

S. HRG. 112–590, Pt. 6

**DEPARTMENT OF DEFENSE AUTHORIZATION FOR
APPROPRIATIONS FOR FISCAL YEAR 2013 AND
THE FUTURE YEARS DEFENSE PROGRAM**

HEARINGS

BEFORE THE

**COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE**

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

ON

S. 3254

TO AUTHORIZE APPROPRIATIONS FOR FISCAL YEAR 2013 FOR MILITARY
ACTIVITIES OF THE DEPARTMENT OF DEFENSE, FOR MILITARY CON-
STRUCTION, AND FOR DEFENSE ACTIVITIES OF THE DEPARTMENT OF
ENERGY, TO PRESCRIBE MILITARY PERSONNEL STRENGTHS FOR
SUCH FISCAL YEAR, AND FOR OTHER PURPOSES

**PART 6
PERSONNEL**

MARCH 28; APRIL 25; JUNE 21, 2012



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FUTURE YEARS DEFENSE PROGRAM—Part 6 PERSONNEL**

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**DEPARTMENT OF DEFENSE AUTHORIZATION
FOR APPROPRIATIONS FOR FISCAL YEAR
2013 AND THE FUTURE YEARS DEFENSE
PROGRAM**

WEDNESDAY, MARCH 28, 2012

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

**ACTIVE, GUARD, RESERVE, AND CIVILIAN PERSONNEL
PROGRAMS**

The subcommittee met, pursuant to notice, at 2:03 p.m. in room SR-232A, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, Begich, Blumenthal, Brown, Ayotte, and Graham.

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

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

Staff assistant present: Jennifer R. Knowles.

Committee members' assistants present: Gordon Peterson, assistant to Senator Webb; Lindsay Kavanaugh, assistant to Senator Begich; Ethan Saxon, assistant to Senator Blumenthal; Charles Prosch, assistant to Senator Brown; Brad Bowman, assistant to Senator Ayotte; and Sergio Sarkany, assistant to Senator Graham.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. Good afternoon.

The subcommittee meets today to receive testimony from the Department of Defense (DOD) on military and civilian personnel programs contained in the administration's Defense Authorization Request for Fiscal Year 2013 and the Future Years Defense Program (FYDP).

I am pleased to have Senator Graham by my side again this year as the subcommittee's ranking member.

With us today are senior DOD leaders with whom we will discuss not only DOD personnel policy issues but specific budget items in furtherance of our subcommittee's oversight responsibilities, which I take very seriously. Our witnesses are: the Honorable Jo Ann Rooney, Acting Under Secretary of Defense for Personnel and Readiness; the Honorable Robert F. Hale, Under Secretary of De-

fense, Comptroller, and Chief Financial Officer (CFO) for DOD; Mr. David L. McGinnis, Acting Assistant Secretary of Defense for Reserve Affairs; and the Honorable Jonathan Woodson, Assistant Secretary of Defense for Health Affairs and Director of TRICARE Management Activity.

Virtually every leader in DOD who testifies before the Senate Armed Services Committee addresses the importance of their personnel. In just the past few weeks, for example, we heard: “as we move forward, the Department is committed to our most important asset, our sailors, marines, civilians, and their families.” “The individual marine is our greatest asset.” “The hallmark of our success as an Air Force has always been and will always be our people.” “The strength of our Army is our soldiers.”

We agree. Taking care of our military and civilian personnel and their families is the priority for this subcommittee. There are a number of military and civilian personnel policy issues on our radar this year. They include the administration’s proposal to reduce military end strength by more than 120,000 personnel by the end of fiscal year 2017. Past experience tells us this cannot be accomplished through attrition alone. Many servicemembers who have served multiple combat tours will be asked to leave the military even though they want to remain in the ranks. This subcommittee will seek to provide the Services with the force management tools necessary to reduce end strength in a responsible manner while keeping faith with those who have sacrificed so much. We also want to ensure that the Services have robust transition programs to assist servicemembers and their families as they leave the Active Duty military.

DOD has just released a proposed policy change that will open more than 14,000 positions to women at the conclusion of the congressionally required notification period in a few months. We are encouraged that the Services are continuing to explore the possibility of opening additional specialties and positions to women.

This subcommittee will continue to monitor the implementation of the Secretary of Defense’s decision to eliminate, reduce, or reallocate 140 general and flag officer positions and 150 Senior Executive Service positions.

The subcommittee remains concerned about the number of servicemember suicides and will continue to monitor Service suicide prevention policies and programs.

Sexual assault prevention and response remains a priority for this subcommittee. Last year we enacted a number of legislative provisions to assist victims of sexual assault. Secretary Panetta has announced that he will have additional proposals this year, some of which will require legislation. We stand ready to work with him on this important issue.

Our National Guard and Reserves are an integral part of the military forces. As an operational reserve, the Reserve component is an economical force multiplier, providing flexibility and access to valuable capabilities resident in the National Guard and Reserves. This subcommittee will continue its effort to ensure that there is adequate legislative authority for optimal use of the operational reserve.

The total force includes military personnel, DOD civilian employees, and contractor personnel. This subcommittee will continue to press the Services to include civilians and contract personnel when addressing total force requirements.

The subcommittee remains committed to the care and treatment of our wounded warriors and their families. We believe that the Integrated Disability Evaluation System is an improvement over the legacy disability evaluation system, but it is still too bureaucratic and timeconsuming.

The subcommittee faces a very clear challenge this year as we address the need to control the increasing costs of personnel programs. As the Chief of Staff of the Air Force stated during a recent hearing, “among all the other challenges facing us, the reality of fewer members of the Armed Forces costing increasingly more to recruit, train, and retain for promising careers is, ‘in his view,’ the monumental defense issue of our time.”

The total personnel-related base budget in DOD’s fiscal year 2013 request, including the costs of providing health care to servicemembers, their families, and retirees, amounts to \$168 billion, or about 32 percent of the overall DOD base budget. However, while we must achieve savings in our defense programs, we must do this in a way that does not unfairly impact military benefits for a force that is serving and has served so well during more than 10 years of combat operations.

Our task is even more difficult this year because of the funding limitations imposed by the Budget Control Act (BCA) passed by Congress last year. To comply with this act, the administration has proposed several major actions to reduce military personnel costs, including end strength reductions of more than 120,000 military personnel, limiting pay raises beginning 2015, establishing a base realignment and closure (BRAC)-like commission to conduct a comprehensive review of military retirement, and increasing health care fees for military retirees. Each of these proposals warrants careful consideration.

There is no greater responsibility for Congress and military leaders than to care and provide for our servicemembers and their families. Our military—Active, Guard, and Reserve—is still engaged in the longest sustained period of major conflict in our Nation’s history. We look forward to learning more about the programs and priorities DOD has emphasized to make certain that despite today’s fiscal challenges, our servicemembers, civilian personnel, retirees, and their families will continue to receive the support and benefits they have earned commensurate with their service.

I look forward to all of your testimony today on all of these issues, and as always, I encourage you to express your views candidly and to tell us what, in your view, is working and to raise any concerns and issues you may want to bring to the subcommittee’s attention. Please let us know how we can best assist our servicemembers and their families to ensure that our military remains steadfast and strong.

Senator Graham.

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. Thank you, Mr. Chairman. It has been a pleasure working with you.

We have our work cut out for us. The BCA is going to require some \$400-plus billion in defense spending reductions over the next decade. Sequestration—I hope in a bipartisan fashion—we can stop that. That would be devastating according to Secretary Panetta to do \$600 billion on top of the \$400-plus billion. To get there, you are going to have to put everything on the table like reducing the numbers of people we have in the military, looking at benefits anew. But as the chairman just mentioned, the number one priority of the Federal Government from my point of view is to defend the Nation, and you can only do that with people who are willing to serve, and taking care of those who have served is the best way to recruit people in the future.

The chairman has a unique background in terms of his experience in the government and being a marine. So as we try to find out solutions to hard problems, we will work together the best we can. I look forward to hearing from each of you.

Senator WEBB. Thank you, Senator Graham. As always, it has been a pleasure working with you on this subcommittee and on other issues as well.

We have received statements for the record from a number of different military and veterans organizations. Rather than list them all—I may be missing some here—all of those that will have been submitted by close of business today will be included at the end of this record, if there is no objection from anyone on this subcommittee.

Senator WEBB. We will now hear opening statements from our witnesses. Their complete prepared statements will be included in the record. I am going to make a point here because I really got into trouble on a recent hearing—we are going to have 7-minute rounds for questions from the subcommittee once the testimony is over. Those of you here will recall that when we had a panel full of lawyers and a subcommittee full of lawyers, the conversations went on for about 2 hours. So we will do it 7 minutes at a turn here. I think everybody on this end of the table is an attorney.

Welcome, Dr. Rooney, why do you not begin?

**STATEMENT OF HON. JO ANN ROONEY, ACTING UNDER
SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS**

Dr. ROONEY. Thank you. Chairman Webb, Senator Graham, and distinguished members of the subcommittee, I appreciate the opportunity to appear before you to discuss the personnel and readiness programs in support of the President's budget request for fiscal year 2013.

Thank you for your support of our Active and Reserve military members, their families, and our government civilians who have done everything we ask of them and more.

As you have heard from Secretary Panetta, the fiscal year 2013 budget request was the product of an intensive review of our defense strategy necessitated by the critical turning point of our country after a decade of war and substantial growth in our budgets.

Today, I will describe how we can sustain the All-Volunteer Force for generations to come, a force that has a proven record of unprecedented success in operations around the world. Accomplishing this will require DOD to make hard choices regarding competing priorities for limited funding. This budget plan is predicated on the assumption that the Services are appropriately trained, resourced, and flexible enough to rapidly adapt to emerging threats. Resourcing the reset of the force while maintaining readiness will undoubtedly be one of the most challenging issues of our time.

As the Acting Under Secretary of Defense for Personnel and Readiness, my priorities focus on total force readiness, improving the military health system, and total force support.

After 10 years of intensive operations, our forces are among the most capable in our Nation's history. Our Active and Reserve servicemembers and defense civilians are well-prepared to execute current operations and respond to emergent needs. They are experienced and proficient in a wide range of real-world operations, including those that were not traditionally within DOD's scope of responsibility. As we end today's wars and adjust to new and changing missions, we find ourselves naturally transitioning back toward a broader range of security missions.

Although this transition is occurring in the midst of unavoidable fiscal pressure, we have committed to maintaining a ready, capable All-Volunteer Force.

The performance of our military medical system at a time of war continues to set new standards. DOD strives to provide the best health care in the world to our servicemembers, but the current cost growth of the military health system is unsustainable. DOD is pursuing a balanced, four-pronged approach for improving the health of our population and the fiscal stability of the health care system to ensure we can continue to provide this benefit in the future. Our four approaches include: moving from a system of health care to one of health; continuing to improve our internal efficiencies; implementing provider payment reform; and rebalancing cost sharing.

