new procurement of combat vehicles is in accordance with specific military mobility, force protection, and survivability requirements codified in the required capability document and translated to the vehicle performance specification. Fuel cell containment or fire suppression is part of the Performance Specification for the Ground Combat Vehicle and Paladin Integrated Management self-propelled howitzer, which are the only new combat vehicles in the design phase.

Question. The Committee understands that the Joint Lite Tactical Vehicle, that will replace the HMMWV, will have automatic fire extinguishers, and self-sealing fuel tanks. However, the Army has about 155,000 HMMWVs. HMMWVs will very likely remain in use for another 15 years. Is there a plan to make the HMMWVs more fires resistant?

Answer. The Army plans to continue fire suppression improvement efforts for the High Mobility Multipurpose Wheeled Vehicle (HMMWV) that include investigating fuel tank, wheel well, battery box, and engine compartment protection. There is currently an Automatic Fire Extinguisher System in the crew compartment of approximately one-half of the Up Armored HMMWV (UAH) fleet of more than 53,000 vehicles. This includes a Manual Fire Suppression System which provides an additional crew compartment fire suppression bottle that can be manually activated from outside the vehicle, if additional fire suppressant is required.

CLERK'S NOTE.—End of questions submitted by Mr. Young.]

THURSDAY, MARCH 8, 2012.

DEFENSE HEALTH PROGRAM

WITNESSES

HON. DR. JONATHAN WOODSON, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

LIEUTENANT GENERAL PATRICIA HOROHO, THE SURGEON GENERAL OF THE UNITED STATES ARMY

VICE ADMIRAL MATTHEW L. NATHAN, MC, USN, SURGEON GENERAL OF THE NAVY

LIEUTENANT GENERAL (DR.) CHARLES B. GREEN, THE SURGEON GENERAL OF THE AIR FORCE

OPENING STATEMENT OF CHAIRMAN YOUNG

Mr. YOUNG. The committee will be in order. Good morning, everybody. Thank you for attending.

The committee's hearing this morning has to do with the fiscal year 2013 budget request for the Defense Health Program. I want to welcome Assistant Secretary of Defense for Health Affairs, Dr. Jonathan Woodson; the Surgeon General of the Army, Lieutenant General Patricia Horoho, who has been here with us on different occasions in different categories; the Surgeon General of the Navy, Vice Admiral Matthew Nathan, who comes to us from having commanded the hospital at Bethesda; and the Surgeon General of the Air Force, Lieutenant General Charles Green, who at our last hearing gave us some very impressive testimony. General, we appreciated that then and we look forward to today.

The hearing should be a little bit different. The subject is a little bit different today than it was a few weeks ago.

General Green, by the way, this probably will be your last time to testify before our subcommittee.

General GREEN. It may be, sir.

Mr. YOUNG. I would say that it has been good, all of your testimony has been good, and we will miss you.

General GREEN. Thank you, sir.

Mr. YOUNG. And we wish you the very best.

Many challenges are facing the Department; growing costs, long-term sustainability of the military health system, still very serious injuries that you are dealing with coming out of the war zones. Military health care costs have risen from $19 billion in fiscal year 2001 to $53 billion in fiscal year 2012, and I would say this committee is committed to providing whatever is needed to properly care for these wounded warriors and America's heroes.

This year, for the first time in the last decade, the budget request of $48.7 billion for the entirety of military health care is lower than the previous year's level. However, this level assumes savings associated with several TRICARE benefit cost sharing pro-

posals, proposals that must ultimately be approved by Congress, and today I can't predict what that will be. So we are interested to hear about these proposals today.

Additionally, the committee remains interested in the final recommendations recently announced by the Department related to the restructuring of the military health system as a whole and governance and multi-service markets in particular. We want to ensure that any changes to the military health system adequately reflect your input as the senior medical officers of your respective services.

Additionally, the Department continues to focus on the need for mental health counseling and readjustment support for our service members returning from deployments. It is imperative for the Department to get to the heart of the issues that service members and their families face during and after the deployments.

The committee is anxious to hear about what progress the Department has made in the past year with regard to psychological health, traumatic brain injury, and suicide prevention and what this subcommittee can do to assist in making further advances as we progress into the future.

We look forward to your testimony and to a good question and answer session. As I mentioned to you, we are going to have votes at an untimely point this morning, so we are going to expedite as quickly as we can. In other words, we would be asking you to stand by while we went to vote for about an hour and I just don't want to do that to you. You have got very important things to do. I am sure the members of the committee, and the attendance is not all that great this morning anyway, but we will do our very best to be completed with everything that you have to say before we have to break to vote, and then we will just close the hearing and let you get on about your business.

I would like to yield now to my friend, my partner, former chairman, Norm Dicks.

OPENING STATEMENT OF RANKING MEMBER DICKS

Mr. DICKS. Thank you, Mr. Chairman. I want to welcome all of the witnesses. Although we saw you just a few weeks ago, we welcome you both in your appearances as Surgeon Generals of your services. Also I would like to thank General Green for his many years of service to the Nation and for his insights on military health. We understand this is his last appearance with the committee. We appreciate your dedication in caring for our service members and their families and look forward to your testimony today.

The costs for the Defense Health Program have more than doubled over the past decade, from $19 billion in 2001 to $48.7 billion in the fiscal year 2013 request. Military health care allows service members, their families and retirees to maintain a standard of health as well as peace of mind that world class health care is available, not only when serving but after their active service is done.

However, the cost of the Defense Health Program in light of increasing budgetary pressures will be difficult to support. As a result, a significant part of the Defense Department's budget initia-

tives is focused on reducing health care costs. The 2013 budget request is $4.1 billion less than the 2012 enacted level of $52.8 billion, and $12.9 billion in savings is included in the Future Year Defense Program. The majority of these savings are from proposed changes to the TRICARE fees, mainly affecting retired service members.

Are these estimated savings realistic? How do you think those proposals will be received, and most importantly, would these initiatives affect the quality, availability or expectation of care?

Physical and mental health of our service members affects readiness, especially when faced with the task of filling deployable units in, and in the case of the Army and Marine Corps, concurrently drawing down end strength. Preventive health and resiliency programs can only raise the health of the force, which translates into increased readiness, but may also lead to reduced health care costs for physical and mental health care. We look forward to hearing how you are addressing this aspect of health care.

Conversely, the committee is also concerned about the care service members receive when they are injured on the battlefield and sometimes in training, both physically and mentally. Much has been accomplished in the treatment of amputees and the advancement of prosthetics, in many cases allowing our wounded warriors to live a full life. However, much work still needs to be done with the invisible wounds of traumatic brain injury and post-traumatic stress disorder.

Centers of Excellence for these wounds help to combine treatment and research, but somehow members still fall through the cracks and gaps for treatment and recovery. Today we hope to learn about your progress treating those injuries and how the results from the efforts have been implemented.

We strongly support your efforts to provide the best possible medical care for service members, their families and military retirees. We look forward to your testimony on how to best maintain and where possible improve this care.

Thank you, Mr. Chairman.

OTHER OPENING REMARKS

Mr. YOUNG. Thank you, Mr. Dicks.

During the 6 years that I had the privilege of serving as chairman of the Appropriations Committee, this committee was chaired by Jerry Lewis for 6 years, who did a really great job. Do you want to make any opening comments?

Mr. LEWIS. No opening comments. Thank you, sir.

Mr. YOUNG. Mr. Frelinghuysen is not only an important member of this subcommittee, but he also represents this subcommittee as an adjunct through the House Permanent Select Committee on Intelligence. In addition to that, he chairs his own subcommittee, which is important to national defense because he deals with all of the nuclear laboratories and all of our nuclear facilities.

Mr. Frelinghuysen, do you want to make any opening comments?

Mr. FRELINGHUYSEN. No, thank you, Mr. Chairman.

Mr. YOUNG. Thank you all very much. We will proceed to hearing your statements. As usual, you summarize them any way you like. Your entire statement will be put into the record.

Secretary, I assume we will begin with you.

SUMMARY STATEMENT OF DR. WOODSON

Dr. WOODSON. Thank you, Mr. Chairman, members of the committee, thank you for the opportunity to appear before you today to discuss the future of the military health system and in particular our priorities for this year.

Over the last 10 years, the men and women of the military health system have performed with great skill and undeniable courage in combat. Their contributions to advancing military and American medicine are immense. The military health system's ability to perform this mission and be able to respond to humanitarian crises around the globe is unique among all military and non-military organizations on this globe, and I am committed to sustaining this indispensable instrument of national security.

The budget we have proposed provides the resources we need to sustain the system and maintain our readiness. We must also be responsible stewards of the taxpayers' dollars. The 2011 Budget Control Act required the Department to identify $487 billion in budget reductions over the next 10 years, and health care costs could not be exempt from this analysis.

The military health system is undertaking four simultaneous actions to reduce costs: One, internal efficiencies to better organize our decisionmaking and execution arm; two, a continuation of our efforts to appropriately pay private sector providers; three, initiatives that promote health, reduce illness, injury and hospitalization; and, four, proposed changes to beneficiary cost sharing under TRICARE. The military and civilian leaders in the Department developed these proposals and have publicly communicated their support for these proposals to you in writing and in person.

We have recently submitted to the Congress the Secretary's recommended path forward for how we should organize the military health system. We have learned a great deal from our joint medical operations over the last 10 years and we recognize that there is much opportunity for introducing even a more agile headquarters operation that shares common services and institutes common clinical and business practices across our system of care.

The budget we have put forward for 2013 is a responsible path forward to sustaining the military health system in a changing world and recognizes that the fiscal health of the country is a vital element of national security. I am proud to be here with you today to represent the men and women that comprise the military health system, and I look forward to answering your questions.

[The statement of Dr. Woodson follows:]

Prepared Statement

of

The Honorable Jonathan Woodson
Assistant Secretary of Defense for Health Affairs

REGARDING
THE MILITARY HEALTH SYSTEM OVERVIEW

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE
DEFENSE SUBCOMMITTEE

March 8, 2012

Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to appear before you today on behalf of the men and women who comprise the Military Health System (MHS) and address our strategic priorities for the coming year.

We enter 2012 now having over ten years of experience in preparing for and responding to the consequences of war. We have seen the end of one major conflict and the implementation of a concrete timeline for the drawdown of the other. Yet, even with these milestones in our sights, we have many challenges to address in the coming year, both operational and fiscal.

I am proud of the performance of our military medical personnel on the battlefield and here at home. Last year, I provided this Committee with some of the accomplishments achieved in combat – the lowest levels of disease, non battle injury (DNBI) rates in warfare; the highest survival from wounds rate; the safety and speed of an aeromedical evacuation system that has no peer; and the treatment and rehabilitation of wounded warriors that is allowing ever greater numbers of our severely wounded to return to their units, or to pursue careers in the civilian sector.

These accomplishments bear repeating. I do this not simply to honor the men and women who made them happen, but also to point out that the actions and lessons that led to these outcomes are now being replicated in trauma centers, surgical suites, and rehabilitation centers around the country and around the world. The MHS is transferring our medical knowledge gained from battlefield medicine to the rest of society.

As we share our experiences with our colleagues in American medicine, we are also mindful of the need to look internally and assess what lessons we have learned – and consider how we should be organized to meet our future missions. In June 2011, the Deputy Secretary of Defense established an internal task force to study this issue. We have now also shared the task force report and the Deputy Secretary's planned reorganization with the Congress, consistent with Section 716 of the National Defense Authorization Act for fiscal year (FY) 2012. The plan we developed increases unity of effort, agility, and the opportunity for cost savings both through reduced overhead and, more importantly, through the implementation of common clinical and business practices across the enterprise. Our ability to implement this model will enhance virtually all of the programmatic issues we discuss in the MHS today.

The Department has proposed a $32.5 billion Defense Health Program (DHP) appropriation (Figure 1), reflecting a small increase from the FY2012 enacted budget.

Figure 1: FY2013 Defense Health Program (DHP) Summary

$ in Millions

Appropriation Summary	FY 2011[1] Actual	Price Growth	Program Growth	FY 2012[2] Enacted	Price Growth	Program Growth	FY 2013[3] Estimate
Operation & Maintenance	29,953.5	721.7	-89.0	30,586.2	859.6	-96.6	31,349.3
RDT&E	1,205.8	22.9	38.1	1,266.8	22.8	-616.6	673.0
Procurement	546.7	12.4	73.4	632.5	14.2	-140.2	506.5
Total, DHP	**31,706.0**	**757.0**	**22.5**	**32,485.5**	**896.4**	**-853.4**	**32,528.7**
MERHCF Receipts[4]	8,600.0			9,470.6			9,727.1
Total Health Care Costs	**40,306.0**			**41,956.1**			**42,255.8**
					Numbers may not add due to rounding		

[1] FY 2011 actuals include Operation and Maintenance (O&M) funding of $1,394.0M and Research and Development funding of $24.0M from the FY 2011 Overseas Contingency Operations (OCO), Title IX, Public Law 112-10.

[2] FY 2012 enacted (base), excludes O&M funding of $1,215.3M of OCO.
[3] FY 2013 estimate excludes O&M funding of $993.9M for OCO. The Department of Defense projects $135.6M O&M funding should transfer in FY 2012, and $139.2 million in FY 2013 to the Joint Department of Defense – Department of Veterans Affairs Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84 (National Defense Authorization Act for Fiscal Year 2011).
[4] Reflects Departmental DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) for FY 2011, FY 2012, and FY 2013 (O&M

Our proposal includes realistic cost growth for pharmacy, TRICARE contracts and other services provided both in our medical treatment facilities (MTFs) and care purchased from the private sector; as well as sustained investment in medical research and development.

I will outline the major elements of our strategy for 2013, using the Quadruple Aim -- the MHS strategic framework -- to discuss our initiatives. This framework captures the core mission requirements of the MHS: Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care.

Assuring Readiness

The MHS continues to closely monitor the health and medical readiness of the military force. We have consistently witnessed improvements in the medical preparedness of our service members, both active and Reserve Component.

We have ensured that our medical forces are also ready through sustained investments in our enlisted and officer training programs, through our comprehensive Graduate Medical Education (GME) programs conducted at a number of our MTF training platforms throughout the MHS and with select civilian partners; at the Medical Education and Training Center

(METC) in San Antonio, Texas, in our military medical school, the Uniformed Services University of the Health Sciences.

We also assess the health of the force upon their return from deployment. In our continued commitment to ensuring the mental health of our service-members, the Department has issued policy that Service members deployed in connection with a contingency operation receive a person-to-person, privately-administered mental health assessment before deployment, and three times after return from deployment. These person-to-person assessments are conducted by licensed mental health professionals or by designated individuals trained and certified to perform the assessments.

As part of our monitoring of the medical readiness of the force, we also assess our performance in ensuring that those service members who are identified as needing behavioral health services receive a referral and seek treatment. In this area, we have also witnessed improvement each year in both the referral for behavioral health services, and the rate at which service members seek ongoing treatment.

Senior leaders, both officer and enlisted, have led the effort to reduce the stigma associated with seeking mental health care. A DoD Mental Health Advisory Team (MHAT) survey from February 2011 showed that Marines who screened positive for mental health issues, had a substantial (and statistically significant) decrease in behavioral health stigma levels from 2006. The percent of Marines who agreed that seeking mental health care would harm their career dropped by more than fifty percent. Responses by the Marines on whether seeking mental

health care would cause members of their unit to have less confidence in them, cause unit leaders to treat them differently, cause unit leaders to blame them for the problem, or cause the Marine to be seen as weak, also saw similar statistically significant decreases.

Together with the Department of Veterans Affairs (VA), we have developed an integrated Mental Health Strategy that has 28 discrete strategic actions designed to strengthen access to clinical services, improve continuity of care across the Departments, streamline the adoption and implementation of evidence-based practices and ensure our mental health providers are delivering state-of-the-art care.

We have increased the number of behavioral health care providers over the past 3 years and embedded more in front line units. Along with providing care, we have undertaken the largest study of mental health risk and resilience ever conducted among military personnel. This study will identify risk and protective factors as well as moderators of suicide-related behaviors by 2014.

The Department continues to improve access to behavioral health services through a number of initiatives. In FY12, we have begun the process of embedding, over a four-year period, over 400 behavioral health providers into our patient-centered medical homes. We enhanced confidential, non-medical counseling through the Military Family Life Consultants (MFLC) and Military OneSource (MOS) programs, to include surge support – for both deployment/reintegration points in time, as well as other crises that emerge on a short-notice basis, such as the Ft Hood shooting and the Japanese earthquake/tsunami/nuclear incident.

Recent legislation now permits mobile VA Readjustment Counseling Services to provide outreach and readjustment counseling to active duty service members.

We have also made efforts to ensure continuity of behavioral health care for members in transition – to a new installation, from active to reserve status, or to the VA. We offer a diverse set of services to reach those military members seeking greater support. One notable program -- "*inTransition*" – was developed in response to the Mental Health Task Force recommendation to "maintain continuity of care across transitions for service members and veterans," and offers a voluntary telephonic coaching program designed to facilitate a smooth transition to a new source of care. *Afterdeployment.org* is another program, serving over 5,000 users monthly, that provides service members and their families with behavioral health information in a setting that preserves anonymity, and offers tools to help them recognize problematic behavioral health issues early and how to address these challenges. Recently, the VA has been using the site's interactive workshops in their walk-in clinics.

Just as the Department has established a comprehensive approach to its mental health destigmatization efforts, we have employed the same model for our suicide prevention programs. The Deputy Assistant Secretary of Defense for Readiness is standing up the Defense Suicide Prevention Office that will be staffed and resourced to develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities across the Department. This action specifically addresses a key recommendation contained in the DoD Task Force Report on Suicide Prevention and will greatly facilitate the timely implementation of additional recommendations contained in the report.

The Department of Defense has made great strides in implementing early identification and treatment programs for traumatic brain injuries (TBIs). Through the work of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), the DoD in-theater concussion policy has significantly improved the early detection of Service members with concussion by providing clear and specific guidelines for the management of acute concussions. The Department's focus on TBI treatment has resulted in the standardization of 62 TBI programs at military treatment facilities (MTFs) in the non-deployed setting and the cultivation of 11 concussion restoration/care centers in the deployed setting. We have also helped update the behavioral health curriculum for all medical technicians and corpsmen at our Medical Education and Training Center (METC) to ensure our knowledge base is advanced throughout the MHS.

Our FY13 program sustains the significant investments we have made in all of our medical research and development programs, and in particular in the area of TBI and Post-Traumatic Stress (PTS). The Center for Neuroscience and Regenerative Medicine (CNRM) is a collaborative intramural federal program that bridges DoD and the National Institutes of Health (NIH) in order to catalyze innovative approaches to TBI research, and emphasizes research that is relevant to military populations. Our other focus areas for the Defense Medical Research and Development Program include polytrauma and blast injury; operational health and performance; regenerative medicine; rehabilitation; psychological health and well-being for military personnel and families; and military medical training systems and health information technology applications.

Within the readiness area, the health of our service members is also protected through sound occupational health practices. This past fall, the Institute of Medicine (IOM) concluded its independent study of the long-term health consequences of exposure to burn pits in Iraq and Afghanistan. The IOM was unable to identify any long-term health risks from these exposures. Nonetheless, DoD and the VA are continuing to monitor of the health of deployed Service members and veterans and provide for a longer period of post-exposure health assessments to ensure these initial findings are sustained over time.

Finally, at the core of our medical readiness posture is our people. Our recruitment of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remains high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses. We will continue to work with Congress on potential new flexibilities to ensure we remain competitive in this environment.

Improving Population Health

Closely linked with our readiness mission are our efforts to improve the health of the entire MHS population. We are going to engage in a multi-year effort on two of the greatest contributors to ill health --- tobacco use and obesity in our population.

Our service members use tobacco and tobacco products at a much higher rate than their peers; we have started to reduce tobacco use, but we plan to do more. In addition to the existing suite of smoking cessation pharmaceuticals available at MTFs, and counseling services, we will soon offer the pharmaceutical benefit through our mail order program, and allow for a 24/7 smoking cessation line with counseling services over the phone.

In the area of obesity and overweight persons, in some circumstances we reflect what is occurring within the larger society. Our active-duty service members – as you would expect –do well in maintaining their weight and their fitness, and exceptionally well when compared to their peers. However, the influence of nutritional habits in the larger society is having effects on the military population and particularly on entry-level candidates. When those in uniform leave active service, too many reverse the physical fitness habits and discipline of military service. There is a financial cost to this; one DoD study found that $1.4 billion could be attributed to overweight and obesity-related medical problems and services. But, more importantly, the quality of life for our overweight and obese beneficiary population is often far worse than it should be as many are affected by obesity-related disease, such as diabetes and heart disease.

We have worked across the Services to develop and launch both adult and childhood obesity management and prevention guidelines, emphasizing the provider's role and positive steps to take in assisting and advising patients. We have also implemented a demonstration project to determine whether monetary incentives can be used to improve the overall health and wellness of the MHS population. We do not yet have the results of this demonstration project, but will report interim findings to the Congress this year. Finally, we have joined with a broader

set of partners in DoD, that includes bringing together everyone on a military installation – commanders, senior enlisted advisors, the military family program leaders and medical personnel – in a set of initiatives aimed at further improving the fitness of our entire community. Our military dining halls, schools and child development centers are offering healthier food choices – both here and in Afghanistan; our commissaries and exchanges will help identify better nutritional choices; and we're redesigning our military communities in ways that will increase exercise and fitness.

Enhancing the Patient Experience of Care

As the MHS moves into 2012, we will re-evaluate our efforts and mission through the lens of enhancing the patient experience of care by focusing on maximizing the value we provide to our beneficiaries.

The MHS is continuing the implementation of the Patient-Centered Medical Home (PCMH), a program with the principle focus of developing a cohesive relationship between the patient and the provider team. The PCMH is a transformative effort within our system, with the potential to positively affect all aspects of our strategic focus – readiness, population health, patient experience and per member cost. Begun in 2009 as a strategic initiative, the MHS has formalized through directive and accreditation our PCMH program. In 2011, 44 of our facilities were formally recognized by the National Committee on Quality Assurance (NCQA), with 93 percent recognized as Level 3 PCMHs (as compared to a private sector rate of 60 percent with Level 3 recognition). Our more mature PCMHs – at facilities throughout the Army, Navy and

Air Force, and representing more than 25% of our medical homes -- are achieving the outcomes we sought: improved access to care (increased percentage of the enrolled population getting an acute appointment within 24 hours, and a routine appointment in 72 hours); improved continuity with the same team of providers (increased percentage receiving care from their assigned primary care manager); and reduced emergency room utilization. In FY12, we will further augment our medical homes with a 24/7 nurse advice line to offer both enrollees (and all beneficiaries) access to essential health information. This nurse advice line will be linked with MTF appointing to further improve access to care, and reduce bureaucratic hurdles for our patients.

The Department has long been a national leader in developing and deploying a global, electronic health record (EHR). Our first EHR was put into the field in the late 1980s. We are now on the cusp of developing our third generation EHR – and the first to be co-developed with the Department of Veterans Affairs – the integrated Electronic Health Record (iEHR). Both DoD and the VA are encouraged by the progress that our interagency teams have made in refining or developing the IPO charter, and the principles, strategies and architectural framework for the iEHR as we embark upon this landmark effort.

The DoD/VA Interagency Program Office has been rechartered to give them more responsibility and authority as the program execution office for the iEHR. In addition, the VA has signed an agreement with the Defense Information Systems Agency to move the data centers for two of VA's regions into DoD data centers. Most recently, this week we announced the selection for the Director of the Interagency Program Office.

As we expand the amount of health care information that we collect and share, we remain vigilant about the security of this sensitive health information. In the last year, a DoD contractor responsible for the maintenance of aspects of our electronic health record experienced a serious security breach in which 4.9 million medical records were potentially compromised. In the wake of that incident, we have conducted a critical review of the contractor's performance, as well as a review of our existing policies and procedures, and we have strengthened our guidance and future contract requirements for a number of security and encryption standards.

Our work with the VA on the iEHR is only one element of a comprehensive strategy to further partner with the Department of Veterans Affairs. We have successful joint ventures or fully integrated operations at ten locations in the United States, and, in addition, we are pursuing other opportunities for joint purchasing, shared education and training opportunities, and joint construction, where feasible.

The Military Construction (MILCON) program continues to recapitalize our inventory of MTFs. Our current investment program was substantially increased five years ago and has been essential in facilitating the BRAC transition and continued improvement of our MTFs. Both the Walter Reed National Military Medical Center in Bethesda, Maryland and the Fort Belvoir Community Hospital in Fort Belvoir, Virginia have opened their doors, showcasing the investments made, using evidence-based design standards. Construction and renovation of medical facilities in San Antonio is also complete. Along with other military medical facility projects in the U.S. over the last seven years, with the support of Congress we have just

completed one of the most transformative periods in the history of our military medicine infrastructure.

As budgets and force structure are reduced in the Department, we recognize that there is a need to reassess the size and scope of major construction projects, as we are currently doing with the Landstuhl Regional Medical Center in Germany. We will, however, sustain our commitment to the operational mission, patient-centered design and clinical quality, even if sizing issues are reconsidered. The recapitalization of military medical facilities is essential to our efforts to recapture health care that has migrated to the civilian sector.

Responsibly Managing Cost

We are proud of our achievements in combat and peacetime medicine. We offer a superb benefit to our 9.7 million beneficiaries, no matter where they live, through our direct health care system and through our managed care support contracts. This health care benefit is justifiably one of the finest and most generous in the county and is an appropriate benefit for those who serve our country. However, the costs of providing this care continue to increase more rapidly than overall inflation. For a number of years, and through several Administrations, there have been continuous, incremental steps taken to reduce the rate of growth in the costs of healthcare.

In addition, the requirements of the Budget Control Act of 2011 compelled the Department to identify $487 billion in budget reductions over the next ten years. The process of identifying these budget cuts was developed by the senior civilian, military officer and enlisted

leadership from throughout the Department. Difficult choices were made. Over ninety percent of the cost reductions were external to personnel compensation and benefits. Still, health care was not exempt from this process. The proposals being put forward in this budget appropriately balance the need for a superb benefit that assists with both recruitment and retention of an all-volunteer force with our need to sustain a cost-effective approach for the long-term.

This Administration is pursuing a four-pronged approach by which all stakeholders share responsibility for improving the health of our population and the financial stability of the system of care.

Our four approaches – moving from a system of healthcare to one of health; continuing to improve our internal efficiencies; implementing provider payment reform; and rebalancing cost-sharing – are further described below. In some instances, they reflect efforts already underway, or new initiatives that the Department is implementing within existing legislative and regulatory authorities.

Moving from Healthcare to Health

The Department of Defense's military medical leaders are leading a strategic effort to move our system to one that promotes and sustains the optimal health of those we serve, while providing world class healthcare when and where it is needed.

Central to this effort are the Department's investments in initiatives that keep our people well; that promote healthy lifestyles; and that reduce inappropriate emergency room visits and unnecessary hospitalizations. These initiatives have been addressed in earlier parts of my testimony and include the Patient-Centered Medical Home (PCMH) initiative; the embedding of behavioral health staff within these medical homes; the introduction of a 24/7 nurse advice line; and our many population health initiatives. We have also taken a number of steps to support preventive services. Our TRICARE beneficiaries – whether enrolled to TRICARE Prime or in TRICARE Standard – have no co-payments for recommended preventive services, such as influenza immunizations.

The "Healthcare to Health" element of our strategy will not produce immediate cost savings. Nonetheless, based on knowledge of well-constructed wellness programs in the private sector, we are confident that these, and other ongoing enhancements to the TRICARE program, will produce improvements to health that also "bend the cost curve." In the longer term, it is the strategy most likely to produce the greatest amount of savings to our system.

Internal Efficiencies

The Department has instituted internal cost reduction efforts by decreasing headquarters administrative overhead; jointly purchasing medical supplies and equipment; and directing patients to lower cost venues for medications. The cumulative savings from all of these internal efforts for FY2013 are estimated at $259 million.

I have also previously noted the proposed reorganization of the MHS, following the work of the Task Force on Military Health System (MHS) Governance, which evaluated options for the long-term governance of the MHS as a whole; governance in those areas where more than one Service operates medical treatment facilities – referred to as multi-Service markets, and governance for the National Capital Region (NCR).

Implementation of any organizational efficiencies resulting from this Task Force has been placed on hold at the direction of Congress, subject to a review by Congress and by the Comptroller General. We will provide Congressional Committees with the information requested regarding the Task Force work and will develop more detailed cost and savings estimates for any eventual governance model. After the Deputy Secretary of Defense approves the "way ahead," we will be prepared to answer any additional questions that you have. We believe that further integration of health services across the Services and with the TMA are needed in order to provide a continued high quality of care in an environment of diminishing resources while ensuring the preservation of the health benefit for future generations.

Provider Payment Reform

We are committed to identifying greater efficiencies and cost savings in all areas of our operations. In addition to internal efficiencies, we are also seeing significant savings through a number of provider payment reforms that we have introduced in the last several years. These include the implementation of the outpatient prospective payment system; the policy changes we

made for reimbursement to select hospitals and health plans in the TRICARE network; and further use of federal ceiling prices for acquisition of pharmaceuticals.

The Department has undertaken a broad-based, multi-year effort to ensure all aspects of our provider payments for care purchased from the civilian sector are aligned with best practices in Medicare and in private sector health plans. The most notable efforts have included implementation of changes to the outpatient prospective payment system (OPPS) and reform of payment to Sole Community Hospitals.

OPPS is modeled after the payment process that Medicare uses for similar health care services – setting a fixed fee per procedure, inclusive of provider and institutional charges for care. In order to allow medical facilities to transition to this new method of payment, TRICARE phased in the reimbursement levels over four years, with the full implementation of this policy set to occur in 2013. In FY 2012, we project $840 million in savings, and $5.5 billion over the fiscal years 2012-2017.

Our provider payment reform for Sole Community Hospitals (SCH) was also phased-in over time, and will provide a projected $31 million in savings in the first year, and will grow to about $100 million in savings through 2017.

In the area of purchasing prescription drugs, in 2009 we instituted a process for obtaining discounts on drugs distributed through retail network pharmacies, pursuant to authority provided in the 2008 National Defense Authorization Act. Known as Federal Ceiling Prices (FCP),

prescriptions purchased under FCP are at least 24 percent less than non-Federal Average Manufacturer prices. In 2012, the FCP program will save the Department over $1.6 billion, and will grow to over $2 billion in savings by 2017.

Beneficiary Cost-Shares

In addition to the focus on internal and external efficiencies, our proposed budget introduces changes to the health care out-of-pocket costs for our beneficiaries.

I want to make three critical points related to these proposals. First, even accounting for these proposed fee changes, the TRICARE benefit will remain one of the finest and most generous health benefits available in the country, with among the lowest beneficiary out-of-pocket costs available to anyone – and certainly lower than costs by other federal government employees. We believe that is appropriate and properly recognizes the special sacrifices of our men and women in uniform, past and present.

Second, as mentioned earlier in my testimony, these proposals were developed within the Department, and represent the input and consensus of our uniformed leadership, both officer and enlisted.

Third, we recognize that some beneficiary groups should be insulated from increases in out-of-pocket costs. We propose to exempt those service members, and their families, who were medically retired from military service, as well as the families of service members who died on

active duty. We also propose to establish cost-sharing tiers, with lower increases for retirees based on their military retirement pay. More junior enlisted retirees, for example, will experience the lowest dollar increases in out-of-pocket costs. Finally, we have also avoided any changes in cost-sharing for active duty families with the exception of prescription drug co-payments obtained outside of our MTFs. Prescription drugs distributed within MTFs will continue to be free of charge for all beneficiaries.

For over fifteen years, the Department had not increased patient out-of-pocket costs for any beneficiary. In fact, the TRICARE benefit was enhanced in many ways, and a number of out-of-pocket costs were decreased. A few of these enhancements include: active duty family members enrolled in TRICARE Prime had their co-pays eliminated; retirees and their families using TRICARE Prime had their catastrophic cap reduced from $7,500 to $3,000 per year; Medicare-eligible retirees and their families received TRICARE For Life coverage, and a TRICARE pharmacy benefit. Last year, we introduced very modest changes in one segment of our population – increasing TRICARE Prime enrollment fees for retiree families by $5/month, and indexed these fees so that future increases continue to be modest and beneficiaries can plan for them. We greatly appreciate the Congress' support for these proposals in the FY2012 budget, and have implemented those fee changes in the current year.

Although last year's changes were a necessary step, the Department has proposed further cost reduction efforts in 2013 as an element of our strategy to meet the requirements of the 2011 Budget Control Act. All of these changes are phased in over time. For select fees the Department has proposed "tiers" of co-pays based on the retirement pay of the beneficiary. Fee

changes are distributed across the various TRICARE programs, so that no one beneficiary group bears the entire burden for these changes in cost-sharing. Retirees in TRICARE Prime, TRICARE Standard and TRICARE For Life each have a share of the increases; all beneficiaries (except uniformed personnel) have additional costs for prescription drugs outside of MTFs.

The following sections provide a high-level overview of the proposed changes in beneficiary out-of-pocket costs. Figure 2 summarizes the proposed fees:

- Fee increases for TRICARE programs. The following proposed changes represent increases from existing patient out-of-pocket costs.
    - TRICARE Prime Enrollment Fees. We propose to raise the enrollment fees in 2013 for retired service members and their families from between $80 – $300 per year, based on the retirement pay of the service member, and continue to provide similar increases through 2016.
    - TRICARE Deductibles. We propose to increase deductibles for the TRICARE Standard program for retired service members and their families beginning in FY13. TRICARE deductibles have not been changed since before the TRICARE program was introduced, having last been adjusted over 20 years ago.
    - TRICARE Pharmacy Co-Pays. We propose to increase pharmacy copayments for generic, brand name and non-formulary prescriptions in both the retail and mail order settings, although we will continue to offer significant incentives for beneficiaries to elect mail order over retail pharmacy networks. Additionally, non-formulary prescription drugs will no longer be available in the retail network. These changes are proposed for all non-active duty beneficiaries, to include active

duty family members. Prescription drugs obtained in military hospitals and clinics will continue to be provided without co-pay for any beneficiaries.

- New fees for TRICARE programs. Our proposed budget also calls for the introduction of new fees not previously part of the TRICARE program.
    - TRICARE Standard/Extra Enrollment Fee. We propose to introduce an annual enrollment fee in TRICARE Standard for retired service members and their families. The proposed fee for 2013 will be $70/ year for an individual retired beneficiary, or $140 per retired family.
    - TRICARE For Life (TFL) Enrollment Fee. When TFL was introduced in 2002, there was no enrollment fee in the program, only a requirement that beneficiaries be enrolled in Medicare Part B to enjoy their TFL benefit. Medicare Part B was always a step that we recommended our retirees elect, and prior to 2002, over 95% of eligible military retirees were enrolled in Medicare Part B. The TFL benefit has reduced beneficiary out-of-pocket costs by thousands of dollars per year in co-payments or Medicare supplemental health insurance plan payments. The proposed TFL enrollment fees, similar to the TRICARE Prime enrollment fees, are tiered, based on an individual's retirement pay – and range from $35 to $115 per beneficiary per year in FY2013.
    - Exclusion of Enrollment Fees from the Catastrophic Cap. We propose that enrollment fees, which had previously accumulated toward a retiree's catastrophic cap limit, will not be counted toward the cap beginning in 2013.

- In addition to the indexing of the TRICARE Prime enrollment fee, which is already indexed, we propose to index other beneficiary out-of-pocket costs identified in this set of proposals, to include the TRICARE Standard deductible, TRICARE Standard enrollment fee, TRICARE For Life enrollment fees, pharmacy co-payments, and catastrophic caps.

Figure 2. Summary of TRICARE Proposals

- TRICARE Prime for Working Age Retirees (under Age 65)
- As part of the FY 2013 President's Budget, the Department will seek additional increases in the **TRICARE Prime** (Health Maintenance Organization (HMO) type plan) enrollment fees in order to bring the beneficiary cost share closer to the original levels mandated by Congress when the program was established. These increases will be phased-in over a 4-year period and will be tiered based on the amount of the beneficiary's military retirement pay.

- Table 1 displays the proposed fees by fiscal year for the three tiers of retired pay. After FY 2016, the enrollment fees will be indexed to increases in National Health Expenditures (NHE). The retired pay tiers will also be indexed to ensure beneficiaries are not pushed into a higher tier as a result of annual cost-of-living (COLA) increases. The construct and tiering are generally based on recommendations of the 2007 *Task Force on the Future of Military Health Care*.

Table 1 – TRICARE Prime Annual Family Enrollment Fees (Individual Fees = 50%)

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$460/$520	$600	$680	$760	$850	$893
Tier 2: $22,590 – $45,178	$460/$520	$720	$920	$1,185	$1,450	$1,523
Tier 3: $45,179 & above	$460/$520	$820	$1,120	$1,535	$1,950	$2,048

- * Indexed to medical inflation (National Health Expenditures) after FY 2016

- TRICARE Standard and Extra for Working Age Retirees (under Age 65)
- The **TRICARE Standard and Extra** (fee-for-service type) benefit programs currently have no enrollment fees and modest annual deductibles of $150 per individual and $300 per family. For FY 2013, the Department proposal will seek to implement an annual enrollment fee and increase deductibles. These increases displayed in Table 2 will be phased-in over a 5 year period and will then be indexed to increases in NHE.

Table 2 – TRICARE Standard/Extra Fees/Deductibles

Annual Enrollment Fees	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017*
Individual	$0	$70	$85	$100	$115	$130
Family	$0	$140	$170	$200	$230	$250
Annual Deductibles						
Individual	$150	$160	$200	$230	$260	$290
Family	$300	$320	$400	$460	$520	$580

- * Indexed to medical inflation (National Health Expenditures) after FY 2017

- TRICARE-for-Life Benefit (TFL) Benefit Program for Retirees age 65 and Older
- Like almost all Americans, upon reaching age 65, TRICARE beneficiaries must enroll in Medicare and begin paying Medicare Part B (outpatient care coverage) premiums. With Part B coverage, Medicare typically covers only 80 percent of eligible health care services and some people choose to be covered by "Medigap" or other private insurance policies to lower cost-sharing and receive additional coverage. Enacted in 2001, the TFL program acts as a second payer plan for

TRICARE beneficiaries covering the costs not paid by Medicare. While the average "Medigap" plan with comparable coverage carried premiums $2,100 per individual in 2009, there are currently no annual fees for TFL coverage. As part of the FY 2013, President's Budget, the Department is proposing to implement modest annual fees for TFL coverage. These fees will be phased in over a 4-year period and use the same tiering based on the beneficiary's retired pay along with the same indexing and exemptions as the proposed TRICARE Prime fees. Table 3 displays the proposed TFL fees by fiscal year for the three tiers of retired pay.

Table 3 – TRICARE-for-Life Annual Enrollment Fees – Per Individual

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$0	$35	$75	$115	$150	$158
Tier 2: $22,590 – $45,178	$0	$75	$150	$225	$300	$317
Tier 3: $45,179 & above	$0	$115	$225	$335	$450	$475

- * Indexed to medical inflation (National Health Expenditures) after FY 2016

- **Pharmacy Co-Pays**
- This proposal will adjust pharmacy co-pay structure for retirees and active duty family members to incentivize the use of mail order and generic drugs. Prescriptions will continue to be filled at no cost to beneficiaries at Military Treatment Facilities (MTFs). No fees would continue to apply to prescriptions for active duty service members.

- Table 4 displays the proposed co-pays for prescriptions filled through the TRICARE retail and mail order pharmacy programs.

Table 4 – Pharmacy Co-Pays

Retail – 1 month fill	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Generic	$5	$5	$6	$7	$8	$9
Brand	$12	$26	$28	$30	$32	$34
Non-Formulary*	$25	N/A	N/A	N/A	N/A	N/A
Mail-Order – 3 month fill						
Generic	$0	$0	$0	$0	$0	$9
Brand	$9	$26	$28	$30	$32	$34
Non-Formulary*	$25	$51	$54	$58	$62	$66
Military Treatment Facilities	No Change – Still $0 Co-Pay					

- * Non-Formulary pharmaceuticals will have limited availability in retail pharmacies
- **Catastrophic Cap**
- In order to maintain the adjusted beneficiary cost share, the annual catastrophic cap $3,000 per family will also be indexed to NHE and exclude enrollment fees.

- Finally, to protect the most vulnerable, these proposals exempt survivors of members who die on active duty and medically retired and their family members from these increases. However, it should be noted that even once the proposal is fully implemented, the TRICARE Prime program remains a very generous benefit with the average beneficiary cost share well below the original 27 percent of health care costs when the program was fully implemented in 1996.

These proposed changes continue to be modest by historic standards of cost-sharing in the TRICARE program. In 1996, when TRICARE was implemented, a working age retiree's family of three contributed approximately 27% towards the total cost of their care; today that

percentage has dropped to just over 10 percent. Even with these proposed changes, the percentage would still remain below the percentage originally set by Congress, averaging approximately 14% of range of overall health care costs in 2017 – and stabilizing at that level for the out-years.

These adjustments are an important step to setting the TRICARE benefit on a more sustainable path that maintains the quality of the medical benefit for future generations. Moreover, the overwhelming majority of these adjustments will be phased in over a four to ten year period and will be appropriately indexed to ensure future sustainability and guarantee transparency. These proposals – one element of a four-pronged effort at cost control – will help shift us toward more effective and cost-efficient processes that will allow us to provide better care while meeting our obligations to help reduce our budgets.

We are cognizant of the strains placed on our economy and the government by federal budget deficits and long-term debt. We recognize that the Department of Defense must shoulder its share of responsibility and that we must tighten our belts just as so many Americans have been forced to do in recent years. We have not taken any proposed change lightly. The health benefit exemplifies the Department's gratitude to veterans for their service and acts as an integral part of recruiting, retaining, and maintaining a healthy force. We worked to ensure that cost changes would be minimized and that any reforms would not degrade the quality of the benefit. We are confident that this is the case.

I am honored to represent the men and women of the Military Health System before you today, and I look forward to answering any questions you may have.

Mr. YOUNG. Mr. Secretary, thank you very much. We appreciate your being here today.

General Horoho, we will be happy to hear from you at this point.

SUMMARY STATEMENT OF GENERAL HOROHO

General HOROHO. Thank you, sir. Chairman Young, Ranking Member Dicks and distinguished members of the committee, thank you for providing me this opportunity to share with you today my thoughts about the future of U.S. Army medicine and highlight some of the incredible work being done by dedicated men and women.

From July to October of 2011, I was privileged to serve as the International Security Assistance Force Joint Command Special Assistant for Health Affairs. My multidisciplinary team of 14 medical health professionals conducted an extensive evaluation of theater health service support to critically assess how well we are providing health care from the point of injury to evacuation from theater.

It cannot be overstated that the best trauma care in the world resides with the U.S. military in Afghanistan and Iraq. The AMED is focused on building upon these successes on the battlefield as we perform our mission at home and is further cementing our commitment to working as a combined team anywhere and any time.

MHS governance changes will change the way we currently operate for everyone. These recommended changes will strengthen our system in the delivery of military medicine. The military departments have more activities in common than not. Together, we will drive toward greater common approaches in all areas, except where legitimate uniquenesses require a service-specific approach. Our commitment is to achieve greater unity of effort, improve service to our members and beneficiaries and achieve greater efficiency through a more rapid implementation of common services and joint purchasing, as well as other opportunities for a more streamlined service delivery.

We are at our best when we operate as part of a joint team, and we need to proactively develop synergy with our partners as military medicine moves towards a joint operating environment. Continuity of care and continuity of information are key to the delivery of care as DOD and the VA team.

There are significant health-related consequences over 10 years of war, including behavioral health needs, post-traumatic stress, concussive care, burns or disfiguring injuries, chronic pain and loss of limb. A decade of war in Afghanistan and Iraq has led to tremendous advances in knowledge and care of combat-related physical and psychological problems. We have partnered with the Department of Veterans Affairs, the Defense and Veterans Brain Injury Center, and the Defense Center of Excellence for Traumatic Brain Injury and Psychological Health, and academia, as well as the National Football League to improve our ability to diagnose, treat and care for those affected by TBI.

Similar to our approach with concussive care injuries, Army medicine has harvested the lessons of almost a decade of war and has approached the strengthening of our soldiers' and families' behavior health and emotional resiliency through a campaign plan. We

will increase our efforts on decreasing variance and implementing standards across Army medicine in the areas of a behavioral health and integrated disability evaluation system. We are implementing recommendations from the Pain Management Task Force and incorporating this capability across all forms of health care.

I am incredibly honored and proud to serve as the 43rd Surgeon General in the Army and Commander of the U.S. Army Medical Command. There are miracles that are happening every day across our command outposts, forward operating bases, posts, camps and stations because of the dedicated soldiers and civilians that make up the Army Medical Department.

To the Ranking Member Dicks, it has been an honor to serve with you over the years. I appreciated your support when I served at the Western Region Medical Command at Joint Base Lewis-McChord. As you conclude your service to our Nation, on behalf of the Army Medical Department, I want to express our deepest gratitude and my personal thanks for your enduring support of Army medicine throughout these significant times in our history.

With the continued support of Congress, we will lead the Nation in health care and our men and women in uniform will be ready when the Nation calls, wherever they need to. I look forward to answering your questions and thank you for the opportunity to be here today.

[The statement of General Horoho follows:]

WRITTEN STATEMENT OF

LIEUTENANT GENERAL PATRICIA D HOROHO

THE SURGEON GENERAL OF THE UNITED STATES ARMY

AND COMMANDER, US ARMY MEDICAL COMMAND

TESTIMONY FOR

COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEFENSE

UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 112TH CONGRESS

FY 2013 DEFENSE HEALTH PROGRAM HEARING

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COMMITTEE ON APPROPRIATIONS

Chairman Young, Ranking Member Dicks and distinguished members of the committee. Thank you for providing me this opportunity to share with you today my thoughts on the future of the U.S. Army Medical Department (AMEDD) and highlight some of the incredible work being performed by the dedicated men and women with whom I am honored to serve alongside. We are America's most trusted premier medical team, and our successful mission accomplishment over these past ten years is testimony to the phenomenal resilience, dedication, and innovative spirit of Soldier Medics, Civilians, and Military Families throughout the world.

Since 1775, Army Medicine has been there. In every conflict the US Army has fought, Army Medicine stood shoulder to shoulder with our fighting forces in the deployed environment and received them here at home when they returned. The past ten years have presented the AMEDD with a myriad of challenges, encompassing support of a two-front war while simultaneously delivering healthcare to beneficiaries across the continuum. Our experiences in Iraq and Afghanistan have strengthened our capacity and our resolve as a healthcare organization. Army Medicine, both deployed and at home, civilian and military, has worked countless hours to ensure the wellness of our fighting force and its Families. Army Medicine continues to support in an era of persistent conflicts, and it is our top priority to provide comprehensive healthcare to support War-fighters and their Families. The Soldier is America's most sacred determinant of the Nation's force projection and the Army's most important resource; it is our duty to provide full spectrum healthcare for our Nation's best. Committed to the health, wellness, and resilience of our force and its Families, we will stand alongside and inspire confidence in our Warriors when our Nation calls. Through the development of adaptive, innovative, and decisive leaders, we stand poised to support the foundation of our Nation's strength.

Over the past decade, Army Medicine has led the joint healthcare effort in the most austere environments. As part of the most decisive and capable land force in the world, we stand ready to adapt to the Army's reframing effort. Ten years of contingency operations have provided numerous lessons learned. We will use these as the

foundations from which we deliver the Army's vision. The following focus areas are the pillars upon which we deliver on that effort.

Support the Force

I was privileged to serve as the International Security Assistance Force Joint Command (COMIJC) Special Assistant for Health Affairs (SA-HA) from July – October 2011. My multi-disciplinary team of 14 military health professionals conducted an extensive evaluation of Theater Health Services Support (HSS) to critically assess how well we were providing healthcare from point of injury to evacuation from theater. It cannot be overstated that the best trauma care in the world resides with the US military in Afghanistan and Iraq. From the most forward combat outposts to the modern Role 3 facilities on the mature forward operating bases, the performance and effectiveness of the US military health system is remarkable. The medical community holds the trust of the American Service Member sacred. The fact that Service Members are willing to go out day to day and place themselves in harm's way in support of our freedom is strongly dependent on the notion that, if they become injured, we will be there providing the best medical care in the world. This has been proven time and time again with MEDEVAC remaining an enduring marker of excellence in the CJOA-A. The average mission time of 44 minutes is substantially below the 60 minute mission standard established by the Secretary of Defense in 2009. The survival rate for the conflict in Afghanistan is 90.1 %. This ability to rapidly transport our wounded Service Members coupled with the world-class trauma care delivered on the battlefield has resulted in achievement of the highest survival rate of all previous conflicts. The survival rate in WWII was about 70%; in Korea and Vietnam it rose to slightly more than 75%. In WWII only 7 of 10 wounded troops survived, today more than 9 out of 10 do. Not only do 9 in 10 survive, but most are able to continue serving in the Army.

Enhanced combat medic training has without question contributed to the increased survival rates on the battlefield by putting the best possible care far forward. The need for aerial evacuation of critical, often post-surgical patients, presented itself in Afghanistan based on the terrain, wide area dispersement of groundbased forces, as

well as increased use of forward surgical teams. En route management of these patients required critical care experience not found organic to MEDEVAC. In response to these needs, our flight medic program (AD, NG, AR) is raising the standard to the EMT-Paramedic level to include Critical Care nursing once Paramedic certified for all Components. This will enhance our capabilities to match the civilian sector and make our flight medics even more combat ready for emergencies while on mission. We've just begun the first course that will pave the way with 28 flight medics coming from all components. By 2017, we will have all flight medics paramedic certified. In the area of standardization of enlisted medical competencies, we are ensuring that our medics are being utilized as force multipliers to ensure world-class health care in our facilities. We are working with our sister services to ensure that all medics, corpsmen, and medical technicians are working side-by-side in our joint facilities and training to the highest joint standard.

We have an enduring responsibility, alongside our Sister Services and the Department of Veterans Affairs (VA), to provide care and rehabilitation of wounded, ill and injured service members for many years to come. We will stand alongside the Soldier from point of injury through rehabilitation and recovery, fostering a spirit of resiliency. The Warrior Care and Transition Program is the Army's enduring commitment to providing all Wounded, Ill and Injured Soldiers and their Families a patient-centered approach to care. Its goal is to empower them with dignity, respect, and the self-determination to successfully reintegrate either back into the force or into the community. Since the inception of Warrior Transition Units in June 2007, more than 51,000 wounded, ill, or injured Soldiers and their Families have either progressed through or are being cared for by these dedicated caregivers and support personnel. Twenty-one thousand of these Soldiers, the equivalent of two Divisions, have been returned to the force, while another 20,000 have received the support, planning, and preparation necessary to successfully and confidently transition to civilian status. Today, we have 29 Warrior Transition Units (WTU) and 9 Community Based Warrior Transition Units (CBWTU). More than 9,600 Soldiers are currently recovering in Warrior Transition Units (WTUs) and Community-Based Warrior Transition Units with more than

4,300 professional Cadre supporting them. Standing behind these Soldiers each stage of their recovery and transition is the Triad of care (Primary care manager, Nurse Case Manager and Squad Leader) and the interdisciplinary team of medical and non-medical professionals who work with soldiers and their families to ensure that they receive the support they deserve.

The Army remains committed to supporting Wounded, Ill, or Injured Soldiers in their efforts to either return to the force or transition to Veteran status. To help Soldiers set their personal goals for the future, the Army created a systematic approach called the Comprehensive Transition Plan, a multidisciplinary and automated process which enables every Warrior in Transition to develop an individualized plan, which will enable them to reach their personal goals. These end goals shape the Warrior in Transition's day-to-day work plan while healing.

For those Soldiers who decide to transition to Veteran status the Warrior Transition Command's (WTC) mission is to assist them to successfully reintegrate back into the community with dignity, respect and self-determination. One example of how the WTC is working to better assist this group of Soldiers is the WTC sponsored, joint service Wounded Warrior Employment Conference (WWEC) held in February. This is the second year the WWEC has brought together key stakeholders in the federal government and private industry. The goal is improved alliance and collaboration between military, civilian, federal entities and employers to encourage them to cooperatively support employment related objectives and share best practices in hiring, retaining, and promoting Wounded Warriors, recently separated Disabled Veterans, their Spouses and Caregivers.

The Care Experience

The Warfighter does not stand alone. Army Medicine has a responsibility to all those who serve, to include Family members and our Retirees who have already answered the call to our Nation. We continue to fully engage our patients in all aspects of their

healthcare experience. At each touch point, starting with the initial contact, each team member plays an important role in enhancing patient care. We will make the right care available at the right time, while demonstrating compassion to those we serve and value to our stakeholders. Beneficiaries will choose hospitals who give them not only outstanding outcomes but the best possible experience. And we aim to elevate the patient care experience across the enterprise to make the direct care system the preferred location to receive care. I am proud to share today that our patient satisfaction rate is currently above 92% and we are in the top 10 percent of health plans in the United States according to Healthcare Effectiveness and Data Information Set (HEDIS®), a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care. This said, my challenge --and my personal belief is that we can get better--we must be better. I'd like to outline a few areas where we continue to better ourselves in order to better the care experience for our patients.

Army Medicine is committed to accountable care - where our clinical processes facilitate best practice patterns and support our health care team in delivering competent, compassionate care. In everything we do, there is a need for accountability — to our patients, our team members, and ourselves. Accountability is not just providing competent delivery of health care; our Warfighters deserve more than that. Accountability is about taking ownership of the product we create and how it is delivered, considering it a reflection of ourselves and the organization. At the end of the workday, accountability is not measured by Relative Value Units, but by impact on patients. It is not about the final outcome, but about the process and upholding our commitment to Soldiers and their Families. Soldier well-being and health are absolutely our top priorities. The Army Medicine Team will continue advocating for patients and their well-being. As an Army at war for over a decade, we stand shoulder-to-shoulder with the Warfighter, both on the battlefield and at home. This means never losing sight of the importance of caring for our Nation's heroes and their Families. Realizing that this Army Medicine team is working around the clock and around the world to ensure Soldiers and their Families are cared for with compassion and dignity, I have asked our leaders to focus on caring for those who are giving care. The Army Medicine Team is

not immune to the stress of deployments, workload demands, and challenging circumstances. We provide the best care for our patients when we take care of each other. By doing that, we give our best to all those entrusted to our care.

Army Medicine has consciously committed to building a "Culture of Trust." Trust in patient care, trust within Army Medicine and the Army Family. In healthcare, trust plays a critical and important role. This strategic initiative is focused on an organizational culture change within Army Medicine and creating a lifestyle of trust. A culture of trust in Army Medicine is a shared set of relationship skills, beliefs and behaviors that distinguish our commitment to our beneficiaries to provide the highest quality and access to health services. Every initiative aimed at reducing variance and standardizing and improving patients' healthcare experiences, outcomes and readiness will be founded on a Culture of Trust. Last fall the Culture of Trust task force began piloting the initial Culture of Trust training. This foundational training provides information on trust behaviors, tenets and fundamentals creating a baseline upon which we will grow and expand.

We constantly seek to establish stronger more positive relationships with all that we serve in Army Medicine, to produce the very best possible individual care experience. To that end, Army Medicine has implemented a training program titled, "Begin with the Basics." The central theme of this training is individual personalized engagement practiced by each and every member of Army Medicine. Through these relationships we increase understanding and in understanding our patients better, we are able to provide better solutions. The goal is full deployment of the basics of this model across Army Medicine in the next eighteen months. We are using this model for care and service training as we deploy our medical home care model across Army Medicine.

In February 2011, Army Nursing began implementing a patient-centered outcomes focused care delivery system encompassing all care delivery environments; inpatient, outpatient, and deployed. The Patient Caring Touch System (PCTS) was designed to reduce clinical quality variance by adopting a set of internally and externally validated best practices. PCTS swept across Army Medicine, and the last facility completed implementation in January 2012. PCTS is a key enabler of Army Medicine's

Culture of Trust and nests in all of Army Medicine's initiatives. PCTS is enhancing the quality of care delivery for America's Sons and Daughters. PCTS has improved communication and multi-disciplinary collaboration and has created an increased demand and expanded use of multi-disciplinary rounds. Several facilities have reported that bedside report, hourly rounding, and multi-disciplinary rounding are so much a part of the routine that they cannot recall a time when it was not part of their communication process.

The collective healthcare experience is driven by a team of professionals, partnering with the patient, focused on health promotion and disease prevention to enhance wellness. Essential to integrated health care delivery is a high-performing primary care provider/team that can effectively manage the delivery of seamless, well-coordinated care and serve as the patient's medical home. Much of the future of military medicine will be practiced at the Patient-Centered Medical Home (PCMH). We have made Patient Centered Medical Homes and Community Based Medical Homes a priority. The Army's 2011 investment in patient centered care is $50M. Patient Centered Medical Home (PCMH) is a primary care model that is being adopted throughout the Military Health System (MHS) and in many civilian practices throughout the nation. Army PCMH is the foundation for the Army's transition from a "health care system to a system for health" that improves Soldier Readiness, Family wellness and overall patient satisfaction through a collaborative team based system of comprehensive care that is ultimately more efficient and cost effective. The PCMH will strengthen the provider-patient relationship by replacing episodic care with readily available care with one's personal clinician and care team emphasizing the continuous relationship while providing proactive, fully integrated and coordinated care focusing on the patient, his or her Family, and their long term health needs. The Army is transforming all of its 157 primary care practices to PCMH practices. A key component of transformation to the Army Patient Centered Medical Home requires each practice to meet the rigorous standards established by the National Committee for Quality Assurance (NCQA). In December of 2011, 17 Army practices received NCQA recognition as PCMHs and I anticipate we will have 50 additional practices that will obtain NCQA recognition by the end of this calendar year. It is expected that all Army

primary care clinics will be transformed to Army Medical Homes by FY15. Transformation to the PCMH model should result in an increased capacity within Army military treatment facilities of over 200,000 beneficiaries by FY16. The Army has established Community Based Medical Homes to bring Army Medicine closer to our patients. These Army operated clinics in leased facilities are in off-post communities closer to our beneficiaries and aim to improve access to healthcare services, including behavioral health, for active duty family members by expanding capacity and extending the military treatment facility services off post. Currently we are approved to open 21 clinics and are actively enrolling beneficiaries at 13 facilities.

Unity of Effort

The ability to form mixed organizations at home and on the battlefield with all Service and coalition partners contributing to a single mission of preserving life is proof of the flexibility and adaptability of America's medical Warfighters. It is our collective effort – Army, Air Force and Navy - that saves lives on the battlefield. It is an Army MEDEVAC crew who moves a wounded service member from the point of injury to a jointly staffed Role III field hospital. It's the Air Force provided aeromedical evacuation to Landstuhl Regional Medical Center where a triservice medical care team provides further definitive care. And then finally it's a joint team's capabilities at locations such as Walter Reed National Military Medical Center and the San Antonio Military Medical Center that provide the critical care and rehabilitative medicine for this Service member, regardless if they are a Soldier, Sailor, Airman, or Marine. The AMEDD is focused on building upon these successes on the battlefield as we perform our mission at home and is further cementing our commitment to working as a combined team, anywhere, anytime.

We are at our best when we operate as part of a Joint Team, and we need to proactively develop synergy with our partners as military medicine moves toward a joint operating environment. The wars in Afghanistan and Iraq have led to increased collaboration and interoperability with allied medical services, and have highlighted differences and gaps in our respective combat health service support systems. While the Combatant Commands have a responsibility to harvest and publicize lessons

learned and implement new best practices operationally, the MHS has the opportunity to address and apply, at the strategic, operational and tactical levels, the lessons learned regarding combat casualty care and medical coalition operations.

MHS governance changes will change the way we currently operate for everyone. These recommended changes will strengthen our system. In the delivery of military medicine, the Military Departments have more activities in common than not – together we will drive toward greater common approaches in all areas, except where legitimate uniqueness requires a service-specific approach. Our commitment is to achieve greater unity of effort, improve service to our members and beneficiaries, and achieve greater efficiency through a more rapid implementation of common services and joint purchasing, as well as other opportunities for more streamlined service delivery.

Our MHS is not simply a health plan for the military it is a military health system. A system that has proven itself in war and peace time. Our focus continues to be on supporting Soldiers, other Warriors and their Families--past, present and future--and on the most effective and efficient health improvement and healthcare organization to add value in the defense of the Nation. The best way to do that is through a unified and collaborative approach to care, both on the battlefield and in garrison. We must have outcome and economic metrics to measure and accountability assigned. And we must develop standard and unified performance measures across a wide range of health and care indicators e.g., population health, clinical outcomes, access, continuity, administrative efficiency, agile operational support, Warrior care and transition programs, patient satisfaction, cost, and others, to ensure we are effective, efficient and timely.

Innovate Army Medicine and Health Service Support

Many innovations in healthcare have their origins on the battlefield. Army Medicine's medical innovations borne from lessons learned in combat have become the worldclass standard of care for Soldiers on the battlefield and civilians around the world. As our presence in the current war begins to change, we must remain vigilant in developing and assessing strategies to protect, enhance, and optimize Soldier wellness,

prevention and collective health. Through leverage of information technology and militarily relevant research strategies, we will continue to develop new doctrine and education programs to reflect best practice healthcare on and off the battlefield, while ensuring that Army Medicine remains responsive and ready. Our speed of execution, combined with the ability to leverage knowledge and actionable ideas quickly, is paramount to optimize the constancy of improvement. Our biggest competitive edge is our knowledge and our people.

In 2004 the Assistant Secretary of Defense for Health Affairs directed to the formation of the the Joint Theater Trauma System (JTTS) and the Joint Theater Trauma Registry (JTTR). The Joint Theater Trauma System coordinates trauma care for our wounded warriors. Since that time the Services, working together, have created a systematic and integrated approach to battlefield care which has minimized morbidity and mortality and optimized the ability to provide essential care required for the battle injuries our Soldiers are facing. The vision of the JTTS is for every Soldier, Marine, Sailor or Airman wounded or injured in the theater of operations to have the optimal chance for survival and maximal potential for functional recovery and they are. Our 8,000 mile operating room stretches from Kandahar to Landstuhl to Walter Reed National Military Medical Center at Bethesda, to San Antonio Military Medical Center to the Veteran's Administration and other facilities throughout the United States. It's collaborative, it's integrated, and it knows no boundaries. JTTS changed how the world infuses blood products for trauma patients. In fact we just had a patient receive 400 units of blood. He coded three times on the battle field. And today he is recovering in Walter Reed National Medical Center at Bethesda. The JTTS also led to materiel changes in helmets, body armor and vehicle design. This is not a success of technology or policy. This is a success of a trauma community that expects and values active collaboration across its 8,000 mile operating room.

The JTTR, is the largest combat injury data repository and is an integral and integrated part of the JTTS. It provides the information necessary to advance the improvement of battlefield and military trauma care and drive joint doctrine and policy, while enabling process improvement and quality assurance. Additionally it enables more efficient and effective medical research in a resource-constrained environment.

The improvements in trauma care driven by both the JTTS and JTTR are increasing the survival rate on today's battlefield and saving lives in our Nations civilian trauma centers through shared lessons learned. We must maintain this critical capability to ensure that we continue to drive innovation and are able to respond to our next threat.

An area in which the Army and our Sister Services have innovated to address a growing problem is in concussion care. The establishment of a mild Traumatic Brain Injury (TBI)/concussive system of care and implementation of treatment protocols has transformed our management of all battlefield head trauma. Traumatic Brain Injury (TBI) is one of the invisible injuries resulting from not only the signature weapons of this war, improvised explosive devices and rocket propelled grenades, but also from blows to the head during training activities or contact sports. Since 2000, 220,430 Service Members have been diagnosed with TBI worldwide (Armed Forces Health Surveillance Center, 2011). In 2010, Military Medicine implemented a new mild traumatic brain injury management strategy to disseminate information that our healthcare workers needed and outlined the unit's responsibilities, creating a partnership between the medical community and the line units. This policy directed that any Soldier who sustained a mandatory reportable event must undergo a medical evaluation including a mandatory 24 hour down time followed by medical clearance before returning to duty. The mandatory events are a command-directed evaluation for any Soldier who sustains a direct blow to the head or is in a vehicle or building associated with a blast event, collision or rollover, or is within 50 meters of a blast. Since the DoD implemented Policy Guidance for Management of Concussion/mTBI in the Deployed Setting in June 2010, deployed Commanders screened over 10,000 Service Members for concussion/mild TBI, temporarily removed them from the battlefield to facilitate recovery, and ensured that each of them received a mandatory medical evaluation. Codification of this concussive care system into AMEDD doctrine is ongoing. To further support the TBI care strategy over the past 21 months the Services have stood up 11 facilities devoted to concussive care far forward on the battlefield, staffed with concussion care physicians and other medical providers, in order to care for those with TBI at the point of

injury. The Army has medical staff at 9 of these facilities. These centers provide around-the-clock medical oversight, foster concussion recovery, and administer appropriate testing to ensure a safe return to duty. The current return to duty rate for Soldiers who have received care at Theater concussion centers is over 90%.

To further the science of brain injury recovery, the Army relies on the US Army Medical Research and Materiel Command's TBI Research Program. The overwhelming generosity of Congress and the DoD's commitment to brain injury research has significantly improved our knowledge of TBI in a rigorous scientific fashion. Currently, there are almost 350 studies funded by DoD to look at all aspects of TBI. The purpose of this program is to coordinate and manage relevant DoD research efforts and programs for the prevention, detection, mitigation and treatment of TBI. In the absence of objective diagnostic tools, MRMC is expediting research on diagnostic biomarkers and other definitive assessment tools that will advance both military and civilian TBI care. By identifying and managing these injuries on the battlefield, we have eliminated many unnecessary medical evacuation flights and facilitated unprecedented return to duty rates. The Army realizes that there is much to gain from collaboration with external partners and key organizations. We have partnered with the Department of Veterans Affairs, the Defense and Veterans Brain Injury Center, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, academia, civilian hospitals and the National Football League, to improve our ability to diagnose, treat, and care for those affected by TBI.

There are significant health related consequences of over ten years of war, including behavioral health needs, post-traumatic stress, burn or disfiguring injuries, chronic pain or loss of limb. Our Soldiers and their Families need to trust we will be there to partner with them in their healing journey, a journey focused on ability vice disability.

A decade of war in Afghanistan and Iraq has led to tremendous advances in the knowledge and care of combat-related physical and psychological problems. Ongoing research has guided health policy, and multiple programs have been implemented in theater and post-deployment to enhance resiliency, address combat operational stress

reactions and behavioral health concerns. Similar to our approach to concussive injuries, Army Medicine harvested the lessons of almost a decade of war and has approached the strengthening of our Soldiers and Families' behavioral health and emotional resiliency through a campaign plan to align the various Behavioral Health programs with the human dimension of the ARFORGEN cycle, a process we call the Comprehensive Behavioral Health System of Care (CBHSOC). This program is based on outcome studies that demonstrate the profound value of using the system of multiple touch points in assessing and coordinating health and behavioral health for a Soldier and Family. The CBHSOC creates an integrated, coordinated, and synchronized behavioral health service delivery system that will support the total force through all ARFORGEN phases by providing full spectrum behavioral health care. We leveraged experiences and outcome studies on deploying, caring for Soldiers in combat, and redeploying these Soldiers in large unit movements to build the CBHSOC. The CBHSOC is a system of systems built around the need to support an Army engaged in repeated deployments - often into intense combat – which then returns to home station to restore, reset the formation, and re-establish family and community bonds. The intent is to optimize care and maximize limited behavioral health resources to ensure the highest quality of care to Soldiers and Families, through a multi-year campaign plan.

The CBHSOC campaign plan has five lines of effort: Standardize Behavioral Health Support Requirements; Synchronize Behavioral Health Programs; Standardize & Resource AMEDD Behavioral Health Support; Access the Effectiveness of the CBHSOC; and Strategic Communications. The CBHSOC campaign plan was published in September 2010, marking the official beginning of incremental expansion across Army installations and the Medical Command. Expansion will be phased, based on the redeployment of Army units, evaluation of programs, and determining the most appropriate programs for our Soldiers and their Families.

Near-term goals of the CBHSOC are implementation of routine behavioral health screening points across ARFORGEN and standardization of screening instruments. Goals also include increased coordination with both internal Army programs like Comprehensive Soldier Fitness, Army Substance Abuse Program, and Military Family

Life Consultants. External resources include VA, local and state agencies, and the Defense Centers of Excellence for Psychological Health.

Long-term goals of the CBHSOC are the protection and restoration of the psychological health of our Soldiers and Families and the prevention of adverse psychological and social outcomes like Family violence, driving under intoxication violations, drug and alcohol addiction, and suicide. This is through the development of a common behavioral health data system; development and implementation of surveillance and data tracking capabilities to coordinate behavioral health clinical efforts; full synchronization of Tele-behavioral health activities; complete integration of the Reserve Components; and the inclusion of other Army Medicine efforts including TBI, patient centered medical home, and pain management. We are leveraging predictive modeling tools to improve our insight into data, research advances, and electronic medical record systems in order to provide "genius case management" for our patients with BH disease, that is, care that is tailored for each patient, and a care plan aimed at better understanding the patient, and not just their disease. Integral to the success of the CBHSOC is the continuous evaluation of programs, to be conducted by the Public Health Command.

For those who do suffer from PTSD, Army Medicine has made significant gains in the treatment and management of PTSD as well. The DoD and VA jointly developed the three evidenced based Clinical Practice Guidelines for the treatment of PTSD, on which nearly 2,000 behavioral health providers have received training. This training is synchronized with the re-deployment cycles of US Army Brigade Combat Teams, ensuring that providers operating from MTFs that support the Brigade Combat Teams are trained and certified to deliver quality behavioral healthcare to Soldiers exposed to the most intense combat levels. In addition, the US Army Medical Department Center & School collaborates closely with civilian experts in PTSD treatment to validate the content of these training products to ensure the information incorporates emerging scientific discoveries about PTSD and the most effective treatments.

Work by the Army Medical Department and the Military Health System over the past 8 years has taught us to link information gathering and care coordination for any

one Soldier or Family across the continuum of this cycle. Our Behavioral Health specialists tell us that the best predictor of future behavior is past behavior, and through the CBHSOC we strive to link the management of issues which Soldiers carry into their deployment with care providers and a plan down-range and the same in reverse. We have embedded behavioral health personnel within operational units circulate across the battlefield to facilitate this ongoing assessment.

The management of combat trauma pain with medications and the introduction of battlefield anesthesia was a tremendous medical breakthrough for military medicine. The first American use of battlefield anesthesia is thought to have been in 1847 during the Mexican-American War, and the use of opioid medication during the Civil War was not uncommon. Military Medicine has worked very hard to manage our Service Members' pain from the point of injury through the evacuation process and continuum of care. The management of pain- both acute and chronic or long-standing pain – remains a major challenge for military health care providers and for the Nation at large. We have launched a major initiative through a multi-disciplinary, multi-service and DOD-VA Pain Management Task Force to improve our care of pain. The use of medications is appropriate, if required, and often an effective way to treat pain. However, the possible overreliance on medication-only pain treatment has other unintended consequences, such as prescription medication use. The goal is to achieve a comprehensive pain management strategy that is holistic, multi-disciplinary and multi-modal in its approach, uses state of the art modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain. The military is developing regional pain consortiums that combine the pain expertise from DoD with local Veterans Health Administration and civilian academic medical centers. The first of many of these relationships has been established in Washington State between Madigan Army Medical Center, VA Puget Sound Health Care System, and University of Washington Center for Pain Relief. Some of the largest research projects dealing with wounded-warrior pain have been facilitated through partnerships with VHA research leaders. Collaborations of this type will ensure the latest, evidence-based pain-care techniques and protocols are available to patients. Pain research in direct support of military requirements will also be facilitated by these federal and civilian partnerships. Other

partnerships include working with organizations such as the Bravewell Collaborative and the Samuelli Institute, both of whom provide DoD with expertise in building mature integrative medicine capabilities to compliment and improve our existing pain medicine resources.

Another concerning area of emphasis for military medicine that has emerged from the current wars is "Dismounted Complex Blast Injury" (DCBI), an explosion-induced battle injury (BI) sustained by a warfighter on foot patrol that produces a specific pattern of wounds. In particular, it involves traumatic amputation of at least one leg, a minimum of severe injury to another extremity, and pelvic, abdominal, or urogenital wounding. The incidence of dismounted complex blast injuries has increased during the last 15 months of combat in the Afghanistan Theater of Operations (ATO). The number of Service Members with triple limb amputation has nearly doubled this past year from the sum of all those seen over the last eight years of combat. The number of genital injuries increased significantly from previous OIF rates. The severity of these injuries presents new challenges to the medical and military communities to prevent, protect, mitigate and treat. Army Medicine has spearheaded a Task Force comprised of clinical and operational medical experts from the Departments of Defense (DoD) and Veterans Affairs (VA) and solicited input from subject matter experts in both Federal and civilian sectors to determine the way forward for healing these complex injuries.

Evidence-based science makes strong Soldiers and for this we rely heavily on the US Army Medical Research and Material Command (MRMC). MRMC manages and executes a robust, ongoing medical research program for the MEDCOM to support the development of new health care strategies. I would like to highlight a few research programs that are impacting health and care of our Soldiers today.

The Combat Casualty Care Research Program (CCCRP) reduces the mortality and morbidity resulting from injuries on the battlefield through the development of new life-saving strategies, new surgical techniques, biological and mechanical products, and the timely use of remote physiological monitoring. The CCCRP focuses on leveraging cutting-edge research and knowledge from government and civilian research programs to fill existing and emerging gaps in combat casualty care. This focus provides

requirements-driven combat casualty care medical solutions and products for injured Soldiers from self-aid through definitive care, across the full spectrum of military operations.

The mission of the Military Operational Medicine Research Program (MOMRP) is to develop effective countermeasures against stressors and to maximize health, performance, and fitness, protecting the Soldier at home and on the battlefield. MOMRP research helps prevent physical injuries through development of injury prediction models, equipment design specifications and guidelines, health hazard assessment criteria, and strategies to reduce musculoskeletal injuries.

MOMRP researchers develop strategies and advise policy makers to enhance and sustain mental fitness throughout a service member's career. Psychological health problems are the second leading cause of evacuation during prolonged or repeated deployments. MOMRP psychological health and resilience research focuses on prevention, treatment, and recovery of Soldiers and Families behavioral health problems, which are critical to force health and readiness. Current psychological health research topic areas include behavioral health, resiliency building, substance use and related problems, and risk-taking behaviors.

The Clinical and Rehabilitative Medicine Research Program (CRMRP) focuses on definitive and rehabilitative care innovations required to reset our wounded warriors, both in terms of duty performance and quality of life. The Armed Forces Institute of Regenerative Medicine (AFIRM) is an integral part of this program. The AFIRM was designed to speed the delivery of regenerative medicine therapies to treat the most severely injured US service members from around the world but in particular those coming from the theaters of operation in Iraq and Afghanistan. The AFIRM is expected to make major advances in the ability to understand and control cellular responses in wound repair and organ/tissue regeneration and has major research programs in Limb Repair and Salvage, Craniofacial Reconstruction, Burn Repair, Scarless Wound Healing, and Compartment Syndrome.

The AFIRM's success to date is at least in part the result of the program's emphasis on establishing partnerships and collaborations. The AFIRM is a partnership

among the US Army, Navy, and Air Force, the Department of Defense, the VA, and the National Institutes of Health. The AFIRM is composed of two independent research consortia working with the US Army Institute of Surgical Research. One consortium is led by the Wake Forest Institute for Regenerative Medicine and the McGowan Institute for Regenerative Medicine in Pittsburgh while the other is led by Rutgers – the State University of New Jersey and the Cleveland Clinic. Each consortium contains approximately 15 member organizations, which are mostly academic institutions.

The health of the total Army is essential for readiness, and prevention is the best way to health. Protecting Soldiers, retirees, Family members and Department of Army civilians from conditions that threaten their health is operationally sound, cost effective and better for individual well-being. Though primary care of our sick and injured will always be necessary, the demands will be reduced. Prevention—the early identification and mitigation of health risks through surveillance, education, training, and standardization of best public health practices—is crucial to military success. Army Medicine is on the pathway to realizing this proactive, preventive vision.

The newest addition to the Army Medicine team is the Public Health Command,. having reached initial operational capability in October 2010 with full operational capability is targeted for October 2011. As part of the overall US Army Medical Command reorganization initiative, all major public health functions within the Army, especially those of the former Veterinary Command and the Center for Health Promotion and Preventive Medicine have been combined into a new PHC, located at Aberdeen Proving Ground in Maryland. The consolidation has already resulted in an increased focus on health promotion and has created a single accountable agent for public health and veterinary issues that is proactive and focused on prevention, health promotion and wellness. Army public health protects and improves the health of Army communities through education, promotion of healthy lifestyles, and disease and injury prevention. Public health efforts include controlling infectious diseases, reducing injury rates, identifying risk factors and interventions for behavioral health issues, and ensuring safe food and drinking water on Army installations and in deployed environments. The long-term value of public health efforts cannot be overstated: public health advances in the past century have been largely responsible for increasing human

life spans by 25 years, and the PHC will play a central role in the health of our Soldiers, deployed or at home. A significant initiative driven by the Public Health Command which will be instrumental to achieving public health is our partnering with Army installations to standardize existing Army Wellness Centers to preserve or improve health in our beneficiary population. The centers focus on health assessment, physical fitness, healthy nutrition, stress management, general wellness education and tobacco education. They partner with providers in our Military Treatment Facilities (MTFs) through a referral system. I hold each MTF Commander responsible for the health of the extended military community as the installation Director of Health Services (DHS).

Army Medicine has put a closer lens on women's health through a recently established Women's Health Task Force to evaluate issues faced by female Soldiers both, in Theater and CONUS. Women make up approximately 14 percent of the Army Active Duty fighting force. As of August 2011, almost 275,000 women have deployed in support of OIF/OND/OEF. The health of female Soldiers plays a vital role in overall Army readiness. Army medicine recognizes the magnitude and impact of women's health and appreciates the unique challenges of being a woman in the Army. In order for women to be fully integrated and effective members of the team, we must ensure their unique health needs are being considered and met. The Task Force combines talent from different disciplines: civilian and military, officer and enlisted, as well as collaborates with our private industry partners. We will assess the unique health needs and concerns of female Soldiers, conducting a thorough review of the care currently provided, identifies best practices and gaps, and revises, adapts and initiates practices so that we may continue to provide first class care to our female Warriors. The Women's Health Campaign Plan will focus on standardized education and training on women's health, logistical support for women's health items, emphasis on the fit and functionality of the Army uniform and protective gear for females; and research and development into the psychosocial effects of combat on women. While Sexual Assault is not a gender specific issue, the Women's Health Task Force is working with HQDA G1 to evaluate Theater policy with regards to distribution of Sexual Assault Forensic Examiners and professionalizing the role of the Victim Advocate. The Task Force is

collaborating with Tri-Service experts to investigate the integration of Service policies and make recommendations.

While proudly acknowledging our many healthcare accomplishments at home and in theater, I want to turn to the future. It is time we further posture Army Medicine in the best possible manner that aligns with the MHS strategic vision that moves us from healthcare to health. We must ask, where does "health" happen, and I have charged Army Medicine leadership to spearhead the conversion to health and to fully integrate the concept into readiness and the overall strategy of health in the Force. Improved readiness, better health, better care, and responsibly managed costs are the pillars on which the MHS Quadruple Aim stands, but between those pillars, or in that "White Space", is where we can create our successful outcomes. Sir William Osler, considered to be the Father of Modern Medicine, said "One of the first duties of the physician is to educate the masses not to take medicine". A snapshot of the average year with the average patient shows that healthcare provider spend approximately 100 minutes with their patient during that year. How much health happens in those 100 minutes? There are approximately 525,600 minutes in that year, yet we focus so much of our time, effort, and spending on those 100 minutes; the small fraction of a spot on the page. But what happens in the remaining 525,600 minutes of that year? What happens in the "White Space?" I will tell you what I think happens – that is where health is built, that is where people live. The "White Space" is when our Soldiers are doing physical fitness training, choosing whether to take a cigarette break, or deciding whether they will have the cheeseburger or the salad for lunch. It's when Family Members are grocery shopping or cooking a meal. The "White Space" is when Soldiers spend time with their family, or get a restful night of sleep, or search the internet to self-diagnose their symptoms to avoid adding to those 100 minutes in the clinician's office. We want to lead the conversation with Army leadership to influence the other 525,600 minutes of the year with our Soldiers…the "White Space". In order for us to get to health, we must empower patients, move beyond the 100 minutes, and influence behaviors in the white space. The way ahead is connected, collaborative, and patient centered.

I have discussed but a few of the important medical issues and programs that are relevant to the current wars and vital to the future of Military Medicine require solutions

and funding that will go years beyond the end of the current wars. Our Nation, our Army and Army Medicine have a duty and responsibility to our Soldiers, Families, and retirees. There will be considerable ongoing health care costs for many years to support for our wounded, ill, or injured Soldiers. The programs we have established to care for our Soldiers and Families cannot falter as our deployed footprint diminishes. The level of care required does not end when the deployed Soldier returns home.

Optimize Resources

One of Army Medicine's greatest challenges over the next 3-5 years is managing the escalating cost of providing world-class healthcare in a fiscally constrained environment. People are our most valuable resource. We will employ everyone to their greatest capacity and ensure we are good stewards of our Nation's resources. To capitalize on the overall cost savings of procurement and training, we will standardize equipment, supplies, and procedures. And we will leverage our information technology solutions to optimize efficiencies.

Despite the cost containment challenges we face, we must accomplish our mission with an eye on reducing variance, focusing on quality, and expecting and adapting to change. These are our imperatives. Army Medicine will focus on collaborative international, interagency, and joint partnerships and collective health, including prevention and wellness, to ensure the enduring capabilities required to support the current contemporary operating environment and those of the future are retained.

We will be methodical and thoughtful in our preparation for budget restraints to ensure that the high quality care our Warriors and Military Family demand is sustained. With the anticipated downsizing of forces, there will be a need to critically look at where medical services could be consolidated. However, we will use this as an opportunity to evaluate workloads to maximize efficiencies while maintaining effectiveness and focus on what services are best for our beneficiary population and dedicate resources to those.

The rising cost of healthcare combined with the increasingly constrained defense budget poses a challenge to all within the MHS. The Department of Defense offers the

most comprehensive health benefit, at lower cost, to those it serves than the vast majority of other health plans in the nation - and deservedly so. The proposed changes in TRICARE fees do not change this fact - the TRICARE benefit remains one of the best values for medical benefits in the United States with lower out-of-pocket costs compared to other health care plans. Adjustment to existing fees, and introduction of new fees are proposed. Importantly, these benefit changes exempt Soldiers, and their Families, who are medically retired from active service, and Families of Soldiers who died on active duty from any changes in cost-sharing. I support these modest fee changes when coupled by the MHS's shift in focus from healthcare to health, maintaining health and wellness, identifying internal efficiencies to capitalize on, and instituting provider payment reform.

A major initiative within Army Medicine to optimize talent management and move towards a Culture of Trust, discussed earlier in this testimony, is the Human Systems Transformation, led by a newly established Human Systems Transformation Directorate. Army Medicine's ability to efficiently transform our culture requires a roadmap for achieving planned systemic change. The plan focuses on enhanced investment in four human system tiers (lines of effort) to: Improve senior leader development (new command teams/designated key staff positions), increase investment in the development of Army Medicine workforce members, establish a cadre of internal Organizational Development professionals, leverage partnering and collaboration opportunities with internal and external stakeholders. In order to change the culture of our organization, we must invest in our people.

Develop Leaders

At the core of our medical readiness posture is our people. The Army calls each of us to be a leader, and Army Medicine requires no less. We will capitalize on our leadership experiences in full spectrum operations while continuing to invest in relevant training and education to build confident and competent leaders. Within this focus area, we will examine our leader development strategy to ensure that we have clearly identified the knowledge, skills, and talent required for leaders of Army Medicine. We

will continue to develop adaptive, innovative, and decisive leaders who ensure delivery of highly-reliable, quality care that is both patient-centered and inherently trustworthy. Being good stewards of our Nation's most treasured resources, through agile, decisive, and accountable leadership, we will continue to build on the successes of those who have gone before us. Our recruitment, development and retention of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remains high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses.

Support the Army Profession

Army Medicine has a rich history of sustaining the fighting force, and we need to tell our story of unprecedented successes across the continuum of care – from the heroic efforts of our medics at the point of injury to the comprehensive rehabilitation of our Wounded Warriors in overcoming exceptional challenges. After more than ten years of persistent conflict, it is time to renew our collective commitment to the Army, its ideals, traditions, and ethos. As we have stood alongside our warfighters on the battlefield we have earned the trust of our combat tested Warfighters, and it is critical that we continue to demonstrate integrity and excellence in all that we do.

Worldwide Influence

Army Medicine reaches around the world; from those supporting two theaters of war and humanitarian relief efforts to those conducting militarily relevant research and providing care to our military Families overseas, Army Medical Department Soldiers and civilians answer our Nation's call. The time that two oceans protected our freedom-loving nation is long gone, and replaced with ever-present risks to our way of life. The Nation relies on its Army to prepare for and conduct full spectrum operations from humanitarian and civil support to counterinsurgency and general war throughout the world. Army Medicine stands committed to sustain the Warfighter and accomplish the mission, supporting the world's most decisive land force and the strength of the Nation.

In the MHS, one of our biggest challenges lies in integrating the shared electronic health record information available in our systems with the information that is provided through our civilian network providers and VA partners. Without that seamless integration of data, health care cannot be coordinated properly for the patient's across all providers and settings. To support DoD and VA collaboration on treating PTSD, pain, and other health care issues, the Electronic Health Record (EHR) should seamlessly transfer patient data between and among partners to improve efficiencies and continuity of care. The DoD and the VA share a significant amount of health information today and no two health organizations in the nation share more non-billable health information than the DoD and VA. The Departments continue to standardize sharing activities and are delivering information technology solutions that significantly improve the secure sharing of appropriate electronic health information. We need to include electronic health information exchange with our civilian partners as well – a health information systems which brings together three intersecting domains – DoD, VA, civilian – for optimal sharing of beneficiary health information and to provide a common operating picture of health care delivery. These initiatives enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country. Previously, the burden was on service members to facilitate information sharing; today, we are making the transition between DOD and VA easier for our service members. The AMEDD is committed to working collaboratively with our partners across the MHS to seek solutions that will deliverable a fully integrated electronic health record that will enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country.

At the core of our Army is the Warfighter. A focus on wellness and prevention will ensure that our Warriors are ready to heed the Nation's call. Yet in the Army today we have more than a Division of Army soldiers who are medically not ready. This represents a readiness problem. We created a Soldier Medical Readiness Campaign to ensure we maintain a health and resilient force. The deployment of healthy, resilient and fit Soldiers and increasing the medical readiness of the Army is the desire end state of this campaign. The campaign's key tasks are to provide Commanders the tools to manage their Soldiers' medical requirements; coordinate, synchronize and integrate

wellness, injury prevention and human performance optimization programs across the Army; identify the medically not ready population; implement medical management programs to reduce the MNR population; assess the performance of the campaign; and educate the force.

Those Soldiers who no longer meet retention standards must navigate the Physical Disability Evaluation System (PDES). The present disability system dates back to the Career Compensation Act of 1949. Since its creation problems have been identified include long delays, duplication in DOD and VA processes, confusion among Service members, and distrust of systems regarded as overly complex and adversarial. In response to these concerns, DOD and VA jointly designed a new disability evaluation system to streamline DOD processes, with the goal of also expediting the delivery of VA benefits to service members following discharge from service. The Army began pilot testing the Disability Evaluation System (DES) in November 2007 at Walter Reed Army Medical Center and has since expanded the program, now known as the Integrated Disability Evaluation System (IDES), to 16 military treatment facilities. DOD has replaced the military's legacy disability evaluation system with the IDES.

The key features of the of the IDES are a single physical disability examination conducted according to VA examination protocols, a single disability rating evaluation prepared by the VA for use by both Departments for their respective decisions, and delivery of compensation and benefits upon transition to veteran status for members of the Armed Forces being separated for medical reasons. The DoD and VA continue to move towards reform of this process by identifying steps that can be reduced or eliminated, ensuring the service members receive all benefits and entitlements throughout the process. Within the Army, I recently appointed a task force focused on examining the Integrated Disability Evaluation Process in parallel with ongoing MHS efforts. The AMEDD is committed to working collaboratively with our partners across the MHS to seek solutions that will best serve those who have selflessly served our country.

I would like to close today by discussing the Army Medicine Promise. The Promise, a written covenant that will be in the hands of everyone entrusted to our care over the next year, tells those we care for what we, the Army Medicine Team, believe

they deserve from us. It articulates what we believe about the respect and dignity surrounding the patient care experience. The Promise speaks to what we believe about the value of the care we deliver, about the compassion contained in the care we deliver and how we want to morally and ethically provide care for those we serve. I'll share two items from the Promise with you---

"We believe our patients deserve a voice in how army medicine cares for them and all those entrusted to our care." Our patients want to harness innovation to improve or change their health and we are empowering their efforts via our wellness centers. At our premier wellness clinics, we collaborate with patients to not only give them the tools they need to change their health, but also a lifespace partner to help them change their life. Our wellness clinics are new and still evolving but I am committed to increasing their numbers and expanding their capabilities in order to dramatically impact those over 500,000 minutes out of the year when our patients are living life outside the walls of our hospitals. The wellness clinics allow us to reach out to those we care for rather than them having to reach in.

"We believe our patients deserve an enhanced care experience that includes our belief in their desire to heal, be well, and have an optimal life." The warrior transition care comprehensive transition plan supports this promise by providing countless wounded warriors with a dynamic plan for living that focuses on the soldier's future across six domains of strength---career, physical, emotional, social, family and spiritual strength. The plan empowers soldiers to take control of their lives."

In conclusion, the AMEDD has served side-by-side with our sister services in Iraq and Afghanistan, and at home we will continue to strengthen those collaborative partnerships to provide responsive, reliable, and relevant healthcare that ensures a healthy fighting force and healthy Families. To succeed, we must remain ready and relevant in both our medical proficiencies as well as our Soldier skills. We will continue to serve as a collaborative partner with community resources, seek innovative treatments, and conduct militarily relevant research to protect, enhance, and optimize Soldier and military Family well-being. Soldiers, Airmen, Sailors, Marines, their Families and our Retirees will know they are receiving care from highly competent and compassionate professionals.

I am incredibly honored and proud to serve as the 43rd Surgeon General of the Army and Commander, US Army Medical Command. There are miracles happening at our command outposts, forward operating bases, posts, camps and stations every day because of the dedicated Soldiers and civilians that made up the Army Medical Department. With continued support of Congress we will lead the Nation in healthcare, and our men and women in uniform will be ready when the Nation calls them to action. Army Medicine stands ready to accomplish any task in support of our Warfighters and Military Family.

SUMMARY STATEMENT OF VADM NATHAN

Mr. YOUNG. General, thank you very much. And I want to comment when it is my turn about your comment about miracles, because I have something to say about that.

Admiral Nathan. The Admiral and I have had a chance to spend a lot of time together because as we visit wounded soldiers and marines at our hospitals at Walter Reed, Bethesda, he is on the spot. Problems that are brought to his attention are fixed. I just really appreciate Admiral Nathan. Thank you very much. We are glad to hear your statement now, sir.

Admiral NATHAN. Thank you, sir. Good morning. Chairman Young, Ranking Member Dicks, distinguished members of the subcommittee, I am pleased to be with you today to provide an update on Navy Medicine, including some of our collective strategic priorities, our accomplishments and our opportunities.

I want to thank the committee members for the tremendous confidence, support and resourcing you have shown us in Navy Medicine. I will abbreviate my opening comments in the interest of time, but may I also add my thanks to Ranking Member Dicks for your service, sir, on behalf of the men and women who serve in the Pacific Northwest, specifically at Naval Hospital Bremerton and at the submarine clinic at Bangor. Your advocacy and your support of them is not forgotten.

I will report to you that Navy Medicine remains strong, capable and mission ready to deliver world class care any time, anywhere. We are operating forward and we are globally engaged, no matter what the environment and regardless of the challenge. The men and women of Navy Medicine are flexible, they are agile and they are resilient. They are meeting their operational and wartime commitments, including humanitarian assistance and disaster response, and concurrently delivering outstanding patient and family centered care to our beneficiaries. Force Health Protection is what we do and it is the very foundation of our continuum of care in support of the war fighter and optimizes our ability to promote, protect and restore their health.

What is obviously a priority to this committee is clearly a priority to us. It is supporting the warfighter, enabling them to perform their mission. It is taking care of the warfighter upon return from their mission and taking care of their families. It is the ability to operate forward and to remain congruent in readiness with our Navy and Marine Corps partners.

In closing, let me briefly address one topic I am sure is of interest, which is MHS governance. We appreciate the opportunity to begin this dialogue with you that started a month ago when you held a hearing on this issue. The Deputy Secretary of Defense has submitted his report to Congress required by section 716 of the Fiscal Year 2012 National Defense Authorization Act. It addresses the Department's plans, subject to review and concurrence by the Government Accounting Office (GAO), to move forward with governance changes.

Throughout my remarks this morning and in my statement for the record I have referred to our jointness in theater, in our classrooms and labs, and in common pursuit of solutions for challenges

like Tramatic Brain Injury (TBI). I stress our commitment again to the interoperability and cost-effective joint solutions in terms of overall governance, and I look forward to partnering with my fellow Surgeons General and the Assistant Secretary of Defense for Health Affairs in finding these solutions.

Navy Medicine looks forward to working on the next phase of the Deputy Secretary's plan. We must proceed in a deliberative and measured manner to ensure that our readiness to support our services' missions and core warfighting capabilities will be maintained and our excellence in health care delivery will be sustained.

On behalf of the men and women of Navy Medicine, I want to thank the committee for your tremendous support, confidence and your leadership. It is my pleasure to testify before you today, and I look forward to your questions.

[The statement of Admiral Nathan follows:]

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THE HOUSE COMMITTEE ON APPROPRIATIONS

STATEMENT OF

VICE ADMIRAL MATTHEW L. NATHAN, MC, USN

SURGEON GENERAL OF THE NAVY

BEFORE THE

SUBCOMMITTEE ON DEFENSE

OF THE

HOUSE COMMITTEE ON APPROPRIATIONS

SUBJECT:

DEFENSE HEALTH PROGRAM

MARCH 8, 2012

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE COMMITTEE ON APPROPRIATIONS

Introduction

Chairman Young, Ranking Member Dicks, distinguished Members of the Subcommittee, I am pleased to be with you today to provide an update on Navy Medicine, including some of our collective strategic priorities, accomplishments, and opportunities. I want to thank the Committee Members for the tremendous confidence and support of Navy Medicine.

I can report to you Navy Medicine remains strong, capable and mission-ready to deliver world class care, anytime, anywhere. We are operating forward and globally engaged, no matter what the environment and regardless of the challenge. The men and women of Navy Medicine remain flexible, agile and resilient in order to effectively meet their operational and wartime commitments, including humanitarian assistance; and concurrently, delivering outstanding patient and family-centered care to our beneficiaries. It is a challenge, but one that we are privileged to undertake.

One of my top priorities since becoming the Navy Surgeon General in November 2011 is to ensure that Navy Medicine is strategically aligned with the imperatives and priorities of the Secretary of the Navy, Chief of Naval Operations and Commandant of the Marine Corps. We are fully engaged in executing the operational missions and core capabilities of the Navy and Marine Corps – and we do this by maintaining warfighter health readiness, delivering the continuum of care from the battlefield to the bedside and protecting the health of all those entrusted to our care. Our focus remains in alignment with our Navy and Marine Corps leadership as we support the defense strategic guidance, *"Sustaining U.S. Global Leadership: Priorities for the 21st Century"* issued by the President and Secretary of Defense earlier this year. The Chief of Naval Operations in his "Sailing Directions" has articulated the Navy's core

responsibilities and Navy Medicine stands ready as we move forward at this pivotal time in our history.

Navy Medicine appreciates the Committee's strong support of our resource requirements. The President's Budget for FY2013 adequately funds Navy Medicine to meet its medical mission for the Navy and Marine Corps. We recognize the significant investments made in supporting military medicine and remain committed to providing outstanding care to all our beneficiaries. Moving forward, we must innovate, position our direct care system to recapture private sector care and deliver best value to our patients. Driving these changes is critical and necessary, but not sufficient. The Secretary of Defense has articulated that the current upward trajectory of health care spending within the Department is not sustainable. Accordingly, the President's Budget includes important health care proposals designed to address this situation, including adjustments in TRICARE fees. The Department of Navy supports these proposals and believes they are important for ensuring a sustainable and equitable benefit for all our beneficiaries. We deliver one of the most comprehensive health benefits available and these changes will help us better manage costs, provide quality, accessible care and keep faith with our beneficiaries. As the Navy Surgeon General, I appreciate the tremendous commitment of our senior leaders in this critical area and share the imperative of controlling costs and maintaining an affordable and sustainable benefit.

Value – a key analytic in our decision-making – must inherently address cost and quality as we implement efficiencies and streamline operations. All of us in the MHS recognize the challenges ahead are significant, including rising health care costs, increased number of beneficiaries and maintaining long-term care responsibilities for our medically-retired warriors.

Additionally, we are very focused on improving internal controls and financial procedures in response to Congressional priorities to obtain a clean financial audit. We have mandated the use of standard operating procedures at all our activities for those business processes which impact financial transactions. I have also emphasized the responsibility of every commanding officer in setting and maintaining appropriate internal controls. We are regularly evaluating our progress through financial transactions and process reviews which help us identify if any changes need to be made. We are making progress and our leadership is fully engaged and leaning forward to ensure the best possible stewardship of our resources.

Alignment is also critical as we focus on more joint solutions within the Military Health System (MHS) and in conjunction with the Army and Air Force. We see tremendous progress in joint medical operations, from battlefield medicine to education and training to research and development. As we continue to synchronize our collective efforts through deliberative planning and rigorous analyses, I believe we will have more opportunities to create synergies, reduce redundancies and enhance value across the MHS.

Our continuing joint efforts in the integration of the Quadruple Aim initiative is helping to develop better outcomes and implement balanced incentives across the MHS. The Quadruple Aim applies the framework from the Institute for Healthcare Improvement (IHI) and customizes it for the unique demands of military medicine. It targets the MHS and Services' efforts on integral outcomes in the areas of readiness, population health and quality, patient experience and cost. Our planning process within Navy Medicine is complementary to these efforts and targets goals that measure our progress and drive change through constructive self-assessment. I have challenged Navy Medicine leaders at headquarters, operational and regional commands and treatment facilities to maintain strategic focus on these key metrics.

Our Mission is Force Health Protection

Force Health Protection is at the epicenter of everything we do. It is an expression of our Core Values of Honor, Courage and Commitment and the imperative for our world-wide engagement in support of expeditionary medical operations and combat casualty care. It is at the very foundation of our continuum of care in support of the warfighter and optimizes our ability to promote, protect and restore their health. It is both an honor and obligation.

Our Force Health Protection mission is clearly evident in our continued combat casualty care mission in Operation ENDURING FREEDOM (OEF). Navy Medicine personnel are providing direct medical support to the operating forces throughout the Area of Responsibility (AOR). We continue to see remarkable advances in all aspects of life-saving trauma care. These changes have been dramatic over the last decade and enabled us to save lives at an unprecedented rate. We are continuously implementing lessons learned and best clinical practices, ensuring our providers have the most effective equipment available and focusing on providing realistic and meaningful training. Mission readiness means providing better, faster combat casualty care to our warfighters.

The NATO Role 3 Multinational Medical Unit (MMU), operating at Kandahar Airfield, Afghanistan is a world-class combat trauma hospital that serves a unique population of U.S. and Coalition forces, as well as Afghan National Army, National Police and civilians wounded in Afghanistan. Led by Navy Medicine, the Role 3 MMU is an impressive 70,000 square foot state-of-the-art facility that is the primary trauma receiving and referral center for all combat casualties in Southern Afghanistan. It has 12 trauma bays, four operating rooms, 12 intensive care beds and 35 intermediate care beds. The approximately 250 staff of active component (AC) and reserve component (RC) personnel includes 30 physicians with multiple surgical

specialties as well as anesthesia, emergency medicine and internal medicine. RC personnel currently make up 27% of overall manning and provide us unique and invaluable skill sets. With trauma admissions averaging 175 patients per month, the unit achieved unprecedented survival rates in 2011. In addition, MMU has two Forward Surgical Teams deployed in the region to provide frontline surgical trauma care demonstrating agility to meet changing operational requirements.