Another key component of overall health and readiness of the force is support to the families of our servicemembers. One of the four overarching principles of the defense strategy guidance is to preserve the quality of the All-Volunteer Force and not break faith with our men and women in uniform or their families. Despite difficult economic circumstances requiring budget reductions across all levels of the Federal Government, DOD remains committed to providing servicemembers and military families with support programs and resources, empowering them to address the unique challenges of military life.

Ensuring the needs of military families and servicemembers are met contributes to the overall well-being of the total force. This includes access to mental health care, providing for the educational needs of servicemembers' children, support of morale, welfare, and recreation programs, and maintaining benefits at defense commissaries.

Secretary Panetta has directed that family programs continue to be a priority for DOD and it remains my priority as well.

Putting together this year's budget request in a balanced package was a difficult undertaking and took the combined effort of our senior military and civilian leadership. Throughout that process, I believe we have developed the right mix of programs and policies in place to shape the force we need. Yes, we will reduce the rate of growth of manpower costs, including reductions in the growth of compensation and health care costs. But as we take these steps, we will do so in a way that we continue to keep faith with those who serve.

During the past decade, the men and women who comprise the All-Volunteer Force have demonstrated versatility, adaptability, and commitment, enduring constant stress and strain of fighting two overlapping conflicts. They have also endured prolonged and repeated deployments. 47,775 have been wounded, and 6,376 members of our Armed Forces have lost their lives. As DOD reduces the size of the force, we will do so in a way that respects and honors these sacrifices.

I look forward to continuing to work with you, Chairman Webb, Senator Graham, and distinguished members of the subcommittee, to support the men and women in our Nation's Armed Forces.

Accompanying me today is the Under Secretary of Defense Comptroller, Mr. Robert F. Hale, and two senior members of my staff, Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs and Director of TRICARE Management Activity, and Mr. David L. McGinnis, Acting Assistant Secretary of Defense for Reserve Affairs. All of us before you today look forward to your questions.

[The prepared statement of Dr. Rooney follows:]

PREPARED STATEMENT BY HON. JO ANN ROONEY

INTRODUCTION

Chairman Webb, Senator Graham, and distinguished members of the subcommittee, I appreciate the opportunity to appear before you to discuss Personnel and Readiness programs in support of the President's budget request for fiscal year 2013. Thank you for your support of our Active, Reserve component military members, their families, and our government civilians who have done everything we have asked of them and more.

As you have heard from Secretary Panetta, the fiscal year 2013 budget request was the product of an intensive review of our defense strategy necessitated by the fact that our country is at a critical turning point after a decade of war and substantial growth in our budgets. Today, I will describe how we can sustain the All-Volunteer Force for generations to come—a force that has a proven record of unprecedented success in operations around the world. Accomplishing this will require the Department to make hard choices regarding competing priorities for limited funding. This plan is predicated on the assumption that the Military Services are appropriately resourced, experienced, and flexible enough to rapidly adapt to emerging threats. Resourcing the reset of the force, while maintaining force readiness, will undoubtedly be one of the most challenging issues of our time.

As the acting Under Secretary of Defense for Personnel and Readiness my priorities focus on: Total Force Readiness, Improving the Military Health System, and Total Force Support.

READINESS

After 10 years of intensive operations our forces are among the most capable in our Nation's history. Our Active and Reserve component members and defense civilians are well prepared to execute current operations and respond to emergent needs, and are experienced and proficient in a wide range of real world operations. We have, by necessity, mastered a host of specialized capabilities that depend heavily on language and culture, governance, rule of law, development, and other special-

ized skills; not all of which are within the Department's traditional scope of responsibility. However, fully preparing for these missions means that there have been fewer capabilities available for large-scale, major combat operations. As we end today's wars and adjust to new strategic guidance, we find ourselves naturally transitioning back toward a broader range of security missions.

The first sign of this transition is the return of full-spectrum exercises that we have seen over the last year. Specifically, the Marine Corps exercised its first large-scale amphibious assault in 10 years just a few weeks ago. Similarly, the Army is shifting to decisive action training exercises at the Combat Training Centers. We will see more of these exercises as forces return and reset from current operations. In addition, the Army has begun to regionally align maneuver and enabler forces to some combatant commands to conduct security cooperation and security force assistance activities. These forces will have appropriate language, culture, advisor training and skills to enable expanded engagement with critical partners in the region.

Although this transition is occurring in the midst of unavoidable fiscal pressure, we have committed to maintaining a ready, capable All-Volunteer Force. Program reductions were deliberately managed to preserve operational flexibility and to keep faith with servicemembers and their families who have made significant sacrifices. We realize that sometimes, either due to unforeseen circumstances or a changing world, even the most well-conceived plans must be revised. For this reason, my office is maintaining its role of closely monitoring the readiness of our forces for the dual purposes of identifying and remediating critical deficiencies or unmet requirements.

End Strength

We know that multiple deployments to Iraq and Afghanistan, with limited time at home for recovery, have stressed our military members and their families. With the draw down in Iraq and Afghanistan, this stress is fundamentally reduced. We have withdrawn 50,000 troops from Iraq since 2010, and will have reduced Afghanistan troop levels by 30,000 at the end of this year. Barring unforeseen events, the Secretary's goal of 2 or more years at home for every year deployed will likely be met this coming year. The All-Volunteer Active and Reserve Force is healthy, and our Services are achieving or exceeding their recruiting and retention goals.

Today, our overall military end strength, which includes the base force and overseas contingency operations, is at 2,269,700 in fiscal year 2012. While the initial changes to force size are muted, a 1.4 percent reduction equating to a 31,300 person reduction in fiscal year 2012, ultimately the Department will be at 2,145,800 by fiscal year 2017. This 5.5 percent reduction equates to 123,900 fewer troops and will be spread throughout the components of the force.

- Army Active, Reserve, and Army National Guard (NG) end strength in fiscal year 2013 is projected to be 1,115,300—0.9 percent less than fiscal year 2012. In fiscal year 2017 the end strength will be 1,048,200, a 6.8 percent reduction from fiscal year 2012.
- Navy Active and Reserve end strength in fiscal year 2013 is projected to be 385,200—1.7 percent less than fiscal year 2012. In fiscal year 2017, the end strength will be 376,600, a 3.9 percent reduction from fiscal year 2012.
- Marine Corps Active and Reserve end strength in fiscal year 2013 is projected to be 236,900—2.0 percent less than fiscal year 2012. In fiscal year 2017 the end strength will be 221,700, an 8.3 percent reduction from fiscal year 2012.
- Air Force Active, Reserve, and Air NG end strength in fiscal year 2013 is projected to be 501,000—1.9 percent less than fiscal year 2012. In fiscal year 2017, the end strength will be 499,300, a 2.3 percent reduction from fiscal year 2012.

A force drawdown of this size has not been experienced since well before September 11.

Total Force Management and Planning

The Department relies on a Total Force of Active and Reserve military, government civilians, and contracted support to provide for the Nation's defense and execute its core missions. We will face force management challenges over the next several years which are far greater than those we have experienced since September 11, 2001 and, therefore, must balance the competing requirements for equipment reset, modernization and support for our servicemembers and their families in a climate of reduced budgets. Responsibly managing the required force reduction, while ensuring we keep faith with those who have sacrificed so much to secure our Nation's interests, and properly caring for our military families as many

servicemembers transition to veteran status is a responsibility taken very seriously and one which my organization is helping to facilitate. Congress aided this effort immeasurably by recently enacting legislation that expanded voluntary separation programs which provide appropriate recognition for significant military service, such as the temporary early retirement authority (TERA) which gives the military departments the flexibility to offer retirement to servicemembers with more than 15 but less than 20 years of service. We will continue to work with Congress to reinstate additional expired authorities from previous drawdowns that would offer the Department the ability to focus separations and avoid the loss of critical expertise.

The Department's Total Force of Active and Reserve military, government civilians and contracted services represents a carefully coordinated approach that balances operational needs, satisfies mission requirements, and recognizes fiscal constraints. Our future plans will seek to balance the capabilities and cost of all elements of the Total Force. They cannot be managed in isolation if we are to avoid a hollow force and unnecessary expense. Our plans recognize:

- Decreased operational commitments and revised overseas posture;
- A Reserve Force that is an operational asset;
- A highly skilled civilian workforce capable of performing mission essential and inherently governmental tasks;
- Contracted support that is cost effective and designed to provide appropriate and complimentary support to our operational needs;
- Civilian decreases that have been carefully targeted to deliver efficiencies initiated by Secretary Gates; and
- Efficient management of our contracted support as part of our Total Force mix and not as just an acquisition management action.

Active Duty Recruiting

Recruiting for the All-Volunteer Force continues at unprecedented levels. The Department closed out fiscal year 2011 with all active Services meeting or exceeding recruiting objectives, both numerically and by recruit quality. As shown in Table 1, we continue that record pace into fiscal year 2012, with 44,414 new recruits against an objective of 44,323 through January of this year. Recruit quality remains considerably above Department benchmarks (or standards), with 98 percent of new recruits having a high school diploma (90 percent benchmark) and 80 percent scoring above average in aptitude (60 percent benchmark) on the Armed Forces Qualification Test (AFQT). Of particular note is the fact that very few recruits accessed at or below the 30th percentile on the AFQT through January of this year.

Table 1—Recruit Quality (Fiscal Year 2012 Through January) Active Components

AC Enlisted Recruiting Fiscal Year 2012 (End of January)	Quantity			Quality		
	Accessions	Goal	Percent of Goal	Percent High School Graduate: Benchmark=90 percent	Percent Scoring at/ above 50th Percentile on AFQT; Benchmark=60 percent	Percent Scoring at/ above 30th Percentile on AFQT; Benchmark=4 percent
Army	17,123	17,050	100 G	95 G	64 G	<1 G
Navy	9,289	9,289	100 G	99 G	93 G	0 G
Marine Corps	7,795	7,777	100 G	100 G	76 G	0 G
Air Force	10,207	10,207	100 G	100 G	99 G	0 G
DOD Total	44,414	44,323	100	98	80	<1

Quantity Key: 100 percent or above goal; 90–99 percent of goal; below 90 percent of goal.

Quality Key: 100 percent or above benchmark; 90–99 percent of benchmark; below 90 percent of benchmark.

Generally, a slow economy makes recruiting less challenging, and operates to the advantage of those who are hiring, including the U.S. military; clearly, the current state of our economy has been one of the drivers of this recruiting success. As we see signs of economic improvement, we will remain vigilant and continue to monitor the impact of that improvement on our recruiting efforts. Despite the positive effect of the economy on recruiting, there remain other factors counterbalancing our ability to attract bright, young Americans into the Armed Forces—the lower likelihood of influencers of youth (e.g., parents and teachers) to recommend service, a large and growing proportion of youth who are ineligible to serve in the military, higher numbers of youth going to college directly from high school, and continuing concerns about the prolonged worldwide, irregular campaign with its concomitant high operations tempo. Therefore, we are in uncharted waters with significant factors directly affecting military recruiting in both positive and negative ways.

Due to these direct effects on recruiting, and as the Nation faces a demographic shift, it is important that the Department align its recruiting assets to tap emerging markets. Leveraging the diverse perspectives, and cultural, language and regional competencies present in our force ensures we encourage innovation and optimize mission success with respect to evolving challenges we will face well into the 21st century. We are carefully reviewing recruiting programs to align funding and policies with current realities as we recognize the necessity of current and future budget constraints. We will strive to ensure the resources dedicated to recruiting are reasonable and remain at levels that will not compromise success. The Services will decide where best to take those cuts and any realignments undertaken will be done carefully and their effects closely monitored.

Recruit Quality: The Department generally reports recruit quality along two dimensions—aptitude and education. Both are important, but for different reasons.

Aptitude is an indicator of trainability and job performance. All recruits take an enlistment test called the Armed Services Vocational Aptitude Battery (ASVAB). One component of the ASVAB, the Armed Forces Qualification Test (AFQT), measures math and verbal skills. Those who score at or above average on the AFQT are in Categories I–IIIA, while those who score between the 10th and 49th percentile are placed in Categories IIIB and IV. Applicants scoring below the 10th percentile are ineligible to enlist. We value higher-aptitude recruits because their training and job performance are superior to those who score in the lower categories.

The Department's educational enlistment policy groups education credentials into three tiers—Tier 1, consists primarily of traditional high school diploma graduates; Tier 2 consists of alternate credential holders, to include home-school and virtual/correspondence schools; and Tier 3 is nongraduates. Education credential is used not to measure the quality of education or the intelligence of the applicant, but rather the applicant's likelihood of completing his or her enlistment term. Years of research and experience indicate about three-quarters of recruits with a high school diploma complete their first 3 years of service, whereas only about half of those without a high school credential will complete 3 years. The attrition rates of those holding an alternative credential (e.g., GED) fall between these extremes. The Department's benchmark is that 90 percent of new recruits are high school diploma graduates.

As a result of the evolving methods of education delivery across the Nation, the National Defense Authorization Act (NDAA) for Fiscal Year 2012 required restructuring of the education credential tiers we use to determine enlistment priority. Specifically, the act expanded Tier 1, "High School Diploma Graduate," to include graduates of alternative educational delivery methods. From past experience, we find these individuals, on average, have significantly higher attrition rates—the current first-term attrition rate for high school diploma holders is 28 percent; alternate credential holders average a 38 percent rate. We remain concerned about the long-term impacts of this policy change as it costs the Services approximately \$55,000 to replace (recruit, train, equip, pay) each individual who fails to complete his or her initial term of service. Nevertheless, the new policy will be in place by July of this year as directed, and we will monitor the attrition behavior of these recruits. Additionally, as encouraged in the legislation, we will continue to develop new methods of identifying those who are qualified for recruitment and enlistment. These methods may include use of a non-cognitive test, adaptive personality assessment, or other operational attrition screening tools to predict performance, behaviors, and attitudes of potential recruits which influence attrition and ability to adaptively perform the required missions.

Active Component Retention:

Similar to our recruitment numbers, the Army, Air Force, Navy, and Marine Corps all exhibit strong retention numbers for the first 4 months of fiscal year 2012 continuing a trend from the previous year (Table 2). The resilience of the All-Volunteer Force through two wars continues to prove the tremendous dedication and patriotism of the men and women serving our great Nation. I am humbled by their willingness to place themselves in harm's way and do their Nation's bidding.

That said, I also recognize we will face new challenges as the economy improves, conflicts subside, and uncertainty rises over the drawdown of the force. The Department must ensure meaningful missions, support for our military families, and complete transparency regarding our reduction efforts. Despite budget pressures we are committed to careful and deliberate reviews of servicemember and family programs with an eye on retention. We can ill afford to arrive at the end of the drawdown with a force that does not match the capabilities the Nation requires and without the resources necessary to make adjustments. Towards this end, I am encouraged by the plans offered by the Services as they make difficult force reduction decisions. For example, the Services are limiting reductions in accessions to ensure we meet

future requirements, and they are offering voluntary separation programs to servicemembers prior to taking involuntary separation actions whenever possible. We also intend to extend to Congress our commitment of transparency in these efforts. Together I am convinced we can create an environment that avoids the pitfalls experienced throughout history by most post-conflict militaries. While this will undoubtedly prove extraordinarily challenging, I believe you will agree we owe it to our Nation and to the soldiers, sailors, airmen, and marines who will continue to stand watch for the generations to come.

Table 2
Active Duty FY 2012–January Retention Report:

Active Duty Retention by Service by Zones of Eligibility					
	Status	Reenlisted	Mission YTD ¹		FY12 Retention Goals
Army					
- Initial	G	6,165	5,593	110%	32,893
- Mid-Career	G	3,807	3,662	104%	21,974
- Career	G	1,545	1,545	100%	13,133
Navy					
- Initial	G	3,782	1,992	190%	9,180
- Mid-Career	G	2,349	1,261	186%	4,974

- Career	G	1,947	1,404	139%	3,773
Marine Corps					
First	G	5,305	2,100	253%	6,300
Subsequent	G	5,107	2,733	187%	8,200
Air Force					
- Initial	G	5,998	4,812	125%	15,927
- Mid-Career	G	3,561	2,883	124%	9,543
- Career	G	2,812	2,512	112%	8,315

¹Mission YTD represents the cumulative monthly percentage of the Service's FY Goal.

² Retention year traditionally starts on July 1st even though the numbers are not official reported until October 1st. The Marine Corps frontloads the retention year and first termers tend to reenlist early in the FY.

Women in the Service

The Department has recently completed a review of how we assign women in the Service. As requested by Congress, the Department, in coordination with the military departments, reviewed laws, policies, and regulations, including our co-location policy, to determine if any changes were needed to ensure female members have an equitable opportunity to compete and excel in the Armed Forces. We took a hard look at the current restrictions on women, and recommend changes within the report to Congress (available to the public online <http://www.defense.gov/news/WISR—Report—to—Congress.pdf>). Pending expiration of the congressionally-required notification period, the Department will implement a change to policy that eliminates gender-based assignment restrictions to units and positions that are doctrinally re-

quired to physically co-locate and remain with direct ground combat units that are closed to women. These recommendations will open over 14,000 positions to women, including 6 Army occupational specialties. The Department is not stopping with the policy changes set forth in the report. The Services will continue to evaluate these recommendations to inform future policy revisions in addition to developing gender-neutral standards for physically demanding occupations. Secretary Panetta directed the Secretaries of the Military Departments and Chiefs of Military Services to report their progress on the development of gender-neutral standards, assessment of newly opened positions and recommendations for any further positions that can be opened, 6 months after implementing these changes. We continue to reiterate our commitment to removing all barriers that would prevent servicemembers from rising to the highest level of responsibility that their talents and capabilities warrant.

Implementation of the Repeal of "Don't Ask, Don't Tell"

Since September 20, 2011, the effective date of repeal, the Services report there have been no significant issues related to the implementation of the repeal of "Don't Ask, Don't Tell." By all accounts, implementation is going smoothly across the force. We attribute this success to our comprehensive pre-repeal training programs, combined with the discipline of our servicemembers and continued close monitoring and enforcement of standards by our military leaders at all levels. Prior to repeal, the Department saw a preponderance of the force, 2.25 million servicemembers, trained regarding the necessary policy and regulation changes that went into effect on "Repeal Day."

The Department and the Services remain engaged in ongoing implementation efforts. A formal monitoring process ensures continual assessment and reporting to the Secretary of Defense. Elements of this monitoring process include regular Service assessment reports and periodic surveys of servicemembers. Through this feedback mechanism, the most common question we hear from the field is about benefits—specifically, whether or not benefits will be extended to same-sex partners. The Department is engaged in a comprehensive review of the possibility of extending eligibility for additional benefits, when legally permitted, to same-sex partners, and our goal is to complete this review by the end of the fiscal year. With leadership, professionalism, discipline, and respect, the Department and our servicemembers remain fully committed to the implementation effort, consistent with our standards of military readiness, effectiveness, unit cohesion, and recruiting and retention for the Armed Forces.

General, Flag Officer, and Civilian Senior Executive/Equivalent Efficiencies

In 2011, the Secretary of Defense made the decision to eliminate, reduce, or reallocate 140 general or flag officer (GFO) positions and a minimum of 150 Civilian Senior Executive/Equivalent (CSE) positions. The Department designated 102 GFO positions for elimination (complete removal from structure or downgrade of a position to a grade of O-6 or below) and 211 CSE positions for elimination. By the end of the year, we had eliminated 29 GFO positions and reduced 20 positions to a lower grade of GFO. We are moving forward to implement the remaining efficiencies gradually over the next several years as conditions allow, not adversely affecting missions or forcing readiness. Three years ago, Congress' authorization of the Joint Pool created the foundation for increased flexibility for the Department in the management of positions. This latest efficiency effort will take those policies to the next level and will create flexibility for each of the Military Departments to ensure their readiness to respond to any emerging threat. CSE reductions are being implemented based on a 2-year strategy. To date, 93 Senior Executive Service, Senior Level or Senior Technical (SES/SL/ST) positions, and 57 Defense Intelligence Senior Executive and Defense Intelligence Senior Level (DISES/DISL) positions have been reduced. The remaining CSE efficiencies will be completed by March 2013.

Growing Language and Culture Capabilities

The President directed the Department to sustain U.S. global leadership as we transition from a long-term engagement in two wars toward a more global presence focused on the Asia-Pacific and the Middle East. Though Service end strengths will decrease, the demand for language skills, regional expertise, and cultural awareness will increase, as these capabilities are essential not only to our mission readiness but to achieving national security, building partner capacity, and strengthening alliances. Currently, 9 percent of military personnel have tested or self-professed foreign language skills at any level of proficiency and 5 percent have skills that meet the Department's need for limited working language proficiency or above.

Increasing the language capabilities of the Department depends on recruiting policies, training, assignment policies, retention, overall career management, and the U.S. educational system. We have efforts underway to coordinate national and De-

partmental language capabilities, as well as initiatives for long-term sustainment. The goal is to ensure a spectrum of programs that include pre-accession, and in-service military and civilian training, while establishing new career paths for personnel with language and culture skills. These efforts include increasing the foreign language skills of the Department's military and civilian personnel, as well as outreach to our Nation's schools and universities to promote the teaching of critical languages. All these efforts are essential to achieving a force, a Nation, and a citizenry capable of facing the threats, opportunities, and challenges we will confront in the 21st century.