Training is critical for our personnel deploying to the MMU Role 3. This year, we established a targeted training program at the Naval Expeditionary Medical Training Institute (NEMTI) onboard Marine Corps Base Camp Pendleton for our personnel deploying to the MMU. The training is part of an effort designed to foster teamwork, and build medical skills specific to what personnel require while on a six-month deployment. Navy Medicine and U.S. Fleet Forces Command (FFC) recognized the need to integrate medical training scenarios to expand upon the knowledge and skills required to fill positions at the Kandahar Role 3 facility. In January, I had the opportunity to see this impressive training in action during the course's final exercise and saw our personnel implement the clinical skills they honed during the two-week course. They participated in a scenario-driven series of exercises, including staffing a fully equipped hospital receiving patients with traumatic injuries, simulated air strike, and a mass casualty drill. This training, as well as the program at the Navy Trauma Training Center (NTTC) at Los Angeles County/ University of Southern California Medical Center where our personnel train as teams in a busy civilian trauma center, help ensure our deployers have the skills and confidence to succeed in their combat casualty care mission.

Recognizing the importance of ensuring our deployed clinicians have access to state-of-the-art capabilities, Navy Medicine, in conjunction with the Army, Air Force, and our

contracted partners worked successfully to deliver the first ever magnetic resonance imaging (MRI) technology in a combat theatre to aid the comprehensive diagnosis and treatment of concussive injuries. Efforts included the planning, design and execution of this new capability as well as ensuring that clinical, logistical, transportation, environmental, and sustainment considerations for the MRIs were fully addressed prior to the deployment of the units to the battlefield. The fact that we were able to design, acquire and deliver this new capability to the battlefield in approximately six months from contract award is a testament to the commitment of the joint medical and logistics teams. MRIs are now in place Role 3 MMU in Kandahar, Role 3 Trauma Hospital in Camp Bastion and the Joint Theatre Hospital located on Bagram Airfield.

Navy Medicine also supports stability operations through multiple types of engagements including enduring, ship-centric humanitarian assistance (HA) missions such as PACIFIC PARTNERSHIP and CONTINUING PROMISE, which foster relationships with partner countries. During 2011 PACIFIC PARTNERSHIP 2011, 86 Navy Medicine personnel augmented with non-governmental organization, interagency and other Service personnel conducted activities in Tonga, Vanuatu, Papua New Guinea, Timor Leste, and Federated States of Micronesia. Engagements included engineering projects, veterinary services, preventive medicine/public health, and biomedical equipment repair. CONTINUING PROMISE 2011 involved 480 Navy Medicine personnel conducting activities in Jamaica, Peru, Ecuador, Colombia, Nicaragua, Guatemala, El Salvador, Costa Rica, and Haiti. Over 67,000 patients were treated and 1,130 surgeries were performed during this important mission. In addition to our efforts at sea, Navy Medicine also supports land-based HA engagements including Marine Corps

exercises such as AFRICA PARTNERSHIP STATION and SOUTHERN PARTNERSHIP STATION as well as multiple Joint exercises such as BALIKATAN in the Philippines.

Medical Home Port: Patient and Family-Centered Care

We completed our initial deployment of Medical Home Port (MHP) throughout the Navy Medicine enterprise. MHP is Navy Medicine's adaptation of the successful civilian Patient-Centered Medical Home (PCMH) concept of care which transforms the delivery of primary care to an integrated and comprehensive suite of services. MHP is founded in ensuring that patients see their assigned provider as often as possible, and that they can access primary care easily rather than seeking primary care in the emergency room. Strategically, MHP is a commitment to total health and, operationally, it is foundational to revitalizing our primary care system and achieving high quality, accessible, cost efficient health care for our beneficiaries.

We are also working with the Marine Corps to implement the Marine-Centered Medical Home (MCMH) as a complementary analogue to the MHP. Likewise, we are working with U.S. Fleet Forces Command to establish a fleet-based model of the PCMH using the same principles. The first prototype carrier-based PCMH concept will be developed for USS ABRAHAM LINCOLN (CVN-72).

Initial results are encouraging. MHP performance pilots at the Walter Reed National Military Medical Center (WRNMMC) and Naval Hospital Pensacola have shown improvement in key health care outcomes such as: increased patient satisfaction: improved access to care: and improved quality of care associated with decreased use of the emergency room (an important cost driver). Data show similar results enterprise-wide through October 2011, and also indicate improved continuity with assigned provider, decreased emergency room utilization and better cost containment when compared with FY2010.

Healing in Body, Mind and Spirit

Health is not simply the absence of infirmity or disease – it is the complete state of physical, mental, spiritual and social well being. As our wounded warriors return from combat and begin the healing process, they deserve a seamless and comprehensive approach to their recovery. Our focus is integrative, complementary and multidisciplinary-based care, bringing together clinical specialists, behavioral health providers, case managers, and chaplains. There are approximately 170 medical case managers who work closely with their line counterparts in the Marine Corps' Wounded Warrior Regiment and the Navy's Safe Harbor program to support the full-spectrum recovery process for Sailors, Marines and their families.

We have made remarkable progress in ensuring our wounded service members get the care they need – from medical evacuation through inpatient care, outpatient rehabilitation to eventual return to duty or transition from the military. With our historically unprecedented battlefield survival rate, we witness our heroes returning with the life-altering wounds of war which require recovery and long-term care. We must continue to adapt our capabilities to best treat these conditions and leverage our systems to best support recovery.

To that end, we are committed to connecting our wounded warriors to approved emerging and advanced diagnostic and therapeutic options within our MTFs and outside of military medicine. We do this through collaborations with major centers of reconstructive and regenerative medicine while ensuring full compliance with applicable patient safety policies and practices. The Naval Medical Research and Development Center in Frederick, Maryland, is aggressively engaged in furthering support for cooperative medical research between multiple centers of regenerative and reconstructive medicine. Their collaborative efforts, in conjunction with the Armed Forces Institute of Regenerative Medicine (AFIRM), are essential in developing new

regenerative and transplant capabilities, both at the civilian and the military institutions with ultimate sharing of knowledge, expertise and technical skills in support of restoration of our wounded warriors.

Navy Medicine continues a robust translation research program in wound healing and wound care, moving technologies developed at the bench to deployment in the clinic to enhance the care of the wounded warfighter. Concurrently, we are focused on improving the capability and capacity to provide comprehensive and interdisciplinary pain management from the operational setting to the MTF to home. This priority includes pain management education and training to providers, patients, and families to prevent over-prescribing, misuse of medications and promoting alternative therapies.

Preserving the psychological health of service members and their families is one of the greatest challenges we face today. The Navy continues to foster a culture of support for psychological health as an essential component to total force fitness and readiness. Navy and Marine Corps Combat Operational Stress Control (OSC) programs provide Sailors, Marines, leaders and families the skills and resources to build resiliency. We also continue to address stigma by encouraging prevention, early intervention, and help-seeking behaviors. Training is designed to build teams of leaders, Marines, Sailors, medical and religious ministry personnel to act as sensors for leadership by noticing small changes in behavior and taking action early. These efforts support in fostering unit strength, resilience, and readiness.

Navy Medicine has continued to adapt psychological health support across traditional and non-traditional health care systems. Access to psychological health services have increased in venues designed to reduce the effects associated with mental health stigma. These efforts are also focused on suicide prevention and are designed to improve education, outreach and

intervention. In 2011, more than 1,000 health providers received targeted training in assessing and managing suicide risk. We are also integrating behavioral health providers in our MHP program to help address the needs of our patients in the primary care setting.

Post-Traumatic Stress Disorder (PTSD) is one of many psychological health conditions that adversely impacts operational readiness and quality of life. Navy Medicine has an umbrella of psychological health programs that target multiple, often co-occurring, mental health conditions including PTSD. These programs support prevention, diagnosis, mitigation, treatment, and rehabilitation of PTSD. Our efforts are also focused on appropriate staffing, meeting access standards, implementing recommended and standardized evidence-based practices, as well as reducing stigma and barriers to care.

We recently deployed our fifth Navy Mobile Mental Health Care Team (MCT) in Afghanistan. Consisting of two mental health clinicians, a research psychologist and an enlisted behavioral health technician, their primary mission is to administer the Behavioral Health Needs Assessment Survey (BHNAS). The results give an overall assessment and actionable intelligence of real-time mental health and well-being data for our deployed forces. It can also identify potential areas or sub-groups of concern for leaders on the ground and those back in garrison. The survey assesses mental health outcomes, as well as the risk and protective factors for those outcomes such as combat exposures, deployment-related stressors, positive effects of deployment, leadership perceptions, and morale and unit cohesion. The MCT also has a preventive mental health and psycho-education role and provides training in Combat and Operational Stress Control (COSC) and Combat and Operational Stress First Aid (COSFA) to Sailors in groups and individually to give them a framework to mitigate acute stressors and promote resilience in one another.

Data from previous MCT deployments and BHNAS analyses indicate continued need for implementation of COSC doctrine and command support in OEF. In addition, the Joint Mental Health Assessment Team (J-MHAT 7) surveillance efforts conducted in Afghanistan during 2010 indicate an increase in the rate of Marines screening at-risk for PTSD relative to similar surveys conducted in Marine samples serving in Iraq during 2006 and 2007. This assessment also shows increases in training effectiveness regarding managing combat deployment stress, as well as a significant reduction in stigma associated with seeking behavioral health treatment.

In collaboration with the Marine Corps, the Operational Stress Control and Readiness (OSCAR) program represents an approach to mental health care in the operational setting by taking mental health providers out of the clinic and embedding them with operational forces to emphasize prevention, early detection and brief intervention. OSCAR-trained primary care providers recognize and treat psychological health issues at points where interventions are often most effective. In addition, OSCAR includes chaplains and religious personnel (OSCAR Extenders) who are trained to recognize stress illness and injuries and make appropriate referral. Over 3,000 Marine leaders and individual Marines have been trained in prevention, early detection and intervention in combat stress through OSCAR Team Training and will operate in OSCAR teams within individual units.

Through the Caregiver Occupational Stress Control (CgOSC) Program, Navy Medicine is also working to enhance the resilience of caregivers to the psychological demands of exposure to trauma, wear and tear, loss, and inner conflict associated with providing clinical care and counseling. The core objectives include: early recognition of distress; breaking the code of silence related to stress reactions and injuries; and engaging caregivers in early help as needed to maintain both mission and personal readiness.

Our emphasis remains ensuring that we have the proper size and mix of mental health providers to care for the growing need of service members and their families who need care. Within Navy Medicine, mental health professional recruiting and retention remains a top priority. Although shortfalls remain, we have made progress recruiting military, civilian and contractor providers, including psychiatrists, clinical psychologists, social workers and mental health nurse practitioners. We have increased the size of the mental health workforce in these specialties from 505 in FY2006 to 829 in FY2012. Notwithstanding the military is not immune to the nation-wide shortage of qualified mental health professionals. Throughout the country, the demand for behavioral health services remains significant and continues to grow.

Caring for our Sailors and Marines suffering with Traumatic Brain Injury (TBI) remains a top priority. While we are making progress, we have much work ahead of us as we determine both the acute and long-term impact of TBI on our service members. Our strategy must be both collaborative and inclusive by actively partnering with the other Services, our Centers of Excellence, the Department of Veterans Affairs (VA), and leading academic medical and research centers to make the best care available to our warriors afflicted with TBI.

Navy Medicine is committed to ensuring thorough screening for all Sailors and Marines prior to deployment, while in theatre, and upon return from deployment. Pre-deployment neurocognitive testing is mandated using the Automated Neuropsychological Assessment Metrics (ANAM). The ANAM provides a measure of cognitive performance, that when used with a patient with confirmed concussion, can help a provider determine functional level as compared to the service member's baseline. In-theatre screening, using clinical algorithms and the Military Acute Concussion Evaluation (MACE), occurs for those who have been exposed to a potentially concussive event, as specified by the event driven protocols of the TBI Directive-

type Memorandum (DTM) 09-033 released in June 2010.

DTM-09-033 has changed the way we treat TBI in theatre. It requires pre-deployment on point of injury care, improved documentation and tracking of concussion by line and medical leaders, as well as a move towards standardization of system-wide care.

In-theatre, the Concussion Restoration Care Center (CRCC) at Camp Leatherneck Afghanistan, became operational in August 2010. CRCC represents a ground-breaking, interdisciplinary approach to comprehensive musculoskeletal and concussion care in the deployed setting. As of December 1, 2011, the CRCC has seen over 2,500 patients (over 750 with concussion) with a greater than 95% return to duty rate. I am encouraged by the impact the CRCC is having in theatre by providing treatment to our service members close to the point of injury and returning them to duty upon recovery. We will continue to focus our attention on positioning our personnel and resources where they are most needed.

Post-deployment surveillance is accomplished through the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA), required for returning deployers. Navy Medicine has conducted additional post-deployment TBI surveillance on high risk units and those Marines with confirmed concussions in theatre, with a goal of improving patient outcomes and better informing leaders.

Access and quality of care for treating TBIs are being addressed through standardization of Navy Medicine's current six clinical TBI specialty programs at Naval Medical Center Portsmouth, Naval Medical Center San Diego, Naval Hospital Camp Lejeune, Naval Hospital Camp Pendleton, Naval Health Clinic New England - Branch Health Clinics Groton and Portsmouth. Additionally, we have an inpatient program at WRNMMC which focuses on moderate and severe TBI while also conducting screening for TBI on all polytrauma patients

within the medical center.

The National Intrepid Center of Excellence (NICoE) is dedicated to providing cutting-edge evaluation, treatment planning, research and education for service members and their families dealing with the complex interactions of mild traumatic brain injury and psychological health conditions. Their approach is interdisciplinary, holistic, patient and family-centered. The NICoE's primary patient population is comprised of active duty service members with TBI and PH conditions who are not responding to current therapy. The NICoE has spearheaded partnerships with many military, federal, academic and private industry partners in research and education initiatives to further the science and understanding of these invisible wounds of war. The Department of Defense (DoD) has recently accepted an offer from the Intrepid Fallen Heroes Fund to construct several NICoE Satellite centers to treat our military personnel suffering from PTSD or TBI locally. The first installations to receive these centers will be Fort Belvoir, Camp Lejeune and Fort Campbell. The Services are actively working together to determine the details regarding project timelines, building sizes, staffing, funding, and sustainability.

We need to continue to leverage the work being done by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, including the Defense and Veterans Brain Injury Center, given their key roles in the expanding our knowledge of PH and TBI within the MHS, the VA and research institutions. This collaboration is also evident in the work being conducted by the Vision Center of Excellence (VCE), established by the National Defense Authorization Act of 2008. VCE, for which Navy Medicine currently provides operational support, exemplifies this important symmetry with military medicine, the VA and research partners. They are developing a distributed and integrated organization with regional locations that link together a network of clinical, research, and teaching centers around the world. The

VCE encompasses an array of national and international strategic partners, including institutions of higher learning, and public and private entities.

Family readiness supports force readiness so we must have programs of support in place for our families. We continue to see solid results from FOCUS (Families Over Coming Under Stress), our evidence-based, family-centered resilience training program that enhances understanding of combat and operational stress, psychological health and developmental outcomes for highly stressed children and families. Services are offered at 23 CONUS/OCONUS locations. As of December 2011, 270,000 families, service members, and community support members have been trained on FOCUS. Based on the program's annual report released in July 2011, we can see there has been a statistically significant decrease in issues such as depression and anxiety in service members, spouses and children who have completed the program as well as a statistically significant increase in positive family functioning for families.

For our Marine Corps and Navy reserve populations, we have developed the Reserve Psychological Health Outreach Program (PHOP). PHOP provides psychological health outreach, education/training, and resources a 24/7 information line for unit leaders or reservists and their families to obtain information about local resources for issues related to employment, finances, psychological health, family support, and child care. PHOP now includes 55 licensed mental health providers dispersed throughout the country serving on 11 teams located centrally to Navy and Marine Force Reserve commands.

Returning Warrior Workshops (RWWs) began with the Navy Reserve more than five years ago and are conducted quarterly in each Navy Reserve Region across the country. As of September 2011, over 10,000 service members and their families have participated in RWWs.

RWWs assist demobilized service members and their loved ones in identifying immediate and potential issues that often arise during post-deployment reintegration.

Navy Medicine maintains a steadfast commitment to our Substance Abuse Rehabilitation Programs (SARPs). SARPs offer a broad range of services to include alcohol education, outpatient and intensive outpatient treatment, residential treatment, and medically managed care for withdrawal and/or other medical complications. We have expanded our existing care continuum to include cutting-edge residential and intensive outpatient programs that address both substance abuse and other co-occurring mental disorders directed at the complex needs of returning warriors who may suffer from substance abuse disorders and depression or PTSD. In addition, Navy Medicine has developed a new program known as MORE – My Online Recovery Experience. In conjunction with Hazelden, a civilian leader in substance abuse treatment and education, MORE is a ground-breaking web-based recovery management program available to service members 24/7 from anywhere in the world. Navy Medicine has also invested in important training opportunities on short-term interventions and dual diagnosis treatment for providers and drug and alcohol counselors, markedly improving quality and access to care.

Our Naval Center for Combat & Operational Stress Control (NCCOSC) – now in its fourth year – continues to improve the psychological health of Marines and Sailors through comprehensive programs that educate service members, build psychological resilience and promote best practices in the treatment of stress injuries. The overarching goal is to show Sailors and Marines how to recognize signs of stress before anyone is in crisis and to get help when it is needed. NCCOSC continues to make progress in advancing research for the prevention, diagnosis and treatment of combat and operational stress injuries, including PTSD. They have 50 on-going scientific projects and have doubled the number of enrolled participants from a year

ago to over 7,100. Similarly, they have expanded the enrollment in their Psychological Health Pathways (PHP) pilot project to 2,248 patients - a 38% increase over last year.

Force Multipliers: Research and Development and Graduate Medical Education

Innovative research and development and vibrant medical education help ensure that we have the capabilities to deliver world-class care now and in the future. They are sound investments in sustaining our excellence to Navy Medicine to our mission of Force Health Protection.

The continuing mission of our Medical Research and Development program is to conduct health and medical research in the full spectrum of development, testing, clinical evaluation (RDT&E), and health threat detection in support of the operational readiness and performance of DoD personnel worldwide. In parallel with this primary operational research activity, our Clinical Investigation Program (CIP) continues to expand at our teaching MTFs with direct funding being provided to support the enrichment of knowledge and capability of our trainees. Where consistent with this goal, these programs are participating in the translation of knowledge and tangible products from our RDT&E activity into proof of concept and cutting edge interventions that are directly applied in benefit of our wounded warriors and our beneficiaries.

Navy Medicine's five strategic research priorities are set to meet the war fighting requirements of the Chief of Naval Operations and the Commandant of the Marine Corps. These pursuits continue with appropriate review and the application of best practices in meeting our goals. These five areas of priority include:

- Traumatic brain injury (TBI) and psychological health treatment and fitness
- Medical systems support for maritime and expeditionary operations
- Wound management throughout the continuum of care
- Hearing restoration and protection for operational maritime surface and air support personnel
- Undersea medicine, diving and submarine medicine

We continue to strengthen our medical partnerships in Southeast Asia, Africa and South America through the cooperation and support provided by our Naval Medical Research Units and medical research operations in those geographical regions. We find that the application of medical and health care diplomacy is a firm cornerstone of successful pursuit of overarching bi-lateral relations between allies. These engagements are mutually beneficial – not only for the relationships with armed forces of engaged countries, but for generalization of health care advances to the benefit of peoples around the globe.

Graduate Medical Education (GME) is vital to the Navy's ability to train board-certified physicians and meet the requirement to maintain a tactically proficient, combat-credible medical force. Robust, innovative GME programs continue to be the hallmark of Navy Medicine. We are pleased to report that despite the challenges presented by ten years of war, GME remains strong.

Our institutions and training programs continue to perform well on periodic site visits by the Accreditation Council for Graduate Medical Education (ACGME) and most are at or near the maximum accreditation cycle length. The performance of our three major teaching hospitals, in particular, has been outstanding with all three earning the maximum five-year accreditation cycle length. Board certification is another hallmark of strong GME. The overall pass rate for Navy trainees in 2011 was 96 percent, well above the national average in most specialties. Our Navy-trained physicians continue to prove themselves exceptionally well-prepared to provide care to all members of the military family, and in all operational settings ranging from the field hospitals of the battlefield to the platforms that support disaster and humanitarian relief missions.

Overall, I am pleased with the progress we are making with our joint enlisted training efforts at the Medical Education and Training Campus (METC) in San Antonio, Texas. I had an

opportunity to visit the training center earlier this year and meet with the leadership and students. We have a tremendous opportunity to train our Sailors with their Army and Air Force counterparts in a joint environment, and I am working with my fellow Surgeons General to ensure we optimize our efforts, improve interoperability and create synergies.

Interoperability and Collaborative Engagement

Navy Medicine continues to leverage its unique relationships with the Army, Air Force, the VA, as well as other federal and civilian partners. This interoperability helps create system-wide synergies and foster best practices in care, education and training, research and technology.

Our sharing and collaboration efforts with the VA continue throughout our enterprise and Navy Medicine's most recent joint venture is a unique partnership between the Naval Health Clinic Charleston, Ralph H. Johnson Veterans Affairs Medical Center, Naval Hospital Beaufort and the Air Force's 628th Medical Group. This partnership will manage joint health care services and explore local joint opportunities for collaboration. In addition, our new replacement facility at Naval Hospital Guam, currently under construction, will continue to provide ancillary and specialty service to VA beneficiaries.

Operations continue at the Captain James A. Lovell Federal Health Care Center (FHCC) in Great Lakes, Illinois – a first-of-its-kind fully integrated partnership that links Naval Health Clinic Great Lakes and the North Chicago VA Medical Center into one health care system. This joint facility, activated in October 2010, is a five year demonstration project as mandated by the National Defense Authorization Act of FY2010. During its first year, FHCC successfully completed the Civilian Personnel Transfer of Function which realigned staff from 1,500 to more than 3,000. The USS Red Rover Recruit Clinic processed more than 38,000 U.S. Navy recruits and delivered more than 178,000 immunizations to the Navy recruits. We continue to work with

DoD and the VA to leverage the full suites of information technology capabilities to support the mission and patient population.

In addition, our collaborative efforts are critical in continuing to streamline the Integrated Disability Evaluation System (IDES) in support of our transitioning Wounded, Ill and Injured service members. Within the Department of Navy (DON), we have completed IDES expansion to all 21 CONUS MTFs and we are working to implement improvements and best practices in order to streamline the IDES process to allow for timely and thorough evaluation and disposition. Further collaboration between DoD, the Services and the VA regarding information technology improvements, ability for field-level reports for case management and capability for electronic case file transfer is ongoing.

In support of DoD and VA interagency efforts, we are leveraging our information technology capabilities and building on joint priorities to support a seamless transition of medical information for our service members and veterans. This ongoing work includes the development of an integrated electronic health record and the Virtual Lifetime Electronic Record (VLER), including the Naval Medical Centers San Diego and Portsmouth participation in VLER pilot projects.

We completed the requirements associated with the Base Realignment and Closure (BRAC) in the National Capital Region (NCR) with the opening of the Walter Reed National Military Medical Center and Fort Belvoir Community Hospital. The scope of this realignment was significant and we are continuing to devote attention to ensuring that our integration efforts reduce overhead, maintain mission readiness and establish efficient systems for those providing care our patients. We have outstanding staff members comprised of Navy, Army, Air Force and civilians, who are executing their mission with skill, compassion and professionalism. The

opening of these impressive facilities represented several years of hard work by the men and women of military medicine, as well as generous support from Members of Congress. I am proud of what we accomplished and, moving forward, encouraged about the opportunities for developing a sustainable, efficient integrated health care delivery model in the NCR. I, along with my fellow Surgeons General, am committed to this goal and recognize the hard work ahead of us.

People – Our Most Important Asset

The hallmark of Navy Medicine is our professional and dedicated workforce. Our team consists of over 63,000 active component (AC) and reserve component (RC) personnel, government civilians as well as contract personnel – all working around the world to provide outstanding health care and support services to our beneficiaries. I am continually inspired by their selfless service and sharp focus on protecting the health of Sailors, Marines and their families.

Health care accessions and recruiting remain a top priority, and, overall, Navy Medicine continues to see solid results from these efforts. Attainment of our recruiting and retention goals has allowed Navy Medicine to meet all operational missions despite some critical wartime specialty shortages. In FY2011, Navy Recruiting attained 101% of active Medical Department officer goals, and 85% of reserve Medical Department officer goals. In a collaborative effort with the Chief of Navy Reserve and Commander, Navy Recruiting Command, we are working to overcome challenges in the RC medical recruiting missions. We recently held a recruiting medical stakeholders conference during which we discussed the challenges and courses of action to address them. Using a variety of initiatives such as the Health Professions Scholarship Program (HPSP), special incentive pays and selective re-enlistment bonuses, Navy Medicine is

able to support and sustain accessions and retention across the Corps. We are grateful to Congress for the authorities provided to us in support of these programs.

As a whole, AC Medical Corps manning at the end of FY2011 was 100% of requirements; however, some specialty shortfalls persist including general surgery, family medicine, and psychiatry. Aggressive plans to improve specialty shortfalls include continuation of retention incentives via special pays, and an increase in psychiatry training billets. Overall AC Dental Corps manning was at 96% of requirements, despite oral and maxillofacial surgeons manning at 77%. A recent increase in incentive special pays was approved to address this shortfall. General dentist incentive pay and retention bonuses have helped increase general dentist manning to 99%, up from 88% manning a year ago. At the end of FY2011, AC Medical Service Corps manning was 94% of requirements. A staffing shortage does exist for the social work specialty, manned at 45%. This shortage is due to increased requirements and billet growth during the past three years. We anticipate that this specialty will be fully manned by the end FY2014 through increased accessions and incentive programs. Our AC Nurse Corps manning at the end of FY2011 was 94% of requirements. Undermanned low density/high demand specialties including peri-operative nurses, certified registered nurse anesthetists and critical care nurses are being addressed via incentive special pays.

Our AC Hospital Corps remains strong with manning at 96%. Critical manning shortfalls exist in several skill sets such as behavioral health technicians, surface force independent duty corpsmen, dive independent duty corpsmen, submarine independent duty corpsmen, and reconnaissance corpsmen. Program accession and retention issues are being addressed through increased special duty assignment pay, selective re-enlistment bonuses and new force shaping policies.

Reserve component Medical Corps recruiting continues to be our greatest challenge. Higher AC retention rates have resulted in a smaller pool of medical professionals leaving active duty, and consequently, greater reliance on highly competitive Direct Commission Officer (DCO) market. RC Medical Corps manning at the end of FY2011 manning was at 71% of requirements while our Nurse Corps RC manning was 88%. To help mitigate this situation, there is an affiliation bonus of $10K or special pay of up to $25K per year based on specialty, and activated reserves are also authorized annual special incentive pays as applicable. Due to robust recruiting efforts and initiatives, the reserve component Nurse Corps exceeded recruiting goals for the second consecutive year. Dental Corps and Medical Service Corps RC manning is 100% and 99%, respectively.

Overall RC Hospital Corps manning is at 99%; however, we do have some shortfalls in surgical, x-ray and biomedical repair technicians. Affiliation bonuses are specifically targeted towards those undermanned specialties.

We are encouraged by our improving overall recruiting and retention rates. Improvements in special pays have mitigated manning shortfalls; however, it will take several years until Navy Medicine is fully manned in several critical areas. To ensure the future success of accession and retention for Medical Department officers continued funding is needed for our programs and special incentive pays. We are grateful for your support in this key area.

For our federal civilian personnel within Navy Medicine, we have successfully transitioned out of the National Security Personnel System (NSPS) and, in conjunction with the Assistant Secretary of Defense for Health Affairs and the other Services, we have begun a phased transition to introduce pay flexibilities in 32 health care occupations to ensure pay parity among health care providers in federal service. The initial phase occurred in FY 2011 when over 400

federal civilian physicians and dentists were converted to the new Defense Physician and Dentist Pay Plan. Modeled on the current VA pay system, the Defense Physician and Dentist Pay Plan provides us with the flexibility to respond to local conditions in the health care markets. We continue to successfully hire required civilians to support our Sailors and Marines and their families - many of whom directly support our Wounded Warriors. Our success is largely attributed to the hiring and compensation flexibilities granted by Congress to the DoD's civilian health care community over the past several years.

The Navy Medicine Reintegrate, Educate and Advance Combatants in Healthcare (REACH) Program is an initiative that provides wounded warriors with career and educational guidance from career coaches, as well as hands-on training and mentoring from our hospital staff. To date, Navy Medicine has launched the REACH Program at WRNMMC, Naval Medical Centers Portsmouth and San Diego, as well as Naval Hospital Camp LeJeune. The ultimate goal of the REACH Program is to provide a career development and succession pipeline of trained disabled veterans for Federal Civil Service positions in Navy Medicine.

I am committed to building and sustaining diversity within the Navy Medicine workforce. Our focus remains creating an environment where our diversity reflects that of our patients and our Nation and where our members see themselves represented in all levels of leadership. We embrace what we learn from our unique differences with the goal of a work-life in balance with mind, body, and spirit. I believe we are more mission-ready, stronger and better shipmates because of our diversity. Navy Medicine will continue to harness the teamwork, talent, and innovation of our diverse force as we move forward into our future.

Conclusion

In summary, Navy Medicine is an agile and vibrant health care team. I am grateful to those came before us for their vision and foresight; I am inspired by those who serve with us now for commitment and bravery; and I am confident in those who will follow us because they will surely build on the strength and tradition of Navy Medicine. I have never been more proud of the men and women of Navy Medicine.

On behalf of the men and women of Navy Medicine, I want to thank the Committee for your tremendous support, confidence and leadership. It has been my pleasure to testify before you today and I look forward to your questions.

SUMMARY STATEMENT OF LTG GREEN

Mr. YOUNG. Admiral, thank you very much. We appreciate especially the conversations we had at the last hearing with all of you about the new governance. I don't know that we are going to do too much on that issue today. We might. We will see how it goes.

General Green, again, thank you for being here. You have always been very, very direct in your statements and very direct in your answers to our questions that are probing on occasion, and we just appreciate that honesty and we appreciate you. We are sorry this is going to be your last time to visit with us, but we are still your friends and we will still be here even after you move on to your next role in life.

So we are glad to hear from you at this point, sir.

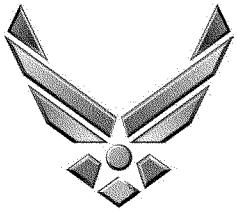
General GREEN. Thank you, sir. I too will abbreviate my comments today.

Chairman Young, Representative Dicks and members of committee, thank you for inviting me here and for your very kind words. The Air Force Medical Service could not achieve our goals of readiness, better health, better care and best value, without your support, and we thank you. To meet these goals, the Air Force Medical Service is transforming deployable capability, building patient centered care, and investing in education, training and resource to sustain world class health care. In the coming year we will work shoulder to shoulder with the Army, Navy and DOD counterparts to be ready, provide that better health, better care and best value to America's heroes. We will find efficiencies and we will provide even higher quality care with the resources we are given, and together we will implement the right governance of our military health system.

I thank this committee for your tremendous support to military medics, and a special thank you to Representative Dicks. Our success, both at home and on the battlefield, would not be possible without your persistent and generous support. Thank you, and I look forward to answering your questions.

[The statement of General Green follows:]

United States Air Force



Presentation before the House Appropriations Committee, Subcommittee on Defense

FY 2013 Medical Programs

Statement of
Lieutenant General (Dr.) Charles B. Green
The Surgeon General of the Air Force

March 8, 2012

Not for publication until released by the House Appropriations Committee, Subcommittee on Defense

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) CHARLES B. GREEN

Lt. Gen. (Dr.) Charles B. Green is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Green serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Green has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 42,800 people assigned to 75 medical facilities worldwide.

General Green was commissioned through the Health Professions Scholarship Program and entered active duty in 1978 after completing his Doctorate of Medicine degree at the Medical College of Wisconsin in Milwaukee. He completed residency training in family practice at Eglin Regional Hospital, Eglin AFB, Fla., in 1981, and in aerospace medicine at Brooks AFB, Texas, in 1989. He is board certified in aerospace medicine. An expert in disaster relief operations, he planned and led humanitarian relief efforts in the Philippines after the Baguio earthquake in 1990, and in support of Operation Fiery Vigil following the 1991 eruption of Mount Pinatubo.

General Green has served as commander of three hospitals and Wilford Hall Medical Center. As command surgeon for three major commands, he planned joint medical response for operations Desert Thunder and Desert Fox, and oversaw aeromedical evacuation for operations Enduring Freedom and Iraqi Freedom. He has served as Assistant Surgeon General for Health Care Operations and Deputy Surgeon General, prior to his current assignment.

EDUCATION

1974 Bachelor of Science degree in chemistry, University of Wisconsin-Parkside, Kenosha
1978 Doctorate in Medicine and Surgery, Medical College of Wisconsin, Milwaukee
1981 Residency in family practice, Eglin Regional Hospital, Eglin AFB, Fla.
1987 Air Command and Staff College, by seminar
1988 Master's degree in public health, Harvard University, Cambridge, Mass.
1989 Residency in aerospace medicine, Brooks AFB, Texas
2000 Air War College, by correspondence

ASSIGNMENTS

1. June 1978 - July 1981, family practice resident, later, chief resident, Eglin AFB, Fla.
2. July 1981 - August 1984, flight surgeon, U.S. Air Force Hospital, Mather AFB, Calif.
3. August 1984 - September 1985, officer in charge, Family Practice Clinic, Wheeler AFB, Hawaii
4. September 1985 - August 1987, Chief of Clinic Services, Hickam AFB, Hawaii
5. September 1987 - June 1988, student, graduate aerospace medical resident, Harvard University, Cambridge, Mass.
6. June 1988 - July 1989, resident in aerospace medicine, U.S. Air Force School of Aerospace Medicine, Brooks AFB, Texas
7. July 1989 - August 1991, Chief of Aerospace Medicine, and Commander, 657th Tactical Hospital, Clark AB, Philippines
8. September 1991 - August 1993, Commander, 65th Medical Group, Lajes Field, Portugal
9. August 1993 - August 1995, Commander, 366th Medical Group, Mountain Home AFB, Idaho
10. August 1995 - January 1997, Commander, 96th Medical Group, Eglin AFB, Fla.
11. January 1997 - July 1999, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
12. July 1999 - June 2001, Command Surgeon, North American Aerospace Defense Command, U.S. Space Command and Air Force Space Command, Peterson AFB, Colo.
13. June 2001 - July 2003, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
14. July 2003 - July 2005, Commander, 59th Medical Wing, Wilford Hall Medical Center, Lackland AFB, Texas
15. July 2005 - August 2006, Assistant Surgeon General for Health Care Operations, Office of the Surgeon General, Bolling AFB, D.C.
16. August 2006 - August 2009, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, D.C.
17. August 2009 - present, Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C.

SUMMARY OF JOINT ASSIGNMENTS

1. January 1997 - July 1999, Command Surgeon, U.S. Central Command, MacDill AFB, Fla., as a colonel
2. July 1999 - June 2001, Command Surgeon, North American Aerospace Defense Command and U.S. Space Command, Peterson AFB, Colo., as a colonel
3. June 2001 - July 2003, Command Surgeon, U.S. Transportation Command, Scott AFB, Ill., as a brigadier general
4. July 2003 - July 2005, Director, DOD Region 6 (TRICARE South) Lackland AFB, Texas, as a major general

FLIGHT INFORMATION

Rating: Chief flight surgeon
Flight hours: 1,200
Aircraft flown: B-52, C-5, C-9, C-21, C-130, C-141, H-53, KC-135, T-43, F-15, F-16, P-3, T-37, T-38, UH-1 and UH-60

MAJOR AWARDS AND DECORATIONS
Distinguished Service Medal with oak leaf cluster
Defense Superior Service Medal with oak leaf cluster
Legion of Merit
Defense Meritorious Service Medal
Airman's Medal
Meritorious Service Medal with four oak leaf clusters
Joint Service Commendation Medal
Air Force Commendation Medal with two oak leaf clusters
Air Force Achievement Medal
National Defense Service Medal with bronze star
Armed Forces Expeditionary Medal
Humanitarian Service Medal with bronze star
Philippine Bronze Cross

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
American Medical Association
American College of Physician Executives
Fellow, Aerospace Medical Association
Fellow, American Academy of Family Physicians
Uniformed Services Academy of Family Physicians
Aerospace Medical Association
Society of U.S. Air Force Flight Surgeons (former President)
Air Force Association
Association of Military Surgeons of the United States

EFFECTIVE DATES OF PROMOTION
Captain June 18, 1978
Major May 26, 1984
Lieutenant Colonel May 25, 1990
Colonel May 31, 1994
Brigadier General Aug. 1, 2001
Major General Sept. 1, 2004
Lieutenant General Aug. 3, 2009

(Current as of February 2010)

Chairman Young, Ranking Member Dicks and distinguished members of the Committee, thank you for inviting me to appear before you today. The men and women of the Air Force Medical Service (AFMS) have answered our nation's call and maintained a standard of excellence second to none for more than a decade of sustained combat operations. We provide service members, retirees and families the best care America has to offer. We take tremendous pride in providing "Trusted Care Anywhere" for the nation.

We support the President's budget and the proposed changes to the military health benefit. I am confident that the recommendations included in the budget reflect the proper balance and the right priorities necessary to sustain the benefit over the long term. National health care costs continue to rise at rates above general inflation and DoD is not insulated from this growth as we purchase over 60 percent of our care from private sector. DoD beneficiaries' out-of-pocket costs with the proposed changes remain far below the cost-sharing percentage they experienced in 1995. We understand we cannot ask our beneficiaries to share more of the cost for health care without seeking significant internal efficiencies. We are increasing efficiency by reducing administrative costs, improving access, recapturing care, and introducing cutting-edge technology to better connect our providers and patients.

Ready, Better Health, Better Care, and Best Value are the components of the Quadruple Aim for the Military Health Services. To meet these goals, the AFMS set priorities to transform deployable capability, build patient-centered care, and invest in education, training and research to sustain world class health care. We have made significant inroads in each of these areas over the past year.

Transform Deployable Capability

In times of war there are always significant advances in the field of medicine. Today we are applying these lessons to shape future readiness and care. We have found new ways to manage blood loss and improve blood replacement. Significant improvements in the blood program improved transfusion capability and changed the way we use fluids to resuscitate patients. Air Force trauma surgeons in deployed hospitals better control hemorrhage and treat vascular injury by designing and using new arterial shunts that have been adopted by civilian trauma surgeons. These innovations contribute to a very low case fatality rate and allow earlier transport of casualties.

Through innovative training and quick thinking, Air Force, Army and Navy medics continue to perform miracles in field hospitals. Last spring in Balad, Iraq, our critical care air transport teams (CCATT) saved the life of a soldier who had suffered blunt force trauma to his chest, causing his heart to stop. After an unknown period without a pulse, there was significant risk of brain injury. Using coolers of ice, the team undertook a rare therapeutic hypothermia procedure to lower body temperature, decreasing tissue swelling and damage to the brain. The soldier was transported to Landstuhl Medical Center in Germany where his temperature was slowly raised, bringing him back to consciousness. Within four days of injury, the soldier arrived at Brooke Army Medical Center, San Antonio, Texas, and walked out of the hospital with thankful family members. Incredible ingenuity, dedication, and teamwork continue to save lives every day.

We have an impressive legacy of building highly capable deployable hospitals over the past decade. This year we have established 10 new Expeditionary Medical Support (EMEDS)

Health Response Teams (HRT). These newly tested and proven 10-bed packages enable us to arrive in a chaotic situation, provide emergency care within 30 minutes and perform surgery within 5 hours of arrival. The entire package is transportable in a single C-17, and full base operating support for the hospital requires only one additional C-17. The HRT was used successfully in a Trinidad humanitarian mission in April and will be our standard package to provide rapid battlefield medicine and humanitarian assistance. This year we will establish intensive training with the HRT and will expand its capability with additional modular sets to respond to specialized missions such as obstetrics, pediatrics or geriatrics required for humanitarian response.

We are also pursuing initiatives to improve air evacuation capability. New advances in ventilators allow us to move patients sooner and over longer distances with less oxygen. We pursued new capabilities for heart-lung bypass support by reducing the size of extracorporeal membrane oxygenation (ECMO) equipment. ECMO has been in use for many years transporting neonatal patients, and we now have critical care teams using this advanced technology for adult patient transportation. We moved the first patient on full heart lung bypass out of Afghanistan in 2011. We are working to miniaturize and standardize ECMO equipment so it can be operated by less specialized teams. David Grant Medical Center at Travis AFB, California, recently became the first DoD recipient of the smallest ECMO device. Known as CARDIOHELP, the device is light enough to be carried by one person and compact enough for transport in a helicopter or ambulance. Researchers will utilize CARDIOHELP to evaluate the effects of tactical, high altitude and long-haul flights on patients who require the most advanced life support. We continue to advance the science of patient transport moving the sickest of the sick, as we decrease the amount of time from point of injury to definitive care in the United States.

The insertion and integration of CCATT into the air evacuation system continues to be a dominant factor in our unprecedented high survival rates. These teams speed up the patient movement process, bring advanced care closer to the point of injury, free up hospital beds for new causalities, allow us to use smaller hospitals in theater and move patients to definitive care sooner. We have improved CCATT equipment with more wireless capability aboard aircraft to simplify connection of medical equipment to critical care patients. We are continuously finding better technologies for more accurate patient assessment in flight and working to standardize equipment and supplies used by coalition teams.

We developed and fielded the Tactical Critical Care Evacuation Team in 2011. This team was built to deliver the same level of care during intra-theater transport on non-AE platforms as that provided by our CCATT teams. Our first deployed team safely transported 130 critical patients on rotary aircraft. The team is composed of an emergency physician and two nurse anesthetists that separate and fly individually with a pararescue Airman or 68W to move the sickest patients. We are now able to move critical patients between Level II and Level III facilities in theater even more expeditiously, using either rotary or fixed wing aircraft.

The Theater Medical Information Program Air Force continues to make tremendous progress supporting the war-fighting community both on the ground and in the air. We leveraged existing information management and technology services to integrate with Line of the Air Force communication groups at all deployed Air Force ground-based units. This decreased end user devices, numbers of personnel at risk, and contractor-support requirements in theater. This integration allowed us to remotely support deployed units from state-side locations for the first time and with improved timeliness. Today, AFMS units are documenting all theater-based

patient care electronically, including health records within the air evacuation system, and securely moving information throughout the DoD healthcare system.

Build patient-centered care

At home, we continue to advance Patient-Centered Medical Home (PCMH) to improve delivery of peacetime healthcare. The foundation of patient-centered care is trust, and we have enrolled 920,000 beneficiaries into team-based, patient-centered care. Continuity of care has more than doubled with patients now seeing their assigned physician 80% of the time and allowing patients to become more active participants in their health care. PCMH will be in place at all Air Force Medical Treatment Facilities (MTFs) by June of this year. The implementation of PCMH is decreasing emergency room visits and improving health indicators.

We have also implemented pediatric PCMH, focused on improving well child care, immunizations, reducing childhood obesity and better serving special needs patients. A recent American Academy of Pediatrics study analyzed the impact of medical home on children. Their report concluded, "Medical home is associated with improved health care utilization patterns, better parental assessment of child health, and increased adherence with health-promoting behavior." We anticipate completing Air Force pediatric PCMH implementation this summer through simple realignment of existing resources.

Our PCMH teams are being certified by the National Committee for Quality Assurance (NCQA). NCQA recognition of PCMH is considered the current gold standard in the medical community, with recognition levels ranging from 1-3, 3 being the highest. To date, all MTFs who completed evaluation were officially recognized by NCQA as a PCMH, with 10 sites

recognized as a level 3. This level of excellence far exceeds that seen in the nation overall. An additional 15 Air Force sites will participate in the NCQA survey in 2012.

We are enabling our family health care teams to care for more complex patients through Project ECHO (Extension for Community Healthcare Outcomes). This program started at the University of New Mexico to centralize designated specialists for consultation by local primary care providers. ECHO allows us to keep patients in the direct care system by having primary care providers "reach back" to designated specialists for consultation. For example, rather than send a diabetic patient downtown on a referral to a TRICARE network endocrinologist, the primary care team can refer the case to our diabetes expert at the 59th Medical Wing, Lackland AFB, Texas, without the patient ever departing the clinic. ECHO now includes multiple specialties, and has been so successful, the concept has been adopted by the Mayo Clinic, Johns Hopkins, Harvard, DoD, and the VA.

Our personalized medicine project, Patient Centered Precision Care (PC2), which builds on technological and evidence-based genomic association, received final Institutional Review Board approval. We enrolled the first 80 patients this year with a goal of enrolling 2,000 patients in this research. PC2 will allow us to deliver state-of-the-art, evidence-based, personalized health care incorporating all available patient information. A significant aspect of PC2 is genomic medicine research, the advancement of genome-informed personalized medicine. With a patient's permission, we analyze Deoxyribonucleic Acid (DNA) to identify health risks and then ensure follow up with the health care team. De-identified databases will allow us to advance research efforts. Research groups can determine associations or a specific area where they think there may be merit in terms of how we can change clinical practice. This research

will likely change the way we view disease and lead to much earlier integration of new treatment options.

MiCare is currently deployed to our Family Practice training programs and will be available at 26 facilities before the end of 2012. This secure messaging technology allows our patients to communicate securely with their providers via email. It also allows our patients to access their personal health record. Access to a personal health record will provide the ability to view lab test results at home, renew medications and seek advice about non-urgent symptoms. Healthcare teams will be able to reach patients via MiCare to provide appointment reminders, follow up on a condition without requiring the patient to come to the MTF, provide medical test and referral results, and forward notifications on various issues of interest to the patient. We anticipate full implementation by the end of 2013.

We are also testing incorporation of smart-phones into our clinics to link case managers directly to patients. Linking wireless and medical devices into smart phones allows the patient to transmit weight, blood pressure or glucometer readings that are in high risk parameters directly to their health team for advice and consultation. Patients with diabetes or congestive heart failure can see significant reductions in hospitalizations when interventions with the health care team are easily accessible on a regular basis. This improves quality of life for the diabetic or cardiology patient, reduces health care costs, and increases access for other patients. We have a pilot effort underway with George Washington University Hospital to use this tool in diabetes management.

Safeguarding the well-being and mental health of our people while improving resilience is a critical Air Force priority. We remain vigilant with our mental health assessments and

consistently have Post-Deployment Health Reassessment completion rates at 80 percent or higher for Active Duty, Guard and Reserve personnel. In January 2011, we implemented Section 708 of the 2010 National Defense Authorization Act for active duty Airmen, and in April 2011, for the Reserve Component. The two-phased approach requires members to complete an automated questionnaire, followed by a person-to-person dialogue with a trained privileged provider. Whenever possible, these are combined with other health assessments to maximize access and minimize inconvenience for deployers. Each deployer is screened for post-traumatic stress disorder (PTSD) four times per deployment including a person-to-person meeting with a provider.

Although Air Force PTSD rates are rising, the current rate remains low at 0.8 percent across the Air Force. Our highest risk group is explosive ordnance disposal at about 7 percent, with medical personnel, security forces, and transportation at less risk, but higher than the Air Force baseline. Our mental health providers, including those in internships and residencies, are trained in evidence-based PTSD treatments to include Prolonged Exposure, Cognitive Processing Therapy and Cognitive Behavioral Couples Therapy for PTSD. "Virtual Iraq/Afghanistan" uses computer-based virtual reality to supplement Prolonged Exposure Therapy at 10 Air Force sites. Diagnosis is still done through an interview, supported by screening tools such as the PTSD Checklist (PCL) and other psychological testing as clinically indicated.

We are working closely with Air Force leadership to inculcate healthy behaviors. Comprehensive Airmen Fitness focuses on building strength across physical, mental and social domains. Airman Resiliency Training (ART) provides a standardized approach to pre-exposure preparation training for redeploying Airmen, including tiered training that recognizes different

risk groups. Traumatic stress response teams at each base foster resiliency through preparatory education and psychological first-aid for those exposed to potentially traumatic events.

The Deployment Transition Center (DTC) at Ramstein AB, Germany, soon to be 2 years old, provides an effective reintegration program for our redeploying troops. More than 3,000 deployers have now processed through the DTC. A study of the first 800 Airmen to go through the DTC, compared with 13,000 Airmen matched to demographics, mission set, and level of combat exposure, demonstrated clear benefit from the DTC. Analyzing their PDHRAs, Airmen who attended the DTC showed positive results -- significantly fewer symptoms of Post Traumatic Stress, lower levels of alcohol use, and lower levels of conflict with family/coworkers. This study provided solid evidence that the DTC helps Airmen with reintegration back to their home environment. We are now partnering with the RAND Corporation in two other studies, looking at the overall Air Force Resilience Program and studying the effectiveness of the current ART program.

While we experienced a drop in the active duty suicide rate in 2011, we remain concerned. Guard and Reserve suicide levels have remained steady and low. The major risk factors continue to be relationship, financial and legal problems, and no deployment or history of deployment associations have been found. We strive to find new and better ways to improve suicide prevention efforts across the Total Force. By summer of this year, we will embed behavioral health providers in primary care clinics at every MTF. The Behavioral Health Optimization Program reduces stigma by providing limited behavioral health interventions outside the context of the mental health clinic, offering a first stop for those who may need counseling or treatment. The Air Reserve Components instituted on-line training tools and products that support ACE (Ask, Care, Escort), our peer-to-peer suicide prevention training. The

Air Force Reserve Command also added a new requirement for four deployment resilience assessments beginning last April.

We are increasing our mental health provider manning over the next 5 years with more psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and technicians. We increased Health Professions Scholarship Program (HPSP) scholarships for psychologists, as well as psychiatry residency training billets and the psychology active duty PhD program and internship billets. To enhance social worker skills, we placed social workers in four internship programs and dedicated HPSP scholarships and Health Professions Loan Repayment Program slots for fully qualified accessions. Accession bonuses for fully qualified social workers were approved for FY12 for 3- and 4-year obligations. These actions will help us to meet mental health manning requirements for both joint deployment requirements and at home station in compliance with Section 714 in the 2010 National Defense Authorization Act. Air Force tele-mental health is now in place at 40 sites across the Air Force, and is planned for a total of 84 sites..

Like our sister Services, the Air Force continues to be concerned about, and focused on, the consequences of traumatic brain injury (TBI). We fully implemented TBI testing across the Air Force, and collected more than 90,000 ANAM assessments in the data repository. The Air Force accounts for 10-15 percent of total TBI in the military with approximately 4 percent of deployment-associated TBI. Most Air Force cases, more than 80 percent, are mild in severity. Of all our completed post-deployment health assessments and reassessments, less than 1 percent screened positive for TBI with persistent symptoms.

Despite our relatively lower incidence, the Air Force continues to work with DoD partners to better understand and mitigate the effects of TBI. In collaboration with Defense and Veterans Brain Injury Center, Air Force and Army radiologists at the San Antonio Military Medical Center (SAMMC) are working jointly to study promising neuroimaging techniques including volumetric MRI using the FDA-approved software NeuroQuant, functional MRI, spectroscopy, and diffusion tensor imaging to identify structural changes that may result from TBI. Ongoing studies will find more definitive answers to this complex diagnostic and treatment problem..

As co-chairman of the Recovering Warrior Task Force, I have come to understand all Services Wounded Warrior Programs. I have been on site visits with our committee as we seek to discern best practices to help our wounded, ill and injured members recover. The joint efforts of DoD and the Department of Veterans Affairs to streamline the Integrated Delivery Evaluation System (IDES) are paying dividends. In the Air Force, we are augmenting pre-Medical Evaluation Board (MEB) screening personnel to streamline IDES processing. Our electronic profile system gives us full visibility of those in the process and close coordination with the VA is reducing the time to complete the IDES processing.

Invest in Education, Training and Research

Providing "Trusted Care Anywhere" requires our people to have the best education and training available to succeed in our mission. We strive to find new and better ways to ensure our Airmen not only survive but thrive.

This is the goal of the Medical Education and Training Campus (METC), and it truly is a joint success story. METC has already matriculated 10,000 graduates from the Army, Navy and Air Force, and now has numerous international students enrolled. The majority of the Services' education and training programs have transferred to METC, and the remainder will transfer during the course of this year. The Institute for Credentialing Excellence (ICE) awarded METC the ICE Presidential Commendation for the pharmacy technician program and praised it as being the best program in the United States.

Air Force graduate medical education (GME) programs continue to be the bedrock for recruiting top-notch medics. Since the 1970s, many of our GME programs have been affiliated with renowned civilian universities. These partnerships are critical to broad-based training and build credibility in the U.S. and international medical communities. GME residencies in Air Force medical centers develop graduates who are trained in humanitarian assistance, disaster management, and deployment medicine. National recognition for top quality Air Force GME programs improves our ability to recruit and retain the best. First-time pass rates on specialty board exams exceeded national rates in 26 of 31 specialty areas, and stand at 92 percent overall for the past 4 years.

Over the next few years, we will transform training to support new assets in air evacuation and expeditionary medical support. Flight nurse and technician training and AE contingency operations training curriculums have been entirely rewritten to capture lessons from 10 years of war. The Centers for Sustainment of Trauma and Readiness Skills – C-STARS – in Baltimore, St. Louis and Cincinnati, have been extraordinarily successful in maintaining wartime skills. We have expanded training sites to establish sustainment of traumas skills -- Sustainment

of Trauma and Resuscitation Skills Programs (STARS-P) -- to University of California Davis, Scottsdale, University of Nevada- Las Vegas, and Tampa General Hospitals. This will include greater use of simulation at C-STARS, STARS-P, and other Air Force medical sites. We have many testimonials from deployed graduates who credit their competence and confidence in theater to C-STARS and STARS-P training. We will continue efforts to expand this training so we will have full-up trauma teams and Critical Care Air Transport teams that are always ready to go to war.

One of our most significant partners in GME and resource-sharing is the Department of Veterans Affairs. We are proud of our six joint ventures, 59 sharing agreements and 63 Joint Incentive Fund (JIF) projects, all win-wins for the military member, veteran and American taxpayer. All four Air Force JIF proposals submitted for FY 2012 were selected. These include a new CT Scan at Tyndall AFB, FL, that will also benefit the Gulf Coast VA Health Care System; establishment of an orthopedic surgery service for Mountain Home AFB, Idaho, and the Boise VAMC; funding for an additional cardiologist at Joint Base Elmendorf-Richardson and the Alaska VA Health Care System – critical to reducing the number of patients leaving our system of care; and an ophthalmology clinic at Charleston with the Naval Health Clinic Charleston and the Charleston VA Medical Center. The JIF program is extremely helpful in supporting efficiencies that make sense in the federal government, while improving access to care for our beneficiaries.

Collaboration with the VA in the Hearing Center of Excellence (HCE) continues as we pursue our goals of outreach, prevention, enhanced care, information management, and research to preserve and restore hearing. Compounding hearing loss related to noise, the effect of

improvised explosive devices (IEDs) that military personnel experience in Iraq and Afghanistan expands the threat and damage to the audiovestibular system. Traumatic brain injury may damage the hearing senses and the ability to process sound efficiently and effectively. Dizziness is common, and almost half of service members with TBI complain of vertigo following blast exposure.

We are coordinating and integrating efforts with the other congressionally mandated centers of excellence to ensure the clinical care and rehabilitation of the nation's wounded, ill and injured have the highest priority. Partnering with the Defense and Veterans Eye Injury Registry has resulted in the Joint Theater Trauma Registry adding ocular and auditory injury modules to look at the effect and relation eye and ear injury has on TBI and psychological health rehabilitation. And the Vision Center of Excellence under Navy lead and HCE have contributed to the planning, patient management, and clinical guidelines with the National Intrepid Center of Excellence, the Center for the Intrepid, and within the Institute of Surgical Research.

We have expanded our research with the opening of the new School of Aerospace Medicine at Wright Patterson and our collaborative efforts with the Army in the San Antonio Military Medical Center. The 59th Medical Wing at Lackland AFB, Texas, is using laser treatment to improve range of motion and aesthetics in patients with burn scars. In the 10 subjects enrolled to date in the research, the laser treatments have resulted in an immediate reduction in scar bulk, smoothing of irregularities, and the production of scar collagen. The scars have also shown improved pliability, softness and pigmentation. This is encouraging for our wounded warriors and Service members who have received thermal or chemical burns.

Another promising laser initiative is the Tricorder Program, a collaboration effort with the University of Illinois, Chicago, designed to detect/characterize laser exposure in "real time," assisting in the development of force health protection measures, such as laser eye protection. Air Force and Navy testers evaluated the prototype laser sensors in simulated air and ground field environments. An upcoming exercise with the FBI Operational Technology Division will assess the laser sensor for forensic capability in a domestic aircraft illumination scenario.

Another collaborative effort, with the Department of Homeland Security, is the development of an environmental/medical sensor integration platform that provides real-time data collection and decision support capability for medical operators and commanders, integrating environmental and medical sensor data from the field into a hand-held platform. The sensor integration platform was demonstrated successfully several times, including its deployment for environmental monitoring capability with the Hawaii National Guard, where the platform quadrupled Hawaii's radiation monitoring capability after the tsunami in Japan. It is now the backbone of Hawaii's state civil defense system real-time environmental monitoring capability.

The U.S. Air Force School of Aerospace Medicine (USAFSAM), Wright-Patterson AFB, Ohio, developed the Cone Contrast Test (CCT) for detection of color vision deficiency. The CCT was selected as a winner of the 2012 Award for Excellence in Technology Transfer, presented annually by the Federal Laboratory Consortium to recognize laboratory employees who accomplished outstanding work in the process of transferring a technology developed by a federal laboratory to the commercial marketplace. The technology was developed by vision scientists in USAFSAM's Aerospace Medicine Department and uses computer technology to

replace the colored dot Ishihara Plates developed in the early 1900s. The CCT indicates vision deficiency type and severity, and can distinguish hereditary color vision loss from that caused by disease, trauma, medications, and environmental conditions – ensuring pilot safety while facilitating the detection and monitoring of disease.

The Way Ahead

I look back 10 years to 9/11 and marvel at how far we have come in a decade. While sustaining the best battlefield survival rate in the history of war, we have simultaneously completed complex Base Realignment and Closure projects, and enhanced our peacetime care worldwide. We changed wartime medicine by moving the sickest of the sick home to the United States within 3 days, while shifting one million enrolled patients into team based, patient centered care that improved continuity of care 100 percent. One thing has not changed…the talent, courage, and dedication of Air Force medics still inspires me every day! As I retire later this year, I know that I leave our Air Force family in exceptional hands. Air Force medics will always deliver "Trusted Care, Anywhere" for this great nation.

The AFMS will work shoulder to shoulder with our Army, Navy and DoD counterparts to be ready, and provide better health, better care, and best value to America's heroes. Together we will implement the right governance of our Military Health System. We will find efficiencies and provide even higher quality care with the resources we are given. I thank this Committee for your tremendous support to military medics. Our success, both at home and on the battlefield, would not be possible without your persistent and generous support. Thank you!

REMARKS OF CHAIRMAN YOUNG

Mr. YOUNG. General, thank you very, very much.

I told you, General, that I wanted to make a comment on your statement about miracles. If you remember a few years back, Walter Reed got beat up in the media because of that Building 18 issue that really had nothing to do with medical care, and I got beat up because I wouldn't join in the chorus condemning Walter Reed because I made the point numerous times that at Walter Reed and at Bethesda, I personally, not being a medical expert, but I personally have seen what I consider to be miracles happen at both of those hospitals. And I can cite examples, I can cite the patients, I can cite the doctors who performed these miracles, and I suspect that God's hand was with them. Otherwise some of these soldiers and marines might not have made it.

But there was one marine that was given up for dead, the family left the hospital, went home to prepare the final arrangements for their son, and this one doctor said, I am not going to let this kid die. And he tried something that I think maybe today is still a little bit unorthodox, but he saved the kid.

I was surprised a few months later when a police officer walked into my office in Washington and he said, you don't remember me, do you? I said, no, I don't. He said, well, I am the one they gave up for dead and I am the one that they brought back to life. I am the miracle. So he survived, he went on to go to the police academy and he is serving today as a patrolman in the City of New York. So that is just one of the miracles that I think I have witnessed there at the hospitals.

Anyway, I told President Bush right after 9/11 when, of course, we all huddled together quickly to do what we had to do to recover, to respond, and I said, Mr. President, when we go into this war, you are going to find out that our warriors are going to be hurt bad. Because of the great advances in military medicine, the new medicines, the new training, the ability to have corpsmen and medics who are more capable than ever, the ability to evacuate from the battle zone and just everything, the kids are going to live today who would have not survived in a previous war. The issue is they are going to be hurt worse, and it is going to require a lot to take care of them. And all of you have seen exactly what I am talking about, and all the Members of Congress that I can get to come see for themselves are amazed by the care and the treatment and the ability to save the lives of some of the quadriplegics who maybe will not have much of a life left, but, anyway, they are alive and their families still have them.

So this committee is prepared to do whatever we need to do to make sure that you have the adequate resources, whatever it is, supplies, personnel, whatever you need to make sure that these heroes are properly and adequately taken care of, so that they can get on about their life and receive the benefits that they really, really deserve and have earned with the sacrifices they made.

So, that is my preaching for the day.

I want to yield to Mr. Lewis.

Mr. LEWIS. Go to Mr. Dicks, Mr. Chairman.

Mr. YOUNG. Let me go to Mr. Dicks then.

MADIGAN ARMY MEDICAL CENTER

Mr. DICKS. Thank you very much, and, again, I want to commend the witnesses for their great service.

General Horoho, we have talked about this Madigan situation. Would you like to just give an overview of what you are doing and why you are doing it?

General HOROHO. Yes, sir. We found back in the September–October timeframe that we had 17 service members that came forward with concerns that their diagnosis was changed from a behavioral health diagnoses to one that was non-behavioral health after being reevaluated by our forensic psychiatry department out at Fort Lewis, Washington, and based on those concerns we offered them the opportunity for a reevaluation at Walter Reed National Military Medical Center, and then as they were being reevaluated we found that there was a brief that was provided by one of the forensic scientists that alluded to a focus on compensation and the cost of PTSD. So, because of that and some other concerns, I initiated an investigation to look at the climate and the practices and variance and to make sure that we were fairly treating our service members and providing them the best care possible. That investigation is ongoing.

We also initiated an IG assessment across all of Army medicine to make sure that we didn't have variance or systemic issues. That is still ongoing. Both of those should be completed shortly. In addition to that, when we got the results back from Walter Reed, we found that 12 out of 14 of the service members' diagnoses were reverted back to the original decision by Behavioral Health. So then we looked and evaluated every single service member that had gone through forensic psychiatry as a second evaluation going back to 2007, and that was about 1,600 service members.

When we relooked, there are 285 of those service members that had their diagnoses changed. Each one of those are going to be personally contacted and offered the opportunity to come back to be reevaluated. So currently that is where we are right now, sir.

Mr. DICKS. In the press there has been some insinuation that this is being done in a politically correct way. I know that is inaccurate. But I think what we are trying to do is to have it be done in a medically correct way so that there is not pressure for these people to have the decisions reversed, it is just review the decisions and make sure they are accurate. Isn't that correct?

General HOROHO. Yes, sir. But what we are looking at is one, to make sure that our service members received the best care possible, and we are also looking at variance. And across our processes, forensic psychiatry is not a good capability, it is not a bad capability, it is a capability. But it introduces variance into the Integrated Disability Evaluation System (IDES) process, and that is what is being evaluated as well.

Mr. DICKS. Also, and I was quite concerned about this, the closure of the intensive outpatient clinic at Madigan in 2010, and there was concern because a lot of people, and I know this is part of the investigation, but there was concern because a lot of people thought this was an extraordinarily effective program and was having a good result for the wounded warriors, and then the program

was canceled. So we are doing that investigation, and we are looking at Landstuhl, isn't that correct?

General HOROHO. Yes, sir.

OMBUDSMAN PROGRAM

Mr. DICKS. Because there were concerns raised there. Tell us about the Ombudsman Program. What are you doing on that?

General HOROHO. The Ombudsman Program is a program that started in 2007 in response to concerns of making sure that we had the ability for service members' voices to be heard with any concerns that they have. So we have over 50 ombudsmen that are working across Army medicine. They don't report to the chain of command. They actually report to me as the medical—well, Frank Berlingis is one level, and then it is to the MEDCOM commander. And it is a fair way to allow any concerns to be raised and to kind of look at resolution of issues at the lowest level.

Because of this occurring out at the Fort Lewis area and some concerns, I had an evaluation done to see if there was any concerns at Fort Lewis. And then we have also asked AAA, our Army Audit Agency, if they would please review the entire Ombudsman Program going back to 2007 to ensure that it is working in the way that we want it to be working. So that is ongoing as well.

Mr. DICKS. Well, we appreciate the way you have dealt with this problem and the fact that the Army, I think, is trying to be as fair as possible with these soldiers. What concerned Senator Murray and myself was the fact that some of these soldiers felt that the reversal of their diagnosis was not accurate. So we are pleased that you are doing this. I know it takes a lot of work and effort to get it done, but I think it will clear the air so the people will have a chance, if their evaluation was reversed, to have it reevaluated.

General HOROHO. Yes, sir.

Mr. DICKS. That is all I have today, Mr. Chairman. Thank you.

Mr. YOUNG. Thank you, Mr. Dicks.

Mr. Lewis, are you prepared?

POST TRAUMATIC STRESS DISORDER

Mr. LEWIS. I am, Mr. Chairman.

General Horoho, I have similar questions to Mr. Dicks' question. They are the result of some communication to me from my good friend Dr. Michael Walter, a retired Brigadier General from the U.S. Army who is currently employed as a gastroenterologist at Loma Linda University Medical Center. He brought to my attention the case of Colonel Dallas Homas at Madigan. Dr. Walter served and traveled with Dr. Homas in Afghanistan and knows him to be an outstanding soldier, physician and leader, whose highest priority is taking care of soldiers.

I specifically want to associate myself with the comments of Mr. Dicks, and I do appreciate your effort in connection with this very complex and difficult problem.

While not getting into the specifics of this case, I do have some questions about the manner in which PTSD is diagnosed throughout the U.S. military. Has MEDCOM published any guidance in diagnosing PTSD? General Horoho, do you have or have you ever en-

dorsed the use of forensic psychology testing in the evaluation process of PTSD diagnosis?

And further, my last question, while I know each case is different and unique, I would like to know if all the services feel it would be helpful to have general uniform guidelines in place in determining the diagnoses of PTSD?

General HOROHO. Thank you, sir. For the very first question, there are Department of Defense guidelines for diagnosing PTSD which each one of our services follows, so those guidelines have been in place and we are all consistent with following those. There is also uniform training for our providers across the Department of Defense.

Mr. DICKS. Would my friend yield? Are they the same? Is there a difference in how PTSD, post-traumatic stress disorder, is evaluated? Is it different for each service?

General HOROHO. I will speak just for the Army and then let my fellow Surgeon Generals speak to that—there is a common standard for diagnosing PTSD. There is the clinical judgment that is part of that, because it is not a hard science. So we do have standards, but we also have the clinical judgment of each provider that is providing that behavioral health care.

Mr. LEWIS. Please proceed.

FORENSIC PSYCHIATRY

General HOROHO. Thank you, sir. So we have those standards that are out there. The second question that I believe you asked is whether or not I have ever endorsed Forensic psychiatry. Forensic psychiatry stood up back in 2007. I took command of Madigan Army Medical Center in 2008, so this capability was in place.

What was ongoing at that time was in 2007 we were just standing up warrior transition units across the Army. We didn't have the Integrated Disability Evaluation System. So out West we were looking at using all of our behavior health assets to work with the backload of medical evaluations and providing behavioral health, and then we were also over those ensuing years developing a behavioral health system of care.

In 2010 the Department of Defense rolled out the Integrated Disability Evaluation System, which then took the compensation piece away from our providers and actually had that as one disability rating with the VA. So it took that friction point away.

Then regarding Colonel Homas, sir, there are a couple things. When we started the investigation, the chief of forensics was actually administratively suspended pending the investigation. The warrior transition surgeon was also administratively suspended pending the investigation; and then Colonel Homas was administratively suspended pending the investigation. And those are normal procedures when an investigation is ongoing.

Mr. DICKS. I think the point is that is not an aspersion on these officers, it is just that this is the way you do it during an investigation. So there is a good chance that they could all be cleared, or some of them could be cleared.

General HOROHO. Yes, sir. What we are doing right now——

Mr. DICKS. Are they being investigated?

General HOROHO. Sir, the command climate, the variance in the practice and why this deviation had occurred is all being looked at. It is a very comprehensive investigation, because the standard across Army Medicine is that we don't typically use forensics as part of the disability system once that stood up in 2010. So we are looking at all of that.

Mr. LEWIS. I am satisfied. Thank you, Mr. Chairman.

Mr. YOUNG. Okay, Mr. Lewis.

Mr. Frelinghuysen.

BATTLEFIELD EYE TRAUMA

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman. Good morning. All of us salute the work you do at home and abroad. It is remarkable how you get those from the battlefield, evacuate them from Bagram or in the past maybe from Balad in Iraq and get them to Landstuhl and get them home and the service that they get.

I would like to focus just for a few minutes on battlefield eye trauma. I know often the focus is on loss of limbs and remarkable things are done in terms of rehabilitation and prostheses, and TBI is a huge issue. But would one or more of you focus for a few minutes, I believe the VA has vision injuries as sort of the fourth largest injury component.

What are we doing in terms of investments in this area of research? It is pretty basic. I just wonder, what are we doing? What are you doing jointly or individually to meet these types of needs?

Admiral NATHAN. Thank you for the question, sir. I can speak to one arm of engagement, which is the Vision Center of Excellence which has been stood up. It is one of the four Centers of Excellence that is under the aegis of the Defense Center of Excellence umbrella portfolio. It exists at Walter Reed National Military Medical Center. It is being staffed as we speak.

Mr. FRELINGHUYSEN. So it exists now?

Admiral NATHAN. Yes, sir, it exists now. It has not reached its robust operating tempo yet as they are still staffing and hiring the requisite personnel. But it will not be a clinical entity, although it is proximal to the very large ophthalmology and optometry units at Walter Reed Bethesda. It is designed to be a clearinghouse and collating repository for the Department of Defense in eye injuries, eye trauma and eye care related to wounded warrior care.

Mr. FRELINGHUYSEN. So in the overall scheme of things, sort of translate for me, this is a priority? Certainly if it is the fourth largest combat injury, and we are not minimizing the others, is this a priority? Is it reflected in your funding?

Dr. WOODSON. Yes, sir, and there is approximately $15 million that is available for competitive research, so we are trying to make sure that we have the best of intramural and extramural research and partners to address this.

Mr. FRELINGHUYSEN. I ask the question because I think sometimes quite honestly, I have quite a lot of people visit my office on this issue and they don't feel that there is enough research going on, and often I think the statistics are sort of underreported. And even more alarming, Mr. Chairman, I hear somewhat anecdotally, and I would like your reaction, that there are reports that some of our troops have been—some eye damage has been caused by some

of our own forces, lasers, things from our own, shall we say, friendly fire. Would one or more of you comment often that issue?

Admiral NATHAN. Well, my comment would be, sir, that I am not aware of the specific numbers of these injuries.

Mr. FRELINGHUYSEN. So you are not aware of any of those that have suffered retinal damage or accidental exposure to these types? I wonder, because I just think if there is an issue there, how are we dealing with it?

Admiral NATHAN. I certainly wouldn't rule out that possibility, and perhaps my colleagues know of a more codified review, and the line operators may well have more information on that.

Mr. FRELINGHUYSEN. No one does it deliberately, but when you have choppers out there, you have fighters out there and they are providing close support, things happen. I just wondered if you could address it. General Green?

General GREEN. Sir, just so you know, we pay very close attention to this because of the potential injuries to our fliers, because it is a credible threat. So we have some research that goes on in terms of detectors, things that can actually tell us the wavelength and the power so that we know what the damage may be. There is a reporting system in the theater that actually captures laser eye injuries. A lot of this is worked through the School of Aerospace Medicine. I don't have a lot of details today, but I will be happy to bring back the details.

Mr. FRELINGHUYSEN. Certainly there is the vulnerability of pilots to all sorts of lasers. But I am talking about troops on the ground. If you don't have the information, would you be willing to focus on that for me? I would appreciate it. I think it is an issue, and if it should be part of some sort of a doctrine here—you are providing the air support, or the Army may be doing it too. I just think there are some issues here.

Admiral NATHAN. Sir, ideally the Visual Center of Excellence will be able to wrap its arms around all of the various——

Mr. FRELINGHUYSEN. Will you ask them to wrap their arms around that probability as well?

Admiral NATHAN. Yes, sir.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman.

[The information follows:]

The Air Force Medical Service is actively engaged in efforts to manage and counter the medical threat posed by lasers. In accordance with Department of Defense (DoD) Instruction 6055.15 (May 4, 2007), "The Secretary of the Air Force shall establish, administer and maintain the Tri-Service Laser Injury Hotline to provide immediate expert medical advice in the event of an injury or suspected injury to DoD personnel from lasers. The Secretary of the Army shall establish, administer and maintain the Laser Accident and Incident Registry for DoD Components and analyze data for use in laser safety, protection, and treatment programs."

The United States Air Force School of Aerospace Medicine at Wright-Patterson Air Force Base, Ohio operates the Tri-Service Laser Injury Hotline. A Laser Radiation Accident/Incident Reporting form is used to record all events. It has recently been revised and will be distributed along with a Laser Injury Guide that is also currently being updated.

In addition, the Air Force Surgeon General's Modernization Directorate has been engaged in research efforts to develop laser sensors that possess the capability to detect and characterize incident laser beams as well as assessing their potential eye hazard threat.

VISION RESEARCH PROGRAMS

Mr. YOUNG. Thank you, Mr. Frelinghuysen.

Mr. Moran.

Mr. MORAN. Thank you, Mr. Chairman, and I appreciate Mr. Frelinghuysen bringing that up. The subcommittee's concern has been that you continue to reduce peer-reviewed vision with the justification that the Center for Excellence is doing it, but we don't see the research component within the Center for Excellence. So that is what Mr. Frelinghuysen was getting at, and I share his concern that it is not the same kind of activity and we want to make sure that there is an ongoing research component. That is why the subcommittee put the money in.

Mr. FRELINGHUYSEN. Will the gentleman yield?

Mr. MORAN. Sure.

Mr. FRELINGHUYSEN. Can we ask the chairman whether you would help to assure that? Could you assure us that that would be part of this center?

Admiral NATHAN. Absolutely, sir. We will communicate directly to the VCOE.

Mr. FRELINGHUYSEN. Thank you for yielding.

PROPOSED SAVINGS INITIATIVES

Mr. MORAN. Very good. Now, my first question is with regard to cost sharing in the Defense Health Program. In 2000, as you know, the Pentagon spent $17.7 billion on medical benefits, and now we spend $44.3 billion, a 150 percent increase. So you have proposed things like coinsurance, copays and so on, that Federal employees currently pay in their health care coverage but that TRICARE beneficiaries don't. I know that those changes will not apply to active duty service members or their families.

But I was struck by your quote, Dr. Woodson, and I quote, "That given the constraints of the Budget Control Act, if no adjustments are made in TRICARE fees and we don't achieve more than $12 billion in savings over the 5–year defense plan, additional force structure cuts will need to be made." Would you amplify on that a bit, Doctor?

Dr. WOODSON. Yes. Thank you very much for that question. And just to create a context, before we even considered TRICARE fees, there were a number of initiatives and considerations taken. The initiatives to control costs really are multiple.

First of all, you know we are in a multi-year set of initiatives to control headquarters costs. Last year we removed 440 FTES from headquarters and by the end of this year we will have achieved removing 780 FTEs. We put in a number of management reforms that have yielded very positive results in reducing costs, including a robust fraud and recuperative program that has yielded $2.6 billion over the last 4 years, a pharmacy management program that has yielded $3.4 billion, medical supply and acquisition standardization yielding $31 million annually, other management efficiencies as it relates to, again, headquarters management, and the prospective payment system that yield about $1 billion annually. So we have been aggressively addressing the issue of costs.

But in the last year, the world has changed. There has been a global fiscal crisis, a national fiscal crisis, a reevaluation of bond ratings, the super committee and then the Budget Control Act. And under Title I of the Budget Control Act, the Department of Defense is required to achieve $487 billion in savings over 10 years, $269 billion over the FYDP.

The Secretary and senior line leadership in the Pentagon had to look at everything. Personnel and benefits costs are about a third of the budget, but the decision was made in fact that 90 percent of the savings would come from other areas, force structure, weapons programs, et cetera, and then only 10 percent would reflect personnel costs. In truth, the health care fee adjustments only represent 5 percent of the savings and, as you have correctly indicated, trying to achieve about $12 billion-plus over the FYDP.

When looking at what adjustments should be made, we went back to the 2007 Task Force on the Future of the Military Health Care Report to look at what we had done and what could still be done to achieve savings in health care costs. We looked at, there was somewhat I think about 12 separate initiatives, and we had made progress really on all except the recommendation to update retiree cost share. And what we did is we followed that formula, including the tiering. And that is how we arrived at the fee adjustments, and we spread it out over all of the programs so not one particular program would take maximum effect.

So we consider taking care of men and women who have committed to the defense of this Nation seriously and long term, but we had to create a structure that would ensure an enduring and sustainable program.

TOBACCO USE

Mr. MORAN. Well, thank you. My response was little more of an opening statement kind of response than I anticipated, but you stand by that statement that if we don't make adjustments to health care, it is going to show in the need to further reduce force.

I just had two follow-ups related to the original question. We have got a couple of areas where we really are not saving the kind of money we are outside the military. One is in smoking. Smoking among service men and women is twice as prevalent as it is outside the military. Two-thirds of those in deployed status are smoking and half started smoking after joining the military. So there is about a quarter of a million veterans who are going to develop a tobacco-related illness which is going to have to be paid for by TRICARE, which is an element of spending that we don't have in private insurance plans. That is correct, I gather?

Dr. WOODSON. Absolutely, sir, and thank you so much for bringing this up, because one of my priorities this year, one of the other broad buckets of how we are addressing health care costs, is moving from what we call health care to health, really creating population health which in the outyears will reduce costs. And one of the targeted areas for this year is smoking cessation, trying to create more smoke-free campuses and disincentives for smoking, bringing leadership, particularly senior enlisted leadership, into the campaign to reduce smoking among service men and women.

PRESCRIPTION DRUGS

Mr. MORAN. Well, that and the issue of drugs, in some cases over half of the money spent on drugs is wasted because we try to find the right drug and mix of drugs, and if we have got 300,000 returning veterans who have been given drugs to deal with PTSD and depression and traumatic brain injury and combinations, it is enormously expensive and it is not necessarily immediately effective. It is kind of a trial and error situation.

You can respond if you want. I know I am out of time though and I don't want to indulge on the chairman's leniency, but those are two areas I do think we need further focus. Thank you. Is there anything you wanted to say very quickly?

Admiral NATHAN. If I could just add, for example, one of the things we have just been able to obtain is relief from the provision that we had to sell tobacco products on our Navy facilities at reduced prices. So now that has been alleviated. Again, we are looking at every disincentive we can to have the service member take the path of least resistance, being to not smoke, to not use smokeless tobacco products. More of our hospitals are becoming smoke free and we are increasing access to smoking cessation programs in conjunction with pharmaceutical smoking cessation products.

General HOROHO. Sir, just to address that, in the overall movement towards health is we are looking at tobacco cessation, as well as sleep management, anger and alcohol abuse, all of those stress relievers that may have someone turn to smoking, and really look at it from a comprehensive perspective to increase their health.

Mr. MORAN. Good. Well, you are trying. Thank you.

Mr. YOUNG. Thank you very much, Mr. Moran. I appreciate your raising that issue, believe me. It is important.

Mr. Crenshaw.

CONGRESSIONALLY DIRECTED MEDICAL RESEARCH PROGRAM

Mr. CRENSHAW. Thank you, Mr. Chairman, and thank you all for being here. I wanted to ask a couple of questions about the congressional-directed medical research program. You all know that is a program that Chairman Young pioneered and it has made some tremendous breakthroughs in a lot of areas.

There is an area that I know you all have worked on, inflammatory bowel disease. I know a little bit about it because my daughter has suffered with it for about 12 years. It is interesting, when I go, we do a lot of advocacy work, and it seems like we will be at a large gathering, either raising money or raising awareness, and it seems like every time there is a situation, I will meet somebody in the military that has come up and said you know, I had IBD. I had to leave the military, or it caused a real problem. I think it affects about one out of every 200 people. People don't like to talk about it because it is about the digestive tract and all that kind of stuff.

But I think it is great that some of the money we have appropriated and I know you all have used, they don't know what causes it, they don't know how to cure it, but they are discovering some of the genetics aspects, and I think that is wonderful what you are doing. I wanted to ask you a couple of questions about that whole

program. Maybe touch on just a couple other success stories that you can talk about, number one.

Number two, talk about how you decide what areas to study? Is it more that it benefits the military or is it just research in general? And maybe talk about what is the difference between the research you do through the Department of Defense and what other research is done, say through Health and Human Services. Can you just talk briefly about those three items?

Dr. WOODSON. Well, first of all, let me thank you for the question and thank the entire committee and the Congress for supporting Congressionally-directed research programs. It is enormously important. Not only does it add value to military medicine but obviously American medicine by the advances that are made.

In regards to the specific program, what I would love to do is take your question for the record and give you specifics. But in general, of course, as you correctly indicated, no one knows exactly why this problem comes about and various treatment modalities have in fact been devised to address the symptoms depending on severity.

As it relates to men and women in the military, of course, we would love to pursue avenues in which they didn't have to take immuno-suppressive agents and then not be deployable and impact their career. So that is one avenue clearly that we want to address, is better strategies for care so that they can remain fully employable in the military. But I would love to take your question for the record.

[The information follows:]

Starting in 2008, the Department of Defense has supported research on inflammatory bowel disease. The research projects are part of the Congressionally Directed Medical Research Programs at the U.S. Army Medical Research and Materiel Command. Research in this area is by Congressional direction which distinguishes it from research on that topic conducted by other Federal agencies. From 2008 to 2010, eight research projects have been awarded and research is underway. In addition, there are four research awards in this area that are pending final approval. We look forward to providing significant contributions to the field of inflammatory bowel disease when these research projects conclude.

Mr. CRENSHAW. But in general, I am just curious how you decide, like when you decide to study disease, is it more just research in general, or do you look at a disease that might more directly impact military personnel?

Dr. WOODSON. Both. In some of the Congressionally-directed research programs, it is particular areas that Congress might be interested in that we pursue. But also, you know, our research portfolio is always driven by priorities affecting the military. So certainly after 10 years of war, a lot of our priorities are driven by the invisible and visible wounds of war and how to prevent those issues or make wounded warriors whole.

MEDICATION TO TREAT PTSD

Mr. CRENSHAW. Maybe just one more brief question. When we talked about PTSD, I have talked to some people but I guess it is a broad category and you have different symptoms and things like that. Do you all try to kind of gear, particularly when you are dealing with medication, is there one particular drug that is used in general, or are there specific drugs that deal with specific aspects

of that overall condition? Because I have heard some criticism sometimes that people say, well, I got PTSD, and they say take this drug and things will be fine, and it is maybe more complicated than that.

General HOROHO. Sir, I will answer that question. There is a lot of work that is being done with not just looking at providing medication, but actually looking at yoga and stress reduction, virtual reality and many different forums that we can actually try to help someone with their behavioral health and help them on the healing journey. So there are some medications that may work better than others for one individual and then may not be as effective on another individual.

So the Pain Management Task Force has stood up over the last 12 to 15 months, and we are really looking at it from a holistic perspective, from the behavioral health to pain management and to decreasing the stress using all different therapies that are out there.

Mr. CRENSHAW. But in the prescribing of medication, it is based on individual symptoms, not kind of one pill cures all?

General HOROHO. It is individual.

Mr. CRENSHAW. Got you. Thank you very much.

Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Crenshaw.

Mr. DICKS. He wanted to make a statement.

Mr. YOUNG. I am sorry.

General GREEN. I was going to contribute to the discussion so you hear it beyond a single service.

In the Air Force, we train all of our mental health providers in the diagnostics as well as the treatment. The actual treatment in terms of the evidence base for PTSD falls into two categories, which is the prolonged exposure training and the cognitive processing training, and it is not necessarily tied to any particular drug. So the drugs are always individually prescribed.

And the clinical diagnostics actually are the same as they would be in the civilian community. We do have DoD guidelines, but they draw heavily from the DSM and basically the guidelines that are put out for mental health providers to do this. So it is very standardized training. It is a clinical diagnose.

In terms of your research question, if I could contribute to that one, we put much more money, into things that affect, for instance, Aerovac or wartime skills. We put a lot more things into how do we track equipment; for instance, the RFID efforts that have been going on to make certain we can track things in the Aerovac system, get them back into the system, take care of the next patient. Also things like pre-hospital care to try and increase the survival rate, can we use new devices in addition to the tourniquets and some of the new dressings. Are there ways to use new things to stop bleeding.

So there are a lot of things that go into that. We have also reduced the ability to actually transport a patient on heart-lung machines so that we can take the sickest of the sick. So when you look at what we focus our efforts on, we do some research on just diseases that are common that affect the deployability, but the majority of our research is actually focused on wartime care.

Admiral NATHAN. If I could just add, I think it is critically relevant as far as post-traumatic stress, which is a syndrome, and post-traumatic stress disorder, which is a diagnosis that is clinically defined across the spectrum of the services and American healthcare that, we found the multidisciplinary approach is really the best. And whereas we used to take care of people sequentially, they would first see the psychiatrist, then the neurologist, then perhaps maybe somebody trained in complementary medicine such as acupuncture or manipulation. Now we find that if we can approach the patient and the patient's family in a multidisciplinary environment with all the medical specialists in tow and look at the patient in total, we get the best results. That is good news.

This is personnel intensive, though, because that requires a lot of resources at one time. So we are trying to model what we have learned in areas such as the National Intrepid Center of Excellence (NICOE) at Walter Reed Bethesda, a Center of Excellence for TBI and Post-Traumatic Stress, and we are branding that now and sending out what we have learned, those algorithms of care, to NICOE satellites in other places like Camp Lejeune, Fort Belvoir and other Navy and Army facilities.

Mr. YOUNG. Okay.

Mr. DICKS. Would the gentleman yield just briefly on this point?

Mr. YOUNG. I yield.

Mr. DICKS. Thank you. There was a story today in The New York Times, veterans with post-traumatic stress disorder are more likely to be prescribed opioid, I hope that is how you say it, painkillers than other veterans with pain problems and more likely to use the opioids in risky ways, according to a study published Wednesday by the Department of Veterans Affairs. The study, published by the Journal of the American Medical Association, also found that veterans returning from Iraq and Afghanistan who were prescribed opioids for pain, and particularly those with post-traumatic stress disorder, had a prevalence of adverse clinical outcomes like overdoses, self-inflicted injuries, and injuries caused by accidents or fighting.

Are you aware of this concern?

Dr. WOODSON. Yes, and thank you very much for bringing this issue up. We know that veterans and individuals, even civilians who have post-traumatic stress disorder, are at risk for other substance abuse, use of polypharmacy, and then being at risk for adverse events as a result of those medications that they take. And I think this study that was carried out actually confirms those suspicions, and it is why I think within the military as we try and advance our strategies for managing PTSD we are trying to move away from drugs and medication to alternative therapies and other strategies to reduce the PTSD symptoms.

General HOROHO. Sir, there has been a tremendous amount of work done over the past several years when we look at trying to move more towards wellness and prevention. So we have been using telebehavioral health in Afghanistan so we can early on provide behavioral health support in a deployed environment. We have got five touch points when our service personnel are redeployed back with behavioral health where they see a behavioral health provider face-to-face.

We have put in policies where if any service member is on four or more medications, one of them being opiates, that there is a clinical pharmacologist that actually reviews their records and works with the triad of care: the physician, the cadre member, and the nurse case manager. And then we have also put in a policy—because our concern was that when individuals may get medication from going to a dentist or someone else—that we have stopped the shelf life of the medication, so that it is 6 months and then it expires. We have limited it down to 30 days of supply so that we reduce the amount of drugs.

And then we also have a sole provider. When we have a concern of an individual that may be on an increased number of medications, we will then have one provider that monitors the medication that they get in the civilian sector as well as what they get in the military so that we make sure we are providing them the best oversight of care.

Mr. DICKS. Thank you.

AUTISM

Mr. YOUNG. Mr. Hinchey.

Mr. HINCHEY. Yes, thank you very much, Mr. Chairman, and thank you all very much. I just want to express my deep appreciation to everything you are doing, the complex circumstances that you are involved in, and the clarity of that is very, very much expressed in the responses that you provide for the questions that are asked of you here.

So I want to thank you for all your efforts in improving the lives of our service members and their families, and I would like to particularly applaud on some of the mental and behavioral health initiatives.

But there is one thing that I wanted to mention which seems to be also complicated, but is not really being dealt with effectively. I am sure that you know there is an estimated 20,000 military children suffering from autism and, based on the data that I have seen, these children are not receiving the level of care that they deserve and they are not receiving it really by a long shot. In the treatment of autism, early intervention and intensive behavioral therapy, including applied behavioral analysis therapy, are imperative to success, obviously, and I am sure you really know that and deal with these things very effectively.

ABA therapy is the most widely utilized treatment recommended by many national medical policy institutions. It is recognized as medically necessary in 29 States, but not under TRICARE. In fact, TRICARE segregates ABA therapy under the ECHO program, which is only available to active duty service members. And even the therapy available to active duty service members falls far short, providing only about 10 hours per week out of the 25 to 40 hours per week prescribed by doctors. In some areas, such as this place where we are, for example, Washington, D.C., it apparently only provides 5 hours. Dependents of military retirees are not eligible, and this also includes wounded warriors who are forced to retire medically. Imagine being wounded in Iraq or Afghanistan and forced to medically retire because of your injuries, and your child, the child losing his or her autism therapy.

We have an obligation to provide the health care needs of our military families. Policy changes are urgently needed to recognize the medical necessity of behavioral health treatment such as ABA and fund them appropriately. Military families who serve our Nation, as you provide for them, really deserve the best kind of treatment that they could get. And I know that is the basic kind of things that go about in so many things, but this is one thing that seems to me to be something that really needs to be more attention.

So can you comment on what is being done to ensure that all military children get the doctor-prescribed amount of therapy for autism?

Dr. WOODSON. Thank you very much for that question, and I appreciate your concern and support of service men and women who have children who may be afflicted with this condition. Part of the issue for us is that it is not an issue of a policy change, but it is an issue of a statute change. As it turns out, ABA is not considered a medical treatment, but an educational intervention for the management of autism, and we currently provide about $36,000 a year in benefits for active duty service members for dependents who have this condition. As you have correctly outlined, once they retire, because of statutes again, we cannot provide that care.

So the issue is not—and then we are statutorily prohibited from providing this service under TRICARE except through the vehicle of the ECHO program, which I have just signed an extension of that program until we can figure out how to do this. It is not a policy issue. In many cases, it is under an educational benefit.

Mr. DICKS. What is the ECHO program?

Dr. WOODSON. It is the Exceptional Care Program—let me get you the right acronym. But it is an exceptional care program that allows us to extend these benefits for certain conditions in which perhaps the medical proof is not there, but it seems reasonable to provide certain care. But in this case the issue is that it is considered an educational intervention, not a medical intervention, and so we are limited to providing reimbursement for it under TRICARE.

[The information follows:]

The Extended Care Health Option (ECHO) is a supplemental program to the TRICARE Basic Program and provides eligible Active Duty Family Members (ADFMs) with additional financial resources for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. ECHO is established in law at Section 1079(d)–(f) of Title 10 of the United States Code. The ECHO is not an enrollment program but does require registration. TRICARE ECHO provides financial assistance only for active duty family members with specific qualifying mental or physical conditions, including:

- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability
- Extraordinary physical or psychological condition causing the beneficiary to be homebound
- Moderate or severe mental retardation
- Multiple disabilities
- Serious physical disability

ECHO provides benefits not available through the basic TRICARE program, such as coverage for:

- Assistive services (e.g., those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance

- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Medical and rehabilitative services
- In-home respite care services (Can only be used in a month when at least one other ECHO benefit is being received)
- Training to use assistive technology devices
- Institutional care when a residential environment is required
- Special education (does not include tuition for a beneficiary to attend private school)
- Transportation under certain circumstances
- Other services that the Director of TMA determines are capable of reducing the disabling effects of a qualifying condition, such as ABA services for eligible beneficiaries with a diagnosis of ASD.

Mr. HINCHEY. Well, I express appreciation for your response, because apparently this is something you are deeply concerned about and you are doing everything you can to correct it and make it much better. So thank you very, very much, much. I appreciate it and I appreciate everything you are doing. Thank you very much.

MILITARY HEALTH SYSTEM GOVERNANCE REVIEW

Mr. YOUNG. Mr. Hinchey, thank you very much. My turn.

The chairman has to produce a markup bill to the subcommittee and get as much for our national defense as possible with the dollars that we are going to have available. In order to do that, we have to really tighten up where we can tighten up, but we want to make sure that we don't over tighten in places like medical care or taking care of our wounded heroes.

Now, in view of that, I am going to open a subject, and I want to assure you this is not a rerun of the February 8th hearing where we sort of dissected the JTF CapMed. That is not my intention. But I do have a question that I think relates to money and the good use of money. I have two questions on the subject.

One is, when the JTF was created, it was intended to help facilitate the merger of the two flagship hospitals of international excellence, Walter Reed and Bethesda, and that merger is now complete. But the JTF appeared to be another layer of governance over, in addition to, what we already had and what we have worked with for many, many years. So I am concerned about that. And there is considerable cost to JTF CapMed, but I know there are going to be some changes, and that is why we are not going to dissect it again.

But here is my question: There was another joint task force that was created to consider what the new system of governance should be in the capital region. There were six options. My question, Dr. Woodson, would go to you, because I think it was at your level where these decisions were made.

Mr. YOUNG. There were nine voting members. Five of the members of that task force voted for the same option. None of the other options got five votes. However, the majority Option was not chosen. And I am curious. In view of the task force that the Defense Department created, the recommendation that they made that was supported by the task force was basically ignored. And I am wondering why.

Dr. WOODSON. Thank you, Chairman Young, for the question and, again, for your support of the men and women in the military health system.

To address your question specifically, the purpose of the task force was to present options to the Deputy Secretary for reorganizing the military health system governance. And the task force, as you correctly pointed out, presented a set of recommendations with the voting, as you have indicated, but there was a second layer of consideration that involved senior leaders in the Department of Defense with line leadership, where they vetted the options; and out of that process—so a group of recommendations were presented—the decision was that the best way to proceed was with the Defense Health Agency and the recommendations that the Deputy Secretary came out with.

So it wasn't that they were ignoring what they presented. Their task was to present a set of recommendations and then that second level review with the line leadership then produced the final proposals for the MHS governance restructure.

So that doesn't come out I think when you read the initial task force report because you see the work that the task force did in sort of racking and stacking the options that were considered. But there was a second level review by the senior leadership and line leadership to say, well, what is the best way to go? And remember, the issue of cost was considered, but also the issue of ease and implementation and the possibility of what would be left open to do in the future. So what I mean by that is, we are presently involved in a war, and to try to take the departments apart, let's say, and create a unified medical command seemed to be an onerous task.

But any concept, let's say, of a unified medical command would require the building of a Defense Health Agency, because we have to deal with garrison care and the TRICARE insurance program and other shared entities. So when all of these options and issues were considered, it was decided that a Defense Health Agency with enhancement of the multiservice market managers would be the most appropriate way to go because it didn't stop us from doing other things down the road, and it didn't cause such disruption in the organizational scheme at the time when we are trying to deliver care in wartime. It just seemed to be the prudent way to go. So there was another layer of analysis that went on, sir.

Mr. YOUNG. Doctor, the Army's representative on that task force and the Navy's representative on that task force—and those are the two organizations that have to provide the medical care—supported the majority option. They did not support the other options. So tell me what in the wisdom of the Pentagon—tell me, how does the new system of governance, the extra layer of governance, as I see it—I may be simplifying that. But I see it as an extra layer of governance over and above the Army and the Navy that have done this for years. What will that extra layer of governance do to enhance what these surgeons general and their medical professionals are going to do to protect our kids? What will it do to enhance the medical care?

Dr. WOODSON. I think it will bring better command and control and coordination to the National Capital Region and oversight for the two new joint facilities, Walter Reed National Military Medical Center at Bethesda and the Fort Belvoir community hospital. Plus it will act as the multiservice market area management command authority. So in essence, it doesn't add another layer.

If you look at San Antonio, where you have more than one service operating in the area, you still have to establish a multiservice market manager which requires personnel to effectively develop the business plan for the areas. The Joint Task Force CAPMED in reduced form—so it is not going to exist the way it does now.

Mr. YOUNG. I do understand that, yes.

Dr. WOODSON. It will be downsized—will provide that oversight, develop the business plans for the National Capital Region, which is really a complicated market in and of itself. So I think you need that command and control. And then when you have two joint entities, you have to have a command structure to effectively command and control the joint entities.

Mr. YOUNG. But Doctor, if this is such a good idea, why aren't we doing it worldwide at all of our military installations, hospitals, clinics? If it is so good in the Washington, D.C., area, why isn't it good for somewhere else?

Dr. WOODSON. That is also a very good question. Again, I think it gets back to the point I was trying to make before, that if you believe that, let's say, a unified medical command is the ultimate option, in order to do that, to create that, number one, I think it would be a more expensive option, which I think the report to Congress points out the number of FTEs you have to add to this four-star headquarters. Could we do that now in the fiscal environment that we are now in?

But more importantly, the issue is that this is an iterative approach, a sequential, reasonable approach to producing greater unity of effort, greater efficiency, particularly in those shared entities, without causing major disruption at this time. It doesn't prevent us from dealing with other things if the time becomes right or the conditions become right to do those things.

So I think this is a responsible iterative approach that allows us to manage the transition to greater collaborative joint processes, develop common business plans, common clinical plans, manage the shared interests, like IT pharmacy, graduate medical education, medical education research, much more effectively without causing a major disruption that might make us weaker for a period of time.

Mr. YOUNG. When will this new plan be effective?

Dr. WOODSON. So Mr. Chairman, as you know, under the NDAA, we have got a prohibition from instituting any restructuring until the GAO has had 180 days to consider the proposal and then Congress has another 120 days to reflect upon it. So we have a minimum, what, of around 300 days or so that we cannot do any implementation. I would just point out, though, that considering all of the things that the members have brought forth today and all of the considerations that are ongoing, we clearly needed to do some things to enhance the joint approach to, again, these shared services. That is imperative, absolutely imperative for securing the future of the military health system and its sustainability. So we fully appreciate the involvement of the Congress in analyzing our proposals, but it is the Department's position that this is the responsible iterative way forward that will produce the maximum efficiency with the least disruption.

Mr. YOUNG. Well, let's hope. Let's hope.

Let me ask the surgeons general, is there any uncertainty where you work because of the delay? And Congress has required the delay, so we understand that. But is there any uncertainty now waiting for that time to run out before the new governance actually becomes effective?

Admiral NATHAN. Mr. Chairman, I think that the only prong of the task force recommendations and the Deputy Secretary's plan is in the National Capital Region, which currently enjoys a little bit of ambiguity in command and control. The two facilities, Walter Reed—Bethesda Walter Reed, were under a BRAC process. And by charter of the Deputy Secretary of Defense a JTF was stood up to complete the BRAC process and to provide integrated care in the National Capital Region. So the Services have retained administrative control. The Navy retains administrative control over Bethesda and the Army over Belvoir. Operational control and tactical control rests in the Joint Task Force (JTF). It works currently directly for the Deputy Secretary of Defense. I believe the task force, one of the reasons it was assembled, was to try to find a better command and control venue for those facilities, for those flagship facilities.

And so your recommendations, when they are put into effect, will completely remove the services, those two facilities, as well as the other National Capital Region facilities, from the Service oversight. They will no longer be Navy facilities or Army facilities or Air Force facilities, in the case of Malcolm Grove.

That is somewhat different than the other—in reference to your previous question—as to the other markets throughout the country, whereas the services will retain control of those facilities. San Diego will remain a Navy facility but will have an enhanced multiservice market management role to oversee care for all the Services in the area. Madigan in the Northwest; Brooke down in San Antonio.

But the National Capital Region has been given a different twist in that there will be a medical directorate placed over it, presumably a migration of what JTF is now, which will report to the Assistant Secretary of Defense, the Under Secretary of Defense and then to the Deputy Secretary of Defense with oversight to the Defense Health Agency. So the big difference being that the facilities in the National Capital Region will be under the control of the Defense Health Agency, whereas the remaining facilities throughout the world will be under the control of the Services.

Mr. YOUNG. I will let the others respond to that if you like. But let me ask a follow-up question there: Is this a test case? Is this an opportunity to test this system to see if you want to expand it throughout the entire system? Or is this just something for the Capital Region? And if it is only for the Capital Region, if it is good for the Capital Region, why isn't it good for everybody else? And if it is not good for everybody else, why is it good for the Capital Region? I am just having a little bit of trouble. In my own mind, I see additional—I know there are additional costs.

We questioned the Director of the Joint Task Force about the additional costs and the cost versus investment versus return. We didn't get any answers. So we are using our own processes. We will have those answers very shortly. And you all will be contacted with our people that are running that down.