Drug Demand Reduction

The abuse of illicit and prescription drugs in the U.S. military has substantial implications on force readiness and safety. The goal of the Drug Demand Reduction (DDR) Program is to protect readiness and the well-being of our civilian and military personnel by detecting and deterring drug abuse. Toward that end, the Department and Services have recently expanded the existing panel of tested drugs to include frequently abused prescription medications, such as Vicodin and Valium. The Department's minimum random drug testing goal is 100 percent with a positive rate below 2 percent. Overall, drug positive rates for active duty military personnel across all Services have continued to decline and the current rate of positive specimens is below 1 percent, the lowest in the program's history. As with many programs, the DDR Program incurred a reduction in budget which will require additional efficiencies in collection, outreach, and educational programs. This will also require increased targeted random drug testing.

Suicide Prevention

Every person within the Department of Defense is a valuable team member and each loss to suicide is a preventable tragedy. For this reason, we are taking aggressive steps to address suicide by enacting policies, providing supportive services and assistance, implementing training initiatives and publishing education materials, and conducting data surveillance and research to support servicemembers and their families. For example, the Department increased behavioral health providers from 6,590 to 8,898 total providers, a 35 percent increase over the past 3 years, adding mental health providers in primary care settings and embedding them with front-line units. We have also partnered with the Department of Veterans Affairs (VA) to build a continuum of support for transitioning members. This partnership will not only provide more service options for our members, it will allow us to compile more complete data that could lead to better predictive and preventative measures.

We are building and shaping resiliency and coping skills through realistic and interactive training to ensure every servicemember can recognize the warning signs of suicide and encompass the skills and knowledge necessary to purposely intervene. We are also committed to further research on understanding and preventing suicide as with the Army Study to Assess Risk and Resilience in servicemembers (ARMY STARRS), which is the largest study of mental health risk and resilience factors ever conducted among military personnel. Conceived by scientists at the National Institute of Health's National Institute of Mental Health (NIMH), ARMY STARRS was formalized through a memorandum of agreement that authorized NIMH to conduct an extensive investigation with Army funding. The ARMY STARRS program is led by an interdisciplinary team of Army, Academic, and NIH investigators.

Though we have been able to arrest the increasing rate of suicides over the past 3 years, the Department continues to work hard to reduce these tragedies. We have established a Defense Suicide Prevention Office to serve as the focal point for developing and overseeing suicide prevention policy, training, and programs across the Department. This office will also collaborate with Military Departments to implement the recommendations of the Department of Defense Task Force on the Prevention of Suicide, and serve as our lead with the VA and nongovernment organizations to identify and institute a continuum of suicide prevention efforts for personnel leaving the Department.

Sexual Assault Prevention and Response

As Secretary Panetta has stated, this Department has a zero-tolerance policy against sexual assault and this is a leadership issue first and foremost. We have received the final numbers from the Services and the Department had 3,192 reports of sexual assault in fiscal year 2011; because of underreporting, estimates are closer to 19,000 (per a fiscal year 2010 Defense Manpower Data Center survey). This is in stark contrast to the first sample survey in 2006, when the estimate was 34,000. Since 2006, more victims are stepping forward to report assaults and the percentage of alleged sexual assault offenders facing court-martial proceedings has increased.

In this past year alone, we have made significant strides. We recently published a revised Directive expanding our support to assault victims to include military spouses and adult military dependents, the Department's civilians stationed abroad and the Department's U.S. citizen contractors in combat areas. In addition, two new policies address expedited transfers and the retention of law enforcement records for 50 years. To ensure national standards for victim services, we are establishing a sexual assault advocate certification program and, we established the DOD Safe Helpline which provides anonymous and confidential, 24/7 hotline and texting support to victims anywhere in the world. We are collaborating with the VA and Department of Labor (DoL) to establish a continuum of care for victims of sexual assault transitioning from military to civilian life and will use the DOD Safe Helpline as a vehicle to help these transitioning servicemembers.

To improve the tracking of reports, the Defense Sexual Assault Incident Database will be implemented by March 31 and be fully operational by August 31st. Because sexual assault cases are some of the toughest cases to investigate and to prosecute, the Department has committed funding through fiscal year 2017 to provide sexual assault specific training for judge advocates and criminal investigators and we are assessing the Sexual Assault Prevention and Response training for commanding officers and senior enlisted leaders. We will continue to hold the perpetrators appropriately accountable and all military servicemembers will live up to the high standards set.

Compensation

Senior leaders in the Department place a high value on the willingness of America's military personnel to serve their country. We understand our compensation system must be competitive, recognize the demands of military service, and always provide sufficient compensation to attract and retain qualified personnel. The 9th Quadrennial Review of Military Compensation shows that servicemembers need to be paid equal to or better than 70 percent of their civilian counterparts.

Through the work of Congress, our servicemembers received generous military pay raises over the past decade and, as a result, military compensation has increased and significantly exceeds that 70th percentile. Additionally, over the past decade, the Department and Congress addressed a host of challenges ensuring military compensation remained competitive, and this has allowed the Department to continue to succeed in recruiting and retaining the high-quality, All-Volunteer Force required by the Nation, despite nearly a decade at war.

As we reset following the end to combat operations in Iraq, the beginnings of force reductions in Afghanistan, and in light of the Nation's economic crisis and our expected manpower reductions, slowing the future growth of military compensation will be important. As mentioned earlier, we expect challenges in recruiting and retention to grow over the next few years as both the economy and labor market continue to improve. The current, competitive military compensation package makes the Department well suited to respond to those challenges, even during this time of war. As a result, we have requested full pay raises for fiscal year 2013 and fiscal year 2014, and more limited pay raises beginning in fiscal year 2015. For fiscal year 2013, this would provide an increase in military basic pay for all servicemembers of 1.7 percent, which is in line with earnings increases seen in the private sector as measured by the annual change in the Employment Cost Index.

The Department also understands current fiscal pressures demand change, and that the costs of military compensation are significant. Some cost savings will be achieved through proposing more limited pay raises beginning in fiscal year 2015. However, in the continuing search for budget cuts and efficiencies, we are evaluating the military compensation system, focusing first on military retirement. As I stated before the subcommittee in October of last year, we have been conducting a vigorous, internal review, and are working diligently to identify and evaluate retirement alternatives. In addition to this ongoing review, the Department recommends Congress establish an independent commission to review military retirement, as requested by the administration. We fully support formation of such a commission, and if enacted, we will provide significant input. Most importantly, our review is performing critical and rigorous modeling and analysis of various alternatives. While many in the private sector, and elsewhere, have suggested alternatives to the current military retirement system, few have undergone rigorous modeling or analysis. We are committed to ensure any proposal we develop is sound and does not harm the Department's ability to recruit and retain the future force. Secretary Panetta has also made clear that current members will be grandfathered; for those who serve today, there will be no changes in retirement benefits. Following the review of military retirement, we plan to continue our comprehensive, broad-based review of military compensation in search of additional efficiencies and savings.

Reserve Component

The fiscal year 2013 budget supports the increased utilization of the Reserve components (RC) as called for in the National Defense Strategy and will enable the RCs to continue to fulfill their vital national security role. The Department's Ready Reserve totaling about 1.1 million members contributes 43 percent of total military end strength at a cost of 9 percent of the total base budget. The National Guard (NG) and Reserve provide trained, ready, and cost-effective forces that can be employed on a regular operational basis, while also ensuring strategic depth for large-scale contingencies or other unanticipated national crises.

Prior to 2001, the RCs were primarily a strategic reserve with occasional operational missions as needed to augment active forces. Since 2001, RC units and individuals have been heavily employed across the full spectrum of military operations and have demonstrated their readiness and criticality. Our current NG and Reserve is, arguably, the most combat seasoned reserve force ever, and we plan to capitalize on this significant investment to provide needed military capacity during current austere economic times.

The fiscal year 2013 budget anticipates the Department will continue to use the Guard and Reserve as a vital part of the operational force and—where it makes sense—as a force of first choice. Today's Citizen Warriors have made a conscious decision to serve, with full knowledge that their decisions mean periodic recalls to active duty under arduous and hazardous conditions. In approximate numbers, as of December 31, 2011, the Ready Reserve currently consists of:

- Selected Reserve: 844,400
- Individual Ready Reserve: 220,000
- Inactive NG: 3,700

Reserve Component Utilization

The Reserve component has become an integral part of the Nation's military force participating in nearly every mission worldwide for the past two decades. As this practice continues, the Department has emphasized prudent and judicious management and use of the RC to help mitigate stress on the Total Force. Total Reserve component usage in support of Contingency Operations since September 11, 2001 is 835,689 (809,913 Selected Reserve and 25,776 Individual Ready Reserve). Of those, 80 percent have deployed in the U.S. Central Command area of responsibility. On December 31, 2011, there were 86,213 Reserve component members activated in support of Operation Noble Eagle (ONE) and Operation Enduring Freedom; of those, 35,361 were deployed in the Central Command theater.

Realigning Capabilities

The Reserve component is well suited for use as a source of strategic depth as well as in a wide variety of operational roles, including providing: (1) rotating operational units deployed in response to Combatant Commander needs and Service requirements; (2) units and teams deployed in support of Theater Security Cooperation and Building Partner Capacity activities around the globe; (3) individual augmentees who can be deployed in response to Combatant Commander, Defense agency, or Service needs; (4) units, teams, and individuals to support core Unified Command Plan missions such as Homeland Defense and Defense Support of Civil Authorities, as well as to support Governors in state security; and (5) units, teams, and individuals assigned to support Department or Service institutional needs. Reserve component forces are well-suited for missions and tasks in support of Theater Security Cooperation and Building Partner Capacity activities and specialty missions requiring unique skills, particularly when the RC units have an enduring relationship with a supported command.

Individual and Medical Readiness

One of the key aspects of maintaining a viable, operational RC is to ensure that our military members and our civilian employees maintain the highest level of individual readiness. We must focus on maintaining the appropriate physical fitness levels for a force that has a higher average age than the Active component. Similarly, ensuring that our RC members are medically and dentally ready to serve is of the utmost importance.

Employing the RC as operational force requires modifications to training schedules and funding requirements. Before we operationalized the RC, normal minimum training profiles consisted of training 2 days per month plus 14–15 days of active duty for training annually. During that training time, RC personnel were required to meet the same standards as their Active counterparts. While that training profile remains in-place for some types of units, for those with planned deployments, training days prior to mobilization increases. This training profile, with more training

pre-deployment and less post-deployment, minimizes mobilized time away from families and civilian jobs. Increasing individual readiness by modifying training profiles with resources and policies is a major focus area that will allow the Guard and Reserve to capitalize on the gains made during the last decade and enable sustained use of the RC as an operational force.