But please, Generals, if you have any comment you would like to make on the same issues.

General HOROHO. Mr. Chairman, in an attempt to answer the question that you have asked, I believe that it will give a comparison of the effectiveness of the structure and the processes that are used in the National Capital Area with the structures and the processes that will be used for these enhanced multiservice market areas. And then over the years, to evaluate which one is more effective in patient outcomes, decreasing costs and increasing in efficiencies.

General GREEN. And, sir, I think there is work to be done to actually establish—there is actually a task force that will be working while the Congress is looking at this to see exactly what the Defense Health Agency's authorities will be and how things will be aligned to try to save costs and figure this out. The 300-day delay, as you folks look at it, delays the implementation for probably—I mean, realistically, if you approve the guidance that has come out of the Department, my guess is, the first time they would reach an initial operating capability would be October of possibly 2013, if you think it through. So in terms of whether this is a pilot or—I think it was something that was put together essentially to get us through a very difficult, very large hospital—two large hospital systems integration. And the difficulty that we have now is—and honestly the biggest problem with the 300 days is, there will continue to be ambiguity in terms of what the actual guidance is at each of the hospitals. So the Joint Task Force (JTF) clearly will still have the authority, but there still remains the problem that there is not joint credentialing nor joint nursing policy nor joint patient administrative policy in terms of how you would run a hospital because we do that by service.

And so that ambiguity will continue. We have had some of that ambiguity over the last couple of years, as we stood up the JTF. So I don't know that it will stop. I don't think it will affect the quality of care because we have been working to basically solve these things. But until there is a joint execution or a joint policy evolution, if you will, on how we would do this, it is going to continue to be a problem. And that is part of what has to be done with this DHA setup as well.

Mr. YOUNG. Well, General, I think you hit the nail right on the head. And as Admiral Nathan knows, my wife and I visit our wounded soldiers and Marines a number of times each week. And as we inquire, we find that the wounded kids—they are not kids anymore by the time they get there, by the way. But they believe they are getting excellent medical care, which is good. And I agree with that. I think they are getting excellent medical care. But we don't need the uncertainty that goes with the ambiguity, as you pointed out. And I know that you all will be able to work this out. Whatever has to be worked out, you will work it out. And the medical care for our wounded warriors is going to be first class, like it has always been.

Admiral NATHAN. Mr. Chairman, Walter Reed Bethesda just underwent the Joint Commission Accreditation Survey.

Mr. YOUNG. Yes. I am aware of that, sir.

Admiral NATHAN. They passed with flying colors. And for the record, I would say it is a tribute to the jointly staffed and jointly led team at that hospital, not that Naval Bureau of Medicine (BUMED) or Army Medicine or JTF would take credit for it. I don't believe any joint oversight from the service surgeon generals that are in control of that facility was the main engine for success. I give all the credit to the soldiers, the sailors, the airmen who work together; and the staff that leads; a joint staff leadership. That hospital, by any definition that I have, is a joint hospital. It is a hospital where you walk in, you see members of all services, of all enlisted and officer ranks working seamlessly together, getting the work done, putting patient care first. Sometimes they are doing effective work because of the system we have handed them. Occasionally, they are doing good work in spite of the system we have handed them. But nonetheless, the key thing is they are doing great work.

Mr. YOUNG. I appreciate that. And I agree with that. You know, maybe we spend more time than we should out there. Maybe we just get in the way sometimes. But there are a lot of things the government doesn't do, especially for the families. The wounded kids are being very well taken care of. Some of the families have problems that the government does not address. And that is where we play a role in helping—if you recall, one day, we brought quite a wealthy family in. And before they left, they left $47,000 with families who were losing their homes or losing their cars or having their electricity turned off. And as General Horoho knows, that has been a commitment that my wife has had ever since we began in Iraq and Afghanistan.

TRICARE PROPOSALS

Let me change the subject just a minute. And we are getting very close to the vote that I told you we were going to get to. But I want to pick up on what Mr. Moran started because it is going to be a very important issue, both with the Appropriations Committee and with the Armed Services Committee, and that is issue about TRICARE and retirements. Let me ask, how much savings do we expect to be realized with the proposed changes to TRICARE fees and pharmacy copays? And are these estimates, or are they guestimates? Or are they pretty hard numbers?

Dr. WOODSON. Fairly hard numbers based upon what has happened over the last few years. But it looks like we are recouping about $1 billion a year. We have gotten back about $3.4 billion and would expect to do that in the next few years as well.

Mr. YOUNG. Doctor, suppose Congress doesn't approve—you know, there is a bit of an outcry throughout the country on the Medicare issue—suppose Congress decided not to approve these changes. What would be the effect? What would happen?

Dr. WOODSON. As I previously testified, there would have to be additional considerations to force structure, with a gross estimate of 50 percent more troop reductions in the categories that have already been talked about to make up for the $12.9 billion or so that we estimate will happen with the TRICARE adjustments.

Mr. YOUNG. Have you been asked by the Armed Services Committee specifically about the program?

Dr. WOODSON. We have a hearing scheduled; I believe one next week and one the following week.

Mr. YOUNG. We will follow that hearing as well because we are running out of time, and they have more time. And they have more staff to work the issues. Our staff is outnumbered by about 10–to-one with other committee staffs. But the quality of our staff is outstanding. So we want to follow this issue closely because we want to do what is right. And for whatever role that the appropriators have to play here, we want to make sure that our contribution is right.

Now do you all have anything else you would like to add before we do break up?

CLOSING REMARKS

Dr. WOODSON. I would just like to say, thank you for your superb support of all of the military health systems.

Mr. DICKS. Mr. Chairman?

Mr. YOUNG. Let's let the witnesses go first.

General HOROHO. I would just like to echo and say thank you very much for the support over the years with MILCON funding and funding for all the new initiatives that we initiated for our servicemembers.

Admiral NATHAN. I would thank you again for your personal advocacy, as you take time to visit the wounded warriors and as you take their cases and their interests. It is always comforting to know that the senior leaders have this kind of attention and engagement with this precious part of our country.

Mr. YOUNG. Well, thanks for letting us do that, Admiral. We appreciate it.

General GREEN. And from my perspective, it has been an honor to represent the services to come and talk with you folks who support us so well. And I would also tell you that it has been an honor to work with your very professional staff. Thank you, sir.

Mr. YOUNG. Thank you very much, General. I will add, we will miss you.

Mr. Dicks, any closing thoughts or questions?

AUTISM

Mr. DICKS. Yes. One thing I wanted to add, on this question about autism, I read an article recently that there is a special school in New York—maybe in New York City—where they have intensive interaction with these autistic children, and they start really young, or I guess when they diagnose it. And that intensive interaction makes a big difference. Now I don't know if that is even possible. This is kind of an experimental thing. But I don't know if that is possible for us to do in the military setting or not. But it was interesting that it proved to be quite effective and that these kids did much better after they had had this intensive interaction. It is like one-on-one per child, somebody working with them. I don't know if you saw this, but I saw it recently.

Dr. WOODSON. Yes. I don't know the details of the program, but about the special schools. Again, one of the things we need to do in trying to craft the benefits for our service men and women with

children afflicted is to understand what needs to be addressed within the educational lane versus the health care lane. So I think we need a more—how can we say—involved discussion to bring the educational folks into it in crafting these benefits.

Mr. DICKS. I was under the impression that sometimes the military has compassionate assignments, where if there is a good program—years ago, we did the Evergreen School at Fort Lewis, and this was aimed at a lot of special needs children. So people who had a special needs child could be assigned to go to Fort Lewis and then their child got this special care. Do we still do that?

Dr. WOODSON. I will allow surgeon generals to talk about assignments. I think I have heard of and actually witnessed servicemembers who have gotten or wished to be assigned to certain areas because of certain facilities when they have an exceptional needs child. And when it can be accommodated with the interests of the services being protected, I think they do make an attempt to do that. But I will let the surgeon generals talk to that.

General HOROHO. Sir, we do take that into consideration, and then just the opposite, we try not to assign family members in places where we can't support them because of the medical needs of either their children or their family members. So it is something that is considered in assignments.

Admiral NATHAN. The Navy has an exceptional family member program, which all of the Services enjoy which actually can codify a patient, a family member with special needs, to remain in a certain area for proximity of medical care. It prohibits or precludes the active duty member from being assigned outside of that area, to provide continuity of care. And there also is a mechanism called compassionate or humanitarian transfer. So if an active duty member or family member has an overwhelming humanitarian need to relocate to some area, either for medical care or to take care of a sick relative or for some other reason, that mechanism is available through the Bureau of Personnel.

General GREEN. And the Air Force has the exact same programs with the exceptional family members programs, where constantly the families are reviewed to make certain we don't assign them somewhere they would not have services. And does have what you call compassionate assignments, the humanitarian assignments. There are some restrictions in terms of the length of time, in terms of when things are expected to resolve, which may affect the ability to get those assignments, particularly with an autistic child, where there may not be an end point. But I am not as familiar with the New York program, sir.

Mr. DICKS. Thank you very much.

Thank you, Mr. Chairman.

TRAUMATIC BRAIN INJURY RESEARCH

Mr. YOUNG. Mr. Lewis, a closing issue?

Mr. LEWIS. Thank you very much, Mr. Chairman. I have some interest in the research and development that may be taking place regarding treatment of traumatic brain injuries. Could each of you speak to that question? Current and future research on drugs that may affect traumatic brain injury.

General HOROHO. Sir, there is a lot of research out of MRMC as well as our Defense Center of Excellence for Traumatic Brain Injury looking at not just different types of drugs but concussive care, different types of therapy for mild, moderate, and severe. There is collaborative outreach with some of our civilian academia partners, and we are also partnered with the NFL as well as Boston VA in an effort of really looking and saying: what are the right therapies out there in addition to, sometimes nutrition, and a combination of drugs to see whether or not that is having an impact. We can get you more information on details in that area if you would like.

Mr. LEWIS. Thank you, General.

Admiral NATHAN. Sir, I would add that in the spectrum from post-traumatic stress, which heretofore was a psychological diagnosis or assessment, to traumatic brain injury, which was an anatomical diagnosis, we are finding that more and more folks with post-traumatic stress actually may have an underlying TBI-type symptoms. And that at the microcellular level, with our new sophisticated imagery and research, we are researching that. I would echo what General Horoho said which is, I think the real utility is going to be in the partnerships that we are now doing with Centers of Excellence in the private and academic sectors. And that if we don't widen the aperture for TBI to include the VA, the DoD and the private and academic sectors, we are not going to be able to get our arms around this, not only from a research and diagnostic standpoint, but from a therapeutic one. As our patients leave our epicenters and military treatment facilities, where we do a pretty good job with this, or our polytrauma units in the VA and go out to the interstitial spaces of America.

General GREEN. And I would say we are locked arm in arm in terms of these efforts. The most significant right now being what we are doing in theater in terms of how we are managing concussion and ensuring rest and time for people to recover after a potential injury that could lead to a traumatic brain injury.

In addition to that, we also, as you know, are exploring other things that have made popular press but have not yet been proven effective, such as that HBO program that is going on. The HBO therapy, the hyperbaric therapy, and the study that the Air Force did did not show a significant difference with that, but it was not the definitive study. It was a preliminary study, and the other study is ongoing with multiple sites, essentially collecting patients to see if we can get a definitive answer on whether hyperbarics can help.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Frelinghuysen.

WOMEN'S HEALTH

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman, for your indulgence. Since we have been talking about post-traumatic stress, I have some issues that relates to women. This is a report that is only anecdotal, but I heard that some women are being told that in order for a female soldier to be diagnosed and treated for post-traumatic stress syndrome, they must claim military sexual abuse; the rationale being post-traumatic stress results from action in

combat and women are not permitted in combat. Are you familiar with this issue?

General HOROHO. Sir, not specifically with that issue. But I can tell you what we have stood up is a women's health task force; it will be tri-service. And we are looking at PTSD. We are looking at sexual assault, sexual abuse. We are looking at predeployment, deployment, and postdeployment issues that are very specific just to women.

Mr. FRELINGHUYSEN. We had, yesterday Secretary McHugh came in; General Odierno came in. Mr. Lewis actually raised the issue. But I was unaware of this sort of anecdotal report that somehow with the post-traumatic stress, since women are not in combat—and obviously, if it involves rape, that is stress. That is a serious crime of course. Are you aware of this issue at all?

General HOROHO. Sir, I would say that women——

Mr. FRELINGHUYSEN. To be treated for post-traumatic stress.

General HOROHO. Maybe I am not understanding the question. I am sorry.

Mr. FRELINGHUYSEN. With post-traumatic stress, women are not allowed in combat. So do they qualify for post-traumatic stress only because they have been raped?

General HOROHO. No, sir.

Mr. FRELINGHUYSEN. So clarify that for me.

General HOROHO. A couple of things. One, for PTSD, you do not have to be exposed to combat to have a diagnosis for PTSD. And that is with women or men. So that is not a criteria. The second one that I would clarify is that, in Afghanistan and Iraq, women may not be in combat, but they are exposed to combat.

Mr. FRELINGHUYSEN. Absolutely.

General HOROHO. We have had 10 years where women have been exposed to some of the same combat that our servicemembers on the male side have. So they are being treated with the same treatment modalities that we have for men and women. I sat and met with almost 2,000 women over the last probably 18 months, talking with them. And there are concerns with females of how they experience some of the same encounters that a male may. So what we are looking at now and saying——

Mr. FRELINGHUYSEN. They are under the same combat stress. They may be in the region, so they certainly would qualify for it.

General HOROHO. Absolutely.

Mr. FRELINGHUYSEN. There are a lot of issues out here.

General GREEN. Yes, sir. And if I could add to that conversation. We actually see that in the top three suffering PTS—not necessarily PTSD—our own medics who are exposed to combat injuries, which are not necessarily associated with being fired upon and those kinds of things that you are talking about. And so I would tell you that we do not restrict our treatment in any way. If someone identifies with post-traumatic stress, we treat them appropriately. If they actually progress into the disorder, we treat them appropriately, and it has nothing to do with whether or not they have been assaulted in that manner.

Mr. FRELINGHUYSEN. We are pleased to have that reassurance.

Thank you, Mr. Chairman.

CLOSING REMARKS

Mr. YOUNG. Thank you all for a very good hearing. We appreciate the directness of your answers and your willingness to be totally transparent and let us know what you know—at least I think you let us know what you know. Maybe there are some secrets you have that we don't know about. But anyway, we really appreciate the openness.

But even more importantly than that, we appreciate how you take care of our sick and wounded troops. And that is a tremendous, tremendous obligation to all of you, to all of us, to the Congress. The Constitution made it very clear that we have that responsibility, and you do it well. And I just want to compliment you all for that.

Thank you for a good hearing. The committee will be adjourned. We are reconvening right now on the floor, and the vote will come here just in a few minutes. So timing worked out just right. Thanks again. It is good to see all of you.

General Green, we are going to miss you.

And Admiral Nathan, General Horoho, we look forward to seeing you all again.

And Dr. Woodson, stay in touch.

General GREEN. Thank you.

Admiral NATHAN. Thank you, sir.

Mr. YOUNG. We are adjourned.

[CLERK'S NOTE.—Questions submitted by Mr. Kingston and the answers thereto follow:]

OVERALL BUDGET COSTS

Question. In 2008, the request for health care funding was $38.7 Billion, where as in FY12 this request has grown to $52.5 Billion.., which is a nearly a 36% increase in four years. The FY13 request of $48.7B for the Military Healthcare System is a decrease of $4.1B from the FY 12 enacted level, a decrease of more than 7%. While we are pleased to see a decrease, absent a detailed cost analysis, do we know where these savings are coming from?

Answer. The table below highlights the specific line items of the Unified Medical Budget and displays the FY 2012 appropriated amount compared to the FY 2013 Request. $4.0B of the decrease is due to reduced Medicare Eligible Retiree Health Care Fund (MERHCF) Normal Cost Contributions (NCC).

[$ in Milliions]

	FY 2012 Approp	FY 2013 Request	Change
Operation and Maintenance	$30,586.2	31,349.3	763.0
Procurement	632.5	506.5	−126.1
Research, Development, Test & Evaluation	1,266.8	673.0	−593.8
Defense Health Military Personnel	8,475.0	8,415.0	−60.0
Defense Health Military Construction	1,130.1	1,037.3	−92.8
MERHCF Normal Cost Contribution	10,728.0	6,682.2	−4,045.8
Total Unified Medical Budget	52,818.7	48,663.2	-4,155.5

The table below details the additional adjustments to the MERHCF per capita rates assumed in the FY 2013 budget submission, which generates the $4.0 billion savings.

	MERHCF Rates		Reduction in Accruals ($B)
	Full-Time	Part-Time	
FY 2012 Medicare-Eligible Health Care Fund Normal Cost Accrual Rates	5,580	3,260	.....

	MERHCF Rates		Reduction in Accruals ($B)
	Full-Time	Part-Time	
FY 2013 Medicare-Eligible Health Care Fund Normal Cost Accrual Rates*	4,702	2,597	1.7
Additional Adjustments to FY 2013 MERHCF Rates:			
Enactment of US Family Health Program Legislative Proposal (FY12 NDAA - Sec. 708)	(295)	(217)	0.6
FY 2013 President's Budget Proposal Increasing Pharmacy Co-Pays	(487)	(338)	0.9
FY 2013 President's Budget Proposal Implementing Enrollment Fees for TRICARE-for-Life	(219)	(105)	0.4
Total Adjustments to FY 2013 MERHCF Normal Cost Accrual Rates	(1,001)	(660)	1.9
FY 2013 Medicare-Eligible Health Care Fund Normal Cost Accrual Rates for PB13	3,701	1,937	3.6
End Strength Reductions & Shift of Non-Enduring Army/USMC Strength to OCO Request**	.....	.....	0.4
Total Reduction in Base Budget MERHCF Accruals From FY 2012 to FY 2013	.....	.....	4.0

* August 9,2011 letter from DoD Board of Actuaries.
** FY 2013 Overseas Contingency Operations (OCO) request includes $272M in MERHCF Contributions for Army/USMC non-enduring strength.

BENEFITS OF CONSOLIDATION

Question. Have any of the services started to analyze the costs associated with and saved by these consolidations, combinations and eliminations?

Answer. The Task Force on MHS Governance did provide an initial analysis of cost savings and all Services were represented on the Task Force. The Department will stand up an Implementation Planning Team consisting of representatives of key organizations across the Military Services, the Joint Staff, and the OSD staff to identify the actions required and to analyze costs associated with any finally approved changes. At this time the Team has not been formed, so the Services have not begun their analyses.

Question. How would the recommended changes to governance structure, especially those selected which provide increased budget and personnel authority, impact the ability of MHS to efficiently and effectively utilize, integrate, and procure technological resources?

Answer. The proposed MHS governance changes should enable accelerated implementation of shared services, identification and proliferation of common clinical and business practices, and implementation of entirely new approaches to delivering shared services. In the specific area of technology, common processes in requirements generation for purchases across the system should lead to volume discounts. In addition, reducing duplication in program management, acquisition, and sustainment across the entire MHS will provide more effective and efficient services. These efforts and single clinical and business processes should enable the MHS to more efficiently and effectively use, integrate, and procure technological resources, and should allow for significant savings.

Question. Do we have anything quantifiable to show the impact of procuring technical solutions in order to realize some efficiencies?

Answer. The Military Health System (MHS) has developed plans to achieve efficiencies in response to the Secretary of Defense' call for efficiencies, to include data center consolidation.

Approaches to consolidation. Our approaches to technical efficiencies include:

- Decommissioning—turn off or eliminate servers not being used (or used infrequently).
- Site Centralization—migrate servers/storage to selected (larger) data centers.
- Server/Storage Consolidation—eliminate individual physical servers and consolidate to blade architecture.
- Virtualization—utilize virtualization technologies at selected data centers to maximize central management, enhance disaster recovery, and improve utilization metrics (power usage, rack space, and floor space).
- Cloud Computing—migrate application functions to standard, vendor supported enterprise platforms or services.

Data Center Consolidation. A specific example is to reduce the total number of data centers. Actions plans formed to support this includes:

- Consolidate MHS and service applications to regional data centers through virtualization and standardization. Application decommissioning will also occur

when analysis determines this alternative to be the most appropriate course of action.

• Walter Reed Army Medical Center merged with the National Naval Medical Center to become the Walter Reed National Military Medical Center (Bethesda, MD).

• DeWitt Army Community Hospital (Ft Belvoir, VA) moved assets into the new Fort Belvoir Community Hospital.

• Advanced Technology Integration Center (TMA, Falls Church, VA) moved assets to the new Development and Test Center (Richmond, VA) and other sites.

• Denver Center Irvington (TMA/DHSS, Denver, CO).

Question. How are these impacts being measured—is there any applicable personnel and budget information that was used to make the analysis and/or recommendations for changes?

Answer. The impacts of the proposed Military Health System consolidations are not being measured yet because the Department has not completed planning for the recommendations. An implementation team must decide what changes will take place and only after implementation of such changes would it be possible to start measuring results.

Question. Has a cost analysis been accomplished? What gains have we made in the management of our budgetary and procurement processes?

Answer. A detailed cost analysis was not required by the Terms of Reference for this 90-day Task Force on MHS Governance. However, the Task Force provided a rough order of magnitude estimate of staffing increases or reductions based on each organizational construct considered. The Task Force acknowledged that no allocations of personnel revisions should be considered until a more detailed analysis was completed. In attachment 4 of the Department's report to Congress on MHS Governance, March 2, 2012, we provided additional cost analyses related to the options presented by the MHS Governance Task Force. However, cost analyses for the final decisions for MHS Governance reform must await the results of an Implementation Planning Team that will identify all the actions necessary for reform and perform more detailed cost analyses.

How Do We Claim Success?

Question. Overall Organization / Re-Organization—have we identified how we can become more efficient, and know that what we are doing is working? For example, unifying some medical commands/structures that will provide shared services seems like it would yield some savings and efficiency gains—do we have any data to show that? Have we identified specific areas that would benefit from increased oversight?

Answer. The Department's report to Congress, March 2, 2012, provides the best overview to answer these questions and show the breadth of the analysis to come up with proposed Military Health System (MHS) Governance reforms. We do believe there are opportunities to accelerate the process for a shared services model across a range of common MHS activities. These activities include, but are not limited to: medical education and training, medical logistics, facility planning and construction, health information technology, medical research and development, public health, acquisition, and other common clinical and business processes.

Areas for Continued Improvement

Question. Lack of Joint Standards (amongst the services) has been brought up as a potential problem area in the Defense Health Area—how do we ensure this gets looked at?

Answer. The Military Services do follow joint standards. For example, all of our medical treatment facilities, regardless of Service affiliation, must meet the standards of and be accredited by The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations, which is a United-States-based, not-for-profit organization that accredits more than 19,000 health care organizations and programs in the United States. However, if your concern is that there are more opportunities for the Services to share common services, we agree. The Department believes that a great opportunity exists to accelerate shared services across a range of common Military Health System activities. These activities include, but are not limited to medical education and training, medical logistics, facility planning and construction, health information technology, medical research and development, public health, acquisition, and other common clinical and business processes. The Department's report to Congress of March 2, 2012, provides more detail.

Question. Where are we with respect to the integration of services in the National Capital Region? What do we still need to accomplish? Do we know enough to say that the Bethesda/Ft. Belvoir effort has been successful?

Answer. The Department conducted a comprehensive examination of its medical infrastructure in the National Capital Region and determined that it did not make sense to continue to have large in-patient hospitals operating in close proximity to each other when the physical assets were aging and the mode of treatment was shifting to more outpatient care. This examination resulted in the closure of the aging Walter Reed Army Medical Center, the replacement of the Fort Belvoir hospital, the expansion of medical facilities at Bethesda (establishing the Walter Reed National Military Medical Center), and the closure of the inpatient facility at Joint Base Andrews.

Over the long term, this change is avoiding costs of operating four inpatient hospitals in close proximity and having to recapitalize each. Moreover, it matches the infrastructure to current medical practices. In this particular case estimates at the time indicated that it would cost $600–700 million to replace or renovate Walter Reed and that, under existing budget assumptions, the work would take many years to complete (6–8 years for replacement, 10–15 years for renovation). While that is a major cost avoidance for which we could take credit, the Department has elected to be conservative in its savings estimates and have focused instead on estimating the savings or avoidances that are derived by calculating the net facility overhead costs (i.e. the sum of the support personnel, base operating support, and sustainment and modernization costs saved at the closing location less the sum of the incremental increase of those costs at the new location).

JTF CapMed has been a model for efficiencies in the Military Health System and has saved the Department money through its oversight of transitioning four inpatient Military Treatment Facilities (MTFs) in the National Capital Region (NCR) into two and implementing an integrated healthcare delivery system (IDS). Specific initiatives (implemented and future) include:

IMPLEMENTED INITIATIVES

- $114M in cost avoidance through equipment re-use programs
- $109M+ in savings through using a single contractor to provision Initial Outfitting and Transition (IO&T)
  - $77M upfront by competitively bidding the equipment and relocation costs
  - $32M in savings due to incentive plan allowing IO&T contractor to share in savings due to lowering equipment costs through competitive pricing events, bulk buying power, as well as a willingness for vendors to accommodate the needs of such a volume customer
  - The total savings from this contract cannot be quantified at this time, but will be realized after the contract optimization is completed
- $16M per year in savings through staffing and operational efficiencies
  - $15M a year through establishing a Joint Pathology Center to assume core functions of the Armed Forces Institute of Pathology (now closed)
  - $810K a year through establishing a regional Civilian Human Resources Center
  - $230K a year by consolidating appointment call centers in the NCR

FUTURE INITIATIVES

- Installation of an Integrated Healthcare Data Network (Joint Medical Network) across the NCR will reduce IM/IT sustainment costs throughout all NCR MTFs as well as provide better performance
- Consolidation of the workforces at Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) and authorities sufficient to implement shared services will enable efficiencies and economies of scale that will result in contractor and civilian personnel savings of approximately $60M per year (FY 2011 dollars)
- With command and control over WRNMMC and FBCH, JTF CapMed continues to identify additional opportunities to develop shared services capabilities and achieve efficiencies in the NCR IDS.

BATTLEFIELD INJURIES

Question. Due to TED blasts there are reports of large numbers of wounded having suffered a variety of injuries including sensory loss of vision and hearing trauma. Have the departments identified "battlefield gaps" in research for these traumatic injuries? Along with TBI and limb extremity research programs, are there other injuries that require increased funding to improve patient outcomes on the front lines?

Answer. The Department of Defense has identified battlefield gaps in research in order to further understand the relationship between blast exposure and traumatic injuries to the sensory systems. Current research initiatives focus on developing injury risk criteria and guidelines for protecting Service members. With respect to restorative and rehabilitative care, research efforts are addressing gaps associated with the development and evaluation of novel regenerative medicine, pharmacological, and sensory substitution approaches to restore blast-induced visual and auditory impairments. As more research is conducted to elucidate the mechanistic and correlative underpinnings of blast-induced sensory system dysfunction, battlefield gaps will evolve and be refined to mitigate the deleterious effects of both acute and chronic blast-induced sensory system dysfunction.

Recently, there has been a reported heightened incidence of dismounted complex blast injuries characterized by genitourinary/lower abdomen trauma. While there is some overlap between the injuries that characterize limb and extremity trauma and genitourinary/lower abdomen trauma, there also are notable differences. Pelvic and urogenital reconstruction are two examples that fall outside of the current research efforts addressing limb and extremity trauma. We are working to address these battlefield gaps in our research planning.

Question. I understand that the Air Force, through its San Antonio Medical Command, has deployed a new FDA certified NeuroRadiology volumetric process that produces an early-stage medical diagnostic image that can be used to identify Mild Traumatic Brain Injury (MTBI) in a service member who has been subject to an IED attack or other injury that would cause trauma to the brain. What is the status of this new diagnostic technology?

Answer. NeuroQuant is a proprietary medical image processing software cleared for marketing as a medical device by the Food and Drug Administration in 2006. NeuroQuant provides a quantitative measurement of the volume of specific areas of the brain, including the hippocampus. Because Traumatic Brain Injury (TB!) can result in loss of brain volume over time, NeuroQuant has potential application for longitudinal monitoring of service members who have sustained TBI. Air Force acquired this technology on October 11, 2011 at the San Antonio Military Health System. Because the TBI population is predominantly Army, we installed the equipment at the San Antonio Military Medical Center. To date, this application has been applied to images of 92 patients with history of mild Traumatic Brain Injury (mTBI), the overwhelming majority for routine clinical TBI care. The technology is also being utilized on four institutional review board approved research projects, including the iSCORE project (an imaging subset of the national Study of Cognitive Rehabilitation Effectiveness in mTBI). On April 1, 2012 the Wilford Hall Ambulatory Surgical Center will begin performing the high resolution sagittal sequence required for NeuroQuant software application on all routine brain imaging.

Question. How could the AF use this technology in regular clinical practice in order to determine if service members should either be treated or returned to duty, and thus avoid the risk of repetitive concussive injuries that aggregate into a disabling condition?

Answer. As an adjunct in the imaging evaluation of mild Traumatic Brain Injury (TBI), NeuroQuant provides a quantitative assessment of brain volume, particularly the hippocampus, which can be assessed in the subacute period and followed longitudinally over a service member's career. If progressive hippocampal volume loss is identified and it correlates with clinical history, signs, and symptoms of TBI, the service member's provider can use this information to aid in return to duty or duty limitation decisions that may be required to reduce the risk of additional head injuries. Volumetric measurements near the time of injury can serve as a baseline measurement to aid in detection of volume loss over time, but cannot be used as an acute diagnostic tool for mild TBI.

Question. Can this technology be deployed in a way that assists the AF in early MTBI diagnosis in a commt environment?

Answer. Brain volume loss following Traumatic Brain Injury (TBI) has been documented in the medical literature, but is not a universal finding and it remains unclear what severity and frequency of mild Traumatic Brain Injury (mTBI) is sufficient to produce gradual volume loss. Because mTBI may result in a small degree of swelling which can skew the evaluation of quantitative brain volume, an initial post-injury volumetric measurement should not be performed until the subacute period (beyond two weeks from time of injury).

Question. How can the AF use the technology to support the activities of the Physical Disability Evaluation System to render more quantitative evaluations of service members?

Answer. Deploying the use of NeuroQuant in the Air Force Medical Service, the Department of Defense and the Department of Veterans Affairs will provide a

means for quantitative assessment of brain volume, particularly hippocampal volume that can be followed longitudinally from the initial injury through separation or medical discharge and beyond. Though hippocampal volume loss after Traumatic Brain Injury (TBI) has been well documented in the medical literature, especially with moderate to severe TBI, it is not a universal finding in all who have sustained TBI. In addition, there are other medical conditions which may result in hippocampal volume loss. Thus, NeuroQuant may provide objective support for the clinical diagnosis of cognitive deficits from TBI but cannot be used a sole diagnostic tool. This information must be used in conjunction with clinical assessment, laboratory evaluation, and other imaging assessment tools to support the activities of the Physical Disability Evaluation System.

Question. Could this technology be deployed in such a way as to establish a longitudinal study that would follow a patient through their military service and into the VA system?

Answer. A longitudinal study to follow a service member through their career and into the Department of Veterans Affairs system would require standardized Traumatic Brain Injury imaging techniques across the Department of Defense to include a high resolution sagittal sequence required to process NeuroQuant data, an accessible database for our wounded warriors' Magnetic Resonance Imaging data at any Department of Defense facility and Department of Veterans Affairs, and incorporation of imaging and volumetric data with the patient's electronic medical record.

[CLERK'S NOTES.—End of questions submitted by Mr. Kingston. Questions submitted by Mr. Calvert and the answers thereto follow:]

TRICARE FEES

Question. TRICARE for Life is currently a mandatory program. Enrollment is automatic. Will this continue to be automatic after the enrollment fees are imposed? What will happen if a retiree does not want to enroll in or cannot afford the program?

Answer. TRICARE for Life (TFL) provides TRICARE payment secondary to Medicare when a beneficiary entitled to Medicare Part A is also enrolled in Medicare Part B. Participation in TFL is not automatic. Currently, a beneficiary who is eligible for premium-free Medicare Part A participates in TFL by choosing to purchase Medicare Part B. By statute, a beneficiary who is eligible for premium-free Medicare Part A but declines to purchase Medicare Part B will lose his or her TRICARE benefits, except for care in military treatment facilities on a space-available basis. These provisions will remain in effect, with the Administration's proposed TFL enrollment fee becoming an additional prerequisite for participation in TFL. Beneficiaries who choose not to, or cannot pay the enrollment fee will not have TFL coverage.

TRICARE CONTRACT MANAGEMENT

Question. The TriWest health care contractor, which provides TRICARE services in California, was recently fined $10 million for mismanaging its contract and failing to pass savings it had obtained from providers on to the federal government. In one instance TriWest billed the U.S. $370,000 for care delivered to a patient that had not been eligible for care for two years!

Is anyone at the TRICARE Management Activity being held accountable for failing to oversee this contract? Are programs being initiated to review all the other TRICARE contractors?

Answer. TMA currently has multiple contracts performing statistical audits of claims processing. Due to the volume of claims, tens of millions of claims per year, audits are post pay; currently TMA post pay audits established an overall error rate in FY 2010 of .24%. In FY 2010 TRICARE processed 199.4 million claims.

TMA/Program Integrity actively works to protect the Program from fraud and abuse so that tax payer dollars are utilized to properly provide benefits to our beneficiaries, under all of our contracts. In the TriWest situation TMA/Program Integrity received a qui tam filing against the provider in 2008. A review of the services specifically identified in the filing was properly provided to TRICARE beneficiaries.

In assisting DOJ, a review of each of the issues by TMA/PI determined that two of the issues were unsubstantiated. The third issue, Letters of Agreement (LOAs) is more complex in that the contractor paid claims within the Regulation's maximum allowable charge, thus raising no payment/processing flags. Additionally, LOA's are not required by regulation or contract, however, if negotiated, the benefit of the lower rate *must* be passed onto the government.

Since, LOAs are not processed as a separate distinguishable subset of claims and these claims in particular paid within the maximum allowable charges, the claims would not have created an identifiable pattern. TMAJPI's findings on this third issue created concerns within the DOJ on TriWest's failure to apply negotiated discounts and to identify and recoup government dollars in a timely manner thereby causing DOJ's limited intervention.

DEFENSE HEALTH AGENCY

Question. Do you anticipate cost-savings from creating the Defense Health Agency? If so, how much do you expect to save? What do you expect the start up costs to be for the Defense Health Agency?

Answer. A detailed cost analysis was not accomplished during this 90-day Task Force on Military Health System (MHS) Governance; one was not required by the Terms of Reference for the Task Force. In attachment 4 of the Department's report to Congress on MHS Governance, March 2, 2012, we provided additional cost analyses related to the options presented by the MRS Governance Task Force. However, cost analyses for the final decisions for MRS Governance reform must await the results of an Implementation Planning Team that will identify all the actions necessary for reform and perform more detailed cost analyses.

TRAUMATIC BRAIN INJURY (TBI)

Question. As you know, the incidence of traumatic brain injury (TBI) among deployed military members has been increasing. However, there seems to be some hope in understanding what happens to the brain after TBI. Knowledge gained from boxing and football injuries and now from troops who have suffered TBI, indicates that TBI may cause minute changes in the brain that in turn cause normal tau proteins to change to a toxic prion protein. The prion protein then rapidly multiplies, causing cognitive and behavioral degeneration. Research suggests that with medication, these toxic proteins can be stopped. While the injury to the brain cannot be reversed, the progressive damage and brain degeneration can be slowed or possibly stopped. We have the ability to screen for prions which means we can test troops who have experienced TBI and immediately begin medication if they test positive for prion proteins. This offers great hope in our efforts to treat TBI-related depression, alcoholism, and drug use, and to prevent the most devastating outcome—suicide. I know the Department of Defense is pursuing several TBI research initiatives, but I'm told that the funding for prion drug trials has yet to be released.

Please provide an update on this research and explain why that money is being held back. Is the Department of Defense collecting data and/or analyzing whether members who commit or attempt suicide have suffered a TBI?

Answer. Research funding is not being held back. The Department of Defense is aggressively working with the Department of Veteran Affairs to establish joint funding for a broad, multi-year research consortium to investigate the role of Chronic Traumatic Encephalopathy, including tau and other factors, in military and veteran populations.

Yes, we collect these data. According to the Department of Defense Suicide Event Report (DoDSER), of the 281 Service members who died by suicide confirmed by the Armed Forces Medical Examiner System in 2010, eight (2.25 percent) had a diagnosis of traumatic brain injury. Of the 863 attempted suicides reported in DoDSER, 21 (2.4 percent) had a diagnosis with traumatic brain injury.

[CLERK'S NOTE.—End of questions submitted by Mr. Calbert. Questions submitted by Mr. Moran and the answers thereto follow:]

TRAUMATIC BRAIN INJURY (TBI)

Question. The CDC reports that traumatic brain injury (TBI) contributes to a substantial number of deaths and cases of permanent disability. In fact, TBI is a contributing factor to a third (30.5%) of all injury-related deaths in the United States. Of the 1.7 million people who sustain a TBI each year in this country: 52,000 people die and 275,000 people are hospitalized. The estimated economic cost of TBI in 2010, including direct and indirect medical costs, is estimated to be approximately $76.5 billion. To this effect, combat veterans and civilians afflicted from brain injury deserve to have collaborative support from the brain research and advocacy communities to advance TBI research, significantly improving outcomes and curb the cost burden to the U.S. health system. We believe that the intellectual capabilities of our

healthcare workforce can be better harnessed using collaborative technology platforms and to this we offer the following questions:

Approximately how much money has the DoD spent on combat casualty care, TBI, PTSD, since the beginning of the wars?

Answer. The table below provides an estimation of costs, where available, for Combat Casualty Care, TI and Psychological Health (to include PTSD).

[$ Millions]

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Psych Health (to include PTSD)*				1,010	1,270	1,5I2	1,836	2012
Traumatic Brain Injury*	Data not readily available			108	135	147	184	214
Combat Casualty Care**	30	50	52	124	114	113	67	72

*Psych Health (to include PTSD) and TBI funds represent Active Duty and their Family Members (to include Activated Guard and Reserve and their Family Members) and do not include Retiree.

**Combat Casualty Care represents funds obligated through the Overseas Contingency Fund (OCO).

Question. How is the Department consolidating care for TBI, PTSD, and other combat-related mental disorders to provide better care for our uniformed service members?

Answer. Multidisciplinary programs throughout the Military Healthcare System (MHS) provide high quality, consolidated care for Service members (SMs) with traumatic brain injury (TBI). In addition, posttraumatic stress disorder (PTSD) and combat-related mental disorders are addressed through coordinated programs. These conditions frequently present with similar symptoms and are often seen together, making diagnostic and treatment decisions challenging. There are currently over 60 TBI programs in the MHS that systematically coordinate care for SMs with TBI and co-occurring conditions, which may include chronic pain, headaches, PTSD, mood, and sleep disorders. These programs provide four levels of care to SMs who sustain a TBI, depending on the individual severity of injury and needed care requirements. Programs such as Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil) and the Behavioral Health Optimization Project (BHOP) enable Department of Defense (DoD) primary care providers to screen and treat health-seeking patients in primary care clinics for PTSD, suicidal ideation, and depression while integrating behavioral health care providers into routine care. These programs place psychological health (PH) care providers in nontraditional primary care clinic treatment settings, and enhance access to PH care while increasing the care quality of both primary care and PH care.

As one means of communicating the state of the evidence to clinical providers in the field, the DoD and Department of Veterans Affairs (VA) jointly developed Clinical Practice Guidelines (CPGs), including a CPG for the Management of Posttraumatic Stress (2010), and one for Concussion/Mild Traumatic Brain Injury (2009). The DoD also developed companion Clinical Support Tools for providers, veterans, and SMs. The PTSD tools are currently in development and scheduled for public release mid-2012. In addition, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), which was established in 2007, facilitates weekly PH and TBI conference calls with representatives from the Services and VA to coordinate care and identify best practices to ensure that SMs with these clinical conditions receive high quality, evidence-based care in alignment with current scientific literature. The DoD continues in its effort to provide high quality, consolidated PH and TBI care, which includes initiatives to reduce the stigma associated with seeking PH or TBI care, identify improved methods to access healthcare, establish standards for training to improve quality of care, implement telehealth technologies to increase access to care, and expand collaboration between Departments and stakeholders.

Question. In light of the recent unfortunate events in Afghanistan, what practical diagnostic tools have be developed by DoD's R&D investments that can reliably differentiate between the diagnosis of TBI, PTSD, or patients with elements of both?

Answer. There are a number of research projects underway supporting the development of evidence-based scientifically-evaluated techniques for improving diagnostic accuracy of PTSD and TBI (with a particular focus on concussion/mild TBI (mTBI)), to include differential diagnosis as well as co-occurring PTSD and TBI. Several research efforts utilize brain imaging techniques to elucidate brain indices of risk for PTSD and mTBI that are correlated with techniques and technologies that are more fieldable (for example, neurocognitive testing, eye-tracking, balance platforms). These research studies will yield empirically-validated diagnostic tools.

There is an effort to develop a validated concussion dosimeter to predict likelihood of injury. Concurrently, foundational research is underway to understand underlying unique and common neurobiological mechanisms of PTSD and TBI in order to inform development of improved diagnostics. Lastly, research is focused on understanding the potential reciprocal interaction between psychological and physical neurotrauma. It is hypothesized that neurotrauma may predispose some Service members to the development of PTSD. Within the next several years, these research studies are expected to produce tools and results that will inform guidelines for improved accuracy of PTSD and TBI diagnoses.

Question. Please describe any tangible benefits in the form of delivered and deployed products or improved processes or patient care protocols that our wounded warriors have received from the R&D dollars appropriated for TBI and PTSD to date. Please distinguish this from advances and contributions our military physicians have made in the absence of R&D funding.

Answer. The Department has a significant research investment in this area and our research strategy is aligned to the continuum of TBI care model. Basic research and epidemiology projects focus on understanding mechanisms of injury and incidence of the injury. In addition, research projects are being conducted in the following categories of the continuum of TBI care model: Medical Standards for Protective Equipment; Objective Measures of Head Impact/Blast Exposure; Valid Criteria for mild TBI/Concussion Screening Tools; Portable Diagnostic Devices for Theatre and Garrison; Pharmaceutics and Surgical Technologies for Treatment; Recovery Time-Course and Rehabilitation Strategies; and Valid Return to Duty Standards and Measures of Rehabilitation.

Question. What is the status of the helmet sensor for blast detection funded through MRMC? Please differentiate from the blast detector already deployed with the 4th ID that was developed by DARPA.

Answer. The Generation II helmet sensor is a Program Executive Office (PEO) Soldier initiative designed to provide an objective way to measure and record soldier head impact and blast exposures in combat and training environments. In a blast or head impact event, the sensors measure and record helmet acceleration and blast pressure. These sensors are not medical devices, and they are not used to diagnose TBI; however, they do provide a means for documenting possibly injurious head impact and blast exposures, and they provide a mechanism for rapidly identifying soldiers who should be referred for medical evaluation and treatment.

The U.S. Army Medical Research and Materiel Command (USAMRMC) is supporting the PEO Soldier Gen II helmet sensor fielding initiative. The USAMRMC, through the Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) program, will help to assess sensor performance by leading a sensor data analysis project that will determine if the sensor data correlate with events and injuries. The JTAPIC program has developed an operational exposure screening tool that will be used to rapidly screen the sensor data as they are downloaded from soldiers' helmets. The screening tool produces a red-amber-green (R-A-G) output indicating the probability of a concussion based on existing concussion data from the automotive safety community and the National Football League. Soldiers with amber or red events will be referred for medical evaluation in accordance with the existing DoD policy on the management of concussion/mild traumatic brain injury in the deployed setting.

The DARPA blast detector is a different technological application. USAMRMC is collaborating with DARPA and PEO Soldier to provide an objective way to measure and record soldier head impact and blast exposures in combat and training environments using the DARPA technology.

Question. How can the DoD enhance its collaborations with other governmental and non-governmental organizations to more effectively translate basic science advances in the care of neurological disease into tangible benefits for the warriors, and their families?

Answer. The Department of Defense (DoD) is collaborating with other government agencies, academia, and industry on many initiatives:

- DoD and the Department of Veterans Affairs (VA) collaborate on many diverse research initiatives, in terms of identification of scientific gaps, evaluation of research proposals for funding and the progress of research programs. In addition, DoD funds nearly 350 VA and VA-affiliated investigators who perform medical research, including projects for traumatic brain injury (TBI) and psychological health research.
- DoD and VA collaborated in the establishment of four Centers of Excellence: Psychological Health and Traumatic Brain Injury (DCoE), Vision, Hearing, and Extremity and Amputation Care. These Centers facilitate research planning.

• The DCoE develops collaborative projects, such as the Common Data Elements Project, with the National Institutes of Health (NIH), VA, and the Department of Education.

• DoD is working with NIH to develop a comprehensive comparative effectiveness research program on the diagnosis, treatment, and outcomes of TBI.

• NIH and VA representatives serve on the DoD Neurotrauma Steering Committee and the Joint Program Committees that plan and monitor research. DoD and NIH, in partnership, are building the Federal Interagency Traumatic Brain Injury Research database to accelerate comparative effectiveness research on brain injury treatment and diagnosis.

• DoD and VA are embarking on a jointly funded research consortium to address the chronic effects of neurotrauma, to include psychologic, neurologic, cognitive, and sensory effects.

• In addition to collaborating with various governmental agencies, DoD partners with numerous industries that conduct clinical trials to develop products that will aid in the diagnosis and treatment of TBI.

With so many promising avenues in simultaneous development, it is reasonable to anticipate exciting successes within the next 5 to 7 years. We believe that the most promising approach to treatment and rehabilitation will not be through any single organization, but rather through collaboration of existing government and non-government research partners. This will require continued dedicated support and the combined, coordinated efforts of many agencies, academia and industry.

[CLERK'S NOTE.—End of questions submitted by Mr. Moran. Questions submitted by Mr. Rothman and the answers thereto follows:]

TRAUMATIC BRAIN INJURY (TBI)

Question. Traumatic Brain Injury continues to be a leading cause of death and disability among our military personnel. Recent figures indicated that explosive blast TBI accounted for 60% of combat casualties on Operation Enduring Freedom (OEF) and Operation Iraqi Freedom OIF)). Many patients die or are disabled by the initial brain injury; but many more suffer additional, often fatal, secondary brain damage during the days to weeks after the original injury. Despite advances in medical care, therapies for secondary brain injury have so far proven minimally effective. There is promising new research being done in my home state of New Jersey to decrease or eliminate the consequences of secondary brain injury, such as delayed cerebral ischemis and rebleeding. Research of this type has the potential to categorize secondary injuries of this type as preventable. I am aware that there is a wide range of research being conducted by the Services and the Defense Centers of Excellence on the subject of traumatic brain injury. Developing effective mitigation and treatment of secondary brain injury is a critical component of an improved TBI system of care.

What type of projects or initiatives, and level of resources, has the Department devoted to investigate early intervention, mitigation and treatment modalities to prevent secondary brain injury following TBI?

Answer. The Department has a significant research investment in this area and our research strategy is aligned to the continuum of TBI care model. Basic research and epidemiology projects focus on understanding mechanisms and incidence of the injury. Additionally, research projects are underway in the following categories of the continuum of TBI care model: Medical Standards for Protective Equipment; Objective Measures of Head Impact/Blast Exposure; Valid Criteria for mild TBI/Concussion Screening Tools; Portable Diagnostic Devices for Theater and Garrison; Pharmaceutics and Surgical Technologies for Treatment; Recovery Time-Course and Rehabilitation Strategies; and Valid Return to Duty Standards and Measures of Rehabilitation.

[CLERK'S NOTE.—End of questions submitted by Mr. Rothman. Questions submitted by Mr. Hinchey and the answers thereto follow:]

APPLIED BEHAVIOR ANALYSIS (ABA)

Question. Mr. Woodson, in your testimony, you stated that Applied Behavior Analysis or ABA therapy cannot be covered under TRICARE Basic because it does not meet statutory requirements. You further clarified that it is not a policy issue that it is a statutory requirement. Can you please explain why this does not meet the

statutory requirements and include the Department's current interpretation of the law or DoD policies that you believe support this assertion?

Answer. Title 10 United States Code Chapter 55, Section 1071 authorizes a uniform program—Civilian Health and Medical Program of the Uniformed Services—of medical benefits and dental care for members and certain former members of the Uniformed Services and their dependents. Based on the recent change to 10 USC 1073 (in NDAA FY 2011, Section 711), the Secretary of Defense is solely responsible for administering the TRICARE Program and making any decisions affecting it. The other Secretaries have remaining responsibilities for otherwise administering provisions of Chapter 55 in general, but not with respect to TRICARE. TRICARE is authorized at Sections 1079, 1086, and 1091 to contract with civilian providers for the health care program benefits authorized under Section 1077.

32 C.F.R. § 199.1(d) specifies that the program authorized under Chapter 55, Title 10, United States Code, includes a program of medical benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services. Although similar in structure in many of its aspects, it is not an insurance program in that it does not involve a contract guaranteeing the indemnification of an insured party against a specified loss in return for a premium paid. Further, the program is not subject to those state regulatory bodies or agencies that control the insurance business generally.

Paragraph 32 C.F.R. § 199.1(e) specifies that the appropriated funds furnished annually by the Congress are used to adjudicate claims received under Part 199. That paragraph establishes that Part 199 is the regulatory guidance for administering the program, including setting out the benefits that are eligible for reimbursement.

In accordance with 32 C.F.R. § 199.4(g)(15), any proposed TRICARE Basic Program benefit that is characterized as a drug, device, medical treatment, diagnostic or therapeutic procedure must be determined by the Director, TRICARE to be safe and effective in accordance with the reliable evidence criteria. Reliable evidence is defined in 32 C.F.R. § 199.2(b) as meaning only:

(i) Well controlled studies of clinically meaningful endpoints, published in refereed medical literature.

(ii) Published formal technology assessments.

(iii) The published reports of national professional medical associations.

(iv) Published national medical policy organization positions.

(v) The published reports of national expert opinion organizations.

Specifically not included in the meaning of reliable evidence are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or professional opinions. Furthermore, the hierarchy of reliable evidence of proven medical effectiveness as listed above is the order of the relative weight to be given to any particular source.

Health care technology assessments were conducted by the ECRI Institute, the Blue Cross Blue Shield (BCBS) Technology Evaluation Center (TEC) and Hayes, Inc. There is insufficient evidence to establish that ABA is medically or psychologically necessary or that it is a medical treatment for Autism Spectrum Disorders (ASD). Additionally there is insufficient reliable evidence to establish that ABA is "proven" as medically or psychologically necessary for ASD. Therefore, there is no current authority to provide ABA coverage under the TRICARE Basic Program. However, the results of this assessment do support the conclusion that DoD has authority under Title 10 U.S.C. Section 1079(d–e) (the TRICARE ECHO program) to provide coverage of ABA for ASD for ECHO eligible beneficiaries.

Question. Dr. Woodson, the statutory law that provides the basis for the ECHO program, 10 USC 1079(d)(e)(f), makes no specific mention of autism or ABA therapy. Under 10 USC 1079(d)(3)(B) it defines qualifying conditions as "mental retardation, has a serious physical disability, or has an extraordinary physical or psychological condition." Furthermore, "extraordinary physical or psychological condition" and "special education" are not defined anywhere. There is a strong case to be made that this therapy more appropriately falls under 10 USC 1077(a)(5), the basis for TRICARE Basic, which makes beneficiaries eligible for treatment of "nervous, mental, and chronic disorders." It should be noted that legislation pending in the House (H.R. 2288) would simply amend 10 USC 1077 to include autism as its own subsection. Other diseases and disorders have not needed specific mention in the statute to be eligible for coverage.

Answer. TRICARE recognizes an Autism Spectrum Disorder (ASD) as a neurobiological condition, generally of unknown etiology, which requires medical treatment. The TRICARE Basic Program provides such medically necessary services as speech therapy, physical therapy, occupational therapy, and psychological testing and treatment for ASD conditions. By statute and regulation, only medical services

may be provided in the TRICARE Basic Program. While ABA generally involves "education", it is considered a behavior modification modality that is neither "special education" nor a medical treatment for autism. The statute proposes to include ABA as medical care when there is yet to be sufficient reliable evidence documented in the medical community establishing it as a proven safe and effective medical treatment for the underlying condition of autism. Instead of relying on a thorough review of its safety and efficacy as a medical treatment, which is required for all other medical treatments covered by TRICARE, this statute would allow individual providers to determine if the ABA services being requested are safe, effective and appropriate for the beneficiary—unlike the process for covering all other medical treatments under the TRICARE Basic Program.

TMA conducted an assessment of ABA in October, 2010, and reliable evidence reviewed indicated that ABA does not satisfy the definition of proven medical care that statute and regulation require TRICARE to use. By implying that ABA is a medical intervention for ASD, the legislation goes against the weight of in-depth health care technology assessments conducted by the ECRI Institute and assessments by the Blue Cross Blue Shield (BCBS) Technology Evaluation Center (TEC) and Hayes, Inc.

It is inappropriate to incorporate a non-medical service into the TRICARE Basic Program, which has heretofore been restricted to provision of medical care. Congress has consistently recognized this and established by statute the separate Extended Care Health Option (ECHO) to enable provision of certain non-medical services to active duty family members.

Question. Even more appropriate is 10 USC 1077(a)(17) which provides "rehabilitative therapy to improve, restore or maintain, or to minimize or prevent deterioration of function, of a patient when prescribed by a physician." Because the ECHO program does not define autism under "extraordinary physical or psychological condition" within the statute or define ABA therapy as "special education," why do you believe that this is a statutory issue? It seems to me that this is a policy issue. Don't you agree that if DoD considers autism as something other than an "extraordinary physical or psychological condition" and/or ABA therapy as something other than "special education" that the law would not need to be re-written?

Answer. ABA has been characterized by the majority of the reliable evidence reviewed as not being a medical treatment, but instead as involving non-medical, behavioral intervention services. Additionally, except as otherwise specifically permitted by law, TRICARE has no authority to provide coverage of "special education" (10 U.S.C. 1079(a)(9)) or "self-help, academic education or vocational training services and supplies" (32 C.F.R. 199.4(g)(42)) under the Basic Program (32 C.F.R., 199.4). Consequently, reimbursement can be made by the DoD for these services only if authorized by some other statutory authority under Chapter 55 of Title 10.

Section 1079(d)(1)–(3) provides additional authority for payment for non-medical services. However, this statutory provision is limited to dependents of Active Duty Family Members with a qualifying condition. Under 10 U.S.C. 1079(d)(3), the term "qualifying condition" means the condition of a dependent who is moderately or severely mentally retarded, has a serious physical disability, or has an extraordinary physical or psychological condition. Active duty dependents diagnosed with ASD may have one of these qualifying conditions.

Although the literature characterizes ABA services by the use of several non-medical terms, and there does not appear to be consensus on any one characterization, a precise characterization of ABA is not required for coverage under ECHO as long as ABA: 1) does-not meet the definition of a benefit under the medical program; and 2) can be reasonably characterized as a benefit under any one of the seven categories listed in 1079(e).

In sum, DoD has authority under title 10 U.S.C. Section 1079(d–e) (the TRICARE ECHO Program) to provide coverage of ABA as a non-medical service for eligible beneficiaries to minimize the effects of ASD. As discussed above, there is no current authority to provide ABA coverage under the TRICARE Basic Program.

Question. Dr. Woodson, you stated during the hearing that ABA therapy is an "educational intervention" and not "medical treatment." I disagree with your classification. First, TRICARE and most other insurance companies require a board-certified medical doctor in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology, pediatric psychology, or a specially trained physician or PhD psychologist who works with children to diagnose autism. Second, ABA therapy is a doctor-prescribed medical treatment and is recommended and endorsed by the U.S. Surgeon General, American Academy of Pediatrics, National Institute of Mental Health and other national medical policy organizations as effective treatment for autism. The 2007 American Academy of Pediatrics report concluded that the benefit of ABA-based interventions in autism spectrum disorders (ASDs) "has

been well documented" and that "children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior." Third, Board Certified Behavior Analysts (BCBA) administer most of the treatment and have no affiliation with Special Education. They are highly trained and spend the majority of their careers working with doctors, psychologists, and psychiatrists—not special educators. Based on these endorsements by reputable people and institutions, why do you not believe ABA therapy is a "medical treatment?" Please provide any supporting documentation the Department used to make its decision to classify ABA therapy as special education.

Answer. See attached TRICARE MANAGEMENT ACTIVITY Assessment of Applied Behavior Analysis for Autism Spectrum Disorders.

TRICARE
MANAGEMENT
ACTIVITY

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
SKYLINE FIVE, SUITE 810, 5111 LEESBURG PIKE
FALLS CHURCH, VIRGINIA 22041-3206

ACTION MEMO

FOR: GEORGE PEACH TAYLOR, JR., M.D., ACTING DIRECTOR, TRICARE MANAGEMENT ACTIVITY 10/19/2010

FROM: RADM C. S. Hunter, Deputy Director, TRICARE Management Activity 10/14/10

SUBJECT: Medical Benefit Determinations—Applied Behavior Analysis for the Treatment of Autism Spectrum Disorders

Pursuant to the appeal of a denied claim of a retiree dependent seeking TRICARE coverage for Applied Behavior Analysis (ABA) services as a medical benefit, a technical assessment was conducted to determine the following: **(1)** Does the reliable evidence support a conclusion that ABA is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)? **(2)** Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and that it is appropriate medical care for ASD in accordance with the requirements of 32 Code of Federal Regulations, Section (Sec.) 199.4(g)(15)? **(3)** Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, United States Code (U.S.C.), if it is concluded that ABA is not medically, or psychologically necessary and that it is not appropriate medical care for ASD, or that it is not proven as medically or psychologically necessary or that it is not appropriate medical care for ASD?

The assessment results do not support a conclusion that ABA is medically or psychologically necessary or that it is appropriate medical care for ASD. Furthermore, the assessment results do not support a conclusion that ABA is proven medically or psychologically necessary for ASD, within the meaning of TRICARE regulations. However, the assessment results do support a conclusion that TRICARE has authority to pay for ABA services for ASD for qualified dependents under the Extended Care Health Option (ECHO) program as authorized under 10 U.S.C., Sec. 1079(d).

RECOMMENDATION: That the (A) Director review the technical assessment and make decisions regarding the three enclosed recommendations as a final agency action.

COORDINATION: TAB C

Attachments:
As stated

Prepared by: Mr. Michael Kottyan, MB&RB, TRICARE Policy & Operations, (303) 676-3520, Livelink # 182440, 182441

MEDICAL BENEFIT DETERMINATIONS
FOR
APPLIED BEHAVIOR ANALYSIS FOR THE TREATMENT OF
AUTISM SPECTRUM DISORDERS

RECOMMENDATIONS FOR THE DIRECTOR, TMA:

- Recommendation #1: Sufficient reliable evidence ***does not exist*** to find that Applied Behavior Analysis (ABA) is either medically or psychologically necessary or appropriate medical care for Autism Spectrum Disorders (ASD). The majority of the reliable evidence reviewed indicates that ABA is characterized as an educational intervention and does not meet the TRICARE definition of medical care.

_____Approve Date: 10/19/2010

_____Disapprove Date: _____

- Recommendation #2: Sufficient reliable evidence ***does not exist*** to find that ABA is ***proven*** as medically or psychologically necessary or as appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15).

_____Approve Date: 10/19/2010

_____Disapprove Date: _____

- Recommendation #3: The Department of Defense (DoD) has authority under Chapter 55 of Title 10, U.S.C. Section 1079(d - e) (the TRICARE Extended Care Health Option (ECHO) program, as implemented by 32 C.F.R. § 199.5) to provide coverage of ABA for ASD to eligible dependents as defined under 1079(d).

_____Approve Date: 10/19/2010

_____Disapprove Date: _____

October 14, 2010

TRICARE MANAGEMENT ACTIVITY[1] ASSESSMENT OF APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDERS

I. PURPOSE

To make recommendations regarding the following:

- Key Issue #1: Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?

- Key Issue #2: Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15).

- Key Issue #3: Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?

II. RECOMMENDATIONS

KEY ISSUE #1: Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?

RECOMMENDATION #1: The results of this assessment do not support a conclusion that ABA is either medically or psychologically necessary or appropriate medical care for ASD. To the contrary, the results support the conclusion that ABA is neither medically or psychologically necessary nor appropriate medical care for ASD. The reliable

[1] The TRICARE Management Activity (TMA) administers the DoD health program commonly referred to originally as the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), and later as the TRICARE Program. See 32 C.F.R. Part 199. The purchased care portion of this health benefit program, the TRICARE Basic Program, is essentially a supplemental program to the care provided by the Uniformed Services in the Military Treatment Facilities (MTFs) (*i.e.* military hospitals), also referred to as the DoD direct medical care system. See 32 C.F.R. § 199.4(a). Additional, non-medical benefits not otherwise available under the TRICARE Basic Program are provided to certain eligible active duty family members under the TRICARE Extended Care Health Option (ECHO) program (32 C.F.R. 199.5).

evidence reviewed indicates that ABA is an educational intervention and does not meet the TRICARE definition of medical care.

KEY ISSUE #2: Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and that it is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15)?

RECOMMENDATION #2: A recommendation has been made that the Director, TMA find that ABA is neither medically or psychologically necessary nor appropriate medical care for ASD. However, in the event that the Director, TMA disagrees and finds that ABA is medically or psychologically necessary and appropriate medical care for ASD, the results of this assessment support the conclusion that ABA has not been shown by reliable evidence to meet the requirements of 32 C.F.R. §199.4(g)(15) to be proven as medically or psychologically necessary or as appropriate medical care for ASD.

KEY ISSUE #3: Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?

RECOMMENDATION #3: There is insufficient evidence to establish that ABA is medically or psychologically necessary or that it is appropriate medical care for ASD. Additionally there is insufficient reliable evidence to establish that ABA is "proven" as medically or psychologically necessary for ASD. Therefore, there is no current authority to provide ABA coverage under the TRICARE Basic Program. However, the results of this assessment do support the conclusion that DoD has authority under Title 10 U.S.C. Section 1079(d - e) (the TRICARE ECHO program) to provide coverage of ABA for ASD for ECHO eligible beneficiaries.

III. BACKGROUND

A. What are the Autism Spectrum Disorders?

In the *Diagnostic and Statistical Manual of Mental Disorders,* (DSM-IV-TR (fourth edition, text revision))[2] each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (*e.g.*, a painful symptom) or disability (*i.e.*, impairment in one or more important areas of functioning) or with a

[2] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

DSM-IV-TR contains a section of disorders that are usually first diagnosed in infancy, childhood, or adolescence, although sometimes those disorders are not diagnosed until adulthood. A sub-section lists the Pervasive Developmental Disorders (PDD) and their associated *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic code: Autistic Disorder (299.00), Rett's Disorder (299.80), Childhood Disintegrative Disorder (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise Specified (Including Atypical Autism) (299.80).

PDDs are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age.

Autistic Disorder

The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (*e.g.*, eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communications. There may be failure to develop peer relationships appropriate to developmental level that may take different forms at different ages. The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. There may be delay in, or total lack of, the development of spoken language. In individuals who do speak, there may be marked impairment in the ability to initiate or sustain a conversation with others or a stereotyped and repetitive use of language or idiosyncratic language. There may also be a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level. Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus; an apparently inflexible adherence to specific, nonfunctional routines or rituals; stereotyped and repetitive motor mannerisms; or a persistent preoccupation with parts of objects. Individuals with Autistic Disorder display a markedly restricted range of

interests and are often preoccupied with one narrow interest (*e.g.*, dates, phone numbers, radio station call letters). The disturbance must be manifest by delays or abnormal functioning in at least one (and often several) of the following areas: social interaction, language as used in social communication, or symbolic or imaginative play.

Rett's Disorder

The essential feature of Rett's Disorder is the development of multiple specific deficits following a period of normal functioning after birth. Individuals have an apparently normal prenatal and perinatal period with normal psychomotor development through the first 5 months of life. Between ages 5 and 48 months, head growth decelerates. There is a loss of previously acquired purposeful hand skills between ages 5 and 30 months, with the subsequent development of characteristic stereotyped hand movements resembling hand-wringing or hand washing. Interest in the social environment diminishes in the first few years after the onset of the disorder, although social interaction may often develop later in the course. Problems develop in the coordination of gait or trunk movement. There is also severe impairment in expressive and receptive language development, with severe psychomotor retardation. Data are limited to mostly case series, and it appears that Rett's Disorder is much less common than Autistic Disorder. This disorder has been reported only in females.

Childhood Disintegrative Disorder

The essential feature of Childhood Disintegrative Disorder is a marked regression in multiple areas of functioning following a period of at least 2 years of apparently normal development reflected age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior. After the first 2 years of life (but before age 10 years), the child has a clinically significant loss of previously acquired skills in at least two of the following areas: expressive or receptive language, social skills or adaptive behavior, bowel or bladder control, play, or motor skills. Most typically, acquired skills are lost in almost all areas and individuals with this disorder exhibit the social and communicative deficits and behavioral features generally observed in Autistic Disorder. Although initial studies suggested an equal sex ratio, the most recent data suggest that the condition is more common among males.

Asperger's Disorder

The essential features of Asperger's Disorder are severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests, and activities. The disturbance must cause clinically significant impairment in social, occupations, or other important areas of functioning. In addition, during the first 3 years of life, there are no clinically significant delays in cognitive development as manifested by expressing normal curiosity about the environment or in the acquisition of age-appropriate learning skills and adaptive behaviors (other than in social interaction). Finally, the criteria are not met for another specific Pervasive Developmental disorder or for Schizophrenia. This condition is also termed Asperger's syndrome. The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (*e.g.*, eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communication. There may be failure to develop peer relationships appropriate to developmental level that may take different forms at different ages.

Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

This category is used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for other specific PDDs or other diagnoses. For example, this category includes "atypical autism" — presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold synptomatology, or all of these.

The National Institute of Mental Health (NIMH) states that those five PDDs are more often referred to today as autism spectrum disorders (ASD).[3] We specifically note that the Centers for Disease Control and Prevention[4] stated that there is currently no cure for ASD.

[3] "Autism Spectrum Disorders-Pervasive Developmental Disorders (NIH 08-5511)." National Institute of Mental Health. Online. July 22, 2009. Accessed September 27, 2010. <http://www.nimh.nih.gov/health/publications/autism/complete-index.shtml>

[4] "Facts About ASDs". Centers for Disease Control and Prevention. May 13, 2010. Accessed September 27, 2010. <http://cdc.gov/ncbddd/autism/facts.html>

B. What is Applied Behavior Analysis?

As described by the Behavior Analyst Certification Board, Inc.® (BACB®),[5] behavior analysis, which grew out of the scientific study of principles of learning and behavior, has two main branches: experimental and applied behavior analysis. The experimental analysis of behavior is the basic science that over the decades has accumulated a substantial and well-respected foundation of research literature. This literature is the scientific foundation for the second branch—applied behavior analysis.

To summarize the description by the BACB®, applied behavior analysis is 1) an applied science that develops methods of changing behavior and 2) a profession that provides services to meet diverse behavioral needs. Applied behavior analysis is a well-developed discipline among the helping professions, with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and education requirements for practice, and identified sources of requisite education in universities. Professionals in applied behavior analysis engage in the specific and comprehensive use of principles of learning, including operant and respondent learning, in order to address behavioral needs of widely varying individuals in diverse settings. Examples of these applications include: building the skills and achievements of children in school settings; enhancing the development, abilities, and choices of children and adults with different kinds of disabilities; and augmenting the performance and satisfaction of employees in organizations and businesses.

Frequently, references to applied behavior analysis or ABA are associated with the "Lovaas" model of applied behavior analysis because of the seminal works for advancing treatment of children with autism by Dr. O. Ivar Lovaas. Often cited is the publication[6] wherein Dr. Lovaas re-states that medically and psychologically oriented therapies [for autism] have not proven effective in altering outcome (DeMyer, Hingtgen, & Jackson, 1981), and reports the results of his behavioral-intervention project that sought to maximize behavioral treatment gains by treating autistic children during most of their waking hours for many years. The project hypothesized that construction of a special, intense, and comprehensive learning environment for very young autistic children would allow some of them to catch up with their normal peers by first grade. The operative method of this therapy consisted of using reinforcement, which, as a last resort could take the form of an aversive technique (*e.g.*, loud "no" or a slap on the thigh) to modify behavior by teaching imitation, expressive and early abstract language, interactive play with peers, and appropriate and varied expressions of emotions (physically aversive techniques are no longer considered appropriate).

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[5] Consumer Information. About Behavior Analysis. Behavior Analyst Certification Board. Web. Accessed September 19, 2010. <http://www.bacb.com/consum_frame.html>

[6] Lovaas, O.I. (1987) "Behavioral treatment and normal educational and intellectual functioning in young autistic children." Journal of Consulting and Clinical Psychology, 55. 3-9.

The current model of intensive behavioral intervention is generally begun by age 3 ½ and consists of up to 40 hours per week of intensive therapy for 2 years or longer. It aims to teach social, motor, and verbal behaviors as well as reasoning skills using careful behavioral observation and positive reinforcement and prompting to teach each step of a behavior. Skills are broken down into small tasks, which are taught in a very structured manner, accompanied by praise and reinforcement. Undesirable behaviors are reduced by ignoring them or introducing more socially acceptable forms of behavior.[7]

C. Statutory and Regulatory Requirements for Coverage under TRICARE

Statutory Authority

Title 10 United States Code Chapter 55, Section 1071[8] authorizes a uniform program—Civilian Health and Medical Program of the Uniformed Services—of medical benefits and dental care for members and certain former members of the Uniformed Services and their dependents. Administration of that chapter is the responsibility of the Secretary of Defense and certain other Secretaries (Section 1073). TRICARE is authorized at Sections 1079, 1086, and 1091 to contract with civilian providers for the health care program benefits authorized under Section 1077.

Regulations

Title 32 Part 199 of the Code of Federal Regulations (32 C.F.R. 199)[9] prescribes the guidelines and policies for the administration of the TRICARE Program.

32 C.F.R. §199.1(d) specifies that the program authorized under Chapter 55, Title 10, United States Code, includes a program of medical benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services. Although similar in structure in many of its aspects, it is not an insurance program in that it does not involve a contract guaranteeing the indemnification of an insured party against a specified loss in return for a premium paid. Further, the program is not subject to those state regulatory bodies or agencies that control the insurance business generally.

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[7] Berkovitz, Carol, and Dena Hofkosh. "Autism Spectrum Disorders." First Consult. MD Consult, 23 August 2007. Web. Accessed September 9, 2010. <http://www.mdconsult.com/das/pdxmd/body/207062080-3/0?type=med&eid=9-u1.0-_1_mt_1014440>.

[8] United States Code. Title 10-Armed Forces, Subtitle A-General Military Law, Chapter 55-Medical and Dental Care. Web. <http://frwebgate.access.gpo.gov/cgibin/U.S.C..cgi?ACTION=BROWSE&TITLE=10U.S.C.SA&PDFS=YES>

[9] Code of Federal Regulations, Title 32, Part 199-Civilian Health and Medical Program of the Uniformed Services (TRICARE). Section 199.2 *Definitions*. [32 C.F.R. 199.2] Web. <http://eC.F.R..gpoaccess.gov/cgi/t/text/text-idx?c=eC.F.R.&sid=beb8decc3a2f2855decce34acfd2a9fb&rgn=div8&view=text&node=32:2.1.1.1.8.0.1.2

Paragraph 32 C.F.R. §199.1(e) specifies that the appropriated funds furnished annually by the Congress are used to adjudicate claims received under Part 199. That paragraph establishes that Part 199 is the regulatory guidance for administering the program, including setting out the benefits that are eligible for reimbursement.

The TRICARE regulation 32 C.F.R. §199.2(b) (*Definitions*) defines the following terms:

"Medical"

> The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of TRICARE, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

"Medically or psychologically necessary"

> The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

"Appropriate medical care"

> (i) Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;
>
> (ii) The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and
>
> (iii) The services are furnished economically. For purposes of this part, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to

provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

"Mental disorder"

For purposes of the payment of [TRICARE] benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, *and* that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.[10]

"Major life activity"

Breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking.

D. Requirements for Reliable Evidence

In accordance with 32 C.F.R. §199.4(g)(15), any proposed TRICARE Basic Program benefit that is characterized as a drug, device, medical treatment, diagnostic or therapeutic procedure must be determined by the Director, TMA to be safe and effective in accordance with the reliable evidence criteria. Reliable evidence is defined in 32 C.F.R. §199.2(b) as meaning only:

(i) Well controlled studies of clinically meaningful endpoints, published in refereed medical literature.
(ii) Published formal technology assessments.
(iii) The published reports of national professional medical associations.
(iv) Published national medical policy organization positions; and
(v) The published reports of national expert opinion organizations.

Specifically not included in the meaning of reliable evidence are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or professional opinions.[11] Furthermore, the

[10] Subsequent and current editions of the DSM are accepted as the equivalent to citation to DSM-III.
[11] The documents reviewed for this assessment include those cited in the text and/or listed in Attachment 1. Other articles and websites regarding the subject of ASD and ABA were identified during our literature and database searches, but were determined not to be reliable evidence in accordance with 32 C.F.R. § 199.2(b).

hierarchy of reliable evidence of proven medical effectiveness as listed above is the order of the relative weight to be given to any particular source.[12]

IV. REVIEW, DISCUSSION AND RECOMMENDATIONS

A. Review under the Reliable Evidence Standard Related to Key Issue #1: Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?

The following summarizes our conclusions based on a thorough review of the reliable evidence cited herein and the documents listed in Attachment 1:[13]

Clinical Literature: Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature.

Using subject-relevant terms including autism, autism spectrum disorder, intensive behavioral intervention, early intensive behavioral intervention, and Lovaas, an online search for clinical literature published during 2009-2010 did not find reliable evidence that explicitly referred to applied behavior analysis as medical care.

Technology Assessments: Published formal technology assessments.

Full In-Depth Health Care Technology Assessments[14,15,16] by the ECRI Institute and assessments by the Blue Cross Blue Shield (BCBS) Technology Evaluation Center (TEC)[17] and Hayes, Inc:[18]

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[12] 32 C.F.R. §199.2(b).

[13] In the course of preparing this technology assessment the beneficiary had also submitted an appeal to the TMA presenting numerous documents for that appeal relating to ABA and their claim that it should be covered under the medical program. In an effort to ensure that TMA had not overlooked any relevant material meeting the regulatory requirements or reliable evidence, the documents submitted for the appeal and which are listed in Attachment 1 were also reviewed.

[14] "Comprehensive Programs for the Treatment of Children with Autism." ECRI Institute. Health Technology Assessment Information Service. August 17, 2000.

[15] "Comprehensive Educational and Behavioral Interventions for the Treatment of Autism Spectrum Disorders." ECRI Institute. Health Technology Assessment Information Service. November 25, 2008.

[16] "Focal Educational and Behavioral Interventions for the Treatment of Autism Spectrum Disorders (ASDs)." ECRI Institute. Health Technology Assessment Information Service. January 12, 2009.

[17] "Special Report: Early Intensive Behavioral Intervention Based on Applied Behavior Analysis among Children with Autism Spectrum Disorders." BlueCross BlueShield Association. Assessment Program. Volume 23, No. 9. February 2009.

[18] "Intensive Behavioral Intervention Therapy for Autism." Hayes, Inc. April 6, 2008. Accessed 6 July 2010. <http://www.hayesinc.com>

In "Table 3-1. Key Aspects of the Comprehensive Treatment Programs Assessed in This Technology Assessment", ECRI (2000) lists the Lovaas program as a behavioral intervention and provides further discussion in paragraph "3.1. The Lovaas Program":

> The first stage of the Lovaas program of early intensive behavioral intervention is to attempt to establish a good rapport between child and therapist, usually within the child's own home. This is facilitated by presenting the child with simple tasks that he or she can readily master in combination with constant reinforcement. As the intervention process progresses, food and other intensive reinforcement protocols are replaced, whenever possible, by more common reinforcers from everyday life. The intervention process is structured so that positive behaviors (behaviors that are deemed appropriate) are maximized through prompting and positive reinforcement. High rates of aggressive and/or self-stimulatory behaviors are reduced by being ignored and by teaching alternate, more socially acceptable forms of behavior. On occasion, punishment is administered in the form of a slap on the thigh. The intervention process progresses very gradually from teaching elementary self-help and receptive language skills to teaching nonverbal and verbal imitation skills and establishing the foundations of appropriate toy play. Teaching imitative skills to a child with autism is an essential aspect of the Lovaas program. Once learned, imitation is used as one of the prime teaching tools of the program.
>
> The second stage emphasizes the teaching of expressive and early abstract language and interactive play with peers. In more advanced stages of the intervention, the child is taught at home and at school (1) early academic tasks such as beginning reading, writing, and arithmetic; (2) socialization skills; (3) cause-effect relationships; and (4) to learn by observing other children learning.
>
> In this second stage, each child is taught on a one-to-one basis for up to 7 hours per day, 7 days per week (accumulating a treatment exposure time of at least 40 hours per week). The teaching schedule is adjusted to the needs of the individual child and may, for example, include time for an afternoon nap.
>
> After a period of 6 to12 months of one-to-one home-based teaching, a determination is made as to whether the child is in a position to take advantage of a group or classroom situation. At this third stage, the teaching procedures become less structured as the child

progresses, and the procedures are generalized to the child's school and everyday environment.

In the second ECRI assessment (2008), three of five "Key Questions" focus on the outcomes of educational or behavioral intervention, specifically:

- Improved over another course of action, *i.e.*, no treatment, wait list, *etc.*;
- Improved based on comparison with other comprehensive interventions;
- Improved based on setting, *i.e.*, home-based vs center/clinical setting

We conclude from that technology assessment that regardless of how the intervention is oriented, that is, behaviorally such as ABA, or developmentally such as the "Denver Model"[19], the over-arching methodology of the intervention is an educational process based on presenting a behavior opportunity to the individual and then responding to the exhibited behavior, *i.e.*, praise/reward for appropriate response, withholding praise/reward for inappropriate response.

The 2009 ECRI assessment targeted "focal educational and behavioral interventions;" however, its "Key Questions" 1 and 2 virtually mirrored the 2008 ECRI assessment. While ABA, which is generally part of a comprehensive treatment program, is not specifically included, the review of focal treatments finds that they rely on an educational process. Whether the method is 'Video Monitoring', 'Peer-mediated intervention', 'Reinforcement Schedules and Activities', Social Stories, or other form, the goal of treatment is improving social skills through the process of learning interaction with others and behaviors that are acceptable. This same educational process underlies focal interventions that target improving communication skills and stereotyped/problem behaviors.

The BCBS TEC assessment (2009) presents a systematic review of the research literature on the use of early intensive behavioral intervention (EIBI) based on ABA; its intent was to inform the public discussion regarding EIBI. It does not refer to ABA as a medical intervention.

The Hayes technology assessment (2008) states that treatment of autistic children has undergone substantial change in the last 20 years, with behavior modification replacing psychotherapy as the dominant and preferred treatment modality. The behavioral programs, referred to as EIBI, ABA, or 'Lovaas' therapy, involve structured

[19] The "Denver Model" is a developmentally-based program employing behavioral techniques, which began in 1981 at the University of Colorado Health Sciences Center, Denver, CO.

and precise teaching techniques administered by a trained therapist. The Hayes assessment does not refer to ABA as medical intervention.

Published Reports: Published reports of national professional medical associations; published national medical policy organization positions; and published reports of national expert opinion organizations.

Under "Treatment Options" the NIMH[20] states that while there is no single best treatment package for all children with ASD, most professionals agree that early intervention is important and that most individuals with ASD respond well to highly structured, specialized programs. Among the many methods available for treatment and education of people with autism, ABA has become widely accepted as an effective treatment. The report continues:

> An effective treatment program will build on the child's interests, offer a predictable schedule, teach tasks as a series of simple steps, actively engage the child's attention in highly structured activities, and provide regular reinforcement of behavior.
>
> As soon as a child's disability has been identified, instruction should begin. Effective programs will teach early communication and social interaction skills. In children younger than 3 years, appropriate interventions usually take place in the home or a child care center. These interventions target specific deficits in learning, language, imitation, attention, motivation, compliance, and initiative of interaction. Included are behavioral methods, communication, occupational and physical therapy along with social play interventions. Often the day will begin with a physical activity to help develop coordination and body awareness; children string beads, piece puzzles together, paint, and participate in other motor skills activities. At snack time the teacher encourages social interaction and models how to use language to ask for more juice. The children learn by doing. Working with the children are students, behavioral therapists, and parents who have received extensive training. In teaching the children, positive reinforcement is used.
>
> Children older than 3 years usually have school-based, individualized, special education. The child may be in a segregated class with other autistic children or in an integrated class with children without disabilities for at least part of the day.

[20] "Autism Spectrum Disorders-Pervasive Developmental Disorders (NIH 08-5511)." National Institute of Mental Health. Online. July 22, 2009. Accessed September 27, 2010.

The Centers for Disease Control and Prevention[21] stated that there is currently no cure for autism; however, research shows that early intervention treatment services can greatly improve a child's development. For parents, caregivers, educators, or medical professionals concerned that their child might have a problem, the CDC recommends a referral to see a developmental pediatrician or other specialist, or contact with the local early intervention agency (for children under 3) or public school (for children 3 and older), as provided by the Individuals with Disabilities Education Act (IDEA).

The American Academy of Pediatrics states in clinical report:[22]

> ASDs, similar to other neurodevelopmental disabilities, are generally not "curable" and chronic management is required. Although outcomes are variable and specific behavioral characteristics change over time, most children with ASDs remain within the spectrum as adults and, regardless of their intellectual functioning, continue to experience problems with independent living, employment, social relationships, and mental health. The primary goals of treatment are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress. Facilitating development and learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families can help accomplish these goals. Ideally, interventions should help mitigate the core features of ASDs, which include impairment in social reciprocity, deficits in communication, and restricted, repetitive behavioral repertoire;

and

> [e]ducational interventions, including behavioral strategies and habilitative therapies, are the cornerstones of management of ASDs. These interventions address communication, social skills, daily-living skills, play and leisure skills, academic achievement, and maladaptive behaviors.

The report continues:

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[21] "Facts About ASDs". Centers for Disease Control and Prevention. May 13, 2010. Accessed September 27,2010. <http://cdc.gov/ncbddd/autism/facts.html>

[22] Myers SM, Johnson CP; American Academy of Pediatrics, Council on Children With Disabilities. Management of children with autism spectrum disorders. *Pediatrics.* 2007;120 (5):1162 –1182. >http://pediatrics.aappublications.org/cgi/content/full/120/5/1162>

> [e]ffective medical management may allow a child with an ASD to benefit more optimally from educational interventions;

and states that there is growing consensus that important principles and components of effective early childhood intervention for children with ASDs include, among others:

> [p]rovision of intensive intervention, with active engagement of the child at least 25 hours per week, 12 months per year, in systematically planned, developmentally appropriate educational activities designed to address identified objectives.

RECOMMENDATION REGARDING KEY ISSUE #1 (Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?): The results of this assessment do not support a conclusion that ABA is medically or psychologically necessary and appropriate medical care for ASD. To the contrary, the results support the conclusion, and it is recommended that the Director, TMA find that ABA is not medically or psychologically necessary and appropriate medical care for ASD. The reliable evidence reviewed indicates that ABA is an educational intervention and does not meet the definition of medical care.

B. Review under the Reliable Evidence Standard Related to Key Issue #2: Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15)?

Clinical Literature: Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature.

Using subject-relevant terms including autism, autism spectrum disorder, intensive behavioral intervention, early intensive behavioral intervention, and Lovaas, an online search for clinical literature published during 2009-2010 did not find reliable evidence that explicitly referred to applied behavior analysis as medical care. [Note: Literature published prior to 2009 is included in, or was available to the references cited.]

Technology Assessments: Published formal technology assessments.

In Summary, the ECRI assessment (2000) states:

> [T]hat there are interventions that are associated with some improvement in autistic symptoms. However, claims of turning autistic children into children indistinguishable from normal children

> have not been substantiated. The best programs evaluated require substantial effort and may result in real gains, but may not work for all children;

and:

> [i]t is likely that as researchers discover more about the subcategories of autism and its underlying causes, there will be improvements in educational, psychological, and pharmacological interventions. Until then, the ability to effect change remains modest.

Regarding Key Question 2: "Is one comprehensive educational or behavioral intervention more effective than another in improving outcomes for children with ASD?", the 2008 ECRI assessment states:

> For intellectual/cognitive status, language/communication skills, and adaptive behavior, clinical differences, and study size prevented the assessment from drawing conclusions about whether intensive applied behavior analysis was more effective than an intensive eclectic intervention program in improving these outcomes for children with ASD.

Regarding the efficacy of ABA, the ECRI 2008 noted in response to Key Question 5: "What is the consensus among experts about the safety and efficacy of comprehensive educational or behavioral interventions for the treatment of children with ASD?", that:

> In general, the published guidelines [reviewed in that ECRI assessment] recommend that treatment involving behavioral interventions, such as ABA, should be initiated when the child is young, include a minimum of 15-20 hour per week of one-to-one instruction, be designed to fit the needs of the individual child, and include the family in the planning and provision of services. However, there is overall agreement among the organizations that the existing evidence supporting one comprehensive intervention over another is limited due to methodological flaws (*e.g.*, lack of randomized controlled trials, small sample sizes, *etc.*) in most of the published research.

The BCBS TEC (2009) assessment found that:

> Overall, the quality and consistency of results of this body of evidence are weak. Consequently, no conclusions can be drawn from this literature on how well EIBI works.

BCBS TEC recommends additional research is needed to identify those characteristics of treatment—content, technique, intensity, starting and ending age, *etc.*—that maximizes its effectiveness. To be effective, research needs to include greater emphasis on randomized, controlled trials, substantially larger sample sizes, uniformity of outcomes evaluated and instruments used to measure them, and consistent treatments that do not vary widely within treatment groups.

The Hayes assessment (2008) assigned Intensive Behavioral Intervention Therapy for Autism a rating of "C". Regarding the Hayes rating:

> This rating ["C"] reflects the modest but positive effect of IBI in some children with autism, the overall weakness of the body of evidence surrounding IBI for autism, and the lack of criteria to identify children most likely to benefit from an IBI program.

It is further noted that the updated literature search and review by Hayes indicated there was no anticipated impact on the rating given in the 2008 assessment.[23]

Published Reports: Published reports of national professional medical associations; published national medical policy organization positions; and published reports of national expert opinion organizations.

In the section on "Educational Interventions", the American Academy of Pediatrics clinical report (2007) states:

> The effectiveness of ABA-based intervention in ASDs has been well documented through 5 decades of research by using single-subject methodology and in controlled studies of comprehensive early intensive behavioral intervention programs in university and community settings. Children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups.

[23] Update Search. Hayes, Inc. May 13, 2010. Accessed 6 July 2010. <https://www.hayesinc.com>

An online search did not locate any National Coverage Determinations (NCDs) published by the CMS regarding ABA or behavioral therapy for ASDs.[24]

Additional Information: The following information, while not conclusively meeting the definition of reliable evidence, is included to provide context and additional relevant information.

Defense Health Board:[25] Following a review of evidence, including more than 120 published articles related to ASD and ABA, the Department of Defense Health Board found that:

> A paucity of data resulting from few studies, as well as lack of long-term follow-up, exists that could inform questions and provide answers related to the absolute and relative effectiveness of ABA for ASD;

and concluded:

> [t]he Board appreciates the opportunity to provide input on the important issue of ABA treatment for autism spectrum disorders (ASD). However, the principal factor limiting the ability of the Board to draw firm conclusions regarding the relative efficacy of ABA is the lack of sufficient sound and thorough peer-reviewed evidence on this issue.

The primary purpose of the National Standards Project[26] was to identify the level of research support currently available for educational and behavioral interventions used with individuals (below 22 years of age) with Autism Spectrum Disorders; it was not intended to dictate which treatments can or cannot be used with autism spectrum disorder. The Guidelines included applied behavior analysis, among others, as an established treatment.

Under a grant from the U. S. Department of Education, the New York State Department of Health developed clinical practice guidelines to support the efforts of the statewide Early Intervention Program.[27] While the work represents neither standards nor

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[24] Medicare Coverage Database, National Coverage Determinations (NCDs); retrieved 17 June 2010. <http://www.cms.gov/mcd/index_list.asp?list_type=ncd#PO.

[25] "Defense Health Board Findings Pertaining to Autism Treatment." Memorandum for Ellen P. Embrey, Deputy Assistant Secretary of Defense (FHP&R), Performing the Duties of the Assistant Secretary of Defense for Health Affairs. September 18, 2009.

[26] "Findings and Conclusions. Addressing the Need for Evidence-Based Practice Guidelines for Autism Spectrum Disorders." National Standards Project. National Autism Center. 2009. Web. Accessed 23 September 2010. http://www.nationalautismcenter.org/pdf/NAC%20Standards%20Report.pdf

[27] "Clinical Practice Guideline. Quick Reference Guide for Parents and Professionals. Autism/Pervasive

policies, the discussion regarding behavioral and educational approaches recommends "that principles of applied behavior analysis (ABA) and behavior intervention strategies be included as important elements in any intervention program for young children with autism."

RECOMMENDATION REGARDING KEY ISSUE #2 (Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15)?): A recommendation has been made that the Director, TMA find that ABA is neither medically or psychologically necessary nor appropriate medical care for ASD. However, in the event that the Director, TMA disagrees and finds that ABA is medically or psychologically necessary and appropriate medical care for ASD, the results of this assessment support the conclusion that ABA has not been shown by reliable evidence to meet the requirements of 32 C.F.R. §199.4(g)(15) to be proven as medically or psychologically necessary or as appropriate medical care for ASD.

C. Discussion Related to Key Issue #3: Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?

Status of Authority under the TRICARE Basic Program

ABA has been characterized by the majority of the reliable evidence reviewed as not being a medical treatment, but instead as involving non-medical, behavioral intervention services. Additionally, except as otherwise specifically permitted by law, TRICARE has no authority to provide coverage of "special education" (10 U.S.C. 1079(a)(9)) or "self-help, academic education or vocational training services and supplies" (32 C.F.R. 199.4(g)(42)) under the Basic Program (32 C.F.R., 199.4). Therefore, as explained in Issues 1 and 2, ABA does not meet the TRICARE definition as a medical treatment for ASD. Additionally, special education or educational services are not payable under the medical program. Consequently, reimbursement can be made by the DoD for these services only if authorized by some other statutory authority under Chapter 55 of Title 10.

Other Available Authority:

Developmental Disorders. Assessment and Intervention for Young Children (Age 0-3 Years)." Web. Accessed 23 September 2010. <http://www.health.state.ny.us/publications/4216.pdf>

Section 1079 (d) (1)-(3) provides additional authority for payment for non-medical services. However, this statutory provision is limited to dependents of Active Duty Family Members with a qualifying condition. Under 10 U.S.C. 1079(d)(3), the term "qualifying condition" means the condition of a dependent who is moderately or severely mentally retarded, has a serious physical disability, or has an extraordinary physical or psychological condition. Active duty dependents diagnosed with ASD may have one of these qualifying conditions.

The services that are authorized under this provision have changed over the past, thus the history of this statutory provision is important. Prior to December 28, 2001, Section 1079(d) of Title 10 of the United States Code, implemented at 32 C.F.R. §199.5, was initially known as the Program for Persons with Disabilities (PFPWD) and authorized DHP reimbursement for:

- Diagnosis.
- Inpatient, outpatient, and home treatment.
- Training, rehabilitation, and special education.
- Institutional care in private nonprofit, public and State institutions and facilities and, when appropriate, transportation to and from such institutions and facilities.

Section 701(b) of the National Defense Authorization Act (NDAA) for Fiscal Year 2002[28] replaced 1079(d)-(f) with new section 1079(d)-(f). Section 1079(e) from the 2002 NDAA authorized the previous benefits, and provided for additional benefits as follows:

- Diagnosis.
- Inpatient, outpatient, and comprehensive home health care supplies and services which may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).
- Training, rehabilitation, special education, and assistive technology devices.
- Institutional care in private nonprofit, public, and State institutions and facilities and, if appropriate, transportation to and from such institutions and facilities.
- Custodial care, notwithstanding the prohibition in section 1077(b)(1) of this title.
- Respite care for the primary caregiver of the eligible dependent.

[28] Web. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ107.107.pdf>

- Such other services and supplies as determined appropriate by the Secretary, notwithstanding the limitations in subsection (a)(13).

Following publication of the ECHO Final Rule in the Federal Register on August 20, 2004, the new extended benefits program, known as the Extended Care Health Option (ECHO), was implemented on September 1, 2005.

The materials reviewed in this assessment support the conclusion that ABA may be considered as part of an integrated set of services and supplies designed to assist in the reduction of the disabling effects of ASD for an ECHO-registered beneficiary with a qualifying condition. See 32 C.F.R. 199.5(a)(2).

Although the literature characterizes ABA services by the use of several non-medical terms and there does not appear to be consensus on any one characterization, a precise characterization of ABA is not required for coverage under ECHO as long as ABA: 1) does not meet the definition of a benefit under the medical program; and 2) can be reasonably characterized as a benefit under any one of the seven categories listed in 1079(e). The DoD has in the past reimbursed these services as special education or as special education services under 1079(e)(3). However, prior reimbursement under 1079(e)(3) does not preclude reimbursement under other applicable subsections of 1079(d –e).

In sum, DoD has authority under title 10 U.S.C. Section 1079(d - e) (the TRICARE ECHO Program) to provide coverage of ABA as a non-medical service for eligible beneficiaries to minimize the effects of ASD. As discussed above, there is no current authority to provide ABA coverage under the TRICARE Basic Program.

RECOMMENDATION REGARDING KEY ISSUE #3 (Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?): There is insufficient evidence to establish that ABA is medically or psychologically necessary or that it is appropriate medical care for ASD. Additionally there is insufficient reliable evidence to establish that ABA is "proven" as medically or psychologically necessary for ASD. Therefore, there is no current authority to provide ABA coverage under the TRICARE Basic Program. However, the results of this assessment do support the conclusion that DoD has authority under Title 10 U.S.C. Section 1079(d - e) (the TRICARE ECHO program) to provide coverage of ABA for ASD for ECHO eligible beneficiaries.

Question. Dr. Woodson, currently, ABA therapy is authorized under the Extended Care Health Option (ECHO) Program which is not available to military retirees, including Wounded Warriors who are forced to medically retire. Please discuss why ABA therapy is placed under this program when the intent of Congress is to provide basic health care to all active duty military and military retirees?

Answer. ABA has been characterized by the majority of the reliable evidence reviewed as not being a medical treatment, but instead as involving non-medical, behavioral intervention services. Additionally, except as otherwise specifically permitted by law, TRICARE has no authority to provide coverage of behavior modification modalities or other non-medical services under the Basic Program (32 C.F.R., 199.4). Consequently, reimbursement can be made by the DoD for these services only if authorized by some other statutory authority under Chapter 55 of Title 10.

Section 1079(d)(1)–(3) provides additional authority for payment for non-medical services. However, this statutory provision is limited to dependents of Active Duty Family Members with a qualifying condition. Under 10 U.S.C. 1079(d)(3), the term "qualifying condition" means the condition of a dependent who is moderately or severely mentally retarded, has a serious physical disability, or has an extraordinary physical or psychological condition. Active duty dependents diagnosed with ASD may have one of these qualifying conditions.

Although the literature characterizes ABA services by the use of several non-medical terms, and there does not appear to be consensus on any one characterization, a precise characterization of ABA is not required for coverage under ECHO as long as ABA: 1) does not meet the definition of a benefit under the medical program; and 2) can be reasonably characterized as a benefit under any one of the seven categories listed in 1079(e).

Question. Dr. Woodson, doctors recommend children suffering from autism must receive at least 25–40 hours of ABA therapy each week to be effective. However, the ECHO program limits therapy to $36,000 per year which only amounts to an average of about 10 hours per week. In some states like the District of Columbia and California, this only pays for 5 hours per week. This is far less than the recommended amount. This is causing military families to pay out of their own pockets to make up this difference.

Answer. The National Defense Authorization Act for Fiscal Year 2009, Public Law 110–417, 110th Cong., 2nd sess. (14 Oct 2008), Section 732 established the limit of Government liability for ECHO benefits at $36,000 per year. This change was implemented on April 1, 2009. Prior to April 1, 2009 there was a monthly government liability limit of $2,500 per beneficiary.

Based on data generated using TRICARE purchased-care ECHO claims incurred during FY11 (October 1, 2010 through September 30, 2011), of the 5091 TRICARE beneficiaries with an ASD diagnosis using the ECHO program, 207 beneficiaries had expenditures above $35,000 per year. Another 489 beneficiaries had expenditures between $30,000 and $35,000 in FY11. Thus, approximately 14% of the TRICARE beneficiaries with an ASD diagnosis using the ECHO program are potentially facing out-of-pocket costs.

Question. Why has DoD not funded this program for beneficiaries to receive the doctor-prescribed amount? If it is a statutory issue, what has DoD done to notify Congress that the ECHO program does not provide adequate funding? Have any recommendations ever been made to Congress to increase deductibles or put any other measures in place to mitigate the financial burden placed on these military families? Please submit all related documentation if Congress has been informed of this issue in the past.

Answer. The National Defense Authorization Act for Fiscal Year 2009, Public Law 110–417, 110th Cong., 2nd sess. (14 Oct 2008), Section 732 established the limit of Government liability for ECHO benefits at $36,000 per year. This change was implemented on April 1, 2009. Prior to April 1, 2009 there was a monthly government liability limit of $2,500 per beneficiary.

The Joint Explanatory Statement (JES) to accompany the Duncan Hunter National Defense Authorization Act for Fiscal Year (FY) 2009 requests the Secretary of Defense to submit a report semiannually on the status of the TRICARE Autism Services Demonstration. Pursuant to the JES, the semiannual RTC includes an overview of the purpose, scope, and key features of the TRICARE Autism Services Demonstration; and information related to beneficiary utilization, provider participation, and whether reimbursement levels are sufficient to retain qualified providers. The most recent report was submitted in September 2011 and the current report is in coordination to be submitted by the end of April 2012.

Question. Dr. Woodson, it has been brought to my attention that DoD does not want to offer ABA therapy under TRICARE Basic because it will cost too much. Can you confirm or deny that this is the reason why you are not offering this therapy

under TRICARE Basic? Has cost consideration played any role in determining whether this treatment should be offered under TRICARE Basic? If so, please elaborate on how cost has affected DoD's decision making and classification of autism.

Answer. TRICARE conducted an assessment of ABA in October, 2010, and reliable evidence reviewed indicates that ABA does not satisfy the definition of proven medical care that statute and regulation require TRICARE to use. It is inappropriate to incorporate a non-medical service into the TRICARE Basic Program, which has heretofore been restricted to provision of medical care. Congress has established by statute the separate Extended Care Health Option (ECHO) to enable provision of certain non-medical services to active duty family members. Cost was not a factor in TRICARE's assessment of ABA.

Question. Dr. Woodson, please provide estimates of how much additional funding would be needed if ABA therapy is placed under TRICARE Basic. Please include all assumptions used to formulate this amount.

Answer. Using DEERS data, we estimate that there are approximately 1.6 million active duty family members (ADFM) younger than age 22 (99.9 percent of ECHO ASD users are age 21 or younger). The CDC currently estimates that about 1 percent of the general population has ASD implying that roughly 16,000 ADFM beneficiaries younger than age 22 have ASD. With 5,091 ADFM users in the ECHO ASD program during FY11, we estimate that roughly one third of the ASD population receives services.

In FY11, the average annual cost per TRICARE beneficiary diagnosed with an ASD using the ECHO program was $16,249. At the end of FY10, there were 5562 retired family members with an ASD diagnosis. Using the rough estimate in the paragraph above, we would expect that approximately 1800 retired family members would receive services. Therefore, if ABA therapy were placed under the TRICARE Basic program, at a minimum it is estimated that approximately $30 million annually would be required to cover the additional beneficiaries. This does not take into account additional costs for all beneficiaries if the annual cap of $36,000 under the ECHO program was lifted. This would add significantly to the cost.

It should be noted that annual TRICARE costs for ECHO program participants with ASD diagnoses in FY11 was $82.7 million.

Question. Dr. Woodson, from everything that I have read ABA therapy is clearly the therapy that works best to give kids suffering from autism the best shot of living a functional life. My perception is that DoD is going out of its way to classify ABA therapy as something that does not meet TRICARE Basic classification. If there are no statutory requirements for DoD's classification of ABA therapy as special education, which has been used as justification to prevent coverage under TRICARE Basic, what is preventing DoD from recognizing ABA as a medically prescribed treatment that would obviously be covered under 10 USC 1077(a)(5)?

Answer. See attached TRICARE MANAGEMENT ACTIVITY Assessment of Applied Behavior Analysis for Autism Spectrum Disorders.

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TRICARE
MANAGEMENT
ACTIVITY

ACTION MEMO

FOR: GEORGE PEACH TAYLOR, JR., M.D., ACTING DIRECTOR, TRICARE MANAGEMENT ACTIVITY 10/19/2010

FROM: RADM C. S. Hunter, Deputy Director, TRICARE Management Activity 10/14/10

SUBJECT: Medical Benefit Determinations—Applied Behavior Analysis for the Treatment of Autism Spectrum Disorders

Pursuant to the appeal of a denied claim of a retiree dependent seeking TRICARE coverage for Applied Behavior Analysis (ABA) services as a medical benefit, a technical assessment was conducted to determine the following: **(1)** Does the reliable evidence support a conclusion that ABA is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)? **(2)** Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and that it is appropriate medical care for ASD in accordance with the requirements of 32 Code of Federal Regulations, Section (Sec.) 199.4(g)(15)? **(3)** Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, United States Code (U.S.C.), if it is concluded that ABA is not medically, or psychologically necessary and that it is not appropriate medical care for ASD, or that it is not proven as medically or psychologically necessary or that it is not appropriate medical care for ASD?

The assessment results do not support a conclusion that ABA is medically or psychologically necessary or that it is appropriate medical care for ASD. Furthermore, the assessment results do not support a conclusion that ABA is proven medically or psychologically necessary for ASD, within the meaning of TRICARE regulations. However, the assessment results do support a conclusion that TRICARE has authority to pay for ABA services for ASD for qualified dependents under the Extended Care Health Option (ECHO) program as authorized under 10 U.S.C., Sec. 1079(d).

RECOMMENDATION: That the (A) Director review the technical assessment and make decisions regarding the three enclosed recommendations as a final agency action.

COORDINATION: TAB C

Attachments:
As stated

Prepared by: Mr. Michael Kottyan, MB&RB, TRICARE Policy & Operations, (303) 676-3520, Livelink # 182440, 182441

MEDICAL BENEFIT DETERMINATIONS
FOR
APPLIED BEHAVIOR ANALYSIS FOR THE TREATMENT OF
AUTISM SPECTRUM DISORDERS

RECOMMENDATIONS FOR THE DIRECTOR, TMA:

- Recommendation #1: Sufficient reliable evidence ***does not exist*** to find that Applied Behavior Analysis (ABA) is either medically or psychologically necessary or appropriate medical care for Autism Spectrum Disorders (ASD). The majority of the reliable evidence reviewed indicates that ABA is characterized as an educational intervention and does not meet the TRICARE definition of medical care.

_____ Approve Date: 10/19/2010

_____ Disapprove Date: _____

- Recommendation #2: Sufficient reliable evidence ***does not exist*** to find that ABA is ***proven*** as medically or psychologically necessary or as appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15).

_____ Approve Date: 10/19/2010

_____ Disapprove Date: _____

- Recommendation #3: The Department of Defense (DoD) has authority under Chapter 55 of Title 10, U.S.C. Section 1079(d - e) (the TRICARE Extended Care Health Option (ECHO) program, as implemented by 32 C.F.R. § 199.5) to provide coverage of ABA for ASD to eligible dependents as defined under 1079(d).

_____ Approve Date: 10/19/2010

_____ Disapprove Date: _____

October 14, 2010

TRICARE MANAGEMENT ACTIVITY[1] ASSESSMENT OF APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDERS

I. PURPOSE

To make recommendations regarding the following:

- Key Issue #1: Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?

- Key Issue #2: Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15).

- Key Issue #3: Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?

II. RECOMMENDATIONS

KEY ISSUE #1: Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?

RECOMMENDATION #1: The results of this assessment do not support a conclusion that ABA is either medically or psychologically necessary or appropriate medical care for ASD. To the contrary, the results support the conclusion that ABA is neither medically or psychologically necessary nor appropriate medical care for ASD. The reliable

[1] The TRICARE Management Activity (TMA) administers the DoD health program commonly referred to originally as the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), and later as the TRICARE Program. See 32 C.F.R. Part 199. The purchased care portion of this health benefit program, the TRICARE Basic Program, is essentially a supplemental program to the care provided by the Uniformed Services in the Military Treatment Facilities (MTFs) (*i.e.* military hospitals), also referred to as the DoD direct medical care system. See 32 C.F.R. § 199.4(a). Additional, non-medical benefits not otherwise available under the TRICARE Basic Program are provided to certain eligible active duty family members under the TRICARE Extended Care Health Option (ECHO) program (32 C.F.R. 199.5).

evidence reviewed indicates that ABA is an educational intervention and does not meet the TRICARE definition of medical care.

KEY ISSUE #2: Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and that it is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15)?

RECOMMENDATION #2: A recommendation has been made that the Director, TMA find that ABA is neither medically or psychologically necessary nor appropriate medical care for ASD. However, in the event that the Director, TMA disagrees and finds that ABA is medically or psychologically necessary and appropriate medical care for ASD, the results of this assessment support the conclusion that ABA has not been shown by reliable evidence to meet the requirements of 32 C.F.R. §199.4(g)(15) to be proven as medically or psychologically necessary or as appropriate medical care for ASD.

KEY ISSUE #3: Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?

RECOMMENDATION #3: There is insufficient evidence to establish that ABA is medically or psychologically necessary or that it is appropriate medical care for ASD. Additionally there is insufficient reliable evidence to establish that ABA is "proven" as medically or psychologically necessary for ASD. Therefore, there is no current authority to provide ABA coverage under the TRICARE Basic Program. However, the results of this assessment do support the conclusion that DoD has authority under Title 10 U.S.C. Section 1079(d - e) (the TRICARE ECHO program) to provide coverage of ABA for ASD for ECHO eligible beneficiaries.

III. BACKGROUND

A. What are the Autism Spectrum Disorders?

In the *Diagnostic and Statistical Manual of Mental Disorders,* (DSM-IV-TR (fourth edition, text revision))[2] each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (*e.g.*, a painful symptom) or disability (*i.e.*, impairment in one or more important areas of functioning) or with a

[2] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

DSM-IV-TR contains a section of disorders that are usually first diagnosed in infancy, childhood, or adolescence, although sometimes those disorders are not diagnosed until adulthood. A sub-section lists the Pervasive Developmental Disorders (PDD) and their associated *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic code: Autistic Disorder (299.00), Rett's Disorder (299.80), Childhood Disintegrative Disorder (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise Specified (Including Atypical Autism) (299.80).

PDDs are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age.

Autistic Disorder

The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (*e.g.*, eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communications. There may be failure to develop peer relationships appropriate to developmental level that may take different forms at different ages. The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. There may be delay in, or total lack of, the development of spoken language. In individuals who do speak, there may be marked impairment in the ability to initiate or sustain a conversation with others or a stereotyped and repetitive use of language or idiosyncratic language. There may also be a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level. Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus; an apparently inflexible adherence to specific, nonfunctional routines or rituals; stereotyped and repetitive motor mannerisms; or a persistent preoccupation with parts of objects. Individuals with Autistic Disorder display a markedly restricted range of

interests and are often preoccupied with one narrow interest (*e.g.*, dates, phone numbers, radio station call letters). The disturbance must be manifest by delays or abnormal functioning in at least one (and often several) of the following areas: social interaction, language as used in social communication, or symbolic or imaginative play.

Rett's Disorder

The essential feature of Rett's Disorder is the development of multiple specific deficits following a period of normal functioning after birth. Individuals have an apparently normal prenatal and perinatal period with normal psychomotor development through the first 5 months of life. Between ages 5 and 48 months, head growth decelerates. There is a loss of previously acquired purposeful hand skills between ages 5 and 30 months, with the subsequent development of characteristic stereotyped hand movements resembling hand-wringing or hand washing. Interest in the social environment diminishes in the first few years after the onset of the disorder, although social interaction may often develop later in the course. Problems develop in the coordination of gait or trunk movement. There is also severe impairment in expressive and receptive language development, with severe psychomotor retardation. Data are limited to mostly case series, and it appears that Rett's Disorder is much less common than Autistic Disorder. This disorder has been reported only in females.

Childhood Disintegrative Disorder

The essential feature of Childhood Disintegrative Disorder is a marked regression in multiple areas of functioning following a period of at least 2 years of apparently normal development reflected age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior. After the first 2 years of life (but before age 10 years), the child has a clinically significant loss of previously acquired skills in at least two of the following areas: expressive or receptive language, social skills or adaptive behavior, bowel or bladder control, play, or motor skills. Most typically, acquired skills are lost in almost all areas and individuals with this disorder exhibit the social and communicative deficits and behavioral features generally observed in Autistic Disorder. Although initial studies suggested an equal sex ratio, the most recent data suggest that the condition is more common among males.

Asperger's Disorder

The essential features of Asperger's Disorder are severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests, and activities. The disturbance must cause clinically significant impairment in social, occupations, or other important areas of functioning. In addition, during the first 3 years of life, there are no clinically significant delays in cognitive development as manifested by expressing normal curiosity about the environment or in the acquisition of age-appropriate learning skills and adaptive behaviors (other than in social interaction). Finally, the criteria are not met for another specific Pervasive Developmental disorder or for Schizophrenia. This condition is also termed Asperger's syndrome. The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (*e.g.*, eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communication. There may be failure to develop peer relationships appropriate to developmental level that may take different forms at different ages.

Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

This category is used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for other specific PDDs or other diagnoses. For example, this category includes "atypical autism" — presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold synptomatology, or all of these.

The National Institute of Mental Health (NIMH) states that those five PDDs are more often referred to today as autism spectrum disorders (ASD).[3] We specifically note that the Centers for Disease Control and Prevention[4] stated that there is currently no cure for ASD.

[3] "Autism Spectrum Disorders-Pervasive Developmental Disorders (NIH 08-5511)." National Institute of Mental Health. Online. July 22, 2009. Accessed September 27, 2010. <http://www.nimh.nih.gov/health/publications/autism/complete-index.shtml>

[4] "Facts About ASDs". Centers for Disease Control and Prevention. May 13, 2010. Accessed September 27, 2010. <http://cdc.gov/ncbddd/autism/facts.html>

B. What is Applied Behavior Analysis?

As described by the Behavior Analyst Certification Board, Inc.® (BACB®),[5] behavior analysis, which grew out of the scientific study of principles of learning and behavior, has two main branches: experimental and applied behavior analysis. The experimental analysis of behavior is the basic science that over the decades has accumulated a substantial and well-respected foundation of research literature. This literature is the scientific foundation for the second branch—applied behavior analysis.

To summarize the description by the BACB®, applied behavior analysis is 1) an applied science that develops methods of changing behavior and 2) a profession that provides services to meet diverse behavioral needs. Applied behavior analysis is a well-developed discipline among the helping professions, with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and education requirements for practice, and identified sources of requisite education in universities. Professionals in applied behavior analysis engage in the specific and comprehensive use of principles of learning, including operant and respondent learning, in order to address behavioral needs of widely varying individuals in diverse settings. Examples of these applications include: building the skills and achievements of children in school settings; enhancing the development, abilities, and choices of children and adults with different kinds of disabilities; and augmenting the performance and satisfaction of employees in organizations and businesses.

Frequently, references to applied behavior analysis or ABA are associated with the "Lovaas" model of applied behavior analysis because of the seminal works for advancing treatment of children with autism by Dr. O. Ivar Lovaas. Often cited is the publication[6] wherein Dr. Lovaas re-states that medically and psychologically oriented therapies [for autism] have not proven effective in altering outcome (DeMyer, Hingtgen, & Jackson, 1981), and reports the results of his behavioral-intervention project that sought to maximize behavioral treatment gains by treating autistic children during most of their waking hours for many years. The project hypothesized that construction of a special, intense, and comprehensive learning environment for very young autistic children would allow some of them to catch up with their normal peers by first grade. The operative method of this therapy consisted of using reinforcement, which, as a last resort could take the form of an aversive technique (*e.g.*, loud "no" or a slap on the thigh) to modify behavior by teaching imitation, expressive and early abstract language, interactive play with peers, and appropriate and varied expressions of emotions (physically aversive techniques are no longer considered appropriate).

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[5] Consumer Information. About Behavior Analysis. Behavior Analyst Certification Board. Web. Accessed September 19, 2010. <http://www.bacb.com/consum_frame.html>

[6] Lovaas, O.I. (1987) "Behavioral treatment and normal educational and intellectual functioning in young autistic children." Journal of Consulting and Clinical Psychology, 55. 3-9.

The current model of intensive behavioral intervention is generally begun by age 3 ½ and consists of up to 40 hours per week of intensive therapy for 2 years or longer. It aims to teach social, motor, and verbal behaviors as well as reasoning skills using careful behavioral observation and positive reinforcement and prompting to teach each step of a behavior. Skills are broken down into small tasks, which are taught in a very structured manner, accompanied by praise and reinforcement. Undesirable behaviors are reduced by ignoring them or introducing more socially acceptable forms of behavior.[7]

C. Statutory and Regulatory Requirements for Coverage under TRICARE

Statutory Authority

Title 10 United States Code Chapter 55, Section 1071[8] authorizes a uniform program—Civilian Health and Medical Program of the Uniformed Services—of medical benefits and dental care for members and certain former members of the Uniformed Services and their dependents. Administration of that chapter is the responsibility of the Secretary of Defense and certain other Secretaries (Section 1073). TRICARE is authorized at Sections 1079, 1086, and 1091 to contract with civilian providers for the health care program benefits authorized under Section 1077.

Regulations

Title 32 Part 199 of the Code of Federal Regulations (32 C.F.R. 199)[9] prescribes the guidelines and policies for the administration of the TRICARE Program.

32 C.F.R. §199.1(d) specifies that the program authorized under Chapter 55, Title 10, United States Code, includes a program of medical benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services. Although similar in structure in many of its aspects, it is not an insurance program in that it does not involve a contract guaranteeing the indemnification of an insured party against a specified loss in return for a premium paid. Further, the program is not subject to those state regulatory bodies or agencies that control the insurance business generally.

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[7] Berkovitz, Carol, and Dena Hofkosh. "Autism Spectrum Disorders." First Consult. MD Consult, 23 August 2007. Web. Accessed September 9, 2010. <http://www.mdconsult.com/das/pdxmd/body/207062080-3/0?type=med&eid=9-u1.0-_1_mt_1014440>.

[8] United States Code. Title 10-Armed Forces, Subtitle A-General Military Law, Chapter 55-Medical and Dental Care. Web. <http://frwebgate.access.gpo.gov/cgibin/U.S.C..cgi?ACTION=BROWSE&TITLE=10U.S.C.SA&PDFS=YES>

[9] Code of Federal Regulations, Title 32, Part 199-Civilian Health and Medical Program of the Uniformed Services (TRICARE). Section 199.2 *Definitions*. [32 C.F.R. 199.2] Web. <http://eC.F.R..gpoaccess.gov/cgi/t/text/text-idx?c=eC.F.R.&sid=beb8decc3a2f2855decce34acfd2a9fb&rgn=div8&view=text&node=32:2.1.1.1.8.0.1.2

Paragraph 32 C.F.R. §199.1(e) specifies that the appropriated funds furnished annually by the Congress are used to adjudicate claims received under Part 199. That paragraph establishes that Part 199 is the regulatory guidance for administering the program, including setting out the benefits that are eligible for reimbursement.

The TRICARE regulation 32 C.F.R. §199.2(b) (*Definitions*) defines the following terms:

"Medical"

> The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of TRICARE, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

"Medically or psychologically necessary"

> The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

"Appropriate medical care"

> (i) Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;
>
> (ii) The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and
>
> (iii) The services are furnished economically. For purposes of this part, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to

provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

"Mental disorder"

For purposes of the payment of [TRICARE] benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, *and* that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.[10]

"Major life activity"

Breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking.

D. Requirements for Reliable Evidence

In accordance with 32 C.F.R. §199.4(g)(15), any proposed TRICARE Basic Program benefit that is characterized as a drug, device, medical treatment, diagnostic or therapeutic procedure must be determined by the Director, TMA to be safe and effective in accordance with the reliable evidence criteria. Reliable evidence is defined in 32 C.F.R. §199.2(b) as meaning only:

(i) Well controlled studies of clinically meaningful endpoints, published in refereed medical literature.
(ii) Published formal technology assessments.
(iii) The published reports of national professional medical associations.
(iv) Published national medical policy organization positions; and
(v) The published reports of national expert opinion organizations.

Specifically not included in the meaning of reliable evidence are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or professional opinions.[11] Furthermore, the

[10] Subsequent and current editions of the DSM are accepted as the equivalent to citation to DSM-III.
[11] The documents reviewed for this assessment include those cited in the text and/or listed in Attachment 1. Other articles and websites regarding the subject of ASD and ABA were identified during our literature and database searches, but were determined not to be reliable evidence in accordance with 32 C.F.R. § 199.2(b).

hierarchy of reliable evidence of proven medical effectiveness as listed above is the order of the relative weight to be given to any particular source.[12]

IV. REVIEW, DISCUSSION AND RECOMMENDATIONS

A. Review under the Reliable Evidence Standard Related to Key Issue #1: Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?

The following summarizes our conclusions based on a thorough review of the reliable evidence cited herein and the documents listed in Attachment 1:[13]

Clinical Literature: Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature.

Using subject-relevant terms including autism, autism spectrum disorder, intensive behavioral intervention, early intensive behavioral intervention, and Lovaas, an online search for clinical literature published during 2009-2010 did not find reliable evidence that explicitly referred to applied behavior analysis as medical care.

Technology Assessments: Published formal technology assessments.

Full In-Depth Health Care Technology Assessments[14,15,16] by the ECRI Institute and assessments by the Blue Cross Blue Shield (BCBS) Technology Evaluation Center (TEC)[17] and Hayes, Inc:[18]

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[12] 32 C.F.R. §199.2(b).

[13] In the course of preparing this technology assessment the beneficiary had also submitted an appeal to the TMA presenting numerous documents for that appeal relating to ABA and their claim that it should be covered under the medical program. In an effort to ensure that TMA had not overlooked any relevant material meeting the regulatory requirements or reliable evidence, the documents submitted for the appeal and which are listed in Attachment 1 were also reviewed.

[14] "Comprehensive Programs for the Treatment of Children with Autism." ECRI Institute. Health Technology Assessment Information Service. August 17, 2000.

[15] "Comprehensive Educational and Behavioral Interventions for the Treatment of Autism Spectrum Disorders." ECRI Institute. Health Technology Assessment Information Service. November 25, 2008.

[16] "Focal Educational and Behavioral Interventions for the Treatment of Autism Spectrum Disorders (ASDs)." ECRI Institute. Health Technology Assessment Information Service. January 12, 2009.

[17] "Special Report: Early Intensive Behavioral Intervention Based on Applied Behavior Analysis among Children with Autism Spectrum Disorders." BlueCross BlueShield Association. Assessment Program. Volume 23, No. 9. February 2009.

[18] "Intensive Behavioral Intervention Therapy for Autism." Hayes, Inc. April 6, 2008. Accessed 6 July 2010. <http://www.hayesinc.com>

In "Table 3-1. Key Aspects of the Comprehensive Treatment Programs Assessed in This Technology Assessment", ECRI (2000) lists the Lovaas program as a behavioral intervention and provides further discussion in paragraph "3.1. The Lovaas Program":

> The first stage of the Lovaas program of early intensive behavioral intervention is to attempt to establish a good rapport between child and therapist, usually within the child's own home. This is facilitated by presenting the child with simple tasks that he or she can readily master in combination with constant reinforcement. As the intervention process progresses, food and other intensive reinforcement protocols are replaced, whenever possible, by more common reinforcers from everyday life. The intervention process is structured so that positive behaviors (behaviors that are deemed appropriate) are maximized through prompting and positive reinforcement. High rates of aggressive and/or self-stimulatory behaviors are reduced by being ignored and by teaching alternate, more socially acceptable forms of behavior. On occasion, punishment is administered in the form of a slap on the thigh. The intervention process progresses very gradually from teaching elementary self-help and receptive language skills to teaching nonverbal and verbal imitation skills and establishing the foundations of appropriate toy play. Teaching imitative skills to a child with autism is an essential aspect of the Lovaas program. Once learned, imitation is used as one of the prime teaching tools of the program.
>
> The second stage emphasizes the teaching of expressive and early abstract language and interactive play with peers. In more advanced stages of the intervention, the child is taught at home and at school (1) early academic tasks such as beginning reading, writing, and arithmetic; (2) socialization skills; (3) cause-effect relationships; and (4) to learn by observing other children learning.
>
> In this second stage, each child is taught on a one-to-one basis for up to 7 hours per day, 7 days per week (accumulating a treatment exposure time of at least 40 hours per week). The teaching schedule is adjusted to the needs of the individual child and may, for example, include time for an afternoon nap.
>
> After a period of 6 to12 months of one-to-one home-based teaching, a determination is made as to whether the child is in a position to take advantage of a group or classroom situation. At this third stage, the teaching procedures become less structured as the child

progresses, and the procedures are generalized to the child's school and everyday environment.

In the second ECRI assessment (2008), three of five "Key Questions" focus on the outcomes of educational or behavioral intervention, specifically:

- Improved over another course of action, *i.e.*, no treatment, wait list, *etc.*;
- Improved based on comparison with other comprehensive interventions;
- Improved based on setting, *i.e.*, home-based vs center/clinical setting

We conclude from that technology assessment that regardless of how the intervention is oriented, that is, behaviorally such as ABA, or developmentally such as the "Denver Model"[19], the over-arching methodology of the intervention is an educational process based on presenting a behavior opportunity to the individual and then responding to the exhibited behavior, *i.e.*, praise/reward for appropriate response, withholding praise/reward for inappropriate response.

The 2009 ECRI assessment targeted "focal educational and behavioral interventions;" however, its "Key Questions" 1 and 2 virtually mirrored the 2008 ECRI assessment. While ABA, which is generally part of a comprehensive treatment program, is not specifically included, the review of focal treatments finds that they rely on an educational process. Whether the method is 'Video Monitoring', 'Peer-mediated intervention', 'Reinforcement Schedules and Activities', Social Stories, or other form, the goal of treatment is improving social skills through the process of learning interaction with others and behaviors that are acceptable. This same educational process underlies focal interventions that target improving communication skills and stereotyped/problem behaviors.

The BCBS TEC assessment (2009) presents a systematic review of the research literature on the use of early intensive behavioral intervention (EIBI) based on ABA; its intent was to inform the public discussion regarding EIBI. It does not refer to ABA as a medical intervention.

The Hayes technology assessment (2008) states that treatment of autistic children has undergone substantial change in the last 20 years, with behavior modification replacing psychotherapy as the dominant and preferred treatment modality. The behavioral programs, referred to as EIBI, ABA, or 'Lovaas' therapy, involve structured

[19] The "Denver Model" is a developmentally-based program employing behavioral techniques, which began in 1981 at the University of Colorado Health Sciences Center, Denver, CO.

and precise teaching techniques administered by a trained therapist. The Hayes assessment does not refer to ABA as medical intervention.

Published Reports: Published reports of national professional medical associations; published national medical policy organization positions; and published reports of national expert opinion organizations.

Under "Treatment Options" the NIMH[20] states that while there is no single best treatment package for all children with ASD, most professionals agree that early intervention is important and that most individuals with ASD respond well to highly structured, specialized programs. Among the many methods available for treatment and education of people with autism, ABA has become widely accepted as an effective treatment. The report continues:

> An effective treatment program will build on the child's interests, offer a predictable schedule, teach tasks as a series of simple steps, actively engage the child's attention in highly structured activities, and provide regular reinforcement of behavior.
>
> As soon as a child's disability has been identified, instruction should begin. Effective programs will teach early communication and social interaction skills. In children younger than 3 years, appropriate interventions usually take place in the home or a child care center. These interventions target specific deficits in learning, language, imitation, attention, motivation, compliance, and initiative of interaction. Included are behavioral methods, communication, occupational and physical therapy along with social play interventions. Often the day will begin with a physical activity to help develop coordination and body awareness; children string beads, piece puzzles together, paint, and participate in other motor skills activities. At snack time the teacher encourages social interaction and models how to use language to ask for more juice. The children learn by doing. Working with the children are students, behavioral therapists, and parents who have received extensive training. In teaching the children, positive reinforcement is used.
>
> Children older than 3 years usually have school-based, individualized, special education. The child may be in a segregated class with other autistic children or in an integrated class with children without disabilities for at least part of the day.

[20] "Autism Spectrum Disorders-Pervasive Developmental Disorders (NIH 08-5511)." National Institute of Mental Health. Online. July 22, 2009. Accessed September 27, 2010.

The Centers for Disease Control and Prevention[21] stated that there is currently no cure for autism; however, research shows that early intervention treatment services can greatly improve a child's development. For parents, caregivers, educators, or medical professionals concerned that their child might have a problem, the CDC recommends a referral to see a developmental pediatrician or other specialist, or contact with the local early intervention agency (for children under 3) or public school (for children 3 and older), as provided by the Individuals with Disabilities Education Act (IDEA).

The American Academy of Pediatrics states in clinical report:[22]

> ASDs, similar to other neurodevelopmental disabilities, are generally not "curable" and chronic management is required. Although outcomes are variable and specific behavioral characteristics change over time, most children with ASDs remain within the spectrum as adults and, regardless of their intellectual functioning, continue to experience problems with independent living, employment, social relationships, and mental health. The primary goals of treatment are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress. Facilitating development and learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families can help accomplish these goals. Ideally, interventions should help mitigate the core features of ASDs, which include impairment in social reciprocity, deficits in communication, and restricted, repetitive behavioral repertoire;

and

> [e]ducational interventions, including behavioral strategies and habilitative therapies, are the cornerstones of management of ASDs. These interventions address communication, social skills, daily-living skills, play and leisure skills, academic achievement, and maladaptive behaviors.

The report continues:

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[21] "Facts About ASDs". Centers for Disease Control and Prevention. May 13, 2010. Accessed September 27,2010. <http://cdc.gov/ncbddd/autism/facts.html>

[22] Myers SM, Johnson CP; American Academy of Pediatrics, Council on Children With Disabilities. Management of children with autism spectrum disorders. *Pediatrics*. 2007;120 (5):1162 –1182. >http://pediatrics.aappublications.org/cgi/content/full/120/5/1162>

> [e]ffective medical management may allow a child with an ASD to benefit more optimally from educational interventions;

and states that there is growing consensus that important principles and components of effective early childhood intervention for children with ASDs include, among others:

> [p]rovision of intensive intervention, with active engagement of the child at least 25 hours per week, 12 months per year, in systematically planned, developmentally appropriate educational activities designed to address identified objectives.

RECOMMENDATION REGARDING KEY ISSUE #1 (Does the reliable evidence support a conclusion that Applied Behavior Analysis (ABA) is medically or psychologically necessary and that it is appropriate medical care for Autism Spectrum Disorders (ASD)?): The results of this assessment do not support a conclusion that ABA is medically or psychologically necessary and appropriate medical care for ASD. To the contrary, the results support the conclusion, and it is recommended that the Director, TMA find that ABA is not medically or psychologically necessary and appropriate medical care for ASD. The reliable evidence reviewed indicates that ABA is an educational intervention and does not meet the definition of medical care.

B. Review under the Reliable Evidence Standard Related to Key Issue #2: Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15)?

Clinical Literature: Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature.

Using subject-relevant terms including autism, autism spectrum disorder, intensive behavioral intervention, early intensive behavioral intervention, and Lovaas, an online search for clinical literature published during 2009-2010 did not find reliable evidence that explicitly referred to applied behavior analysis as medical care. [Note: Literature published prior to 2009 is included in, or was available to the references cited.]

Technology Assessments: Published formal technology assessments.

In Summary, the ECRI assessment (2000) states:

> [T]hat there are interventions that are associated with some improvement in autistic symptoms. However, claims of turning autistic children into children indistinguishable from normal children

> have not been substantiated. The best programs evaluated require substantial effort and may result in real gains, but may not work for all children;

and:

> [i]t is likely that as researchers discover more about the subcategories of autism and its underlying causes, there will be improvements in educational, psychological, and pharmacological interventions. Until then, the ability to effect change remains modest.

Regarding Key Question 2: "Is one comprehensive educational or behavioral intervention more effective than another in improving outcomes for children with ASD?", the 2008 ECRI assessment states:

> For intellectual/cognitive status, language/communication skills, and adaptive behavior, clinical differences, and study size prevented the assessment from drawing conclusions about whether intensive applied behavior analysis was more effective than an intensive eclectic intervention program in improving these outcomes for children with ASD.

Regarding the efficacy of ABA, the ECRI 2008 noted in response to Key Question 5: "What is the consensus among experts about the safety and efficacy of comprehensive educational or behavioral interventions for the treatment of children with ASD?", that:

> In general, the published guidelines [reviewed in that ECRI assessment] recommend that treatment involving behavioral interventions, such as ABA, should be initiated when the child is young, include a minimum of 15-20 hour per week of one-to-one instruction, be designed to fit the needs of the individual child, and include the family in the planning and provision of services. However, there is overall agreement among the organizations that the existing evidence supporting one comprehensive intervention over another is limited due to methodological flaws (*e.g.*, lack of randomized controlled trials, small sample sizes, *etc.*) in most of the published research.

The BCBS TEC (2009) assessment found that:

> Overall, the quality and consistency of results of this body of evidence are weak. Consequently, no conclusions can be drawn from this literature on how well EIBI works.

BCBS TEC recommends additional research is needed to identify those characteristics of treatment—content, technique, intensity, starting and ending age, *etc.*—that maximizes its effectiveness. To be effective, research needs to include greater emphasis on randomized, controlled trials, substantially larger sample sizes, uniformity of outcomes evaluated and instruments used to measure them, and consistent treatments that do not vary widely within treatment groups.

The Hayes assessment (2008) assigned Intensive Behavioral Intervention Therapy for Autism a rating of "C". Regarding the Hayes rating:

> This rating ["C"] reflects the modest but positive effect of IBI in some children with autism, the overall weakness of the body of evidence surrounding IBI for autism, and the lack of criteria to identify children most likely to benefit from an IBI program.

It is further noted that the updated literature search and review by Hayes indicated there was no anticipated impact on the rating given in the 2008 assessment.[23]

Published Reports: Published reports of national professional medical associations; published national medical policy organization positions; and published reports of national expert opinion organizations.

In the section on "Educational Interventions", the American Academy of Pediatrics clinical report (2007) states:

> The effectiveness of ABA-based intervention in ASDs has been well documented through 5 decades of research by using single-subject methodology and in controlled studies of comprehensive early intensive behavioral intervention programs in university and community settings. Children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups.

[23] Update Search. Hayes, Inc. May 13, 2010. Accessed 6 July 2010. <https://www.hayesinc.com>

An online search did not locate any National Coverage Determinations (NCDs) published by the CMS regarding ABA or behavioral therapy for ASDs.[24]

Additional Information: The following information, while not conclusively meeting the definition of reliable evidence, is included to provide context and additional relevant information.

Defense Health Board:[25] Following a review of evidence, including more than 120 published articles related to ASD and ABA, the Department of Defense Health Board found that:

> A paucity of data resulting from few studies, as well as lack of long-term follow-up, exists that could inform questions and provide answers related to the absolute and relative effectiveness of ABA for ASD;

and concluded:

> [t]he Board appreciates the opportunity to provide input on the important issue of ABA treatment for autism spectrum disorders (ASD). However, the principal factor limiting the ability of the Board to draw firm conclusions regarding the relative efficacy of ABA is the lack of sufficient sound and thorough peer-reviewed evidence on this issue.

The primary purpose of the National Standards Project[26] was to identify the level of research support currently available for educational and behavioral interventions used with individuals (below 22 years of age) with Autism Spectrum Disorders; it was not intended to dictate which treatments can or cannot be used with autism spectrum disorder. The Guidelines included applied behavior analysis, among others, as an established treatment.

Under a grant from the U. S. Department of Education, the New York State Department of Health developed clinical practice guidelines to support the efforts of the statewide Early Intervention Program.[27] While the work represents neither standards nor

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[24]Medicare Coverage Database, National Coverage Determinations (NCDs); retrieved 17 June 2010. <http://www.cms.gov/mcd/index_list.asp?list_type=ncd#PO.

[25] "Defense Health Board Findings Pertaining to Autism Treatment." Memorandum for Ellen P. Embrey, Deputy Assistant Secretary of Defense (FHP&R), Performing the Duties of the Assistant Secretary of Defense for Health Affairs. September 18, 2009.

[26] "Findings and Conclusions. Addressing the Need for Evidence-Based Practice Guidelines for Autism Spectrum Disorders." National Standards Project. National Autism Center. 2009. Web. Accessed 23 September 2010. http://www.nationalautismcenter.org/pdf/NAC%20Standards%20Report.pdf

[27] "Clinical Practice Guideline. Quick Reference Guide for Parents and Professionals. Autism/Pervasive

policies, the discussion regarding behavioral and educational approaches recommends "that principles of applied behavior analysis (ABA) and behavior intervention strategies be included as important elements in any intervention program for young children with autism."

RECOMMENDATION REGARDING KEY ISSUE #2 (Does the reliable evidence support a conclusion that ABA is proven as medically or psychologically necessary and is appropriate medical care for ASD in accordance with the requirements of 32 C.F.R. §199.4(g)(15)?): A recommendation has been made that the Director, TMA find that ABA is neither medically or psychologically necessary nor appropriate medical care for ASD. However, in the event that the Director, TMA disagrees and finds that ABA is medically or psychologically necessary and appropriate medical care for ASD, the results of this assessment support the conclusion that ABA has not been shown by reliable evidence to meet the requirements of 32 C.F.R. §199.4(g)(15) to be proven as medically or psychologically necessary or as appropriate medical care for ASD.

C. Discussion Related to Key Issue #3: Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?

Status of Authority under the TRICARE Basic Program

ABA has been characterized by the majority of the reliable evidence reviewed as not being a medical treatment, but instead as involving non-medical, behavioral intervention services. Additionally, except as otherwise specifically permitted by law, TRICARE has no authority to provide coverage of "special education" (10 U.S.C. 1079(a)(9)) or "self-help, academic education or vocational training services and supplies" (32 C.F.R. 199.4(g)(42)) under the Basic Program (32 C.F.R., 199.4). Therefore, as explained in Issues 1 and 2, ABA does not meet the TRICARE definition as a medical treatment for ASD. Additionally, special education or educational services are not payable under the medical program. Consequently, reimbursement can be made by the DoD for these services only if authorized by some other statutory authority under Chapter 55 of Title 10.

Other Available Authority:

Developmental Disorders. Assessment and Intervention for Young Children (Age 0-3 Years)." Web. Accessed 23 September 2010. <http://www.health.state.ny.us/publications/4216.pdf>

Section 1079 (d) (1)-(3) provides additional authority for payment for non-medical services. However, this statutory provision is limited to dependents of Active Duty Family Members with a qualifying condition. Under 10 U.S.C. 1079(d)(3), the term "qualifying condition" means the condition of a dependent who is moderately or severely mentally retarded, has a serious physical disability, or has an extraordinary physical or psychological condition. Active duty dependents diagnosed with ASD may have one of these qualifying conditions.

The services that are authorized under this provision have changed over the past, thus the history of this statutory provision is important. Prior to December 28, 2001, Section 1079(d) of Title 10 of the United States Code, implemented at 32 C.F.R. §199.5, was initially known as the Program for Persons with Disabilities (PFPWD) and authorized DHP reimbursement for:

- Diagnosis.
- Inpatient, outpatient, and home treatment.
- Training, rehabilitation, and special education.
- Institutional care in private nonprofit, public and State institutions and facilities and, when appropriate, transportation to and from such institutions and facilities.

Section 701(b) of the National Defense Authorization Act (NDAA) for Fiscal Year 2002[28] replaced 1079(d)-(f) with new section 1079(d)-(f). Section 1079(e) from the 2002 NDAA authorized the previous benefits, and provided for additional benefits as follows:

- Diagnosis.
- Inpatient, outpatient, and comprehensive home health care supplies and services which may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).
- Training, rehabilitation, special education, and assistive technology devices.
- Institutional care in private nonprofit, public, and State institutions and facilities and, if appropriate, transportation to and from such institutions and facilities.
- Custodial care, notwithstanding the prohibition in section 1077(b)(1) of this title.
- Respite care for the primary caregiver of the eligible dependent.

[28] Web. <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ107.107.pdf>

- Such other services and supplies as determined appropriate by the Secretary, notwithstanding the limitations in subsection (a)(13).

Following publication of the ECHO Final Rule in the Federal Register on August 20, 2004, the new extended benefits program, known as the Extended Care Health Option (ECHO), was implemented on September 1, 2005.

The materials reviewed in this assessment support the conclusion that ABA may be considered as part of an integrated set of services and supplies designed to assist in the reduction of the disabling effects of ASD for an ECHO-registered beneficiary with a qualifying condition. See 32 C.F.R. 199.5(a)(2).

Although the literature characterizes ABA services by the use of several non-medical terms and there does not appear to be consensus on any one characterization, a precise characterization of ABA is not required for coverage under ECHO as long as ABA: 1) does not meet the definition of a benefit under the medical program; and 2) can be reasonably characterized as a benefit under any one of the seven categories listed in 1079(e). The DoD has in the past reimbursed these services as special education or as special education services under 1079(e)(3). However, prior reimbursement under 1079(e)(3) does not preclude reimbursement under other applicable subsections of 1079(d –e).

In sum, DoD has authority under title 10 U.S.C. Section 1079(d - e) (the TRICARE ECHO Program) to provide coverage of ABA as a non-medical service for eligible beneficiaries to minimize the effects of ASD. As discussed above, there is no current authority to provide ABA coverage under the TRICARE Basic Program.

RECOMMENDATION REGARDING KEY ISSUE #3 (Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, U.S.C. if the answers to Issues 1 and 2 above are "no"? This would mean that if ABA is not medically or psychologically necessary care and it is not appropriate medical care for ASD, or that ABA has not been proven to be medically or psychologically necessary and is not appropriate medical care for ASD, then is there another authority under which these services could be covered?): There is insufficient evidence to establish that ABA is medically or psychologically necessary or that it is appropriate medical care for ASD. Additionally there is insufficient reliable evidence to establish that ABA is "proven" as medically or psychologically necessary for ASD. Therefore, there is no current authority to provide ABA coverage under the TRICARE Basic Program. However, the results of this assessment do support the conclusion that DoD has authority under Title 10 U.S.C. Section 1079(d - e) (the TRICARE ECHO program) to provide coverage of ABA for ASD for ECHO eligible beneficiaries.

[CLERK'S NOTE.—End of questions submitted by Mr. Hinchey. Questions submitted by Mr. Young and the answers thereto follow:]

Question. Mr. Secretary, often times the civilian sector can develop outstanding technologies, methods, and programs that provide efficiencies to enhance industry and government performance. As indicated in your Department's response to senate defense Appropriations questions on April 6 of last year, we were encouraged to see that you have identified such a program at TATRC in your TS–PASS program (since that time, we understand the even Johns Hopkins University Medical is beginning to adopt these methods). As such, we included report language in the FY 2012 Defense Subcommittee bill encouraging you to establish a ten site pilot program using this new method for the care of military hospital patients. Can you please inform the committee of the status of this implementation?

Answer. Presently, Tri-Service Patient Acuity Schedule System is not an operational data system in the Military Health System nor is there any funding allocated to implement it. It is a set of functional requirements for which a technological solution has not yet been determined. We are exploring some new concepts to staff scheduling with TATRC which do appear to have some possible merit in the civilian healthcare industry, as you have alluded. The TATRC studies will not be complete until later this year and we need this information before we can make plans for further pilot studies. I want to assure you that my staff is working closely with TATRC and if this technology proves to be useful in the military healthcare setting we will follow up on that course of action.

[CLERK'S NOTE.—End of questions submitted by Mr. Young.]

WEDNESDAY, MARCH 28, 2012.

FISCAL YEAR 2013 NATIONAL GUARD AND U.S. ARMY RESERVE BUDGET OVERVIEW

WITNESSES

GENERAL CRAIG R. McKINLEY, CHIEF, NATIONAL GUARD BUREAU
LIEUTENANT GENERAL WILLIAM INGRAM, JR., DIRECTOR, ARMY NATIONAL GUARD
LIEUTENANT GENERAL HARRY WYATT, DIRECTOR, AIR NATIONAL GUARD
LIEUTENANT GENERAL JACK C. STULTZ, CHIEF, ARMY RESERVE AND COMMANDING GENERAL, UNITED STATES ARMY RESERVE COMMAND

OPENING STATEMENT OF CHAIRMAN YOUNG

Mr. YOUNG. The committee will be in order.

The hearing this morning is on National Guard and U.S. Army Reserve readiness. We will focus primarily on near-term readiness issues related to personnel, training, and equipment, repair, reset, and battle loss replacement.

Because the senior services have consistently underfunded the Reserve components, Congress has provided funding for the National Guard and Reserve Equipment Account for over 30 years. And, at times, this funding has made all of the difference in the ability of units to perform their critical missions.

We are pleased to welcome several very distinguished general officers as witnesses this morning.

From the National Guard, we have General Craig R. McKinley, Chief of the National Guard Bureau and—congratulations, General—the first four-star chief of the National Guard. Additionally, General McKinley's position has recently been made permanent on the Joint Chiefs of Staff, and that is something that we all sort of pushed for for a long time. Congratulations again. This recognition and inclusion will be very important to the defense of our Nation.

But, sadly, this will be the last time we will hear from General McKinley in his capacity as chief. General McKinley, originally from Jacksonville, Florida, from Mr. Crenshaw's district, will be retiring and moving back to Florida this year. That is a good decision, moving back to Florida.

General McKinley, we thank you very much for your many, many years of dedicated service to our country.

General McKinley is accompanied by Lieutenant General William E. Ingram, Jr., the Director of the Army National Guard. This is General Ingram's first time to testify before this committee. General Ingram, congratulations on your recent appointment.

Lieutenant General Harry M. Wyatt, III, the Director of the Air National Guard. This will be General Wyatt's last time to testify

before the committee in the capacity as the Air Guard Director. General, hopefully, we will have the opportunity to hear from you in a future role in your service to our country.

Finally, we are pleased to welcome the Chief of U.S. Army Reserve, Lieutenant General Jack C. Stultz, another Floridian and soon to be retired and moving back to Florida. The General and I have had a long relationship dating back to the Gulf War. We have done some interesting work together. Let me put it that way. I know that he cares about his soldiers and is eager to stand up for their rights and needs. General Stultz, we will miss you terribly in the capacity as the Army Reserve Chief. Congratulations on your upcoming retirement.

So welcome. We are eager to hear your testimony on better determining the needs of guardsmen and reservists deployed around the world. These officers, I say to my colleagues, are very well qualified to answer the questions of the committee. I know that there were many questions and many concerns that we have, along with the officers that are here.

The committee is concerned about the readiness of the National Guard and the Army Reserve. Your soldiers and airmen performed so magnificently in Iraq and with distinction in Afghanistan and in many other hot spots around the globe. The committee would like to commend the soldiers and the airmen of the Guard and Reserve for their dedication throughout these years in Iraq and Afghanistan.

This hearing, however, comes at a difficult time for the Guard and Reserve components and especially for the Air Guard at a time when we find that the Air Force is making every attempt to cut equipment and force structure from the Air Guard. We find our valued leaders moving on to a well-deserved retirement. Still, this committee will do everything possible to make sure adequate force structure remains to carry out both your homeland and wartime missions.

So we look forward to your testimony. Your full statements will be placed in the record. You can speak them as you will.

But, before we do that, I would like to recognize my friend, Mr. Rothman, for any opening comments he would like to make.

Mr. ROTHMAN. I thank my distinguished chairman.

Generals, good morning. It is an honor to be with you.

Mr. Chairman, I would also like to welcome our Guard and Reserve leadership to discuss the fiscal year 2013 budget request. Specifically, I would like to recognize two of our witnesses. First, to thank General Craig McKinley, Chief of the National Guard Bureau, for his 38 years of service to our Nation and to the men and women of the Air and Army National Guard. Thank you, General.

General MCKINLEY. Thank you, sir.

Mr. ROTHMAN. I would also like to recognize Lieutenant General Jack Stultz, who has selflessly said yes twice when asked to continue as the Chief of Army Reserve. Thank you, General Stultz, for your dedication to our Nation and your men and women who serve under you.

You will both be missed.

Gentlemen, this morning we look forward to your views on the fiscal year 2013 budget request and the current status of the Na-

tional Guard and Army Reserve. We look forward to hearing how all of you are meeting the unique challenges of Reserve service for your soldiers and airmen, as well as meeting the needs of the families who support them.

Over the past decade, the Reserve component, especially your organizations, have moved from a strategic force waiting to join the fight until needed to an operational Reserve called upon in every conflict and war since Desert Shield/Desert Storm, serving side by side with your Active component brethren. This fundamental shift in the employment of the Guard and Reserve erases the perception of the weekend warrior. It is now difficult to tell a guardsman or reserve soldier from the active one on the battlefield.

However, as an operational reserve, readiness takes on a new meaning. Maintaining the people and the hard-earned skills and competencies from the decades worth of deployments, as well as the readiness of the equipment that supported those missions, will take time and resources.

The committee has great interest in ensuring your equipment needs are being met and will be met through the National Guard and Reserve Equipment Account. It is important for us to hear just how your requirements are being filled or not filled through this approach.

And just as the Active force is dealing with the profound effects of prolonged war, so, too, are the Guard and Reserve. Injuries, both physical and psychological, are realities of war and Reserve members have not been spared. Access to medical care after returning home can be challenging, even without a life-changing injury. We are interested in hearing about your efforts to help your heroes heal once they are released from Active Duty and return home to their families and community.

Gentlemen, we look forward to your testimony. Again, thank you from the bottom of my heart and all of our Members for your service.

Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Rothman, thank you very much.

General McKinley, we would like to recognize you first. We will listen attentively, and we will try not to interrupt you as you make your statement, as well as the other officers. But then we will barrage you with some interesting questions.

SUMMARY STATEMENT OF GENERAL MCKINLEY

General MCKINLEY. Thank you, Chairman Young. It is always a pleasure to appear before your committee.

Mr. ROTHMAN, thank you. I know Congressman Dicks will be joining us later, but it is a pleasure to have you up on the front, too.

And to all of the members of the committee, thank you so much for your dedicated support to the men and women of our military services and in particular to the men and women of the National Guard.

I wanted to take this opportunity to thank all of you for your dedication to the soldiers and airmen that we represent here in front of you today.

Bud Wyatt to my left and Bill Ingram to my right are my battle buddies, my wingmen, who assist me in my preparation to do my job as chief. Both of them are former Adjutant's General, so they have a unique perspective on the issues and concerns of our soldiers and airmen in State Active Duty and Title 32, and I couldn't be more pleased with the support I get from both of these gentlemen.

And I would like to thank my very, very good friend, Jack Stultz, for his dedicated years of service to our Nation. I have enjoyed working with Jack recently in these last 7 years here because we have both been through those years together. Thanks, Jack, and the best to you.

We find ourselves in the midst of constrained budgets and tough choices. No doubt we must curb spending but hopefully not at the expense of our security. That is why I must tell you that sequestration is not in the best interest of our Nation. It would result in further severe reductions in the National Guard, Reserve, and our Active component. The National Guard is already facing difficult budget cuts, cuts that impact equipment and personnel. Further reductions would significantly limit the Guard's ability to function as an operational force, decrease the total force's overall capability, and reduce the Department's capacity to protect the homeland and respond to emergencies.

The National Guard is a more ready, more capable and a more rapidly deployable force than ever in our Nation's history; and we thank the members of this committee for helping us be that way. We have and will continue to answer the call for mobilizations and volunteer in support of our combatant commanders.

More than 50 percent of our Guardsmen have combat experience. As a part-time force, the National Guard is a proven, affordable defense option for America. During a time of constrained budgets, we must continue to be used as an operational force to ensure the Nation is getting the most defense capability at the lowest cost. As an operational force, the National Guard is a strategic hedge for unforeseen world events. At any time, the National Guard can augment the Active Duty to surge and regenerate forces. The Nation also counts on the National Guard to protect our homeland, your home States, territories, and the District of Columbia.

The National Guard is the primary military force to respond to complex catastrophes and contributes to our security by protecting our airspace and borders. While representing only a small portion of the Guard's response capability, last year, Federal and State authorities called on one of our 57 civil support teams to use their unique weapons of mass destruction assessment skills almost twice a day every day in your hometowns.

The National Guard is crucial to our governors. Over the past 3 years, members of the National Guard responded to an unprecedented string of natural disasters. We are poised, forward deployed in our communities, and ready to provide that support again. The Guard is the best and first military option for domestic response. We have proven this time and again, most recently during the devastating tornadoes in the Midwest.

According to Federal Emergency Management Agency (FEMA) Administrator Fugate, speed is critical to domestic response. He

has stated recently during the National Governors Association Conference here in Washington that aviation assets need to be organic to the National Guard. Other options, he added, may not provide the same speed and capacity.

We are located in over 3,000 communities across the country. The National Guard is the connective tissue between the military and the American people and is positioned to respond quickly and efficiently to any domestic emergency.

Our dual role requires that we continue to improve the quality and quantity of our equipment. The National Guard and Reserve Equipment Account (NGREA) has been and will continue to be crucial to that endeavor. NGREA is vital to the Guard, as it provides the ability to meet requirements, including homeland defense needs and modernization of legacy equipment.

After 11 years of war, we continue to work closely with the Army and Air Force to reset our force to ensure our equipment levels meet the defense strategy. As citizen soldiers and airmen, guardsmen are able to blend their unique combination of military training and civilian-acquired skills to provide innovative approaches to support our Nation's security strategy.

The State Partnership Program is a cornerstone of the new defense strategy and demonstrates the Guard's versatility. Our partnerships with more than 60 foreign countries have strengthened their military capacity and competence as well as our alliances. The United States benefits as well. National Guard partner nations have reduced the demand on U.S. forces. Twenty-two partner nations have provided 11,000 troops in Afghanistan, and 40 partner nations have provided over 31,000 personnel in support of U.N. peacekeeping operations.

This year, we celebrate 20 years of the State Partnership Program, and we look forward to continuing to provide the combatant commanders and the State Department with this innovative, low-cost, small-footprint approach to theater security cooperation in the future.

Each year we continue to adapt our skills to better serve the Nation's strategy, and that is why this year we are instituting a threat-based resourcing model for our counterdrug activities. This will direct funding to the States with the most pressing needs. The breadth of our skills allows the Guard to take on new and emerging missions. For example, since many of our guardsmen and women work in the civilian IT field, we are ideally suited to support future cyber missions.

I would also like to address our most important asset, our soldiers and our airmen. They are the reason that the National Guard has been so successful over the last decade, indeed, for the last 375 years. Today, your National Guard is the most capable and competent in history, and that is because we are recruiting the highest-quality soldiers and airmen.

Our noteworthy enlistment and retention numbers since 9/11 are proof that they join because they want to be used and expect to be used. This dedication would not be possible without the support of our families, communities, and employers. That is why I am dedicated to working closely with our Army and Air Force to provide

our service members, their families, and employers with the best and most effective support available.

Thank you again, Chairman Young and members of this committee, for the opportunity to appear before you today.

I would now like to ask the directors of the Air and the Army Guard to provide brief comments on their perspectives, and I look forward to your questions.

[The statement of General McKinley follows:]

STATEMENT BY

GENERAL CRAIG R. McKINLEY

CHIEF, NATIONAL GUARD BUREAU

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

SUBCOMMITTEE ON DEFENSE

SECOND SESSION, 112TH CONGRESS

ON

THE FISCAL YEAR 2013 GUARD AND RESERVE BUDGET

MARCH 28, 2011

NOT FOR PUBLIC DISSEMINATION
UNTIL RELEASED BY
THE HOUSE APPROPRIATIONS COMMITTEE

Opening Remarks

Chairman Young, Ranking Member Dicks, distinguished members of the subcommittee; I am honored to appear before you today, representing more than 460,000 Citizen-Soldiers and Airmen in the Army and Air National Guard, an organization that is historically part of the foundation of our great democracy. America's National Guard remains ready, reliable, and accessible. As members of an operational force that's a critical piece of our nation's military response both overseas and here at home, the Soldiers and Airmen of the National Guard contribute daily to our nation's overseas and domestic security objectives.

The National Guard: Security America Can Afford

For 375 years, the National Guard has played a significant role in maintaining peace and security for our states, territories, the District of Columbia and the nation. I am very proud of our rich heritage and our present-day resolve as we continue our role preserving the ideals upon which our country was established.

Today, we are faced with a historic opportunity as we stand at the confluence of a new fiscal environment, the transition from combat to stability operations and a new military strategy. This convergence is leading to new defense-wide budgetary realities and challenging our decision makers as they formulate difficult spending choices that are sustainable and keep America safe and secure.

Today's global security environment is characterized as having asymmetric threats which pose danger to the United States. In light of this, we

must remain vigilant and capable. The United States faces greater security challenges today than at the end of the Cold War, the last time the military was significantly downsized. Therefore, we must look beyond simple cost accounting methods calling for across the board spending reductions. This method was used in the past and it did not serve us well. The result was widely characterized as a hollow force. Our new military strategy ensures we will not risk a hollow National Guard in the future.

An Operational Force for Domestic and Overseas Missions

The National Guard is well-suited to provide support to our new military strategy. The past ten years brought vast improvements in the overall training, equipping, and readiness of our force. This reality, combined with significant combat experience, has created a "dividend" in the National Guard. We have the most proficient, capable, accessible, and battle-tested National Guard in the history of the United States. Failure to continue the reliance on, and modernization of, the National Guard would squander a decade's worth of progress and result in an enormous loss of experience and capability.

As a ready and rapidly deployable force, the National Guard has proven its value over the past decade. Both the Army and Air National Guard have contributed thousands of soldiers and airmen to Iraq, Afghanistan, the Balkans, Guantanamo Bay, Djibouti, the Sinai, and other locations across the globe. In 2011, over 29,000 National Guardsmen were mobilized for operations around the world. An example of our ability to rapidly project United States power occurred on March 17, 2011. As the United Nations Security Council debated the Libyan

no-fly zone resolution, Air National Guard aircraft and air crews were already en route to Forward Operating Bases to await orders. The National Guard offers America not only affordable defense, but also a "reversibility" option -- a strategic hedge for unforeseen world events which could dictate a change of course for our nation's military strategy. At any time, the National Guard can augment the active duty to surge and regenerate forces.

The National Guard is also a crucial component of the Department of Defense primary mission to provide support to civil authorities and defend the homeland. Each year, the National Guard responds to a myriad of domestic emergencies. Last year alone, the Army National Guard performed more than 900,000 duty days (459,724 in State Status and 447, 461 in Title 32 Status) in response to wildfires, tornadoes, floods, Hurricane Irene, and other alerts and emergencies. Air National Guardsmen also fully participate in these missions including protecting American skies through the Aerospace Control Alert mission, critical infrastructure protection and assisting their local communities with disaster recovery.

The National Guard also brings innovative response capabilities to respond to major disasters including weapons of mass destruction incidents. The National Guard is home to 70% of the Department's capability to respond to weapons of mass destruction. By the end of the 2012, the National Guard will fully establish 10 Homeland Response Forces. These forces are part of an escalating capability that complements the National Guard's 17 Chemical, Biological, Radiological, Nuclear Enhanced Response Force Packages and 57

Weapons of Mass Destruction Civil Support Teams. Most importantly, time and distance equal lives saved. The National Guard is fully integrated into over 3,000 communities across the country and the innovative response task forces are within 250 miles of 80% of the U.S. population.

The National Guard Counter Drug Program (CDP) is leading the effort to engage in funding based on measurable metrics and threats. The implementation of the Threat Based Resource Model budget will strengthen the National Guard's national security capability by allocating resources to all states and territories based on the severity of the narcotics threat faced by each state. In an era of ever-changing global challenges, the CDP provides critical support to Law Enforcement Agencies and Combatant Commanders with full spectrum capabilities that helps our nation detect, interdict and disrupt transnational criminal organizations. CD personnel helped LEAs seize almost $18.5 billion in drugs, property, weapons, and cash in FY11. The CDP also operates five Counterdrug Training Centers located in Mississippi, Florida, Iowa, Pennsylvania, and Washington; these centers trained 5,836 military personnel, 56,093 law enforcement officers and 9,792 interagency partners in 2011.

The National Guard's Value and Unique Capabilities

The National Guard provides a cost effective, proven solution to our country's budgetary crisis while helping to ensure our security. The National Guard allows the nation to maintain a robust military capability at the least possible cost to the taxpayer and is a viable resource for reducing the Department's cost of doing business. In the Army National Guard, more than

50% of our Soldiers are now seasoned combat veterans. The Air National Guard is similarly filled with combat veterans. To ensure reversibility, the experience these Soldiers and Airmen have gained over the past decade of conflict cannot be lost.

As the nation looks for Innovative, low-cost, and small-footprint approaches to achieving our security objectives, the National Guard is providing a blueprint of success. Celebrating nearly 20 years of enduring relationships with 63 countries, the National Guard's State Partnership Program provides unique military-to-military activities with partner countries using National Guard expertise. Participation in SPP events is designed to enhance partner capabilities, advance defense reform efforts and achieve greater military interoperability to support U.S. security cooperation efforts.

Among other benefits, SPP alignments have resulted in joint National Guard and partner country deployments in support of multi-national operations in Afghanistan. These critical partner-country deployments reduce pressure on U.S. forces worldwide and hedge against the need for more direct and costly U.S. military involvement in future contingencies.

The Department of Defense is also currently refining its framework to thwart cyber attacks in the future while defending our critical military networks today. The National Guard has access to a wealth of information technology talent within its ranks, including Guardsmen working in numerous information technology companies. These Soldiers and Airmen have a unique blend of

civilian and military skills across the information technology spectrum, making the National Guard a ready defense asset in the national cyber security mission.

Support Soldiers, Airmen, and Families

Our Soldiers and Airmen are our greatest asset, and that is why we are committed to effectively responding to the needs of National Guardsmen and their families. The Army Guard currently has more than 3,100 wounded warriors in Warrior Transition Units (WTUs) that are focused on healing each injured Soldier as he or she either transitions back to military duty or leaves the military to assume a productive, responsible role in society. WTUs provide non-clinical support, complex case management, and transition assistance for Soldiers of all components at medical treatment facilities on Active Army installations. The Air Guard's Wounded Warrior program provided awareness, identification and information / referral to over 160 wounded Airmen. The program's mission is to provide the best possible non-medical care and professional support from the point of injury to life after separation or retirement.

The National Guard has made suicide prevention a top priority by promoting resilience and risk reduction programs that will enhance coping skills in our Soldiers, Airmen, families, and civilians through leadership awareness, training, and intervention programs. As the foundation of each Soldier's support network, Army Guard families and employers are being trained to assist in identifying high risk individuals. States have capitalized on community-based resources and solutions to provide services outside of military installations.

One of the many challenges that we face today is unemployment for our returning Guardsmen. Based on the Department of Defense Civilian Employment Information database, we estimate that 20 percent of returning National Guard Soldiers and Airmen are unemployed. The rate of unemployed Gulf War-Era II Veterans remains much higher than the national non-veteran rate. Gulf War-Era II Veterans who have left military service in the past have an unemployment rate in January 2012 of 9.1 percent.

The National Guard Bureau has been and remains deeply concerned with the employment status of our Soldiers and Airmen. They are our most important asset and their well-being and retention are essential for the National Guard as an operational force. As early as 2004, the National Guard Bureau funded a unique resource, titled "Program Support Specialist", at each of the 54 State Joint Force Headquarters. This individual serves as the subject matter expert for the Adjutant General regarding local issues with employers of Air and Army National Guard members.

While initially focused on specific employer support issues and complaint resolution, the duties of the Program Support Specialist expanded to include employment facilitation. In addition to coordinating employment opportunity events and linking unemployed Guardsmen with available resources, Program Support Specialists are serving as case managers for unemployed Guardsmen by connecting them with local resources, the Department of Veterans Affairs, and the Department of Labor. Last year, Program Support Specialists participated in over 1,000 "Yellow Ribbon Reintegration" events nationwide – supporting units

throughout the country returning from deployment by identifying employment opportunities and providing other requested assistance. We continue to develop metrics to measure the effectiveness of our program.

The Program Support Specialists also work closely with our Transition Assistance Advisors in the State Joint Force Headquarters to ensure our Guard members are registered with Veterans' Affairs (VA) and can access their VA benefits, to include vocational and job training. Both of these programs are essential when developing and establishing community-based program networks in support of Veterans, Service Members and Families.

The Army National Guard Directorate offers several national programs to assist the states with their local employment programs. The "Job Connection Education Program" (JCEP) is a web-based program that interfaces with Facebook and provides the ability for Guardsmen and their families to research, obtain, and retain civilian employment. The "Guard Apprentice Program Initiative", in partnership with the Department of Labor and the Department of Veterans' Affairs, continues to build relationships with employers and colleges to facilitate civilian apprenticeship and employment opportunities for National Guard and other Reserve Component members. "Drive the Guard" is a collaborative effort with the Commercial Driver Training Foundation, Inc. which links Guardsmen with training and certification programs in their communities. Once completed, the Guardsman has the potential to begin a career in the truck driving industry.

Closing Remarks

Thank you for the opportunity to be here today, I look forward to your questions.

SUMMARY STATEMENT OF GENERAL WYATT

General WYATT. Chairman Young and Mr. Rothman, thank you and the committee for your support for the extraordinary men and women of the Air National Guard, some 106,700 strong. I would like to open with a brief review of 2011 before looking to the future of the Air National Guard.

Your Guard airmen continue to make significant contributions to our Nation's defense both here at home and around the globe. Last year, Guard airmen filled approximately 56,000 requests for manpower. About 90 percent of these requests were filled by volunteers.

Air National Guard responsiveness and adaptability was clearly demonstrated a year ago, on 17 March, 2011. As the United Nations Security Council passed Resolution 1973 authorizing a no-fly zone over Libya, Air National Guard KC–135s from the 134th Aerial Refueling Wing Tennessee Air National Guard and 168th Aerial Refueling Wing Alaska Air National Guard were diverted en route to forward operating bases. These Guard airmen began flying operational missions in support of Operation Odyssey Dawn 48 hours later and were joined by a significant KC–135 force from other Air National Guard State organizations, clearly demonstrating that the Air National Guard is both accessible and ready to serve.

Last year, National Guard airmen spent over a half a million man days performing domestic civil support missions, a third of it on State Active Duty. This included assisting local authorities with explosive ordnance disposal, helping with security at special events, such as the Arkansas Governor's Inauguration and the Boston Marathon, helping victims of floods and other natural disasters, and helping to save lives by assisting in search and rescue efforts.

In addition to supporting civil authorities, Guard airmen spent an additional million man days in homeland defense. This included helping to defend United States' airspace and aerospace control alert, assisting U.S. Customs and Border Protection on our Southwest border, and supporting America's counterdrug program.

Congressional funding through the National Guard and Reserve Equipment Account has been essential to the Air Guard fulfilling both its Federal and State missions. For example, Air National Guard F–16 and A–10 squadrons deployed to Afghanistan with LITENING generation 4 targeting pods for the first time as a direct result of NGREA funding.

Fiscal year 2011 NGREA funds were also used to procure and install equipment for a cyber critical infrastructure range, allowing Air National Guard cyber units to train and develop tactics, techniques, and procedures for cyber warfare without disrupting networks used to accomplish day-to-day missions.

While the fiscal year 2013 budget has challenges for the Air National Guard, it also has opportunities, and we adjusted our priorities to take full advantage of those opportunities. The Air National Guard's priorities in preparing this budget were, number one, posture the Air National Guard by aligning force size and composition to be flexible, agile, and ready, with special attention to new missions such as MC–12 and remotely piloted aircraft, (RPA) maintaining a combat-ready force able to quickly surge and integrate seamlessly into joint operations and by repairing units broken by

the base closure and realignment process that we recently completed.

In conclusion, Mr. Chairman, thank you. I am grateful to be here today, and I look forward to answering any questions that you and the committee may have for me.

[The statement of General Wyatt follows:]

STATEMENT BY

LIEUTENANT GENERAL HARRY WYATT.

DIRECTOR, AIR NATIONAL GUARD

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

SUBCOMMITTEE ON DEFENSE

SECOND SESSION, 112TH CONGRESS

ON

THE FISCAL YEAR 2013 GUARD AND RESERVE BUDGET

MARCH 28, 2011

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Chairman Young, Ranking Member Dicks, members of the subcommittee; I am honored to appear before you today, representing the nearly 106,000 men and women of our nation's Air National Guard.

Every year at this time, I look back on the accomplishments of our Air National Guard and every year I am humbled by professionalism, dedication, patriotism, and hard work of the men and women who make up the Air National Guard family, including the Guard Airmen, their families, and their civilian employers. This past year was no exception, as our Guard Airmen -- supported by their families and employers -- have continued to defend and protect our nation and its citizens both at home and abroad.

An Operational Force for Overseas and Domestic Missions

The men and women of the Air National Guard continue to work as both an operational force, augmenting the Active Duty Air Force on operational missions, and a reserve force, providing combat-ready surge capabilities to respond to increased demands. The Air National Guard also continues to fulfill its dual-role as both a Reserve Component to the US Air Force (federal mission) and Air Component to the National Guard (state mission).

Federal Mission

The men and women of the Air National Guard continued to serve their nation in record numbers – primarily as volunteers. Last year the Air National

Guard filled 54,000 requests for active service in support of the Air National Guard's federal mission. Of those Guard Airmen filling the requests, 91% volunteered to service on active duty. This makes a total of 510,408 filled mobilization requests since 9/11.

Air National Guard responsiveness and adaptability was clearly demonstrated a year ago. On 17 March 2011, as the United Nations Security Council passed Resolution 1973 authorizing a no-fly-zone over Libya, Air National Guard KC-135s from the 134th Aerial Refueling Wing (Tennessee) and 168th Aerial Refueling Wing (Alaska) were diverted en route to forward operating bases and began flying operational missions in support of OPERATION Odyssey Dawn 48 hours later.

In addition to those serving in support of Overseas Contingency Operations, Guard Airmen continue to serve the nation on nearly every continent around the globe including Antarctica.

Homeland Defense and Support to Civil Authorities

Last year National Guard Airmen spent over half a million man-days performing domestic civil support missions, a third of it on State Active Duty. This included assisting local authorities with explosive ordinance disposal, helping with security at special events such as the Arkansas Governor's Inauguration and the Boston Marathon, helping victims of floods and other natural disasters, and helping to save lives by assisting in search and rescue

efforts. Air National Guard C-130s equipped with Aerial Modular Fire Fighting Systems dropped over 675,000 gallons of fire suppressant assisting the U.S. Forestry Service in fighting wild fires across the country. Whether it is something small such as four Guard Airmen helping local officials responding to a major car accident in remote Wyoming or 30,000 man-days assisting flood victims last April, the men and women of the Air National Guard prove their value to America every day.

In addition to supporting civil authorities, Guard Airmen spent an additional million man-days in Homeland Defense. This includes helping to defend U.S. airspace in Aerospace Control Alert, assisting U.S. Customs and Border Protection on our southwest border, and supporting America's Counter-Drug program.

The Air National Guard's accomplishment of its Homeland Defense and Support of Civil Authorities missions continue to be accomplished primarily on the "dual-use" assumption, *i.e.*, using equipment and training for its federal mission, thus avoiding additional costs for the states or Air Force. However, this also means that changes in equipment or manpower for the Air National Guard's federal mission may affect the Air Guard's Homeland Defense and Civil Support capabilities.

National Guard & Reserve Equipment Account (NGREA)

The Air Guard has used National Guard & Reserve Equipment Account (NGREA) funding to fulfill its federal and state missions. Air National Guard F-16 and A-10 squadrons deployed to Afghanistan with LITERNING Gen4 targeting pods for the first time as a direct result of NGREA funding. FY2011 NGREA funds were also used to procure and install equipment for a Cyber Critical Infrastructure Range allowing Air National Guard cyber units to train and develop tactics, techniques, and procedures for cyber warfare without disrupting networks used to accomplish day-to-day missions.

In response to Congressional concerns about management of the NGREA, the Air National Guard developed process improvements to enable longer-term, higher-confidence planning by Program Management Offices (PMOs), thus helping the Air Guard meet the Office of the Secretary of Defense (OSD) obligation rate standards for procurement funds. Each fall, three-year investment plans are developed using ranges of potential funding levels, based on NGREA appropriations in recent years. Prioritizing procurement requirements in funding bands (highest likelihood of funding, significant likelihood of funding, and potential likelihood of funding) will enable program management offices to accomplish advanced planning to incorporate NGREA into planned contracts and separate NGREA-funded equipment purchases. Specifically, procurements with the longest contractual lead times will be prioritized in the band with the highest likelihood of funding. In this way, PMOs will plan for NGREA as if it was

budgeted, and they can have confidence that resources invested in advance planning and preparation will not be wasted

Support for Airmen and Families

The men and women of the Air National Guard serve with pride and distinction, but 20 years of combat have taken a toll on our Airmen and their families. In 2011, the Air National Guard had 17 members die by suicide. While a lower rate than in 2010, the overall rate has been slightly upward since 1992. The Air National Guard launched its Psychological Health Program last year by placing licensed mental health professionals in each wing, a peer-to-peer "Wingman Project," and other suicide awareness and prevention initiatives. The goal of the Wingman Project is multifaceted. First, the Air National Guard will ensure our Airmen and their families are prepared psychologically for the traumas and stress of combat deployments. Following their deployments, we need to ensure our Guard Airmen are welcomed home as the heroes they are and received the appropriate recognition for a job well done. Finally, we must make sure that the member and their families are aware of the potential after affects and the resources available to help them cope.

The Future of the Air National Guard

I have seen two major post-war draw-downs in my career. The first occurred in the 1970's as the Vietnam War was drawing to a close. The second was in the 1990s at the end of the Cold War. In 1970, Secretary of Defense Melvin B. Laird put his faith in the Reserve Components and created the Total Force that served the nation through the end of the Cold War.

In 1990, our Air Force faced challenges not unlike those of today. And, the threats to national security and interest had not gone away with the fall of the Berlin Wall, in fact, the future looked just as unknown and ominous as it does today. First, there was a new strategy shifting focus from the Soviet Union to major regional conflicts. There was growing concern about the security implications of a possible breakup of the Soviet Union; economic, political, and geographic expansion of China; and, new challenges in the Middle East. The U.S. was trying to get the budget deficit under control – at that time it was sequestration under the Gramm-Rudman-Hollings Balanced Budget and Emergency Deficit Control Act of 1985. Faced with significant budget cuts and amorphous but growing threats abroad, Secretary of the Air Force Donald Rice decided to follow Secretary Laird's lead from the 1970s. As Secretary Rice wrote in his 1990 Report to Congress:

"The Air Force Total Force policy, formalized in 1973, has evolved to the current policy for a mix of Active and Reserve component forces, using all available assets, to ensure that maximum military capability is achieved at minimum cost. We intend to allow as much force structure growth in the Air

Reserve Component (ARC) as possible while maintaining a realistic balance between the ability of the Guard and Reserve to absorb that growth and the ability of the Active force to meet peacetime and contingency tasking."[1]

It was the Air Force that Secretary Rice built that maintained Northern and Southern Watch after operation Desert Storm. This Air Force, built upon heavy reliance on the Air Force Reserve and Air National Guard, also responded to the crisis in Bosnia and Kosovo, fought operation Enduring Freedom and operation Iraqi Freedom. Air Guard KC-135s were the first on the scene for operation Odyssey Dawn protecting Libyan civilians. Secretary Rice's Total Air Force also responded to numerous humanitarian crises around the world including Pakistan, Japan, Haiti, and here at home.

The Air National Guard's priorities in preparing the FY13 budget were:

- Funding readiness accounts to include flying hours and Depot Purchased Equipment Maintenance
- Mission conversions included in the FY2013 President's Budget
- Modernization

Closing Remarks

I believe that working together we can emerge from these times a stronger, more capable Total Air Force. Thank you for the opportunity to be here today, I look forward to your questions.

[1] *The United States Air Force Report to the 101st Congress of the United States,* Fiscal Year 1991

Mr. YOUNG. Thank you very much. I suspect that the issue you just talked about isn't going to stir up a lot of interest.

General Ingram.

SUMMARY STATEMENT OF GENERAL INGRAM

General INGRAM. Thank you, Mr. Chairman.

Chairman Young, Mr. Rothman, members of the subcommittee, it is truly my honor and privilege to be with you today representing the nearly 360,000 soldiers of the Army National Guard. The patriotism and sacrifice of these great citizen soldiers, their families, and their employers is a source of pride for all Americans.

We are now the best-manned, best-trained, best-equipped and most experienced force in our 375-year history. It truly is congressional support for the Army National Guard that has contributed to our transformation and enhanced our readiness. As a result, the Army National Guard is a ready and reliable force, fully accessible for contingencies at home and abroad. We provide equipped and trained citizen soldiers, giving the President and the governors maximum flexibility in times of crisis. We are an operational force and a full partner with the Active component.

Since September 11, 2001, the Army National Guard has completed a half million soldier mobilizations in support of domestic operations and overseas missions. We have more than 35,000 Army National Guard soldiers currently mobilized. In fiscal year 2011 alone, nearly 60,000 Army guardsmen have deployed in support of ongoing missions around the world.

Our soldiers represent every ZIP Code in America. They play a vital role as Department of Defense first responders for natural disasters and terrorist attacks on our soil. Today's Army National Guard soldiers continue the proud tradition of service to their States and our Nation. In 2011 alone, it was citizen soldiers who provided over 900,000 duty days of support to communities across the Nation.

We are attracting skilled soldiers and future leaders. With the Nation at war as a backdrop, our recruitment rate for 2011 was at 94 percent of our goal. This mark is complemented by a retention rate of 131 percent of our goal for the same period. We have maintained above our authorized strength since 2011.

The Army National Guard is equipping to meet the 21st century challenges through your support of the necessary resourcing for modernization of our 28 brigade combat teams, including one Stryker brigade and our eight combat aviation brigades. We understand our readiness level is dependent upon the level of resourcing we receive. The overall Army National Guard equipment on hand for our Modified Table of Organization Equipment (MTOE)—our combat units, is currently at 88 percent, an increase from 85 percent just 2 years ago.

Overall critical dual-use equipment on hand is at 92 percent, an increase from 86 percent 2 years ago and a significant increase from the 65 percent it was during the Hurricane Katrina response.

From December, 2011, through June, 2013, the Army National Guard is programmed to receive over 120,000 pieces of equipment from Army procurement funding. Army National Guard installa-

tions are the foundation of our readiness. We have facilities in more than 3,000 communities.

Providing quality facilities across 54 States and territories, however, is an ongoing challenge. More than 46 percent of our readiness centers are over 50 years old. Many are unable to meet the needs of a 21st century operational force, while failing to meet modern building standards, especially in terms of energy efficiency.

The Army National Guard continues to make suicide prevention a top priority. Our soldiers are our most precious resource. We are addressing high-risk behaviors and suicidal tendencies through preventive measures, comprehensive training, and a range of intervention programs.

In addition, we are addressing sexual harassment and assault response and prevention—that is called SHARP in Army terms—through an aggressive training program executed at the State level.

It is crucial that these behavioral health programs receive funding in our base budget.

In closing, I acknowledge the continued support you have demonstrated throughout the budget process in program planning for an operational Army National Guard through fiscal year 2015. I want to express the Army National Guard's sincere appreciation of the critical role your committee plays in resourcing and sustaining the most capable National Guard that our Nation has ever had.

I invite your questions and comments. Thank you.

[The statement of General Ingram follows:]

STATEMENT BY

LIEUTENANT GENERAL WILLIAM INGRAM, JR.

DIRECTOR, ARMY NATIONAL GUARD

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

SUBCOMMITTEE ON DEFENSE

SECOND SESSION, 112TH CONGRESS

ON

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Opening Remarks

Chairman Young, Ranking Member Dicks, members of the subcommittee; I am honored to appear before you today, representing the nearly 360,000 Citizen Soldiers in the Army National Guard. For 375 years the Army National Guard has been central to how the nation defends itself at home and abroad. Through resolve and readiness, our Citizen Soldiers deliver essential value to our nation and its communities and contribute immeasurably to our national security. Since September 11, 2001, through the end of Fiscal Year 2011, the Army National Guard has completed more than 495,000 Soldier mobilizations in support of domestic operations and overseas missions.

The Army National Guard of 2012 is the best manned, best trained, best equipped and most experienced force in our history. We are an Operational Force and a full partner with the active component. More than 50% of our Soldiers are seasoned combat veterans. That statistic speaks to our overseas credentials. But we have been given a dual mission. Domestically, our Soldiers represent every zip code where they play a vital role and have earned the respect of hometown America.

An Operational Force for Domestic and Overseas Missions

Our nation has endured a decade at war relying upon an all-volunteer force. Despite the challenges this has presented, our young people still want to join the Army National Guard. Our recruitment rate for 2012 is 93.7% of goal (as of January 31, 2012).

Along with this positive trend is an impressive retention rate among those who are already serving. The Army National Guard retention rate stands at 131.2% of goal as of January 31, 2012. Today's Army Guard Soldiers continue the proud tradition of meeting the needs of our local communities and our nation at home and around the world. In 2011 alone, Citizen Soldiers responded to floods, wildfires, tornadoes, and hurricanes as well as providing key security forces along our nation's Southwest Border. Concurrent with these critical missions the Army National Guard continues to deploy overseas in support of peacekeeping, humanitarian disasters and combat operations.

For years the Army National Guard was viewed as a "strategic" reserve. The events of September 11, 2001 and the subsequent hostilities in Iraq and Afghanistan challenged all previous troop strength and deployment assumptions.

The Army had to consider – and utilize – our Citizen Soldiers as an Operational Force. Now, when the Department of Defense formulates war plans, the Army National Guard is integral to the overall design and operations tempo (OPTEMPO). We realize this inclusion makes the ARNG responsible for maintaining units trained to the highest standard of readiness. Funding is required to maintain this level of readiness. The result is that for the first time in 2013 the Operational Force is partially funded in the base budget request which supports additional duty days and operation tempo (OPTEMPO) to facilitate rapid deployment of functional and multi-functional units required to deploy on a compressed timeline.

Ready and Reliable Deployments: The Accessibility Advantage

In Fiscal Year 2011, Army National Guard Soldiers were deployed for a total of 58,903 tours in support of a multitude of ongoing missions around the world.

The breakdown, by tour, includes the following: 32,752 tours in support of Operation Enduring Freedom; 24,552 tours in support of Operation Iraqi Freedom/New Dawn; 877 tours in support of Operation Joint Guardian in Kosovo; 45 tours in support of Operation Noble Eagle; 2 tours in support of Operation Joint Endeavor in Bosnia; and 675 tours as part of Deployment Support Cell (DSC) operations.

The Army National Guard has continuously proven to be a ready and reliable force for both domestic and overseas missions. A determining factor in Army National Guard global deployments has been the change to Title 10, USC Section 12304, which may have a direct impact on increasing the accessibility and rotational possibilities for the Army National Guard. The Army National Guard has developed into a responsive, Operational Force, contributing to "boots-on-the-ground" requirement for deployments. A change in the law (2011 NDAA) has made the Army National Guard more accessible for predictable, operational missions. With the implementation of the Army Force Generation (ARFORGEN) cycle as well as the new law, our leaders now have greater flexibility, predictability and choice in how they deploy forces. Our Soldiers and their Families will now have the same type of predictability with more dwell time between deployments and additional time for training.

Closer to home, the Army National Guard provided more than 907,185 duty-days of support to communities across the nation in 2011. This figure represents our commitment to the nation in response to natural disasters and fulfills our enduring pledge to sustain local, state, and federal law enforcement agencies. Notably, that number of duty-days nearly doubles that of 2010—and is three times greater than 2009. The Southwest Border Security mission along with an active year of flood, tornado, wildfire, and hurricane response operations accounts for the majority of this increase. However, I want to emphasize that the nearly one million duty-days performed last year clearly exemplifies the unique capability of Army National Guard forces and the dedication of Citizen Soldiers who serve in our ranks.

Equipping an Operational Force for the 21st Century

In 2012 the Army National Guard is better equipped than ever. We understand our readiness level is entirely dependent on our level of resourcing. So the challenge, as always, is to do everything efficiently.

The Army National Guard equipment on-hand (EOH) posture is evaluated and published twice a year. This important review process informs senior leaders and policy makers of Army National Guard fill levels for equipment supporting every mission. MTOE authorizations and on-hand inventory are used to determine EOH for both contingency operations and domestic missions. In collaboration with HQDA, the Army National Guard identifies specific equipment on MTOE documents as critical to domestic response missions. This equipment

is identified as Critical Dual Use (CDU). The Department of the Army considers CDU items when prioritizing equipment procurement.

The overall Army National Guard Equipment On Hand (EOH) for MTOE units is currently at 88%, an increase from 85% two years ago. Overall CDU EOH is 92%, an increase from 86% two years ago and a significant increase from 65% during Army National Guard operations supporting the Hurricane Katrina response. From December 2011 through June 2013 the Army National Guard is programmed to receive over 120,000 pieces of equipment from Army procurement funding.

Equipment modernization remains an area of concern. Despite significant progress improving EOH levels, the Army National Guard continues to have critical shortfalls in UH-60 A-A-L modernization, CH-47F, HMMWV Recapitalization, and General Engineering Equipment.

We are working closely with the Army to minimize any shortages with priority going to deploying units. The Army National Guard continues to pursue equipment modernization, greater efficiencies and economies of scale through Department of the Army procurement and National Guard and Reserve Equipment Appropriation (NGREA) funding.

Sustaining the Army National Guard as an Operational Force depends upon having the same equipment as the Active Component, including rotary wing aircraft. The Army National Guard currently has 1277 rotary wing aircraft against an authorized fleet of 1394 aircraft; 85% of Army National Guard aircraft authorizations are filled with the same modern and capable aircraft as the Active

Army fleet. The inventory includes a mix of the most modern capabilities (AH-64D Block II Longbow Apaches, CH-47F Chinooks, UH/HH-60M Black Hawks and UH-72A Lakotas), older but capable airframes (AH-46D Block I Apaches, CH-47D Chinooks, UH-60A/L Black Hawks, and OH-58D Kiowa Warriors) and 98 legacy aircraft (OH-58A/C Kiowas and AH-64A Apaches).

Programmed Army procurements will ensure the Army National Guard fleets are modernized on pace with the other components, except in the case of the Black Hawk fleet. Even in 2020, only 25% of the Army National Guard Black Hawk fleet will be equipped with the new UH/HH-60M. Rotary wing aircraft remain a critical dual-use asset whether mobilizing for the warfight or responding to domestic emergencies.

Domestic Operations (DOMOPS)

In 2011 Citizen Soldiers' support of the Southwest Border mission spanned the 1,933-mile border of California, Arizona, New Mexico, and Texas. This critical mission called upon three Army National Guard capabilities. First, observation and reporting of border activities to U.S. Customs and Border Protection. The second capability is our analytical expertise which augments Immigrations and Customs Enforcement agents. Finally, the command and control of personnel within the Army National Guard of each Southwest Border state ensures cohesive action and coordinated operations.

In February 2012, the Southwest Border mission transitioned from a ground-based force to an air-based force. The Southwest Border transition reduced manpower requirements from 1,200 to no more than 300. The continued

Southwest Border mission for calendar year 2012 will cost $60M. The current Southwest Border support focuses on criminal analysis and aerial detection and monitoring.

During 2011, the Army National Guard also provided support to law enforcement and special events. The law enforcement support required 60,636 duty-days of assistance and special events required another 2,685 duty-days of assistance.

The Army National Guard actively supported several environmental requests during 2011.

These request included:

Our winter storm response included 24 events in 18 states. The full scope of these actions required 11,152 duty-days of support. Firefighting support required 10,920 duty-days of support. Our flood response during 2011 totaled 201,866 duty-days of support. Hurricane and tropical storms demanded 67,795 duty-days of support. When twisters made their way across our nation in 2011 the Army National Guard responded with 14,775 duty-days of support to devastated communities.

Aviation's Role in Domestic Operations (DOMOPS)

Army National Guard Aviation flew more than 3,000 hours in response to domestic disasters in 2011. Domestic Operations missions included response to hurricanes, wildfires, tornados, and floods; civil search and rescue (SAR) missions; and counterdrug support. Our Hurricane Irene response in August was

a major domestic operation that included 37 aircraft from seven States. These aircraft flew 540 hours in support of SAR, evacuation, commodity distributions and support to local law enforcement agencies.

The National Guard's Value and Unique Capabilities

The Army National Guard, with its unique range of skills, expertise and experience level has structured itself for the future. As an Operational Force, our Citizen Soldiers are the most cost-effective means of calibrating capabilities in response to ever changing demand from conventional and unconventional threats.

The National Guard has the only Department of Defense network that reaches all 54 states and territories. GuardNet is a nation-wide information systems and mission command network that spans ten time zones, fifty-four States, three Territories, and the District of Columbia, serving the Adjutants General of the States and the national capital region. GuardNet is the functional channel of communications for the NGB and is the mission command capability for the Adjutants General of the several States for non-federalized units in generating force and defense support for civil authorities. Guardnet reaches all of the Army National Guard readiness centers in all of the States and Territories and is a model of IT efficiency and services.

The Army National Guard possesses the largest military intelligence force structure of any of the reserve components of any of the services. This force includes all of the intelligence disciplines and more than 3,000 linguists and

cultural experts, provides the nation with a robust, agile, and cost-effective responsive capability.

Army National Guard Installations – The Foundation of Readiness

The Army National Guard transformed from a strategic reserve to an Operational Force during a decade of deployments. This significant organizational shift has changed facility requirements. The Army National Guard has facilities in more than 3,000 communities; however, providing quality facilities across 54 States and Territories is an on-going challenge. Currently, more than 46% of our readiness centers are over 50 years old. Many fail to meet the needs of a 21st century Operational Forceand the standards for modern buildings to include energy efficiency. Facilities are critical to readiness and support unit administration, training, equipment maintenance, and storage. They serve as platforms for mobilization during times of war and as command centers and often as shelters during domestic emergencies.

This wide array of use makes MILCON and SRM funding a critical issue directly impacting unit readiness and morale, continuity of operations and interagency partnership, community awareness, and family and employer involvement.

Innovative Programs Leverage Our Range of Civilian Skills

Our state mission, combined with grass-roots community based support of today's Army National Guard, position us to play a significant role in global

Security Cooperation (SC). We are partner to creating an enduring stability presence in scores of countries. Army National Guard Soldiers possess a wide variety of civilian, professional, and education experiences that are helpful when the soldiers are engaged in security cooperation activities..

In 2011, the Army National Guard provided approximately 18,575 Soldiers to support 69 military exercises in 104 partner countries. The Army National Guard global presence for Security Cooperation expanded in the 1980s through Overseas Duty Training opportunities

Army National Guard Security Cooperation programs are unique because of Guard Soldiers' ability to forge these enduring relationships with key individuals over long periods of time. In some cases, the crucial bonds with foreign countries have been cultivated and maintained for more than two decades.

Army National Guard partnership capacity-building activities serve to deepen and strengthen a foreign country or region's positive perception of the United States as a valued partner, which can serve to *prevent* future conflicts; one of our key objectives in the 2010 Quadrennial Defense Review (QDR).

In 2011, 4,200 Army National Guard Soldiers participated in the State Partnership Program that included 63 partnerships and 2 bilateral agreements with 63 partner countries. This program promotes Security Cooperation activities such as emergency management, disaster response, border and port security, medical, and peacekeeping operations.

Citizen Soldiers exercise soft power. Each possesses a range of valuable professional skills and expertise acquired as civilians. Within the ranks of the Army National Guard are 5,798 first responders (firefighters, law enforcement, emergency medical technicians, analysts), 3,655 medical professionals, 778 legal professionals, 2,655 engineers,1,119 agricultural specialists, 5,186 educators, 2,296 mechanics, 511 plumbers, and 34,309 students (in a wide array of disciplines). That explains why Guardsmen are frequently called upon to conduct soft power across the range of conflict. A prime example is the innovative Agribusiness Development Teams (ADTs) in Afghanistan.

Agribusiness Development Teams provide training and advice aimed at supplementing current Afghan farming practices by introducing advanced techniques and new, profitable crops. These teams are making significant contributions to Afghanistan's economy and achieving sustainable, yearly growth of the nation's economic output.

One of our most relevant National Guard missions is to impart knowledge and transplant economic recovery to the Afghan people. The Agribusiness Development Team combines 58 Soldiers and Airmen with backgrounds and expertise in various sectors of the agribusiness field. ADTs ensure that improvements are sustainable with local assets and within the context of the Ministry of Agriculture, Irrigation, and Livestock (MAIL) abilities. The ADTs conduct stability operations by building agricultural capacity, establishing a safe and secure environment, enhancing the rule of law, sustaining economic development, developing sustained governance, and fostering social well being.

Nine ADTs are deployed to Regional Command East and Regional Command South in Afghanistan. Deployed teams hail from Texas, Missouri, Kentucky, Kansas, Indiana, Oklahoma, Nevada, Iowa, and Arkansas. To date 28 teams operated in 15 provinces and contributed to over 578 agriculture projects generating more than $31 million in economic impacts for the people of Afghanistan. ADT Soldiers bring their military capabilities and their civilian skills and education to work directly with the farmers of Afghanistan. These Citizen Soldiers leverage the assets and expertise of land-grant universities and cooperative services within their home states.

Support of Soldiers and Their Families

The Army National Guard continues to make suicide prevention a top priority. Mitigating high risk behaviors and reducing suicidal urges ensures a ready and resilient force. Increased resilience and risk reduction leadership awareness, training, and intervention programs continue to enhance coping skills in our Soldiers, Families, and DA Civilians. Due to limited Comprehensive Soldier Fitness training seat allocations, and to better support the needs of Guard Soldiers and Families, the Army National Guard established a Master Resilience Trainer Course (MRT-C) in Fort McCoy, Wisconsin in July 2011. By doing so, the number of Army National Guard Master Resilience Trainers are expected to exceed 1,000 by the in early FY12. The Army National Guard also trained 334 Applied Suicide Intervention Skills Training (ASIST) program trainers in FY11.

An additional 150 ASIST trainers are being trained in FY12. These trainers will train approximately 35,000 gatekeepers in advanced intervention skills.

The Army National Guard recently teamed with the Office of the Secretary of Defense of Reserve Affairs, as well as the Air National Guard, to launch a highly successful peer support line, Vets4Warriors. The peer support line is designed to serve all Army National Guard and Reserve Component members nationwide. As the foundation of each Soldier's support network, Army National Guard families and employers are being trained to assist in identifying high risk individuals. States have capitalized on community-based resources and solutions to provide services outside of military installations.

The Army National Guard has been, and remains, deeply concerned with the employment status of our Soldiers. They are our most important asset and their well-being is essential for the Army National Guard as an operational force. Furthermore, the Army National Guard's employment challenges extend beyond returning mobilized Soldiers and we continue to work diligently to find solutions to assist our geographically dispersed population.

New legislation was recently enacted to assist unemployed veterans. The Veterans Opportunity to Work (VOW) Act of 2011, to Hire Our Heroes, mandates the Transition Assistance Program (TAP) for all Soldiers separating from a Title 10 active duty tour of more than 180 days. The Army National Guard is working closely with the Department of the Army and OSD to implement the transition mandates set forth in the legislation. The Army National Guard seeks to utilize these expanded transition services as a platform to enhance and increase

participation in the myriad of employment assistance programs currently managed by the Army National Guard.

The Army National Guard Directorate offers several national programs to assist the states with their local employment programs. The Job Connection Education Program (JCEP) is a high-touch employment approach assisting our Soldiers and their Family members in researching, obtaining, and retaining civilian employment.

The Job Connection Education Program, a pilot program in Texas, provides support services such as job skills training, workshops, and job search assistance which expose Soldiers and Family members to jobs offered by over 480 established business partners. To date, over 720 Soldiers and Family members have connected to employment opportunities, earning an average hourly wage of $16.57.

The Guard Apprentice Program Initiative (GAPI), in partnership with the Department of Labor and the Department of Veterans' Affairs, continues to build relationships with employers and colleges to facilitate civilian apprenticeship and employment opportunities for the Army National Guard and other Reserve Components. As a pilot state, Maryland has six Army National Guard Soldiers hired in the Independent Electrical Contractors Chesapeake (IECC) Apprenticeship Program. The IECC has progressive wages starting at $18.00 per hour with medical benefits. By the end of the five year program commitment, participants will earn $23.00 per hour with benefits along with receiving a national certification as journeymen electricians. Drive the Guard (DTG) is a collaborative

effort with the Commercial Driver Training Foundation, Inc. which links Army National Guard Soldiers with training and certification programs in their communities. Once completed, the Soldier has the potential to begin a career in the truck driving industry. Applicants seeking their Commercial Driver's License (CDL) are assisted through our DTG program. Upon completion, the Soldier can begin a career in the trucking industry, with a salary varying between $35,000 and $45,000 annually. This is above the national starting salary of most college graduates with a bachelor degree.

Closing Remarks

As the nation enters an era of budgetary pressure, the Army National Guard has already structured itself for success in the future. We are an Operational Force; highly trained, experienced and professional. We represent a scalable Army component that is far less expensive to engage and deploy than a full-time force. We are flexible and adaptable so we are ready to meet the wide array of 21st century security challenges.

With committed Citizen Soldiers, our state and national leaders have the advantage of complete access to our forces and facilities. When employed judiciously, the Army National Guard presents cost-effective value to American communities where Guardsmen live, work and serve. This makes the Army National Guard not only trained, equipped and ready defenders of our freedoms, but also good stewards of taxpayer dollars.

We stand ready, as always, to take on any mission. After all, America's Minutemen have been successfully completing missions for 375 years.

Thank you for the opportunity to be here today. I welcome your questions.

Mr. YOUNG. Thank you, General Ingram, very much.

General Stultz.

SUMMARY STATEMENT OF GENERAL STULTZ

General STULTZ. Congressman Young, Mr. Chairman, Ranking Member Rothman, and other members, it is an honor to be here.

Sir, I want to personally thank you for all that you have done throughout my tenure in this position to provide unwavering support for our soldiers and our families. And your wife Beverly doing the same. She is a champion for us.

I just returned this weekend from a trip to Afghanistan, and so I got a chance to see firsthand what you are getting for your tax dollars, and I can assure you, you are getting a good return on investment.

You know, when you look at those soldiers—and I told them—you are going to be in history. Because when I testify next Wednesday, I am going to tell your story.

Standing on a platform in Bagram and a day later standing on a platform in Kandahar, looking soldiers in the eye, some of which are getting ready to go out on another route clearance mission, whose unit just got hit the day before, and lost a couple soldiers to wounds. Luckily, no one killed but some pretty significant wounds. And before they go on the mission, they raise their hand and take an oath of reenlistment to stay in uniform and to stay at war. That is a national treasure.

And when I talk to them in the town hall meetings and I say, the word I am using to describe you today and that I will use next Wednesday is indispensable. You are an indispensable force for this Nation. And that doesn't come by chance. That comes by design.

Because as we have shaped the Army in the past 8 or 9 years at war, we have leveraged the capabilities we have in our Reserve components, as was mentioned, into an operational force. But we have also created an Army.

Number one, my buddy LTG William Ingram and I are over 50 percent of the strength of the Army. But, more importantly, when you look at certain capabilities—transportation, all of the logistics—we are 85 percent of the Army's capability. When you look at engineers, route clearance, those types of capabilities, we are over 75 percent of the Army's capabilities. When you look at medicine, that life-saving feature out on the battlefield or back here at home, we account for 70 percent of the Army's capabilities. Civil Affairs, 85 percent. Military Police, 70 percent. I can go on and on. We have built an Army that is dependent on the reserve component for those capabilities, and they have demonstrated that they can do it.

Just as I have talked to the senior leadership in Afghanistan this last week, they said, we can't tell you which soldiers are Reserve and which are Active. We don't know. We just know they are all performing.

SUPPORT TO COMBAT MULTIPLIERS

And it is because of what you have done for us, given us the resources over the last several years to get the equipment, get the training, to get the support systems that we need for our families

that we are able to do this. And what we are is we are a great return on investment for this Nation. For the amount of the budget that we take out of the defense budget, which is very minimal, and what we are able to give back, and not only give back on the battlefield, but when those soldiers, those young men and women, go home, they give back in their communities. They are policemen, they are firemen, they are Boy Scout leaders, and coaches and teachers, and they are bringing that skill set back and applying it there.

And when we turn around and say, now put the uniform back on for us, they use those same civilian skills on the battlefield, and we call it a combat multiplier. That soldier who may be there as an infantryman or a mechanic but back home happens to work, as General McKinley said, in information technology and can take care of all of the computer systems. It is just amazing how we see those skill sets over and over.

So my message to you is we have done well with what you have given us. We have invested those tax dollars wisely. Our commitment is to continue to.

The challenge we have, as we all know, is we are in an era of declining resources. We know we have to tighten our belts as a Nation. And so what we have to do is we have to be good stewards of the moneys you give us and use them effectively and use them efficiently.

But I have to maintain that readiness levels that I have achieved over the last 8 to 9 years. Because that indispensable force, we cannot let it atrophy. So I have got to focus on training, and I have to migrate some dollars that are in OCO dollars back into my base budget, probably around $150–200 million a year, so that I get the training requirements that I need to maintain that readiness. I have got to continue to depend on the NGREA funds to give me some flexibility, because those soldiers coming home expect to be able to train on the same level of equipment that they are going to operate in theater.

And then I have to continue to focus on engaging. As was mentioned earlier, if we are going to get the soldiers and we are going to train them, we have to use them.

I can tell you, I have spent the last 3 months in Africa and Europe and Asia and places like that visiting our soldiers engaged in stability operations, as General McKinley mentioned, engaged in a lot of the partnering with other nations. Whether it was in Ethiopia, where they were helping a Catholic priest set up an orphanage for Ethiopian women, or whether it was in Djibouti, Africa, where Captain Yeb, an aerospace engineer for Lockheed Martin, who is one of my civil affairs captains, is establishing libraries for the education system, or other places around the world, those mission sets are still there.

And we can leverage this capability we have in the future and not have to deploy them for 12 months. But we can send them to El Salvador for 90-day rotation to provide some medical support to win the hearts and minds of those people in those countries. Or, as we have done before, we can send them to a foreign army in Africa to help train them, as we have done with the Ugandans and

the Ethiopians so that they can take on the mission in Somalia so that we don't have to. But we have to continue that support.

And the last thing I will tell you is what I have said before, our soldiers love America because they know America loves them. And they know you are committed to them, just as I am. So thank you for all of the support you and the Members of Congress have given us.

I look forward to your questions.

[The United States Army Reserve Posture Statement follows:]

UNITED STATES ARMY RESERVE
An Enduring Operational Army Reserve:
Providing Indispensable Capabilities to the Total Force

The United States Army Reserve 2012 Posture Statement

Submitted by

LIEUTENANT GENERAL JACK C. STULTZ
Chief, Army Reserve and Commanding General, United States Army Reserve Command

And

COMMAND SERGEANT MAJOR MICHAEL D. SCHULTZ
Command Sergeant Major, United States Army Reserve

To the Committees and Subcommittees of the

UNITED STATES SENATE and the HOUSE OF REPRESENTATIVES

Second Session, 112th Congress

The annual Army Reserve Posture Statement is an unclassified summary of Army Reserve roles, missions, accomplishments, plans and programs. The 2012 Army Reserve Posture Statement also addresses the support required by the Army Reserve to continue its transition to an operational force during FY 2013.

Unless otherwise noted, all statistics and facts are current through March 2012.
This document is available on the Army Reserve Web site at: www.usar.army.mil.

March 2012

Providing Indispensable Capabilities to The Total Force

Never before in the history of our nation has the United States Army Reserve been more indispensable to the Army than it is today. Forged through 10 years of persistent conflict across the globe, the Army Reserve has out of necessity evolved into an indispensable part of the operational force. Steady demands for Army Reserve enabler capabilities introduced a new paradigm of interdependence within the Total Force that changed the structure of our defense strategy, ushering in an era of reliance on an operational Reserve as part of our national security architecture.

The Army Reserve is a foundational element providing operational and strategic depth to our military. As a key component of the Total Force, the Army Reserve provides key enabler capabilities to the Army; including 100 percent of the Army's Theater Engineer and Civil Affairs Commands, Training Divisions, Biological Detection Companies, Railway Units and Replacement Companies. Our professional men and women support Army needs in many other fields such as transportation, logistics, supply chain management, law enforcement and public safety, health care, telecommunications, information technology, finance, legal services and human resources.

Continued investment in the Army Reserve as an *enduring* operational force places it on a solid path to support combat operations and theater security cooperation missions worldwide. As operations draw down in Iraq and Afghanistan, it is essential that we maintain the right mix of forces and professional personnel with operational experience and relevant skill sets. The Army Reserve forces provide critical enablers to the active component as a complementary and essential capability—not a redundant force—allowing the AC structure to focus around more complex formations.

In years past, we allowed our most seasoned and best-trained Soldiers to leave the Army during post-conflict drawdowns. In the current security environment this is not an option. One of our key initiatives this year is to work with Army to create a Continuum of Service program to retain this pool of experienced, talented Soldiers through continued service in the reserve components. Our goal is to inspire Soldiers to a lifetime of military service, which includes seamless transitions between active and Reserve statuses, as well as between reserve categories and civilian service, providing variable and flexible service options and levels of participation consistent with Department of Defense manpower requirements.