We continue to monitor Individual Medical Readiness of the NG and Reserve to ensure availability of ready RC members for deployment, as it is a priority for the Department. By the fourth quarter of fiscal year 2011, the RC had increased its Fully and Partially Medically Ready (FMR/PMR) rate 5 percent over first quarter fiscal year 2011 rates, and reduced the Indeterminate population by 6 percent. Most notably, the Marine Corps Reserves improved their FMR status by 16 percent and reduced the PMR rate by 14 percent—over half of the fiscal year 2011 first quarter rates. The Coast Guard Reserve also made great improvements increasing their FMR rate by 9 percent, and reducing their Indeterminate and Not Medically Ready population by 4 and 6 percent respectively. While we continue to face challenges with Dental Readiness, all Services are over the 75 percent goal except Army Reserve and Army NG which are at 71 and 73 percent respectively. We are working diligently to improve access to medical and dental services for RC members. For example, the Army Reserve now budgets additional medical and dental services into their Readiness Accounts for RC members if needed.

Yellow Ribbon Reintegration Program (YRRP)

The YRRP is a Congressionally-mandated program whereby the Services provide RC servicemembers and their families with critical support, information, services, and referrals throughout the entire deployment cycle focused primarily on local community resources to maximize successful servicemember reintegration back into their civilian lives. During the past 3 years, the YRRP has evolved into a successful, forward-leaning program providing essential readiness and resiliency training and resources to over 800,000 servicemembers and designees. In fiscal year 2011, Congress appropriated \$16 million to the YRRP for enhanced outreach and reintegration employment activities which allowed the Department to support various State-led initiatives. YRRP's fiscal year 2012 funding is entirely dedicated to supporting its legislatively mandated core activities. To support the use of the operational reserve in the future, we will ensure funding for Service YRRPs is moved to their base line budgets.

Transition to Veterans Affairs

Today's Veterans face a number of challenges in making the transition to civilian life, and among these is embarking on a productive post-military career. For every success story of a Veteran who has turned skills developed in the military into success in the civilian workplace, there are, as President Obama has said, stories of Veterans who come home and "struggle to find a job worthy of their experience and worthy of their talent." We see these struggles most clearly in high unemployment rates for Veterans. Making this situation more urgent is that, as we draw down from the wars in Iraq and Afghanistan and we make difficult decisions about our future force structure in light of the fiscal challenges the Nation faces, the number of servicemembers—particularly young servicemembers—departing the military over the next several years will increase.

Making a firm commitment to employ America's Veterans, in August 2011, the President called for the creation of a Task Force led by the DOD and VA with and other agencies including the DoL, Department of Education (DoE), Department of Commerce, Small Business Administration, and the Office of Personnel Management, to develop proposals to maximize the career readiness of all servicemembers. In coordination with our VA, DoL, and DoE partners, DOD's role involves implementing and sustaining a comprehensive plan to ensure that all transitioning servicemembers have the support they need and deserve when they leave the military. This includes working with other agencies in developing a clear path to civilian employment; admission into and success in an academic or technical training program; or successful start-up of an independent business entity or nonprofit organization. The effort is fully aligned with the VOW to Hire Heroes Act of 2011 and is consistent with DOD's commitment for keeping faith with all of our military members and their families, providing them a comprehensive set of transition tools and support mechanisms as they complete their service to our Nation.

Civilian Personnel

The Department continues to hold, with limited exceptions, the civilian workforce to authorized fiscal year 2010 levels. This continues the direction from last year's efficiency initiative and was implemented in conjunction with organizational assessments and mission/function prioritization. This direction reflects the Department's

commitment to challenge workload demand; more appropriately size our workforce to meet our most pressing and critical priorities; and focuses on reducing administrative functions associated with headquarters staff while realigning resources to warfighting capability, recapitalization, and unit readiness. As Secretary Panetta has testified, our spending choices must be based on sound strategy and policy, and reductions in the civilian workforce reflect changes in the Department's strategy, overseas presence, and force structure.

Despite the overall decreases to the Department's civilian workforce, there have been areas where mission workload, requirements, and fiscal considerations warranted growth and exceptions. Growth and increases to the civilian workforce have continued in critical areas such as acquisition, cyber, and intelligence. Targeted exceptions to fiscal year 2010 levels have also been approved for shipyard and security guard workforces in the Navy; the test and evaluation workforce in the Army and Air Force; joint basing requirements for the Navy and Air Force; and in-sourcing of contracted services at some combatant commands and defense agencies.

Reductions in the Department's civilian workforce are being executed very deliberately to minimize adverse impacts to our dedicated civilian service workforce and to avoid unintended consequences, such as:

- “borrowing” or “repurposing” military personnel for non-military tasks, which would risk hollowing the force;
- potentially paying more for contracted services or inappropriately realigning work to the private sector; and
- jeopardizing our ability to sustain and develop mission critical skills and competencies.

To support these goals, I reconstituted the Defense Human Resources Board (DHRB) on December 8, 2011. The DHRB is my primary advisory body for Total Force management across the Department. Specifically, the DHRB serves to promote and facilitate improved Department-wide Total Force management, both current and future, through the improved alignment of statutes, policy, business practices, information technology, and resources.

It is imperative we improve the management of our Total Force of Active and Reserve military, government civilians, and contracted services. To do so, leaders and managers throughout the Department must be provided the information, tools, and flexibility necessary to make sound and well-reasoned decisions. To that end, there are a number of specific areas that we have focused attention on.

In October 2011, the Office of Federal Procurement Policy (OFPP) issued its policy letter regarding inherently governmental (IG) and other work Reserved for government performance. The Department was an active participant in developing that policy letter, and my staff is currently working to ensure its implementation and application across the Department. The identification of IG functions, work that is closely associated with IG, and workload critical to the Department's ability to execute its mission are fundamental processes in our Total Force management strategy.

Ensuring the Department's workforce is sufficiently sized and comprised of the appropriate mix of personnel is critical to maintain readiness and capabilities in our constrained fiscal environment. The Department's “sourcing” of necessary functions and work between military, civilian, and contracted services must be consistent with workload requirements, funding availability, readiness and management needs, and applicable laws. In particular, workforces must be structured to not use military personnel outside of their primary specialty to perform functions or tasks that would limit their availability to mobilize and perform the operational mission, support and maintain necessary states of readiness, or impede their training and career progression requirements. As planned military end strength reductions happen, the Department will continue to focus on the proper mix of personnel.

Inventory of Contracts for Services (ICS)

Contracted services remain the largest element of the Total Force. The Department remains committed to meeting its statutory obligations under title 10 to annually review its contracted services. After 6 months of working with the more than 40 components that comprise the Department, we delivered, on November 22, 2011, a consolidated plan to the congressional defense committees that identified both short- and long-term actions that will improve the ICS, make it a more reliable and complete data set, and improve visibility and accountability in the area of contracted services. Consistent with changes to the statute, this plan, and subsequent guidance issued on December 29, 2011, specifically addresses how the Department will:

- measure contracted support level of effort using direct labor hours and associated cost data collected from contractors;

- assess the type of work being performed by the private sector and for whom based on standardized taxonomies and portfolio groups;
- strengthen the relationship between the ICS and annual budget justification materials; and
- ensure the ICS supports strategic workforce planning and an appropriately balanced, effective, and efficient workforce.

The actions being taken will improve the long-term utility of the ICS, beginning with the next submission this summer, and will enable us to more accurately and holistically assess contracted workload. Coupled with an improved IG&CA Inventory, the ICS will help us achieve the right balance in our workforce, aligning inherently governmental activities to military and civilian workforces, and commercial activities to the most cost effective service provider.

In-sourcing

The Department greatly values the support provided by private sector firms and recognizes the private sector is a vital source of expertise, innovation, and support to the Department's Total Force. However, in-sourcing continues to be a necessary workforce shaping tool to reduce excessive or inappropriate reliance on contract support; appropriately align inherently governmental activities; and protect the public's interest while providing the best value for taxpayers. Therefore, we are continuing to in-source contracted services that are closely associated with inherently governmental work; that provide unauthorized personal services; or that may otherwise be exempted from private sector performance (to mitigate risk, ensure continuity of operations, build internal capability, and to meet and maintain readiness requirements). While some contracted services may be identified for in-sourcing, some services may no longer be required, or be of lower priority, and therefore reduced in scope or eliminated. Contracted services that meet the necessary criteria (i.e. consistent with statutes, policies, and regulations) will be in-sourced by:

- absorbing work into existing government positions by refining duties or requirements;
- establishing new positions to perform contracted services by eliminating or shifting equivalent existing manpower resources (personnel) from lower priority activities; and
- as appropriate or necessary, requesting an exception to the civilian levels currently reflected in the budget.

Our in-sourcing efforts are focused on rebalancing the workforce, rebuilding critical internal capabilities (including the acquisition workforce), and reducing operational risks.

OMB Circular A-76

Consistent with statutory changes that restrict the "direct" conversion of work currently performed (or designated for performance) by any number of civilian personnel to private sector (contract) performance, I issued guidance to the Department on December 1, 2011. In it, I urged vigilance to prevent the inappropriate conversion of work to contract performance, as we adapt to declining budgets and operating in a constrained fiscal environment. We are also preparing guidance that reiterates the current statutory moratoriums on public-private competitions.

As noted earlier, contract support is critical to the Department's operations. Last summer, we submitted a report on our public-private competition policy and procedures under OMB Circular A-76, making recommendations to improve the end-to-end competition process. The public-private competition process can be a useful tool for our commanders and managers to validate an organization's manpower and other requirements; drive a more consistent delivery of mission support and services to our servicemembers and families; improve business process; and deliver readiness while minimizing fiscal opportunity costs to meet the compelling needs of the Department. Congress, in the NDAA for Fiscal Year 2012, accepted many of our recommendations and made changes to the governing statute for public-private competitions. We are committed to making improvements to ensure the process is more equitable, less time consuming, and minimizes disruptions to incumbent workforces. Together with improvements to the ICS that will enable us to more accurately gauge the extent of private sector reliance, we look forward to providing an improved A-76 process to our decision makers in the future. In summary, we must shape an efficient, effective, and viable Total Force aligned to strategy and is supported by robust analysis. The fiscal year 2013 budget and our associated plans reflect our best judgment today.

Strategic Human Capital Management and Competency Management

The Department is making progress toward developing a more systematic approach and enterprise tools for strategic human capital planning that covers over 750,000 civilian employees in over 600 occupations. In fiscal year 2012, we developed initiatives to meet statutory civilian strategic workforce planning requirements by fiscal year 2015. First, the Department expanded its functional community construct to cover all major occupations in the civilian workforce. Previously, only mission critical occupations, which made up less than 40 percent of the workforce, were covered in the DOD Strategic Workforce Plan. Second, the Department updated criteria for designating mission critical occupations following a more structured process defined by the Federal-wide Strategic Human Capital Management High Risk Initiative. Third, an Enterprise Competency Management Framework has been designed that includes phased development of Department-wide occupational competency models and deployment of a tool for competency assessments. An Army system is now being updated for Department-wide use to replace multiple competency tools with a single enterprise system. That system, the Defense Competency Assessment Tool is scheduled for deployment in fiscal year 2013; and through it, we will be able to assess workforce competencies and develop strategies to reduce critical skill gaps that may impact mission accomplishment by fiscal year 2015.