Everything we do within the operational and institutional Army Reserve supports the Army Force Generation (ARFORGEN) model. We progressed from a demand-based, theater-request dependent, reactive ARFORGEN, to a five-year supply-based ARFORGEN, providing much needed predictability to our Soldiers, their Families and their employers. Today, every Soldier knows his unit's available force pool date and has the expectation that they will be used to support ongoing operations or theater security cooperation missions worldwide.

Our biggest challenge is manning. We need Congress' support for our FY 2013 budget request for recruitment and retention incentives, and transition incentives for Soldiers leaving the active component

during the drawdown, to allow us to shape the force with less reliance on cross-leveling to offset our mid-grade strength imbalances. Our current Full Time Support model remains a strategic reserve legacy. We need the support of Congress for key policy modifications to change personnel support processes. We are currently working with the Army to create additional Full Time Support capability to provide much needed continuity in operational units and generating force units. These policy modifications will allow eligibility for enlistment and reenlistment bonuses, education loan repayment, and other incentives.

One area where our focus will remain steadfast is our support programs for Soldiers and Family members, especially in remote locations without access to installation-based support. The past decade has taught us a lot about the physical and emotional needs of Soldiers and Families, and we have taken steps to reduce stress on the force. We've implemented a Comprehensive Soldier Fitness program to train our Soldiers, Civilians and Family members to both maximize their potential, and prepare them for the physical and psychological challenges of sustained operations. We have taken a holistic approach to suicide prevention Army-wide, integrating educating the force with efforts to reduce the stigma of seeking behavioral healthcare.

We are also reaching out and providing resources to geographically dispersed Soldiers and Family members and involving Family members in suicide prevention training. Not only have we established the Fort Family 24-7 hotline for Soldiers and Family members to access services at remote locations, we continue to establish Army Strong Community Centers (ASCC) in remote locations to allow Soldiers, Family members, retirees and veterans access to installation-like support at remote locations.

Working together, with the continued support of Congress, we can meet the challenges we face in implementing a Continuum of Service and "Soldier for Life" concept, a sustainable ARFORGEN cycle for the Army Reserve, and demonstrate the positive investment that our nation makes in its Army Reserve. A relatively small investment in the Army Reserve provides security to the homeland and supports the full range of military operations at home and abroad. The value added of the Army Reserve and its critical enabler capabilities is that the nation pays the full cost for a reserve component Soldier only when he/she is mobilized.

As we look to the future, our commitment is steadfast and the focus is clear: the Army Reserve is an essential part of the Total Force, and we will do all we can to ensure this combat seasoned, highly skilled force of Warrior-Citizens remains ready to support a full range of military operations well into the future. We provide a solid, experienced foundation for expansibility. The strategic decisions and direction chosen now will set the framework for the next decade. With your help and the help of those who support America's operational Army Reserve, we will put this organization on a solid path to success for our Soldiers, civilians, and Family members; our future leaders; and our national security.

Lieutenant General Jack C. Stultz
Chief, United States Army Reserve

Command Sergeant Major Michael D. Schultz
Command Sergeant Major, United States Army Reserve

ACHIEVEMENTS

HUMAN CAPITAL

Personnel: A new Automated Senior Enlisted Promotion Board Process that uses standardized criteria ensures the best qualified Soldiers are selected for Master Sergeant, First Sergeant, and Sergeant Major positions. Implementation of the Army Reserve Theater Individual Replacement Operations policy and procedures more effectively achieves the Army Reserve goal for individual replacements to report to theater within 60 days of the initial request. Army Force Generation (ARFORGEN) Manning Strategy focuses on "unit" rather than individual manning, thereby allowing a unit to train and proceed through the ARFORGEN cycle as a cohesive unit. This shift in strategy allows commanders and noncommissioned officers to focus on leading and developing their organizations without the distraction of constant cross-leveling. Since force structure defines the needs of individual units, this approach brings personnel and force structure closer to one another.

Surgeon: The Medical Management Activity in 2011 reviewed over 6,000 medical profiles, of which 50 percent were amended and 20 percent were sent for an administrative retention board, allowing these Soldiers to remain in the Army Reserve. Since the establishment of the reserve component Medical Support Center in 2011, the Army Reserve now has better visibility of Soldiers progressing through the Medical Evaluation Board process, with over 540 packets submitted for review and adjudication.

Chaplain: The Army Reserve Strong Bonds program continues to be a success story as 12,500 individuals participated in over 300 events. The curricula expanded to provide more skills training to Soldiers, their spouses and their children. The program provides the tools to enable Families to not just survive but thrive in the current environment of high operations tempo and multiple deployments.

Employer Partnership of the Armed Forces program: Launched a state-of-the-art Career Portal in November 2010. The portal grew from zero to nearly 30,000 registered users and the number of Employer Partners more than doubled to 2,500 through September. The Army Reserve has also launched a partnered Soldier training program with GE Healthcare.

Family Programs: Opened a fourth Army Strong Community Center pilot site in conjunction with Clackamas Community College in Oregon City, Ore. The Fort Family Support & Outreach Center responded to multiple crisis and disaster situations while maintaining contact with the Families of deployed Army Reserve Soldiers. During FY11, Fort Family had 28,340 successful contacts with Soldiers and Families, providing information and assistance for many issues, including TRICARE, legal matters, retirement, the GI Bill, and child and youth programs.

MATERIEL

New Equipment Fielding Facilities enabled the Army Reserve to issue over 3,800 trucks/trailers and 63,700 support items, allowing the Army Reserve to have 91 percent of equipment on hand, with 67 percent modernized, putting us on par with the active component. In support of equipping missions, the Army Reserve has executed over 19,500 commercial movements of over 340,000 pieces of equipment. The Army Reserve combined its Fleet Management System and its Logistics Information Systems Support Contract into one product, thereby reducing costs from $18.4 million to $14.4 million—a 22 percent savings. Additional savings were achieved by relocating the tactical computers system for new equipment fielding in a leased facility from Hopewell, Va., to Gaithersburg, Md., in a government owned facility—realizing an additional savings of $288K a year.

In addition, we equipped the first unit in the Army with the new Palletized Load System and the new M915A5 Line Haul Tractors and executed Operation Clean Sweep to improve the inventory of equipment through the Army Reserve, re-establishing property book control of $105M of equipment.

READINESS

The Army Reserve has transitioned to an Operational Force within the Army by implementing a Supply Based Army Force Generation process in order to provide needed capabilities to the Army's Mission Force each year, while providing predictability to Soldiers, Families and employers. The result is an integrated, rotational force that achieves cyclic unit readiness for all Army Reserve rotational units over a defined, predictable planning horizon.

A wide array of missions in the unit's available year can include deployments in support of named operations, theater security cooperation (TSC) missions, humanitarian assistance, or domestic response missions. The Army Reserve continues to provide approximately 19,000 Soldiers annually in organized units to the Army for worldwide named operations as well as contingencies. Many of these units satisfy joint capability requirements for types of organizations only found in the Army Reserve. One such unit is an aviation task force established in October of 2011 from the 11th Theater Aviation Command to provide the medium lift, heavy lift and MEDEVAC capability required to support NORTHCOM in the Defense CBRN Response Force mission.

The Army Reserve continues to stand ready to provide forces on an as-required basis in support of the nation. As we continue to sharpen our focus on providing the proper force, appropriately trained, at the right time and place throughout the world, we will move ever closer to our strategic vision—the Army Reserve as a cost effective, trained, ready and relevant enabling security force for the nation.

SERVICES AND INFRASTRUCTURE

Services and Infrastructure Core Enterprise (SICE) is the Core Enterprise that underpins all of the platforms and provides the support services that enable an operationalized Army Reserve. The FY11 focus centered on the completion of all assigned 2005 Base Realignment and Closure (BRAC) tasks to construct 125 facilities and close and consolidate 176. Through this significant effort, the Army Reserve facilities portfolio achieved a 17 percent improvement in facility age, modernization and operational capability that directly supports training, equipping and manning strategies in support of ARFORGEN.

To achieve efficiencies in Army Reserve funded training installations (Fort McCoy, Fort Hunter Liggett, Fort Buchanan, Army Support Activity—Dix) the Army Reserve consolidated Director of Logistics activities under Army Materiel Command, as well as the consolidating and transferring Information Management activities under NETCOM.

All challenges to our infrastructure (Army Reserve Centers, Installations, and Communications Networks) to include tornadoes, hurricanes and flooding were met with a determination that restored facilities and communications quickly and ensured mission accomplishment. As a participating partner at the Department level, the Army Reserve is very close to achieving a developed and synchronized Facility Investment Strategy and is a leader in environmental conservation and energy sustainability. The Army Reserve continues to maintain Military Technician strength at levels mandated by law and is actively working toward transforming the civilian workforce to support the Operational Army Reserve.

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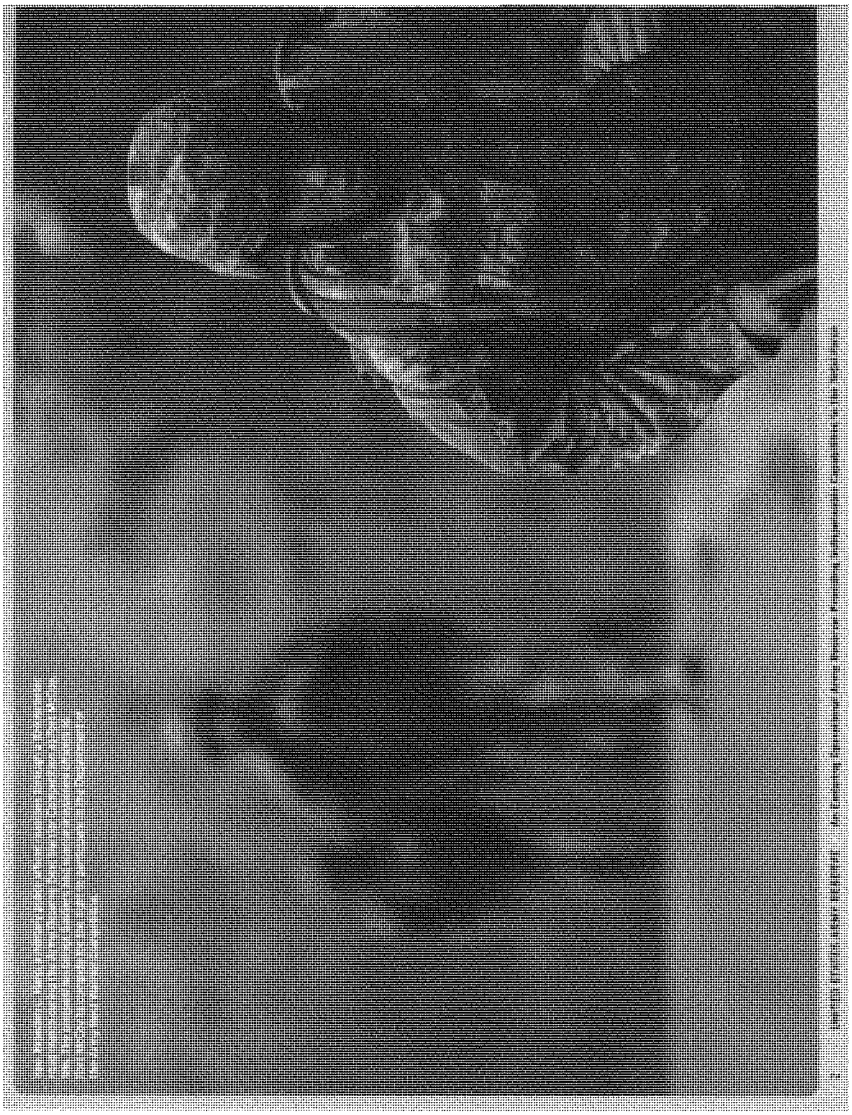
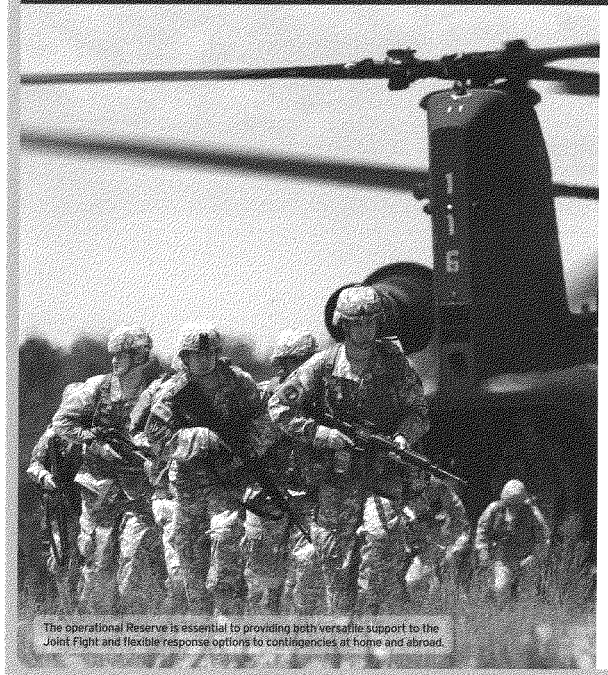


ARMY RESERVE PRIORITIES
THE PRESIDENT'S BUDGET

THE POSTURE OF THE ARMY RESERVE: TODAY'S READINESS AND STRATEGIC AGENDA



The operational Reserve is essential to providing both versatile support to the Joint Fight and flexible response options to contingencies at home and abroad.

The Army Reserve is a trained, experienced, resilient force of Warrior Citizens supported by strong Families and employer partnerships. Forged through the persistent conflicts across Iraq and Afghanistan, the Army Reserve is an indispensable provider of essential enabler capabilities to the Total Force. The Army Reserve is prepared to provide the nation with both versatile support to the Joint Fight and flexible response options to contingencies at home and abroad. The operational Reserve is essential for building expansibility within the Total Force. The Army Reserve's 205K citizen Soldiers across the nation form the Army's best connection to hometown America. These Warrior-Citizens are the best ambassadors for the Army in their communities across this great country.

Having reconfigured organizationally and functionally to adapt to the demands of sustained operational deployment, the Army Reserve must now focus on sustaining its operational capacity to meet diverse and unpredictable threats—while operating in an era of fiscal austerity. **Together,** the Army and the Army Reserve will leverage the tremendous benefits of the multi-component Total Force and make the most of all available opportunities to preserve the investment in trained and ready Soldiers and units. The Army cannot accomplish its mission without the reserve component. Much of the support capability and critical specialties reside predominantly or exclusively in the Army Reserve. Such units include civil affairs, medical, transportation, engineer and military information support operations. These are indispensable capabilities to the Total Force.

Strategic Agenda

The Army Reserve Strategic Agenda reflects the most essential objectives the Army Reserve must achieve based on both Army and Army Reserve Leadership guidance and direction. Nested within the Army Reserve 2020: Vision & Strategy, the Army Reserve Strategic Agenda identifies specific priorities to

optimize the application of collective effort and fiscal resources. The fiscal year 2012 Strategic Agenda focuses on key components of an operational force.

Access

The Total Army Force relies on critical enabler capabilities provided by trained and equipped Army Reserve Soldiers and units that are ready to respond to global and domestic requirements. An ongoing collaborative effort across the Department of Defense has resulted in the addition of expanded access to the reserve components. New authorities contained within the 2012 National Defense Authorization Act allow for access to the reserve component for missions other than war, with the proper planning, programming and budgeting. With *access*, Army Reserve personnel can mobilize in support of specified missions, such as Theater Security Cooperation. This allows the Total Force to leverage the unique cost benefits of using a seasoned, exceptional Reserve force in a sustained operational role.

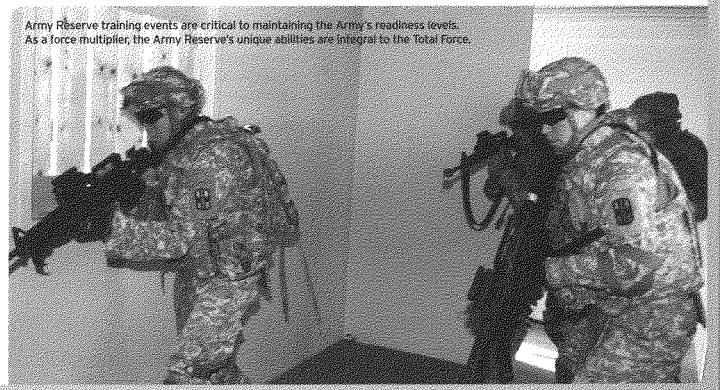
Funding for Operational Reserve

As military forces withdraw from Iraq and Afghanistan, and Overseas Contingency Operations (OCO) funding is significantly reduced, continued use of the Army Reserve in an operational role is contingent upon adequate and assured funding in the base budget. With adequate and assured funding, the Army Reserve will continue to provide the required enabler capabilities to support the Army's ARFORGEN readiness cycle. Funding in the Base Budget is crucial for the required training events and supporting costs necessary for use of the Army Reserve operational capabilities. Without assured funding in the base budget, Army Reserve forces cannot be a full participant in ARFORGEN—thus degrading readiness levels. Over time, the hard-won operational expertise of Army Reserve Soldiers will be lost. The Army Reserve will not be ready for planned or contingency operations at home or abroad. As a result, critical Army Reserve enabler availability as part of the Total Army Force will be limited to use as a strategic Reserve. In today's security environment, the Army and the nation cannot afford anything less than an operational force. Therefore, the Army Reserve will continue to work with the Army to ensure adequate and assured funding in the Army base budget and Program Objective Memoranda for planned use of Army Reserve operational capabilities.

Continuum of Service

Continuum of Service (CoS) is an integrated Human Capital management strategy for the total Army. The future of retaining the extraordinary capabilities and experience of our Soldiers now resides in how well we can implement change in the way we manage our Soldiers in the face of constrained resources. Creating a management strategy that facilitates and supports the transparent movement of individuals between the active component, the reserve components, and civilian careers is essential to preserving a cost effective, expansible foundation of talent and experience for the future.

The intent of a continuum of service is to not just allow but to encourage and incentivize Soldiers to continue serving the Army while preserving the Army's investment. We must offer and manage varying levels of participation from the active component to the traditional Reserve or to the Individual Ready Reserve. It is a paradigm shift to attempt the management of one force across the total Army. This will require considerable transformation to the current, rather inflexible, human capital management system in each component. However, this shift will poise us to best meet the impact of anticipated fiscal constraints. CoS provides an efficient and cost-effective solution to retaining the investment and experience of our best



Army Reserve training events are critical to maintaining the Army's readiness levels. As a force multiplier, the Army Reserve's unique abilities are integral to the Total Force.

Army Reserve Soldiers zero their weapons during pre-deployment training at Fort Dix, N.J. Army Force Generation (ARFORGEN) focuses training, training support and other resources for units in a timely, predictable manner as they prepare for operational deployment.

Soldiers, building the foundation of expansibility and reversibility into our force in the future.

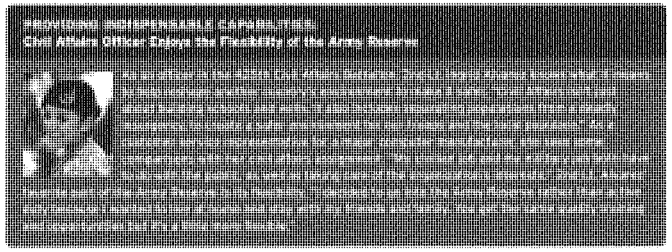
There are many aspects to this initiative and it will require perseverance to change each institutional process that creates barriers or separation. This ranges from the creation of an Individual Ready Reserve (IRR) Affiliation Program and Army Transition Process transformation. These forward-thinking institutional policy changes will provide an underpinning to the best, most efficient practices in human capital management.

Institutionalize ARFORGEN

Army Force Generation (ARFORGEN) is a cyclic process the Army uses to man, equip, and train all units to meet combatant commander requirements. ARFORGEN is designed to focus training, training support and other limited resources for units in a timely, predictable manner as they prepare for operational employment using a common set of standards. Approximately half of Army capabilities are in the reserve component. This includes the Combat Support and Combat Service Support units of the Army Reserve. The Total Army Force relies upon these Army Reserve enablers to be ready and fully integrated as part of an expeditionary force within the time frame when they are needed. To the Army Reserve, ARFORGEN goes beyond process and policy adaptation, it includes cultural change both within the Army and the Army Reserve.

Full Time Support (FTS)

Full Time Support is an essential element of the Army Reserve's ability to conduct training, personnel and administrative functions and leading Army Reserve units in the operational force. Historically, the Army Reserve has been under resourced in Full Time Support. This has been mitigated by the use of Overseas Contingency Operation funding and leveraging the use of volunteers to bring operating units to required readiness levels. Despite the war time demands placed on our Nation's ground forces throughout the last decade, Full Time Support manning levels in the Army Reserve have remained, on a percentage basis, the lowest among the service branches. To increase readiness of operational units in the future, assets and personnel policy will be shifted to direct support to the operational Army Reserve. *Note: Full-time support was compared by totaling all AGR, Military Technicians and other civilian positions.*

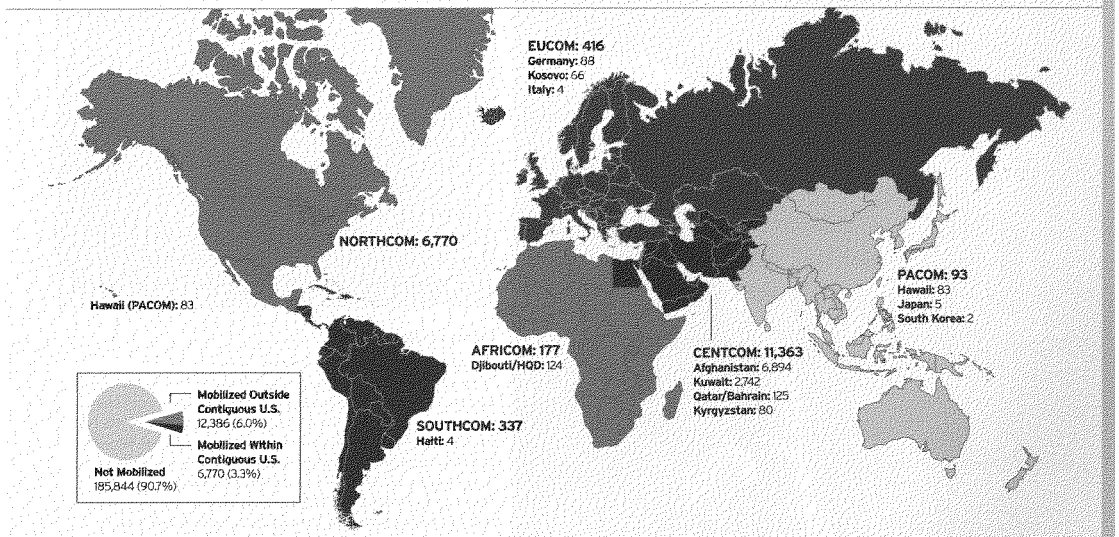


Operations and Research Captain, Army
Civil Affairs Officer Enjoys the Flexibility of the Army Reserve

ARMY RESERVE COMMITMENTS

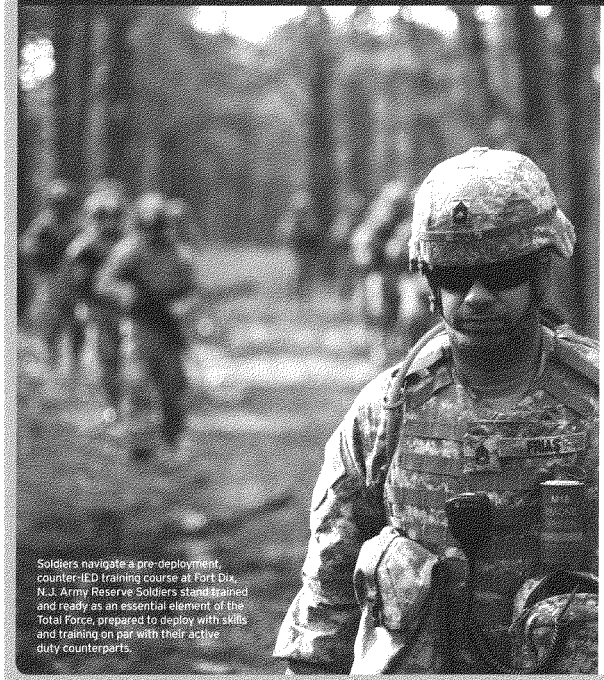
19,156 Army Reserve Soldiers are currently mobilized and deployed around the world*

The Army Reserve continues to provide critical enabling capabilities worldwide, supporting the Total Force across a range of military operations. Missions include theater security cooperation, humanitarian assistance and contingency operations. Army Reserve Theater Commands are uniquely capable of providing global support—addressing specific and emerging geographical and political issues as they arise. Missions include theater security cooperation, humanitarian assistance and contingency operations.



*As of Feb. 24, 2012. Does not include Individual Ready Reserve and Individual Mobilization Augmentee Soldiers. Source: MDIS Mobilization and Deployment Tracking Information System)

THE FY 2013 BUDGET REQUEST: WHERE WE ARE GOING



Soldiers navigate a pre-deployment, counter-IED training course at Fort Dix, N.J. Army Reserve Soldiers stand trained and ready as an essential element of the Total Force, prepared to deploy with skills and training on par with their active duty counterparts.

Human Capital

CRITICAL HUMAN CAPITAL PROGRAMS THAT SUSTAIN AN OPERATIONAL ARMY RESERVE

- Manning an Operational Army Reserve
- Medical Non-Ready Initiative
- Yellow Ribbon Reintegration Program
- Medical and Dental Readiness
- Medically Not Ready Soldiers for Case Management/Referral
- Post Deployment Health Reassessments
- Strong Bonds
- Manpower for Family Programs Mission Requirements
- Communication and Outreach to Soldiers and Families
- Family and Soldier Support thru Responsive and Relevant Services

Personnel Management

Manning an Operational Army Reserve

The mission of our incentives program, according to the Army Reserve Manning Strategy, is to focus our funds in support of the supply-based Army Force Generation (ARFORGEN). This will focus the use of incentives to ensure that ARFORGEN cycle Aim Points for unit required strength are met. We will tailor our incentives programs and priorities, as specified on the Selected Reserves Incentives Program (SRIP) List, to enable pinpoint manning in the Recruit Quota System (REQUEST). This occurs by diversifying types of incentives to meet a myriad of personnel requirements for the current Army Reserve operational environment. This will reduce overall costs and increase the readiness posture of the Army Reserve.

Health Care

Medical Non-Ready Initiative

The Medical Non-Ready Initiative aggressively expedites medical board evaluations to minimize hardships to both Soldiers and Families and return our most valuable resources back to our formations. The Initiative places emphasis on leader education and involvement, coupled with the processes to gain rapid, unconstrained and inclusive treatment through the medical system for our wounded, ill and injured Soldiers. As for the way ahead, the Army Reserve will leverage the following medical readiness programs Reserve Health Readiness Program, Army Selected Reserve Dental Readiness System, The Psychological Health Program, Medical Management Activity, reserve component Soldier Medical Support Center (RCSMSC). We will also use case managers to monitor the medically non-ready population, coordinate with the Soldier and the command for required/requested medical evaluations, and gather information for review by the Medical Management Activity or the Regional Support Command (RSC) Surgeons for appropriate profiling. Soldiers who have medical conditions that warrant permanent profiles are issued one, and then referred to the Regional Support Command Personnel Health Service Branch for medical boarding action.

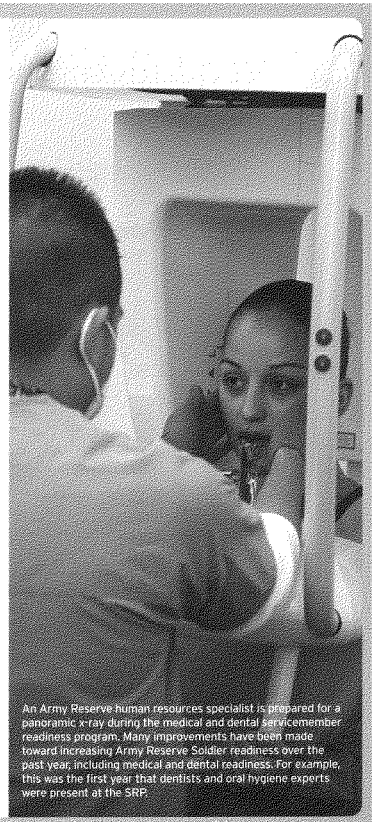
Medical and Dental Readiness

The Army Reserve is an enduring operational force, and as such must be medically ready to respond to immediate global requirements across the full range of military operations. Sixty-three percent of the Army Reserve is medically ready; numbers have been increasing from 24 percent since October 1, 2008. Seventy-four percent of Army Reserve Soldiers are dentally ready; numbers that have been positively increasing from 52 percent on October 1, 2008. Programs such as the Army Selected Reserves Dental Readiness System (ASDRS) have made a difference in improving baseline dental readiness. The ASDRS program covers examinations and dental treatment cost to convert an Army Reserve Soldier to a deployable status.

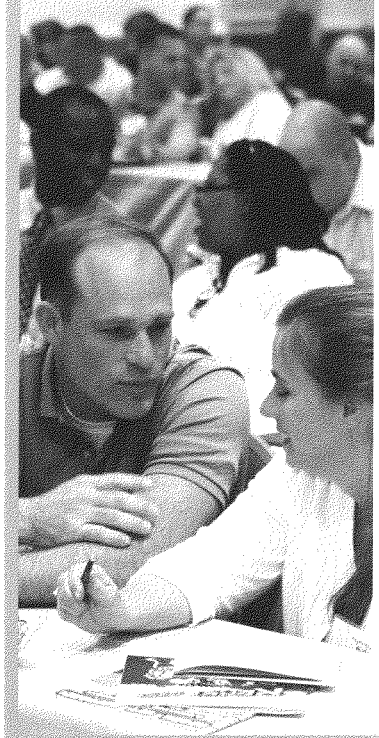
Medically Not-Ready Soldiers

The Army Reserve's fully medically ready status means that over one third of our Soldiers are not medically ready, meaning they cannot deploy to support worldwide missions if needed and are deficient in one of five measures (dental, periodic health assessment, routine adult immunizations, no deployment limiting conditions or medical equipment). Fifteen percent of these Soldiers are available but must complete a periodic health assessment or a dental screening in order to be deemed medically ready, and 11.3 percent have a medical condition that renders them temporarily or permanently non-deployable and either need additional care or are awaiting medical board determination on their ability to continue to serve.

In 2011, the Army Reserve moved aggressively to reduce the number of medically non-deployable Soldiers. The Army Reserve Surgeon, working with members of the Office of the Surgeon General and the Department of the Army, implemented two initiatives to review medical profiles and prepare Soldiers for medical evaluation boards. First, the Medical Management Activity was established on January 3, 2011, to support the rapid evaluation of permanent medical profiles and improve the identification process of those Soldiers who are not ready through increased use of the Medical Protection System (MEDPROS) and the electronic profile. Since the inception of the Medical Management Activity in 2011, over 6,000 medical profiles have been reviewed, of which 50% were amended and 20% were sent for an MOS administrative retention board, allowing these Soldiers to remain in the Army Reserve. The number of profiles requiring review decreased from 16,758 in January 2011 to 9,913 in November 2011. The number of P3 and P4 profiles not requiring a medical evaluation board has steadily increased from 2,065 in January 2011 to 3,298 in November 2011.



An Army Reserve human resources specialist is prepared for a panoramic x-ray during the medical and dental servicemember readiness program. Many improvements have been made toward increasing Army Reserve Soldier readiness over the past year, including medical and dental readiness. For example, this was the first year that dentists and oral hygiene experts were present at the SRP.



Army Reserve Family Support programs such as the Yellow Ribbon program proactively reach out to Soldiers and their Families with information, education, services and referrals through all phases of the deployment cycle.

Second, the reserve component Soldier Medical Support Center was established January 18, 2011, to review Medical Evaluation Board Packets and improve the medical boarding process. Since the establishment of the reserve component Soldier Medical Support Center in 2011, the Army Reserve has better visibility of Soldiers entering the Medical Evaluation Board process, with over 540 Packets submitted to military treatment facilities.

Post Deployment Health

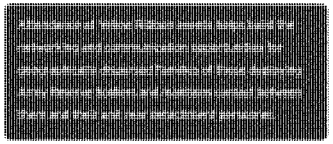
Repetitive deployments have significantly increased the strain on the Army Reserve force. To assess post deployment needs and to protect the health and well-being of Soldiers who have redeployed from combat, our Soldiers complete the Post Deployment Health Reassessment.

The Army Reserve is moving out aggressively to mitigate the effects of persistent conflict and build a strong resilient force. On 4 March 2011, the Army Reserve Psychological Health Program concept plan was approved, and four Directors of Psychological Health began working in 2011 to better meet the behavioral health needs of Army Reserve Soldiers. Our case management program is expected to begin within the Army Reserve this fiscal year as well.

Family Support

Yellow Ribbon Reintegration Program

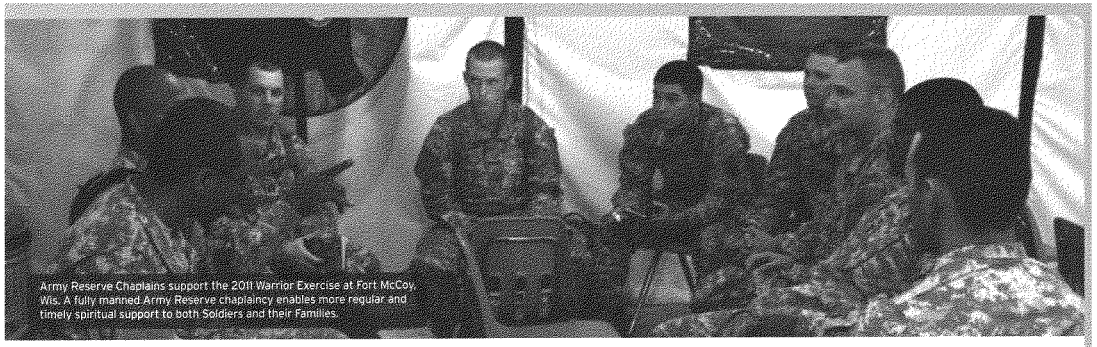
The Army Reserve promotes Soldier and Family resiliency through the Yellow Ribbon Reintegration Program that proactively reaches out with information, education, services and referrals through all phases of the deployment cycle to over 22,400 Soldiers and 25,500 Family members. Our ability to provide services and support resources to the Total Army Reserve Family (Soldiers, Family members, retiree recalls, civilians and wounded warriors) is challenging due to the Army Reserve geographic dispersion. Yellow Ribbon events, of which there were over 550 in 2011, allow units to build cohesion, morale and camaraderie. We strive to ensure each Family is healthy while preparing for, during and after a deployment. Attendance at Yellow Ribbon events helps build the networking and communication opportunities for geographically dispersed Families of those deploying Army Reserve Soldiers, and it maintains contact between them and their unit rear detachment personnel. We can identify and assist any at-risk Family members easier through this method of gathering them together



during the deployment. Yellow Ribbon events also provide a platform to demonstrate the energy, enthusiasm and impact of local, regional and national community and businesses leaders' support of our commands and individual Soldiers who deploy.

Manpower for Family Programs Mission Requirements

Army Reserve Families continue to bear the challenges of a nation at war and adjust to the realities of an operational force. Army Reserve Family Programs must maintain a baseline level of skilled and quality professionals to provide responsive services and mitigate the corollary effects of Family separations due to ongoing conflicts, humanitarian missions, and theater security cooperation missions. A skilled and quality family programs force directly affects the ability to maintain the infrastructure of programs and services that support geographically dispersed Soldiers and Families. Our family programs workforce must be robust enough to provide program standardization and stability; adaptive, full spectrum



Army Reserve Chaplains support the 2011 Warrior Exercise at Fort McCoy, Wis. A fully manned Army Reserve chaplaincy enables more regular and timely spiritual support to both Soldiers and their Families.

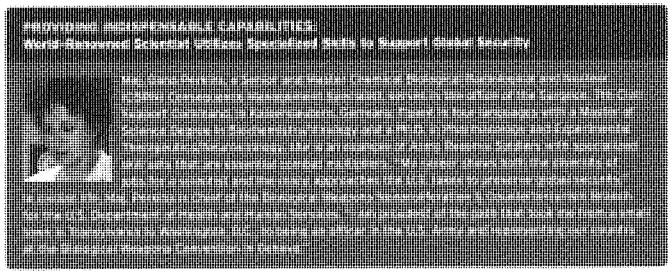
staffing support; and responsive services that meet the complexities of supporting Army Reserve Soldiers and Families.

Strategic Communication Outreach to Soldiers and Families

An important family programs function is disseminating information and timely alerts about programs and services available 24/7, closest to where Soldiers and Families reside. The overarching family programs communication strategy employs a "top-down/internal-to-external" model, which deploys clearly articulated, aligned messages to the appropriate audiences through multiple delivery systems and events. This strategy includes a suitable mechanism for measuring program efficiency, while gaining a heightened awareness of customers' needs through feedback via surveys, one-on-one exchanges and social media. The endstate is a consistent method of determining success in delivering the services that mean the most to Soldiers and Families.

Family and Soldier Support Through Responsive and Relevant Services

Family Programs is synchronizing its requirements for staffing, resourcing and training with the Army Force Generation (ARFORGEN) model. Programs focus on the command/unit and Family partnerships to support Soldiers' readiness and mitigate risk. The intent is to proactively establish a collaborative readiness pattern focused on geographically dispersed Soldier and Family programs support, training and services to ensure Families are resilient and prepared to meet the challenges of an operational force.



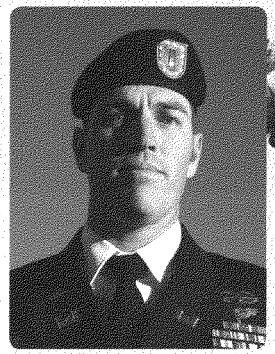
Individual Leader Development Capabilities

Army Reserve School gains specialized skills to support cyber security

Spiritual Care

Strong Bonds provides relationship skills training for married couples, Families, and single Soldiers. The various events empower Soldiers to more fully connect with their loved ones. It is a holistic, preventive program

CONTINUUM OF SERVICE



A 15-year veteran with two deployments, 1st Lt. Paul Gonzalez of Derby, Kan., utilized Army Reserve educational benefits to earn a Bachelor's degree in fire science and a Master's degree in organizational leadership. As a warrior-citizen, Gonzalez contributes to his nation and his community both as a Soldier and as a member of the Firefighter and Rescue Team for the Wichita, Kan., fire department. A married father of three, Gonzalez receives strong support from his Family, friends and employer as he continues to serve—the true embodiment of Continuum of Service.

Continuum of Service is a human capital management strategy that facilitates the movement of Soldiers between the active and Reserve service and civilian employment.

WHO IS INVOLVED?

A Continuum of Service Working Group is pursuing numerous initiatives, including potential changes to current policies to allow for more flexible service options.

WHY NOW?

The Continuum of Service initiative seeks to retain a pool of experienced, talented Soldiers through continued service in the reserve components, thereby allowing the Army to reverse and expand its end strength as required.

WHAT IS BEING DONE?

The Army Reserve has identified those policies that impede the ease of movement between components and has embarked on a strategy of implementing a new personnel management paradigm that meets the needs of an enduring operational force.

Continuum of Service is right for:

THE ARMY: Allows the Army to retain a pool of talented and experienced Soldiers to support potential expansibility of the Army in the future.

THE SOLDIER: Offers opportunity to continue serving with varying levels of participation over the course of a lifetime of service.

THE TIMES: Provides a cost-effective personnel management system for the Army.

The flexibility of the Continuum of Service Human Capital Management Strategy will:

- ★ Help retain a reservoir of talent and experience through incentives and access to transitioning active component personnel
- ★ Ease movement between components and civilian employment by incentivizing transition to the Army Reserve and expanding support for civilian career opportunities
- ★ Flexible Service Options–IRR Affiliation to Reserve unit, Volunteer Only IRR options or Traditional Reserve service

Integrated Human Capital Strategy: Focus is on change to Army regulations, policies and procedures that can be acted on now.

POLICY

- ★ Modifications to existing policy and directives to manage the Army as a Total Force
- ★ Joint education programs

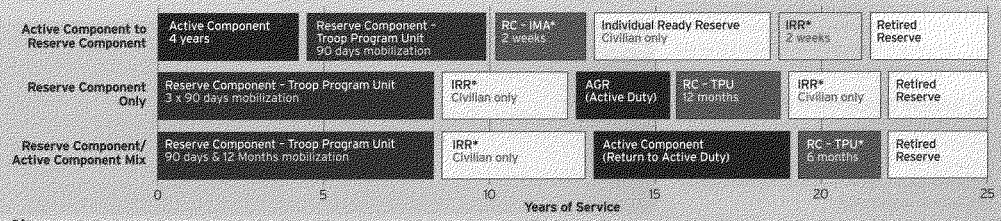
PROCESSES

- ★ Integrated processes and systems for seamless transitions, along with portability of benefits

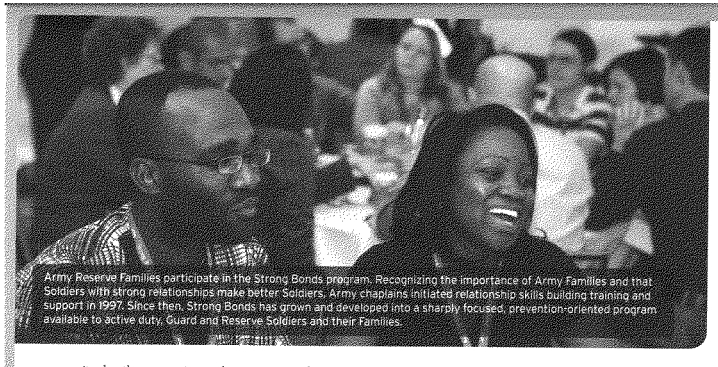
CULTURE

- ★ Requires a culture change in the way the reserve component is used as an indispensable part of the Total Force

Varying Levels of Participation:



*Acronyms:
RC = reserve component • IMA = Individual Mobilization Augmentee • IRR = Individual Ready Reserve • TPU = Troop Program Unit



Army Reserve Families participate in the Strong Bonds program. Recognizing the importance of Army Families and that Soldiers with strong relationships make better Soldiers, Army chaplains initiated relationship skills building training and support in 1997. Since then, Strong Bonds has grown and developed into a sharply focused, prevention-oriented program available to active duty, Guard and Reserve Soldiers and their Families.

committed to the restoration and preservation of Army Families, even those near crisis. Strong Bonds is an Army program led by Army chaplains. More than 90% of those who have attended the program rate it positively. As a direct result, Soldier and Family readiness, resiliency and retention increases. Availability of Strong Bonds programs is a required part of deployment cycle support plan for Soldiers and Families. Currently OMAR funding in the President's Budget will provide for training materials, sites and travel costs for Soldiers and Family members. The Strong Bonds events are continually being updated to meet the needs of our Soldiers and Families throughout the ARFORGEN cycle. These programs and events are critical to Soldier and Family readiness during and long after current deployments.

The Employer Partnership of the Armed Forces

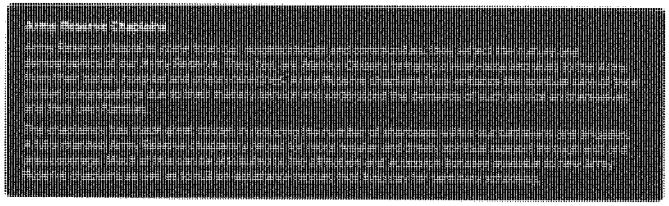
The Employer Partnership of the Armed Forces (EPAF) connects capability with opportunity. Our skilled service members bring skills, reliability and capability to the civilian workplace while the program's Employer Partners provide career opportunities.

The Program is operated and funded primarily by the Army Reserve but supports the civilian employment and career advancement needs of members of all seven reserve components, their Family members, Wounded Warriors and the nation's veterans. The Army Reserve has dedicated staff, continual maintenance and upgrading of the Career Portal: (www.Employerpartnership.org). Army Reserve funding supports the Career Portal as well as the program support managers dispersed across the United States who provide direct assistance to both employer partners and job seekers.

Employers recognize the benefits of the EPAF program. The program now has more than 2,500 employers participating, and the number is steadily growing. These Employer Partners are military-friendly and value the skills, experiences and work ethic of those who serve.

The reserve components also benefit. Best practices and experience with cutting-edge technology and medical procedures flow between military and civilian organizations through EPAF's training partnerships. Access to career opportunities and partnered training initiatives also provide tangible reasons for separating active service members to continue serving in a Reserve capacity.

In the next few years, thousands of Army Reserve and National Guard Soldiers will de-mobilize and tens of thousands of active duty personnel will leave the military. The program's ability to connect these imminent job seekers with employment can make a positive impact on unemployment rates among our newest veterans. Accordingly, the Program is working with both the Office of the Secretary of Defense and the Department of the Army to formally incorporate EPAF into transition programs for the active and Reserve members of all branches of service. EPAF strengthens our military, our economy and—most importantly—strengthens our service members and their Families.



Readiness

Critical Readiness Programs that Sustain an Operational Army Reserve

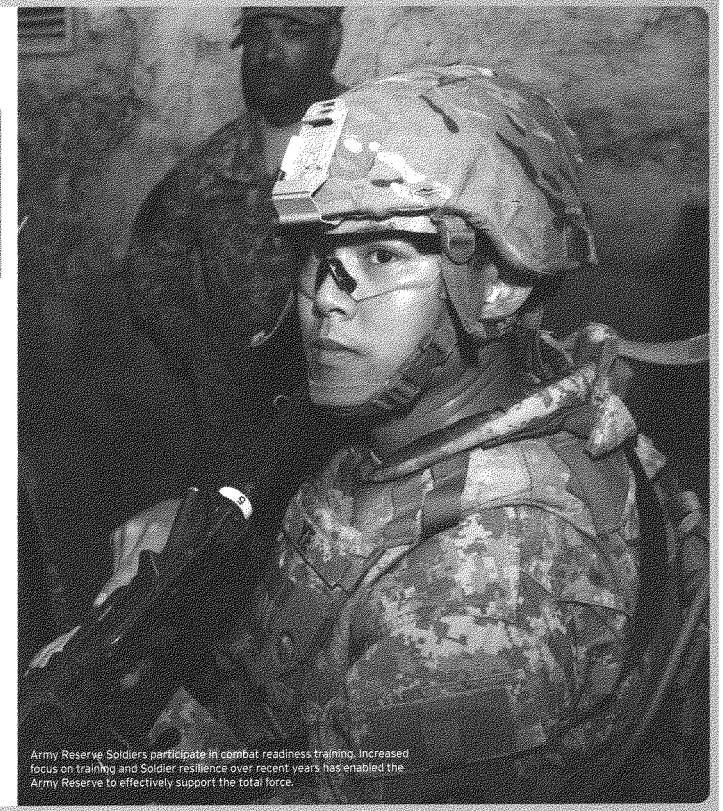
- Sustain an Operational Army Reserve
- Sustain modern training equipment, facilities, and installations that support rapid mobilization capabilities
- Protect the force, physical security, management of the Physical Security Program

Sustain an Operational Army Reserve

The Army Reserve provides operational capabilities and strategic depth to the Army to meet national defense requirements across the full range of military operations. The Army Reserve participates in a full range of missions that support force generation plans. Units and individuals participate in an established cyclic or periodic cycle of readiness that provides predictability for combatant commands, the Total Force, service members, their Families, and employers. In their strategic roles, units and individuals train or are available for missions in accordance with the national defense strategy. This force provides strategic depth and is available to transition to operational roles whenever needed. Accordingly, it is critically important that the Army Reserve provide capabilities and generate a force that is available to support Army needs. Properly sustaining the Army Reserve as an operational force means success in ongoing operations in which the Army Reserve now plays a vital role, as well as in future contingencies in which it will play a critical role.

Mandays to support an Operational Reserve

The Army Reserve was successful in obtaining an approved training strategy to provide trained companies



Army Reserve Soldiers participate in combat readiness training. Increased focus on training and Soldier resilience over recent years has enabled the Army Reserve to effectively support the total force.

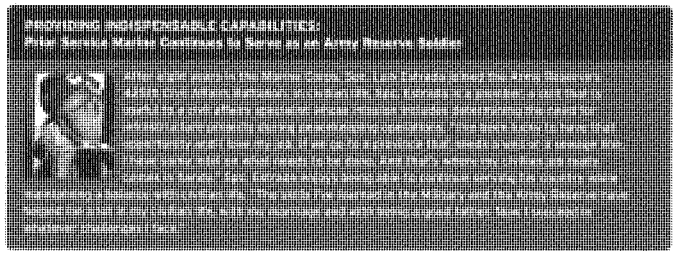
and brigade and battalion staffs to combatant commanders upon mobilization.

Homeland Operations

Homeland Defense, Homeland Security and Defense Support of Civil Authorities: These important missions require the unique enabler capabilities resident in the Army Reserve. Today, the Army Reserve provides seven aviation units in support of the Defense Chemical Biological Radiological Nuclear (CBRN) Response Force (DCRF). These units work directly with their active-duty counterparts as the initial Title 10 response force for CBRN or terrorist incidents. The Army Reserve provides an additional 12 units as part of the Command and Control CBRN Response Element.

Responding to Defense Support of Civil Authorities (DSCA) situations, the Army Reserve provides all of the Army Emergency Preparedness Liaison Officer (EPLO) capability. These Soldiers conduct valuable operations at various federal, state and local emergency operations centers during all phases of incident management operations. The Army Reserve provides the potential for additional incident response forces including, but not limited to, the following types of units: medical aviation, transportation, engineer, communications and civil affairs. These capabilities can be packaged with the appropriate command and staff structure to facilitate assistance to civil authorities. This packaging also provides necessary command and control of Title 10 Department of Defense resources in a defined joint environment. With approval of NDAA 2012 the Army Reserve can provide significant resources to support civil authorities in domestic disasters and emergencies.

The Army Reserve's FY 2013 budget request properly funds the operational reserve to ensure the force structure required for homeland operations. The requirement to maintain a specific portion of our Soldiers on orders to support DCRF mission response time is critical to mission accomplishment and success. National level response goals to save lives and conduct search and rescue operations in the first 72 hours of an incident, requires immediate access to Army Reserve forces for these critical missions. Resourcing to purchase and maintain specialized commercial off the shelf equipment allows interoperability between the Army Reserve forces employed at an incident location with federal, state, and local first responders.



Providing Indispensable Capabilities: Pfc. Jessica Martin Continues to Serve as an Army Reserve Soldier

Pfc. Jessica Martin, a Soldier in the Army Reserve's 1st Battalion, 1st Regiment, Fort Lee, Virginia, is a petroleum supply specialist who has served in the Army Reserve since 2008. She has served in Iraq and Kuwait and is currently deployed to Afghanistan. Martin's unit provides petroleum supply support to the Combined Joint Task Force-Horn of Africa in Djibouti, Africa. Martin's unit provides petroleum supply support to the Combined Joint Task Force-Horn of Africa in Djibouti, Africa.

Sustain modern training equipment, facilities, and installations that support rapid mobilization capabilities

Sustaining modern training equipment, facilities and installations is critical to successful mobilization of the Army Reserve within established timelines when needed. Army Reserve Soldiers and units need to train on the same modernized equipment the Army uses in the field as well as access to modern facilities designed and maintained to sustainable standards. Timely deployments of forces with the skills needed for success in 21st-century engagements depends on Congressional support.

Mission Training Complexes

Mission Training Complexes (MTCs) provide the training for Army Reserve leaders and battle staffs in support of mobilization. This is essential to meet Army Force Generation (ARFORGEN) readiness goals and metrics used to evaluate the readiness of the force. The Army Reserve successfully negotiated for upgrading three of our five MTCs and the new construction of one MTC.

Simulations and Simulators

Simulations and Simulators (weapons and systems simulators) programs are critical in supporting an operational force as well as for collective and individual training. Training for the full range of military operations and for contingencies is evaluated using the aim points in ARFORGEN. To ensure the total force is properly trained, the Army Reserve has a simulation requirement and is programmed to maximize funding from the President's Budget.

Electronic Based Distance Learning

The Army is allowed to provide discretionary payments for selected Reserve Soldiers, not in active service or on active duty, who are directed by their commanders to complete Department of the Army approved training requirements by means of electronic-based distributed learning (EBDL).

Equipment fills for Training Unit Table of Distribution and Allowances

The Army Reserve has Table of Distribution and Allowance (TDA) equipment funding, which is an area of risk within the strategy for training facilities. Modernized pieces of equipment are required to conduct training during various stages of the force generation model. The use of training simulators and equipment loans mitigates equipment shortages.

Transient Training Facilities (Operational Readiness Training Complex) Fort Hunter Liggett

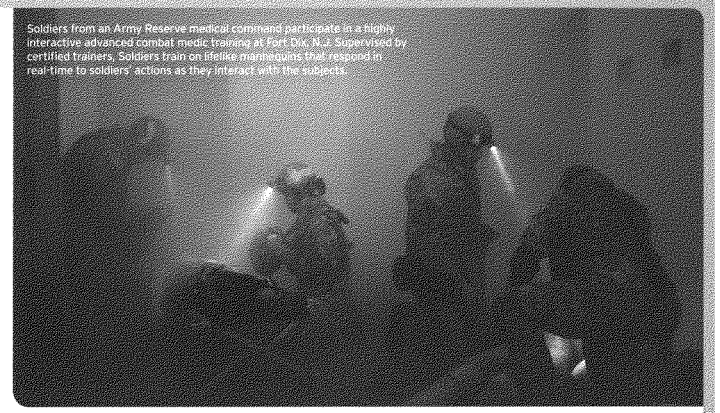
Transient training facilities are critical for requirements for our Army Reserve platforms to support our units as they progress through the ARFORGEN cycle. These facilities provide the barracks, classroom, motor pool and administrative space for units to conduct effective institutional and collective training on our installations. Sufficient resources are included in the Army Reserve's budget to ensure the construction and modernization of transient training facilities for an operational force.

Protect the Force, Physical Security, Management of the Physical Security Program

The Army Reserve faces unique challenges and vulnerabilities when it comes to Physical Security. The Army Reserve span of control includes personnel at over 950 stand-alone facilities across the Continental U.S. (CONUS). Physical security inspectors and antiterrorism assessment specialists in the field mitigate these challenges.

The Army Reserve manages the risk of damage, destruction or loss of personnel, weapons or equipment to criminals or terrorists by having the Intrusion Detection System (IDS)

The IDS systems monitor arms rooms at Army Reserve facilities 24 hours a day. The monitoring program notifies authorities immediately should an arms room at a remote facility be breached. These systems require technology upgrades and maintenance because Army Reserve facilities are distinctive as stand-alone facilities in remote parts of the country.



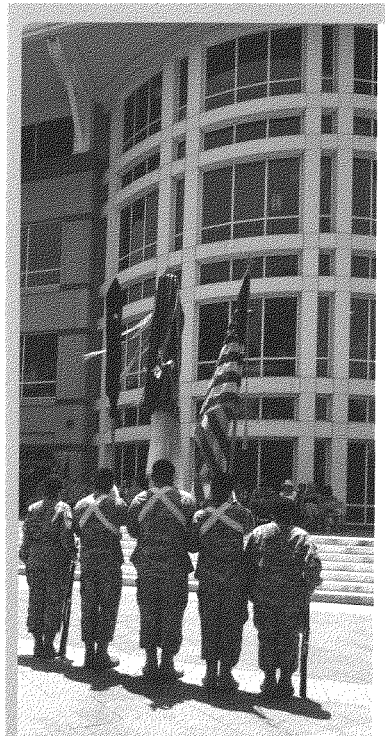
Soldiers from an Army Reserve medical command participate in a highly interactive advanced combat medic training at Fort Dix, N.J. Supervised by certified trainers, Soldiers train on lifelike mannequins that respond in real-time to soldiers' actions as they interact with the subjects.

Provisioning for antiterrorism officers at all major subordinate commands enables commanders to protect the force

Antiterrorism assessment specialists are the key component to the Antiterrorism Program. They conduct vulnerability assessments and program reviews of Army Reserve commands and facilities across the nation. Antiterrorism programs detect, deter and defeat threats against Army Reserve personnel, equipment and facilities. The scope of this mission has grown and requires capable individuals to manage and enact commanders' programs. Antiterrorism officers provide the expertise and ability to synchronize command protection-based programs, which further promotes unit readiness.

Law Enforcement

Adequate resources are required for Law Enforcement functions on all five Army Reserve installations: Fort Buchanan, Fort Devens, Fort McCoy, Fort Hunter Liggett and Camp Parks. Law Enforcement focuses on protecting Army Reserve equities, both human and material, from criminal offenders, as well as assisting and serving the community. The resources provide installation commanders a fully trained and responsive cadre of Army civilian police, support the Military Working Dog (MWD) Program at Fort Buchanan, and provide support to missions in the Caribbean and South America. Funding also assures criminal deterrence, protection and safety of Soldiers, Family members and civilians who work, train and live on Army Reserve installations.



The U.S. Army Reserve Command headquarters cased their command's colors at a ceremony on Fort McPherson, Ga., on Friday, June 3, 2011. The ceremony marked the symbolic relocation of the headquarters from Atlanta to Fort Bragg, N.C., as part of the 2005 Base Realignment and Closure initiative.

Services and Infrastructure

Critical Facilities Programs That Sustain an Operational Army Reserve

- MILCON & MILCON Tails
- Facility Sustainment, Restoration and Modernization
- Energy Security and Sustainability
- Army Reserve Communications

Facilities

The Army Reserve has completed its transition from a strategic Reserve to an operational force through reorganization, realignment and closure of some organizations. With this came greater efficiencies and readiness, but also the need for sufficient facilities to meet mission requirements at the least cost, with acceptable quality and quantity, and at the right locations. Therefore, Services and Infrastructure Core Enterprises (SICE) is poised to anticipate and respond appropriately to emerging requirements to provide training platforms, maintenance facilities and enhanced capabilities to meet Army mission requirements.

Today's Army Force Generation (ARFORGEN) is a supply-based rotational model. ARFORGEN builds a structured progression of readiness over time to produce trained, ready and cohesive units. Last year's move to a supply-based model creates a cultural shift in the way we provide services and installation infrastructure at Reserve Centers and training sites. The "Reserve Center" is no longer an administrative facility but an Operations Complex that supports preparation, training, maintenance of equipment and Family support activities crucial to the health, welfare and morale of Soldiers and Families.

In today's economic environment—the nation as well as the Army Reserve—is required to become even more efficient in the use of our scarce resources. The Army, in concert with the Army Reserve, is developing a Facility Investment Strategy, which focuses on incorporating the major acquisition of units and equipping programs, that serves to advise the Construction Requirements Review Committee and the overall Army Military Construction (MILCON) program prioritization and review process. More importantly, this strategy will ensure our planning is proactive, efficient and capable of supporting long-term mission requirements in both CONUS and OCONUS.

[redacted]

MILCON and MILCON Tails

Under Military Construction Army Reserve (MCAR), we have MILCON & MILCON Tails as our number one budget priority. Sufficient MILCON resources support new Organizational Readiness Training Centers (ORTCs) requirements. Older Reserve centers in the Northeast/Midwest areas of the country no longer support 21st-century recruiting markets, now burgeoning in the southern and western parts of the United States. While Base Realignment and Closure (BRAC) facility construction efforts improved 17 percent of our facility portfolio, the average age remains at 40 years, down from an average age of 43 years prior to BRAC. With adequate resources for

MILCON, we can avoid a continuous cascading effect of project implementation setbacks. Procurement and installation of fixtures, furniture and equipment, National Environmental Protection Act requirements, information technology and security equipment are additional costs that must be factored in.

Facility Sustainment, Restoration and Modernization

Sustainment, the cornerstone of facilities stewardship, inhibits deterioration, improves building systems quality and prevents sustainment migration. Continued support for sustainment activities helps us achieve the 60 years of average facility service life that supports Army Reserve future operational requirements. Restoration and modernization enhancements are increasingly advantageous for the Army Reserve as we anticipate increased efficiencies in military construction.

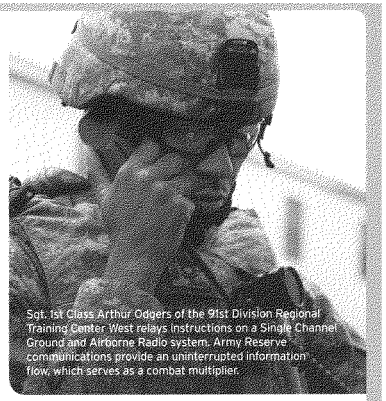
Energy Security and Sustainability

The Army Reserve included in its FY 2013 budget request Energy security and sustainability funding to meet the minimum Congressional and federal energy sustainability mandates. This includes energy metering; green house gas emission reductions; energy consumption and security; expanding our use of renewable energy sources; achieving "Net-Zero" in water, waste and energy; and operational energy requirements to enhance the safety of our Soldiers, Family members, and Army Reserve Civilians.

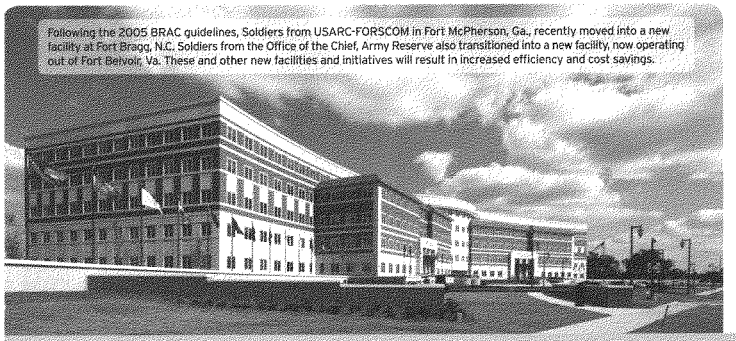
Army Reserve Communications

The Army Reserve Network (ARNet) Management/Security/Defense encompasses three Management Decision Execution Packages (MDEPs): Base Information Management Operations, Defense/Information Assurance, and Long Haul Communications. Army Reserve operations depend on ARNet functionality, agility, reliability and security of critical mission information. ARNET defense denies adversaries and others the opportunity to exploit vulnerabilities. Long Haul Secure Communications are critical for mission command along with mobilization support.

An uninterrupted information flow is a combat multiplier by synchronizing other joint capabilities. Continued funding included in the Army Reserve's budget request supports the information environment with global access, standard infrastructures and common policies that provide information services from the generating force to the tactical edge. Adequate resourcing allows normalization of ARNet defense, tactics, techniques and procedures. Secure Internet Protocol Router Network (SIPRNet) and Secure-Video Teleconferencing (S-VTC) access for battalion and above are vital for pre-mobilization training and readiness requirements. Continued support for these programs permits secure communications and defends the ARNet from compromise.



Sgt. 1st Class Arthur Odgers of the 91st Division Regional Training Center West relays instructions on a Single Channel Ground and Airborne Radio system. Army Reserve communications provide an uninterrupted information flow, which serves as a combat multiplier.



Following the 2005 BRAC guidelines, Soldiers from USARC-FORSCOM in Fort McPherson, Ga., recently moved into a new facility at Fort Bragg, N.C. Soldiers from the Office of the Chief, Army Reserve also transitioned into a new facility, now operating out of Fort Belvoir, Va. These and other new facilities and initiatives will result in increased efficiency and cost savings.

Army Reserve Materiel maintains logistical readiness that is essential for executing missions for the Army and nation. The reserve component has achieved a level of readiness unseen in its history, and it is crucial to maintain this momentum.

Materiel

Critical Equipping Programs that Sustain an Operational Army Reserve

- Equipment Refresh/Life Cycle Replacement
- Standard Army Management Information Systems and Logistics Automation Systems
- Second Destination Transportation of Equipment
- Five-Year Reviews of Resource Management Manpower, Training and Hiring Practices

Army Reserve Materiel

The Army Reserve has reached a level of logistics readiness unseen in its history, enhancing its ability to execute assigned missions for the Army and the nation. There are critical areas where this momentum must be maintained to sustain our current level of readiness and capability—Equipment Refresh/Life Cycle Replacement, Second Destination Transportation and Surface OPTEMPO Tactical Maintenance Shops.

Equipment Refresh/Life Cycle Replacement

The Army Reserve works closely with Software Engineer Center—Lee (SEC-Lee) to ensure that all systems migrating to the Global Combat Support System-Army (GCSS-Army) have the latest technology upgrades. This ensures that Army Reserve logistics information technology systems are replaced by GCSS-Army and are robust enough to operate the new system. GCSS-Army fielding does not have hardware associated with it so it is essential that legacy systems are capable of operating the new software platform. GCSS-Army is an Enterprise Resource Planning (ERP) solution that creates a single, integrated logistics information system across the Army. When finished, the Army will have a single logistics information and management system with an integrated data warehouse across all components.

The system will provide management tools to enable the Army to implement and sustain the Army Force Generation (ARFORGEN) model more efficiently.

Second Destination Transportation

Second Destination Transportation (SDT) is essential to implementing and sustaining ARFORGEN in the Army Reserve. First, it is needed to support the "bridging" strategy of moving equipment from units in Reset and the early years of the ARFORGEN cycle to units in the later years of ARFORGEN. Second, it is needed to execute the Army Reserve's equipping strategy of reducing fleet management and inventory costs by concentrating equipment where it is needed, with the prospect of later cost savings from reduced transportation costs and more efficient management of equipment and maintenance resources.

Surface Optempo Tactical Maintenance Shops

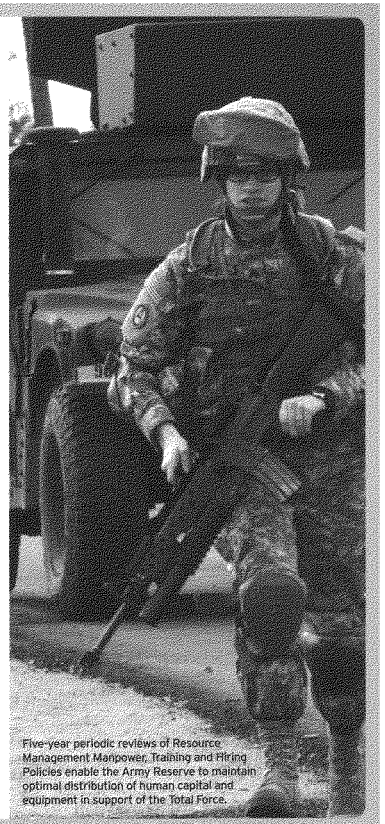
The appropriate level of resourcing will allow Regional Support Commands to continue contract maintenance labor in their Area Maintenance Support Activities and Equipment Concentration Sites. Contract labor addresses manpower shortages in shops as they are currently manned at only 56 percent of requirements. Additionally, actions taken under Grow the Army have increased maintenance intensive equipment by over 18 percent. Once the requirements are documented to maintain this increase in equipment, the maintenance structure of the Army Reserve will only be filled to 39 percent of requirements. As the Army continues to field more equipment to the Army Reserve, these shortfalls will continue to grow.

Resource Management

Five-Year Periodic Reviews of Resource Management Manpower, Training and Hiring Policies

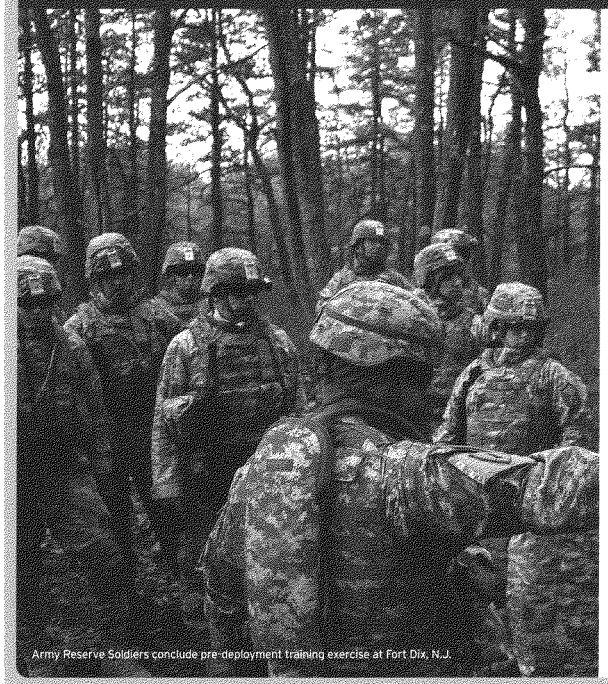
Funding for periodic reviews (every five years) and authority within available funding allows the Army Reserve to implement changes in Resource Management Manpower Authorizations, Training, Hiring Policies and Procedures unique to the Army Reserve, execute fiduciary responsibilities, and support the Army Reserve mission. This review includes a comprehensive examination of the distinctive systems/software used by the Army Reserve to conduct its core business processes (the Reserve Level Application System [RLAS], is one primary example) and provides the ability to fund changes necessary due to advances in technology.

PROVIDING INDISPENSABLE CAPABILITIES:
Citizen Warriors Serving Our Communities, While Serving Our Country



Five-year periodic reviews of Resource Management Manpower, Training and Hiring Policies enable the Army Reserve to maintain optimal distribution of human capital and equipment in support of the Total Force.

CONCLUSION: THE FORCE IS IN GOOD HANDS



Army Reserve Soldiers conclude pre-deployment training exercise at Fort Dix, N.J.

The Army Reserve provides trained, cost-effective and ready units, that enable the Total Army Force to meet and sustain global and domestic requirements. As military forces draw down and Overseas Contingency Operations (OCO) funding diminishes, continued use of the Army Reserve in an operational role is contingent upon Congressional support of the FY 2013 base budget request.

The greatest asset the Army Reserve has today is the high quality and devotion to country of our warrior-citizens. The skills they bring to the fight and the leadership they bring back to their jobs and their communities is remarkable. Establishing a Continuum of Service that enables Soldiers to meet the needs of serving their nation, their Families and their civilian careers is paramount. Their dedicated service to the nation should never be hindered by outmoded bureaucratic complexity. We need to think in terms of cultivating a "Soldier for Life" to retain the quality, highly experienced Soldiers needed to sustain the expansible/reversible Army Reserve as an enduring operational force.

With the impending downsizing of Army strength in the coming years, the Army Reserve will focus on retaining mid-grade enlisted and officers in key specialties required by the Army Reserve. We will increase our presence at active component transition points and reach out to Soldiers well before they are due to transition to help them recognize the value of continued service to their nation in the Army Reserve.

We will promote the Army Reserve managed Employer Partnership of the Armed Forces program as a tool for transitioning active component Soldiers, leveraging the program to develop the careers of Soldiers through extensive internship and externship programs with key organizations. A great example of this is the Army Reserve's partnership with GE Healthcare to provide civilian training and certification of our Army Reserve X-ray technicians. We see this part of the program expanding as we move to share training and resources with our industry partners to our mutual benefit.

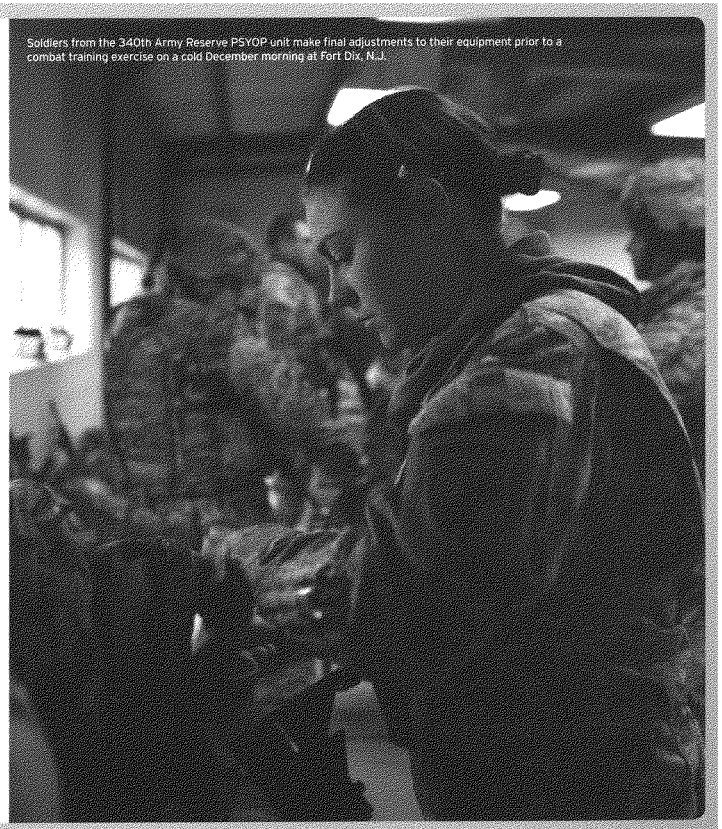
We seek continued funding of recruitment, retention and transition incentives to allow us to shape the force with less reliance on cross leveling to

offset our mid-grade strength imbalances. Future recruiting efforts will target incentives to more prior-service military personnel, who bring more experience than first-term Soldiers into the Army Reserve. These experienced Soldiers are critical in filling shortages among mid-level commissioned and noncommissioned officers.

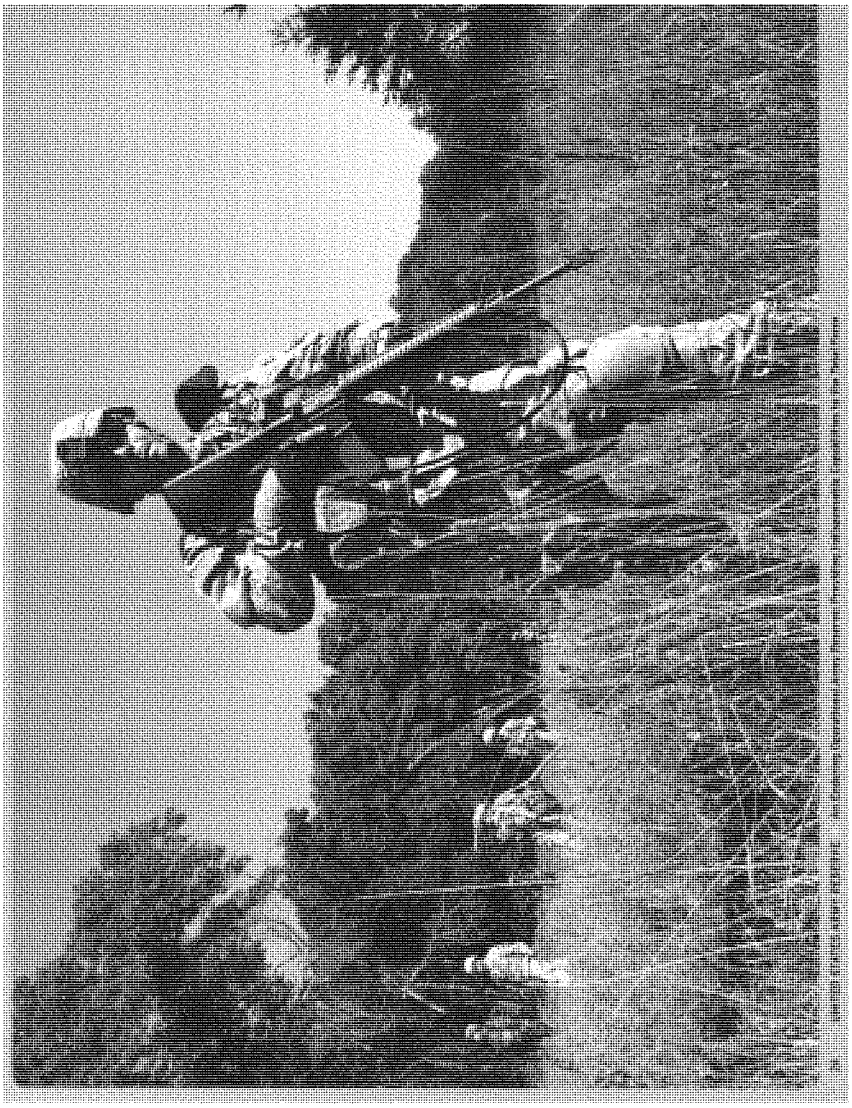
Realization of a five-year supply-based Army Force Generation (ARFORGEN) Cycle means all of our operational units now have an "available force pool" date, which will allow us to build progressive readiness throughout the cycle and tailor our manning, equipping and training strategies, and our Soldier and Family Support programs to best sustain the force throughout deployment cycle.

Why an enduring operational force? Army Reserve capabilities are well suited to support and participate in security cooperation activities and peace operations worldwide. Security cooperation builds relationships that promote specified U.S. interests, develops allied and friendly capabilities for self-defense and coalition operations and provides U.S. forces with peacetime and contingency access. The extensive operational experience and relevant civilian skill-sets resident within the Army Reserve are essential in meeting Combatant Command requirements for international engagement activities that improve infrastructure, security and institutions within foreign nations of strategic interest to the United States.

We take our commitments to our nation, to our Army, and to our Soldiers, Families, and our employer partners seriously. We are effective stewards of our nation's resources. America's sons and daughters serve with an unwavering commitment, willingly answering the call to duty in a time of war or national emergency. As we position ourselves as an essential provider of combat support and combat service support to the United States Army, we look to Congress and our fellow citizens for strength and support as our partners in maintaining an enduring operational Army Reserve for the 21st century.



Soldiers from the 340th Army Reserve PSYOP unit make final adjustments to their equipment prior to a combat training exercise on a cold December morning at Fort Dix, N.J.



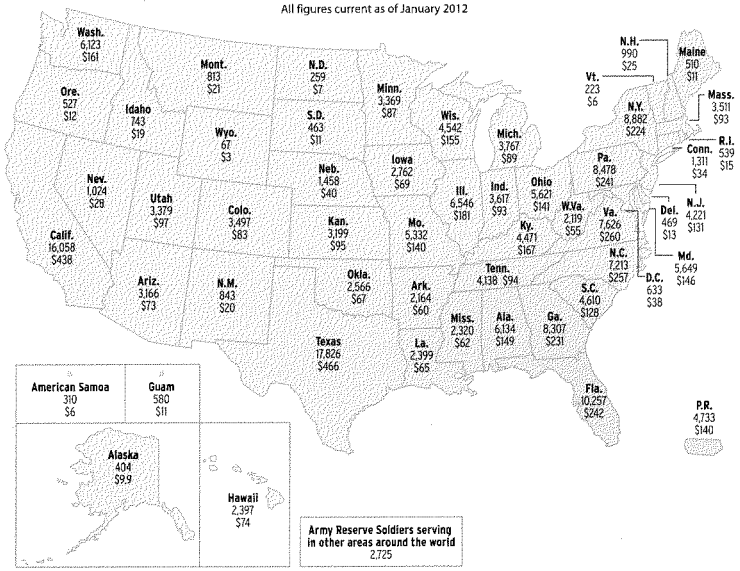
YOUR ARMY RESERVE

The United States Army Reserve provides trained units and qualified Soldiers available for active duty in the armed forces in time of war or national emergency, and at such other times as the national security may require. Throughout the United States, the Army Reserve has four Regional Support Commands that provide base support functions, and 13 Operational and Functional Commands available to respond to homeland emergencies and expeditionary missions worldwide.

ARMY RESERVE SOLDIERS AND ECONOMIC IMPACT BY STATE

Dollars in Millions

All figures current as of January 2012



Economic impact consists of the payroll for Select Reserve Soldiers and Civilian support, Army Reserve military construction (MILCON) projects, leases, utilities, municipal services, engineering services, fire and emergency services, maintenance and repair, minor construction, environmental compliance, environmental conservation, and pollution prevention.

ARMY RESERVE SNAPSHOT

MISSION: The Army Reserve provides trained, equipped, and ready Soldiers and cohesive units to meet global requirements across the full spectrum of operations.

VISION: As an enduring operational force, the Army Reserve is the premier force provider of America's Citizen-Soldiers for planned and emerging missions at home and abroad. Enhanced by civilian skills that serve as a force multiplier, we deliver vital military capabilities essential to the Total Force.

KEY LEADERS

Secretary of the Army:
The Honorable John M. McHugh

Army Chief of Staff:
General Raymond T. Odierno

Chief, Army Reserve and Commanding General, U.S. Army Reserve Command:
Lieutenant General Jack C. Stultz

Assistant Chief, Army Reserve:
Mr. James Snyder

Deputy Commanding General, (Operations)
Major General Jon J. Miller

Deputy Chief Army Reserve, Individual Mobilization Augmentee:
Major General Marcia M. Anderson

Deputy Chief Army Reserve/Human Capital Enterprise:
Brigadier General James V. Young

Deputy Commanding General (Support)/Chief of Staff:
Major General Keith L. Thurgood

Director for Resource Management/Materiel Enterprise:
Mr. Stephen Austin

Deputy Chief of Staff, G3/5/7/Force Programs Division/Readiness Enterprise:
Brigadier General Scott L. Donahue

Chief Executive Officer/Director, Services and Infrastructure Enterprise:
Mr. Addison D. Davis

Command Chief Warrant Officer:
Chief Warrant Officer 5 James E. Thompson

Command Sergeant Major:
Command Sergeant Major Michael D. Schultz

ARMY RESERVE BASICS

Established: April 23, 1908
2011 Authorized End Strength: 205,000
Selective Reserve Strength: 204,647
Accessions Goal for FY 2011: 19,000
Accessions Achieved FY 2011: 19,608
Accessions Goal for FY 2012: 16,000
Reenlistment Goals for FY 2011: 10,990
Reenlistment Goals Achieved for FY 2011: 11,719
Reenlistments Goals for FY 2012: 13,106
Soldiers Deployed around the World: 19,156
Soldiers Mobilized Since September 11, 2011: 200,148
Number of Army Reserve Centers: 1,100

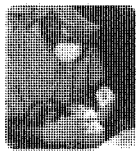
DISTINCTIVE CAPABILITIES

The Army Reserve contributes to the Army's Total Force by providing 100% of the:

Theater Engineer Commands
Civil Affairs Commands
Training Divisions
Biological Detection Companies
Railway Units
Replacement Companies

...more than two-thirds of the Army's:

Medical Brigades
Civil Affairs Brigades
PSYOPS Groups
Expeditionary Sustainment Commands
Dental Companies
Combat Support Hospitals
Army Water Craft
Petroleum Units
Mortuary Affairs Units



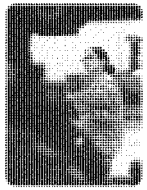
...and nearly half of the Army's:

Military Police Commands
Information Operations Groups
Medical Units
Supply Units

ARMY RESERVE DEMOGRAPHICS

Ethnicity

Caucasian:	57.9%
Black:	21.9%
Hispanic:	13.4%
Asian:	4.0%
Pacific Islander:	1.0%
Native American:	0.7%
Other:	1.1%



Average Age:	32.1
Officers:	40.5
Enlisted:	30.3
Warrant:	43.0

Married	45.2%
Officers:	66.2%
Enlisted:	40.7%
Warrant:	73.3%

Gender

Male:	76.9%
Female:	23.1%

ARMY RESERVE BUDGET FIGURES

Total FY 2012 Enacted Budget:	**$8.8 Billion**
Operations and Maintenance:	$3.3 Billion
Military Personnel:	$5.2 Billion
Military Construction:	$281 Million

ARMY RESERVE INSTALLATIONS

Fort Buchanan, P.R.
Fort Devens, Mass.
Fort Dix, N.J.
Fort McCoy, Wis.
Fort Hunter Liggett, Calif.
Camp Parks, Calif.

Legislative Affairs Contact: (703) 806-7741

Mr. YOUNG. General, thank you very much.

All four of you, thank you very much.

I think you will find that this committee is really supportive of the Guard and Reserve. I am going to go a little bit out of order today, and I am going to yield my first time to Mr. Cole, because sometimes we don't get to him because we run out of time. And then I am going to yield Mr. Dicks' time to Mr. Rothman, and then I am going to yield to Mr. Hinchey. These are the two members that usually end up at the tail end. So we are reversing.

So, Mr. Cole, you are recognized.

SEQUESTRATION

Mr. COLE. It is almost biblical, Mr. Chairman. The last shall be first. I am very appreciative.

I do want to make just one point. Not everybody on this panel is retiring and going home to Florida. You have an Oklahoman here. We don't expect him to retire, but we expect him to come home when he does. We are very proud of General Wyatt and his service to the country. And I would be remiss, gentlemen, if I did not tell you how proud we are of all of you and the men and women that you lead.

I think the great untold story of this decade will be the role that the Guard and Reserve played at the most critical moment in our history in providing us the capability to respond to an outrageous attack and sustain operations. Every single man and woman that you command has enlisted or reenlisted knowing that they were likely to be deployed and expecting that, and that is a dramatic change over history. Not to disparage any previous eras, but this has been an incredibly distinguished time.

I, like you, gentlemen, am very worried going forward. And I know every member of this committee is extremely worried about the cuts in front of us, the restraints, how we can maintain the superb capability, and particularly at the Guard.

General Wyatt, talk to us about two levels of reductions. One, what are you looking at? What capabilities do you have now that you simply are not going to have given the Budget Control Act and some of the requests that have been made of us?

And, number two, if sequester were to happen, what would that do to your ability to deploy and how would it impact the regular forces that you work with?

General WYATT. Congressman, I think I would answer the first question on capabilities by looking at the force structure cuts that the Air National Guard will be taking: three A–10 units, one F–16 unit, a C–130 unit, and the Reserve component being cut 60 of the 63 C–130s out of this year's budget.

I am concerned that, while we will be able to continue the Title 10 fight with the new strategy going forward, I think we have the forces to do that, I am concerned that when you cut forces out of the Air National Guard you cut forces that are also available to the governors when they are not doing the Federal war fight. So I think about things like lift. I think about all of the capabilities that come with the Fighter Wing, such as communications, engineering, medical, security forces that will no longer be available to the governors, much less the President, should we need them.

To get to the sequester part of this, it would severely handicap, I think, the Air Force going forward on the Federal war fight and, by implication, also the domestic response that the governors expect out of the Air Guard.

Mr. COLE. I would like to ask the same question of all of you regarding your respective services.

General INGRAM. Congressman, from the Army National Guard, right now we are not scheduled for any significant cuts. We have 28 brigade combat teams, two special forces groups, eight division headquarters, 12 combination of combat aviation brigades and theater aviation brigades, and that is our aviation structure in the Army Guard. With that, I think the cuts that will affect us more in our ability to train. We have moved some money from future procurement accounts into a training base to train an operational reserve.

As General Stultz just mentioned, training an operational reserve is one thing, but operating it is another. And being able to operate the operational reserve I think is the critical point as we move forward.

Sequestration would severely hamper our ability to do anything and may in fact cause us to have some force structure as well as manpower reductions.

General STULTZ. Along the same lines as General Ingram, under the current budget, the Army Reserve is not being hit with significant cuts. We are going to reduce about a thousand in end strength, which we can absorb.

My concern, though, is what I said earlier. We are indispensable to the Army. My commitment to the chief of staff of the Army is to give him about 25,000 of capability every year that he can count on being trained, ready, and available. And he needs that 25,000 because of the capabilities I listed earlier.

I caution people, do not forget how we got there. I was in Kuwait in 2002 as we built the theater before we were able to launch into Iraq and earlier into Afghanistan; and all of the capabilities to get that equipment there, to get it in place, to get it set up, to get all of the combat capabilities, whatever, was done by Reserve component forces. It is all the logistics, all the transportation, whatever.

So if we are challenged to go somewhere else in this world in the future, we have to have that same capability. And when we have run some of the operational plans—and I won't get into it for classification reasons—but out of the 25,000 that I have, they are committed in the first 30 days of a war. So my challenge is how do I maintain that readiness? How do I train them and equip them to the standard?

My fear is, as we go into future, and especially as we hit sequestration, we won't by able to give them the training days and the type of equipment they need. And we have not been very good about predicting the future. Something will happen in some other place in the world, and we will try to say, how did we get there the last time? And somebody will say, we used the Reserve. Where are they? Well, they are not ready yet. We can't afford to take that risk.

General MCKINLEY. Finally, sir, just briefly, the $487 billion that the Budget Control Act demanded from the Department was done

in a very bipartisan way; and all of the service chiefs, along with Secretary Panetta, did a very good job of trying not to hollow out the force. People our age remember a hollow military, where you had people not matched to equipment, poor leadership, not able to confront the challenges.

And, as Jack said, we just don't see the next decade being any more peaceful than the previous decade, and we have got to use the Guard and Reserve in an integrated fashion, which we have come to do on the battlefield, and be prepared to do it over and over again if we are going to be successful.

Mr. COLE. I just want to comment, Mr. Chairman, this is the best bang for the buck, honestly, out there. And I hope as we go forward we do everything we can to protect this particular part of it. I actually think the regular forces are now much more dependent on you than they were at the beginning of the decade; and, given the budget situation, they will be increasingly dependent on you in the years ahead.

Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Cole.

Mr. Rothman.

OPERATIONAL RESERVE

Mr. ROTHMAN. I thank you, Mr. Chairman.

General Stultz, there was a popular perception that the members of the Guard and Reserve were being overextended individually and that there was an inappropriate level of sacrifice being called upon them and their families, not only physically and emotionally but also in terms of their employment back home. From what you have said, it sounds like that is ancient history. But I would like to hear from you specifically that in fact it is ancient history and that we don't still have those problems where members of the Guard and Reserve feel that they are just being taken advantage of and unduly so.

General STULTZ. Yes, sir. I think you are exactly right. Early on in the war, because of what I said earlier about the capabilities that are resident that we need out of the Reserve, we were in a lot of cases with certain types of capabilities—a medical or civil affairs and our transportation—spinning at a very fast rate.

The other reason was because we weren't ready as a force. We were a lot of times having to pull two or three units together to make one, and then when the next rotation came around, we had to reach back again.

What we have been able to do over the last 6, 7 years is, one, build a readiness across the force, build a manning cycle across the force, but also build in more predictability. We have adopted what we have called the force generation model, the Army force generation, what we say as ARFORGEN.

But critical to our ability to maintain the ability to provide readiness in this 25,000, in my case, to the Army is predictability, predictability for the soldier, predictability for the family, and predictability for the employer.

And so we are adopting a 5-year rotation cycle. So that would say if you are in the Army Reserve and you are in a unit, the first year you are in what we call reset or regeneration. You have just come

back. And then the next 3 years you are training, gradually getting improved training. And then in that fifth year you are available. And that gives you predictability to tell your family, tell your employer, tell everyone, hey, in that fifth year it is my time. So if something happens, I will be the first one to go. That is critical, and that is what our soldiers tell me. Give me predictability.

But then the other thing they say is use me. When it comes to be that fifth year, I want to go do something.

Mr. ROTHMAN. General, now it is only 1 year out of 5 that they are in combat, so to speak, or in theater?

General STULTZ. Yes, sir. For the majority of our units, we are giving them 3 to 4 years of dwell time in that 5-year rotation. Now, we still have some units, some of my civil affairs and transportation and aviation, that there is just not enough in the Army, and we are still spinning at a faster rate. But that is starting to level out, also, with the drawdown in Iraq and the drawdown in Afghanistan.

Mr. ROTHMAN. General, what would you estimate to be the time when this 1 year of combat or being in theater out of 5 would be uniform throughout the Guard and Reserve?

General STULTZ. Well, it is hard for me to foretell the future, but my personal opinion, if we go the direction we are planning with the current administration's drawdown timelines for Afghanistan, I would think by 2014.

Mr. ROTHMAN. What percentage of your force, General, is being called upon to be in combat or be in theater more than once—1 year out of 5?

General STULTZ. Well, I have kept about 25,000 out of 205,000 in some sort of mobilization status, some of them back here in the United States, in the hospitals, in the training bases and whatever. And then in theater about 15,000. I would say out of that 15, probably about 5. So 5,000 out of 205,000 probably on a faster spin cycle than we would like.

COMPENSATION

Mr. ROTHMAN. Are we doing anything special for them in terms of compensating them in any way for that kind of spin cycle?

General STULTZ. Not really. Not like we should.

Mr. ROTHMAN. Is that something we should work on, General?

General STULTZ. Well, we were looking at some programs for extended leave and some other things like that for compensating them. They are getting compensated in terms of lowering their age of retirement and giving them credit for time they are deployed. So they are getting some benefits in that capacity. But it might be something, yes, sir.

Mr. ROTHMAN. Is there a suffering of morale or a decompensating emotionally or psychologically for those 5,000?

General STULTZ. No, sir, I don't see that. They understand in most cases what their mission set is. As I mentioned earlier with the aviation units, they understand it is one Army. They are part of one Army.

Mr. ROTHMAN. Could I ask for the record if you have any statistics with regards to the actual number—I know you are estimating, and I appreciate that, about 5,000—what the experience has been

over the last 5, 7 years in terms of PTSD, God forbid, suicides, or other troubles that these individuals may have faced so we can gauge the urgency of the problem to deal with their spin cycle.

General STULTZ. Yes, sir.

[The information follows:]

Since 9/11, the Army Reserve mobilized and deployed forces in support of global operations at unprecedented levels. Between 1 January 2005 and 7 April 2012, there were 7,698 AR Soldiers who deployed more than once in support of Enduring Freedom or Iraqi Freedom. The average time between deployments was 665 days. Unfortunately, out of the 7,698, we lost eleven of our Soldiers to suicide.

The Army Reserve continues to focus on mentoring and training our leaders to create an environment where it's okay to ask for help and where it's our duty to extend a helping hand. We are committed to ensuring all members of the Army Reserve Family have awareness of and access to the training and resources available to support their personal and professional wellbeing. We will continue to partner with our mental health professionals, chaplains, and Family Readiness personnel in our efforts to constantly refine and improve our programs.

There have been 3,815 Soldiers who have deployed in support of ENDURING FREEDOM or IRAQI FREEDOM between 1 JAN 2005 and 7 APR 2012 who have been diagnosed with Post-Traumatic Stress Disorder. There are currently over 2,000 USAR Soldiers who are medically not ready due to behavioral health related issues; 1,470 of whom were mobilized in support of ENDURING FREEDOM, IRAQI FREEDOM or NEW DAWN. Of the 1,470 Soldiers, 471 have had multiple deployments and have a behavioral health related diagnosis.

In the fall of 2011 the USAR implemented mental health assessments (MHAs) to help identify Soldiers with depression and PTSD. To date 6964 mental health assessments were conducted for Army Reserve Soldiers in conjunction with their Post Deployment Health Re-Assessment (PDHRA); 22% (1,029) of these Soldiers required behavioral health referrals. For comparison, prior to the new Mental Health Assessment, 13% (14,294 of 109,578) of Soldiers were referred for behavioral health evaluation based on the Post Deployment Health Re-Assessment since its inception in 2006.

Mr. ROTHMAN. Thank you very much, Mr. Chairman.

Mr. YOUNG. Mr. Calvert.

FACILITIES

Mr. CALVERT. Thank you, Mr. Chairman. I appreciate the rotation.

Gentlemen, I thank you for your service. I appreciate it very much.

I was going to use the same line before my good friend, Mr. Cole, took that line. We get the best bang for the buck from the Guard and Reserve. You do a wonderful job for our country, and the country appreciates your service.

One thing that was brought up, General Ingram, in your testimony is about the facilities around the United States. I know years ago when those facilities were built after World War II and during the Korean conflict, those facilities were used by the communities, and continue to be. However, as you point out, I would imagine that the maintenance costs and the cost of just keeping those facilities open is significant, a significant cost in an era in which you are looking to consolidate your cost.

I don't want to be parochial about this, but I will be for a second. We have the March Air Reserve Base in southern California, and we have a number of these facilities like in Corona and Riverside and other communities, in Hemet. It seems to me that it would make more sense to consolidate. We just built a beautiful new reserve facility at March, $50 million to train. I know the Guard has

been involved in it, too. Wouldn't it make more sense to consolidate some of these smaller operations into a facility like that? And I would imagine that could be replicated across the country to save money. Plus I think the consolidation, you could maybe bring down some of your maintenance costs and motor pools, on and on and on. What is your comment about that?

General INGRAM. Congressman, there are two schools of thought about that. The Army National Guard, the National Guard in general, is a grass roots organization. We are a local level organization with a militia heritage. And that is part of our culture. So consolidation means you move out of small places into large places, and our base is in small communities.

As far as funding for facilities is concerned, I don't really believe that the National Guard has gotten their fair share, especially with the 2005 BRAC. Most of the Military Construction (MILCON) money that was coming to us was deferred, pushed to the right a bit, and the must do by fiscal year 2011 projects took precedence. So we have suffered in the last 5 or 6 years because of BRAC, for one. Moving the Army home from Europe and consolidating the military back into the United States has taken precedence over some of our projects.

Our MILCON future looks fairly bleak because of budget shortfalls, and our facilities are aging very rapidly. Most of the facilities, unlike the Army Reserve, but most of the facilities in the Army National Guard are 75–25 with the State. So the initial construction was 75 percent Federal money, 25 percent State and local money. And then the maintenance of those facilities is done by the State. And at the conclusion—in most cases, at the conclusion of the life cycle of that particular building, it is returned to the community.

So the consolidation and building one large one instead of having three small ones is a little counter to the culture of the Army National Guard.

Mr. CALVERT. And I recognize in some parts of the country that won't work. But California is not the same State as it was 50–60 years ago. Corona is no longer 25,000 people. It is now 200,000 people. And Riverside is now half a million people. But it seems to me—and I get this from some of your local folks, too—that it would make more sense. You have a much more secure facility, cantonment area, and obviously you have a large airfield and a lot of synergy of utilization.

I would hope you would take a look at that, and I suspect out of 3,000 facilities maybe 500 of them can be consolidated.

General INGRAM. And we truly do that. The goodness of the Army National Guard is having 54 Adjutants General in each State and territory and the District that make those assessments at the local level, and what is right in California might not be right in Missouri.

COUNCIL OF GOVERNORS

Mr. CALVERT. Right. I would hope as you are going through this transition, too, that you are working obviously with your brother and the regular Army and Air Force and, obviously, with the State. We have heard from some of the governors that feel that they weren't involved in some of the discussions about where the Guard

and Reserve are going, especially the Guard, I would say. I guess I would ask, were the governors consulted in this case?

General MCKINLEY. Sir, in 2008, as a result of the Commission on Guard and Reserve, this Council of Governors was formed, five Republican and five Democrat governors. And they met six times specifically to discuss issues that you bring up: efficiencies, consolidation, and things like that.

The Department of Defense budget, as you can imagine, is a pretty tight loop inside the system; and, therefore, there really wasn't a mechanism to confer or discuss the pre-decisional budget with the governors. I think out of this we need to—and I believe the Department will—find a better way to communicate the domestic requirements with our governors. I think that is the long-term vision of why the Council was formed.

We certainly, all of us, understand how important the governors are, and we feel we can do a better job of relating the needs of the Federal Department to our States.

Mr. CALVERT. Thank you.

Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Hinchey.

NATIONAL GUARD FORCE STRUCTURE

Mr. HINCHEY. Thank you very much, Mr. Chairman.

Thank you all very much. I deeply appreciate everything that you do and the leadership you provide. And the things that you have been talking about today here, all of this is very interesting.

One of the big things that we are facing is the reduction of spending. Cuts, very serious, very serious cuts. As I understand it, the Defense Department is seeking to receive $487 billion in savings over 10 years, and so all of that is going to have a very significant change.

In our situation, one of the major issues facing New York is the planned reduction of Air National Guard, the aircraft of Air National Guard. Governor Cuomo wrote to Secretary Panetta to oppose those cuts. Two hundred and eighty Air National Guard aircraft are scheduled to be eliminated over the next 5 years, with more than 100 in fiscal year 2013.

I am sure that these are things that are very heavy in your understanding and the dealings that you have to deal with. All of this is very, very critically important. Anything that you want to say about that, I would appreciate it.

General MCKINLEY. I will let General Wyatt comment, because he was involved intimately with the Air Force budget.

I will say, as I said in my opening remarks, the Budget Control Act created an environment by which all of the services had to make some very, very tough choices. And we were heard. Our feelings were understood by the Department.

But if we have sequestration, another $55 billion per year will come out of the defense budget, which will mean more significant cuts. And so service chiefs, the Secretary of Defense, are going to have some very difficult choices ahead.

The Air Guard was a unique situation this year, and I will let General Wyatt talk about that.

General WYATT. In talking about the decision-making process in the United States Air Force, there were some really tough decisions this year with the Budget Control Act.

As the Director of the Air Guard, I am allowed to participate in the decision-making process. In fact, not only am I asked for my views, I am encouraged to give my views in the corporate process. In fact, I have been very aggressive, I think.

If you ask General Schwartz, he will probably tell you that I advocated not only for the Air National Guard but for air power of the United States Air Force and for the type of air power that I think we need to defend the country. And so I was allowed to make some inputs.

In the end, we are a military organization, and the decision responsibilities rest with the Secretary of the Air Force. When those decisions are made, regardless of the input that I make, my job as a Title 10 officer then becomes to salute the flag and implement the decisions that were made until told otherwise.