The Department continues to focus on life-cycle management of the civilian workforce by integrating strategic workforce planning, competency management, hiring process improvements, and workforce development initiatives to ensure that plans support the recruitment, retention, and development of a ready civilian workforce that is responsive to swiftly changing mission demands and complex challenges. These are multi-year initiatives to improve the Department's ability to rapidly grow, contract, and shift the workforce in response to emerging mission requirements.

Hiring Reform

The Department has made great strides in reforming the hiring process by reducing hiring timelines, streamlining the process, and focusing on efficient practices. Prior to implementing the May 2010 Presidential Memorandum for Improving the Federal Recruitment and Hiring Process, measurement of all hiring practices was inconsistent and lacked input from individual components and servicing agencies. In 2010, we adopted standard measurement practices that enabled our leadership to analyze and measure hiring timelines across multiple dimensions, and to drive mission-critical changes.

In 2011, we continued to make positive and meaningful progress toward reforming civilian hiring practices. We reduced the number of days it takes to hire an employee by developing a common business process, deployed tools to automate key steps in the hiring process, and provided manager and human resources specialist training and job aids. In addition, our arsenal of hiring-related metrics and measurements has grown, thereby enabling transparency and targeted improvements to the hiring process. In fiscal year 2011, the Department reduced its external hiring timeline by 31 percent, from the fiscal year 2010 baseline of 116 days to 91 days. As a result of progress made in the early part of fiscal year 2011, the Department's external hiring timeline target was adjusted downward to 95 days from the original 101 day target. Our goal for external hiring in fiscal year 2012 is 80 days, with quarterly goals established to monitor progress. The overall reduction in hiring timeline for external hires contributed to an overall time to fill for all hiring actions, both internal and external, of 75 days for fiscal year 2011 and 63 days for fiscal year 2012 year-to-date. Another area of improvement is the automation of our hiring process. We procured an automated staffing tool (USA Staffing) in fiscal year 2010 and successfully deployed it to over 70 percent of the Department in fiscal year 2011, and are aggressively working toward completing deployment this year.

The Department continues to partner with the Office of Personnel Management (OPM) on the re-engineering of USAJOBS, the job posting portal used by the Federal Government. The USAJOBS 3.0 project is a high visibility project and DOD is the largest consumer of USAJOBS' services. The deployment of USA Staffing and improvements to USAJOBS are critical initiatives; however, without participation and engagement from our Hiring Managers and Human Resource (HR) Professionals, the benefit of these initiatives cannot be fully realized. As a result, a primary objective is to foster and encourage strong partnerships between these key stakeholders. To assist, the Hiring Reform Website (<http://www.cpms.osd.mil/HiringReform/>) provides a Hiring Managers Toolkit containing 24 guides, and a Webinar series is now available that provides content based on the four phases of the hiring process.

The initiatives outlined represent the Department's continued approach to hiring reform implementation, an approach aligned with the Department's overall mission,

and with its Strategic Workforce Planning objectives. A key success criterion is the involvement of senior leadership. We continue to solicit and use our cadre of senior leaders to guide our efforts, communicate and campaign for process improvements, and provide direction throughout each hiring reform effort. We will continue to monitor these efforts closely.

Termination of the National Security Personnel System (NSPS)/New DOD-wide Performance Management System, Redesigned Hiring, and Workforce Incentives

The NDAA for Fiscal Year 2010 repealed the statutory authority for NSPS, mandating all employees transition from NSPS no not later than January 1, 2012. The Department successfully completed the termination of NSPS and the transition of all employees and positions from NSPS to the appropriate successor statutory pay and personnel system in December 2011. No employees or positions remained under NSPS on the statutory deadline of January 1, 2012.

In September 2010, we launched our “New Beginnings” effort to involve labor representatives in design of a new performance management system and hiring processes. New Beginnings was an evolving effort and included labor and management planning sessions, conferences, and design team working meetings for more than 18 months, which culminated in over 100 pre-decisional proposals developed by labor and management employees for leadership consideration. The pre-decisional process culminated in a comprehensive report from the design teams that captures their research, conclusions, and proposals, and Department leadership has considered the report’s recommendations. We will continue to involve employees through their labor representatives as we move forward on particular recommendations and decisions about the new authorities and practices.

Civilian Leadership Development

The Defense Civilian Emerging Leaders Program (DCELP), as authorized by the NDAA for Fiscal Year 2010, fills a critical need by focusing on a corporate scale on developing civilian leaders at the entry and mid-level. We recognize the need for an improved model to attract, retain, and develop civilian leaders to support pipeline readiness and enhance bench strength. We conducted a gap analysis between existing programs and requirements, and designed a framework to create a new program to recruit and develop new civilian leaders, using proven models such as the Presidential Management Fellows program. Recognizing the financial environment and to ensure we have a sound programmatic framework, we implemented a DCELP pilot in September 2011 with 103 participants at the General Schedule (GS) 7 through 11 level from the Acquisition, Financial Management, and Human Resources career fields. A second cohort, which expands our intake to 180 participants, will begin before the end of 2012.

This new DCELP is additive to the Department’s current leadership programs, which include the Executive Leadership Development Program (ELDP) and the Department of Defense Senior Leader Development Program (DSLDP). DSLDP was established in 2008 to meet emergent leadership needs and provides a competency-based approach to the deliberate development of senior civilian leaders (GS 14 or 15 and equivalent grades) with the enterprise-wide perspective needed to lead organizations and programs and achieve results in the joint, interagency, and multi-national environments. We are pleased to report that DSLDP is soon graduating its second cohort and just commenced its fourth cohort. DSLDP is a critical feeder pipeline for executive talent. Established in 1985, ELDP provides mid-level civilians (GS-12 through GS-14 and equivalent grades) with an extensive exposure to the roles and mission of the Department and our Interagency partners and, an increased understanding of, and appreciation for, today’s warfighters through intensive hands-on field experiences. Both programs are aligned with the 21st century competency framework and designed to ensure application of critical leader competencies and have garnered success for their target senior grade populations. These highly competitive Department-wide programs will serve as building blocks for the new leader development framework.

In addition to the programs just mentioned, another critical building block in this arena is training managers and supervisors. Pursuant to the NDAA for Fiscal Year 2010, the Department has established a holistic training curriculum and baseline learning objectives for each training topic. We have piloted and launched our first course, focusing on new supervisors. Our attention has turned to developing the curriculum for refresher training, which the NDAA requires occur at least every 3 years. The refresher pilot will take place in May 2012. Following that, we will develop and then launch for Departmental use training for managers—those who supervise other supervisors. All courses will be launched this year. Also, we are partnering with OPM and vendors to design assessment and developmental tools

that will help predict interest and success for aspiring and current supervisors. Those assessment tools are planned for use by May 2012.

Senior Mentors/Highly Qualified Experts

In April 2010, in response to media and congressional concern, the Secretary issued policy guidance regarding how the Department may acquire certain advisory services from retired senior officials—the so-called senior mentor (SM) policy. The guidance prohibits contracting for mentoring services and directs that senior mentors must be employed as Federal officials under the specific Highly qualified Expert (HQE) appointing authority, which subjects them to certain Federal ethics rules and salary limits. The NDAA for Fiscal Year 2011 formalized the requirement that senior mentors be hired as HQEs, and comply with all applicable Federal laws and regulations on personnel and ethics matters.

In November 2010, the Deputy Secretary of Defense issued a memorandum directing all HQE-SMs position descriptions be revised within 30 days, requiring all HQE-SMs complete the public disclosure forms. In addition, all HQE-SMs were to submit completed public disclosure forms within 30 days of the position description being updated, but no later than January 12, 2011. Accordingly, all HQE-SM either separated or completed the public financial disclosure form as of January 12, 2011. Currently, the Department has 34 HQE-SMs on board, and approximately 164 HQEs total while Congress has authorized 2,500, and the number of HQEs has declined by 8 percent since December of last year. As a result of ongoing efficiency initiatives, the total number of HQEs will change as functions are discontinued.

To further ensure SM services are acquired in strict compliance with Department policies, the Defense Federal Acquisition Regulation Supplement (DFARS) incorporated the prohibition on contracting for SM services in DFARS 237.102-72 issued on November 24, 2010. After a Department-wide audit, the Department of Defense's Inspector General reported on October 31, 2011, that the Department complied with these new policies for hiring senior mentors as HQEs.

As a result of these changes, the Department has successfully balanced the critical need for SM services with the public's need for confidence in the integrity of the program. We are committed to ensuring consistency and transparency in the use of SM across the Department. Further, as we greatly value the contributions of our SM to the training and professional development of our current and future Joint and Service commanders, we believe this policy provides the rigorous oversight required for the proper employment of these experts.

Civilian Expeditionary Workforce

The Department is working to better employ the talents of our civilian workforce to meet expeditionary mission challenges, including those not directly related to war fighting. Global security challenges require adequate civilian capacity to conduct complex operations, including those missions that require close military-civilian planning and cooperation in theater. Since 2001, approximately 50,000 Department civilians have been involved in contingency operations around the globe. Currently, approximately 4,800 civilian employees are serving in the CENTCOM theater.

The Department institutionalized the Civilian Expeditionary Workforce (CEW) to provide deployable civilian experts to support military operations, contingencies, emergency operations, humanitarian missions, disaster relief, and stabilization and reconstruction operations. The CEW is designed to enhance the Department's ability to work alongside and help build the capacity of partner defense ministries and provide surge support where needed. Since June 2010, CEW deployments have increased by 56 percent, from 171 deployed civilians to 388 as of the end of February 2012. Civilians deployed under the CEW receive general and theatre-specific, urban training, and are eligible for the same health care benefits in-theatre as deployed military personnel, including medical evacuation and access to hospital services.

With the support of Congress, we have obtained important incentives and benefits to help compensate for the inherent risks of deployment. The Department continues to identify pertinent issues and propose fully integrated solutions to ensure force health protection, surveillance, deployment benefits, and medical care for civilians who have been injured, wounded, or have contracted diseases while deployed in support of contingency operations. We have worked in partnership with OPM, the Department of State, and the DoL to ensure all similarly-situated Federal civilians receive consistent and equitable benefits commensurate with the risks of deployment. In this endeavor, working with our partner agencies, we developed proposed legislation to provide a standard benefits package for all Federal employees.

More work is underway to transform the CEW program mission. Consistent with the Department's strategic direction, the goal is to implement an enduring solution which will enable the CEW to achieve a rapid response capability in support of all

Combatant Commands. The transformation will include consolidation of four key functions across the Department, including:

- Policy formulation that enables standard, DOD-level instructions for the deployment of civilians that will allow sufficient flexibility to meet future demand and ensure personnel are identified for potential deployment in any event;
- HR Servicing that provides end-to-end lifecycle support, from recruitment to separation;
- Management support for arranging travel; performing audience targeted training; conducting final medical screening and vaccinations; providing passport services and travel voucher training; issuing travel orders, uniforms, and equipment; tracking time and attendance during deployment; and providing redeployment services; and
- Payroll support allowing for a centralized payroll function to ensure standardized policies and administration.

These efforts will help transform the capability of the CEW to efficiently support future contingency staffing needs to unify and improve the efficiencies in support of operations.

Workforce Shaping

The Department has long experience managing a civilian workforce in transition. Beginning with the first installation closures in the mid-1960s, our predecessors formulated a strategy for maintaining a relatively stable workforce despite the instability that is inherent in major downsizing and restructuring. The centerpiece of that strategy was, and continues to be, the Priority Placement Program (PPP). Through this vital program, we have retained the skills of more than 258,000 transitioning civilian employees by matching them with Department job vacancies. During the last 25 years, which have been largely defined by five Base Realignment and Closure rounds and a workforce reduction of 30 percent¹, our overall objective has been to reshape the Department as efficiently and humanely as possible. By maintaining constant focus on this goal, we have been able to develop a broad-based career transition assistance program to complement the PPP.

In view of the efficiency initiatives implemented by former Secretary Gates, ongoing efforts by Secretary Panetta to further streamline, and the specter of even deeper spending cuts, it is very unlikely that involuntary separations can be avoided in fiscal years 2012 and 2013. Although the scope of involuntary separations is uncertain at this time, we will fully exploit all available tools and resources to minimize the human impact of force restructuring while maintaining mission readiness. Under our current plan, the civilian workforce will decrease in size from about 764,300 full-time equivalents (FTEs) to 756,800 in fiscal year 2013. This represents a reduction of about 1 percent, and is approximately 2 percent lower than our fiscal year 2011 actual execution of 771,300. Absent additional constraints, the workforce will gradually decrease to 738,000 FTEs by fiscal year 2017.

Federal agencies are required to use standard reduction-in-force (RIF) procedures when reorganization, lack of work, shortage of funds, or insufficient personnel ceilings necessitate separating or demoting civilian employees. When RIF becomes necessary, employees compete for retention based on several factors established by law and regulation. These factors include tenure, veterans' preference, length of service, and performance ratings. Together, these factors determine each employee's RIF retention standing.

During periods of force reductions, the Department's policy is to use voluntary separation programs to the maximum extent possible prior to imposing any involuntary actions. The most familiar and publicized of these are Voluntary Separation Incentive Pay (VSIP) and the Voluntary Early Retirement Authority (VERA). The Secretary has independent authority to allow up to 25,000 VSIP buyouts annually. This figure, which does not include incentives paid in conjunction with Base Realignment and Closure (BRAC), has thus far been sufficient to meet our needs. Although there is no limit on the number of VERAs, the use of this authority can be constrained by the VSIP limit, since employees who elect VERA frequently also take VSIP.

The Department also partners with the DoL to provide downsizing and restructuring installations outplacement assistance under the Workforce Investment System (WIS). The WIS is administered through the various State One-Stop Career Centers, and includes assistance such as retraining, career counseling, testing, and job placement assistance. While working constantly to refine and enhance existing force shaping tools, the Department will continue to seek regulatory and legislative

¹ This represents an overall reduction from 1,070,000 in 1987 to 751,000 in 2012.

changes to further assist affected civilian employees in transitioning to other positions, careers, or to private life.

HEALTH AFFAIRS

The Military Health System provides extraordinary care on the battlefield to our servicemembers—both preventing illness and injury to those in harm's way, and rapidly treating those who are wounded. The performance of our military medical system in a time of war continues to set new standards for battlefield survival rates, the reintegration of many who are wounded back into their units and for returning those who need additional care back to the United States.

In addition to these successes, the military health system provides access to care for over 9.6 million beneficiaries, no matter where they live. We provide this access through our direct health care system and through our managed care support contracts. This health care benefit is justifiably one of the finest in the country 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.

The Department is pursuing a balanced, 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.

Over the last 2 years, the Department introduced the Patient-Centered Medical Home and over 2.2 million are currently enrolled. We are beginning to see the benefits of this new model of care with decreases in emergency room visits; increased compliance with provider directions and drug prescriptions; and increased patient satisfaction for those enrolled. We've also placed behavioral health staff within these medical homes, improving access with reduced stigma, for our patients needing the support of mental health providers. A valued component of the medical home is the introduction of secure patient-provider email communications, allowing our patients to directly communicate with their medical providers without the need for a physical visit to the clinic. In 2013, we will continue to expand this model to all of our primary care clinics in the military health system, and increase the tools available to patients to help manage their own care.

Aligned with that initiative is the introduction of a 24/7 nurse advice line for all stateside beneficiaries based on our effective use of this approach for our military beneficiaries in Europe. This will provide beneficiaries with around-the-clock access to toll-free nurse advice services. When the caller requires follow-up care, this service will provide direct appointing services for beneficiaries enrolled to TRICARE Prime in our military treatment facilities. We will implement this added service this year.

In moving from healthcare to health, we have also engaged the broader DOD community—line leaders, commissaries, dining facilities, schools and child development centers. By changing menus, promoting better food choices and healthy lifestyles we will encourage healthy lifestyle changes. The First Lady, Michelle Obama, recently visited one of our leading installations, Little Rock Air Force Base, to highlight the progress we have made.

Finally, we have taken a number of steps to support preventive services. Our TRICARE beneficiaries—whether enrolled to TRICARE Prime or in TRICARE Standard—have no copayments 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 early results from our efforts, as well as experience 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

Over the last 24 months, we have reduced internal costs by decreasing headquarters administrative overhead, reviewing more cost-effective governance models, jointly purchasing medical supplies and equipment, and directing patients to lower cost venues for medications.

Last year, the Secretary of Defense directed specific efficiency targets across the Department. As a result, over the last 11 months we have reduced or eliminated contractor support in the Office of the Assistant Secretary of Defense (Health Affairs) and the TRICARE Management Activity (TMA). Overall savings from internal efficiencies are projected to provide \$259 million in savings for fiscal year 2013.

In June 2011, the Deputy Secretary of Defense established a Task Force on Military Health System (MHS) Governance, with the purpose of evaluating 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). In late September, the Task Force provided their recommendations, after which senior Department leaders including Chairman of the Joint Chiefs of Staff began review of the Task Force recommendations.

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 the Comptroller General and Congress. 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. The Deputy Secretary of Defense approved and released a “way ahead,” on March 2, and while we are still awaiting the Government Accountability Office (GAO) report, we are prepared to answer any additional questions you may have.

The Department has accelerated tri-service processes to standardize and jointly acquire medical supplies and equipment. We project savings that grow from \$31 million in fiscal year 2012 to more than \$69 million in fiscal year 2017. We have also engaged with our beneficiaries who have chronic medical conditions and high utilization of prescription drugs. Through a targeted outreach campaign, we have redirected a significant number of our patients from retail network pharmacies (our most expensive outlet) to home delivery—an option that is more economical for the government and the beneficiary, and has been shown to increase drug compliance.

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 can achieve through reorganization and consolidation, we are also seeing significant savings through a number of initiatives we have introduced in the last several years. These include the implementation of the outpatient prospective payment system; further use of Federal ceiling prices for acquisition of pharmaceutical products; a redirection of patients to our TRICARE mail order pharmacy—where prescription drugs are less expensive to both the government and patients, and is shown to increase patient adherence to their medication regimen; and the policy changes we made for reimbursement to select hospitals and health plans in the TRICARE network.

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. To allow medical facilities to transition to this new method of payment, TRICARE phased in the reimbursement levels over 4 years, with the full implementation of this policy set to occur in 2013. In fiscal year 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 was approved by Congress in the NDAA for Fiscal Year 2012. This reform is also phased-in over time, producing a projected \$31 million in savings in fiscal year 2012, but growing to more than \$108 million in savings by 2017.

In the area of purchasing prescription drugs, in 2009 we instituted a process for obtaining discounts on drugs distributed through retail network pharmacies. 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 pro-

gram will save the Department over \$1.6 billion, and will grow to almost \$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 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, these proposals were developed within the Department, and represent the input and consensus of our uniformed leadership. They have endorsed these proposals, and believe that we have appropriately balanced 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.

Third, we recognize that some beneficiary groups should be insulated from increases in out-of-pocket costs. We propose to exempt those servicemembers, and their families, who were medically retired from military service, as well as the families of servicemembers who died on active duty. We also propose to establish cost-sharing tiers, with lower increases for retirees based on their retirement rank. 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 copayments obtained outside of our medical treatment facilities (MTFs). Prescription drugs distributed within MTFs will continue to be free of charge for all beneficiaries.

For over 15 years, patient out-of-pocket costs were either frozen or decreased. This was true for all beneficiary categories—active duty families; retirees under age 65 and their families; and retirees and their families who are Medicare-eligible. Last year, we introduced very modest changes in one segment of our population—increasing TRICARE Prime enrollment fees for retiree families by \$5/month. We further recommended that these enrollment fees be indexed so that future increases continue to be modest and beneficiaries can plan for them. We greatly appreciate Congress' support for these proposals in the fiscal year 2012 budget, and have implemented those fee changes in the current year.

For fiscal year 2013, we propose additional changes to fees across a broader set of programs. Although last year's changes were a necessary step, the Federal budget crisis and the need to balance cost reduction efforts throughout the Department necessitate these actions begin in 2013, with most changes phased in over time. The following sections provide a high-level overview of the proposed changes in beneficiary out-of-pocket costs, and Table 3 summarizes the proposed phased-in fees through 2017, followed by the estimated indexing of the proposed fees through 2022.

Table 3
New TRICARE Proposals

TRICARE Prime for Working Age Retirees (under Age 55)

As part of the FY 2013 President's Budget, the Department will seek additional increases in the TRICARE Prime (i-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.

Below displayed are 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.

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 55)

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 below will be phased-in over a 5 year period and will then be indexed to increases in NHE.

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. The table below displays the proposed TFL fees by fiscal year for the three tiers of retired pay.

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. Proposed co-pays for prescriptions filled through the TRICARE retail and mail order pharmacy programs follow.

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.