And so in the case of Niagara, the Air Guard was handed a C–130 divestiture bill that we had to meet, and we made some tough decisions. And I think the way the process works certainly is subject to review. But we did the best we could with the marching orders that we were given.

C–17

Mr. HINCHEY. Thank you very much.

General Wyatt, I want to ask another specific question. I know there are many of us here in this subcommittee, all of us with the concerns that we have, we share concerns, among other things, over Air National Guard aircraft, so I would like to ask about C–17s.

One of the things that I have—and I am very proud of, frankly—is the representation of Stewart Air National Guard based in Newburgh, New York, where the 105th airlift wing has almost completely transitioned from a C–5A to C–17 mission. So it is my understanding that some of the Air Force's C–17s aren't going to have the extended range fuel, the tank that they need to provide that extended range fuel. So are any National Guard units using the extended range variant, and are we sacrificing mission readiness or capabilities by providing National Guard air wings entirely with the more limited version of the C–17s?

And, finally, I understand the need to have extended range capabilities in Active Duty, but I would think that even one or two C–17s with the larger fuel tank would greatly increase capabilities of our Air National Guard.

General WYATT. Sir, you are right. The extended fuel tank does increase the capability and the options available to the Secretary and Chief of the Air Force.

Moneys do not allow us to put extended range tanks on all of the C–17s. To my knowledge, none of the Air National Guard C–17s have extended range tanks. Stewart is one location. Jackson, Mississippi, is another location. In the FY 2013 President's Budget Request, you will see Memphis, Tennessee, transitioning to C–17s. And in the outyears, you will see Martinsburg, West Virginia, transition to the C–17.

There is a modernization effort under way at Air Mobility Command seeking to have common configurations across all of their weapon systems, including the C–17. So there is a plan to eventually get there. But the Air Guard will probably be at the end of that plan, as we are with a lot of the legacy airplanes that we have.

Mr. HINCHEY. Well, thanks very much, and I know that, you know, in the context of this situation, there are a lot of things that have to be thought about and a lot of changes that are taking place, and the big thought about is to make these changes as effectively as possible and to maintain the security of these operations. So I am deeply impressed with all of you and all of the dedication that you have and the sincerities that you are approaching on this. I just want to thank you very much for all of that.

You are involved in some problems. You are going to have to do some things that are not easy, but they are more difficult. But I am sure that you can do, and you are going to do them in the most effective way. And for all of those things, I just express my appreciation and gratitude to you and thank you very, very much.

Mr. YOUNG. Mr. Crenshaw.

TANKS

Mr. CRENSHAW. Thank you, Mr. Chairman, in regard to the last shall be first, I will let the record reflect that I am in the middle, so I don't really care whether you start at the bottom or the top. I am always in the same place.

Mr. YOUNG. Well, don't you think that was a nice gesture to Mr. Cole and Mr. Hinchey?

Mr. CRENSHAW. Thank you. But thank you all for being here. You have my words of thanks and respect, and the chairman pointed out that General McKinley is from Jacksonville. He is actually more than that; he is a constituent of mine, a voter. So if you don't mind, I will offer you a special welcome.

But I wanted to ask, I don't know who would be best to answer, but we have had conversations in this subcommittee from time to time about the need for tanks. The Army kind of came in and said, well, difficult budget times; we have all the tanks we need, so we are thinking about closing the production line. And it was pointed out that if you shut down the production line and then start it back up, that has a cost, and there is arguing about whether that cost, a half a billion or a billion dollars or more.

And so, last year, this subcommittee put about $250 million into the budget to keep the production lines open and produced, I think, about 40 SEP tanks. As you all know, there is kind of a two-tiered tank program, the Active Duty folks have the new tanks and the A–1s, most of the National Guard; I think there maybe is one combat brigade that has a SEP tank.

So my question to you all is, is there a advantage for Guard to have the newer tanks, number one, and what would be your preference in terms of utilization? We heard General Odierno kind of talk about maybe the A–1s are less technical and maybe that might be better in terms of training, but it seems to me if you are going to train on something, you ought to train on what you are

going to be using. So comment on that, on that overall concept of the two-tiered tank system, what is your view of that?

General INGRAM. Congressman, I guess I get that one by default. The Army National Guard has tanks.

There are several schools of thought, I think pure fleeting is the right way to go, one unit having the same type of combat vehicle is another. There are not enough System Enhancement Package (SEP) tanks currently for the Army National Guard to field SEP tanks in all of our armor brigade combat teams.

We do have one that is being fielded with the draw down and the change in the Army, they are going to reduce the number of brigades and reduce the number of heavy brigades in the Active component. And as they do that, there will be tanks available to cascade to Army National Guard heavy units.

To answer your question about the assembly line, my understanding is that we are keeping enough tanks in the inventory, as well as in prepositioned stocks that are positioned around the world, for contingency operations, so some of those tanks will go into contingency force pools. Others will be cascaded to Army National Guard units. And, again, from our perspective, as long as all the tanks in our units are the same type, that works well for us.

The SEP tanks are more complicated. The digital systems on those tanks are harder to maintain, but they wouldn't get the same usage unless we were mobilized that they would get in an Active component unit.

Mr. CRENSHAW. Just in terms of training, does that ever present a problem, if you are training on an older tank and then you are deployed and how does that work out?

General INGRAM. Usually, there is enough time that there is not enough difference in those systems, it is all in the fire control systems, so it is just getting used to a different computer in the turret, as I understand it.

OLDER VERSUS NEW EQUIPMENT

Mr. CRENSHAW. But you wouldn't say that you prefer to have the older tank just because it is easier to operate?

General INGRAM. We would not prefer to have the older equipment. No, sir.

Mr. CRENSHAW. Let me ask a question about the——

Mr. DICKS. Would you yield for just one second on one point?

Mr. CRENSHAW. Yes, sir.

Mr. DICKS. We haven't been using tanks very much in Iraq or Afghanistan; isn't that correct?

General INGRAM. We used tanks early on, and we haven't used tanks in Afghanistan. We did use tanks early on in Iraq.

Mr. DICKS. Can you explain why you haven't used them?

General INGRAM. Well, we got into Counter Insurgency operations, and we don't use heavy combat vehicles to that extent in Counter Insurgency operations.

Mr. DICKS. Thank you for yielding.

COUNTERDRUG PROGRAM

Mr. CRENSHAW. Yes, and my only concern is, I think, we all are concerned if we are going to spend money, then we ought to get

something for it, but that is something I think the Army is doing a study to kind of look at that, because if you are going to spend, whether it is half a billion or a billion dollars, it would be better to end up with something that is of value than simply to open and close a production line.

I want to ask about if, be real quick about Florida—the chairman and I have seen how the National Guard Counterdrug Program works, particularly in Florida, tremendous success. And I know last year we funded that program at more than the President's request, and the President's request this year is like $123 million less than last year. And so could you talk about the value of that program, number one; and, number two, what would happen if the funding was cut almost in half?

General MCKINLEY. Obviously, the answer is the reductions will have to be pushed out, phased in, and the highest threat-based model States will have to receive the money, and some other States will have to be reduced. It is not a pretty picture, and we have seen the people who are very interested in this program proclaim that this is not in the best interests of American citizens.

We know that drug demand reduction is a huge part of our Counterdrug Program. Some people said you can eliminate drug demand reduction. We know how effective that is in our high schools and around our country.

So I think the model has stood us well over time. This committee has been very generous in maintaining the capability, but as you say, sir, it looks like a 37 percent reduction in 2013 over the funding in 2012, so we are going to have to make every penny count, and we know that we have a full spectrum counterdrug program, from schools, where we train people, including law enforcement. We have our people who go out and interdict, cut down marijuana plants and use our sophisticated technology to do that. All our States, in fact, do that. But it will create a severe handicap to what we feel has been a very, very successful program over the last two decades.

Mr. CRENSHAW. Thank you.

Thank you, Mr. Chairman.

Mr. YOUNG. Ms. Granger.

C–130

Ms. GRANGER. Thank you.

And thank you all for being here and to remind us of the enormous capabilities and dedication and importance of the National Guard and Reserve. I think you get the sense from here that we think cuts are shortsighted in many cases.

As you know, after the Air Force instructed the Air Guard to divest some of the C–130s, the decision was made to relocate Air Guard C–130s from Texas to Montana. This decision has been widely criticized due to the negative impact it will have on the ability of the Governors of the Gulf States to respond to national disasters.

General McKinley, you quoted FEMA Administrator Fugate, who has frequently referenced the sense of urgency and the speed needed to respond to these national disasters, minimizing the loss of lives and property.

General Schwartz has testified several times that assets are available to make up for the loss of the C–130s from Texas. So, General Wyatt, are you aware of any C–130s under the control of the Gulf State Governors, besides the ones at Fort Worth?

General WYATT. That would be in the nature of the organic C–130s available to the Governor immediately and at the behest of the adjutant generals, and I am not aware of any at this point in time.

Ms. GRANGER. I am not either, and I hope the subcommittee recognizes that is not the testimony we heard earlier in another hearing.

In addition, can you address the challenges of standing up a squadron of new planes in Montana versus Fort Worth, where there are many civilian pilots, due to proximity of DFW airport? And keeping in mind the 136 Airlift Wing has world class pilots and facilities, have you seen any cost estimates for the military construction and the pilot training to include the cost of flight hours and the costs to train new maintainers?

General WYATT. Yes. It is true, Montana currently in the F–15, those F–15s are moving to California. The PB provides for C–130s to move into Montana and the MC–12 to move into Carswell. So you have got two units, Montana unit at Great Falls and the Carswell unit, that will be subjected to training costs to transition in the new airplanes.

We have done some preliminary estimates. We think the MC–12 training in Texas will run in the neighborhood of the around $10 million maybe a little more. The MilCon won't be that much because you already have at Carswell some hangars suitable for C–130s that will need to have a little bit of modification for the MC–12, we think in the range of $2 million.

In Montana, the training will be a little more expensive because those folks are transitioning out of F–15s into C–130s, larger air crew, because of the enlisted folks, enlisted air crew that are on that airplane. So, with the training expense, preliminary estimates are around $54 million, and the MilCon we think will be around $20 million.

Ms. GRANGER. Twenty?

General WYATT. Yes, ma'am for the suitable hangars for the——

Ms. GRANGER. So $54 million for the training, $20 million for the facilities and probably another $12 million to make the changes at Forth Worth?

General WYATT. Yes, ma'am, preliminary estimates.

Ms. GRANGER. Thank you very much.

One other question, you talked about the process, that you were involved in the process in making these decisions. And I know they were very difficult decisions because of the enormous cuts, but can you give us just of an example of a significant proposal you made to retain capability and/or to move capabilities with the Guard that were not approved.

General WYATT. What we did early on was provide the Air Force some inputs regarding different alternatives or different ways that we thought the Air National Guard could be used, to meet not only the emerging national, the new national military strategy, but also provide the type of capability that the Governors need, recognizing

that in the Air National Guard, you have the most cost-effective force. You have probably the most experienced force because most of our folks came from Active Duty.

I am an example. I spent 6 years on Active Duty before I transferred into the Guard.

We rely upon the foundational basis of the Air Force for our training. We train to the same standards as the United States Air Force. General Schwartz has noted that as we get smaller as an Air Force, we will not be able to do tiered readiness in the Air Force on any of the components. We will all be required to be at the high level of readiness that we are now. And, in fact, the Air Force has adequately provided in my organized training and equip account sufficient training to get us at that top level.

My concern is that as we, if we take these cuts out of the Air National Guard, we will be losing the most experienced aviators, the most experienced airmen that we have because we are generally an older, more mature force, having been trained by the Active component.

You couple that with the concern about rotation forces forward; the planning factors are that Air National Guard should be available to rotate on a 1–5 deploy to dwell, the Active component 1–2. And we stand ready to do that. In fact, we are providing more volunteerism right now than the Air Force could get even if they mobilize it.

So our people are trained, experienced. They want to be in the fight. They are in the fight, and we think that one of the alternatives that we proposed was instead of forming or presenting Active Duty forces forward for rotational demands at 1–2, maybe you should first do Air National Guard at 1–5. That would give us predictability. We would know when we would go. It would be easier to schedule with our employers, and we could do 1–5 all day long. We have been doing high operations tempo now for about 15 years so it is not a problem for us, ma'am. That is one of the ideas that we proposed.

Ms. GRANGER. Thank you. I appreciate it very much.

Thank you, Mr. Chairman.

Mr. YOUNG. Ms. Kaptur.

JOINT CHIEFS

Ms. KAPTUR. Thank you, Mr. Chairman.

Gentlemen, thank you so very much for your service to our country and that of all your colleagues here this morning.

General McKinley, I wanted to start with you, if I could. I know you participate in the Joint Chiefs meeting, and I am just wondering whether that has made a difference in the Guard's budget and how you are received and how that is going.

General MCKINLEY. Well, again, the 2008 National Defense Authorization Act (NDAA) gave the Chief of the National Guard Bureau a four star, and former Chairman, Admiral Mike Mullen, incorporated me into the Joint Chiefs, so that I could listen and participate and make comments in support of the National Guard, which I deeply appreciate.

The current Chairman, General Dempsey, has done the same. And then, on January 2, the NDAA permitted me to become a

member now of the Joint Chiefs. So I have only had this position institutionalized now for about 8 or 9 weeks, but I can tell you that I have been, well, warmly received by the other service chiefs. The Chairman has allowed me to make critical comments when needed in support of your National Guard men and women, and I can express clearly all the way up to the Secretary of the Defense now the issues of concern for the National Guard.

Ms. KAPTUR. Do you think it made a difference in your budget this year?

General MCKINLEY. I really haven't had this seat long enough to have participated fully in the budget, so the Army Guard or the Air Guard, but I can assure you that I was fully vested into the National Military Strategy debate that took place, which was very helpful for me to comment about the hedging capability that Jack's force and our force can give to the government if we need more troops and more airmen quickly. I was able to give that recommendation, and it was fully listened to and has been built into the strategy, yes, ma'am.

Ms. KAPTUR. All right. Thank you very much. I also want to thank all of you for the work you are doing to help lead America into a new energy age, and I can't comment on each of your respective forces, but I wanted to say to General Wyatt, thank you very much for the incredible work that was done in Ohio on testing fighter jet with camelina fuel, camelina-based fuel, which was very, very successful. I think that story speaks across the country and across the world, and we encourage you in making your bases more energy efficient and bringing on new technologies. You really have an incredible capability to do that.

COST EFFECTIVENESS OF AIR NATIONAL GUARD

General Wyatt, I also wanted to ask you in terms of sustaining these budget reductions, it is my understanding that the Air National Guard maintains more aircraft per operations and maintenance dollar than the Air Force Reserve or Active Duty Air Force. And as you look to reduce the budget, as we all look to reduce the budget while preserving the greatest capability, shouldn't we be focusing on expanding the role of the Air National Guard in some way since it is so much more cost-effective than the regular standing Air Force?

Could you comment a little bit about and give us a feel as a subcommittee on how those costs can be reduced with additional emphasis on the Guard, Air Guard, as opposed to Air Force, Active Air Force?

General WYATT. Ma'am that is kind of the debate that took place in the Air Force corporate process, and you know, my position was that we should do exactly that; that we should concentrate perhaps at this time, with the budget constraints that we have, knowing what may be out there on the horizon as far as threats, that we might consider a shift of the percentages from the Active Duty to the Air National Guard to the Reserve component.

It was vigorously debated, as I said, inside the Air Force corporate process and it is not to say that any, any particular position is right or wrong because it depends upon, you know, what we anticipate the steady state to be from this point forward. We know

that if there is a huge threat that would require the mobilization of all of the forces, we will all go, and we will go as long as it takes to get the job done.

I think the question is, what level of involvement do we see for the United States Air Force in the next 4 or 5 years? Should we build a force large enough on the Active Duty side to handle that at the, perhaps, expense of more capacity to handle the surge war when that comes? And there is a trade-off between the two, and the decision was made to go with the shift of the forces from the Reserve component to the Active component, stressing the anticipated demand that will be there for the next 4 or 5 years.

But it is a debate that I think was healthy inside the Air Force and will probably continue on the Hill here as we go forward. There are pros and cons of doing it both ways, ma'am.

Ms. KAPTUR. Could you give us a sense, a little additional sense of cost savings if one emphasizes the Guard more, the Air Guard more than Active Air Force?

General WYATT. I saw a RAND study a couple, 2 or 3 years ago, comparing the cost of fighter squadrons. And as with any analysis, I think as important as the answer are the assumptions and the methodology used to get to the answer and what it is exactly that you are measuring.

If you look at the cost of just running a fighter squadron in the Air Guard versus the Active component, we do it for about 40 percent of the cost. But when we deploy, when we deploy, and we bring on all of our part-time airmen in a surge, we are as costly as the Active component, and this kind of goes to the discussion that I was talking about, if you are going to be deployed a lot, obviously the relative cost over time would go up the more a particular unit is deployed.

But the beauty of it is, if the cost goes down, if the demand is not what you anticipate it to be, and your forces can remain in garrison. So it is a trade-off one way or another, but that is kind of—about as brief an explanation as I can give.

Mr. YOUNG. Thank you.

Ms. KAPTUR. Thank you, that is a pretty significant figure.

I thank all of you. Thank you, Generals.

Mr. YOUNG. Thank you.

Thank you, Ms. Kaptur.

Mr. Kingston.

SEQUESTRATION

Mr. KINGSTON. Thank you, Mr. Chairman.

General McKinley, I wanted to get a clarification in my mind, the Joint Chiefs have signed off, maybe not necessarily enthusiastically, but have signed off on the $487 billion reduction proposed by the administration; correct?

General MCKINLEY. Yes, sir, every service chief has looked at that and consulted and given General Dempsey his best military advice and has concurred with the $487 billion.

Mr. KINGSTON. And so then the Guard bureau, the same thing, correct?

General MCKINLEY. Sir, our services, the United States Army, the United States Air Force due to budgets, respective budgets, for

our Army and Air National Guard, those service chiefs incorporate our views into their viewpoint to the chairman, and I can add my comments on top of that.

Mr. KINGSTON. Okay, and then, but the sequestration, what is the Joint Chiefs official position on the sequestration?

General MCKINLEY. I will give you my military opinion. Personal military opinion is that none of the service chiefs welcome or can understand how that will be applied to a budget that has already taken the $487 billion cut.

Mr. KINGSTON. So the Joint Chiefs have not signed off on the sequestration proposal?

General MCKINLEY. No, there has not been any formal decision, but I can assure you from my discussions with many of the service chiefs that we are very, very concerned about the impacts of sequestration.

COST EFFICIENCIES

Mr. KINGSTON. Okay. One of the concerns that we have, as we grapple with the budget, and I don't need to tell anyone in this room that the national debt is 100 percent of the GDP, or for every dollar we spend, 42 cents is borrowed, but sometimes we seem to then shift into, yeah, but don't cut my staff.

And so what I was wondering is recently there was a GAO report that came out that identified, I think, 32 areas in which the Pentagon had practices that were costing more money, 19 areas of duplications. And I was wondering if the Joint Chiefs had embraced that report as, well, here is something new or here is something we can implement. And the reason why that is important is because that would appear to me something that Democrats and Republicans and everybody could agree on if we have got 19 areas of duplication.

And, you know, just kind of a side note to that, I have never been in a group where I have asked how many of you think the military system, procurement system, is broken; I have never had anybody say, no, it is not, it is great.

And I am sure we have all had those conversations, but it always seem like everybody agrees the procurement system is broken, but nobody does anything about it or knows what to do about it. But these 19 areas where the Government Accountability Office (GAO) said are duplications, have the Joint Chiefs looked at that in the context of that GAO report?

General MCKINLEY. I can't comment on the relationship to the GAO report, but I can assure you, sir, that the efficiencies that cover the broad spectrum of how we operate in our respective enterprises has certainly been wrung out, and each of us, including everybody on this panel, has done his or her part to try to squeeze out the efficiencies, which I think you are alluding to.

I think an area that the Department is seriously looking at is our Information Technology (IT) departments. I understand it is about a $37 billion a year bill. There has got to be ways to use best business practices to reduce that bill, so, there is not a servicemember out there today, including the service chiefs, who aren't looking at ways to become more efficient, more capable, to have a more effective force, because it has got to start with us.

MILITARY PENSIONS

Mr. KINGSTON. So, frequently, we find as appropriators the GAO report will be sitting out there, or an Inspector General (IG) report will be sitting out there, and then we hear from various departments, yes, we are addressing that. And then, you know, a year, 2 years later, another GAO report, another IG report, and you know, we are still addressing that. But I think in this budget time, it is critical.

Another question, certainly very sensitive, is military pensions. I think the cost of it now is $46 billion for 33 cents accrued a dollar that is paid out, and yet when we go home and talk to our military officers associations and the Veterans Service Organization (VSOs), certainly you can't touch military pensions, but it is unsustainable on the same, on the current path, but I don't know of a proposal to reduce military pensions.

And, again, at $46 billion, that is the size of Homeland Security, so it is not like it is a small, small item.

General MCKINLEY. Sir, I think this is a very important subject. I think that is why there is projected to be a commission to study the retirement system. I think everything is on the table. From my experiences talking with my colleagues, this is going to be a very, very important subject matter because we feel that we have to do our part within the Department of Defense to work programs that, quite frankly, are very important to recruiting and retaining personnel. But in the same regard, as former Chairman Mullen said, our number one national security issue today potentially is our debt, so it is juxtaposed against those two issues.

DEPLOYMENTS

Mr. KINGSTON. The other thing that, as I listen to 56,000 requests, manpower requests, and 495,000 mobilizations, but you know, General Stultz talked about the troops on the ground in Kabul and Kandahar and Bagram last week. But then General Wyatt mentioned Boston Marathon, and it would appeared to me that there are deployments, then there are deployments. And surely in this budget time when the Governor of Arkansas calls for some, the National Guard to come to his inauguration, I just think we have just got to take a pass; the Boston Marathon, we have got to take a pass. Out of all those deployments, we have got to take a pass.

And then I know one that is very difficult right is this rub right now between the Homeland Security and the Pentagon on the Southwest border that we have had two deployments down there, one in 2006 and 2008; 6,000 troops that cost $1.2 billion; and then there is a current one with 1,200 troops that right now is costing about $180 million and a potential 90-day extension of $35 million. That one is a structural big-picture problem, but it still seems to me like part of the efficiencies are, where are we going to deploy to, and what are we doing about it?

General WYATT. I think it is interesting to note that a couple of things that I mentioned, like the Boston Marathon and the Governor's inauguration, were out of safety concerns. The Guard want-

ed to do that, and they were not paid for with Federal dollars. They were paid for by the States that requested that particular support.

We have a great mechanism in the adjutants general that paid very close attention, sir, to what your concern is, the operations tempo, if you will. And what we are hearing from our adjutants general, what I hear from my airmen when I go to the field is that you have trained us; we want you to use us. If you don't use this, we will go somewhere else because we like what we do, whether it is the State mission or the Federal mission.

I know when I was the adjutant General in Oklahoma, I met my returning soldiers and airmen that were coming back from Katrina at the Texas-Oklahoma border, and they told me that—and they were down there for about 45 days. They said that was one of the most rewarding experiences they ever had because they were taking care of fellow Americans.

And so I think we do have, we do have a mechanism for measuring that operations tempo, and I trust that our airmen and our soldiers and our adjutants generals will tell us if we have reached that point where we are doing too much with our forces.

Mr. KINGSTON. Well, I yield back.

Mr. YOUNG. Thank you. We are about to run out of time.

ARMY NATIONAL GUARD PROCUREMENT

Mr. KINGSTON. Yes.

Mr. YOUNG. Mr. Frelinghuysen.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman, I am sure as others did before I got here, we want to pay tribute to the men and women of our Guard and Reserve and recognize that while maybe the focus isn't on the Middle East, we have paid tribute to the number of times that they were deployed. It is incredible the sacrifice they put forward.

I guess this question goes to General Ingram, Army procurement is up, but Army National Guard procurement is down. Can you talk about this budget before us, this budget submission? And would you put into the mix a lot of equipment still in the Middle East, you know, in a variety of different shapes? Where is the Army National Guard in terms of procurement, and where does it fit into the picture, a lot of the equipment that perhaps could be potentially utilized in the future?

General INGRAM. Congressman, for the Army National Guard, we are probably in the best position we have been in recently with equipment. Pre–9/11——

Mr. DICKS. Do you have your mike on? Is your mike on?

General INGRAM. Yes, sir, it is. Pre–9/11, our percentage of equipment was fairly high, but the quality of the equipment that we had was pretty old.

Today, we are moving into the high 80s in percent of equipment on hand, and it is modern, new equipment for the most part. We don't have the substitute items, as far as all of our equipment is procured through the United States Army, and it is allocated through the United States Army. In the past 10 years, we have been equipped, the mechanism has been next to fight. So the units that are going into theater get the newest and the best. There is

some equipment left in theater, and as that is retrograded and goes through reset, it will be reallocated and given back to our units.

And so far, that has worked rather well. Our units are about a year or so after—it takes about a year to a year and a half to get that equipment through the reset lines and then back.

Mr. FRELINGHUYSEN. So, basically, you are satisfied with your procurement request, meeting the needs of the Guard?

General INGRAM. We are on par with the Active Army. They are not equipped any better at the moment than we are. I think as the equipment, the story will be told after the equipment returns from theater, and there is a tremendous amount of equipment that is in Kuwait that is flowing back from Iraq as we speak. And we are retrograding equipment from Afghanistan now in anticipation of downsizing in Afghanistan in fiscal year 2014.

So if there is enough money in the budget, and that is the key to the question, there is enough money in the budget to repair the equipment at the depots and reset it and get it back to the units, that is the answer to your question, how that equipment is allocated as it comes out of reset to the three components of the Army.

Mr. FRELINGHUYSEN. The bottom line is that you are satisfied with your position?

General INGRAM. Today I am, sir.

READINESS AND TRAINING

Mr. FRELINGHUYSEN. Just lastly, as our Guard and Reserve comes back, the issue of readiness, in other words, you know, they are happy to be back. They go back into their normal lives, they do focus on domestic responsibilities, but how are you going to keep them, keep it so that, I hate to use the term tempo, how are you going to keep the skills that they have learned, you know, the pressures that they learned to live under, how are you going to keep these people who are so dedicated on top of their game, God forbid we get in another situation where we need to act quickly?

General STULTZ. I will take a shot at that one, sir, because it is a big concern for me. We have put these soldiers through the best training. We have equipped them with the best equipment. We have put them into combat, and I would daresay they are not going to be happy if I give them one weekend a month to come back to our Reserve center and sit in a classroom and look at PowerPoint slides.

We have got to give them some meaningful training, and so I think there are two pieces to that, and one of which you just touched on.

Mr. FRELINGHUYSEN. We want to make sure that they are not training some old retrograde equipment.

General STULTZ. Yes, sir. We have got to maximize the use of some of our simulation capabilities that we have out there. And we are using the NGREA funds in some cases to be able to buy some of those systems so if that soldier is going to come to a Reserve center for the weekend, then let me put him into an environment through simulation that replicates what he was using in Afghanistan so that he says, I stay on that edge.

Number two, when I send him to training, and what we have tried to do in the Army Reserve is focus our training at major cen-

ters like Fort Hunter Liggett; Fort Dix, New Jersey; Fort McCoy, Wisconsin, and outfit those training centers with the most modern equipment and systems they have got so that when that soldier shows up at Fort Dix, New Jersey, he is walking into an environment just like he had in Iraq or Afghanistan.

I am concerned to your point earlier about the equipment because in the Army Reserve, while we have approximately 90 percent equipment on hand, we are still in the seventies in modernized equipment. We still have a lot of substitutes. And those substitute items may sound good, but for that soldier who is going to training, he wants to train on the piece of equipment he operated in Afghanistan.

And my concern also is that we can't kick the can down the road and say, well, we are going to put all this stuff coming out of theater through reset, but that is going to take several years. Or we will wait till the Army draws down and see what kind of equipment cascades. I mean, that is a good solution set, but I have got soldiers who need equipment today and so we have got to focus on realism and training. We have got to focus on modernized equipment to keep that cutting edge that has been set. Otherwise, we are going to lose those soldiers.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman.

Thank you for your response.

Mr. YOUNG. Mr. Dicks.

SIMULATORS

Mr. DICKS. On that subject, you mentioned simulators, and I believe that simulation is extremely, is a very valuable tool, aviation, the stories about aviation, pilot training with simulators, is remarkable.

What different scenarios do you use simulators in? Could you describe that for the committee?

General STULTZ. Yes, sir, from my experience, and my colleagues, I am sure, have, especially in the aviation field and others, but I can give you just a plain and simple example.

I commanded a unit in Orlando, Florida, and we have to go qualify with weapons twice a year, live fire. To qualify with a live fire weapon in Florida, you have got really two places to go, MacDill Air Force Base over in Tampa or Camp Blanding, which would require me to put all my soldiers on a bus, bus them over to MacDill Air Force Base and get out on a range, or go to Camp Blanding. When there are simulation, weapons simulation systems that are available that I could set up in that drill center that give you the same, if not better, experience, of firing a live fire weapon at Camp Blanding and can also allow me not only to put that soldier in an environment with a 300-meter target down range and show him how to breathe and picture sight, but then I can switch and say, okay, in the next exercise, okay, we are going to put you in a village in Afghanistan, and you are going to be walking on patrol, and you are going to have determine, friend or foe. You are going to have to make some of those decisions.

Likewise, I went to a simulator with an engineer unit that is a route clearance simulator. I just came back from Afghanistan. They were out there doing this very task. I can put them in a semi trail-

er route clearance system where they sit at four stations in same vehicle they are operating in Afghanistan, looking in the mirror seeing their buddy, just like they saw him in Afghanistan, and go through that whole scenario.

And the soldiers come out of there with their hair tingling a little bit, saying, wow, that is just like it was when I was there. Those are the kinds of systems that I am looking at for the future of how we better, you know, employ simulations and give that soldier a meaningful training period.

Mr. DICKS. If you had to evaluate, which I am sure you are doing, are there a lot of other areas where simulation could be utilized? Are we just kind of at the tip of understanding how this can be done in terms of training?

General STULTZ. Yes, sir, I think we are, I think we are at the very edge of what we do. I mean, there is medical simulations capability to keep our nurses and doctors trained. There is vehicle convoy line fire simulators to keep our transportation, our truck drivers and all trained. The engineers I mentioned, there is command and control simulators where putting them—you know, I was in an area where we were on the deck of an in-shore boat, and on the screen, there was a Humvee driving along the beach. And above us was an Apache, and we were trying to intercept what we thought were drug smugglers in the scenario.

In the next room, you could go in there and there is the Humvee, and on that screen was the boat I just got out of. And in the next room, you could go, and there is the cockpit of the Apache, and you are looking down.

The key was they said, you know, this Apache could be at Fort Campbell, Kentucky. This boat could be in San Diego, and this Humvee could be at Fort Drum, New York. And you are all playing this scenario together before you end up in Iraq or Afghanistan.

That is the kind of things that we just haven't leveraged yet.

General MCKINLEY. Sir, could I jump in here real quick?

Mr. DICKS. Yes.

General MCKINLEY. Very briefly, Bud and I fly fighters, and distributed mission operations, which is the wave of the future, will be the Counter Insurgency of the realm. If our fighter units are not connected virtually, so that we can do as General Stultz said, fly with other units, air refuel in the simulator, the costs of the future aviation units that we have will be decremented greatly without simulation.

And then, finally, Bill Ingram's professional education center down at Little Rock has a cyber lane where you can go in and see cyber attacks occurring on a computer. You can recognize them. It is all done in an educational environment, and that is something that we must pay some attention to in the future.

Mr. DICKS. Well, our committee, we have added money for simulation over the years, and I think it is a great investment. And we have had situations, I know, at Fort Lewis, where you are talking about, you are actually doing the mission that somebody in Afghanistan, or in those days Iraq, were doing, and you are doing it with the exact same situation. I mean, there can't be a better training than that, I would think.

UH–60S

Now, let me go on one, on the Black Hawks; this is for General Ingram. The past 10 years has marked the highest op tempo for the Army National Guard Black Hawk fleet, which carries out a unique dual mission set, not only supporting deployments and other traditional missions, but also emergency response missions, including search and rescue, fire fighting, medical evacuation and disaster relief at home.

The result of these sustained operations is wearing out the National Guard H–60 Black Hawk helicopter fleet much faster than planned. The Army National Guard operates more than 850 UH–60 Black Hawk helicopters; over 500 of these are older A models, and the majority of these are more than 30 years old and nearing the end of their useful life.

General Ingram, is modernization, conversion and procurement keeping up with the aging fleet?

General INGRAM. Congressman Dicks, it is not.

The A–L reset on Black Hawks, it is funded, but it is not funded adequately to address the need. Our procurement of the Mike model, the newest helicopter, although we are getting some, we are not getting as many as we need to keep the fleet modern.

Mr. FRELINGHUYSEN. So would the gentleman yield?

Mr. DICKS. I yield, of course.

Mr. FRELINGHUYSEN. I asked about your procurement needs. Is this one of your unmet needs?

General INGRAM. This is a need that is being partially met, Congressman. It is not fully met.

Mr. FRELINGHUYSEN. Okay.

Mr. DICKS. And so the Army has not budgeted properly. It hasn't put enough money in, whatever it is, shortfalls, the Budget Control Act, for whatever reason it is, we are not getting the Black Hawks that we need, right?

General INGRAM. That would be correct, sir.

Mr. DICKS. I think that is it, Mr. Chairman.

Mr. YOUNG. Okay, thank you very much.

HUMVEES

Mr. VISCLOSKY. General McKinley and possibly General Stultz, following up on a response to Mr. Frelinghuysen's question and I assume a number of others on supplies, it is my understanding that a number of adjutant generals have written to Chairman Rogers as well as the chair of this subcommittee and Mr. Dicks relative to the Guard's Humvee fleets, and given that the Guard has evolved in a strategic Reserve and was mentioned with General Stultz that you fight in one vehicle and you train in another that may be quite some time old and several generations removed from what you are going to use, are you concerned that the majority of Humvees that the Guard uses to train are much different and older than those that they are using in theater, and what is the solution to that problem?

General MCKINLEY. Sir, thanks for the question. I think, quite frankly, we have got to have a commonality in our fleet and that begs the question that I am going to punt over to Bill Ingram on.

The number of our Humvees that are at a certain age or older, what would be a modernization program for those, or is there a modernization program to replace those Humvees, because speaking for the adjutants general, they are concerned that there is an adequate fleet of Humvees that have commonality, that have been refurbished, and that can come back and support the Governors in the domestic mission. That is kind of the wheelhouse I work in.

The overseas mission, obviously Jack and Bill are sending Army Guardsmen and Reservists overseas to fight in up-armored Humvees. But what about the requirement back home for floods, fires, hurricanes, et cetera? I will turn it over to Bill for that number.

General INGRAM. Congressman, right now, we have 55,000 Humvees spread across the Army National Guard; 41 percent of those, that is about 21,000, are 20 years old or older; 76 percent of that fleet is modernized; 30 percent of it are the newer up-armored Humvees; and 33 percent are recapped.

The next vehicle that will replace the Humvee is the joint light tactical vehicle. The Joint Light Tactical Vehicle ((JLTV), the Army plans to purchase about 50,000 of those vehicles and, as I understand it, and this isn't firm, but the Army National Guard will likely receive between 14,000 and 20,000 of those vehicles. But the first fielding will be in the fiscal year 2017–2018 timeframe. That is still a vehicle in procurement.

So the trade-off, and everything is budget driven, as we all know, the trade-off is, how soon do we get the replacement vehicle, and what kind of shape is our fleet in now? Do we want to spend, do we want to spend money on something that is eventually going to go away? And obviously, we want to maintain—we will divest ourselves of the oldest ones first, so it is a trade-off and a budget drill as to whether you modernize now and wait for the new ones, or that is the trade-off.

Mr. VISCLOSKY. One of the concerns, talking about 2017, is that lines tend to move to the right on many of these charts. And if there is a delay, understanding there is going to be replacement at some point, is there a moderate middle ground here as far as refurbishment or some additional purpose to make sure that we are not caught short here relative to training and the domestic needs mentioned?

General INGRAM. Congressman, we believe it is, and we are resetting and modernizing. As I said, 76 percent of our fleet is modernized now, even though they are old.

MODERNIZATION AND SHORTFALL REQUIRED IN BUDGET

Mr. VISCLOSKY. Do you have adequate funds in the budget request for 2013 to continue what you think you need, or is there a shortfall?

General INGRAM. I am confident there is a shortfall. I don't know how much. We are going through some very stringent budget drills, as you can imagine, and again, we work through the Army, Army procurement and Army modernization on these programs.

Mr. FRELINGHUYSEN. Will the gentleman yield?

Mr. VISCLOSKY. Absolutely.

Mr. FRELINGHUYSEN. So you are happy with the vehicles you have now?

General INGRAM. Congressman, you keep asking me that question.

Mr. FRELINGHUYSEN. I do keep asking you that question because quite honestly, the light vehicle is a way off, and General Odierno says it will be 7 years before we have a ground combat vehicle. So I know that the Army has its needs, but where is the Guard? Are you happy with what you have?

General INGRAM. We would be happier if we had everything brand new. I think, in the current budget reality, that is not a reasonable expectation.

My concern is that we get the adequate funds to modernize on a schedule that we can all live with.

Mr. FRELINGHUYSEN. Thank you.

Mr. VISCLOSKY. I appreciate it, and if we could follow up, we also have a significant budget problem within the subcommittee, but I would at least like information if we could have a followup conversation so I have a good perspective, that would be terrific.

Mr. DICKS. Would you yield just for a second?

Mr. VISCLOSKY. Sure.

OFF-THE-SHELF EQUIPMENT

Mr. DICKS. We tried, our committee tried to keep the Humvee going, but the Army was adamant that they did not want to do this. They said we have got enough Humvees, and the Humvees that we have are vulnerable; isn't that correct? I mean, you know, you don't have a double V hull. You don't have the Mine Resistant Ambush Protected (MRAP)-type protection.

So here is the question I have on this subject. The Army's record in bringing something to the forefront in procurement is they need a simulator is what they need, okay, to figure out how to do it.

Now, you know, from the Guard's perspective, would you rather have them buy off-the-shelf equipment, systems that are out there already when you can get them and then incrementally improve them versus try to develop a new system that, with their record, has maybe only a 30 percent chance of ever being fielded? I mean, does the Guard worry about this? I would worry about it if I were the Guard.

General INGRAM. Congressman, from my perspective, I think we need to be equipped the same way as the Army because of all the sustainment systems and all the parts and maintenance that we have to do on these.

Mr. DICKS. But you can get the Stryker or the MRAP or some system right off the shelf, incrementally improve it, why go through this big development program, 7 years, waste all this money, and then, at the end, cancel the program, which has been the record of the Army in recent years?

General MCKINLEY. Sir, I think my colleagues who work in Army and Air Force lanes are trying to follow their service leads, and I would say, as a chief, that their domestic requirements that through no fault of anybody's need to be considered. And we appreciate this committee bringing those needs up so that we can debate them and talk about them. Those domestic needs obviously include

an adequate vehicle so that our National Guard troops in-State status can get to and from the scene of the disaster.

And so I would encourage us to debate both sides of this issue, the needs of the Federal components and also the need for the domestic mission.

General STULTZ. Bill is brand new. I am retiring, so I don't have anything to lose.

Mr. DICKS. You tell us.

Mr. FRELINGHUYSEN. Tell us like it is here.

Mr. VISCLOSKY. But he is retiring, too.

AGING EQUIPMENT

General STULTZ. But, no, I think you are exactly right. The concern I have got. I understand, we have gone through the same dilemma. Of my Humvee fleet, which is about 90 percent on hand, only about I think 10 or 15 percent is up-armored capable.

So how feasible is it for me to put soldiers into combat in those vehicles in the future if we are going to go into a theater where—and I am sure we are, because everybody has gone to school on us and seen how IEDs affect our operations—and so I am concerned that those soldiers coming back from theater come back home and see those Humvees that they are going to train on now and say, you know, this is not really getting me ready to go to war. I need something better, and there are off-the-shelf solution sets with MATVs and everything else.

I have toured the plants at Oshkosh and other places like that, and so I think we have really got to take a serious look and say, what are we going to have to do for the immediacy to give those soldiers, maybe it is not 100 percent, because I am not going to send 100 percent of the Army Reserve at once, but give me enough fleets of equipment that I feel confident that everybody that I send into battle and everybody that I train to go into battle is training on the piece of equipment they will operate in theater and not an old Humvee that is not armor capable, and that soldier knows that.

Mr. DICKS. Thank you.

Thank you for yielding.

Mr. VISCLOSKY. I thank the gentleman.

Mr. VISCLOSKY. One more?

Mr. YOUNG. Yes, sure.

AIRGUARD REDUCTIONS

Mr. VISCLOSKY. General McKinley, I appreciate you bringing up the domestic component because in my mind, it wasn't in my mind until you mentioned that, and I appreciate you doing that.

On equipment again, and the question deals with the Air Guard, Secretary Panetta had talked about a balance relative to the reductions at the Air Force and Air National Guard, but my understanding is that the Air Guard comprises about 21 percent of uniformed members in the total Air Force and yet would bear about 59 percent of the total aircraft cuts. There has been proposals relative to the canceling of the C–27, eliminating 27 older C–5s and 65 C–13s—C–130s, C–130s.

And my understanding is the Council of Governors have at least a proposal or some ideas as to how, if you would, to find a balance

without more money, as I understand it, so that, again, the Air Guard is not decimated. Were they left out of these decisions, or is there still time to have a consideration of this so some balance can be struck? Because, again, I think very importantly here, they are not looking for more money, but they are looking for a better balance.

General WYATT. Yes, sir. The FY 2013 President's Budget Request proposal of the Air Force is right along the lines that you have mentioned, sir; those are the cuts. Subsequently, the Council of Governors, with Secretary Panetta's agreement, have presented an alternative proposal, and that is currently being discussed and evaluated and reviewed inside the Pentagon right now, and we hope to have some sort of answer determination at a later date. I don't know the particular status of the review at this point of time.

Mr. VISCLOSKY. I would, and I speak only for myself, hope that the people within the Department do give it serious consideration because I think the Governors are very serious about it, and again, looking to find the balance relative to the fiscal policy.

Mr. VISCLOSKY. Gentlemen, thank you very much for what you do. I appreciate it.

Mr. YOUNG. My turn.

First of all, thank you for a really good hearing, and I have made more notes than I am going to be able to have time to talk to you about, but I, frankly, have some real concerns.

SEQUESTRATION

Sequestration, I think we are going to find a way to avoid sequestration because all of us realize that would be a disaster for our national defense.

But I, during the hearings that we have had so far and during the hearings today, I am hearing some words, and I might just be a little bit paranoid about this because I think it is so essential to maintain the readiness to face any threat that we might be faced with. And I am not sure—and in this "budget reality" is one of the words, phrases that I heard—I am not sure that in this budget reality that we are going to do that. And let me give you just one example before I go to what you all said.

We had the hearing with General Mattus and General Allen, and they were testifying to the fact that they really needed more naval facilities in their AOR. Good, and I think they are probably right, considering what they have to deal with, the threats, the potential threats they are facing.

On the other hand, we are going to hear this afternoon from Admiral Locklear that we are expanding our activities in the Pacific.

But at the same time, we are just not building enough ships, enough naval resources to take care one area AOR and another AOR and especially to expand them, just an example of why I am just maybe a little bit paranoid on this subject.

WHAT IS "ACCEPTABLE RISK"?

But I hear the word "risk," and I have heard the word, not today but in other hearings, "acceptable risk," and I have heard the phrase "not funded adequately," and I have heard the statement,

"soldiers need good equipment now." And then I hear "marching orders," we have got our marching orders.

Are the marching orders surpassing the real judgment of our military leadership as to what is required to maintain the readiness of this country and to be able to properly equip and train and secure the soldiers who provide that readiness? Does that concern anybody other than me? But it does concern me.

General STULTZ. Yes, sir, it concerns me also. It concerns me because I think, and I hate to use the word reality, but what our leaders are looking at is what they think that they will be given to work with in terms of the defense budget.

And then some of the challenges within that budget, where we know that we need to spend money on equipment, on simulations and training, but we also know that we have got broken soldiers. We have got a lot of medical needs. We have a lot of things that are not in our program budget that we have to take care of.

So I think that is part of the reality also is that we as a Nation need to recognize, and it has been mentioned here, the stress and strain that we put on our men and women in uniform over the past 10 years, and what we owe back to them to get them back to the health they need to be, and what it will take to do that, and don't make us as a military use our resources, that we need to be spending on equipment and other things, to do the right thing. And so I think that is part of the challenge that we are facing right now. Just in our end strengths, as you are talking about bringing down end strengths to save money, there are still a lot of broken soldiers in that end strength. We can't just get rid of them. We will have to keep them. We will have to take them, and we will have to count them, which may force us, to get down to where we need to be, we will have to get rid of good soldiers that we really need to keep.

I think those are the kind of realities we need to grapple with and say: What does it take for this Nation to have a military that we need and we deserve, and to take care of those soldiers, because what we cannot risk, what is not acceptable risk, is that we lose it?

That is my concern on the Reserve. If we don't resource our reserve soldiers correctly, to give them the proper training, to give them the confidence that if they go into battle and get wounded, that we are going to take care of them when they get home, we are going to lose that national treasure. And we will go through another dip, just like we did before, where we dropped in the Army Reserve from 205 down to about 185, and try to climb out of that. And we have. But we will go through that again, and we will hit that bottom right about time the next conflict occurs.

General MCKINLEY. Mr. Chairman, from my vantage point, we cannot squander the gains that we made in the National Guard and Reserve over the last 10 years. It would be a waste of taxpayer money. We have the most capable, trained, highly qualified, eager force that we have ever seen. And they are expecting our leaders to fight hard so that they don't return to a status that we have returned to in most other major conflicts that our Guard and Reserve have fought in.

So we are here today to tell you that while we work within our service lanes, that we also come here to thank you for supporting

us in the unique needs that we have, the fact that the National Guard and Reserve equipment account takes care of an awful lot of things that our services can't take care of, that we can utilize in other things like simulations and dual-use training equipment, that is vitally important to us. And without that, we are going to squander the gains that we have made over this last decade of war.

Mr. YOUNG. Any other comments?

General WYATT. I will just add in from the Air Guard side, we look at the new National Military Strategy and we look at the Air Force's restructuring, I think where we are headed, we have the force structure to do what it is that the country expects us to do.

I think the key, though, is making sure that everybody understands that the days where we might be able to do some peanut butter cuts to hit additional budget cuts are over. And if we go down that sequestration route or if we don't do what we are doing right now properly, we will find ourselves promising some military capability that we can't deliver on.

Internally to the Air National Guard, for example, what we did in 2013 and what we will do for the next 5 years is to improve our readiness because General Schwartz has told me, when I call on your forces, Bud, they better be ready to go. I have said, okay, they will be ready to go. But, sir, what I need some help in is divesting some of the sunset under-resourced lower priority missions so that I can take those resources and put them toward the higher priority, rising missions that we think that we will need in the future. So that is what we are trying to do internally with the Air National Guard.

Mr. DICKS. Would the chairman yield just for a second on that point?

Mr. YOUNG. Go ahead.

NATIONAL GUARD MISSIONS

Mr. DICKS. You said the lesser missions that should be sunsetted; what are those?

General WYATT. Some of those missions might be, as we go forward and we take a look at the need for maybe combat communications, do we have too many combat communications missions across units, across all of the components. And we talked to the combatant commanders and we have talked to the major commands in the Air Force, the Air Guard does, to make sure that we don't have any force structure that is not important to the new fight. Force structure that may have been necessary 10–15 years ago, and we have postured our forces for that fight. But as we move forward, things like combat communications and increasing need. For example, for maybe security forces. We know the growing portfolio in remotely piloted aircraft, intelligence, surveillance, reconnissance, cyber is going to be the focus of the future.

So these are difficult decisions. It is not that these missions are not important. But as you rack and stack them in the level of importance and you try to determine what the risk the country is willing to take, to borrow a word that you used, Mr. Chairman, there can be some internal readjustments of the type of units that you have. That is what we are trying to do, take those lower priority units, those units that maybe have suffered some force struc-

ture cuts along the way that they are not as capable as they should be, and just make the hard call. It is time to divest and get in those mission sets that we think will be important in the future.

OPERATIONAL RESERVE

Mr. YOUNG. General, did you want to comment on my statement?

General INGRAM. Congressman, I do. Every man, woman that has joined the Army National Guard since 9/11 has—every soldier that we have in the Army National Guard has either joined or reenlisted since 9/11. So our force, the most capable we have ever had, expects to do something. And that speaks to the Operational Reserve.

At this point, we have funded the training for an operational Reserve, but we need to have the money to operate the operational reserve, both Guard and Reserve in our United States Army. So the Nation expects that.

The investment that General McKinley just talked about, we have spent a lot of Nation's treasure in the last 10 years manning, equipping and training the Reserve component of the United States Army. And if we don't use that on a periodic, predictable basis to do missions around the world or in the United States, then we will lose that edge that we have gained. I think that is what you are talking about.

Mr. YOUNG. That is pretty much what I am talking about, yes.

Well, this subcommittee understands the importance and the necessity of having your forces and your troops and having them trained properly and equipped properly. You will find if there is something that you would like to slip under the table, a list of things that you need and aren't in the budget, let us take a look at it because we are very supportive.

We are running out of time, so I want to go to the other subject that I have talked about.

AVIATION ASSETS

General McKinley, you and I have discussed this in private meetings. And that has to do with the aviation assets for the National Guard in the respective States, and we haven't talked too much today about how the Governors have all written to this committee and have written to the Armed Services Committee complaining about the loss of their aviation assets. I thought I was going to maybe just make a comment—maybe I sound too serious—but we were really impressed with what you are doing with the simulators. And Mr. Dicks and I are very strong supporters of simulators. We have both used them, and we like them. But I am just wondering, if, when you need that C–130 in Florida for the next hurricane, are you going to use a simulator to do what that 130 should do? And that worries me. Other members of this committee have expressed that concern to the Air Force, to Secretary Donley and General Schwartz. I don't think we have made much progress, but it just seems to me like we are eliminating an asset that may be more important for the State function, the domestic function, as opposed to the overall military function. But it is something that is real.

I have gone with our adjutant general into a hurricane situation where the National Guard is there on the scene and had to get from Hurricane Ivan, for example, that wiped out Pensacola Air Station, and they had to get back to St. Augustine because the next hurricane was heading there. They were able to get there quickly with the aircraft. No aircraft and they would be traveling in trucks or Humvees, and the hurricane would be over. Anyway, that is a concern. Many members of the committee have expressed concern on that very subject.

And I know, General McKinley, I know where you stand on that, and I am not going to get into that any further.

This has been a great hearing.

Mr. DICKS. Mr. Chairman, could I just bring up one quick little one?

Mr. YOUNG. Of course, Mr. Dicks.

POST-TRAUMATIC STRESS DISORDER

Mr. DICKS. Thank you, Mr. Chairman.

We just had a big to-do out of Fort Lewis, Joint Base Lewis-McChord on post-traumatic stress disorder, traumatic brain injury, anxiety. There were a number of people who felt that they had been mistreated, that their diagnosis had been changed. And they were. Some of these were reversed at Walter Reed Bethesda. Now, do you think this is a problem? Are the Guard and Reserve people, are they worried that their diagnoses for disability are not being properly handled, that there is kind of a secret code in the Army—and the Air Force doesn't get this wrap but the Army does—for trying to hold down the cost of treating these people? And there are implications to this.

What if somebody is misdiagnosed or not diagnosed properly, and then they are sent back into combat and then they get into a big mess? Now, Bales, apparently, his wife says he didn't have any post-traumatic stress disorder, but a person could. This has implications beyond just money. It has implications about what these people can do or perform when they are called upon in Active Duty combat.

General STULTZ. Sir, I will give you my perspective in talking with my soldiers.

I don't think that they necessarily think that they are being treated differently in terms of the concern and care. I think their frustration is they are being treated differently because of the bureaucracy. And the challenge we have got is a soldier comes back from Iraq/Afghanistan that is in 1st Cav Division. He is going back to Fort Hood, Texas. He may eventually PCS to another installation. But if he starts manifesting issues that associate back to his deployment, he is still in our system, and he is considered in the line of duty and gets treated.

Our soldiers come back, and we take them off Active Duty, and we send them back home to their communities. In a lot of cases, they don't start to manifest issues for 6 months, maybe a year. And then the bureaucracy of trying to get them back into the system, to get the care they need and everything, is where it is very frustrating for our soldiers. Or our soldiers that we do get back into the system, the Warrior Transition Units at Walter Reed Bethesda

now, and I just met a soldier over there just recently, and he has been in that system for 3 years because—and it is not anybody's evil intention; it is just different types of orders. It is different types of authorities. It is different types of line of duties. It is different types that we don't have a medical system that really is equipped and ready to take care of the needs of the Reserve components. We have a medical system that is struggling to take care of the Active component as it is. We put on top of that the fact that we send them back home, and then they have issues; how do we get them back into that system?

It frustrates me a great deal when I hear somebody questioning a soldier, who we know he was in Iraq; we know he went through an IED blast, whatever, and he has been back 2 years and somebody is asking for a line of duty. Don't ask me for a line of duty. He was in combat. We know that.

If that soldier is, for example, at Fort Hood, Texas, and he is playing basketball and twists his ankle, he is in line of duty, and we take care of him. If one of my soldiers is out there jogging so he can pass his PT test and twists his ankle, he is not in line of duty; he is not a soldier. The hell he isn't; he is a soldier 24 hours a day. He is just not in uniform today. We have to figure out a system to say, how do we provide the medical care for our soldiers in the Reserve components at the same level, not at the same cost, but if we say, hey, this soldier needs care and it is a military responsibility, we can get him back into the system immediately and take care of him.

Mr. DICKS. Thank you, Mr. Chairman.

Mr. YOUNG. And that is a good point. We need to explore that. I know of some cases that would fit into that category, and we need to fix that.

Thank you for a really good hearing. We stand here in support of the Guard and Reserve.

This subcommittee is now in recess until 2 p.m. this afternoon when we will hear regarding U.S. Pacific Command and U.S. Forces Korea.

[CLERK'S NOTE.—Questions submitted by Mr. Moran and the answers thereto follow:]

CLOUD COMPUTING

Questions. The realities of today's difficult budget environment have forced us to look at all aspects of the federal budget to ensure that we meet our fiscal responsibilities and make the best use of limited funding. In the overall budget plan for DoD, I notice a number of programs where savings measures will be achieved through innovations in information technology. In particular, I have been following the implementation of the Administration's "cloud-first" mandate and note the successes of other federal agencies, such as GSA and NOAA, who have been able to achieve IT cost savings by moving some its programs and email users to the cloud. In many instances these savings are reported to be in excess of 50% of their prior operating costs.

Lt. Gen. Wyatt, does the Air National Guard plan to move any of existing programs to a cloud environment? If so, will this include email systems?

Answer. In our efforts to assess the viability of moving the entire Air National Guard to the cloud, we recently reached out to industry with a request for information on available cloud computing solutions. The responses received make us optimistic that we will be able to potentially leverage a solution for core capabilities to include secure e-mail services at a much lower cost. While actual savings are unknown at this time, we do believe the Air National Guard can realize considerable

reductions in hardware, software, environmental and personnel costs by moving to a cloud environment. Just as importantly, we also believe a public cloud environment will not only offer better access to our Drill Status Guardsmen and women, but provide collaboration capabilities with state and local governments not available today.

There are still a number of questions that must be answered. How do we continue to interface with our Active Duty counterparts in the Air Force? Where is the DoD going with the Joint Information Environment and will our cloud computing initiative be compatible with those ongoing efforts? We believe by working with industry we will be able to answer those and other questions going forward.

Question. Will you be considering the lower cost advantages of a Government community cloud in order to achieve the best value for the tax payer?

Answer. Yes, we will be considering both public and private cloud offerings as we fully explore cloud computing. Our recent request for information from Industry yielded solutions for both private and public cloud environments. Ultimately, the security of our information and cost efficiencies offered will probably drive toward one solution over another. At this time, we don't have enough information to say which solution best meets the needs of the Air National Guard.

CLERK'S NOTE.—End of questions submitted by Mr. Moran. Questions submitted by Mr. Young and the answers thereto follow:]

C–27J—SPARTAN MEDIUM SIZED MILITARY TRANSPORT AIRCRAFT

Question. Imagine the visual of brand new C–27Js going from the assembly line to the boneyard at Davis-Monthan Air Force Base in Arizona.

When I look at the long history of the C–27 it seems very confusing and difficult to understand. Can you explain what has happened starting with the Army's control of the program and why you believe the C–27 is such a low priority program within the Department of Defense?

Answer. In 2007, the Department had two robust airlift programs in development. The first was the Army's Future Cargo Aircraft program which in essence was a recapitalization for its aging C–23 Sherpa program. The second was the Air Force's Light Cargo Aircraft program which was to supplement the C–130 and C–17 fleet by moving smaller payloads into smaller, forward-based landing zones. Those programs were merged to leverage a single, common airframe to meet both needs. An original 145-aircraft fleet size was moderated to 78, which represented a moderate-risk to meet both programs' needs.

In April 2009, the fleet size was further reduced from 78 aircraft to only 38 aircraft. The reduced fleet size was seen as a floor and not a ceiling pending more complete fleet mix analyses. In 2010, an Air Mobility Command (AMC)-commissioned RAND study concluded that between 42–92 aircraft would be needed to fulfill the Army's direct support requirement to move time-sensitive, mission-critical supplies and personnel within the joint operational area. AMC believed the retention of the 38 C–27Js, and covering the additional capacity with C–130s, addressed the RAND conclusions.

In 2010, growing fiscal realities began to impact future program funding. In early 2011, the C–27J program had not received a full rate production decision for the final 17 of its forecast 38 aircraft. The principle concern was the cost associated with the aircraft's 25-year Service Cost Position. Later in 2011, the Budget Control Act directed the Department to significantly alter its views on force structure and fiscal requirements. The Department undertook a comprehensive strategic review of its National Defense Strategy. Given the fiscal reality and new strategic direction, the Air Force made the choice to divest older weapons systems and smaller, niche fleets. The Air Force posture, based on a new strategic guidance, is to reduce the overall requirement for intra-theater airlift. The Air Force subsequently determined that both the domestic and direct support missions to be performed by the C–27J could be performed by the existing C–130 fleet. The Air Force remains committed to supporting the original Army premise, and in January 2012 the Joint Chiefs signed a memorandum to provide direct support for the time-sensitive, mission-critical mission. As such, the C–27J fleet would be divested and offered to other services or nation partners.

Question. The Committee understands that the C–27J has served well in state units, and the Ohio National Guard has flown the C–27J in Afghanistan. Generals, has the C–27J program had cost, schedule or performance problems which have led to the decision to end the program?

Answer. The recommendation to end the C–27J program was established by the Air Force. It was based in part on an analysis of estimated lifecycle costs, but more

so by a strategic change in how the Air Force will employ intratheater airlift. The recommendation does not appear to have been driven by any schedule or performance issues. The aircraft is achieving its original key performance parameters, both at home and in theater. Initial issues concerning maintenance reliability have begun to lessen as the parts and sustainment system has matured and overcome the initial stresses imposed by the immediate deployment of the aircraft. For the last six months, the fleet has maintained an average 86% mission capable rate in the U.S., and over 90% while deployed.

Question. General McKinley, because you can answer for both the Army and Air Guard, how many C–27J aircraft did the Department intend to buy at the high point? How many aircraft were to go to Army? How many to Air Force? And what mission were these aircraft to have served?

Answer. In March of 2005, the Joint Requirements Oversight Council approved the Army's Initial Capabilities Document that called for 145 future cargo aircraft. In June 2006, the Army and Air Force Vice Chiefs of Staff signed a memorandum of agreement that established the way ahead for the convergence of the Army Future Cargo Aircraft and Air Force Light Cargo Aircraft programs. The agreement specified the Army would initially procure a minimum of 75 aircraft (48 of which were designated for the Army National Guard), and the Air Force would procure a minimum of 70 aircraft. The total fleet at time was forecast at 145.

In May 2007, the Joint Chiefs of Staff signed a memorandum stating the Army was presently budgeted for 46 aircraft but was fully committed to fund a total of 54 aircraft thru Fiscal Year 2013, 40 of which were for the Army National Guard. The Air Force was also committed to an initial buy of 24 aircraft, bringing the total forecast for the fleet to 78 aircraft. In May 2009, the Secretary of Defense moved the program entirely into the Air Force, and reduced the fleet size to 38 aircraft.

The Joint Cargo Aircraft program's Capability Development Document, April 2007, established the baseline performance parameters and missions to be achieved by the aircraft. The aircraft was to perform intra-theater airlift missions in support of the Joint Force Commander's objectives, and would be capable of performing basic airlift mission sets including general passenger and cargo movement, combat employment and sustainment, aeromedical evacuation, special operations support, and operational support airlift. These missions include operations with night vision equipment, arrivals and departures from unimproved fields, and the airdrop of personnel and containerized supplies.

The mission of the C–27J aircraft is to supply time sensitive, mission critical deliveries to widely dispersed Army units; it would not have replaced the Air Force mission of intra-theater airlift. The Army identified a need for less than a full load of cargo carrying capacity for the "last tactical mile" and the C–27J may be able to operate more effectively and efficiently than other Army or Air Force aircraft. In addition, the C–27J would replace the Army National Guard C–23 aircraft and relieve the pressure on the over-stressed Army rotary wing aircraft, particularly the CH–47. Both the Army and Air National Guard would employ the aircraft in support of civil authorities and homeland defense missions.

Question. The unit cost of the C–27J is about $32 million. The C–130J unit cost is about $65 million. General Wyatt, is there a need for front line tactical airlift, and does the C–27J satisfy that requirement at a lower procurement cost and lower operating cost?

Answer. The C–27J was developed by the US Army to fulfill an operational gap created with the pending retirement of the C–23 Sherpa. The C–27J was designed as a light-cargo airlift aircraft, which would continue to meet the Army's on-demand movement of critical cargo and personnel to forward operating areas. The C–27J is presently meeting that mission set as intended. The aircraft provides the Air Force an agile platform to effectively and efficiently move general support cargo across the joint operating area. The C–27J's smaller platform can be used for those missions that do not meet the general support mission's minimum requirements. Such a fleet would allow the AF to leverage and apply the right-sized platform for the mission at hand. This would maximize the use of airlift capacity at the same time increase the fuel efficiency per mission with no loss in mission effectiveness.

Question. General Wyatt, would the initial buy of C–27Js have allowed for the retirement of an equal number of old C–130s?

Answer. When the Air Force accepted the responsibility of the program, they specifically accepted the responsibility to provide the Army direct support for its intratheater airlift of the time-sensitive, mission-critical supplies and personnel. The Air Mobility Command's Air Mobility Master Plan, Nov 2011, identified that lessons learned from Southwest Asia revealed the need for a smaller airlift aircraft to better support the time-sensitive, mission-critical needs of the combatant commander. The C–27J was seen as the right-sized aircraft to provide that support and would do so

"by adding a more efficient means to move small payloads, shorter distances, into austere locations."

The initial procurement of thirty-eight aircraft gives the Air Force a preliminary means to achieve efficiencies in the movement of smaller general and direct support mission loads. However, the small fleet footprint is not sufficient to generate efficiencies necessary to warrant the replacement of an equal number of C–130s.

Question. General Ingram, have Army National Guard units turned in some or all of their old aircraft, the Sherpas, Hurons, and Metroliners? If you no longer have the C–27J in the fleet, what is the plan to replace those older aircraft, and if the plan is to use C–130s, is that a bit of over kill and wasted money?

Answer. Resource Management Decision 802 (April 2009) directed the Army National Guard divest four C–23 aircraft in fiscal year 2011 and another four by the end of calendar year 2012. The Army National Guard will divest the remaining 34 C–23s no later than calendar year 2014. The Army National Guard has not divested any other types of aircraft. The Army is currently staffing a Fixed Wing Utility Aircraft Initial Capabilities Document to address the replacement of aging C–12 Huron and C–26 Metroliner utility aircraft.

The Army and Air Force both agreed that the C–130 could effectively perform high priority and time sensitive transport/resupply missions involving small passenger and cargo loads to widely dispersed units. The C–130 did not meet some technical requirements for the joint cargo aircraft and was eliminated from the competition in 2006. The C–130 is also a larger aircraft than is required for this mission (a 42,000 pound payload versus 25,000 pounds for the C–27J), and, according to Department of Defense reimbursable rates, it costs approximately three times more to operate than the C–27J.

The C–27J would have replaced the C–23 fleet; no other aircraft is projected to replace Army National Guard C–27s/C–23s.

Question. General Wyatt, the Air Force Chief of Staff says that you were you a full participant in the Air Force budget process. Did you disagree with the decisions put forward in the FY13 PB for the Air Force? Did you provide alternate options to the Air Force during the process? Have alternate options been provided to the Air Force since the release of their budget proposal? If so, how have they been received?

Answer. The National Guard Bureau was directed to cut Air National Guard manpower; an endorsement of the overall decision was not part of the Air Force process for making this decision. The National Guard Bureau participation in selecting force structure changes was to offer advice and options to Air Force leadership. The Air Force mandated how many, which type of aircraft and/or units to cut. The National Guard Bureau offered recommendations for options within the parameters of the decision required. At the conclusion of the Corporate Process deliberations, the Secretary and Chief of Staff of the Air Force made the final decisions on the size, shape and content of the Air National Guard.

Question. The Committee understands that the Department plans to divest of the 21 C–27Js that have been delivered or are in production. What does divest mean exactly: store them, sell them, or give them away . . .?

Answer. The Air Force is presently reviewing options for future utilization of the aircraft. Initial screening has identified the US Coast Guard has interest in 21 aircraft, SOCOM has interest in 6 aircraft, and the Defense Logistics Agency's Law Enforcement Support Office has interest in 5 aircraft. Air Force personnel have indicated that formal screening and a final disposition decision is expected this summer.

Initial plans to move all aircraft to the Aerospace Maintenance and Regeneration Group for temporary storage pending a final disposition decision have been suspended. Instead, the Air Force will support the continued aircraft operations for the four primary aircraft at each of the three operational Air National Guard Wings. All further aircraft, to include those delivered off the production line, will be held at the primary contractor's facility in Waco, Texas, pending final decision on the Fiscal Year 2013 budget.

Question. General McKinley, is this program another example of the requirements process in the Department of Defense being out of control?

Answer. The C–27J Spartan was originally designed to serve as the recapitalization of the Army's aging workhorse, the C–23 Sherpa. The Joint Requirements Oversight Council approved the C–27J as the Army's Future Cargo Aircraft. It was subsequently determined that the airframe also met the program baseline for the Air Force's Light Cargo Aircraft program. This reflected an initial intent to procure 145 aircraft, 75 for the Army and 70 for the Air Force. Eventually, an agreement was signed to merge the programs and thus realize the synergies of procuring one aircraft to achieve both Services' mission need. The initial acquisition baseline was set to initially procure 78 aircraft, 54 for the Army and 24 for the Air Force.

By May 2009, the Services agreed that intratheater airlift was a core competency of the Air Force, and as such an agreement was made that the Air Force would implement the program and execute the mission. This correctly aligned mission sets within the respective Services, and was a prudent step to take. However, the initial procurement was further reduced to 38 aircraft.

Since the program inception, each decision to modify or change the program came with a decision to reduce the total fleet size. The net effect over time has been to produce a program that equates to a significant cost per airframe, and a fleet size/basing strategy that is less than optimal. The requirement to employ an aircraft that would manage smaller cargo loads which must move in 'on-demand' environment favors this aircraft. The requirement is not wrong, but decision to incrementally reduce overall fleet size has hurt the overall program.

Question. Where are the C–27s in the Air Guard inventory currently located? What missions are they filling? Has anything changed in the homeland defense and domestic response mission that would indicate a need to reduce airlift requirements in the Air National Guard?

Answer. The Air National Guard has accepted ten of the twelve C–27J aircraft presently delivered to the Air Force. In accordance with the program of record, each active Wing will receive four primary aircraft. The first four aircraft were delivered to the 179th Airlift Wing, Mansfield, Ohio. Three aircraft have been delivered to both the 135th Airlift Group, Baltimore, Maryland, and the 186th Airlift Wing, Meridian, Mississippi. The Maryland and Mississippi Wings await delivery of their respective fourth and final aircraft. These aircraft still pending delivery this summer from the primary contractor. The final two of the twelve aircraft are stationed at contractor-provided Flight Training Unit, Robins Air Force Base, Georgia. All further aircraft deliveries will be held at the primary contractor's facility in Waco, Texas, pending final action on the Fiscal Year 2013 budget.

The primary focus for the C–27J program was to rapidly field and train units in order to immediately support deployment requirements. The 179th Wing met that goal by deploying two aircraft in support of Operation Enduring Freedom in July 2011. The unit has continued to aggressively complete mission certification training and to sustain deployed operations. The 135th has now deployed to assume the operational commitment from the 179th to return home.

The units maintain a continuous readiness-state to support any homeland defense mission, just as they were available during Hurricane Irene. We see nothing to indicate a reduction in domestic airlift requirements.

COUNTER DRUG FUNDING

Question. Gen. McKinley, the committee understands the National Guard, in a Title 32 status, offers the primary domestic military support to combating the nation's drug epidemic by disrupting both drug trafficking and transnational criminal organizations.

How will the decrease in counter-drug funding effect the National Guard Counter Drug Program? What can the Committee do to make sure that this program remains viable to those states that need it most?

Answer. The National Guard Counterdrug Program has received an overall funding reduction of $86.2 Million or 37% for FY 2013 as compared to the previous fiscal year 2012. The State Plans Project Code 7403 has specifically received a $73.9 Million or 41% reduction from the previous fiscal year. That 41% budget reduction will reduce operational support by approximately 45–50%.

The operational reduction will impact support provided to Law Enforcement Agencies (LEAs) counter narcotic operations in the following mission support areas: Marijuana Eradication, Aerial and Ground Reconnaissance, Criminal Analyst support, and Civil Operations & Coalition Development (formerly Drug Demand Reduction).

The National Guard Counterdrug Training Center budget has been reduced by $1.7 Million or 16% which may result in a reduction of approximately 45,000 Law Enforcement personnel trained at the National Guard Counterdrug Training Centers.

The Committee can assist the National Guard Counterdrug Program by working with Department of Defense to establish a stabilized and adequate funding stream within the Presidential Budget base. This achievement would provide each state program the opportunity to deliberately plan support, train law enforcement, and properly plan funding expenditures.

DOMESTIC MISSION AVIATION

Question. The Air Force budget includes the reduction of 65 C–130s and the divestiture of all C–27s from the fleet. We know that these aircraft are the primary aircraft used in response to domestic emergencies. Without aircraft like these to respond to recent disasters in the Gulf states, missions may have been compromised.

General Wyatt, how will the Air Force's budget impact the Air Guard's ability to respond to domestic emergencies?

Answer. In most cases, the first 72-hours of disaster response is local and no one knows better what a state needs to respond to support its citizens better than the state leadership and their emergency planners. We believe aircraft and personnel that can respond to a Governor's request can be utilized more quickly than assets not under his/her control. The ability to have personnel and aircraft in a standby status can speed the response by many, many hours and that could be the difference in supplying the lifesaving and life-sustaining capabilities needed. Reductions in transport aircraft, search and rescue assets, and other keys capabilities from a Governor's control may slow a response to a domestic event.

Question. Given the Air Force's proposed cut, how many additional aircraft, and of what types will the Air Guard need to adequately perform its domestic mission?

Answer. The Congress has required a study to look at potential capability gaps with the new force structure plan while looking at DoD commitments around the world, historical domestic response needs, and potential domestic needs to support major and/or complex catastrophes. The capabilities based assessments is expected to be completed in Dec 2012. Once complete, we should be able to provide a more detailed response.

Question. General McKinley we understand that the Air Force believes it will be able to provide the necessary aviation assets during domestic emergencies through a combination of Guard, Reserve, and Active forces. Yet, FEMA, the governors, and Adjutants General have all said that time is vital to domestic response and only the Guard is positioned to respond in a timely manner. Is there any explanation to the Air Force's reasoning on this?

Answer. We believe the explanation lies in the lack of an articulated requirement (Refer to #13 response).

AIR NATIONAL GUARD READINESS

Question. The Fiscal Year 2013 budget request for Air National Guard proposes such deep cuts in its funding for maintenance requirements that only 72% of the aircraft would be adequately maintained and ready to fly, while the remaining iron, approximately 200–300 aircraft; would have to be sidelined. This cut is on TOP of the already significant reductions to the number of Air National Guard planes. The Air Force objective is to provide enough funding for maintenance of aircraft and aircraft engines so that 100% of the fleet is mission ready, but this budget seems to fall far short of this goal.

General Wyatt, do you agree with this assessment? How much additional funding would be required so that 100% of the significantly reduced Air National Guard fleet would be mission ready?

Answer. For FY13, the Active Component accepted significant risk in other components of Weapon System Sustainment (WSS), while budgeting aircraft and engines at 100%. The budget for the Air National Guard (ANG) reflects 72% for the entire ANG WSS. While this does allow us to fund aircraft and engines at higher than 72%, while accepting risk in other areas of ANG WSS, it is not sufficient enough for the ANG to fully fund aircraft and engines at 100%.

The Air National Guard projects a $263 million shortfall to ensure 100% of the significantly reduced Air National Guard fleet would be mission ready. This funding would allow the Air National Guard to fund 21 engine depot overhauls ($38.0M) and 7 aircraft programmed depot maintenance (PDM) inductions ($84.5M). The funding would also be utilized to fund Contract Logistics Support for Weapon Systems such as E8–JSTARS and targeting pods ($140.5M). Should this shortfall go unaddressed, aircraft and engines will be deferred ultimately resulting in groundings.

Question. The Committee understands that the active Air Force includes approximately $250 million in funding in its Overseas Contingency Operations budget for Air National Guard maintenance. Could the Air National Guard use this funding to supplement the shortfall?

Answer. In Fiscal Year 2010, a Air Force General Counsel ruling determined the Air National Guard's (ANG) appropriation is for organizing, training and equipping our force. As a result of the decision, all Overseas Contingency Operations (OCO) funds (other than Yellow Ribbon funds) in the ANG baseline budget were "reprogrammed" out and we support all OCO missions in a "reimbursable" status. That

is to say, any time we support the active forces, that duty is paid for from the active appropriations. Since our baseline budget is designed to support our peacetime training, the peacetime (baseline funding) would need to be increased to resolve the shortfall. All OCO support we provide drives increased maintenance costs, the reimbursement from Air Force pays only that OCO bill.

Any additional OCO funding we receive is a direct correlation with additional flying, thus the shortfall is not decreased. The money would need to be reprogrammed into the ANG's baseline to eliminate the shortfall.

[CLERK'S NOTE.—End of questions submitted by Mr. Young.]

WEDNESDAY, MARCH 28, 2012.

U.S. PACIFIC COMMAND/U.S. FORCES KOREA

WITNESSES

ADMIRAL SAMUEL J. LOCKLEAR III, U.S. NAVY, COMMANDER, UNITED STATES PACIFIC COMMAND

GENERAL JAMES D. THURMAN, U.S. ARMY, COMMANDER, UNITED NATIONS COMMAND; COMMANDER, UNITED STATES-REPUBLIC OF KOREA COMBINED FORCES COMMAND; AND COMMANDER, UNITED STATES FORCES KOREA

Mr. YOUNG. The committee will be in order.

The chair recognizes Mr. Dicks for a motion.

Mr. DICKS. Mr. Chairman, I move that those portions of the hearing today which involve classified material be held in executive session because of the classification of the material to be discussed and its sensitivity.

Mr. YOUNG. Without objection, it is so ordered.

Mr. YOUNG. Today, this afternoon, our hearing is on the status of the United States Pacific Command and the United States Forces Korea, welcoming Admiral Samuel Locklear, U.S. Navy, Commander, United States Pacific Command; and General James D. Thurman, U.S. Army, Commander, United Nations Command, and Commander, Republic of Korea-United States Combined Forces Command, and Commander, United States Forces Korea.

Gentlemen, I have a really long opening statement, but I am not going to make it because of this vote situation, and we want to give you all the time that we can give you.

I yield to Mr. Dicks, and I assure he will——

Mr. DICKS. Yes, I would do the same thing.

And thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Dicks.

Admiral, we would like to hear from you, sir, and your entire statements will be put in the record and then you can just state them any way you like.

[CLERK'S NOTE.—The complete transcript of the heading could not be printed due to the classification of the material discussed.]

[The statements of Admiral Locklear and General Thurman follow:]

Admiral Samuel J. Locklear III, USN
Commander, U.S. Pacific Command

Admiral Samuel J. Locklear III is a 1977 graduate of the United States Naval Academy.

His career as a Surface Warfare Officer includes assignments aboard USS William V. Pratt (DDG 44), USS Carl Vinson (CVN 70), USS Callaghan (DDG 994), and USS Truxtun (CG 35), culminating in command of USS Leftwich (DD 984). Subsequent command assignments include Commander, Destroyer Squadron TWO, Commander, NIMITZ Strike Group, Commander, U.S. THIRD Fleet, and Commander, U.S. Naval Forces Europe, U.S. Naval Forces Africa, and Allied Joint Force Command Naples.

Ashore, he served as Executive Assistant to the Vice Chief of Naval Operations, the 78th Commandant of Midshipmen, United States Naval Academy, Director, Assessment Division (OPNAV N81), Director, Programming Division (OPNAV N80), and as Director, Navy Staff.

He is a 1992 graduate of the Industrial College of the Armed Forces, and holds a master's degree in Public Administration from the George Washington University.

Adm. Samuel J. Locklear is the Commander, U.S. Pacific Command, Camp H.M. Smith, Hawaii.

His personal decorations include the Defense Distinguished Service Medal, Distinguished Service Medal with one gold star, Defense Superior Service Medal, Legion of Merit with four gold stars, Bronze Star Medal, and numerous individual, Campaign and Unit awards.

HOUSE APPROPRIATIONS COMMITTEE
DEFENSE SUBCOMMITTEE

STATEMENT OF

ADMIRAL SAMUEL J. LOCKLEAR, III, U.S. NAVY

COMMANDER, U.S. PACIFIC COMMAND

BEFORE THE HOUSE APPROPRIATIONS COMMITTEE

DEFENSE SUBCOMMITTEE

ON U.S. PACIFIC COMMAND POSTURE

28 MARCH 2012

HOUSE APPROPRIATIONS COMMITTEE
DEFENSE SUBCOMMITTEE

Introduction

Chairman Rogers, Congressman Dicks and distinguished members of the Committee, thank you for this opportunity to present an update on United States Pacific Command (USPACOM). I consider myself fortunate to serve as commander during this crucial time in the Asia Pacific region. The President has directed his national security team to make America's "presence and mission in the Asia Pacific a top priority." The testimony that follows will highlight the opportunities we seek to illuminate and address the challenges we must overcome to sustain U.S. leadership in this critical area of the world.

Strategic Environment in the Asia Pacific

The security of the USPACOM Area of Responsibility (AOR) is a vital national interest of the U.S. - a fact underscored by the President's hosting of last year's Asia-Pacific Economic Cooperation (APEC) leaders meeting. The region contains the world's three largest economies and supports over 10 trillion dollars of annual bi-lateral merchandise trade, including more than 1 trillion dollars of U.S. commerce.

The Asia Pacific also hosts the world's largest populations, largest militaries, and includes three nuclear armed states (excluding the U.S.) and the Democratic People's Republic of Korea (DPRK) which continues to pursue a nuclear weapons capability in violation of its international obligations and commitments. While the Asia Pacific has remained relatively peaceful and stable for the past six decades, myriad challenges to its future security will test U.S. resolve, raise the magnitude of the relationships with our five treaty allies and many strategic partners, and test USPACOM as a principle guarantor of security in the region.

Multiple security challenges confront the U.S. across this region, including:

- Defense of the homeland, U.S. territories and compact states in the Pacific.
- Strengthening alliances and partnerships and the need to continuously manage and optimize U.S. alliances and regional partnerships. In particular, focusing on the advancement of the relationship with India.
- China's military modernization and its active development of capabilities in the cyber and space domains. Such recent shifts in capability create uncertainty among China's regional neighbors regarding its current and long-term intentions.
- Three nuclear armed states, including Russia, China, and India, combined with North Korea's pursuit of a nuclear weapons capability and the regional threat of WMD proliferation.
- Numerous transnational threats, ranging from trafficking of narcotics and persons to piracy and the persistent reoccurrence of natural and manmade disasters.
- Challenges to freedom of access to, and security within, maritime and air domains, and space and cyberspace, by both state and non-state actors.

By contrast, the Asia-Pacific also affords immense opportunities. Reinforcing already strong ally and partner associations, the potential for improving the cooperative and constructive security environment in the region is high. Such cooperative engagement activities leverage USPACOM posture and presence and contribute to

advancing military self-sufficiency and security contributions by our partners in the region.

Force Posture Assessment. Generally, USPACOM has been well served with regard to available, ready forces that are able to respond to regional demands. This has occurred despite a decade of wars in the Middle East, to include the USPACOM's rotational contributions to those wars. As a consequence of both history and the nature of challenges in Northeast Asia, USPACOM forward, permanently-based forces are concentrated in Japan and the Republic of Korea. While affording a strong deterrent against challengers such as North Korea, this has placed a premium on USPACOM's ability to deploy and sustain forces elsewhere, specifically in sub-regions such as Southeast Asia, South Asia and Oceania.

USPACOM's submission to the most recent Global Posture Review expressed a need to redistribute postured forces closer to Southeast Asia and South Asia. This redistribution, if implemented, could more efficiently meet the force presence and response demands of those Asia Pacific sub-regions. The recent decisions to rotationally operate a Marine Air Ground Task Force (MAGTF) from Darwin, Australia and U.S. Air Force elements from Australia's northern air bases are initial efforts to rebalance USPACOM force posture for the future.

While the Asia Pacific is often regarded as inherently maritime and contains some of the world's most expansive archipelagos, strategic chokepoints and largest seas and oceans, its militaries tend to be army-centric. For USPACOM, this generates posture and presence considerations and highlights the need to both adapt forces to the maritime challenges of the region and to account for the necessary and effective role

that Army, Marine Corps, and Special Forces play in engaging with our regional partners.

Northeast Asia

Northeast Asia (NEA) contains many of the significant economies and militaries in the Asia Pacific including Japan, South Korea, China, and Russia. U.S. forward presence, permanent basing in Japan and South Korea, habitual accesses, and host nation support in this important sub-region enable USPACOM's front line of homeland defense and provide extended deterrence for allies Japan and South Korea. Additionally, such efforts provide regional deterrence against actors such as North Korea while ensuring rapid response to natural disasters and other contingencies that frequently occur in the Asia Pacific.

North Korea continues to pose one of the most likely and persistent threats to the United States, its allies, and to peace and security in Northeast Asia. Their conventional military threat to the Republic of Korea (ROK) remains a serious concern and its nuclear program, missile development, proliferation activities, and asymmetric military provocations are destabilizing. Collectively, these threats demand that USPACOM Intelligence, Surveillance, and Reconnaissance (ISR) capabilities and capacities be sufficiently robust to view across the North Korea's military apparatus and warn of unfavorable developments. Their continuing pursuit of nuclear weapons and advanced ballistic missile systems places a premium on USPACOM ballistic missile defenses and close cooperation with allies. Japan and the ROK are strong U.S. allies that host U.S. forces, benefit from U.S. extended deterrence, and stand with the U.S. in containing North Korean aggression.

Japan. The 52-year old alliance between the U.S. and Japan remains a cornerstone of security in the Asia Pacific. As was evident in U.S. support to the Japanese Self Defense Forces (JSDF) during the triple disaster in eastern Honshu last year, the extremely close association and inherent interoperability between U.S. forward forces and their Japanese hosts enable prompt and extremely effective contingency responses.

Despite delays in implementing some elements of the Defense Policy Review Initiative (DPRI), including the Futenma airfield replacement facility in Okinawa, the alliance remains strong and is a powerful strategic stabilizing force in the region. It is important to note that of the 19 separate elements contained in DPRI, the vast majority are on track and progressing. In the past year, Japan has increased its regional engagements and association with partners such as Australia, India, Singapore, Indonesia, and the ROK.

Republic of Korea (ROK). The U.S.-ROK alliance remains a strong and visible deterrent to war on the Korean peninsula. This alliance is also transforming to ensure continued currency and relevance in the midst of an evolving Asia Pacific region.

Current alliance initiatives are underpinned by the planned transition of wartime operational control from the Combined Forces Command to the ROK in December 2015. Ongoing transformation also includes the repositioning of on-Peninsula U.S. forces, headquarters, and bases.

Like the JSDF, ROK military forces are engaging throughout the Asia Pacific at an increasing rate. Their contributions to international security initiatives include peacekeeping, counter-piracy, and counter-proliferation efforts.

Trilateral Cooperation. While modest in scope, trilateral cooperation among the U.S., Japan and the ROK continues to progress. While the countries will have to overcome longstanding historical, cultural, and political dynamics to fully realize the potential of trilateral cooperation, policy advances and increasingly frank dialogue among the three allies continues to be encouraging.

Russia. Russia's Pacific armed forces are gradually emerging from the steady decline that followed the end of the Cold War. Increased naval and strategic air force operations, cyberspace activities, and arms sales throughout the Asia Pacific are signaling Russia's emphasis on improved posture in the region. USPACOM enjoys a generally positive military-to-military relationship with Russia, particularly between respective Pacific fleets. In coordination with United States European Command and in accordance with the bilateral Military Cooperation Work Plan, USPACOM seeks improved engagement with Russia's Pacific forces in areas such as counter terrorism (CT), peacekeeping, and search-and-rescue operations.

Mongolia. Mongolia is a small but important partner in Northeast Asia. Its military pursues close engagement with USPACOM through our annual KHAN QUEST exercise series and contributes effectively to coalition efforts in Afghanistan as well as global peacekeeping operations. With Russia to the north and China to the south, Mongolia must finesse its relationships in NEA with its broader security interests. As a consequence of its experience as a member of the Soviet bloc, the Mongolian armed forces continue to maintain ties to European nations such as Germany and even the DPRK. Mongolia is a USPACOM partner with unique and insightful perspectives.

The People's Republic of China. China's growing presence and influence in Asia, and the opportunities and uncertainties that have resulted from it, pose the greatest test for USPACOM among its challenge areas.

In January 2011, President Obama and Chinese President Hu Jintao agreed to "build a cooperative partnership based on mutual interest and mutual respect," which also included a commitment to develop "continuous, stable, and reliable military-to-military relations." To meet this mandate, USPACOM is effectively positioned to contribute to advancing military engagement with the PRC. Military-to-military relations however continue to lag behind other U.S. - China engagements for three main reasons: (1) differences in philosophy regarding the purpose of military-to-military relations where China emphasizes strategic dialogue and the U.S. seeks comprehensive military contact at strategic, operational and tactical levels as a vehicle to build confidence; (2) China's tendency to suspend military-to-military exchanges following U.S. arms sales to Taiwan and, more generally, its linkage between certain U.S. defense policies and continuous bilateral military relations; and (3) inherent Chinese distrust of U.S. regional intentions resulting in demands that perceived impediments to the relationship must be conceded before military relations can advance.

Despite these challenges, China's increasing participation in regional and international security activities and forums such as multi-lateral exercises, counter piracy operations, and peacekeeping can foster informal, but useful U.S. – China military engagement.

Improvements in China's military capabilities and the resultant regional uncertainties also test USPACOM's ability to manage the evolving security dynamics in the Asia Pacific. Areas in which U.S. national interests are being challenged include cyberspace and space as well as maritime security in the international waters around China. China's anti-access/area denial (A2/AD) capabilities extend well into the South China Sea (SCS). China asserts that these military developments are purely defensive in nature and that they pose no threat to regional neighbors. Yet, these developments, when combined with China's broad maritime and sovereignty claims and recent incidents involving lawful operators in the South and East China Sea, create ongoing international concern regarding China's activities in the region.

Taiwan. Following Taiwan's recent Presidential and Legislative Yuan elections in January 2011, many analysts are hopeful that improvements in cross-Strait relations will continue. The focus for Taiwan will be to continue building economic and cultural ties with China. This positive trend supports the security interests of both the United States and Asia. However, Taiwan remains the most acute sovereignty issue for China serving as a key driver of the military modernization programs that have shifted the military balance across the Taiwan Strait in favor of China. USPACOM engages regularly with Taiwan's military within policy guidelines and in accordance with tenets of the Taiwan Relations Act and the three U.S.-PRC Joint Communiqués.

Southeast Asia

Southeast Asia (SEA) is an extremely diverse sub-region, rich in natural resources, and strategically located at the crossroads of the Pacific and Indian Oceans. The region is host to a mix of democratic and authoritarian governments, varied

economies, contrasting military capabilities, and mixed cultures. Prospects for continued economic growth are promising, mainly due to China's substantial economic influence, steady U.S. regional investment and trade, and global initiatives by the European Union and others seeking to capitalize on Asia's rise. Many advancing U.S. partnerships and two U.S. treaty allies, the Republic of the Philippines and the Royal Kingdom of Thailand, are located in this sub-region. Further, the Association of Southeast Asian Nations (ASEAN) and its numerous forums, together with the East Asian Summit (EAS) and APEC, have progressed to become the most effective Asia Pacific multilateral organizations.

That said, SEA is not without its challenges. Disputed islands and features in the SCS, including territorial disputes with China, have generated broad unease in the region. Notably, maritime security has become a regular theme in these multilateral forums. Transnational threats, including violent extremist organizations (VEOs) such as Abu Sayyaf Group (ASG) and Jemaah Islamiya (JI); human and narcotics trafficking; piracy; proliferation; and natural and manmade disasters regularly combine to challenge USPACOM, U.S. allies and partners in this sub-region. Additionally, competition for scarce resources such as water, food and energy generate intense interstate friction across the region, as illustrated by the Mekong River Delta crisis.

Geography is also a factor as SEA contains extensive archipelagos and strategic choke points, such as the Strait of Malacca. Despite this vast maritime domain where naval capabilities and capacities are a necessity, most SEA militaries are army-centric with assigned internal security responsibilities. Consequently, few nations are militarily self-sufficient. USPACOM has focused its engagement on advancing the self-

sufficiency of these partner militaries. Programs such as International Military Education and Training (IMET) are vital to enhancing the education level of military leaders and promoting a network of military-to-military relations that contribute to broader security cooperation in SEA.

Philippines. Underpinned by the 1951 Mutual Defense Treaty, the U.S.-Philippines alliance is an important strategic asset in SEA. Adjoining the SCS, this archipelagic nation straddles several strategic sea lines of communication (SLOCs) and chokepoints, claims a number of disputed islands and features in the SCS, and contends with several internal insurgent movements and VEOs, such as JI and ASG. Possessing an army-centric military as a result of its internal security challenges, the Philippines has recently begun to focus on improving the ability of its navy and air forces to secure the vast maritime area defined by the Philippine archipelago. As a consequence, USPACOM security assistance is focused primarily on supporting the Armed Forces of the Philippines (AFP) in CT efforts in southern Mindanao and the Sulu archipelago, and advancing AFP naval and air capabilities. Improving maritime domain awareness is another primary focus of U.S. security assistance, and we hope to provide a second Hamilton-class Coast Guard cutter to the Philippines this year.

For the last eight years, Joint Special Operations Task Force-Philippines has operated in a strictly non-combat role in support of the AFP in its largely successful efforts to contain ASG and JI VEOs. Additionally, USPACOM engages with the Philippines through the Joint Staff-sponsored exercise BALIKATAN, as well as annual military-to-military consultations, periodic PACIFIC PARTNERSHIP missions, and numerous service component-led exercises.

We welcome recent U.S. – Philippine discussions regarding opportunities to increase joint training with our AFP counterparts, possibly supported by enhanced rotational access to AFP facilities by USPACOM forces.

Thailand. I would begin by offering my personal condolences to the Thai people for the losses they suffered in 2011 during the most devastating flood their country has experienced in 50 years. Their response to this disaster, particularly with regard to containment of potential infectious diseases, was a testament to Thailand's resilience and self sufficiency.

Thailand is an enduring U.S. ally in SEA and a valuable security partner. They are co-host (with USPACOM) to the largest multilateral exercise series in SEA, COBRA GOLD, and provide robust access and logistics support for transiting USPACOM aircraft and ships. The U.S. and Thailand have twice partnered to combat piracy off the Horn of Africa, deploying Thai naval vessels with U.S. Navy personnel onboard to Combined Task Force-151. Notably, Thailand will take command of the task force in the coming year. Additionally, the Royal Thai Army assisted UN humanitarian relief operations in Darfur with a battalion of peacekeepers.

Despite facing challenges such as land and maritime border disputes with neighboring Cambodia, refugee incursions from Burma, a longstanding ethnic insurgency in the south, and transnational challenges such as narcotics and human trafficking, the Thai armed forces are capable and generally self-sufficient.

Singapore. Our bilateral relationship with Singapore continues to strengthen and broaden. Singapore armed forces comprise a small, but extremely capable military. Their main focus continues to be security within the Strait of Malacca and Singapore

Strait and cooperative security patrols within the Straits against piracy and other illicit activities. Singapore's armed forces are also deployed to Afghanistan, working alongside coalition partners to develop the Afghan National Security Forces. Within the context of the 2005 Strategic Framework Agreement, both militaries are seeking to increase engagement across all USPACOM service components. Singapore's offer to host U.S. Littoral Combat Ships (LCS) at Changi naval station will enhance USPACOM's SEA posture.

Indonesia. As the relationship between the U.S. and Indonesia—the world's fourth most populous nation, third largest democracy, and largest Muslim-majority country—continues to advance, the USPACOM –Indonesia relationship is progressing, as well. Following a decade of political, economic, and military reform, Indonesia has surfaced as a vibrant democracy, an emerging economy, and a competent military power. In areas such as disaster risk reduction, CT, Humanitarian Assistance/Disaster Relief (HA/DR), and peacekeeping operations, Indonesia is increasingly recognized for its leadership role. Indonesia and the U.S. were recently designated co-chairs of the Experts Working Group on Counter Terrorism for the ASEAN Defense Ministers Meeting - Plus. This initiative seeks to encourage greater regional CT cooperation, build capacity, and collectively address regional security issues in an open consultative forum.

Following a 12-year hiatus, USPACOM has reestablished security cooperation activities with the Indonesian KOPASSUS army special forces. The measured pace with which this engagement has advanced has included key leader dialogue and small-scale subject matter expert exchanges in areas such as military decision making,

medical planning and law of war / human rights. More activities of this type are planned for 2012 and will gradually expand at a pace commensurate with the demonstrated progress in Indonesian Armed Force transparency and institutional reform.

Vietnam. Military relations with Vietnam continue to grow in areas such as disaster management, search and rescue, conflict resolution, personnel recovery and medical operations. Vietnam is modernizing its military and looks to the U.S. as a partner in maintaining security and stability in SEA, particularly in the SCS. Vietnam's successful chairmanship of ASEAN in 2010 affirmed its emerging role as a leader and spokesman among SEA nations, as has been evidenced by their current role in lower Mekong River delta HA/DR initiatives. Vietnam and China have a long history of competition in the SCS. Both nations' disputes over islands and features, as well as natural resources, have led to confrontations in the past. Vietnam's continued leadership among SEA nations will be a critical component of eventual conflict resolution in this highly important and strategic area. USPACOM will continue to work closely with Vietnam to advance our military relationship and cooperation while remaining mindful of human rights concerns.

Malaysia. Malaysia's vibrant economy, advanced military, strategic position near Malacca and the Singapore Straits and regional leadership combine to define it as an important partner for the U.S. and USPACOM. Malaysia contributes to Strait of Malacca patrols, maritime security in the SCS, and efforts to contain transnational threats, such as piracy, and ASG/JI VEOs. Its direct action against pirates in the Gulf of Aden was evidence of increased confidence and capability. In 2011, Malaysia conducted its second deployment of medical support units to Afghanistan and remains committed to

supporting coalition efforts there until 2014. U.S. naval vessels frequently call in Malaysian ports, and military-to-military exchanges and joint training have expanded over recent years.

Cambodia, Laos, Brunei and Timor-Leste. The U.S. has extensive interests across the rest of SEA, and USPACOM seeks to continue advancing military relations with Cambodia, Laos, Brunei, and Timor-Leste. Cambodia has been a strong supporter of U.S. military engagement in recent years and demonstrates a strong desire to increase military-to-military activities with USPACOM. Military engagements with Brunei, Laos and Timor-Leste have expanded, albeit modestly, over the past year with particular emphasis on relationship-building and enhanced regional cooperation.

Burma. To the extent that any military-to-military relationship exists with Burma, it is extremely limited due to U.S. policies and sanctions directed at the former junta and its actions. The Burmese government's recent steps towards credible political and economic reform combined with their efforts to seek ceasefire agreements with armed ethnic groups have improved U.S.-Burma ties. These improvements have resulted in several initiatives announced during Secretary Clinton's December trip to Burma. Prisoner of War (POW)/Missing in Action (MIA) recovery operations are the first opportunity for military-related engagement with Burma since 2004. It is estimated that the WWII remains of over 700 Americans may be present there. Burma's assimilation into the broader Asia-Pacific regional security order would be a positive event.

South Asia

South Asia is of major strategic importance to the U.S. Anchored by India and containing major SLOCs for the transport of energy and other commerce to Asia and

the Americas from the Middle East and Europe, South Asia security partnerships are increasingly vital to USPACOM's mission.

South Asia is home to a confluence of challenges, including nuclear armed rivals India and Pakistan, numerous transnational VEOs such as Lashkar-e-Tayyiba (LeT), piracy, trafficking in narcotics and persons, disputed borders, and insurgent movements that have affected India, Nepal, and Sri Lanka. South Asia is particularly prone to natural disasters, including cyclones, tsunamis, and earthquakes. Bangladesh has long suffered from annual cyclones and flooding. USPACOM engages throughout South Asia, assisting its militaries to counter and contain VEOs such as LeT, cooperating in maritime security activities such as counter piracy, conducting disaster response planning and training, and exercising extensively, service to service.

India. Pursuing a long-term U.S.-India strategic partnership through a close alignment of respective regional security interests is a priority for the U.S. Department of Defense and USPACOM. Our security relationship involves strategic to tactical-level dialogues, increasingly robust military exercises, security assistance, and personnel exchanges. The United States and India have made steady progress in military-to-military cooperation over the past decade.

It is important that the leadership and staffs of USPACOM and United States Central Command continue to coordinate our respective military activities in this sub-region, especially as they concern India and Pakistan.

Bangladesh. Bangladesh has emerged as a particularly effective partner in the fight against terror, cooperating with India as well as the U.S. to counter VEO activity by actors such as LeT. Further, Bangladesh's military is advancing its capabilities and

contributes broadly to UN peacekeeping operations. Also, the Bangladesh army is primarily responsible for and has achieved major advancements in the protection of its citizens during the annual cyclone season and the resultant flooding.

Maldives, Nepal, Sri Lanka. Although South Asian nations share similar concerns and challenges, these three nations are uniquely individual.

Due to proximity to major commercial sea lanes, the Maldives is concerned with piracy and other illicit activity in its Exclusive Economic Zone (EEZ). For that reason, it is striving to advance its maritime security capabilities by reshaping its coast guard, marine and special operations forces. Additionally, curbing recruitment of its youth into VEOs and reducing narcotics trafficking and addiction are a focus area for the Maldives.

Nepal has emerged from a lengthy Maoist insurgency in 2006 and is seeking to integrate some of the former insurgents into the Nepal Army. In partnership with USPACOM, the Government of Nepal and its Armed Forces have developed plans to respond to a potential earthquake on the scale of Haiti's in 2010.

Sri Lanka is also focused on developing its maritime security capabilities while preventing a resurgence of the Liberation Tigers of Tamil Elam. Sri Lanka's military forces continue to assist in de-mining and other recovery operations following their 25 years of civil conflict. USPACOM's engagement with Sri Lanka will continue to be limited until the Government of Sri Lanka demonstrates progress in addressing allegations concerning violations of international human rights during that conflict.

Each of these nations' militaries partner with USPACOM at varying levels, including leadership exchanges, exercise series, USPACOM Augmentation Team CT capacity-building activities, and security assistance.

Lashkar-e-Tayyiba (LeT). While several VEOs conduct facilitation, recruitment, and seek safe havens throughout South Asia, LeT presents a particularly acute problem. Responsible for many attacks in India, including the horrific attacks into Mumbai, LeT is affiliated with Al Qaida and other VEOs and contributes to terrorist operations in Afghanistan. Additionally, it aspires to operate against Asian, European and North American countries. USPACOM's FY11 Indian Engagement Initiative that resourced and hosted Mumbai CT specialists for training, exercises, and exchanges throughout the U.S., together with capacity-building activities with South Asian partners, are mainly focused on containing LeT and contributing to CT self-sufficiency of the sub-region's militaries.

Oceania

The U.S. alliance with Australia anchors USPACOM's strategy in Oceania. Australia, with additional contributions from New Zealand, invests extensively in security and assistance efforts in this sub-region. The Australian continent notwithstanding, most of Oceania is comprised of Pacific Island nations spread across the vast expanse of the South Pacific Ocean. Security challenges associated with natural resources in this sub-region tend to predominate in the security dialogue. In particular, illegal fishing, resource damage attributed to climate change and global warming, and the susceptibility of low-lying island nations to typhoons and tsunamis define USPACOM and U.S. Coast Guard approaches to engagement in Oceania. Frequently, these efforts are synchronized with Australian and New Zealand actions.

Two new Shiprider Agreements with the Pacific Island nations of Nauru and Tuvalu together with those already in place with the Marshall Islands, Micronesia,

Palau, Tonga, Cook Islands, and Kiribati enable U.S. ships to assist in building maritime capacity in our partner nations through shiprider operations and combating illegal activities in coastal waters.

Oceania is also home to the Compact of Free Association nations of the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands, each of which USPACOM is obligated to defend under our respective Compacts. These agreements also give the US the right to foreclose their territory to all armed forces except those of the United States (and other countries we have invited). The Compacts with these three nations provide USPACOM a strategic buffer along the southern flank of the strategic U.S. territory of Guam. In addition to working with the Department of State, which is responsible for diplomatic relations with the three Compact nations, USPACOM is increasing its collaboration with the Department of the Interior which administers inter-agency assistance funds to the Compact nations (as well as federal policy in the three U.S. territories in Oceania -- American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands). In the near future, we expect a liaison officer from Interior to join the USPACOM staff.

Australia. The U.S.-Australia alliance, our most significant partnership in Oceania, benefits from two new force posture initiatives, the rotational deployment of a Marine Air Ground Task Force (MAGTF) to Darwin and enhanced access to airfields in northern Australia. These initiatives will enable deeper interoperability of our respective forces, expand training opportunities with other countries in the region, and improve access to SEA and Oceania. Australia is also the largest non-NATO contributor of forces to the coalition efforts in Afghanistan.

A trilateral relationship among Australia, Japan, and the U.S. continues to advance and has the potential to enable multilateral approaches to the region's challenges. Bilaterally, the U.S. and Australian militaries collaborate extensively in areas such as information sharing; ISR; HA/DR; combined arms training in exercise TALISMAN SABER; and space and cyber security.

New Zealand. New Zealand is also a recognized leader in Oceania. It is a strong partner of the U.S., and in accordance with the forward-looking spirit of the 2010 Wellington Declaration, USPACOM will continue to look for ways to further strengthen the relationship despite differences over nuclear policy. The U.S. and New Zealand share many security concerns and are cooperative partners in areas such as intelligence sharing, HA/DR and maritime security. In the interest of advancing the partnership, New Zealand is participating fully in the Rim of the Pacific (RIMPAC) exercise for the first time in 2012.

We value New Zealand's contributions to Afghanistan. New Zealand also supports stabilization efforts in Timor-Leste and the Solomon Islands, Armistice enforcement in Korea, and UN peacekeeping efforts globally.

Exercise and Engagement Programs

Exercises. In order to maintain ready forces and to plan, train, and exercise to accomplish the full range of military contingencies, USPACOM requires annual Congressional support for the Combatant Command Exercise and Engagement (CE2) program. USPACOM's portion of this essential program consists of 18 major exercises involving joint military forces, interagency activities, and 27 of 36 USPACOM partner nations. CE2 directly impacts USPACOM's ability to conduct Joint training exercises

and theater security engagement events across the Asia Pacific, and therefore plays a vital role in contributing to security of the AOR.

Engagement Programs. Two very significant engagement programs are PACIFIC PARTNERSHIP and PACIFIC ANGEL. In 2011, the USS CLEVELAND, with personnel from 11 nations, conducted a 4-month deployment to Tonga, Vanuatu, Papua New Guinea, Timor Leste, and Federated States of Micronesia. Combining medical, dental, and engineering support, the mission treated over 38,000 patients, conducted scores of community relations projects, and completed much needed engineering and infrastructure repairs. Likewise, PACIFIC ANGEL '11, utilizing C-17 aircraft, cared for thousands of patients and completed numerous civic action projects in Mongolia, Cambodia, Timor Leste, and Indonesia.

Both of these engagement programs serve to improve regional partnerships, while enhancing the resiliency of object nations to deal more effectively with their own humanitarian crises due to natural disasters or other causes. Moreover, the experience that our service components gain by working alongside non-governmental organizations and other participating militaries in these controlled conditions improves their abilities to conduct disaster response when time is of the essence and lives are on the line. USPACOM considers PACIFIC PARTNERSHIP and PACIFIC ANGEL to be high payoff engagements in the Asia Pacific region.

Global Security Contingency Fund (GSCF)

The GSCF is a new tool available for USPACOM and country teams to develop and deliver security sector assistance in a coordinated fashion, enhancing the capabilities of military forces, other security forces, and relevant government agencies.

The fund also supports the justice sector (including law enforcement and prisons), rule of law programs, and stabilization efforts.

USPACOM Organizations

The following direct-reporting units (DRUs) uniquely contribute to the USPACOM mission:

Asia-Pacific Center for Security Studies (APCSS). APCSS fills a unique role in multi-national security cooperation and capacity-building efforts by equipping and empowering APCSS fellows and alumni to make substantive changes to their countries' security architectures. APCSS brings together communities of interest and influence, comprised of presidents, vice-presidents, ministers of defense and foreign affairs, chiefs of defense, and ambassadors, to enable collaborative solutions to critical regional security challenges. Because the Center engages regularly and often concurrently with Chinese on both sides of the Taiwan Strait, as well as Hong Kong, it is uniquely positioned to assist in moving the U.S.-China military-to-military relationship towards a "sustained and reliable" level of contact.

Joint Intelligence Operations Center (JIOC). The USPACOM and the USFK - CFC JIOCs deliver strategically-focused, operationally-relevant and predictive intelligence products to support Commander USPACOM and our subordinate commands. The JIOCs operate within a larger USPACOM intelligence federation that capitalizes on national intelligence, surveillance, and reconnaissance capabilities as well as two-way information sharing activities with Allies and Partners. The JIOCs serve as a focal point of intelligence collaboration in close coordination with USPACOM Component Commands; National, Defense and Service Agencies; other Combatant

Commands; Sub-unified Commands; and Allies and Partners. This federated approach to intelligence provides for invaluable theater situational awareness and advanced threat warning to enable decision-making.

Joint Interagency Task Force West (JIATF West). Through the execution of USPACOM's counternarcotics program, JIATF West has significantly affected illicit methamphetamine precursor chemical trafficking. This trafficking originates in Asia and is ultimately bound for the Western Hemisphere. JIATF West does so by focusing its efforts on Asian, Eurasian, and other transnational criminal organizations in the USPACOM AOR. In FY11, JIATF West's support to U.S. and partner nation law enforcement agencies resulted in the seizure of over 1,000 metric tons of illicit chemicals used in meth production. The seizures were critical in interrupting distribution within the U.S. and contributed to the disruption of Asian and Mexican drug trafficking organizations.

Joint POW/MIA Accounting Command (JPAC). JPAC successfully accomplished 58 investigation and recovery operations globally last year and, based on resourcing and capacity is projected to execute 78 investigation and recovery operations in 2012. This projection originally included planned resumption of operations in the DPRK. Unfortunately, in protest to unrelated, routine defensive U.S.-ROK exercises, the DPRK recently refused to issue the Visas required to facilitate operations. The sudden refusal of visas, and North Korea's sudden willingness to renege on its commitment to a missile launch moratorium just weeks after announcing the moratorium, calls into serious question the North's ability to live up to any of its commitments. Because of this, the mission is currently suspended indefinitely.

JPAC accounting operations are ongoing in the People's Republic of China, while discussions between JPAC and the governments of India and the Philippines continue in an effort to resume investigation and recovery operations in those countries. JPAC is also preparing to resume discussions with the government of Burma to renew personnel accounting efforts there during FY 2013.

Center for Excellence in Disaster Management and Humanitarian Assistance (COE-DMHA). Based in the USPACOM AOR, the Center has demonstrated a unique capability to enhance civil-military coordination in disaster management and humanitarian assistance through education, training, and applied research. The Center's Defense Department responsibilities and strengths lie in partnering with governmental, non-governmental and international organizations such as the US Agency for International Development (USAID), the International Committee of the Red Cross (ICRC), and the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) to assist in the development of domestic and foreign capacities for disaster management and humanitarian assistance.

Conclusion

As characterized by the President, the U.S. "face[s] an inflection point." Our nation's evolving geopolitical climate and shifting fiscal environment are significant factors in this change. The future of the United States will continue to be tied to the Asia Pacific.

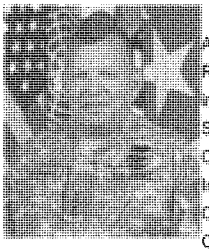
The preceding testimony highlights the importance of optimizing U.S. posture in this region and underscores the specific challenges USPACOM faces, as well as the significant opportunities the region presents. As I return to the Asia Pacific as

USPACOM Commander, I have never been more convinced of its remarkable nature, significant partnership capacity, and criticality to U.S. security.

In closing, your assistance has enabled the more than 300,000 members of USPACOM to accomplish their mission. Further, your personal interest in, and visits to the Asia Pacific have sent a strong signal to this region regarding U.S. national interests and staying power. On behalf of every USPACOM member, thank you for your enduring support for our armed forces and for this unique and important part of the world.

Commander UNC/CFC/USFK

General James D. Thurman



A native of Marietta, Oklahoma, General Thurman earned his commission through ROTC at East Central Oklahoma University in 1975. His first three commands were in Germany where he led a troop in the 11th Armored Cavalry Regiment, the 2nd Squadron, 2nd Armored Cavalry Regiment; followed by the 3rd Squadron, 4th Cavalry Regiment, 3rd Infantry Division. He then commanded 2nd Brigade, 3rd Infantry Division at Fort Stewart, Georgia. His next assignment was as the Commander, Operations Group at the National Training Center and later as the Commanding General. He then commanded 4th Infantry Division at Fort Hood, Texas and Baghdad, Iraq. He also commanded V Corps in Germany. He most recently served as Commander, United States Army Forces Command.

General Thurman has significant Army and Joint staff experience, including Assistant to the Chief of Staff for Plans and Policy(J5), Allied Forces Southern Europe, Regional Command South in Italy; Director of Training, Office of the Deputy Chief of Staff, G-3, Headquarters, Department of the Army; Chief, Operations, Coalition Forces Land Component Command, C3, in Kuwait; Director, Army Aviation Task Force, Office of the Deputy Chief of Staff, G-3, Headquarters, Department of the Army; and Deputy Chief of Staff, G3/5/7, Headquarters, Department of the Army.

He has extensive operational combat experience. His combat assignments were as a battalion executive officer in the 1st Cavalry Division during Desert Shield/Storm from 1990-91; the Chief of the Plans and Policy Division for Allied Forces Southern Europe in Kosovo from 1999-2000; the Chief of Operations, C3, for the Coalition Forces Land Component Command during the invasion of Iraq from 2002-03; and the Multi-National Division Commander responsible for all coalition operations in Baghdad in 2006.

General Thurman holds a Bachelor of Arts degree in History from East Central Oklahoma University and a Master of Arts in Management from Webster University. He has attended numerous military schools and is a graduate of the Command and General Staff College and the Army War College.

His military awards and decorations include the Distinguished Service Medal (two oak leaf clusters), the Defense Superior Service Medal (one oak leaf cluster), the Legion of Merit (three oak leaf clusters), the Bronze Star Medal (one oak leaf cluster), the Meritorious Service Medal (five oak leaf clusters), the Army Commendation Medal and the Army Achievement medal (three oak leaf clusters). General Thurman is a Senior Aviator and has earned the Combat Action Badge, the Parachutist Badge, the Army Staff Identification Badge and the Joint Chiefs of Staff Identification Badge.

General Thurman assumed command of United Nations Command, Republic of Korea – United States Combined Forces Command, and United States Forces Korea on July 14, 2011.

STATEMENT OF
GENERAL JAMES D. THURMAN
COMMANDER, UNITED NATIONS COMMAND;
COMMANDER, UNITED STATES-REPUBLIC OF KOREA COMBINED FORCES COMMAND;
AND COMMANDER, UNITED STATES FORCES KOREA
BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE
28 MARCH 2012

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I. INTRODUCTION

Mr. Chairman and distinguished members of the Committee, it is an honor to provide this statement to you. As the Commander of United Nations Command, United States (U.S.) – Republic of Korea Combined Forces Command (CFC), and United States Forces Korea (USFK), it is a privilege to represent the Soldiers, Sailors, Airmen, Marines, Department of Defense Civilians, and their Families, who serve our great nation in the Republic of Korea (ROK). On behalf of these outstanding men and women, I want to thank the Committee for the support it has provided to American forces stationed in the ROK.

The Korean Peninsula is at the nexus of U.S. interests in Northeast Asia. Northeast Asia is host to four of the world's six largest militaries, a quarter of the world's population, and the fastest growing segment of the global economy. U.S. trade with the region exceeds $750 billion annually, and U.S. direct investment amounts to over $270 billion. As China rises in importance in diplomatic, informational, military, and economic spheres, it maintains an ambiguous relationship with an isolated North Korean regime in pursuit of a robust nuclear program. Our allies in the region look to the U.S. as the key partner to maintain regional stability and prosperity while upholding international norms and a commitment to democratic values.

Significant leadership change is underway in Northeast Asia this year. This change includes the transition of power to Kim Jong-un in North Korea, recently completed elections in Taiwan, Russia, Japan, and upcoming elections in the ROK as well as expected leadership changes in the People's Republic of China later this year. The uncertainty associated with these changes, compounded by lingering historical animosities, territorial disputes, and competition over access to resources, places us in a dangerously uncertain period as we maintain the 1953

Armistice and remain prepared to defend the ROK, as well as the United States, from North Korean aggression.

The defense of South Korea is enabled by a strong U.S.-ROK Alliance. Born on Korean War battlefields 60 years ago, the Alliance is as solid as ever, serving as the foundation for today's combined military readiness. Combined readiness requires mutual trust, transparency, and close working and training relationships at every level of our military organizations. My former deputy at CFC is now the Chairman of the ROK Joint Chiefs of Staff. My new deputy commander was the former J3 Operations Officer for the ROK Joint Chiefs of Staff. These two men are among the most capable military leaders I have had the honor to serve with. Together, we are guiding U.S. and ROK military leaders and units to work and train closely with one another on a daily basis, and that effort builds combined strength, faith and trust – qualities that are essential for us to successfully accomplish our mission in Korea.

This Alliance commitment to security has been rewarded by sustained economic growth and the opportunity to enhance capabilities for the combined defense of the Korean Peninsula as the ROK increases its regional and international role. Examples of the increased role of the ROK – part of President Lee Myung-bak's *Global Korea* vision – include hosting the 2010 G20 Summit, hosting the Nuclear Security Summit, and providing growing levels of foreign developmental assistance. At the same time, the ROK is challenged by a declining birth rate that puts pressure on its ability to sustain a manpower-intensive conscripted military. For both demographic and economic reasons, and in response to North Korean violent provocations in 2010, the ROK military is proposing fundamental military reforms. These reforms are being discussed within the ROK government and will likely be acted on in the coming year.

As the ROK wrestles with these challenges, and against a backdrop of political change and economic uncertainty, it is imperative we remain steady in our commitment to regional stability through vigilant maintenance of the Armistice and unquestioned military readiness. Our combined, joint team provides the trained, ready, and disciplined forces that are prepared to fight and win on the Korean Peninsula, providing a strong deterrent to North Korean aggression.

II. NORTH KOREA

I believe we are in a very uncertain period on the Korean Peninsula with the possibility of unexpected events leading to miscalculation. North Korea remains the greatest threat to stability in Northeast Asia. Upon the death of Kim Jong-il in December 2011, power transferred to his youngest son, Kim Jong-un, who is believed to be 28 years old. North Korea is economically backward, unwilling to operate as part of the global community, and led by an unpredictable regime that controls a large conventional force and a lethal arsenal of asymmetric capabilities, including weapons of mass destruction.

LEADERSHIP TRANSITION

North Korea is currently undergoing its first leadership transition in 17 years and only the second leadership change in its history. We are watching this transition closely. Two to three years prior to Kim Jong-il's death, Kim Jong-un began a grooming process that included naming him to important posts, giving him the rank of general in the Korean People's Army (KPA), and transferring responsibility to him for management of the country. This transition was cut short by the sudden death of Kim Jong-il. However, prior to his death, the elder Kim had assigned senior members of the KPA and the Korean Workers' Party to Kim Jong-un's inner circle. This group, consisting mostly of regime elites in their 70s and 80s, represents earlier generations of leadership with firm commitments to the state's basic ideology and loyalty to the Kim family.

Having these key figures positioned within Kim Jong-un's inner circle strengthens the new ruler's hand and serves to ease his succession to the regime's top leadership role.

It also appears that the regime is making a concerted effort to capitalize on Kim Jong-un's remarkable resemblance to his late grandfather, Kim Il-sung, North Korea's revered ruler from the post-World War Two era until his death in 1994. State-controlled media images have shown Kim Jong-un with swept-back hair and dressed in Maoist suits very similar to those popularized by Kim Il-sung—a carefully stage-managed effort to help the relatively inexperienced Kim Jong-un garner the same adulation the populace had bestowed upon his grandfather.

To date, the leadership transition appears to be proceeding without discernible internal challenges and with significant Chinese political and economic support. With the Kim Jong-un regime focused on continuity and consolidation of power, there are no indications the regime will depart significantly from Kim Jong-il's policies. In particular, the leadership remains committed to continuing its "military first" policy, which places the country's military in the premier position for resources and maintains its status as the world's most militaristic state. North Korea continues to maintain robust conventional forces vastly disproportionate to its population and defensive security requirements. Even in the face of enormous economic hardship, the regime maintains the fourth largest army in the world. The KPA is over one million strong, with over 13,000 artillery systems, over 4,000 tanks, 2,000 armored personnel carriers, 1,700 aircraft, and 800 surface combatants. More than 70% of its combat power is arrayed within 90 miles of the Demilitarized Zone (DMZ).

North Korea continues improving its ability to attack the ROK's center of gravity, the capital city of Seoul, the world's 4th largest city with 24 million residents in the greater

metropolitan area accounting for roughly half the population of the country. This is a population larger than New York City living and working within artillery range of North Korea – including approximately 50,000 private U.S. citizens. North Korea threatens Seoul with a mix of conventional artillery, multiple rocket launchers, and ballistic missiles, a significant percentage of which are positioned in protected positions dispersed across the western half of the peninsula. These systems are capable of ranging Seoul without moving, and can deliver both high explosive and chemical munitions with little or no warning. If employed in a provocation, even a limited attack with these systems could cripple the ROK's economy and panic the populace. These same forces threaten outposts along the DMZ and the Northwest Islands. A North Korean attack on these targets, especially if civilian casualties occur, could lead to an escalating series of North Korean and ROK actions and reactions with the potential to lead to broader conflict. North Korea is quick to capitalize on this concern by frequently threatening to launch such attacks.

MILITARY CAPABILITIES

Since the collapse of the Soviet Union, North Korean forces have been in relative decline compared to ROK and U.S. forces in the south. The economic and demographic breakdown accompanying the severe famine of the 1990s, particularly the rapid decline in the number of healthy military-age males, has made it difficult to maintain the personnel and equipment readiness of the North's large ground forces. To compensate for this decline and continued improvements in alliance capabilities, North Korea is investing heavily in asymmetric capabilities such as cyber-attack, ballistic missiles, and special operations forces that actively train to infiltrate into the ROK to attack civilian and military targets.

North Korea continues to improve the capabilities of the world's largest special operations force, which includes 60,000 soldiers trained in a variety of infiltration methods such

as overland, undersea, and airborne entry into the ROK. Well trained, well resourced, and extremely loyal to the Kim regime, these forces could cause significant disruptions to ROK governance, utilities distribution, infrastructure operations, and mobilization. North Korea's willingness to employ these forces is well documented, with examples of their use dating as far back as the 1960s and as recently as 2011. Last year's attempted infiltration of an assassination team into the ROK highlights the nature of this threat and North Korea's willingness to use it.

The newest addition to the North Korean asymmetric arsenal is a growing cyber warfare capability. North Korea employs sophisticated computer hackers trained to launch cyber-infiltration and cyber-attacks against the ROK and U.S. Such attacks are ideal for North Korea, providing the regime a means to attack ROK and U.S. interests without attribution, and have been increasingly employed against a variety of targets including military, governmental, educational, and commercial institutions.

North Korea's chemical and biological weapons program is a cause for significant concern. We assess North Korea maintains the capability to manufacture, transport, and deliver a variety of both persistent and non-persistent chemicals, to include nerve, blood, choking, and blister agents. Delivery systems include virtually all North Korean artillery and missile systems. If North Korea employs biological weapons, it could use highly pathogenic agents such as anthrax or plague. In the densely populated urban terrain of the ROK, this represents a tremendous psychological weapon.

NUCLEAR PROGRAM

North Korea continues to expend significant resources in its pursuit of a robust nuclear strike capability despite opposition from the international community. The regime believes nuclear weapons would provide legitimacy, power, and prestige, and we assess the regime will

strongly resist efforts to curtail its nuclear weapons and associated delivery platforms. Coupled with a reliable delivery platform, nuclear weapons would enable the Kim regime to hold South Korean, Japanese, and US interests at risk. In addition, such a capability likely would embolden the regime to act more aggressively with its conventional and asymmetric capabilities. Emboldened by its nuclear program, North Korea has already demonstrated its willingness to conduct lethal provocations using conventional capabilities, such as the 2010 sinking of the ROK naval ship Cheonan that resulted in the deaths of 46 ROK Navy sailors, as well as the shelling of Yeongpyong Island (Y-P Do) that killed two ROK Marines and two ROK civilians in November 2010.

North Korea continues to invest heavily in enhancing its already-robust ballistic missile forces, which represent a growing threat and provide a potential delivery capability for nuclear weapons. North Korea's missiles can strike the ROK and Japan, making the deployment of reinforcements and supplies for U.S. forces difficult in the event of hostilities. North Korea remains focused on enhancing these capabilities, as demonstrated by the 2009 launch of a multi-stage rocket and continuing research and development of systems with increased range and lethality.

For the foreseeable future, we expect North Korea to remain an isolated and dangerous nation, with a large conventional force and significant asymmetric capabilities. North Korea threatens the stability and security of the region and U.S. interests in other parts of the world. Although North Korea is currently focused on efforts to engage the ROK and the U.S., history tells us Pyongyang will shift from diplomatic to provocative behavior when conventional diplomacy has run its course and the North Korean leadership perceives coercive diplomacy offers a better chance to realize its objectives. Currently, the greatest threat remains instability in

North Korea or a provocation that culminates in a broader conflict which could, at its extreme, result in the use of weapons of mass destruction.

III. MY PRIORITIES

The Command mission is to deter external aggression against the ROK and U.S.-ROK Alliance and to promote stability on the Korean Peninsula and in Northeast Asia. If deterrence fails, we will decisively defeat external aggression and restore stability on terms favorable to the Alliance. The Command vision is to maintain trained and ready U.S. joint and Alliance combined forces, strengthen the U.S.-ROK Alliance, and provide an operational focus in order to maintain the Armistice in Korea and support the transition to a ROK-led combined defense on the Korean Peninsula in accordance with the Strategic Alliance 2015 plan.

READINESS

Readiness is a key factor in deterring aggression by North Korea and defending the ROK. Trained, ready, and disciplined U.S. joint and Alliance combined commands must be prepared to fight and win, if required to do so. U.S. and ROK forces must be prepared to counter provocations, defeat a North Korean attack on Seoul and the ROK, conduct humanitarian assistance operations, and do so under threat of weapons of mass destruction.

Combined Forces Command and USFK have developed and continue to refine contingency plans that guide the conduct of tough, realistic, combined, and interagency exercises and training. The CFC and ROK military conduct several major exercises every year. The CFC has also added considerable training into its exercise scenarios to improve our ability to defend against North Korean weapons of mass destruction. The CFC and ROK also train to counter North Korean provocations.

Three annual joint and combined exercises warrant special mention: ULCHI FREEDOM GUARDIAN, KEY RESOLVE, and FOAL EAGLE. ULCHI FREEDOM GUARDIAN and KEY RESOLVE are computer-simulated, theater command post exercises conducted by CFC that focus on ensuring readiness for response to provocations, attacks, and instability on the Korean Peninsula. As we approach 2015 and the transition to ROK-led defense of South Korea, these exercises will train the new command and control structure. FOAL EAGLE consists of a series of joint and combined unit tactical level field training events that exercise ground maneuver, air, naval, expeditionary, and special operations capabilities. These events are conducted throughout the Korean Peninsula by off-peninsula units deploying to Korea in order to train with ROK forces.

Force readiness has been strengthened through a significant upgrade to land combat vehicles. New M1A2 Abrams Main Battle Tanks and M2A3 Bradley Infantry Fighting Vehicles now equip the U.S. 2nd Infantry Division and replaced older systems. While this equipment rotation did not increase the number of U.S. combat vehicles on the Korean Peninsula, it did significantly upgrade the combat capability of systems used by the Division. The new vehicles are fitted with improved tracking and fire control systems as well as enhanced armor protection.

The ROK military's posture and capabilities are another key component of readiness that supports the Command's deter and defend mission. Numbering over 600,000 active duty personnel and a large reserve force, it is a modern, capable force that fields an array of advanced weapon systems. The ROK military is led by a professional officer corps and has gained valuable operational experience through deployments to Iraq, Afghanistan, the Gulf of Aden, Lebanon, and participation in a host of United Nations peacekeeping and humanitarian assistance operations. ROK leaders understand the requirements for military readiness. The ROK military

also conducts a realistic and tough exercise program that includes the annual TAEGEUK, HWARANG, and HOGUK exercises.

STRENGTHENING THE U.S.-ROK ALLIANCE

A strong U.S.-ROK Alliance is essential for maintaining combined readiness and warfighting capabilities. As stated in the January 2012 Department of Defense Strategic Guidance document, American relationships with Asian allies and key partners are critical to the future stability and growth of the region. A strong U.S.-ROK Alliance helps ensure a peaceful, secure, and prosperous future for the Korean Peninsula and stability in the Asia-Pacific region. Creating and maintaining a strong Alliance comes from building teamwork, mutual trust and confidence. A key element for building teamwork in the Alliance and shaping its future development is the Strategic Alliance 2015 plan.

At the U.S.-ROK Foreign and Defense Minister's Meeting in July 2010, agreement was reached to transition to a ROK-led Alliance defense of the Korean Peninsula. Called Strategic Alliance 2015, the plan synchronizes multiple U.S. and ROK transformation efforts that are designed to build adaptive and flexible capabilities to deter aggression against the ROK and to defeat aggression should it occur. Key elements of the plan include: refining and improving combined defense plans; defining and developing the new organizational structures required for ROK lead during war time; conducting realistic exercises based on the North Korean threat; transition to ROK-led alliance defense on the Korean Peninsula under the ROK Joint Chiefs of Staff in December 2015; and repositioning and consolidating U.S. military forces in the ROK under the Land Partnership Plan and Yongsan Relocation Plan.

As agreed to in Strategic Alliance 2015, the Commander of CFC will transfer wartime operational control to the ROK Joint Chiefs of Staff and the CFC will be disestablished in

December 2015. The U.S. and ROK will activate complementary commands where the U.S. is in a supporting role to the ROK military. During the transformation process, the U.S. will provide bridging capabilities until they can be replaced by the ROK as it transforms its military from a large, ground-centric conscripted force to a leaner and more advanced and professional force with enhanced capability for operations in Korea and globally. U.S. bridging capabilities are vital to enabling the success of this transformation as the ROK accommodates a declining birthrate that puts pressure on sustaining a manpower-intensive conscripted military. The U.S. will also provide enduring capabilities to the Alliance for key mission areas that include extended deterrence, intelligence/surveillance/reconnaissance, precision strike, space operations, and combating weapons of mass destruction.

Existing Alliance structures that ensure unity of effort and planning should be maintained and strengthened as we transition to a ROK-led Alliance defense. Key among these structures is the Military Committee Meeting and Security Consultative Meeting processes that inform and provide guidance to U.S. and ROK warfighting commanders.[1] Similarly, we need to sustain existing Alliance maintenance structures, including the Korea Integrated Defense Dialogue (KIDD) and ROK-U.S. Status of Forces Agreement Joint Committee and associated subcommittees. These Alliance structures provide a whole-of-government approach to addressing Alliance issues.

The ROK continues to provide financial and in-kind support to help offset the cost of stationing U.S. military forces on its territory.[2] Known as burden sharing contributions, the

[1] Formal members of the Military Committee include the U.S. Chairman of the Joint Chiefs of Staff, ROK Chairman of the Joint Chiefs of Staff, U.S. Pacific Command Commander, ROK Joint Chiefs of Staff J5, and the Combined Forces Command Commander. Participation in the Security Consultative Meeting includes the U.S. Secretary of Defense and the ROK Minister of National Defense.

[2] USFK manages the receipt and expenditure of burden sharing contributions according to provisions established in 10 U.S.C. 2350(g), 10 U.S.C. 2350(j), the Special Measures Agreement, and the Special Measures Agreement Implementation Arrangement.

annual value of these contributions is dictated by terms established in a five-year (2009-2013) Special Measures Agreement (SMA) currently in effect. During calendar year 2012 the ROK will provide USFK with 836 billion won ($765 million) of support under the SMA. This support will be distributed between three categories: labor ($307 million; pays salaries and benefits of USFK's Korean national employees); logistics ($119 million; covers supplies and services); and ROK Funded Construction ($339 million; used for USFK's military building design and requirements). Contributions help to ensure the Command maintains readiness to deter North Korean aggression. These contributions also build and maintain the infrastructure needed for the long-term U.S. military force presence in the ROK. Burden sharing expenditures also stimulate the ROK economy through the payment of wages to Korean national workers, Korean supply and service contracts, and Korean construction contracts, serving as a source of economic growth for communities that host USFK facilities.

OPERATIONAL FOCUS

Due to the change occurring in Northeast Asia, U.S. military forces located in the ROK must be adaptive, agile, well trained, and ready to satisfy multiple operational demands. USFK is transforming its posture on the Korean Peninsula to maintain a capability optimized and mission focused force. The transformation process is centered on enhancing readiness to successfully accomplish the mission. Our plan is designed to enhance force capability at best value and within cost constraints while simultaneously adhering to existing agreements with the ROK. Further, the plan maintains appropriate quality of life for service members, Department of Defense civilians, and their families stationed in the ROK. During my confirmation hearing last year, I was asked to report back to the Congress on two key Command initiatives: force repositioning and service member tour lengths in Korea.

Repositioning of U.S. Forces in the ROK

Congress expressly asked for my assessment of the two major USFK repositioning plans underway. These plans are the Land Partnership Plan (LPP) and the Yongsan Relocation Plan (YRP) which are designed to provide improved readiness at best value to the Alliance. The relocation decision by both the U.S. and ROK governments was prompted by several factors, the foremost of which was better posturing U.S. forces on peninsula. This re-posturing will help accomplish our warfighting mission by improving facilities and consolidating U.S. forces that were previously spread across camps and bases occupied since the Korean War. The plans strengthen mutual trust within the U.S.-ROK Alliance by signaling enduring American commitment. U.S. consolidation of bases contributes to enhanced force protection, survivability, and lower cost for overall force maintenance in Korea as USFK transitions from camps and bases in 107 locations to ultimately less than 50. Upon completion of YRP and LPP, the annual cost for sustainment of U.S. forces in Korea will be reduced from our Fiscal Year 2011 baseline costs. Lastly, and important to our ROK allies, these initiatives will return scarce land, particularly in the city of Seoul, back to the Korean people.

The Land Partnership Plan consolidates most U.S. forces currently in locations north of Seoul to areas south of the capital city and expands infrastructure at Osan Air Base and Camp Mujuk on the East Coast. U.S. Army forces will be concentrated at U.S. Army Garrison (USAG) Humphreys and garrisons in Daegu. Costs associated with the LPP are being shared between the U.S. and ROK.

The Yongsan Relocation Plan will move most forces currently stationed in and around Seoul and Headquarters United Nations Command activities to USAG Humphreys (about 40 miles south of Seoul). Under the YRP, a forward Command element remains in Seoul to

maintain necessary and habitual relationships with the ROK government, U.S. Embassy, and other key organizations and leaders in the capital area. The composition of this command element is under study. This relocation plan was initiated by request of the ROK Government and, as such, the majority of costs associated with this relocation plan are being paid by the ROK My intent is to posture U.S. forces in a way that ensures the optimal defense of the ROK. I continue to assess the LPP and YRP programs and will carefully coordinate any changes with all stakeholders.

Tour Lengths in Korea

At my confirmation hearing, I was asked to report on my assessment of Tour Normalization in Korea. The Department is not able to afford Tour Normalization at this time and I am content to remain at the currently authorized 4,645 Command Sponsored Families. I am convinced, however, that a change in personnel policies will improve the readiness of USFK by reducing turbulence. We are working with the Department of Defense to examine how individual tour length extensions and unit rotations could help address this readiness issue.

IV. UNITED NATIONS COMMAND

This year marks the 59th year of a continuing cease fire under the Armistice Agreement in Korea. United Nations Command's (UNC) Armistice enforcement responsibilities, authorities, and ties to 16 UNC Member Nations greatly enhance regional stability and security on the Korean Peninsula.

As commander of UNC, I have significant authorities and responsibilities to maintain the Armistice. I am responsible under the Armistice Agreement for determining all access to, and authorizing the activities within, the UNC controlled southern side of the demilitarized zone between the North and South Korea. One example of this is the direct review, authorization, and

supervision, by a multinational UNC team, of the hundreds of personnel and vehicles crossing the DMZ each day between the ROK North-South Transit Office and the Kaesong Industrial Complex in North Korea.

I also institute regulations and procedures as UNC commander that maintain separation of opposing forces to ensure Armistice compliance. Further, I establish uniform Armistice Rules of Engagement applicable to all forces on our side that define the use of force when required. These rules of engagement preserve the inherent right of self-defense while preventing escalation and ensure a rapid return to armistice conditions.

In addition to overseeing DMZ Guard Post inspections, as the UNC commander I also direct special investigations of all suspected Armistice violations, provide UNC observers for ROK live fire exercises on the Northwest Islands, and enforce Armistice compliance and adherence to international standards of conduct. To ensure international transparency and credibility I also invite Swiss, Swedish and Polish observers from the Neutral Nations Supervisory Commission to observe and report their findings on these same Armistice maintenance activities.

Another important role of the UNC Commander is to lead, maintain, and strengthen participation of the 16 Member Nations that make up the UNC. This multinational coalition, established under a United Nations Security Council mandate, continues to provide international legitimacy and transparency to the U.S.-led UNC activities that preserve stability in Korea. In addition, the UNC (Rear) Headquarters in Japan oversees seven UNC-flagged bases in Japan for the transit of UNC aircraft, vessels, equipment, and forces upon notification to the Japanese government. During 2011, Headquarters, UNC (Rear) played a key role in contingency

operations, including Operation TOMODACHI, the disaster relief operation that followed the March 2011 earthquake and ensuing tsunami disaster in Japan.

V. SUMMARY

The Korean Peninsula is a keystone in Northeast Asia, a dynamic region whose global influence is growing and where significant U.S. national interests lie. Uncertainties surrounding leadership changes throughout the region in 2012, and North Korea's nuclear and missile programs, accentuate the security challenges in this region. By maintaining ready U.S. military forces in the ROK, strengthening the U.S.-ROK Alliance, and improving operational focus, the UNC, CFC, and U.S. Forces Korea commands provide a stabilizing presence, promoting stability on the Korean Peninsula and in Northeast Asia as a whole. I am extremely proud of the Soldiers, Sailors, Airmen, Marines, Department of Defense Civilians, and their Families serving our great nation in the ROK. Your support for them and the U.S.-ROK Alliance is both critical and greatly appreciated. I look forward to continuing to work with the Congress to address the security issues we face on the Korean Peninsula. Thank you.

THURSDAY, SEPTEMBER 20, 2012.

JOINT IMPROVISED EXPLOSIVE DEVICE DEFEAT ORGANIZATION

WITNESS

LIEUTENANT GENERAL MICHAEL D. BARBERO, U.S. ARMY, DIRECTOR, JOINT IED DEFEAT ORGANIZATION, U.S. DEPARTMENT OF DEFENSE

OPENING STATEMENT OF MR. YOUNG

Mr. YOUNG. The Committee will be in order.

Thank you all for being present this morning.

The hearing today is about the status of the JIEDDO responsibilities and where we are going with it, with the organization, with the devices, with the training—anything related to JIEDDO. And we really are happy to welcome General Barbero, who is, I would say, a very, very distinguished military leader.

And as we looked over your biography, I would tell you, General, it is impressive. And I know this is your first visit with this subcommittee, and so your biography will be placed in our record for history.

Mr. YOUNG. We want recorded the fact that we had the chance to visit with you. So thank you very much for being here.

PROTECTING SOLDIERS

I would have to tell you that the reason I wanted to have this hearing—and I would say to my colleagues, too, because we haven't had much of a chance to discuss it—I have had a major commitment ever since Mr. Dicks and I have been working together on national security issues, and that is to do what whatever needs to be done to provide the proper training for our troops for whatever their mission might be and to be ready to perform that mission; and, also, to guarantee that they have whatever tools, whatever weapons, whatever technology that they need to carry out that mission; and third, and very important, was whatever was necessary to protect our soldiers as they go about their mission. And I am not really satisfied with where we are in protecting our soldiers.

GENERAL DEMPSEY'S STATEMENT

And I can tell you that I was very impressed, and I wanted to read this just briefly for the Members that might not have seen it, with—the Chairman of the Joint Chiefs of Staff made a very telling statement last week when he was in the region. And General Dempsey was quoted as saying, talking about the problem of our soldiers being attacked in Afghanistan, he said, "You can't whitewash it. We can't convince ourselves that we just have to work harder to get through it. Something has to change." I think that

it was a very courageous statement for someone in his position to make, and I certainly agree with that.

He also said, "We are all seized with the insider attack problem," meaning the Afghanis that we are training who are turning on us and murdering our soldiers. Dempsey said, again, you can't whitewash it. We can't convince ourselves that we just have to work harder to get through it. Something has to change.

So you are really responsible, sir, your organization, to help take care of part three of the commitment that I have had, that Mr. Dicks has had, that all the members of this subcommittee have had, and that is to protect our troops.

So I want to give Mr. Dicks a chance to make an opening statement here and then would like to hear whatever you want to tell us about your feelings on this and where we are going with JIEDDO and what we need to be doing to help you provide security for our soldiers, which is a priority to this chairman and to the members of this subcommittee.

Mr. Dicks.

REMARKS OF MR. DICKS

Mr. DICKS. Thank you, Mr. Chairman. I want to second your welcome to our witness, General Barbero, and thank him for the important work his office performs.

Our servicemembers who are deployed in Afghanistan and who were deployed in Iraq are no strangers to the improvised explosive device, also known as IEDs. This weapon of choice for insurgents and terrorist organizations creates havoc and draws much attention to the carnage it leaves behind.

Some reports indicate that undetected roadside bombs have caused over 75 percent of the casualties to coalition forces in Afghanistan. The effects of these casualties have been far-reaching, leaving our troops without limbs, with traumatic brain injuries and horrific memories of their combat experiences.

Last November, members of our subcommittee traveled to Afghanistan and learned that the ISAF forces are finding, detecting 60 to 70 percent of the IEDs that are deployed by the enemy. Advances in training, intelligence, and equipment championed by JIEDDO have diminished the effectiveness of this weapon.

HOMEMADE EXPLOSIVES

However, in recent years, commercially produced calcium ammonium nitrate fertilizer from Pakistan has become a primary component in the production of IEDs. Our efforts to find and track these materials have been like finding a needle in a haystack since 1 percent of the fertilizer produced makes its way to the insurgents. This development has allowed a continuing flow of IED materials into Afghanistan despite our efforts to the contrary. It is frustrating to know the source and yet not stop the flow of this deadly material.

We strongly support your efforts to defeat the enemy and stop as much as possible the use of IEDs. However, the threat is still on the roads and in the villages that our troops patrol every day. We

look forward to your testimony on your efforts and the challenges that still exist with the insurgents' weapon of choice.

Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Dicks, thank you very much.

Mr. YOUNG. General, we do have some interesting questions for you, but we would like to hear from you at this point. And you know our concerns, and I think you understand our commitment. No matter where we stand with General Dempsey or Chairman Young on the feelings about our relationship in Afghanistan, this Committee will commit, will always provide whatever is needed for our soldiers at whatever mission that they are on.

Now, we do not try to substitute our judgment for those of military commanders in the field. Sometimes we do have some strong opinions on the overall mission, which you know that I have discussed with you and others about my feeling, and we will get into that later.

But we would like to hear your statement now, sir, please.

SUMMARY STATEMENT OF GENERAL BARBERO

General BARBERO. Thank you, Chairman Young, Ranking Member Dicks, and distinguished members of the subcommittee. Thank you for the opportunity to update you this morning on the Department of Defense's efforts to counter the IED and to disrupt the global threat networks that employ them.

I have prepared a written statement which I like to submit for the record.

First, let me begin by commenting on the retirement of Congressman Dicks.

Congressman, thank you for your service and your support to our troopers and our military.

And to Congressman Lewis and Congressman Hinchey, thank you, as well. You have been great champions for our Armed Forces throughout your careers, and for that we are very grateful.

Up front, Mr. Chairman, I would like to say I share your concerns, and we try to live the commitment that you talked about. And hopefully I can answer your questions today.

But I would also like to thank you, Mr. Chairman, for your leadership, and the entire subcommittee for recognizing the importance of the counter-IED mission and resourcing it accordingly. The funding support you provide has enabled the Department of Defense to rapidly field critical counter-IED capabilities that our warfighters need to execute their mission.

We still need to do more. And let me say up front that I believe the IED and the networks that use these asymmetric weapons will remain a threat to our forces and here at home for decades. The IED is the weapon of choice for threat networks because they are cheap, readily available, largely off-the-shelf, easy to construct, lethal, and accurate.

PROGRESS IN DEFEATING IEDS

This trend is readily apparent in Afghanistan, as you highlighted, where IED events continue to rise. In the past 2 years, IED events have increased 42 percent, from 9,300 events in 2009

to 16,000 events in 2011. And this year we are on track for 2012 to meet or exceed the historic number of IED events we saw last year. As a matter of fact, this past June, June 2012, we had the highest number of monthly IED events we have recorded.

HOMEMADE EXPLOSIVES

Contributing to these numbers, as Ranking Member Dicks mentioned, are the fertilizer explosives, which remain a significant challenge in Afghanistan. Today, 87 percent of the IEDs employed against coalition forces are made with homemade explosives. And of those, 74 percent are made with ammonium nitrate derived from calcium ammonium nitrate, a common agricultural fertilizer that is ubiquitous in the area.

While the overall number of IED events is high, as you mentioned, our ability to find and neutralize them before detonation has improved steadily, helping to reduce U.S. casualties by more than 40 percent this past year.

Now, many factors have contributed to the decreased effectiveness of IEDs in Afghanistan, including: our attempts to apply the lessons learned in-theater to our predeployment training; fielding the increased number of counter-IED capabilities, everything from airborne sensors to handheld devices, especially focused on our dismounted troopers; and commanders and troopers on the ground continuously refining their tactics, techniques, and procedures tailored to the threat they face in their region.

IED ATTACKS DURING AFGHANISTAN DRAWDOWN

As we begin to transition combat operations in Afghanistan and look to 2014, we must not lose our focus on the mission at hand. U.S. forces and civilian personnel will remain the target of insurgent IED attacks, and the IED will remain the weapon of choice. From our experience in Iraq, the reduction of U.S. forces must not equal a reduction in counter-IED or other critical capabilities.

As the military footprint in Afghanistan decreases, this drawdown and transition will require flexibility to shift priorities rapidly, providing the requisite counter-IED capabilities, situational awareness, and security and protection for these remaining troops.

While the IED has been the focal point of combat operations in Afghanistan and Iraq during the last decade, it is not exclusive to those countries or region. The global spread of threat networks and proliferation of IEDs and associated technology are pervasive and continue to affect U.S. security at home and interests abroad.

Since 2007, IED incidents outside of Iraq and Afghanistan have increased to average more than 500 incidents per month around the globe. Since January 2011, there have been more than 10,000 global IED events, occurring in 112 countries, executed by more than 40 regional and transnational threat networks.

The extremist networks that employ the IEDs have proven to be resilient, interconnected, and extremely violent. Globalization, the Internet, and social media have extended the reach of these organizations, providing platforms for recruiting, technical exchanges, training, planning, funding, and social interaction.

While we in the military adhere to Napoleon's dictum to march to the sound of the guns, these threat networks march to the signs

of insecurity and take the IED with them. We see this in Colombia, Pakistan, Syria, Bahrain, Nigeria, and Somalia, among others. Wherever we see turmoil and insecurity, we see the spread of these networks and their use of the IEDs.

Today, as we see in Afghanistan, and in the future, I believe U.S. forces will operate in an IED environment. I believe it is the reality of the 21st-century warfare, and we must plan accordingly.

ENDURING COUNTER IED CAPABILITIES

Currently, the Department, led by Deputy Secretary Carter, is in the process of reviewing the number of proven capabilities that we have developed over the last 10 years during the course of these conflicts to determine which ones should endure. And as part of these, I have recommended five counter-IED capabilities which I believe should be institutionalized.

The first: We must preserve the ability to rapidly provide counter-IED materiel solutions in response to this dynamic threat. The constantly changing threat environment requires the Department of Defense to maintain a higher level of institutional acquisition agility and continued investment in counter-IED R&D. Moving forward, DOD must acquire and deliver capabilities in months, not years.

The second enduring capability is the ability to fuse operational information and intelligence from all sources to produce actionable intelligence for our commanders, delivering analytical products that meet the needs of both our operational commanders and our domestic security partners. This is accomplished through a robust and powerful network of partners with whom analytical tools, methodologies, and, most importantly, information and intelligence can be shared to identify and then exploit the vulnerabilities of these global networks. The speed at which our enemies operate requires us to operate just as fast and be just as networked.

Third, counter-IED training, as you mentioned, must endure and be permanently integrated into our service and training institutions and centers. This is not a passing phenomenon. As we have learned in Iraq and Afghanistan, we can provide the best counter-IED capabilities and tools to the warfighters, but without the timely and relevant training component, the full capacity of equipment and tactics will never be realized. Moving forward, we must train to conduct operations in an IED environment which includes an agile networked enemy.

The fourth enduring capability is our ability to conduct timely and relevant collection, analysis, and technical forensic exploitation of these devices and identify emerging IED technologies. This is done through a process we call weapons technical intelligence, referred to as WTI. And we are very closely partnered in with FBI on this.

During the past 8 years, JIEDDO, the military services, U.S. interagency, and our multinational partners have developed a highly effective WTI process to derive forensic evidence—fingerprints, DNA, and biometrics—from these devices that we have recovered on the battlefield in order to identify personnel and then target them. Our tactical commanders in Afghanistan increasingly focus

operations to collect biometrics and forensic data, and several have referred to this capability as a "game-changer."

WTI removes a violent extremist's greatest defense, anonymity, and makes them vulnerable to attribution, which is why the WTI capability must endure.

Fifth and finally, the enduring global IED threat requires a whole-of-governments approach. As we move forward, we must continue to synchronize our counter-threat network capabilities among our domestic, international, and other security partners. It is not a military mission alone. And today we are working with an expanded interagency group to identify the vulnerabilities and target some of these networks that we have talked about that are moving these materials into Afghanistan.

Maintaining this momentum against an adaptive threat requires the continued focus of the intelligence community, however, in order to focus on these networks to provide us a common intelligence picture that we can target.

We will continue to face an ever-present threat from an overlapping consortium of networks employing IEDs as a weapon of choice. We have to continue to pursue this whole-of-governments approach, knitting together all the tools we have at our disposal in order to nonkinetically attack these networks, including their finances.

These five recommended enduring counter-IED capabilities are integrated into the Department's process being led, as I said, by Deputy Secretary Carter. With his leadership, I am confident we are on the right track to institutionalize these capabilities, but much work remains to be done.

In closing, the IED and the networks that employ these weapons are here to stay, operationally and here at home. As we have done from previous conflicts, we must account for this enduring threat and retain the hard-earned capabilities. It is our responsibility to learn and adapt our institutions accordingly.

But I would like to leave you with one final thought. I understand the toll that these weapons have taken on our troopers and their families—the deaths, the terrible life-changing injuries. I see this. And I promise you we are committed to providing every possible capability we can to protect our troops into 2014 and beyond. This is my mission.

Chairman Young, Ranking Member Dicks, members of the subcommittee, again, thank you for the opportunity to appear before you today. Thank you for your support. And I now look forward to your questions.

Mr. YOUNG. General, thank you very much, sir.

[The biography and statement of General Barbers follows:]

JOINT IED DEFEAT ORGANIZATION

BIOGRAPHY

ATTACK THE NETWORK — DEFEAT THE DEVICE — TRAIN THE FORCE

Lieutenant General Michael D. Barbero

Lieutenant General Michael D. Barbero was commissioned in the Infantry upon graduation from the United States Military Academy at West Point in 1976. As an infantry officer, Lieutenant General Barbero served in a variety of tactical assignments in mechanized, light and air assault infantry units. He has served in the 1st Cavalry Division, 2d Infantry Division, two tours in the 101st Airborne Division, the 7th Infantry Division, the 10th Mountain Division, and the 4th Infantry Division.

In addition to Infantry assignments at the tactical level, he has commanded at every grade, from Lieutenant Colonel to Lieutenant General. He commanded the 3d Battalion, 187th Infantry Battalion in the 101st Airborne Division and the 2d Brigade, 10th Mountain Division. As a Brigadier General, he commanded one of the Army's Combat Training Centers, the Joint Readiness Training Center and Fort Polk. As a Major General he commanded the United States Army Infantry Center and Fort Benning Georgia. Immediately prior to joining JIEDDO, he commanded the Multi-National Security Transition Command--Iraq and NATO Training Mission-Iraq.

Other staff assignments include service as the Executive Assistant to the commander of Joint Forces Command/Supreme Allied Commander Atlantic, the Deputy Director for Regional Operations on the Joint Staff, and the Chief of Staff, III Corps and Fort Hood, Texas.

LTG Barbero has served almost 46 months in Iraq over three separate tours. During the first year of Operation Iraqi Freedom, from 2003 to 2004, he served as the Assistant Division Commander of the 4th Infantry Division. He next served in Iraq as the Deputy Chief of Staff, Strategic Operations at Multi-National Force-Iraq during 'the surge' in 2007 and 2008. Finally, during his most recent deployment, from 2009 to January 2011, he was responsible for the training, equipping and development of all Iraqi Security Forces and building the ministerial capabilities of both the Ministries of Interior and Defense, while serving simultaneously as the Commander of Multi-National Security and Transition Command – Iraq and the Commander of the NATO Training Mission - Iraq.

He also deployed to Panama and participated in Operation Just Cause in December 1989.

Lieutenant General Barbero holds a master's degree in National Security and Strategic Studies from the National Defense University, Washington, D.C. He is a graduate of the Army's Command and General Staff College and the School of Advanced Military Studies Program. His awards include the Defense Distinguished Service Medal, Defense Superior Service Medal, Legion of Merit and two awards of the Bronze Star Medal. He has also earned the Expert Infantryman Badge, Parachutist Badge, Air Assault Badge, Ranger Tab, Australian Jump Wings and both the Army Staff and Joint Staff Identification Badges.

Statement By

Lieutenant General Michael D. Barbero
Director
Joint Improvised Explosive Device Defeat Organization
United States Department of Defense

Before the

United States House of Representatives
Committee on Appropriations
Subcommittee on Defense

September 20, 2012

NOT FOR PUBLICATION UNTIL RELEASED BY THE HOUSE COMMITTEE ON APPROPRIATIONS, SUBCOMMITTEE ON DEFENSE

Chairman Young, Ranking Member Dicks, and distinguished members of the Subcommittee; it is my privilege to update you on the Department of Defense's (DOD) efforts to mitigate the effects of improvised explosive devices (IED). Let me begin by thanking you for recognizing the importance of the counter-IED (C-IED) mission. The funding support you provide enables DOD to rapidly field critical C-IED capabilities our warfighters require to complete their mission.

Mission

In February 2006, the DOD officially established the Joint Improvised Explosive Device Defeat Organization (JIEDDO) to focus on the IED threat in Iraq and Afghanistan. JIEDDO's mission, as defined by DOD Directive 2000.19E, "is to focus (lead, advocate, coordinate) all DOD actions in support of the Combatant Commanders' and their respective Joint Task Forces' efforts to defeat IEDs as weapons of strategic influence."[1] JIEDDO is singularly focused on the IED threat and exists to rapidly field capabilities to reduce the effectiveness of this asymmetric weapon.

Resourcing the Counter-IED Mission

A large contributor to JIEDDO's support to the warfighter was the establishment of the Joint IED Defeat Fund by Congress in 2007. The flexibility of the three-year, colorless appropriation ensures JIEDDO is able to rapidly respond to urgent warfighter C-IED needs. I want to thank the committee for recognizing the importance of this rapid response capability and providing the requisite funding support needed throughout the years.

The JIEDDO budget requests represent a mixture of deliberate, planned programs as well as estimates for urgent C-IED needs of Combatant Commanders. Three-year funding allows JIEDDO to rapidly apply resources to critical areas of the C-IED fight and the flexibility to provide the warfighter the best C-IED capabilities to meet operational requirements.

[1] *Joint Improvised Explosive Device Defeat Organization,* DOD Directive 2000.19E (14 February 2006), para 4.

From fiscal years (FY) 2006-2008, JIEDDO supported operations in two theaters of conflict requiring budgets ranging from $3.7 billion to $4.5 billion. In 2009, JIEDDO supported the Afghan surge and other requirements with a budget of $3.1 billion. While the Afghanistan area of operation presented evolving challenges, JIEDDO's FY 2011 budget of $2.8 billion reflected the requirements of a single theater of support.

As support to theater and unanticipated needs from the warfighter continue, JIEDDO is predicting to commit more than $2.7 billion during FY 2012, which includes FY 2010 and FY 2011 carryover funds. However, JIEDDO's projected FY 2012 carryover has decreased significantly due to additional urgent requirements to support dismounted operations this year. As a result, the FY 2013 request of $1.9 billion is critical to JIEDDO's ability to meet the urgent C-IED needs of our warfighters.

Lines of Operation

To provide the requisite support to the Combatant Commands, JIEDDO focuses efforts along three lines of operation: Attack the Network, Defeat the Device and Train the Force. To enable a successful C-IED program, these lines of operation must work in harmony. Underpinning these three lines of operation is the organizational requirements of staff and infrastructure.

The first line of operation, Attack the Network, is the decisive endeavor. It encompasses all the material and non-material C-IED enablers to attack threat networks by first identifying, and then exploiting, critical threat network vulnerabilities. Attacking the network is the most complex line of operation, but it is how we achieve decisive results.

From the support provided to U.S. joint and coalition conventional and special operations forces, JIEDDO has built a deep knowledge base on threat networks. JIEDDO's Counter-IED Operations/Intelligence Integration Center (COIC) effectively and rapidly fuses more than 200 data sources and has developed or modified more than 60 software tools to allow analysts embedded with units and through integrated reach-back support to increase force protection and maneuverability of the supported

operational commander. Since 2007, JIEDDO has delivered more than 14,500 intelligence products to U.S. and coalition conventional and special operations customers in response to their requests; trained more than 25,000 civilian, military, interagency and intelligence community personnel; and deployed more than 1,100 personnel in support of operations in Iraq, Afghanistan and other Combatant Commands.

Six intelligence agencies and organizations (Central Intelligence Agency, Defense Intelligence Agency, National Geospatial-Intelligence Agency, National Security Agency, National Reconnaissance Office and the National Ground Intelligence Center) are embedded within the COIC to synchronize intelligence-related responses to our customers. Great Britain, Canada and Australia also have embedded officers within COIC to strengthen communications and information sharing among coalition partners.

Additionally, JIEDDO is embedded at each of the five theater special operations commands, the Combatant Commands and at four interagency organizations (the Counter-Terrorism Center, the Department of Treasury, the Federal Bureau of Investigation/Counter-Terrorism and the Drug Enforcement Agency/Special Operations Division) to facilitate a whole-of-government approach to disrupt the activities of global threat networks.

Since the establishment of the COIC in 2007, JIEDDO has developed an unmatched intelligence fusion, training integration and information technology capability that provides immediate C-IED analysis and decisive tactical edge to our warfighter and Combatant Commands.

The second line of operation, Defeat the Device, is the immediate and most obvious approach to protecting our service members from IEDs. As hard as we try, it is impossible to prevent every IED from being employed. However, once the IED finds its way to the battlefield, we have fielded a wide spectrum of initiatives to detect the components, neutralize the triggering devices and mitigate the effects of an IED blast. JIEDDO developed and rapidly deployed a comprehensive portfolio of capabilities, such as mine rollers, electronic countermeasures (jammers), robotics, handheld detectors,

pelvic protection garments and aerial and ground surveillance systems, to name a few. We do not rely on just one capability. Because the threat varies from region to region within Afghanistan and we face a very agile threat, our warfighters are provided an arsenal of capabilities to customize and apply to the unique IED threat and terrain they face.

JIEDDO's ethos is to rapidly deliver high-valued capabilities to the warfighter. For example, within six months, we funded and delivered several types of handheld devices, such as the Beachcomber and Minehound, to detect buried IEDs during dismounted operations. Since delivering the first device in October 2009, we have fielded more than 8,000 handheld detectors with an additional 2,084 scheduled for delivery in the next 10 months.

In April 2011, during my visit to Afghanistan, warfighters requested a small, lightweight reconnaissance robot they could easily carry during dismounted operations to throw over walls and into buildings to detect IEDs. JIEDDO invested $24 million to rapidly developed and field 1,157 ultra-lightweight reconnaissance robots within 10 months of receiving this requirement.

The continually evolving, adaptive enemy mandates a responsive, agile acquisition and fielding capability. Our warfighters deserve to have the best capabilities as quickly as possible.

The third line of operation, Train the Force, is essential to preparing deploying warfighters on the optimal use of the full range of available C-IED tools and to build expertise in the latest tactics, techniques and procedures. In 2011, JIEDDO provided $24 million to field C-IED training equipment for services' pre-deployment training centers. Based on the positive feedback received from commanders and warfighters on the critical requirement to train on this equipment prior to deployment, JIEDDO funded an additional $36 million for training equipment in 2012. To date, JIEDDO has fielded 249 THOR III Surrogate dismounted jammers; 2,196 handheld detectors; 1,372 Holley Sticks; 75 Hook and Line; 835 search kits; and 276 training aids for pre-deployment training.

Preparing our best C-IED tool — a well-trained warfighter — requires a comprehensive and adaptive pre-deployment training approach to ensure our force has adequate time to understand the integration of all aspects of the C-IED fight before deploying to theater.

Current Threat — Afghanistan

It is clear the IED is the primary weapon of choice for threat networks globally and is one of the enduring operational for the foreseeable future. In Afghanistan, these devices are the greatest source of casualties. In the past two years, IED events have increased 42 percent, from 9,300 in 2009 to 16,000 in 2011, and 2012 is on track to meet or exceed the historic number of IED events we saw in 2011.

While the overall number of IED events is high, our ability to find IEDs and neutralize them before detonation has improved significantly. The rate at which coalition mounted patrols find and clear IEDs improved from 49 percent in June through August, 2010, when we first surged forces in Afghanistan, to 65 percent in June through August, 2012. For coalition dismounted patrols, the IED found-and-cleared rate improved from 62 percent to 78 percent for the same periods. Many factors have increased the IED found-and-cleared rates in Afghanistan including applying lessons learned from Iraq, shifting C-IED systems from Iraq to Afghanistan, fielding increased numbers of C-IED capabilities, improving C-IED training and continuing the refinement of tactics, techniques and procedures tailored to the Afghan threat.

Homemade Explosives Challenge

Fertilizer-based explosives still remain our greatest threat in Afghanistan. Today, 87 percent of IEDs employed against coalition forces are homemade explosives (HME), and of those, 74 percent are made with ammonium nitrate derived from calcium ammonium nitrate — a common agricultural fertilizer. We have also seen these ammonium nitrate-based IEDs used globally.

In the early 1980s, the Provisional Irish Republican Army used ammonium nitrate-based IEDs in multiple attacks in London. The U.S. witnessed firsthand just how deadly

ammonium nitrate can be in the 1995 Oklahoma City bombing that claimed the lives of 168 people. In November 2003, a series of ammonium nitrate-based truck bombs killed more than 50 and injured 700 at multiple locations across Istanbul, Turkey. Just last year, we saw the devastating effects of ammonium nitrate-based HME attacks in Mumbai, India, and Oslo, Norway. This fertilizer and other cheap and easily procured dual-use components present a distinct advantage to our enemies and a security challenge to all of us

The complex nature of the global HME threat requires the support of unique and non-traditional partners. JIEDDO has engaged the International Fertilizer Association and fertilizer community to urge their commitment in countering the illicit use of fertilizer as an explosive. JIEDDO has asked this community to develop a whole-of-industry approach to: implement a universal dye program; explore non-detonable substitutes for ammonium nitrate; institute effective industry-wide standards, regulations and safeguards regarding the production and distribution of nitrogen-based fertilizer; and produce a global education and awareness campaign. Expanding our community of action to include unique and non-traditional partners is critical to addressing this HME challenge.

Global and Enduring Threat

While the IED has been a focal point of combat operations in Afghanistan and Iraq during the last decade, it is not exclusive to those countries or the region. The global spread of threat networks and the proliferation of IEDs and associated technology are pervasive and continue to threaten U.S. interests at home and abroad. Since 2007, IED incidents outside of Iraq and Afghanistan have increased to more than 500 events per month. Since January 2011, there have been more than 10,000 global IED events occurring in 112 countries, executed by more than 40 regional and transnational threat networks[2].

The extremist networks that employ IEDs have proven to be resilient, adaptive, interconnected and extremely violent. Globalization, the Internet and social media have

[2]Worldwide IED Database, Institute for Defense Analysis, June 2012

extended the reach of these organizations, providing platforms for recruiting, technical exchanges, training, planning, funding and social interaction. We see IED tactics and techniques used by insurgents increasing in sophistication and proliferating globally.

While we adhere to Napoleon's dictum to "march to the sound of the guns," these threat networks march to the signs of insecurity, and take the IED with them. We see this in Colombia, Pakistan, Syria, Nigeria and Somalia among others. Wherever we see turmoil or insecurity we see the spread of these networks and the spread of IEDs.

Today's IEDs are relatively simple, low-tech devices, which routinely use command wire, pressure plates or radio-controlled triggers. Many readily available components such as cell phones, agricultural fertilizers and simple electronic transmitters and receivers have legitimate commercial uses, but are easily and increasingly adapted for illicit purposes in manufacturing IEDs. The dual-use nature of IED components poses unique challenges in our ability to regulate and limit terrorist access to IED precursors and trigger components.

In the future, bomb makers will likely incorporate such enhancements as ultra-thin and flexible electronics; advanced communications mechanisms such as blue-tooth, Wi-Fi, and broadband; optical initiators; and highly energetic metals. In addition to more sophisticated technology, threat networks will develop enhanced IED concealment techniques and may even combine IED use with concurrent cyber attacks. The ubiquitous nature of IED materials, their low cost, threat networks ability to share tactics and recipes and potential for significant impact guarantee the IED will remain a threat and main casualty-producing weapon for decades to come.

Enduring Capabilities

Today and in the future, U.S. forces will operate in an IED environment. While IEDs cannot stop our units or deter our commanders from taking the fight to the enemy, these devices are the greatest source of combat casualties this decade. The IED and the threat networks that employ this asymmetric weapon are a reality of 21st century warfare and we must plan accordingly. The department is in the process of reviewing the

number of proven capabilities created during the course of the last 10 years to determine which should endure. JIEDDO has recommended five C-IED capabilities we believe should be institutionalized.

First, we must maintain the ability to rapidly provide C-IED materiel and non-materiel solutions in response to the changes in the IED threat. The constantly changing threat environment requires DOD to maintain a higher level of institutional agility.

For example, as dismounted operations increased in Afghanistan so did severe pelvic injuries to our troops. By leveraging an existing United Kingdom capability, JIEDDO was able to rapidly fund and begin delivering more than 200,000 protective outer and undergarments within 12-weeks from funding release to initial delivery. A study performed by the Army Office of the Surgeon General concluded soldiers not wearing pelvic protection systems are approximately three times more likely to suffer from major genitourinary injury following an IED incident than those wearing pelvic protection. By tapping into an already developed and proven technology and applying our rapid acquisition authorities, JIEDDO was able to rapidly respond to an urgent need within weeks, not years. The traditional DOD acquisition process could not have responded as quickly to this critical requirement.

Ensuring our commanders have freedom of maneuver now and in the future is critical. To preserve our ability to respond to changes in the IED threat, we must institutionalize a rapid acquisition capability and continue to invest in the development and fielding of new technologies. Moving forward, DOD must deliver capabilities in months — not years.

The second enduring capability is the ability to fuse operational information and intelligence, from all sources, to produce actionable intelligence — analytical products that meet the needs of both our operational commanders and domestic security partners. This is accomplished through a robust and powerful network of partners with whom analytical tools, methodologies and most importantly, information and intelligence, can be shared to identify, and then exploit, the vulnerabilities of threat networks. JIEDDO applies a suite of innovative tools to enable analysts to organize

intelligence from more than 200 data sources, resolve identities, correlate events, research patterns of life and geospatially render this information on a map to produce a blended intelligence picture that directly supports operations.

For example, JIEDDO has applied this layered analysis approach to support the interdiction of HME in the U.S. Central Command area of responsibility. Since January 1, 2012, JIEDDO has facilitated coalition force operations against HME production and cache sites, resulting in the interdiction of more than 1,000 pounds of HME and associated precursor materials every 13 days.

Sorting through the explosion of data and proliferation of isolated, independent data feeds, such as full-motion video, imagery, biometrics, intelligence community reporting, open source reporting and raw sensor feeds is a constant struggle for our warfighters and analysts. It is critical we sustain our current capabilities to continue to seamlessly share and fuse this data across the attack-the-network enterprise. We must continue to build upon current techniques to enhance data processing upon intake. The better we can sort or mine data, the faster our analysts can manipulate this information to produce actionable intelligence for our leaders and actionable evidence for our interagency law enforcement partners.

We must produce advanced analytics supporting the rapid identification of threat networks activities and our ability to push relevant analysis quickly to expeditionary forces. The speed at which these threat networks operate mandates the requirement for us to produce faster analytical assessments of emerging operational environments to support rapid exploitation. Threat networks are not going away and they will continue to employ IEDs as their weapon of choice. This requires the U.S. C-IED community to think differently and fully develop an information sharing and fusion capability for DOD, law enforcement and intelligence community information. In addition, we must ensure expedient methods are in place to share this same information with international partners when appropriate. We are all confronted by the same global set of networked enemies requiring us to remain networked in our efforts to defeat them in the future.

Third, we must maintain our ability to train our forces for these enduring threats. Today and in the future, U.S. forces will be operating in an IED environment, which is why C-IED and attack-the-network training must endure and be permanently integrated into our individual Service training institutions and centers. As we have learned in Iraq and Afghanistan, we can provide the best C-IED capabilities to the warfighter, but without the timely and relevant training component, the full capacity of equipment and tactics will never be realized.

During the Cold War we trained to conduct operations in a nuclear, biological and chemical environment. Moving forward, we must train to conduct operations in an IED environment, which includes an agile networked enemy. Individual, leader and collective C-IED and counter-network training must be institutionalized.

The fourth enduring capability is our ability to conduct relevant and timely collection, analysis and technical and forensic exploitation of current and emerging IED technologies through weapons technical intelligence (WTI). During the past eight years, JIEDDO, in conjunction with the military services, U.S. interagency and our multinational partners developed the highly effective WTI process to target extremist networks and defeat the IED.

Outside of combat zones, the WTI process is synonymous with the interagency efforts to detect and disrupt explosive threats by providing subject matter experts to both law enforcement and the intelligence community. The interagency has embraced the WTI lexicon as a means to speak the same language and begin the process of sharing data currently stove-piped in multiple agency systems. The WTI process is also captured as an essential element of the revised U.S. C-IED national strategy.

WTI has evolved from traditional technical intelligence[3] and leverages law enforcement techniques as well as forensic and biometric technology to collect, exploit and analyze

[3] "Intelligence derived from the collection, processing, analysis, and exploitation of data and information pertaining to foreign equipment and materiel for the purposes of preventing technological surprise, assessing foreign scientific and technical capabilities, and developing countermeasures designed to neutralize an adversary's technological advantages. Also called TECHINT." Joint Publication 1-02, 15 January, 2012.

IED-related materials and other weapons systems.[4] This process coordinates and integrates various DOD and federal organizations and programs to facilitate everything from the onsite collection of IED material to the analysis of IED components in national laboratories. This analysis is then delivered to our military commanders to support targeting, track IED materials to their source, aid in host nation criminal prosecution and enhance force protection for our nation's warfighters.

Emerging technologies such as standoff biometric collection, rapid DNA processing and real-time latent fingerprint matching hold enormous potential to advance the WTI process into the next generation of protection. These capabilities will allow security personnel to identify threats before they reach checkpoints and to instantaneously attribute criminal and illicit activities to the perpetrators.

The benefit of the WTI process has unlimited potential and applicability to defeat improvised weapon systems that provide our enemies an asymmetric advantage. Our commanders increasingly focus operations to collect biometric data and several have referred to it as a "game-changer." Biometric, forensic and technical exploitation remove a violent extremist's greatest defense — anonymity — and makes them vulnerable to attribution, which is why the WTI capability must endure.

Fifth, and finally, the enduring global IED threat requires a whole-of-governments approach. As we move forward, the C-IED community must continue to synchronize counter-threat network capabilities and actions among domestic, international and other security stakeholders.

Today, JIEDDO is working with an expanded community of action for C-IED that did not exist previously. We have established an interagency forum consisting of U.S. intelligence and interagency partners, federal law enforcement, the Five Eyes (United States, United Kingdom, Canada, Australia, and New Zealand) community and forward-

[4] WTI is "a category of intelligence and process derived from the forensic and technical exploitation of improvised explosive devices (IEDs), associated components, improvised weapons, and other weapons systems." WTI IED Lexicon, Edition 3.1, July, 2011.

deployed forces to achieve a more transparent and holistic effort to disrupt threat networks employing IEDs against U.S. and coalition forces globally.

We recognize no single government department or international partner has the ability to fully limit access to IED precursors, so we are integrating our efforts to go after the threat networks distributing these materials. Our U.S. government partners bring expertise in defeating and prosecuting criminal networks; applying financial pressures by going after the assets of IED network members, financers, and distributors; enacting export controls and treaty compliance efforts that lead to the interdiction of IED components; advancing C-IED objectives through public diplomacy and policy and regulatory changes; advising on legitimate agricultural requirements; and coordinating and executing national C-IED policy efforts outside of declared combat zones through the interagency Joint Program Office for Countering IEDs. This is by no means a comprehensive list of the actions our interagency partners are applying to the C-IED fight, but it should give an idea of the collaboration occurring on all levels.

For example, the U.S. Department of Commerce added 152 persons to the Entity List because of IED-related matters. This designation stops U.S. companies from trading with these entities — companies, organizations, persons — who violated U.S. export laws. As of September 2012, the U.S. Department of Homeland Security, U.S. Immigration and Customs Enforcement, Homeland Security Investigations' Global Shield Program has produced 40 enforcement actions and 44 seizures totaling 138.70 metric tons of explosive precursor chemicals. Through coordinated efforts and strong partnership across the U.S. government and with our international partners, the C-IED community is going after these nefarious actors and effectively countering the networks that use IEDs. Maintaining this momentum against an adaptive threat requires the continued focus of the intelligence community to build a common intelligence picture. We cannot go back to a stove-piped approach to intelligence.

Moving forward, we will continue to face an ever-present threat from the overlapping consortium of threat networks employing IEDs as their weapon of choice. We have to continue to pursue a whole-of-governments approach, knitting together all the tools we

have at our disposal as we work collectively and seamlessly to understand these threat networks and mitigate the effects of IEDs. These adaptive and constantly evolving threat networks require an agile and responsive counter-threat network to defeat them. The multinational, interagency coordination we have established during the last decade must not attrite.

These five recommended enduring capabilities — rapid acquisition and fielding; operations-intelligence-information fusion, C-IED training, WTI, and a whole-of-governments approach — are synergistic and provide a comprehensive response to an enduring, complex, asymmetric and dynamic threat.

Closing

It is imperative we capture and institutionalize the lessons of a decade of combat operations. In the coming decades, the IED and the networks that employ these asymmetric weapons will continue to be a fixture of the battlefield and a threat here at home. It is our responsibility to learn and adapt institutions accordingly. There is no "silver bullet" to defeat the IED threat; our best defense is a warfighter with the right intelligence, training and equipment before they deploy into harm's way.

Chairman Young, Ranking Member Dicks, members of the Subcommittee, again, thank you for the opportunity to appear before you today. I look forward to your questions.

IED LETHALITY

Mr. YOUNG. You have, in a few minutes, said a lot. And what you are telling me is that this problem is not going to go away anytime soon. But you are telling me and telling the committee that you are prepared to bring together all of the structure that is needed to provide technology designs, training, and I applaud you for that.

And I want to tell you that this is really important. The IED toll that you mentioned, the numbers that you have presented here today are just really disturbing, how the IED attacks are growing. And I know that personally. I have been to Afghanistan, as have all the members of this subcommittee.

But I will tell you, General, I have really learned more about what is happening with the soldiers by visits to Walter Reed in Bethesda. Now, my wife is sitting over there on the corner. She is weekly, at least once a week, at the hospitals to not only visit with the wounded soldiers, who are getting really good care—and if you ask them, they will say, yes, that their care, medical care, is good. And I really applaud our medical corps, Army and Navy. But some of the families need help, and that is where Beverly comes in.

But some of the stories that we hear, you know, when you ask, well, what do you need? Do you have everything you needed? And they tell us, yeah, I have all I needed. But almost every one will say, what we need is a change in the rules of engagement.

RULES OF ENGAGEMENT

Now, I don't know if you could have any influence in changing the rules of engagement. I am not sure that that falls within your charter. But I think what they are concerned about is, and I will just try to paraphrase it, that if they do something that might be a little aggressive or that might appear to be beyond what their stated rules of engagement are, the President of the country that we are trying to help becomes their super-critic, demanding that they be punished. And I just don't think that is right.

AFGHANS ATTACK ON U.S. AND ALLIES

You know, you can't have an ally part-time. You either have an ally or you don't. And I have come to the conclusion, after working on this issue for quite some time, that our part-time ally is not really our ally. And the stories of the Afghanis that we are training turning on us and killing and murdering—and murdering in their sleep our soldiers. And that is not a JIEDDO issue, but it is still an issue of supporting the troops.

But we had talked about a letter that I had received from a soldier, and you said you had not seen the letter. I had distributed it pretty widely through the Pentagon. But I have a copy for you. And I have taken out some of the personal information. I have taken out dates and locations because I know that that should not be revealed.

And I think you know about the case.

General BARBERO. Yes, sir.

LETTER FROM A STAFF SERGEANT

Mr. YOUNG. You can read it at your leisure.

But when I got this letter, I had heard similar stories from other wounded warriors at the hospitals. So I doubled back and talked to some of those that I could still have contact with, and I hear the same story, pretty much, of what you will read in this letter. So it convinced me that there is something really needed to be done about this.

I took this letter, and I talked to leaders at the Pentagon. And I sent a very detailed letter, including a copy of this letter, to the Pentagon. That didn't really get any kind of a response.

And so the next conversation that I had with the leader of the Army was to notify him that the soldier that had written this letter prophesying what was going to happen happened, and he and his platoon sergeant were blown up with a single IED.

There is something wrong with that, when the soldiers can see the problems—and this is a seasoned soldier. He has been there before. And the folks that I have talked to—and a couple of them are still at the hospital, by the way—you get the same story. Now, when you get the same story over and over again, it tends to bother you.

COUNTER IED EQUIPMENT MAINTENANCE

And the issue of the IEDs where, if a troop is told to go into a field or an area that is known to be full of IEDs, there has to be some way to give them some protection. And I know that you have a number of ways to do that. And I know that you have, with the Strykers for example, you have the mine rollers. But my information provided to me is that if a Stryker gets blown up, the mine roller gets destroyed, the Stryker is parked, and it is not repaired. There is no new mine roller put on there, so the troops are put on foot patrol.

This committee is prepared to provide as many mine rollers as those Strykers need. We should not take the kids out of the Strykers—and I apologize for calling them kids, because what they are going through, they are not kids. That Stryker should be repaired so that that IED protection of the mine roller can be redeployed and so the soldier doesn't have to go on foot in a minefield that we know is full of mines.

IED DETECTION AND DESTRUCTION

Now, that is a long lead-up to a question. If you know the minefield is full of mines, what can you do? What can you, the soldiers do? What do you train the soldiers to do, especially if you know that the field is full of mines?

General BARBERO. Uh-huh. Well, Chairman, first of all, I will talk about detection in a minute and what we do to protect our troopers.

But if I could, I am familiar with the incident with Sergeant Sitton and studied it early August when it occurred. And it was troubling, as they all are. And, you know, I spoke in my comments about progress we are making. And I understand, to some kid at Bethesda or some family in Florida or Washington State or Texas or California, that is not progress. They don't want to hear about progress. And I understand that. So, you know, I start every day

looking at, what were the casualties, what were the lessons learned, and, more importantly, what can we do about it?

And to take Sergeant Sitton's example, he was killed on dismounted operations. And we have focused on the dismounted trooper because of the terrible nature of their injuries, the amputations. And we have taken steps over the last 15 months to field a wide variety of 8,000 handheld detectors, protective undergarments, a greater number of sensors and such.

But it is an IED battlefield. A commander said to me, "It is not a case of encountering IEDs on the battlefield. The IED is the battlefield. That is their weapon. And it is combat."

Now, can we do better at detecting where these are? We can, and we are trying. But the enemy, as I said in my comments, is adaptive and smart. They watch us. They know we have handheld detectors, so they have gone to nonmetallic IEDs. The pressure plates—and, in this case, we think the pressure plate was wooden. And what they do is they take carbon rods from D cell batteries, which do not have a very high metallic content but they have enough to complete the circuit when they are touched, and two pieces of wood, a plastic jug filled with homemade explosives, ammonium nitrate, bury it with a battery underneath so we can't pick that up, and that is what they use. So it is a thinking enemy that is watching us and observing.

And our detection rates and found and cleared rates have improved as we have adjusted in this arms race of trying to find and detect and clear these IEDs. We are not going to find every one of them. They are going to continue to adapt.

As far as your question about the (Rules of Engagment) ROE, you know, my job is to provide the tools that answer our commanders' requirements and support them with whatever they need, whatever our troopers tell us or our commanders tell us. So I can't really comment on rules of engagement because I am not there and I have not served in Afghanistan.

But we have taken steps to protect especially our dismounted troopers, our most vulnerable ones. But, Chairman, we could outfit these soldiers like medieval knights and if they step on one of those weapons, this weapon is effectively employed by a thinking enemy, it is going to have effects. And I would be untruthful if I told you something different. There is no silver bullet in this fight.

But we are working as hard as we can. And I can give you a list of all the equipment that has been fielded to our commanders, from handheld devices, dogs, sensors, and undergarments, that have had some effect. But, as I said, to folks who have loved ones deployed, this is not progress, and we realize that. We have to do better.

Mr. YOUNG. Well, General, thank you for that offer, and we would like to have a list of that for our hearing records.

[The information follows:]

The list provided contained classified information.

Mr. YOUNG. And I have a lot more to talk with you about, but the other Members have interest in this issue. And I want to yield to Mr. Dicks, who, by the way, it will possibly be his last hearing with this subcommittee.

Mr. DICKS. Oh, we may have another one, Mr. Chairman, before——

Mr. YOUNG. Well, maybe we can have a couple more just to keep you busy.

Mr. DICKS. Yeah, keep us busy.

Mr. YOUNG. Mr. Dicks has been an outstanding Member of this Congress and of this subcommittee. And his chairmanship was a good chairmanship. It was short-lived, but it was a good chairmanship, and he did outstanding work. And the Congress will miss him, this Committee will miss him, and I personally will miss him because we have worked together for 35 years on all of these important issues.

I yield to Mr. Dicks.

FERTILIZER BASED EXPLOSIVES

Mr. DICKS. Thank you, Mr. Chairman.

And I certainly understand and appreciate your concern. All of us are concerned.

The one issue that just troubles me is the fertilizer that keeps coming in from Pakistan, and somehow we don't seem to be able to do anything about it. Now, that is something, General, we know about, and yet it still exists.

I know it is a small amount of what is produced in Pakistan, but we know it is coming in across the border. I mean, this is—and we choose not to do anything about it. I mean, we talk to the Pakistanis until we are blue in the face, and yet it still comes in.

What do you have to say about that?

General BARBERO. Early in——

Mr. DICKS. I mean, all the little committees here in Washington—but the reality is, that stuff is still coming across the border every day, and we know it.

General BARBERO. Congressman, I agree 100 percent. And early in my—when I first arrived on the job, I looked at the situation, and my assessment was that in Afghanistan we are playing defense. We are sweeping historic amounts of this calcium ammonium nitrate off the battlefield, tons, up 100 percent this year, and yet the number of IED are at historic highs.

You know, when an insurgent can buy a bag of fertilizer, about 110 pounds, for $31, boil it with a little propane, add an accelerant to it——

Mr. DICKS. Where do they buy it?

General BARBERO. It is smuggled across. Hundreds of crossing sites. We, as I said, capture what we can, detect what we can. And they——

Mr. DICKS. Do you think we are doing enough on that issue? I mean, do you think we are—I mean, if it continues to exist week after week, month after month, it is very discouraging.

General BARBERO. It is. And I have been to Pakistan twice to engage the civil leadership and the military leadership about this. And the Pakistanis have a significant problem with these networks and devices also. There were eight Pakistani civilians killed today with an IED aimed at their military, which it was—it misfired.

And our message to the Pakistanis has been on two issues: "We will help you with your problem, with your IEDs, but you have got

to do something about this free flow of calcium ammonium nitrate that is coming into Afghanistan. Here are the effects we are seeing."

And we must continue to press them. They must take action, and I think they can do more. I can and I would like to, in another setting—I can't discuss it now—talk about some of the actions we are taking against these networks that we know are moving this material and the funding behind them. I just can't talk about it here.

But I share your concern. It is a priority for us. And this interagency task force we have put together with Treasury, Commerce, et cetera, is totally focused on this. And to date——

Mr. DICKS. Well, Mr. Chairman, I hope we can have a secure setting, if not today, you know, after the election, to go into this, or even have a briefing for the Members who are going to be here.

Mr. YOUNG. Yeah, well, why don't you yield?

The General and I talked about this yesterday, recognizing there will be some areas that can't be discussed in an open hearing. And I agree and he agrees that we should have——

Mr. DICKS. We could do it tomorrow, as far as I am concerned.

General BARBERO. Absolutely.

Mr. YOUNG. Well, we will see.

Mr. DICKS. All right. At least at some point, I think we need, to do our job, we need to do what is being done and what the problems are.

Mr. YOUNG. Good suggestion. Thank you.

Mr. DICKS. Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Lewis.

IMPROVED IED DETECTION TECHNOLOGY

Mr. LEWIS. Thank you, Mr. Chairman.

General Barbero, it was on Monday that I was last at the Walter Reed Bethesda. The young soldier in front of me who lost his leg just below the knee, that exposure for us tells the entire story.

I would like to have you share with the Committee that which you can share about improved technology to detect exactly where this material is flowing and what actions we can take to stop those flows. I am interested in questions like whether the surveillance available by way of the Predator, for example, is improving our circumstance. Sixteen thousand events in 2011 will tell you that, clearly, we are not on top of the entire picture, that we can do more.

So tell the committee, if you will, how that technology is working and how we can help you.

General BARBERO. Certainly, Congressman.

First, let me describe it as I see it in two fights. There is the mounted fight and the dismounted fight, because different weapons, different variants of the IED are used in each, and it requires different technologies and equipment for each.

First in the mounted fight, we see this primarily using command wires, like we saw in Iraq, where there is an insurgent at the end of the wire and when he sees the vehicle approach at the right point he will touch a button, complete the circuit. And we see increased explosive weights. They are packing more explosives as a counter to our improved armor.

In reaction to this, we fielded everything from additional airborne sensors—which I can talk about their capabilities, or provide it for the record, in a classified forum—and we are pursuing two additional ones. We have received a request from theater for two additional systems, called Copperhead, which have proven very effective, as they were in Iraq, for this operation; and also these handheld devices.

The best technique is, when you approach a spot where we think there are IEDs or indications tell us there are some or a pattern from the past tells us there are, you dismount to clear them or you use a mine roller. One of the technologies in the last 2 years, my organization has spent $269.5 million on mine rollers, repair parts, technicians to repair them. So we will look into this report that is very troubling.

So for the mounted troopers, it is everything from airborne sensors, handheld devices, mine rollers, and improved training at Fort Irwin, for example.

For the dismounted troopers, first it is about, how can we best protect them? And last year we were informed about these undergarments, these pelvic protection undergarments. And in 4 months we fielded 210,000 sets for about $19 million. That is what we get paid to do. The reports are that if our troopers are wearing them—and they all are now—that there is a 40 percent reduction in severe injuries to the area if they are wearing these.

So our technology supports to dismounted includes what we can do to protect them, which is limited, to increased handheld devices and also some airborne sensors.

TRAINING

But I would tell you, for both of these, one of the things over the last year we have greatly invested in is training. Our troopers tell us, hey, sir, this is great equipment, but I don't see it until I get to Afghanistan. Handheld devices, how do I integrate all these sensors? How do I operate a ground-penetrating radar screen and know what to look for?

So, over the last 18 months, we have purchased 75 sets of equipment, and they are fielded out to Fort Campbell, Kentucky, the home of the 101 Air Assault Division, to Camp Lejeune, and also at our big training centers. And then we have a refresher training when they get in-theater.

So before a trooper goes out on operation, he has seen the equipment in his home station and is allowed to operate it, he has seen it at these big training exercises where he gets to integrate it in a very stressful environment, and then he sees it another time on some training lanes when he arrives in Kandahar or Camp Leatherneck or other places.

So training is a nonmateriel factor which I think is contributing to what we are seeing.

Mr. LEWIS. General, I think by your comments you know that NTC Fort Irwin is in our territory. Is that kind of training taking place there, the undergarment sort of training in the field?

General BARBERO. Absolutely. The commander at Fort Irwin is my deputy for training. And not only is it taking place there, it is taking place at Twentynine Palms, at the Marine Corps training at

Fort Polk, Louisiana, the Joint Readiness Training Center, where there are other Army units training.

LESSONS LEARNED

And we take lessons learned from the field. When a brigade deploys, within its first 90 days we have a VTC with them, and Fort Irwin and the Marines and the whole community is on there. And we say, what did you learn in training? What can we do better? And from those VTCs, we take those actions and put them into training.

I will give you an example, Congressman, recently. As we looked at the mounted threat, we noticed that the enemy was taking culverts and underpasses and packing them with explosives at the end of a command wire, the large amounts of explosives they can pack in there. So we heard that in an AAR, so we did two things. We said, okay, Fort Irwin and the rest of the training centers, you have got to replicate this threat and train our forces on it. And then we looked at a solution and then fielded hundreds of barrier devices with sensors that will hopefully keep our insurgents from getting in there.

But, to answer your question, our training centers are fully linked in on this, and we are updating them as we take these lessons learned from individual incidents.

PAKISTANI COOPERATION

Mr. LEWIS. Briefly responding to the chairman's inquiry, do we have any kind of reliable partnership with the Pakistani military leadership relative to identifying the sources of this kind of activity?

General BARBERO. I have been to Pakistan twice and met with the military. We have a framework for cooperation on this area. We press them hard. I think when they hear it from congressional delegations, the State Department, and DoD, it has an effect.

I will tell you that we have talked a lot about cooperation; we have not seen cooperation yet.

Mr. LEWIS. Thank you.

Mr. YOUNG. Thank you, Mr. Lewis.

Mr. Frelinghuysen.

CHAIN OF COMMAND

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman.

General, thank you for your distinguished career since West Point.

I want to get back to the chairman's letter here. Now, we have a chain of command here, these units. And, obviously, we are respectful of what is on the battlefield, the weapon of choice.

So if a soldier brings something to his superior's attention that obviously involves his safety or her safety and the people in that unit, what has happened in this situation? What have you found through your investigation here?

General BARBERO. Well, I have not investigated the chain of command. We look at the incidents and try to learn from them——

COUNTER IED EQUIPMENT POLICY

Mr. FRELINGHUYSEN. Well, no, I am sort of drilling down here of the policy issue here. We are providing resources here, but obviously we are talking about human beings. And if soldiers have an issue about—you know, if all of the equipment has been destroyed, someone might say, well, it might be difficult to get some in here, or maybe the budget has run dry, there are none, you know, in the area that can replace it, soldiers have to go out on patrol. Is that the policy?

General BARBERO. Uh-huh.

Mr. FRELINGHUYSEN. But, more importantly, in this instance, with this situation, how did the chain of command work? And was anybody out there listening?

General BARBERO. I——

Mr. FRELINGHUYSEN. I assume we have had some time to look into this matter?

General BARBERO. I can tell you a couple facts and then tell you what I don't know.

Fourth Brigade, 82nd is in the Zharay province—a very, very tough area. And I visited briefly with them in July, talked to the brigade commander. And since that time, we have had a video after-action review with them on lessons learned and things we can do better. That commander is very open when he needs something or if something hasn't worked.

I have not studied the letter. I have reviewed the incident, but I have not studied the letter or the comments in here, and so I can't comment on that.

Mr. FRELINGHUYSEN. This is a more personal hearing than many of the hearings we have here.

General BARBERO. Right. Right.

Mr. FRELINGHUYSEN. But just run me through the process here. Obviously, soldiers obey the command of their superior officers. And if equipment is destroyed, you know, and there is no replacement, people have to go on foot, right, with all the other devices you refer to here? Is that the policy?

And is there an issue here in this area where there was no other equipment available?

General BARBERO. I don't know what the specific policy is, but I have never heard a commander say, "Listen, we don't have this equipment, but I want you to go out there anyway." I know this commander, in particular, has told me, and I even walked the patrols, that he will not send out a patrol unless it has the following equipment.

And I am not sure—if there was a breakdown—obviously, Sergeant Sitton felt there were—and where that breakdown may have fell, I can't answer that, but——

Mr. FRELINGHUYSEN. Well, this is a—obviously, some letters have gone back and forth here, and, obviously, this is particularly horrific. Of course, all of us as Members have constituents. God forbid, many have died, but many have double amputees. And I have to be quite blunt. I haven't been good enough to question them, in some cases, the way that perhaps—the underpinnings of this discussion. But I do think there is a policy issue here.

PLACING MARKERS IN FERTILIZER

And on another issue, I think this is in the public arena, relative to the ranking member's comments, I thought Members of Congress were interested in putting some markers in some of this material that has been produced down there. And, quite honestly, the response from the bureaucracy was pretty lame. Where do we stand relative to that issue?

General BARBERO. Congressman, this has to deal with the fertilizer, and I would like to take that on in a different session, if I could. I think we will get into some classified information.

Mr. FRELINGHUYSEN. Okay.

General BARBERO. But we have asked four things: So the fertilizer industry writ large, we have engaged them and also, obviously, the Pakistani fertilizer issue, is first dye this stuff, put a dye in it, so a border guard on the Pakistan border who can't read can——

Mr. FRELINGHUYSEN. So you are actually answering my question even though——

General BARBERO. Well, I will tell you the four things that are open. We proposed this.

The first step is dye. Change the color. Right now it is this nondescript white; it is easily repackaged. And we have seen this as detergent and other materials. And if you have an illiterate border guard on the Pakistan-Afghanistan border, it is hard to detect when it has been repackaged.

The second thing is for the fertilizer industry, they need to reformulate this. Ammonium nitrate, in its pure form, existed until Northern Ireland——

Mr. FRELINGHUYSEN. General, this Committee has been talking about this for 4 years.

General BARBERO. Uh-huh.

Mr. FRELINGHUYSEN. You know, I hope we can make some progress. On the policy issue, it would be good if you could provide some clarification as to what it is.

General BARBERO. Okay. I will.

Mr. FRELINGHUYSEN. We would appreciate it.

General BARBERO. In another session, I can describe in detail our conversations of this specific problem.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman.

Mr. YOUNG. We will work with the General to schedule a classified version because I understand the reason why we can't discuss all of the technologies today and some of the tactics.

But I wanted to add to what Mr. Frelinghuysen said when he was talking about the chain of command. And I told you that after getting Sitton's letter that I doubled back with some other soldiers who had told me similar stories to what Matt Sitton told me. And one of those, by the way, was a commissioned officer; they were not just enlisted personnel. It was a commissioned officer who suffered from this same exposure from the same area.

So I wanted to make sure that you knew it wasn't just the soldier walking in the field, in the minefield. It was a commissioned officer that confirmed what Sergeant Sitton said.

Mr. Visclosky.

FUNDING THE EQUIPPING AND TRAINING OF AFGHAN FORCES

Mr. VISCLOSKY. Thank you, Mr. Chairman.

General, thank you very much.

Regarding the IED equipment—and if you have commented earlier, because I apologize, I was late—could you talk about the training and equipping of the Afghan forces and how that is proceeding? Because it appears you have to be trained up, and, even given that, there are very serious dangers here.

General BARBERO. My responsibility and my funding is authorized to support our combatant commanders in support of U.S. forces. I cannot use any of my funding for equipping or even training the Afghan forces. ISAF and the NATO training command there has a different fund to do that.

Mr. VISCLOSKY. Okay. Are they being trained?

General BARBERO. They are being trained.

Mr. VISCLOSKY. Who trains them?

General BARBERO. NATO forces at the institutions, and then when they operate——

Mr. VISCLOSKY. That would be in-country?

General BARBERO. That would be in-country, absolutely.

Mr. VISCLOSKY. And who does pay for that?

General BARBERO. Well, I can explain, give you an example. My last job before this, I had the training command in Iraq. And we had a separate pot of money called ISSF, and in Afghanistan I think it is called ASSF—funding to use to provide training, equipping of these security forces. And that fund is what is used to do that.

They are being trained in-country in EOD, route clearance, basic counter-IED. And the equipping is being procured to allow them to do that.

Mr. VISCLOSKY. It is not coming out of your pot, and you are not responsible for it.

If I could ask the chair or staff, are we responsible for that pot of money and it is simply a different agency under our jurisdiction? Do we know? Where is that money coming from? Do we know?

General BARBERO. It is OCO.

PERFORMANCE OF AFGHAN FORCES

Mr. VISCLOSKY. Okay.

Do you have an impression as to how this is working and, subsequently, whether the Afghans will have money to, you know, do this on their own?

General BARBERO. Well, two points, Congressman.

First of all, Secretary Carter has brought us all together and said, our priorities are to see what we can do to accelerate their capabilities. And so he has taken this on. He has said there are very few higher priorities than to build these capabilities for the Afghan forces. So it is a priority for him and for the Department to support the training command in Afghanistan to do this.

When I talk to our U.S. commanders about equipping and training and what they need and when I was there in July, they comment that when—and the statistics prove this—that when they operate with Afghan forces, their found and cleared rates go up. Be-

cause the Afghans are very, as you would imagine, just like it was in Iraq, they know what to look for, they know what doesn't look right. When they walk into a village to talk to people, they will be more forthcoming than they are with our forces. So they are effective at this.

I will also tell you that they are increasingly being targeted. Statistics also show us, as they get out there more often and they are in the lead and especially effective in these counter-IED operations, they are being targeted more by IEDs.

But beyond how capable they are, I would take that for the record and get you something from the folks in-theater.

[The information follows:]

The Joint Improvised Explosive Device Defeat Organization (JIEDDO) has supported Train the Trainer efforts in support of Afghanistan National Security Forces (ANSF) by assisting Combined Joint Task Force (CJTF) Paladin supporting the National Training Mission-Afghanistan (NTM-A). For example, JIEDDO facilitated contracting of 29 counter-improvised explosive device (C-IED) trainers for CJTF Paladin by assisting with the writing the Statement of Work and providing subject matter expertise on what the contractor should accomplish in this training. These C-IED trainers will provide training to the ANSF on handheld equipment, site exploitation, explosive hazard reduction, and C-TED awareness.

JIEDDO has offered to facilitate NTM-A's efforts to translate the C-IED training materials into Dari and Pashtun, but at this time we have no formal request for this assistance.

JIEDDO is not in any position to evaluate ANSF's C-IED capabilities directly, as that is the mission of NTM-A.

Mr. VISCLOSKY. Thank you.

Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Crenshaw.

TRAINING THE AFGHANIS

Mr. CRENSHAW. Thank you, Mr. Chairman.

Along the lines of training the Afghanis, let me ask you about that in the context of the green-on-blue situations that we are reading more and more about. And I know we have limited the number of those joint efforts. And I am sure that General Allen would say every time you got one of those situations you have a lot of positive interaction that takes place.

But my question is, when we talk about training the Afghanis in terms of counter-IED, is there any concern at all on our part that, as we train in terms of counter-IED, that some of that information becomes a blueprint for those green-on-blue situations, where we are basically telling them what we do, we are training them not only in a positive way, how to deal with that, but in a very negative way, how they can utilize that information in the wrong way? Is that a concern?

General BARBERO. I have not heard that concern raised by our commanders. And I can tell you that there are certain technologies which will not be transferred to the Afghan security forces for a variety of reasons. And we will share with them information, but we won't share with them our full capabilities for a variety of reasons: their ability to integrate that information, classified reasons, and other senses.

But I have not heard a concern from any commander that when they share information with their local Afghan counterpart, that that then is used against them.

BLUE ON GREEN ATTACKS

Mr. CRENSHAW. Is that something that you think that we ought to be thinking about?

General BARBERO. Given the nature and the seriousness of these blue on green attacks, we need to look at all aspects of it, I think. As General Dempsey said, it is not business as usual. I think he is saying we have to change something. So I believe we should look at all aspects of it.

Mr. CRENSHAW. As you say, this is a thinking enemy. It seems like we have to be thinking ahead, not just dealing with what we deal with. Part of my question is what do you see next? For instance, if we are training the Afghanis when we leave, they are going to have these counter-IED capabilities. If we don't tell them everything we know, then we leave, we are leaving them with inadequate information. Yet if we tell them everything we know, the concern that I raise is that they may be able to use that as a blueprint for working against us. So it seems to me that is a pretty complicated situation. What are your thoughts as we leave and as you see what happens day to day, what is next? Where do you see an increased use of IEDs and things like that?

General BARBERO. Let me just, Congressman, take that in the context from what we learned from the drawdown in Iraq and the transition there. We saw an increase in a certain type of weapon, these explosively formed projectiles, copper plates on a command wire. So as we detected this increase, we fielded additional capabilities to find these things and to go after them.

I would also tell you that, as I said in my statement, a smaller number of troops on the ground does not equal a corresponding drawdown in certain capabilities. Counter IED, we know it is still going to be used, and we need to increase our capabilities there.

ISR is another one. As your footprint decreases and you rely more on local forces, the fidelity of reporting and the accuracy of the reporting draws down also. So you must compensate for that. And one of the capabilities is an increase actually, what we did in Iraq, of ISR, to be able to fill in those gaps of situational awareness.

So those are some of the things that we have to keep in mind, that a drawdown in boots on the ground does not equal a drawdown across the board in all of our capabilities. And we are looking for indicators of other threats. And right now we are looking at next spring fighting season. What do we learn now, what can we get postured in time to equip our troops for that inevitable fighting season?

ATTACKING THE NETWORK

If I could make one point, Mr. Chairman. We have talked a lot about the device, defeating the device, and we have to do that. Most of our effort and our technology and our funding goes to that because that is how you limit casualties and that is how our commanders gain freedom of maneuver.

We also talked, we invest a lot in training because a well-trained trooper is our best counter IED tool.

The third line of operation and the one that is decisive is attacking the network. It goes to Congressman Dicks' comments about this network that supplies them these materials. And we must continue to do that and go after these networks, find out where their funds are and bring all the tools of our government to bear on these. And we are doing that also. That is a decisive effort, though.

Mr. CRENSHAW. Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Calvert.

PAKISTAN

Mr. CALVERT. Thank you, Mr. Chairman.

Thank you, General, for coming today. We are all extremely frustrated, as you can tell. And I am sure nobody is more frustrated than you are. As Mr. Frelinghuysen said, this has been going on for years to get a coherent strategy on how to deal with these IEDs. And we keep going back to Pakistan, our supposed ally in the region. What kind of ally would allow for this kind of activity to continue? You know, I keep saying look, if we had two major fertilizers plants in Mexico and people were smuggling across even a small amount of fertilizer and killing five U.S. citizens a week, I am sure we would something about it pretty quickly.

Here we are today losing approximately five U.S. servicemembers a week, or having horrific injuries, and it seems we are unable to do anything with our supposed ally in Pakistan. These markers that we were talking about, the Pakistani Government is not even interested in dealing with the United States in making those markers available. Some people think they are effective or not effective, I don't know. But it tells you something about Pakistan that they don't even want to consider doing anything to help us identify calcium ammonium nitrate as it crosses that border. The Haqqani network continues to operate with impunity in Pakistan and especially in some of the border regions, which we can probably get into a more secure briefing area, without any interference with the Pakistani military at all. And it seems to me you can do a lot of work in Afghanistan and other regions around the world where we are going to have this problem, and that is important, but specifically to the Afghan theater. If the material that is being used continues to cross that border with virtually no interference at all because the border is a sieve, you can smuggle just about anything across that border, without any assistance from the Pakistanis at all, how in the hell are we going to deal with this?

General BARBERO. Congressman, I can't argue with anything that you have said. As I said at the outset when you are just focused on the device and mitigating its impact you are playing defense. In another session——

Mr. CALVERT. I think we are all tired of playing defense.

Mr. Chairman, I think any aid and assistance that we have to Pakistan should be directly tied to their assistance to us to help us deal with these fertilizer plants in Pakistan, especially something as simple as adding a color or an odor to the production of this fertilizer. And I know those offers have been made. Those offers have been made to cover the cost of it and they are not interested in doing it because I am sure the ISI finds it convenient to continue to be able to work with the Haqqani network to smuggle this

across the border. Let's just call it the way it is. They like to destabilize the Afghan Government, destabilize the NATO allies that are fighting in Afghanistan, and the Pakistanis continue to deal with these people. And they continue to kill American soldiers every day.

Mr. YOUNG. Would the gentleman yield?

Mr. CALVERT. Yes, I am happy to yield.

Mr. YOUNG. You remember that in our defense appropriations bill that we passed with a very large number in the House, we had some very tough language dealing with the issue that you are talking about in Pakistan. But when the Senate chose not to take up that bill, that became null and void and we are functioning under a continuing resolution which does not include the strong language on Pakistan.

Mr. CALVERT. And nobody has worked harder on this issue than you have, Mr. Chairman. I appreciate that language. It is frustrating to us to have to operate under a continuing resolution when we could do some things, and I hope maybe during the lame duck session maybe we can work toward a real bill.

Mr. YOUNG. We tried to get that language in the CR as an anomaly, but we weren't successful there. Thank you for raising that issue. It is a very important issue.

Mr. CALVERT. As I mentioned earlier, if these two fertilizer plants were in Mexico, I suspect we would find a way to neutralize that problem. But they are not, they are in Pakistan.

Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Hinchey.

SUSPENSION OF U.S.-AFGHAN JOINT MILITRY OPERATIONS

Mr. HINCHEY. Thank you, Mr. Chairman.

General Barbero, thank you very much. I very much appreciate everything that you are saying. And I think it is very, very good we called this hearing today because this is a whole host of set of circumstances that need to be focused on and dealt with and dealt with as effectively as possible. So I think it is worth discussing the news that U.S.-Afghan joint military operations have been suspended. They have been suspended, and at least below the battalion level after numerous green on blue attacks. So this year already, as I understand it, 51 NATO coalition members have been killed in these types of attacks, various kinds of attacks that have been going on over there. So I know that we have justified our continued commitment to Afghanistan by our willingness to train Afghan forces and hand responsibility as much as possible to them, but the situation to some extent continues although I think we have done things that are apparently making the situation a little bit better, stronger and more effective. Less people are getting killed.

I think it is worth discussing in this Committee since we are spending as I understand it $85.6 billion in and around Afghanistan by maintaining our presence and training and arming people that end up killing our young men and women. So there is a whole host of things that are going on and I deeply appreciate you and I deeply appreciate all of the things that you have been engaged in and how you have been trying to straighten this out.

I wonder how long will training be suspended and what do we realistically hope to achieve between now and the end of 2014? And is that worth the risks to American lives and the tremendous appropriations that are dealt with in the meantime?

As I said, I know that you are dealing with this very effectively, but it is an interesting situation. It is an interesting situation to a large extent with Afghanistan because of the conflicting activities that are being engaged there by that country. So I would appreciate whatever you can tell us about that.

General BARBERO. Thank you, Congressman.

I can tell you what I have seen is that the suspension of joint operations has been described as temporary by ISAF, and I am not sure beyond that when it will resume. The chairman quoted General Dempsey about the seriousness of this, and it is not business as usual and the Department is seized with it. And I do not want to give you any misinformation on that, but I do not deal with green on blue, so I would be just guessing if I told you, gave you my views on that. And some of those are policy decisions, obviously.

But I do, and I would like to say before this Committee that the issues we have talked about underscore why going into fiscal year 2013, having the budgetary flexibility that we have requested in our submission is so important. General Dempsey described the way forward as not a straight line. And we know certain things about 2013, and there are certain things we just don't know. We know there is going to be a tough fighting season. The Secretary said that the other day. We know it is a smart and determined enemy. We have a whole generation of bomb makers. And the IED numbers continue to tell us it is going to be the weapon of choice. And we know that we will be conducting combat operations into 2013.

Why we need flexibility, and how long will we be at 68,000? And how long will we continue to require increased counter IED capabilities. The enemy gets a vote. It is a thinking enemy, and they are going to do this, what we described today and other actions.

If we have a new initiative that comes our way, that could be, have an impact on the counter IED fight, and we are going to get it there as fast as we can. We have one in theater now that is a new capability that I can't talk about here much, although I will tell you it allows us, I think, to detonate certain IEDs at the time and place of our choosing. We have moved that to theater, so we need that flexibility as we go into 2013 to find and field new initiatives. And then there are unforeseen requirements from our commanders, just as we had this year. For robots and undergarments and additional sensors that we need to be able to fund also. So what we have talked about here is a very dynamic situation, and it requires us to have the flexibility to be able to respond and support our commanders and the troopers.

POLITICAL TURBULANCE IN AFGHANISTAN AND PAKISTAN

Mr. HINCHEY. Just one more simple little question. Afghanistan is a complicated set of circumstances. I am just wondering to what extent we are trying to understand just exactly what they are doing, what their motivation is, what their complexity is, how they are dealing with the complex internally within their country. Is

there any sense that we have with regard to what the future might be and if that future is going to be steadily honest, secure, or maybe not?

General BARBERO. I am sure, Congressman, that there are experts and leaders who study this and can answer that. I am not one of them. I have not studied it and I have not formed a view on that. It would be way outside my lane to try to guess on the future of Afghanistan or Pakistan.

Mr. HINCHEY. So this is something we need to deal with more effectively and get the answers to.

Thank you very much, General.

Mr. YOUNG. Mr. Bonner.

AUTHORITY TO SUPPORT OTHER U.S. AGENCIES WITH DOD FUND

Mr. BONNER. Thank you, Mr. Chairman.

General, this has been an enlightening hearing and I think we all look forward to the closed session that we will have a chance to have with you.

The chairman made note of the fact that we had language in our defense bill which has drawn bipartisan support that perhaps would have sent a very blunt and direct message to Pakistan with regard to these fertilizer plants and he also mentioned that because we are operating under a CR that very few on this Committee are excited about that language can't take effect yet from Congress. But it is not, correct me if I am wrong, it would not preclude the leadership of the Department of Defense from recommending it to the Commander in Chief that he initiate this message? Are you familiar enough with the language that Chairman Young was talking about that you could offer a comment about whether you think this might be a possible solution with regard to this issue?

General BARBERO. Is this in relation to funding for Pakistan?

Mr. BONNER. Yes, sir.

General BARBERO. I am not familiar with the specific language that is contained therein. But I am familiar with the legislative proposal that has been submitted from the Department that deals with my authorities to use my funding which I would like to recommend support for. It would allow me to use my funding to support any activity by our other Federal agencies, Border Patrol, FBI and others, to impede the flow of these materials from Pakistan into Afghanistan. Right now I can't do that. If a Federal agency said we want to put this technology in place working with either Afghan border police or Pakistan border police, I can't help them, although it directly impacts the problem that we have talked about, and the language is in the authorization bill, both versions, which would support this. I am concerned that I will not be able to enact this until the NOAA is passed. But that language, I think I know about because we helped prepare it. The Department supported it, and it is in both authorization bills and I think that is a tool that we can use, which I can talk more about in this closed session.

MILITARY WORKING DOGS

Mr. BONNER. You know, every member here has been to Walter Reed Bethesda, none more than Chairman Young and his wife,

Beverly. Every member here has been, like you and others in uniform, to the homes of the young men and women who have come home in a flag-draped coffin.

I had the privilege of having breakfast this morning with a young man from my district who stepped on an IED. Fortunately, I had a chance to have breakfast with him and I didn't have to go to a funeral home to pay respects to his family. He lost a leg, he is fighting to keep the second leg. So when you hear the questions coming from around this table, they are coming with frustration and with heartfelt concern that more has to be done. They are also coming obviously with the greatest respect for the uniform you wear and the tough decisions that you have under your responsibility.

We have talked about the robots and the undergarments and the additional sensors and other things. One thing we haven't discussed is what is being done with regard to dogs going out? Is that something that has been effective? Is that something that could be more helpful until we get a permanent—we know what the weapon of choice is, but until we find a way to take that weapon off the table, are dogs part of the solution? And if so, are you getting adequate funding for that?

General BARBERO. Congressman, we are. Dogs are a part of this. I tell people we are involved in fielding everything from a sensor at 40,000 feet to a four-legged sensor on the ground. And they are effective. And our commanders use them.

Some commanders will not let a dismounted patrol go out without a dog. They have limitations—110 degree heat, climbing over culverts and into canals and things like that, carrying a dog over a wall so you don't go through a likely ambush point. But they are effective. But it boils down to selection of the handler. If you don't have a senior NCO picking the right soldier or marine or airman or sailor to go out there, you are not going to be successful. And I am confident all of our commanders understand that and are engaged in picking the right handler for the dog to really make it an operational team. The other part is the preparation and training of the dogs and getting them trained on the right senses, ammonium nitrate, for example, to sense that. But it is a part of it. It is part of this network and part of the tools that my job is to provide to commanders and NCOs and let them choose which ones they want to take on which mission which is most effective in their specific area. But dogs are effective, and we are committed to that. And we are adequately funded for those.

Mr. BONNER. Thank you, Mr. Chairman.

SITTON LETTER

Mr. YOUNG. I would advise the committee in an agreement the General and I had yesterday on timing, we have time for each member to have a follow-up question. I am going to use my time for a follow-up question. I have had a couple of notes from the audience asking a little more about the Sitton letter which has been mentioned several times. I only have a couple of copies of that letter, but I am going to ask Mr. Paul Terry to actually read the Sitton letter so you know what we are talking about when you hear reference to the Sitton letter.

Mr. TERRY. Hello. My name is Staff Sergeant Matthew Sitton. I am in the 82nd Airborne Division stationed in Fort Bragg, North Carolina. I am currently deployed with the 4th Brigade Combat Team in support of Operation Enduring Freedom in Afghanistan. I am writing you because I am concerned for the safety of my soldiers. This is my third combat tour to Afghanistan. So I have seen the transition in rules of engagement and overall tactics over the past 6 years. I am only writing this email because I feel myself and my soldiers are being put into unnecessary positions where harm and danger are imminent. I know the threat of casualties in war and am totally on board with sacrifice for my country, but what I do not agree with is the chain of command making us walk through, for lack of a better term, basically a mine field on a daily basis. I am in a platoon of 25 soldiers. We are operating at a tempo that is set for a full 35–40 man infantry platoon. We have been mandated to patrol twice daily for 2–4 hours each patrol on top of guarding our forward operating base and conducting routine maintenance of our equipment. There is no end state or purpose for the patrols given to us from our higher chain of command, only that we will be out for a certain period of time. I am all for getting on the ground and fighting for my country when I know there is a desired end state and we have clear guidance of what needs to be done. But when we are told basically to just go walk around for a certain amount of time is not sitting well with me. As a brigade, we are averaging at a minimum an amputee a day from our soldiers, because we are walking around aimlessly through grape rows and compounds that are littered with explosives. Not to mention that the operating tempo that every soldier is on leaves little to no time for rest and refit. The morale and alertness levels on our patrols are low, and it is causing casualties left and right.

Here is an example of how bad things have gotten. Our small forward operating base was flooded accidentally by a local [by a local—that being citizen] Early one morning a few days ago. He was watering his fields and the dam he had broke and water came flooding into our living area. Since our forward operating base does not have portable bathrooms, we had to dig a hole in the ground where soldiers could use for the bathroom. That also got flooded and contaminated the water that later soaked every soldier and his gear. Instead of returning to base and cleaning up, our chain of command was set on us meeting the brigade commanders two patrols a day guidance that they made us move outside the flooded forward operating base and conduct our patrols soaked in urine.

That is just one single instance of the unsatisfactory situation that our chain of command has put us in. At least three of my soldiers have gotten sick since that incident and taken away from our combat power because of their illness caused by unhealthy conditions.

I understand that as a commander you are to follow the orders of those appointed over you. However, there needs to be a time where the wellness of your soldiers needs to take priority over walking around in fields for hours a day for no rhyme or reason, but only to meet the brigade commander's guidance of you will conduct so many patrols for such an allotted time.

I am concerned about the well-being of my soldiers and have tried to voice my opinion through the proper channels of my own chain of command, only to be turned away and told that I need to stop complaining. It is my responsibility to take care of my soldiers, and there is only so much I can do with that little bit of rank I have. My guys would fight by my side and have my back in any condition, and I owe it to them to have their best interest in mind. I know they would and I certainly would appreciate it if there was something that you could do to help us out. I just want to return my guys home to their families healthy.

I apologize for taking your time like this, sir, and I appreciate what you do for us. I was told to contact you by my grandmother who said you had helped my uncle many years ago. He was also serving in the military at that time. Thank you again for allowing soldiers like me to voice their opinion. If anything, please pray for us over here. God bless.

Mr. YOUNG. Paul, thank you very much.

That letter was forwarded to the Pentagon, and a discussion of that letter took place between myself and numerous high ranking leaders at the Pentagon, military and civilian.

Before we got any kind of a response, Sergeant Sitton's prophesy came true. He died. He and his platoon sergeant were both affected by the same IED and they both died.

Mr. Dicks.

FUNDING AUTHORITY

Mr. DICKS. As I understand what you testified, General, you do not have the language that you need in order to deal with this border situation, and it was in both of the authorizing bills but it is not in the continuing resolution; is that correct?

General BARBERO. That is true, Congressman.

Mr. DICKS. So the authorization bills are not enacted and the continuing resolution is not amended, you can't do what you have asked to be able to do; is that correct?

General BARBERO. That is my understanding, Congressman.

Mr. DICKS. Can you tell us what this will not allow you to do that you want to do?

General BARBERO. This would adjust our funding authorities so I can use my funds, which I can commit rapidly to fund initiatives by other Federal agencies, Border Patrol and others, to take actions along the Afghan-Pakistan border to help impede the flow of these materials, either helping Afghan forces, Pakistani forces, or otherwise. And this would allow me to use my funds which were designed to be able to rapidly address issues like this, in my view. So that is what it would allow us to do.

Mr. DICKS. Could this be addressed by a reprogramming? Have you thought about that?

General BARBERO. No, I think it could not be.

Mr. DICKS. So you think it takes legislative language?

General BARBERO. It does. That is what we have been told, and that is what we have been working and the Department has supported this legislative language.

Mr. DICKS. Another reason why we ought to get this defense bill enacted and get our authorization bill passed.

Thank you, Mr. Chairman.

Mr. YOUNG. Thank you, Mr. Dicks.

Mr. Lewis.

FERTILIZER MARKERS

Mr. LEWIS. Thank you, Mr. Chairman.

General, we have noted that the administration has been willing to take direct action when the Congress is not acting in a number of arenas. Relative to fertilizer and ammonium nitrates, relative to markers in fertilizer, are you telling me that the Congress, in spite of the Congress, the administration, the Secretary of Defense, upon your request, could not take action that would specifically require markers placed in ammonium nitrates? Are your hands tied to that extent that you can't take a direct action that will save the lives of our troops by saying, through the Secretary of Defense, by God, we have to do something. I am the General, I am asking you to do something.

General BARBERO. Congressman, throughout the fertilizer industry, there is no one who puts markers or taggants in their fertilizer. The issue is——

Mr. LEWIS. Why?

General BARBERO. I think it is purely cost. We have raised this to them. There are very strict, since Oklahoma City, there are very strict restrictions here on the transfer of ammonium nitrate in the United States. Not so, obviously, in other places in the world.

It is going to take Pakistan to take these actions. We cannot force it. If the Secretary of Defense ordered it, I am not sure how it would happen. It is going to take cooperation from Pakistan and this company to do that, and to treat this specific case that we have been talking about, about the flow of these materials into Afghanistan.

Mr. LEWIS. You know, I do not believe this Committee wants to be in a position of serving the Secretary of State, imposing our willing upon the Commander in Chief, et cetera, but my God, troops are losing their lives. And if we can't indeed at least insist that the government of Pakistan help us place markers in ammonium nitrate, then what are we here for?

General BARBERO. Secretary of State Clinton, this is on the top of her list with engagements and priorities with Pakistan. I can describe in another session the interagency actions that are taking place to get after this problem. But I just can't do it here in this session, Congressman.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Frelinghuysen.

POLICY ON OPERATIONS WITH COUNTER IED EQUIPMENT

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman.

General, correct me if I am wrong, often the most dangerous time in war is when you are getting out of Dodge, when you are leaving, and we are departing out of Afghanistan. We give you I think in our budget $1.7 billion. I am wondering how we marry what you are doing with the policy issues raised in that letter that was written by Mr. Sitton? We can give you, and God bless you for the things that you do and things we have prevented, but if the money

that goes into R&D is not married to some sort of a policy here, what I see, and correct me if I am wrong, is that some of these units are out there. Their equipment is destroyed. They may be in a God forsaken place to begin with, they may be in a forward operating base. Has the equipment been drawn down so much because of destruction, its destruction, that we can't supply to these soldiers some sort of a replacement that would perhaps limit their—the foot patrols that were referenced in that letter. In other words, we give you resources, but how is the chain of command making use of some of these other resources here? We have Stryker equipment. We have a lot of stuff that is out there.

General BARBERO. Right. Congressman, a couple of points. First of all, the most dangerous time in any military operation is a transition. When you go from one to the other.

TRANSITION

Mr. FRELINGHUYSEN. You can call it what it is, but we are in that time.

General BARBERO. We are. We have two this year. There is a transition to an advising training role and different structure, and then the eventual transition to the Afghan security forces. These are fraught with challenges.

Mr. FRELINGHUYSEN. The focus here is what we are going to do with all of the MRAPs. What about the soldiers that are on point now that are suffering these injuries? Are they missing equipment because we can't get the equipment to them? What is going on here?

General BARBERO. Obviously from Sergeant Sitton's letter, there are some issues we need to look into as a Department. But when I talk to commanders, I talk to junior leaders, lieutenants, sergeants and some troopers, I ask what them else they need. And they give us some very specific requirements which we take on.

We are well funded to provide replacement mine rollers, repair parts, and contractors who work on these, and that is a constant point of attention, is where do we have the right people at the right place to rapidly repair these so when our troopers go outside the wire they have what they need. And we will redouble our effort based on this. We are not complacent about it, and we are looking at it.

Mr. FRELINGHUYSEN. Just for the record, there are not shortages of some of this equipment here?

General BARBERO. Not that I am aware of.

Mr. FRELINGHUYSEN. I think we would like to actually maybe get a greater picture as to what is out there. I understand what is referred to and I want to be respectful that we will be looking into it. But in reality, this letter was out there and there was a call for help, and apparently we were not able to meet that call.

Thank you, Mr. Chairman.

General BARBERO. If I could just make additional comments, our budget request for fiscal year 2013 was $1.9 billion. Last year it was $2.4 billion. We looked very seriously at the reduction in troops. We fielded a lot of equipment last year. We did not need to repeat the same funding as last year, so $1.9 billion it is my firm belief will allow us to meet the challenges that we know and those

challenges that I said we were not sure about. And anything below that I believe we would be accepting risk in the area of the number one weapon used against us. So I appreciate your support on that.

Mr. YOUNG. General, if you would provide for the record information relative to the mine rollers and Strykers because the information that we have received was that there were Strykers sitting idle because they did not have a mine roller. If there is a problem in providing mine rollers, this committee will find a way to appropriate the money to get the mine rollers. Whatever it costs for the mine roller will not compare to the cost of a soldier's life or losing arms and legs.

[The information follows:]

Currently, the availability of mine rollers is not impacting operational use of Stryker vehicles in Afghanistan. This was confirmed during a recent site visit by the Project Manager—Stryker Brigade Combat Team.

Of the 144 mine rollers delivered in Afghanistan for use on Stryker Double V-Hull (DVH) vehicles, 52 have been issued and another 92 are available for issue. An additional 114 mine rollers are currently on contract and are being delivered to Afghanistan at a rate of 20 per month with an expected delivery completion in March 2013. This will complete the total requirement of 258 mine rollers.

To allow installation of the mine rollers on the Stryker DVH, an adapter kit, or "Delta" kit has been developed. With regards to the Mine Roller Adapter Kit (MRAK) Delta kit, 80 kits have been delivered in Afghanistan for use on Stryker DVH vehicles. Of these 80 delivered kits, 36 have been issued and 44 are available for issue. An additional 125 are currently on contract and are being delivered to Afghanistan at a rate of 20 per month with an expected delivery completion in April 2013. This will complete the total requirement of 205 MRAK Delta kits.

Currently, all current Stryker DVH vehicle fieldings in Afghanistan include two Light Weight Mine Roller (LWMR) systems per platoon and additional LWMRs are being issued to the current DVH fleet as required.

Mr. DICKS. Mr. Chairman, would you yield?

Mr. YOUNG. Absolutely.

RAPID RESPONSE FUNDING

Mr. DICKS. We received a letter yesterday, a couple of days ago from Secretary Panetta which cited that DoD has a rapid acquisition authority to align funds to provide for the safety of the troops. The Committee was just given this letter on 9/17, and this was authority that was in the 2003 authorization bill. Why couldn't this authority be used? If you can't answer that directly, take a look into this. I think it could address a number of these issues, especially the one dealing with the border issue.

General BARBERO. My funding is rapid response. I can approve $25 million with my signature. Anything above that is rapidly staffed through the four stars and the Deputy Secretary approves that. He has never disapproved one, and it takes us about 7 days to get that approved.

Mr. DICKS. So you could do the mine rollers?

General BARBERO. In total, Congressman, we have spent about $400–500 million on mine rollers, repair parts and contractors to support them. We will look into the mine roller issue and report back to this committee.

Mr. DICKS. We will give you a copy of this letter. Take a look at this authority and see if this authority could be of assistance.

General BARBERO. Absolutely.

Mr. DICKS. Thank you.

Mr. YOUNG. Mr. Visclosky.

IED BOMBER NETWORK

Mr. VISCLOSKY. Thank you, Mr. Chairman.

General, on the networks that protect the bombers and provide them supplies, guide them, what success have you had against these networks in Afghanistan and Iraq? What remains to be done, and particularly as far as the security forces in Afghanistan now, have they been helpful, unhelpful? Are parts of the network embedded in the Afghan security forces? If you could comment.

General BARBERO. I will tell you in a description of the networks, and this could be applied in a number of places around the world, but in the Afghanistan/Pakistan region, we see a cooperation or I call it a consortium of networks. You have the narco, the poppy network. That is the cash crop for the insurgency, and they use IEDs to protect their cash crop. You have a smuggling network which has gone across that border for centuries. That is involved in this. And then you have the insurgents network that is controlling the flow of these materials. So when you talk about the network, it is this consortium of networks that you have to look at.

And I will tell you, I believe and as I have said, I have done this in Iraq, I believe we are being effective against the network. One of the factors I didn't mention, which is driving down the effectiveness rates of these attacks, is we have worn down the network in Afghanistan to a degree. But they are resilient. They are adaptive.

Mr. VISCLOSKY. Can you be specific? In what respect would you characterize you have worn them down?

General BARBERO. Well, leadership. But they are still obviously very active and very lethal. Leadership, we have gone after their supplies. But it is a continuous effort to go after them.

My reports from the NSA is they are effective in providing intelligence and cooperating in the intelligence collection on these networks. And I haven't seen any reports to the contrary on that.

Mr. VISCLOSKY. Have you seen any infiltration of the security forces by the networks?

General BARBERO. That is the question in these blue on green attacks. That is still being determined, whether these are individual actors or part of a concerted effort. I have not seen the conclusion of the intelligence on that.

Mr. VISCLOSKY. Thank you, Mr. Chairman.

Mr. YOUNG. Mr. Calvert.

Mr. CALVERT. Thank you, Mr. Chairman.

I am going to go back to Pakistan for a second. It seems to me it all goes back to this supposed ally. I know we focus a lot of time on Iran and what Iran is doing to fund various terrorist networks throughout the world that affect the stability and United States security, but Pakistan was the country that developed the nuclear weapon and then proliferated that weapon to our adversaries.

Now I hear Mr. Khan is running for public office in Pakistan and is revered by the Pakistani population. The Pakistani Government continues, through the ISI, to fund and help and assist the Haqqani network and other terrorist organizations. And God knows, they continue to shield certain elements of the Taliban in certain communities throughout Pakistan, especially along the border area. They continue to attack NATO troops and U.S. interests

with impunity. And I still have a hard time, I know our intelligence people say that they didn't know Osama bin Laden was hiding under their nose right there in the largest military town in Pakistan, just happened to live there for a few years, and they are upset that we went in and killed him. You know, I am just tired of people saying we have this ally and we have to be sensitive to their feelings. Well, they are not being very sensitive to us when they won't even allow for us to pay to put markers in these two fertilizer plants. I agree it is beyond just Pakistan. We ought to have a national standard for ammonium nitrate throughout the world that has a common odor and other markers put into ammonium nitrate because you are going to see this problem in South America. I wouldn't be surprised if we see it along the border regions of the United States and some of these crazies that want to do harm to the United States Government. We need to be more proactive.

By the way, on this continuing resolution, the Commander in Chief, the definition of a continuing resolution, we give the authority to the President to have a lot of authority to fund what he wants to fund as a Commander in Chief. We give—we relinquished our authority under the Constitution, it doesn't matter who the President is. I think we all agree we should be doing these bills, but I would think that the President has some authority to say to the Pakistan Government, look, you agree to work with us on this or you are not going to get any money. We have to start playing hard ball with these guys. As I said, at the end of the day, you can do all you want in Afghanistan to protect our troops, and I know you are doing a lot, but at the end of the day, it is like you have your finger in the dike. And it is impossible to deal with the amount of stuff that is coming across that border.

Thank you, Mr. Chairman.

Mr. YOUNG. Incidentally, gentlemen, we mentioned there was language in our defense bill that is not in the continuation resolution, and that language does include comments about IEDs, explosive devices, the networks, and the precursor chemicals. And so we actually do address that issue in our language that is not active now because there is no bill.

Mr. Moran.

POLICY

Mr. MORAN. Thank you, Mr. Chairman.

Mr. Chairman, I agree with the tone and the content of what Mr. Calvert has said, and with all of my colleagues on this panel, and I agree with the statements that you most recently made with regard to this Afghan conflict. I am glad we are having a hearing, but we have the wrong guy here. He is doing his job. He is doing the research. He has been given a procedural responsibility. But we are asking him about policy because the policy is the problem. It is not these very competent individuals who are carrying out their assignments. The best way that we can stop these horrendous losses of limbs and lives is to get our troops the hell out of there. That is the way to do it. Instead, we are spending billions and billions of dollars on equipment and research and so on when the real solution, I think, is staring us in the face.

With regard to Pakistan, I couldn't agree more. And I agree with—did we put this language in that I was handed that we are not going to give any more money to Pakistan until they—this is actually in the bill, or we want to put it in? It is in the bill. Geez, I wish we had talked about it more. It is great language. The problem is they have a nuclear weapon, and we can't think that Iran hasn't learned that lesson that we are teaching every day with the hands off or gentle approach we take to Pakistan when they are the problem in Afghanistan.

So I wonder if it is not time to bring the Secretary back after the election in the lame duck session and talk about the policy, talk to the policy people. It is not General Barbero's responsibility to answer the questions that are on our mind and really need answers, but I think it is past time to get some policy answers, particularly when it is clear that the green on blue attacks are stepping up. We are not making progress. And some of the people who have the courage to speak out honestly and forthrightly are telling us look, this is a lost cause. We are not gaining ground, and we have to try a different approach. Maybe the first step is to substantially accelerate our troop withdrawal out of Afghanistan. And the implications of that, the ramifications it seems to me might be helpful to discuss them with the Secretary, even in a public session. But that is your call, Mr. Chairman.

That is all I have to say. I have been told that every thoughtful question that could have been asked of General Barbero has been asked. And so my alternative was to ask an unthoughtful question, and I will pass on that opportunity.

Mr. YOUNG. I will tell you that we started out on a NATO issue, but we did expand to a lot of other issues. And I agree with what you said, that we should be pursuing this whole issue of Afghanistan. You know my thoughts on that.

Mr. MORAN. And I agree with you.

Mr. YOUNG. Mr. Hinchey.

COUNTER IED RESEARCH AND DEVELOPMENT

Mr. HINCHEY. Thank you very much, Mr. Chairman.

This is a very interesting and important issue that we are dealing with. General, I thank you very much for everything that you have said effectively. I just wonder, just briefly, if you can discuss the research and development for future counter-IEDs? Is there any way you may be able to say something about that situation? And are big developments in the work that can just simply continue to save lives?

General BARBERO. Congressman, we take our R&D role and search for new capabilities obviously as a huge part of our mission. General Mattis, one of my bosses, his number one priority to us is predetonation. What can we do to detonate these IEDs to a time and place of our choosing. He has been very vocal about that, but also supportive. We have made—and this is hard physics and you are hearing this from an infantryman now, so bear with me. But to be able to impart enough energy into the ground to activate a blasting cap or something like that with different soil conditions and moisture is very—is a great challenge. But I would like to tell you maybe in the closed session what we are doing in that area,

what capabilities we have fielded, and the progress of the ones that we have behind them in various states of research and development.

SEVEN CAPABILITY GAPS

Also, we have identified seven areas. I identified earlier what I think are some enduring capabilities we need to have to deal with this enduring threat, and the Department is looking at those. But also, we have identified seven areas of our current capability gaps, and we have made this unclassified. We put it on our Web site and we shared it with industry and with academia and with the national labs. I have been to all of them, and they are directly engaged in helping us identify capabilities to help close some of these gaps we have—detection, blast mitigation, predetonation, a greater ability to pull fingerprints or DNA from these devices so we can identify and go after the network.

So it is very active. Probably in a closed session I can tell you what technologies we have recently fielded and which ones are in the pipeline.

Mr. HINCHEY. Thank you very much.

Mr. YOUNG. General, thank you very much for an excellent hearing. I know it expanded beyond where we started at, and we do appreciate your willingness to join with us again to discuss some of the classified materials that are extremely important to the work that we do and to the work that you do. So we will be in touch with you to arrange a compatible time for that purpose.

Unless Members have any other business, we are adjourned.

[CLERK'S NOTE.—Questions submitted by Mr. Moran and the answers thereto follow:]

Question. We have seen significant, but insufficient, progress in JIEDDO's ability to manage the DoD counter-IED effort. To best confront the enemy's techniques, tactics and procedures, I believe we need to leverage the entire defense industrial base so long as our uniformed servicemembers are in harm's way. How can JIEDDO better leverage the entire industrial base, but especially the capabilities of large contractors, in a cost-effective manner as the defense budget generally, and JIEDDO's budget specifically, declines?

Answer. The Joint Improvised Explosive Device Defeat Organization (JIEDDO) routinely engages directly with industry, including large contractors, to identify innovative capabilities in order to enable access to the industrial base to develop and field enablers for counter-improvised explosive device (C-IED) related operational needs. For example:

- JIEDDO solicits proposals from industry, including large contractors, through its Broad Agency Announcement (BAA) process. Over the past year, JIEDDO received 132 proposals through the BAA process from private entities which identified themselves as large businesses (with "large business" meaning a business not eligible for registering with the federal government as a small business).
- JIEDDO invites industry representatives to attend JIEDDO-sponsored technology outreach events, such as the JIEDDO Technology Outreach Conferences (JTOCs).
- JIEDDO works with industry groups in the development of certain kinds of C-IED capabilities—for example, for C-TED solutions involving robotic platforms, JIEDDO leverages industry groups including the National Defense Industrial Association and the Association of Unmanned Vehicle Systems International to maintain awareness of both Department of Defense (DoD) and commercial efforts.

JIEDDO leverages the whole industrial base, including both small business and large contractors, to meet the goal of rapid delivery to the warfighter. JIEDDO seeks opportunities to leverage large firms during the procurement phase of initiatives (i.e., the acquiring and fielding of developed capabilities) in order to achieve cost efficiencies. Currently, JIEDDO has 29 initiatives with large industrial partners.

To more effectively invest in new solutions to counter an evolving enemy, JIEDDO strives to maintain visibility over C-IED capabilities being developed and fielded by other DoD components. JIEDDO's primary effort in this area is serving as the lead for developing a DoD-wide database of C-IED capabilities, which will enable the analysis needed to develop a comprehensive DoD-wide inventory of C-TED capabilities. JIEDDO is currently evaluating alternative technical approaches for developing the database. A timeline for creation and implementation of the database will be developed once JIEDDO has selected a new technical solution. JIEDDO expects to make a decision on the technical approach for the database by the first quarter of FY 2013.

In the absence of this database and the associated comprehensive inventory, JIEDDO employs a number of tools and processes to maintain visibility over other DoD components' development and fielding of C-IED capabilities and how they leverage the industrial base to meet C-TED related operational needs, such as the following:

- DoD Services and Agencies participate in JIEDDO-sponsored JTOCs and mini-JTOCs.
- JIEDDO co-chairs, with the Office of the Assistant Secretary of Defense (Research & Engineering), the DoD C-IED Science and Technology (S&T) Technology Focus Team, a DoD-wide committee which coordinates C-IED S&T issues across DoD.
- JIEDDO conducts direct engagements with other DoD components (Services, Service laboratories, Defense Advanced Research Projects Agency, etc.) on an as-required basis for certain planning, project management, and budget execution tasks.
- There are a number of liaison officers from other DoD components and other federal agencies who are embedded with JIEDDO.
- The Boards within the Joint Improvised Explosive Device Defeat Capability Approval and Acquisition Management Process (JCAAMP) provide an opportunity for DoD entities, such as the Offices of the Under Secretaries of Defense, the Services, and the Chairman of the Joint Chiefs of Staff, to coordinate with JIEDDO on decisions regarding C-IED initiatives brought for review and approval.
- Subject matter experts from other DoD components participate in evaluation panels to review new C-TED-related proposals that are submitted through JIEDDO's BAA Information Delivery System process.

Question. As a multibillion dollar defense organization, can you provide the committee with your timeline and approach to audit readiness for the Statement of Budgetary Resources in accordance with Secretary Panetta's readiness goal of March 2014.

Answer. The Joint Improvised Explosive Device Defeat Organization's (JIEDDO) timeline and approach to achieving audit readiness for Statement of Budgetary Resources (SBR) is through utilization of the General Fund Enterprise Business System (GFEBS) in accordance with Department of Defense guidance. In accordance with the Department of the Army goals, JIEDDO began fielding GFEBS in July 2012 in preparation for utilization during FY2013. GFEBS will improve JIEDDO's financial management capability and in-turn accomplishes audit readiness for SBR by June 2014. Additionally, JIEDDO has implemented monthly and quarterly comprehensive management internal controls testing to closely monitor financial transactions and sequentially facilitate complete audit trails. By 1 October 2013, JIEDDO will execute full utilization of GFEBS and conduct internal controls testing to assess audit readiness standards. JIEDDO expects to meet full audit readiness standards prior to March 2014.

[Clerk's note.—End of questions submitted by Mr. Moran.]

OUTSIDE WITNESS STATEMENTS

Written Testimony Submitted for the Record to the
Senate Defense Appropriations Subcommittee
Regarding FY 2013 Funding for Infectious Disease Research and Development

On behalf of the American Society of Tropical Medicine and Hygiene
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The American Society of Tropical Medicine and Hygiene (ASTMH)—the principal professional membership organization representing, educating, and supporting scientists, physicians, clinicians, researchers, epidemiologists, and other health professionals dedicated to the prevention and control of tropical diseases—appreciates the opportunity to submit written testimony to Senate Defense Appropriations Subcommittee.

A core component of ASTMH membership supports the work of the Department of Defense, and we understand first-hand the important role that research and development play in protecting our servicemen and women deployed abroad from the threat of infectious disease. Military researchers have long taken a primary role in the development of treatments for tropical infectious diseases, such as anti-malarial drugs. As a result of DoD's investment and the innovation employed by these military scientists, they have developed many of the most effective and widely-used treatments for infectious diseases.

ASTMH's central public policy priority is reducing the burden of tropical diseases and conditions in the developing world. To that end, we advocate implementation and funding of federal programs that address the research, prevention, and control of infectious diseases and conditions that are leading causes of death and disability in the developing world and that also can pose threats to U.S. citizens. DoD's tropical disease research is an important part of these efforts.

We respectfully request that the Subcommittee expand funding for the DoD's longstanding efforts to develop new and more effective drugs, vaccines, and diagnostics designed to protect service members from infectious diseases. Specifically, ASTMH requests that increased funding be allocated to the Walter Reed Army Institute of Research (WRAIR) and the U.S. Naval Medical Research Center (UNMC) to ensure that this important research can continue.

Walter Reed Army Institute of Research

A large part of DoD investments in infectious disease research and development are facilitated through WRAIR. Between 2007 and 2010, WRAIR's Center for Infectious Disease Research performed more than $260 million of research for the DoD and had an additional $140 million in collaborative research work with external partner organizations. Through critical public-private partnerships with companies such as GlaxoSmithKline and Sanofi, non-profit organizations such as the Bill & Melinda Gates Foundation, Medicines for Malaria Venture, and PATH, and through collaborative efforts with other U.S. agencies including CDC, USAID, and NIH, WRAIR invests in malaria vaccine and drug development, drug development for leishmaniasis, enteric disease research, vector control for malaria and other vector-born infections, and

HIV/AIDS research and treatment. While each of these investments is crucial to the protection of U.S. troops abroad, WRAIR also partners with the global health community in saving the lives of some of the world's poorest people suffering from some of the most neglected diseases.

WRAIR—along with partner organizations, including the PATH Malaria Vaccine Initiative and GlaxoSmithKline—has developed several exciting vaccine candidates, including RTS,S, which recently underwent the first ever large-scale Phase 3 trial for a malaria vaccine. In trials last year, the vaccine candidate has been shown to decrease clinical episodes of malaria in children in Africa by approximately 50 percent. While we celebrate this news and the promise that it brings for children living in malaria-endemic countries, the vaccine remains unsuitable for deploying personnel and travelers because of its efficacy level in adults. As a result, there remains a significant need for continued research funding in order to achieve more robust results.

WRAIR is headquartered in Silver Spring, Maryland, and has research laboratories around the globe. These include a public health reference laboratory in The Republic of Georgia; dengue fever clinical trials in the Philippines; malaria clinical studies and surveillance in Kenya; military entomology network field sites in Thailand, the Philippines, Nepal, Cambodia, Korea, Kenya, Ethiopia, Egypt, Libya, Ghana, Liberia, and Peru, as well as several other coordination efforts with national health ministries and defense units. This diversity in research capacity puts WRAIR in a unique leadership position in research and development for tropical diseases—research that aids our military men and women as well as people living in disease-endemic countries.

United States Naval Medical Research Center

NMRC and its affiliated labs conduct basic and applied research in infectious disease. The Infectious Disease Directorate of NMRC focuses on malaria, enteric diseases, and viral rickettsial diseases. IDD has an annual budget exceeding $10 million and conducts research on infectious diseases that are considered to be a significant threat to our deployed sailors, marines, soldiers, and airmen.

The NMRC Malaria Program played a key role in the Malaria Genome project, a consortium that determined the entire genetic sequence of the P. falciparum malaria parasite, allowing a better understanding of the parasite in order to develop tools to combat it. The primary objective of the Navy Malaria Program is to develop a vaccine that kills the parasite during the first few days of development in the liver, before it breaks into the blood. The program is also investigating vaccines that would target blood-stage infection to limit the severity of symptoms associated with this stage. Both of these vaccines could alleviate much of the suffering caused by this parasite in tropical areas.

The research is enhanced by IDD's close working relationship with the Navy's three overseas medical research laboratories located in Peru, Egypt, and Indonesia. These laboratories, like those of WRAIR, afford diplomatic advancement through the close working relationships they have developed with governments and citizens of those countries. ASTMH has heard first-hand accounts of the successful diplomatic impact that both the WRAIR and NMRC overseas labs

have on the communities where they are guests. Many of the researchers and staff who work in the labs are local to the area and speak highly of the role of the U.S. military labs.

Tropical Medicine and Tropical Diseases

The term "tropical medicine" refers to the wide-ranging clinical, research,h and educational efforts of physicians, scientists, and public health officials with a focus on the diagnosis, mitigation, prevention, and treatment of vector-borne diseases prevalent in the areas of the world with a tropical climate. Most tropical diseases are located in either sub-Saharan Africa, parts of Asia (including the Indian subcontinent), or Central and South America. Since many of the world's developing nations are located in these areas, tropical medicine tends to focus on diseases that impact the world's most impoverished individuals.

U.S. troops are currently deployed or likely to be deployed in many of these same tropical areas. U.S. citizens, working, traveling, participating in volunteer work, and vacationing overseas are similarly impacted by these same tropical diseases, many of which have been ignored and neglected for decades. Furthermore, some of the agents responsible for these diseases could be introduced and become established in the U.S. (as was the case with West Nile virus), or might even be weaponized.

The U.S. has a long history of leading the fight against tropical diseases that cause human suffering and pose a great financial burden, negatively impacting a country's economic and political stability. The benefits of U.S. investment in tropical diseases extend beyond economics and humanitarianism and into diplomacy as well.

Malaria and U.S. Military Operations

More person-days have been lost among U.S. military personnel due to malaria than to bullets during every military campaign fought in malaria-endemic regions during the 20th century.

Because service members deployed by the U.S. military comprise a majority of the healthy adults traveling each year to malarial regions on behalf of the U.S. government, the U.S. military has understandably taken a primary role in the development of anti-malarial drugs, and nearly all of the most effective and widely used anti-malarials were developed in part by U.S. military researchers. Drugs that continue to save lives throughout the world were originally developed by the U.S. military to protect troops serving in tropical regions during WWII, the Korean War, and the Vietnam War.

In recent years the broader international community has increased its efforts to reduce the impact of malaria in the developing world, particularly by reducing childhood malaria mortality, and the U.S. military plays an important role in this broad partnership. However, military malaria researchers at NMRC and WRAIR are working practically alone in the area most directly related to U.S. national security: drugs and vaccines designed to protect or treat healthy adults with no developed resistance to malaria who travel to malaria-endemic regions. NMRC and WRAIR are working on the development of a malaria vaccine and on malaria diagnostics and other drugs to

treat malaria—an especially essential investment as current malaria drugs face their first signs of drug resistance.

The latest generation of malaria medicines is increasingly facing drug-resistance. The most deadly variant of malaria—*Plasmodium falciparum*—is believed by the World Health Organization to have become resistant to "nearly all anti-malarials in current use." The malaria parasite demonstrates a notorious and consistent ability to quickly develop resistance to new drugs. Malaria parasites in Southeast Asia have already shown resistance; resistant strains of the parasite have also been identified in West Africa and South America. There are early indications that parasite populations in Southeast Asia may already be developing limited resistance to artemisinin, currently the most powerful anti-malarial available.

Developing new antimalarials as quickly as the parasite becomes resistant to existing ones is an extraordinary challenge, and one that requires significant resources, especially as U.S. military operations in malaria-endemic countries increase. Without new anti-malarials to replace existing drugs as they become obsolete, military operations could be halted in their tracks by malaria. The 2003 malaria outbreak affecting 80 of 220 Marines in Liberia is an ominous reminder of the impact of malaria on military operations. Humanitarian missions also place Americans at risk of malaria, as evidenced by several Americans contracting malaria while supporting Haitian earthquake relief efforts.

Tropical Disease Impact on Military Operations

Few other U.S. government agencies devote as much time, funding, manpower, and direct research to tackling these devastating diseases as the DoD. The work ultimately goes beyond protecting soldiers and benefits the people living in the countries where these diseases cause the most harm. The recent success of the RTS,S malaria vaccine and its advancement to Phase 3 trials is just one success story from this program. DoD also conducts research for other tropical diseases, including leishmaniasis and dengue fever, two potentially deadly diseases of great risk to our troops and even greater risk to the citizens of these disease-endemic regions.

Leishmaniasis is a vector borne disease that comes in several forms, the most serious of which is visceral leishmaniasis, which affects internal organs and can be deadly if left untreated. According to the WHO, over 350 million people are at risk of leishmaniasis in 88 countries around the world. It is estimated that 12 million people are currently infected with leishmaniasis and 2 million new infections occur annually. Coinfection of leishmaniasis and HIV is becoming increasingly common, and WHO notes that because of a weakened immune system, leishmaniasis can lead to an accelerated onset of AIDS in HIV-positive patients.

Because of leishmaniasis' prevalence in Iraq, the DoD has spent significant time and resources on the development of drugs and new tools for the treatment of leishmaniasis. As more troops return from Iraq and Afghanistan, it is likely DoD will see an increase in leishmaniasis cases in our soldiers. WRAIR discovered and developed Sitamaquine, a drug that once completed, will be an oral treatment for leishmaniasis. While essential for the safety of our servicemen and women abroad, these types of innovations will also be extremely beneficial to the at-risk populations worldwide that are living in leishmaniasis endemic-countries.

Dengue fever, according to the WHO, is the most common of all mosquito-borne viral infections. About 2.5 billion people live in places where dengue infection is possible and last year we saw a few cases pop up in the U.S. There are four different viruses that can cause dengue infections. While infection from one of the four viruses will leave a person immune to that strain of the virus, it does not prevent them from contracting the other three, and subsequent infections can often be more serious.

The DoD has seen about 28 cases of dengue in soldiers per year. While none of these cases resulted in the death of a soldier, hospitalization time is lengthy. Currently, there are several research and development efforts under way within the DoD both for treatments and vaccines for dengue.

U.S. Government Action is Needed for Mission Readiness

The role of infectious disease in the success or failure of military operations is often overlooked. Even a cursory review of U.S. and world military history, however, underscores that the need to keep military personnel safe from infectious disease is critical to mission success. The drugs and prophylaxis used to keep our men and women safe from malaria and tropical diseases during previous conflicts in tropical regions are no longer reliable. Ensuring the safety of those men and women in future conflicts and deployments will require research on new tools. Additional funds and a greater commitment from the federal government are necessary to make progress in malaria and tropical disease prevention, treatment, and control.

Although several promising new infectious disease drugs are in development at WRAIR and NMRC, the U.S. government's funding level for these programs has been anemic for several years. There are indications that the current budget process may decrease or not keep up with medical research inflation, let alone an increase in real dollars, despite burgeoning evidence that many of our military's current drugs are rapidly approaching obsolescence.

Fortunately, a relatively small amount of increased funding for this program would restore the levels of research and development investment required to produce the drugs that will safeguard U.S. troops. In relation to the overall DoD budget, funding for infectious disease research programs is very small. Cutting funding for this program would deal a major blow to the military's efforts to reduce the impact of these diseases on soldiers and civilians alike, thereby undercutting both the safety of troops deployed to tropical climates and the health of civilians in those regions.

ASTMH feels strongly that increased support for efforts to reduce this threat is warranted. A more substantial investment will help to protect American soldiers and potentially save the lives of millions of individuals around the world. We appreciate the opportunity to share our views in our testimony, and please be assured that ASTMH stands ready to serve as a resource on this and any other tropical disease policy matter.

[Insert Subcommittee Name Here]

Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:

Karen Goraleski
Executive Director
American Society of Tropical Medicine & Hygiene
111 Deer Lake Road, Suite 100
Deerfield, IL 60015

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

On behalf of the American Society of Tropical Medicine and Hygiene

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

Yes **No**

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature: Karen A. Goraleski Date: April 24, 2012

DC01/ 2917458.1

The Neurofibromatosis Network
House Appropriations Subcommittee on Defense

Thank you for the opportunity to submit testimony to the Subcommittee on the importance of continued funding for research on Neurofibromatosis (NF), a terrible genetic disorder closely linked too many common diseases widespread among the American population.

On behalf of the Neurofibromatosis (NF) Network, a national coalition of NF advocacy groups, we speak on behalf of the 100,000 Americans who suffer from NF, as well as approximately 175 million Americans who suffer from diseases and conditions linked to NF such as cancer, brain tumors, heart disease, memory loss, and learning disabilities. Thanks in large measure to this subcommittee's strong support, scientists have made enormous progress since the discovery of the NF1 gene in 1990 resulting in clinical trials now being undertaken with broad implications for the general population.

While not all NF patients suffer from the most severe symptoms, all NF patients and their families live with the uncertainty of not knowing whether they will be seriously affected because NF is a highly variable and progressive disease.

In Fiscal Year 2013, we are requesting **$16 million to continue the Army's highly successful Neurofibromatosis Research Program (NFRP),** the same amount that was included for the NFRP in Fiscal Year 2011. The Peer-Reviewed Neurofibromatosis Research Program, one of the Department of Defense's Congressionally Directed Medical Research Programs (CDMRP), is now conducting clinical trials at nation-wide clinical trials centers created by NFRP funding. These clinical trials involve drugs that have already succeeded in eliminating tumors in humans and rescuing learning deficits in mice. Administrators of the Army program have stated that the number of high-quality scientific applications justify a much larger program.

What is Neurofibromatosis (NF)?
NF is a genetic disorder involving the uncontrolled growth of tumors along the nervous system which depending on the size, location, and the growth pattern of these tumors can cause a variety of symptoms ranging from severe pain, disfigurement, deformity, brain tumors, blindness, deafness, learning disabilities, memory loss, heart disease, orthopedic problems and in some cases death.

There are three forms of NF: NF1, the most common form occurs in 1 out of every 3,000 to 4,000 individuals; NF2 which primarily involves tumors causing deafness and balance problems occurs in 1 out of every 30,000 people; and Schwannomatosis, the hallmark of which is severe pain, occurs in 1 out of every 40,000 births.

NF is not rare. It is the most common neurological disorder caused by a single gene and three times more common than Muscular Dystrophy and Cystic Fibrosis combined, but is not widely known because it has been poorly diagnosed for many years. It strikes worldwide, without regard to gender, race or ethnicity. Approximately 50 percent of new NF cases result from a spontaneous mutation in an individual's genes and 50 percent are inherited.

NF's Connection to the Military
Neurofibromatosis Research addresses areas of great clinical need directly affecting the health of soldiers, including unmanageable pain, cancer, orthopedic abnormalities, deafness, blindness, memory loss, amputation and inflammation similar to that involved in wound healing.

Pain Management - Severe and unmanageable pain is seen in all forms of NF, particularly in one form of NF called Schwannomatosis. Over the past 3 years, Schwannomatosis research has made significant advances and new research suggests that the molecular or root cause of Schwannomatosis pain may be the same as phantom limb pain. Research is currently moving forward to identify drugs that might be able to treat this pain, and these exciting findings could have broad applications for the military.

Wound Healing, Inflammation and Blood Vessel Growth - Wound healing requires new blood vessel growth and tissue inflammation. Mast cells are critical mediators of inflammation in wound healing, and they must be quelled and regulated in order to facilitate this healing. Mast cells are also important players in NF1 tumor growth. In the past few years, researchers have gained deep knowledge on how mast cells promote tumor growth, and this research has led to ongoing clinical trials to block this signaling. The result is that tumors grow more slowly. As researchers learn more about blocking mast cell signals in NF, this research could be translated to the management of mast cells in wounds and wound healing.

Orthopedic Abnormalities and Amputation - One third of children with NF1 are at risk of developing orthopedic abnormalities that as a result break easily. In the leg particularly, repeated injuries lead to amputation below the knee, often in very young children. Recent research has identified the molecular basis of this, and drug trials in humans will begin in the next year. This research will lead to a deeper understanding of how to heal challenging bone breaks and directly benefit war fighters with major bone breakages or recurring bone breaks that heal poorly.

Three-Dimensional Clinical Imaging Technologies - Because NF tumors are often large and abnormally shaped, they lend themselves well to the emerging technology of volumetric MRI. This is used to monitor tumor volume and growth as well as to monitor the effectiveness of a drug treatment to induce tumor shrinkage or cessation of tumor growth. It is anticipated that MRI volumetric imaging could have broad applications in military use.

Link to Other Illnesses
Research has resulted in the determination that the NF gene controls other pathways which are directly related to most forms of human cancer, cognitive disorders and heart disease affecting over 175 million Americans. Research on NF therefore stands to benefit millions of Americans.

Cancer – NF is closely linked to many of the most common forms of human cancer, affecting approximately 65 million Americans. In fact, NF shares these pathways with 70% of human cancers. Research has demonstrated that NF's tumor suppressor protein, neurofibromin, inhibits RAS, one of the major malignancy causing growth proteins involved in 30 percent of all cancer. Accordingly, advances in NF research may well lead to treatments and cures not only for NF patients, but for all those who suffer from cancer and tumor-related disorders. Similar studies have also linked epidermal growth factor receptor (EGF-R) to malignant peripheral nerve sheath tumors (MPNSTs), a form of cancer which disproportionately strikes NF patients.

Heart disease – Researchers have demonstrated that mice completely lacking in NF1 have congenital heart disease that involves the endocardial cushions which form in the valves of the heart. This is because the same *ras* involved in cancer also causes heart valves to close. Neurofibromin, the protein produced by a normal NF1 gene, suppresses *ras*, thus opening up the heart valve. Promising new research has also connected NF1 to cells lining the blood vessels of the heart, with implications for other vascular disorders including hypertension, which affects approximately 50 million Americans. Researchers believe that further understanding of how an NF1 deficiency leads to heart disease may help to unravel molecular pathways involved in genetic and environmental causes of heart disease.

Learning disabilities – Learning disabilities are the most common neurological complication in children with NF1. Research aimed at rescuing learning deficits in children with NF could open the door to treatments affecting 35 million Americans and 5 percent of the world's population who also suffer from learning disabilities. In NF1 the neurocognitive disabilities range includes behavior, memory and planning. Recent research has shown there are clear molecular links between autism spectrum disorder and NF1; as well as with many other cognitive disabilities. Tremendous research advances have recently led to the first clinical trials of drugs in children with NF1 learning disabilities. These trials are showing promise. In addition because of the connection with other types of cognitive disorders such as autism, researchers and clinicians are actively collaborating on research and clinical studies, pooling knowledge and resources. It is anticipated that what we learn from these studies could have an enormous impact on the significant American population living with learning difficulties and could potentially save federal, state, and local governments, as well as school districts, billions of dollars annually in special education costs resulting from a treatment for learning disabilities.

Memory loss – Researchers have also determined that NF is closely linked to memory loss and are now investigating conducting clinical trials with drugs that may not only cure NF's cognitive disorders but also result in treating memory loss as well with enormous implications for patients who suffer from Alzheimer's disease and other dementias.

Deafness – NF2 accounts for approximately 5 percent of genetic forms of deafness. It is also related to other types of tumors, including schwannomas and meningiomas, as well as being a major cause of balance problems.

The Army's Contribution to NF Research

While other federal agencies support medical research, the Department of Defense (DOD) fills a special role by providing peer-reviewed funding for innovative and rewarding medical research through the CDMRP. CDMRP research grants are awarded to researchers in every state in the country through a competitive two-tier review process. These well-executed and efficient programs, including the NFRP, demonstrate the government's responsible stewardship of taxpayer dollars.

Recognizing NF's importance to both the military and to the general population, Congress has given the Army's NF Research Program strong bipartisan support. From FY96 through FY12 funding for the NFRP has amounted to $242.85 million, in addition to the original $8 million appropriation in FY92. In addition, between FY96 and FY10, 269 awards have been granted to researchers across the country.

The Army program funds innovative, groundbreaking research which would not otherwise have been pursued, and has produced major advances in NF research, including conducting clinical trials in a nation-wide clinical trials infrastructure created by NFRP funding, development of advanced animal models, and preclinical therapeutic experimentation. Because of the enormous advances that have been made as a result of the Army's NF Research Program, research in NF has truly become one of the great success stories in the current revolution in molecular genetics. In addition, the program has brought new researchers into the field of NF. However, despite this progress, Army officials administering the program have indicated that they could easily fund more applications if funding were available because of the high quality of the research applications received.

In order to ensure maximum efficiency, the Army collaborates closely with other federal agencies that are involved in NF research, such as the National Institutes of Health (NIH). Senior program staff from the National Institute of Neurological Disorders and Stroke (NINDS), for example, sits on the Army's NF Research Program Integration Panel which sets the long-term vision and funding strategies for the program. This assures the highest scientific standard for research funding, efficiency and coordination while avoiding duplication or overlapping of research efforts.

Thanks in large measure to this Subcommittee's support; scientists have made enormous progress since the discovery of the NF1 gene. Major advances in just the past few years have ushered in an exciting era of clinical and translational research in NF with broad implications for the general population. These recent advances have included:

- Phase II and Phase III clinical trials involving new drug therapies for both cancer and cognitive disorders;
- Creation of a National Clinical and Pre-Clinical Trials Infrastructure and NF Centers;
- Successfully eliminating tumors in NF1 and NF2 mice with the same drug;
- Developing advanced mouse models showing human symptoms;
- Rescuing learning deficits and eliminating tumors in mice with the same drug;
- Determining the biochemical, molecular function of the NF genes and gene products;
- Connecting NF to numerous diseases because of NF's impact on many body functions.

Fiscal Year 2013 Request

The Army's highly successful NF Research Program has shown tangible results and direct military application with broad implications for the general population. The program has now advanced to the translational and clinical research stages, which are the most promising, yet the most expensive direction that NF research has taken. Therefore, continued funding is needed to continue to build on the successes of this program, and to fund this promising research thereby continuing the enormous return on the taxpayers' investment.

We respectfully request that you include $16 million in the Fiscal Year 2013 Department of Defense Appropriations bill for the Army's Neurofibromatosis Research Program. With this subcommittee's continued support, we will prevail. Thank you for your support.

House Appropriations Subcommittee on Defense

Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:

Kim Bischoff
The Neurofibromatosis Network
213 S. Wheaton Ave.
Wheaton, IL 60187
630-510-1115

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

The Neurofibromatosis Network

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

Yes No X

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature: Kimberly Bischoff Date: 4-12-12

AMERICAN LUNG ASSOCIATION®
Fighting for Air

Statement of Charles D. Connor, Capt. U.S. Navy (ret.)
President and CEO

Fiscal Year 2013
American Lung Association
U.S. House of Representatives
Committee on Appropriations
Subcommittee on Defense

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

I have no doubt you recognize the importance of keeping our soldiers' lungs healthy. A soldier who uses tobacco, or has asthma or other lung disease is a soldier whose readiness for combat is potentially compromised. Additionally, healthcare costs for these troops continue to rise, both for the Department of Defense (DoD) and for the Veteran's Administration (VA). We owe it to our soldiers, their families, and taxpayers to prioritize troops' lung health.

The American Lung Association wishes to invite your attention to three issues for the DoD fiscal year 2013 budget: the terrible burden on the military caused by tobacco use and the need for the Department to aggressively combat it; the importance of restoring funding for the Peer-Reviewed Lung Cancer Research Program to $20 million; and the health threat posed by soldiers' exposure to toxic pollutants in Iraq and Afghanistan.

Tobacco Use in the Military

Tobacco use is a significant public health problem for DoD. And it is not a problem DoD has simply inherited. **More than one in seven (15 percent) of active duty personnel begin smoking after joining the service.**

The American Lung Association recognizes the Department of the Navy's recent efforts to reduce tobacco use in the military, such as the Navy's 21st Century Sailor initiative. This initiative will help Sailors and Marines quit tobacco, promote tobacco-free environments and put in place environmental changes that will reduce tobacco use throughout the Navy and Marine Corps. This is an unprecedented investment in the comprehensive health of Sailors, Marines and their families. The American Lung Association hopes this initiative expands to other military branches.

In 2011, DoD released a proposed rule implementing coverage of tobacco cessation treatment through TRICARE. When finalized, this new coverage will give soldiers and their families the help they need to quit tobacco.

Both of these actions follow recommendations in the Institute of Medicine's report *Combating Tobacco Use in Military and Veterans Papulations*. The American Lung Association urges DoD and VA to fully implement all recommendations included in the report.

Lung Cancer Research Program

The American Lung Association strongly supports the Lung Cancer Research Program (LCRP) in the Congressionally Directed Medical Research Program (CDMRP) and its original intent to research the scope of lung cancer in our military. In FY12, LCRP received $10.2 million. **We urge this Committee to restore the funding level to $20 million and that 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"..**

In August of 2011, the National Cancer Institute released results from its National Lung Screening Trial (NLST), a randomized clinical trial that screened at-risk smokers with either low-dose computed tomography (CT) or standard chest x-ray. The study found that screening individuals with low-dose CT scans could reduce lung cancer mortality by 20 percent compared to chest x-ray. These are exciting results, but conclusions can only be drawn for the segment of the population tested by the NLST: (1) current or former smokers aged 55 to 74 years, (2) a smoking history of at least one pack a day for at least 30 years, and (3) no history of lung cancer. As the report made clear, CT scans should be recommended for this narrowly defined population of patients – but evidence does not support recommending them for everyone. The American Lung Association recently endorsed screening for this defined population.

The Lung Cancer Research Program has the potential to further knowledge on the early detection of lung cancer. The program recently funded an exciting study at Boston University aimed at discovering biomarkers to improve the accuracy of lung cancer diagnoses. We encourage the Department of Defense to continue its research into lung cancer.

Respiratory Health Issues

The American Lung Association is troubled by reports of soldiers and civilians returning from Iraq and Afghanistan with lung illnesses. Research is beginning to show that the air troops breathe in the war theater can have high concentrations of particulate matter, which can cause or worsen lung disease. Data from a 2009 study of soldiers deployed in Iraq and Afghanistan found that 14 percent of them suffered new-onset respiratory symptoms, a much higher rate than their non-deployed colleagues. The American Lung Association urges that immediate steps be taken to minimize troop exposure to pollutants and that the DoD investigate pollutants in the air our troops breathe.

Conclusion

In summary, this 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. Troops must be protected from tobacco and unsafe air pollution and the severe health consequences.

Thank you.

U.S. House of Representatives
Subcommittee on Defense, Committee on Appropriations
FY2013

Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:

Charles D. Connor
President and CEO
American Lung Association
1301 Pennsylvania Avenue NW Suite 800
Washington, DC 20005
202-785-3355

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

American Lung Association

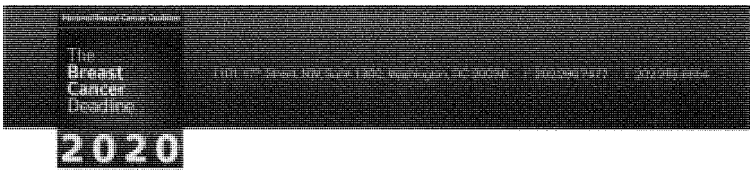
2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

xxxx**Yes** No

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

American Lung Association:
Health and Human Services, Communities Putting Prevention to Work Smokefree Communities, $1,112,010
Centers for Disease Control and Prevention, Breathe Well, Live Well, $200,000
Centers for Disease Control and Prevention, Asthma-Friendly Schools Initiative, $892,191
Centers for Disease Control and Prevention, Reducing the Burden of Asthma at Work, $200,424
Centers for Disease Control and Prevention, Expanding Smokefree Communities (CTG), $800,000
Environmental Protection Agency, Comprehensive Childhood Asthma Management Program, $705,205
Environmental Protection Agency, Environmental Control of Childhood Asthma, $264,999

Signature: Date: April 20, 2012



Testimony of Fran Visco,
President, NBCC

House Appropriations Subcommittee on Defense

April 20, 2012

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

I am Fran Visco, a 24-year breast cancer survivor, a wife and mother, a lawyer, and President of the National Breast Cancer Coalition (NBCC). My testimony represents the hundreds of member organizations and thousands of individual members of the Coalition. NBCC is a grassroots organization dedicated to ending breast cancer through action and advocacy. Since its founding in 1991, NBCC has been guided by three primary goals: to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates wherever breast cancer decisions are made. In September 2010, in order to change the conversation about breast cancer and restore the sense of urgency in the fight to end the disease, NBCC launched **Breast Cancer Deadline 2020®** - a deadline to end breast cancer by January 1, 2020.

Chairman Young and Ranking Member Dicks, we appreciate your longstanding support for the Department of Defense peer reviewed Breast Cancer Research Program. As you know, this program was born from a powerful grassroots effort led by NBCC, and has become a unique partnership among consumers, scientists, Members of Congress and the military. You and your Committee have shown great determination and leadership in funding the Department of Defense (DOD) peer reviewed Breast Cancer Research Program (BCRP) at a level that has brought us closer to ending this disease. I am hopeful that you and your Committee will continue that determination and leadership.

I know you recognize the importance of this program to women and their families across the country, to the scientific and health care communities and to the Department of Defense. Much

of the progress in the fight against breast cancer has been made possible by the Appropriations Committee's investment in breast cancer research through the DOD BCRP. To support this progress moving forward, we ask that you support a $150 million appropriation for Fiscal Year (FY) 2013. In order to continue the success of the Program, you must ensure that it maintains its integrity and separate identity, in addition to this funding. This is important not just for breast cancer, but for all biomedical research that has benefited from this incredible government program.

Vision and Mission

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

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

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

Consumer Participation

Advocates bring a necessary perspective to the table, ensuring that the science funded by this program is not only meritorious, but that it is also meaningful and will make a difference in

people's lives. The consumer advocates bring accountability and transparency to the process. They are trained in science and advocacy and work with scientists willing to challenge the status quo to ensure that the science funded by the program fills important gaps not already being addressed by other funding agencies. Since 1992, more than 700 breast cancer survivors have served on the BCRP review panels.

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

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

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

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

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

Participating in the peer review and programmatic review has been an incredible experience. Working side by side with the scientists, challenging the status quo and sharing excitement about new research ideas…it is a breast cancer survivor's opportunity to make a meaningful difference. I will be forever grateful to the advocates who imagined this novel paradigm for research and continue to develop new approaches to eradicate breast cancer in my granddaughters' lifetime.--Marlene McCarthy, three-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 FY10 DOD BCRP Integration Panel Chair:

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

Unique Structure

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

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

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

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

Distinctive Funding Opportunities

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

Innovation

The Innovative Developmental and Exploratory Awards (IDEA) grants of the DOD program have been critical in the effort to respond to new discoveries and to encourage and support innovative, risk-taking research. Concept Awards support funding even earlier in the process of discovery. These grants have been instrumental in the development of promising breast cancer research by allowing scientists to explore beyond the realm of traditional research and unleash incredible new ideas. IDEA and Concept grants are uniquely designed to dramatically advance our knowledge in areas that offer the greatest potential. They are precisely the type of grants that rarely receive funding through more traditional programs such as the National Institutes of Health and private research programs. They therefore complement, and do not duplicate, other federal funding programs. This is true of other DOD award mechanisms as well.

Innovator awards invest in world renowned, outstanding individuals rather than projects, by providing funding and freedom to pursue highly creative, potentially groundbreaking research that could ultimately accelerate the eradication of breast cancer. For example, in FY10, Dr. Dennis Slamon of the University of California, Los Angeles was granted an Innovator Award to develop new insights that will result in the development of novel treatment initiatives for all of the current therapeutic subtypes of breast cancer. This research builds upon the past gains in understanding of the molecular diversity of human breast cancer which has led treatment away from the "one-size-fits all" therapeutic approaches, and the success of existing treatments of specific breast cancer subtypes. In FY08, Dr. Richard Cote of the University of Miami, School of Medicine received a synergistic IDEA grant to develop a novel, efficient and cost-effective device to capture and image tumor cells in blood. The presence of tumor cells in blood is used to predict the likelihood of disease recurrence, determine whether or not treatment is working, and in some cases can be analyzed to find substances on the cells that can be used as targets for chemotherapy drugs.

The Era of Hope Scholar Award supports 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. Shiaw-Yih Lin from M.D. Anderson Cancer Center, University of Texas received a FY09 Era of Hope Scholar Award to identify gene signature and membrane proteins associated with defective replication stress response (RSR); identify drugs that target these defects; and develop defect-targeting nanoparticles for diagnostic imaging, prevention and treatment of breast cancer. In FY11, Dr. Julie O'Neal of the University of Louisville received an Era of Hope Postdoctoral Fellowship Award to study breast cancer biology with an emphasis on identifying enzymes that are required for breast cancer growth.

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 over-expressed the gene. This research, which led to the development of the targeted therapy, Herceptin, 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 results 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 towards 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. Susan Foy of the Cleveland Clinic Foundation received a FY10 Predoctoral Traineeship Award for work on improving the use of multifunctional magnetic nanoparticles for imaging and targeted breast cancer drug delivery. This type of targeted drug therapy could significantly extend the drug effect, critical for decreasing tumor growth and to prevent relapse, while also reduce its overall toxicity. Dr. Anupama Chandramouli of New York University School of Medicine received a postdoctoral award for fundamental research into causative factors for basal-type breast cancers, a tumor subtype of which little about the etiology is known.

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

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

Scientists and consumers agree that it is vital that these grants continue to support breast cancer research. To sustain the Program's momentum, $150 million for peer reviewed research is needed in FY13.

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 moving us closer to eradicating breast cancer.

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

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

The DOD peer reviewed Breast Cancer Research Program not only provides a funding mechanism for high-risk, high-return research, but also reports the results of this research to the American people every two to three 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 sixth Era of Hope meeting in August, 2011. As MSNBC.com's Bob Bazell wrote, this meeting "brings 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...."

During the 2011 Era of Hope, investigators presented work that challenged paradigms and pushed boundaries with innovative, high-impact approaches. Some of the research presented looked at new ways to treat the spread of breast cancer, including a vaccine for HER2+ breast cancer that has stopped responding to treatment, and an innovative treatment using nanoparticles of HDL cholesterol tied to chemotherapy drugs to more directly zero in on cancer cells.

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

Commitment of the National Breast Cancer Coalition

The National Breast Cancer Coalition is strongly committed to the DOD BCRP in every aspect, as we truly believe it is one of our best chances for reaching **Breast Cancer Deadline 2020®**'s goal of ending the disease by the end of the decade. The Coalition and its members are dedicated to working with you to ensure the continuation of funding for this Program at a level that allows this research to forge ahead. From 1992, with the launch of our "300 Million More Campaign" that formed the basis of this Program, until now, NBCC advocates have appreciated your support.

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

Consumer advocates have worked hard over the years to keep this program free of political influence. Often, specific institutions or disgruntled scientists try to change the program though legislation, pushing for funding for their specific research or institution, or try to change the program in other ways, because they did not receive funding through the process, one that is fair, transparent and successful. The DOD BCRP has been successful for so many years because of the experience and expertise of consumer involvement, and because of the unique peer review and programmatic structure of the program. We urge this Committee to protect the integrity of the important model this program has become.

There are nearly three million women living with breast cancer in this country today. This year, approximately 40,000 will die of the disease and more than 260,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it in a way to make a real difference or how to end 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 Young and Ranking Member Dicks, you and this entire Committee have been leaders in the effort to continue this innovative investment in breast cancer research.

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

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

House Appropriations Subcommittee on Defense
Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:

Frances M. Visco
President, National Breast Cancer Coalition (NBCC)
1101 17th Street, NW, Suite 1300
Washington, DC 20036
(202) 973-0582

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

On behalf of the National Breast Cancer Coalition (NBCC)

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

No

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature: Fran Visco

Date: April 19. 2012

STATEMENT OF BARBARA GORDON, R.D.
EXECUTIVE DIRECTOR
INTERSTITIAL CYSTITIS ASSOCIATION
1760 OLD MEADOW ROAD, SUITE 500, MCLEAN, VA 22102
(703) 442-2070, BGORDON@ICHELP.ORG

REGARDING FISCAL YEAR 2013 APPROPRIATIONS FOR THE
DEPARTMENT OF DEFENSE

SUBMITTED TO THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

APRIL 20, 2012

Chairman Young, Ranking Member Dicks, and distinguished members of the Subcommittee, thank you for the opportunity to present information on Interstitial Cystitis (IC). I am Barbara Gordon, Executive Director of the Interstitial Cystitis Association (ICA). 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 of delay between the onset of symptoms and treatment. Men suffering from IC are often misdiagnosed with bladder infections and chronic prostatitis. Women are frequently misdiagnosed with endometriosis, inflammatory bowel disease (IBD), irritable bowel syndrome (IBS), vulvodynia, and fibromyalgia, which commonly co-occur with IC. When health care 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. It is estimated that as many as 12 million Americans have IC symptoms, more people than Alzheimer's, breast cancer, and autism *combined.*

The effects of IC are pervasive and insidious, damaging work life, psychological well-being, personal relationships, and general health. The impact of IC on quality of life is equally as severe as rheumatoid arthritis and end-stage renal disease. Health-related quality of life in women with IC is worse than in women with endometriosis, vulvodynia, and overactive bladder. IC patients have significantly more sleep dysfunction, higher rates of depression, anxiety, and sexual dysfunction.

The burden of IC among our nation's service members and veterans is significant. The Urologic Diseases in America Project, conducted between 1999 and 2002, found that approximately 1.4 percent of all veterans utilizing the Veterans Health Administration (VHA) had been treated for IC. This study also showed a 14% increase in IC patients within VHA over the same period.

Former Navy Captain Gary Mowrey (ret.) was forced to cut his naval career short as a result of IC. Captain Mowrey was in the Navy for 25 years and has served as commander of the VAQ133 Squadron, operations officer on the *USS Dwight D. Eisenhower*, chief of the Enlisted Performance Division in the Bureau of Naval Personnel, and earned a Southwest Asia service medal with two stars for his service in Operation Desert Strom. In 1994 he began to experience significant pain, could not always make it to the restroom, and was not even able to sit through normal meetings. After months of unsuccessful anti-biotic treatments for urinary tract infections, Captain Mowrey was diagnosed with IC, and retired due to the pain and limitations imposed by IC. He then attempted to teach high school math, but had to retire from this position as well due the pain and frequent urination associated with his IC.

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 2013 budget request did not include renewed funding for the CDC's IC Education and Awareness Program.

On behalf of the IC community, including our veterans, I would like to thank the Subcommittee for recognizing IC as a condition eligible for study through the DOD's PRMRP in the committee reports accompanying the fiscal years 2010, 2011, and 2012 DOD Appropriations bills. The scientific community showed great interest in the program, responding to the grant announcements with an immense outpouring of proposals. We urge Congress to maintain IC's eligibility in the PRMRP in committee report accompanying the the fiscal year 2013 Defense Appropriations bill, as the number of current military members, family members, and veterans affected by IC is increasing.

House Committee on Appropriations Subcommittee on Defense

Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:

Barbara Gordon, R.D.
Executive Director
Interstitial Cystitis Association
1760 Old Meadow Road, Suite 500, McLean, VA 22102
(703) 442-2070

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   The Interstitial Cystitis Association

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

   [Yes] No

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

   Centers for Disease Control and Prevention
   Interstitial Cystitis Education and Awareness Program
   Received by the Interstitial Cystitis Association

   FY 2008 - $658,000
   FY 2009 - $658,000
   FY 2010 - $660,000
   FY 2012 - $654,000

Signature: Date: 4/20/12

STATEMENT OF
NANCY J. NORTON
PRESIDENT AND CO-FOUNDER
INTERNATIONAL FOUNDATION FOR
FUNCTIONAL GASTROINTESTINAL DISORDERS
PO BOX 170864
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REGARDING FISCAL YEAR 2013 APPROPRIATIONS FOR THE
DEPARTMENT OF DEFENSE

SUBMITTED TO THE
HOUSE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON DEFENSE

April 20, 2012

Thank you for the opportunity to present the views of the International Foundation for Functional Gastrointestinal Disorders (IFFGD) regarding functional gastrointestinal disorders (FGIDs) among service personnel and veterans. FGIDs are recognized by the Department of Veterans Affairs (VA) as disabling and connected to military service as a part of Gulf War Illness, and I am here today to request that that the Subcommittee continue support the Department of Defense (DOD) Gulf War Illness Research Program through the Congressionally Directed Medical Research Program.

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

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

a change in bowel pattern, such as diarrhea and/or constipation. Symptoms of functional dyspepsia usually include an upset stomach, pain in the belly, and bloating.

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

In April 2010, the National Academy of Sciences (NAS) published a report titled *Gulf War and Health, Volume 8: Update on the Health Effects of Serving in the Gulf War,* which determined that there is sufficient evidence to associate deployment to the Gulf War and FGIDs, including IBS and functional dyspepsia. According to the report, there have been a large number of FGID cases among Gulf War veterans, and their symptoms have continued to be persistent in the years since that war. The NAS report focused on the incidence of GI disorders among veterans and did not attempt to determine causality. However, the report provides compelling evidence linking exposure to enteric pathogens during deployment and the development of FGIDs. The NAS recommended that further research be conducted on this association.

Based on the report from NAS, VA adopted a final rule on August 15, 2011, stating that there is a presumptive service connection between FGIDs and service in the Southwest Asia theater of operations during the Persian Gulf War. This includes conditions like irritable bowel syndrome and functional dyspepsia.

The DOD Gulf War Illness Research Program conducts important research on the complex set of chronic symptoms that impact Gulf War Veterans. Given the conclusions of the NAS report and the report's recommendations for further research on the link between FGIDs and exposures experienced by veterans in the Gulf War, we ask that you continue to support the Gulf War Illness Research Program and encourage research into FGIDs through this program so that important research on FGIDs among veterans can be conducted.

Thank you again for the opportunity to address the Subcommittee today.

House Committee on Appropriations Subcommittee on Defense

Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:

Nancy J. Norton
President
International Foundation for Functional Gastrointestinal Disorders
PO Box 170864
Milwaukee, WI 53217
(414) 964-1799

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   The International Foundation for Functional Gastrointestinal Disorders

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

   Yes [No]

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature: Nancy J. Norton Date: 4/20/12

WRITTEN TESTIMONY SUBMITTED BY
CNS RESPONSE
TO
HOUSE APPROPRIATIONS DEFENSE SUBCOMMITTEE
APRIL 18, 2012

Chairman Young, Ranking Member Dicks and distinguished members of the Committee. CNS Response greatly appreciates the opportunity to provide written testimony for the hearing record of the House Defense Appropriations Subcommittee.

We are submitting this testimony on an issue of strong interest – the mental health of our armed forces; a technology that offers increased effectiveness in treating mental health patients; and an upcoming study lead by the flagship medical institution of the armed forces – the Walter Reed National Military Medical Center.

As of 2009, more than 1.7 million U.S. troops have deployed to Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) in Afghanistan and Iraq. Early evidence suggests that the psychological toll of these deployments—many involving prolonged exposure to combat-related stress over multiple rotations—may be disproportionately high compared with the physical injuries of combat. In the face of mounting public concern over post-deployment health care issues confronting OEF and OIF veterans, several task forces, independent review groups, and a President's Commission have been convened to examine the care of the war wounded and make recommendations on physical and mental disorders. Concerns have recently centered on two combat-related injuries in particular: post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). With the increasing incidents of suicide and suicide attempts among returning veterans, concern about depression is also on the rise. Unlike the physical wounds of war, these conditions are often unseen, remaining invisible to other service members, family members, and society in general.

The U.S. military seeks the identification and review of currently available practices and technology to improve the treatment of military personnel suffering from non-psychotic mental illness. Considerable resources and personnel have been allocated to identify and treat these men and women, including state-of-the-art diagnostic tools and clinical interventions. Nonetheless, the standard practice for diagnosis, assessment, and treatment of mental health conditions continues to rely on subjective instruments with limited reliability and accuracy. The high projected volume and corresponding requirement for more precise identification of personnel with these conditions calls for more effective and efficient tools and techniques to diagnose and treat them.

There is no objective test for diagnosis or treatment selection for mental health patients. Psychiatry is the only specialty in which there is no test of physiology used

in prescribing drug treatments. While there are expensive diagnostic imaging procedures - such as functional MRI - these tests do not predict which therapies will works they lack normative and treatment outcome biomarkers for common medications. Military physicians have stated, "We can show soldiers detailed pictures of their brains, but they will still leave with the same trial and error therapies as before."

There are currently over 130 psychotropic medications available for treatment of mental health patients. Given that these many medications affect everyone differently, it is difficult for physicians to know which medication is best to prescribe to an individual patient. Physicians use their best clinical judgment, however, we know that the industry standard is about 30% accuracy. Two failed medications characterize a patient as treatment resistant - forcing physicians to use off-label medications and medication combinations with little clinical evidence.

Psychotropic drugs like antidepressants have become the most frequently prescribed medications in America – experiencing a 400% growth in use since the introduction of Prozac. Furthermore, though antidepressants are the most prescribed drug in the US, antipsychotics are the largest by sales. Unfortunately, psychotropic medications often fail: 86% after two medications, 87% failure after three medications with associated, and serious, side effects such as agitation, metabolic syndrome, sexual side effects, tardive dyskinesia and tragically, suicidality. In many instances, times for recovery are significantly lengthened with delays in return to active duty; causing additional emotional stress and strain on the family unit.

Military members have a special situation as it relates to the potential for use of multiple medications in hostile environments. The practice of providing three to six months of medications to deploying soldiers due to anticipated challenges of refilling prescriptions in theater can lead to overdosing, medication exchange in the ranks, and unsupervised and off-label use of powerful psychotropic drugs with unanticipated and unknowable consequences

From the RAND Study "Invisible Wounds of War - Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery":

> On a per-case basis, two-year costs associated with PTSD are approximately $5,904 to $10,298, depending on whether we include the cost of lives lost to suicide. Two-year costs associated with major depression are approximately $15,461 to $25,757. Costs associated with comorbid PTSD and major depression are approximately $12,427 to $16,884. One-year costs for service members who have accessed the health care system and received a diagnosis of traumatic brain injury are even higher, ranging from $25,572 to $30,730 in 2005 for mild cases ($27,259 to $32,759 in 2007 dollars), and from $252,251 to $383,221 for moderate or severe cases ($268,902 to $408,519 in 2007 dollars).

However, these cost figures omit current as well as potential later costs stemming from substance abuse, domestic violence, homelessness, family strain, and several other factors, thus understating the true costs associated with deployment-related cognitive and mental health conditions.

Translating these cost estimates into a total-dollar figure is confounded by uncertainty about the total number of cases in a given year, by the little information that is available about the severity of these cases, and by the extent to which the three conditions co-occur. Given these caveats, RAND used a micro simulation model to predict two-year costs for the approximately 1.6 million troops who have deployed since 2001. The estimate: PTSD-related and major depression–related costs could range from $4.0 to $6.2 billion over two years (in 2007 dollars). Applying the costs per case for TBI to the total number of diagnosed TBI cases identified as of June 2007 (2,726), total costs incurred within the first year after diagnosis could range from $591 million to $910 million (in 2007 dollars).

According to Department of Veterans Affairs' data, 10,000 combat veterans with post-traumatic stress disorder flooded into VA hospitals every three months this year, pushing the number of patients ill with the disorder above 200,000 and straining resources. The increase is more than 5% per quarter and it occurs as the VA struggles to move veterans quickly into therapy.

We need to prescribe mental health medications based on an objective test.

As indicated earlier, we are poised to commence a landmark study at the Walter Reed National Military Medical Center (WRNMMC) and additional military and VA hospitals. The study is scheduled to commence during Summer 2012. There are two objectives of the study:

1. To evaluate if the information provided by a new technology, PEER Interactive, results in improved mental health and/or a reduction of risk as measured by a reduction in psychiatric specific adverse events. We will compare an experimental group using PEER Interactive to inform medication decisions to a control group using treatment as usual. The study population will be comprised of subjects with a primary diagnosis of major depressive disorder with comorbidity of non-psychotic behavioral disorders, including mild traumatic brain injury and posttraumatic stress disorder.

2. To evaluate and validate that the correlation between the information provided by PEER Interactive and the predicted patient outcome is greater than chance.

We expect to demonstrate that PEER Interactive (a comparison of a quantitative electroencephalogram (QEEG) to an existing database of known patient outcomes) provides an objective tool that is more effective in guiding medication decisions than the current standard of practice in the treatment of military personnel suffering from non-psychotic mental illness.

PEER Interactive is a clinical decision support device that uses a combination of software, analytics, and effectiveness outcomes to provide objective clinical decision support to physicians in determining which medications will be most effective for patients with non-psychotic behavioral disorders.

The process of using a QEEG to indicate medication response in mental health patients has been proven in numerous earlier studies.

Stephen C. Suffin, M.D. and Hamlin Emory, M.D. developed the basic technology over an eighteen-year collaboration. Dr. Suffin was responsible for the initial mathematical modeling and computer analysis of the data. Dr. Emory performed the psychiatric assessments, medication management, and monitored physical findings for database development with Brian MacDonald, a co-founder and CNS Response's Chief Technology Officer. In addition, this practice of using a digital EEG to indicate medication response in mental health patients has been studied and validated in 20+ research protocols. The effectiveness of using a digital EEG to specify responsiveness to non-psychotic medications – with specific ratings for each drug - has been studied in four separate trials.

PEER is in use today in the United States and abroad in private and public practices such as the University of California – Irvine hospital. PEER increases prescription accuracy – decreasing risk to the patient, recovery time, trial and error, medication switching, frustration, and cost. The current standard of accuracy – as evaluated the mental health profession – is ~30% across the field of psychiatry. In published, peer-reviewed studies, PEER has demonstrated accuracy of 80%+. Hypothesis for this study is that providing treating physicians with an objective tool, as an adjunct to their clinical medication prescription decision process, will result in improved patient outcomes when compared to treatment as usual. We expect that outcomes will be better than treatment as usual when the percentage of agreement between the information provided by PEER Interactive and the course of treatment selected by the physician is high, we expect.

In closing, the military and VA have consistently led in many areas of medicine whether it is saving an unprecedented percentage of members grievously injured on the battlefield to the ground breaking treatment of extensively burned victims at Brooke Army Hospital in San Antonio and the rehabilitation of physically damaged active duty members and veterans. We strongly believe that the magnitude of this study, executed in a large population of America's defenders, will create a ground swell of support and demand for more informed, and effective, personalized

treatment of mental health conditions. Finally, as more informed, personalized medication choices are available, then we can apply more effective treatments for the men and women who serve our country.

[Defense Subcommittee]

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Your Name, Business Address, and Telephone Number: R. Stewart Navarre 85 Enterprise Suite 410 Aliso Viejo, CA 92656 949 420 4407
1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing. CNS Response
2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008? No
3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature:

Date: 10 April 2012

April 16, 2012

Organization: **Cummins Inc.**
Testimony of Dr. Wayne A. Eckerle
Vice President – Research and Technology

Cummins Inc., headquartered in Columbus, Indiana, is a corporation of complementary business units that design, manufacture, distribute and service engines and related technologies, including fuel systems, controls, air handling, filtration, emission solutions and electrical power generation systems. The funding requests outlined below are critically important to Cummins' research and development efforts, and would also represent a sound federal investment towards a cleaner environment and improved energy efficiency for our nation. We request that the Committee fund the programs as identified below.

Subcommittee: **Defense**
Department: **Department of Defense**

Department of the Army

Army Procurement

1. **Other Procurement, Budget Activity 03, Other Support Equipment, Line No. 171, Generators, Line Item: 0426MA9800, Generators and Associated Equipment:** Support the Administration's request of $60.3M in FY 2013. $67.8M was appropriated in FY 2012. Specifically support the $16.7M for M53500, Medium Generator Sets (5-60 kW) and R62700 Power Units/Power Plants. Advanced Medium Mobile Power System a.k.a. AMMPS generators and AMMPS Power Units and Power Plants (trailer mounted AMMPS generator sets) are the latest generation of Prime Power Generators for the DOD and will replace the obsolete Tactical Quiet Generators (TQG's) developed in the 1980s. AMMPS generator sets are 21% more fuel-efficient, 15% lighter, 35% quieter and 40% more reliable than the TQG. Generators are the Army's biggest consumer of diesel fuel in current war theatres. When AMMPS generator sets are fully implemented, the Army and Marines will realize annual fuel savings of approximately 52 million gallons of JP-8 fuel and over $745 million in savings based on fuel costs and current use pattern. This will mean fewer fuel convoys to bases in active war zones resulting in saved lives of military and civilian drivers. AMMPS generators will result in annual carbon emissions reductions of 500,000 metric tons CO_2 or 7.7 million metric tons over the expected life of the generators.

2. **Weapons & Tracked Combat Vehicles (WTCV), Budget Activity 01, Tracked Combat Vehicles, Line No. 07, Modification of Tracked Combat Vehicles, Line Item 2073GZ0410, Paladin PIM Mod In Service, Paladin Integrated Management (PIM):** Support Administration's request of $206.1M in FY 2013. $46.8M was appropriated in

FY 2012 to begin low rate initial production. The M109A6 Paladin is the primary indirect fire weapons platform in the US Army's Heavy Brigade Combat Team (HBCT) and is expected to be in the Army inventory through 2050. The PIM program will incorporate Bradley-based drive-train and suspension components which reduce logistics footprint and decrease operations & sustainment costs. PIM is vital to ensuring the long-term viability & sustainability of the M109 family of vehicles (Paladin & FAASV). The program will significantly reduce the logistics burden placed on our soldiers, and proactively mitigate obsolescence. The system will feature improved mobility (by virtue of Bradley-based automotive systems) allowing the fleet to keep pace with the maneuver force. The system will improve overall soldier survivability through modifications to the hull to meet increased threats.

Research and Development Test and Evaluation Programs

1. **Budget Activity 05, System Development & Demonstration, Line No. 121, Program Element No. 0604854A: Artillery Systems, Paladin Integrated Management (PIM)**: Support the Administration's request of $167.8M in FY 2013. $120.1M was appropriated in FY 2012. The M109A6 Paladin is the primary indirect fire weapons platform in the US Army's Heavy Brigade Combat Team (HBCT) and is expected to be in the Army inventory through 2050. This request is to further develop Paladin Integrated Management (PIM) vehicles and conclude testing. The PIM effort is a program to ensure the long-term viability & sustainability of the M109A6 Paladin and its companion ammunition resupply vehicle, the M992 Field Artillery Ammunition Support Vehicle (FAASV). PIM is vital to ensuring the long-term viability & sustainability of the M109 family of vehicles (Paladin & FAASV). The program will significantly reduce the logistics burden placed on our soldiers and proactively mitigate obsolescence. The system will feature improved mobility (by virtue of Bradley-based automotive systems) allowing the fleet to keep pace with the maneuver force.

2. **Budget Activity 07, Operational Systems Development, Line No. 165, Program Element No. 0203735A: Combat Vehicle Improvement Programs:** Support the Administration's request of $253.9M in FY 2013. $36.2M was appropriated in FY 2012 to initiate the program. Specifically support $74.1M for the Armored Multi-Purpose Vehicle (AMP-V) program. AMP-V is an Army program that replaces the M113 platforms, which cannot be optimized for future U.S. Army combat operations. The Army has identified a significant capability gap within the Heavy Brigade Combat Team (HBCT) formation. The Bradley Family of Vehicles are the most capable and cost effective platform for replacement of the M113. Along with established production, the recapitalized Bradley vehicles bring combat- proven mobility, survivability, and adaptability to a variety of missions. The Army currently has approximately 1,900 Bradley hulls that could be inducted into the production process. This low cost, low risk, Military-off-the-Shelf (MOTS) to replace the M113 addresses the significant capability shortfalls within the HBCT formation. In addition, it is an efficient use of existing Government owned assets and existing Public-Private Partnership arrangements to bridge

the modernization gap. Recapitalizing existing Bradley chassis provides the most survivable, mobile and protected solution for our soldiers at a significant lower cost.

Department of the Air Force

Other Procurement

1. **Budget Activity 04, Other Base Maintenance and Support Equip, Item No. 62, Mobility Equip:** Support the Administration's request of $23.8M ($14.4M Base and $9.4M OCO) in FY 2013. $20.3M was appropriated in FY 2012. Specifically support $6.7M ($4.6M Base and $2.0M OCO) in FY 2013 for the Basic Expeditionary Airfield Resource (BEAR). The BEAR product is an 800kW prime power mobile generator used by Combat Air Forces to power mobile airfields in-theatre and around the world. The finished product will replace the existing MEP unit that is 25 years old and will offer greater fuel economy, increased fuel options (JP-8), improved noise reduction, and the latest innovative control technology and functionality. With the ever increasing global reach of the US military, the need for reliable mobile power is paramount. This program is currently funded for the design, development and preproduction of 8 individual BEAR units. These units will undergo a battery of validation tests. Design and development of the BEAR product is on schedule. There is interest from other branches of the military for the BEAR product as well given the increased need for mobile electric power.

Department of the Navy

Other Procurement, Marine Corps

1. **Budget Activity 06, Engineer and Other Equipment, Line No. 47, Line Item 6366, Power Equipment Assorted:** Support the Administration's request of $76.5M ($56.3M Base and $20.2M OCO) in FY 2013. $27.2M was appropriated in FY 2012. Specifically support $26.5M ($19.5M Base and $7.0M OCO) in FY 2013 for Advanced Medium Mobile Power System (AMMPS). AMMPS generators are the latest generation of Prime Power Generators for the DOD and will replace the obsolete Tactical Quiet Generators (TQG's) developed in the 1980s. AMMPS generator sets are 21% more fuel-efficient, 15% lighter, 35% quieter and 40% more reliable than the TQG. Generators are the Army's biggest consumer of diesel fuel in current war theatres. When AMMPS generator sets are fully implemented, the Army and Marines will realize annual fuel savings of approximately 52 million gallons of JP-8 fuel and over $745 million in savings based on fuel costs and current use pattern. This will mean fewer fuel convoys to bases in active war zones resulting in saved lives of military and civilian drivers. AMMPS generators will result in annual carbon emissions reductions of 500,000 metric tons CO_2 or 7.7 million metric tons over the expected life of the generators.

Defense Subcommittee

Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
Wayne Eckerle – VP Research and Technology
Paul Miller – Director of External Relations, Cummins Research & Technology
500 Jackson St.
Columbus, IN 47201
812-377-7534

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Cummins Inc.

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

Yes No

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Cummins Inc. DOD Contracts

Agency	Program/Contract Title	Contract Amount
DOD	Basic Expeditionary Airfield Resources (BEAR)	$52,252,046
DOD	Advanced Medium Mobile Power Systems (AMMPS): BD03-BD10	$185,550,415
DOD	Worldwide Emergency Power Support For USACE Military Contingency Response - Operations and Maintenance: W912BU-10-0016 – 001, 002, 003, 004, 005, 006	$41,476,888

Agency	Program/Contract Title	Contract Amount
DOD	TACOM: W56HZV-04-D-0145 W56HZV-09-D-0101	$120,559,223
DOD	TACOM: W56HZV-08-C-0285	$3,443,981
DOD	Tacom Topic #13: W56HZV-08-C-0678	$2,081,314
DOD	Tacom Topic #14: W56HZV-08-C-0679	$987,907
DOD	Sub to SwRI: D60241X	$401,924
DOD	GS-07F-9004D	$361,757
DOD	Sub to BAE Systems PO91526	$10,512,624
DOD	Sub to DYNCORP INTL MA-2011-08-795	Approx < $1M Not specified in the contract
DOD	Sub to THEODOR WILLE INTERTRADE AG BPA # 016 -CUMMINS POWER GENERATOR SPARES	$113,867
Cummins Atlantic, LLC		
DOD	N65540-11-P-5331	$5,600,000
Cummins Crosspoint, LLC		
DOD	SPM7M1-12-M-V059	$498
DOD	SPM4A6-12-V-1686	$323
DOD	SPM5A1-12-V-0550	$49
DOD	SPM5L3-12-V-1154	$165
DOD	SPM8E6-12-V-0248	$230
DOD	SPM8EE-12-V-0131	$107
DOD	SPM4A4-12-M-0421	$1,666
DOD	SPM7M4-12-M-1256	$931
DOD	SPM4A6-12-V-2992	$4,146
DOD	SPM7L2-12-V-2367	$171
DOD	SPM7L4-12-V-2795	$3,850
DOD	SPM8EB-12-V-0528	$540
DOD	SPM5M2-12-M-1548	$29
DOD	SPM5M2-12-M-1553	$41
DOD	SPRBL1-12-C-0007	$192,522
DOD	SPRBL1-12-P-0021	$90,684

Cummins Central Power, LLC		
DOD	W9098S-11-C009	$9,100,200
DOD	W9098S-11-C009-P00001	$136,503
DOD	W52H09-06-A-5012	$7,500,000
Cummins Power Systems, LLC		
DOD	SPRBLI-12-P-0013	$45,000,000
DOD	W911RQ-10-D-0004	$2,416,655
DOD	W15P7T-10-D-F009	$41,459,257
DOD	SPRBL1-12-R-0013	$62,520
DOD	DLA (Defense Logistics Agency):	
	DLA LAND AND MARITIME	
	SPM7L3-11-M-8514	$1,421
	SPM5L3-11-V-2937	$149
	SPM7L1-12-V-1534	$13,027
	SPM7L3-12-M-2681	$1,210
	SPM7L4-12-V-2419	$104
	SPM7M4-12-M-1827	$3,744
	SPM7M4-12-V-2757	$17
	SPM7MX-10-D-9013-0009	$961
	SPM7M4-12-M-2729	$7,769
	SPM7M3-12-M-3719	$484
	DLA TROOP SUPPORT	
	SPMM8E0-12-V-0971	$60
	SPM5M4-12-M-0895	$90
	SPM5E8-12-M-0198	$10
	DLA AVIATION	
	SPM4A4-12-V-4564	$40
	SPE4A0-12-V-0008	$103
Cummins Mid-States, LLC		
DOD	SPM7LX-10-D-9005	$8,853,393

Signature: Wayne Eckerle Date: 4/16/12

STATEMENT OF
JANET HIESHETTER
DYSTONIA MEDICAL RESEARCH FOUNDATION
ONE EAST WACKER DRIVE, SUITE 2810
CHICAGO, IL 60601

REGARDING FISCAL YEAR 2013 APPROPRIATIONS FOR THE
DEPARTMENT OF DEFENSE

SUBMITTED TO THE
HOUSE COMMITTEE ON APPROPRIATIONS;
SUBCOMMITTEE ON DEFENSE

APRIL 20, 2012

Thank you for the opportunity to submit written testimony on behalf of the Dystonia Medical Research Foundation (DMRF). The DMRF is dedicated to serving all people with dystonia and their families, and to advocate on issues of concern, including bolstering critical research through the Department of Defense (DOD) Peer-Reviewed Medical Research Program. In addition to advancing dystonia research, the DMRF works to increase dystonia awareness and provide support for those living with the disorder.

Dystonia is a neurological movement disorder that causes muscles to contract and spasm involuntarily. Dystonia is not usually fatal, but it is a chronic disorder whose symptoms vary in degrees of frequency, intensity, disability, and pain. Dystonia can be generalized, 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 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.

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 that 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 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 anecdotal evidence from medical professionals linking dystonia to trauma. **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 the inclusion of dystonia in the list of conditions eligible for study under the DOD Peer-Reviewed Medical Research Program in fiscal years 2010, 2011 and 2012. 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 understanding of the mechanisms connecting trauma and dystonia. **We urge Congress to maintain dystonia as a condition deemed eligible for study through the Peer-Reviewed Medical Research Program in the fiscal year 2013 Defense Appropriations bill,** as the number of current military members and veterans with dystonia swells.

Thank you again for allowing me to submit written testimony on behalf of the Dystonia Medical Research Foundation. I hope you will continue to include dystonia as a condition eligible for study under the DOD Peer-Reviewed Medical Research Program.

House Defense Appropriations Subcommittee

Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:

Janet Hieshetter
Dystonia Medical Research Foundation
1 E. Wacker Drive, Suite 2810
Chicago, IL 60601
(312) 755-0198

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Dystonia Medical Research Foundation (DMRF), a non-governmental organization

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2008?

X Yes No

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Agency: National Institutes of Health
Program: Office of Rare Diseases Research, Rare Diseases Clinical Research Network II
The DMRF is a subcontractor to this grant and managed:
- in FY11 managed $574,390.00
- in FY12 will manage $649,202

Program: National Institute of Neurological Disorders and Stroke, Conference support for *Designing Clinical Trials for Dystonia* - $20,000

Signature: Janet Hieshetter Date: April 24, 2012

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