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 servicemembers and their families between \$80–\$300 per year, based on the retirement pay of the servicemember, and continue to provide similar increases through 2017.
- **TRICARE Deductibles.** We propose to increase deductibles for the TRICARE Standard program for retired servicemembers and their families beginning in fiscal year 2013. TRICARE deductibles have not been changed since before the TRICARE program was introduced, having last been adjusted over 20 years ago.
- **TRICARE Pharmacy Copays.** 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. This change is 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 copay 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/Extra for retired servicemembers and their families. This enrollment action will require beneficiaries to elect their preferred primary benefit coverage—TRICARE Prime, TRICARE Standard, or other health insurance offered through an employer. The proposed fee for 2013 will be \$40/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 percent 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 copayments 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.
- **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.

- Indexing all fees beginning in 2014. 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, TFL enrollment fees, pharmacy copayments, and catastrophic caps.

These proposed changes continue to be modest by historic standards of cost-sharing in the TRICARE program. In 1994, when TRICARE was originally created, a working age retiree's family of three contributed approximately 27 percent towards the total cost of their care; today that percentage has dropped to 10 percent. Even with these proposed changes, the percentage would still remain below the percentage originally set by Congress, averaging approximately 14 percent 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 4- to 10-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.

Wounded Warriors

The 2007 revelations regarding Walter Reed were a stark wakeup call for us all. In the nearly 5 years since, the Department has worked in tandem with VA to improve policies, procedures, and legislation that impacts the care of our wounded warriors. As a result of efforts in both Departments and in Congress, we have reached important milestones in improving care for our wounded warriors. These milestones include a new disability evaluation system and improved case management that are the result of a programmatic cohesion with the VA that is better than ever before. More so than at any time in our Nation's history, separating service-members are greeted by more comprehensive mental and physical care; by greater opportunity for education, and by a deeper societal commitment to ensuring their welfare.

Disability Evaluation System/Integrated Disability Evaluation System

The genesis of the Disability Evaluation System (DES) was the Career Compensation Act of 1949. The DES remained relatively unchanged until November of 2007 when, as a result of public concern and congressional interest, the joint DOD and VA Senior Oversight Committee (SOC) chartered a DES Pilot designed to create a "servicemember-centric" seamless and transparent DES, administered jointly by the DOD and VA.

The Pilot launched at the three major military treatment facilities (Walter Reed, Bethesda, Naval Medical Center, and Malcolm Grow) in the NCR on November 21, 2007 and successfully created a seamless process that delivers DOD benefits to wounded, ill and injured servicemembers and VA benefits to servicemembers as soon as possible following release from duty. We found the DES Pilot to be a faster, fairer, more efficient system; and, as a result, in July 2010, the SOC co-chairs (Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs) directed worldwide implementation to start in October 2010 and to complete in September 2011. On December 31, 2010, the first Integrated Disability Evaluation System (IDES) site became operational, which marked the end of the pilot, and the name was formally changed to the IDES.

The IDES, similar to the pilot, streamlines the DES process so that the member receives a single set of physical disability examinations conducted according to VA examination protocols, proposed disability ratings prepared by VA that both DOD and VA can use, and processing by both Departments to ensure the earliest possible delivery of disability benefits. Both Departments use the VA protocols for disability examination and the proposed VA disability rating to make their respective determinations. DOD determines fitness for duty and compensates for unfitting conditions incurred in the line of duty (title 10), while VA compensates for all disabilities incurred or aggravated in line of duty during active military, naval, or air service for which a disability rating of 10 percent or higher is awarded, and also determines eligibility for other VA benefits and services (title 38). The IDES permits both Departments to provide disability benefits at the earliest point allowed under both titles. Servicemembers who separate or retire (non-disability) may still apply to the VA for service-connected disability compensation.

In summary, the IDES features a servicemember-centric design, a simplified process, more consistent evaluations and compensation, a single medical exam and disability rating, seamless transition to Veteran status, case management advocacy, and establishment of a servicemember relationship with the VA prior to separation. It also provides increased transparency through better information flow to servicemembers and their families and a reduced gap between separation/retirement from Service to receipt of VA benefits. As of January, IDES enrollment is 23,602 servicemembers (66 percent Army, 14 percent Marines, 10 percent Navy, 10 percent Air Force). Since November 2007, cumulative enrollment has been 40,911, with 12,640 completing the queue and receiving benefits. Including return to duty cases in the process, Active component member IDES completion time averages 380 days as of January 2012, RC members average 441 days, and the Guard averages 371 days. These averages are above our targeted goals but still are significantly lower than the 1940-era legacy system it replaced which averaged an estimated 540 days by combining DOD and VA systems.

This past year, the Department partnered closely with the VA to implement the IDES at all 139 sites worldwide; however, we recognize the need to do better in the areas of timeliness to complete the process. This year our focus will be on such timeliness improvements. We have made significant policy adjustment to remove efficiency impediments, made procedural improvements, enhanced oversight and assistance to the Military Departments, and added resources that should improve Military Department performance in this area. We will enhance our emphasis on leadership, execution, and resourcing the IDES to handle increased volume while decreasing the time spent in the process.

In addition, the Departments are looking closely at the stages of the system that are outside of timeliness tolerances and are developing other options to bring these stages within goal. We are committed to working closely with Congress to explore new initiatives to further advance the efficiency and effectiveness of the disability evaluation process.

Recovery Coordination Program

The Recovery Coordination Program (RCP) was established by the NDAA for Fiscal Year 2008, and was further defined by the Department of Defense Instruction (DODI) 1300.24, entitled "Recovery Coordination Program." Together these provide a comprehensive policy on the care and management of recovering servicemembers, including the assignment of a Recovery Care Coordinator (RCC) to help wounded, ill, and injured servicemembers and families through the phases of recovery, rehabilitation and reintegration. The policy also provides for standardized training, and a caseload ratio of not more than 40 recovering servicemembers per RCC.

Currently, there are 171 RCCs in 84 locations worldwide, placed within the Army, Navy, Marines, Air Force, U.S. Special Operations Command, and Army Reserves. More than 3,800 servicemembers and families have the assistance of an RCC, whose responsibilities include ensuring the servicemember's non-medical needs are met, and assisting in the development and implementation of the Comprehensive Recovery Plan (CRP). Each RCC receives more than 40 hours of Department-sponsored standardized training, including information on roles and responsibilities and concepts for developing the CRP. Additionally, we are now beginning to train Army "Advocates" in order to bring their program into compliance with the legislative mandate that every recovering servicemember be provided a DOD-trained RCC. RCC training is continually enhanced based on feedback from participants. After the October 2011 training, 90 percent of students rated the instruction and course materials as "excellent."

Over the past 5 years, we have added \$26.953 million, resulting in increased numbers of RCCs available to provide care coordination to our recovering servicemembers. Looking ahead, each Military Service will continue to identify and resource their requirements for additional RCCs. In addition to standardized training for RCCs, the CRP has expanded to include several other portfolios, many of them identified as key priorities for the non-medical care management of recovering servicemembers during a Wounded Warrior Care Coordination Summit held in March 2011.

The Wounded Warrior Education and Employment Initiative (E2I) operates on a regional basis and engages recovering servicemembers early in the recovery process to identify skills they have, career opportunities that match those skills, and any additional skills they might need to be successful. The process is overseen by Regional Managers currently located in five regions across the United States. The E2I process also relies on collaboration with the VA, which is governed by a Memorandum of Understanding to provide VA's vocational rehabilitation services earlier in the recovery process than ever before.

The Operation Warfighter program (OWF) also supports this White House priority by placing wounded, ill, and injured servicemembers in Federal internship opportunities that positively impact their rehabilitation and augment career readiness by building resumes, exploring employment interests, obtaining formal on-the-job training, and gaining valuable Federal Government work experience. There are currently more than 500 OWF interns working in approximately 75 Federal agencies and sub-components around the country, with a total of more than 2,500 placements in 105 agencies and sub-components since the inception of the program. The program is also supported by five Regional Coordinators placed across the country. Going forward, the Regional Coordinators will continue to focus on local and regional outreach to strengthen relationships with Federal agencies to improve and enhance internship and employment opportunities for wounded, ill and injured servicemembers.

The Warrior Athletic Reconditioning Program (WARP) engages wounded, ill and injured servicemembers early in individualized physical activities outside of traditional therapy settings, inspiring recovery and encouraging new opportunities for growth and achievement. This new initiative will be implemented throughout the Department. WARP partners include the Service chiefs from each branch of the Military, as well as the United States Olympic Committee. WARP goals include increasing awareness and participation in adaptive sports at the Service-level, as well as preparing athletes for participation in competitive events such as the Warrior Games.

These measures when taken together, substantially and materially affect the life experience of our men and women in uniform and the families who support them. Our work to improve the care of wounded warriors, especially as they transition from DOD to VA, is the core of our efforts to provide those who have sacrificed so much with the care and benefits they deserve. Despite the significant achievements, we should not underestimate what remains to be done as we care for a new generation of veterans who have served under very difficult circumstances for sustained periods. We will continue to work with our colleagues at VA and throughout the government to provide our servicemembers with the highest quality care and treatment. Taking care of our wounded, ill and injured servicemembers is one of the highest priorities for the Department, the Service Secretaries, and the Service Chiefs.

TOTAL FORCE SUPPORT

Military Family Policy

One of the four overarching principles of the Defense strategy is to preserve the quality of the All-Volunteer Force and not break faith with our men and women in uniform or their families. Despite difficult economic circumstances necessitating budget reductions across all levels of government, the Department remains committed to providing military families with support programs and resources that empower them to address the unique challenges of military life. To this end, the Secretary of Defense has directed that Family Programs and Mental Health Care be maintained as a priority for the Department.

The Department conducted a Front End Assessment of family programs and non-medical mental health care. The purpose of the review was to ensure that mission critical needs would be met for family programs or mental health care during the next 5 years. To ensure efficiency of programs, without redundancy, programs were reviewed with the intent of identifying, comparing and contrasting methods of program delivery.

These efficiencies did not cut programs for servicemembers or their families but resulted in a more cost-effective approach to program delivery. The review identified the following efficiencies.

- Maximized use of military family life consultants (MFLC) and Military OneSource counselors;
- Limited number of full-time rotational personal MFLC financial counselors due to identified overlaps with Services' programs, while allowing the capability for surge support through the MFLC program; and,
- Right-sized MyCAA program based on new eligibility criteria, which reduced the number of eligible spouses.

Some key programs and initiatives are:

- Spouse Education and Career Opportunities: The DOD Spouse Education and Career Opportunities (SECO) program is a holistic, spouse-centric initiative designed to meet the needs of all military spouses as they explore portable career interests and strive to overcome common barriers to their education and career goals. One of the components of SECO is the My Ca-

reer Advancement Account (MyCAA) that provides eligible military spouses with tuition assistance as they pursue requirements for a portable career. The Department has also expanded upon the Army's Spouse Employment Partnership program model. A significant number of "Fortune 500 Plus" employers now participate in the Military Spouse Employment Partnership (MSEP), with over 150,000 jobs posted on the www.MSEPJobs.com web portal and 15,000 spouses hired by MSEP employers. We are expanding the portal to include a new function which automatically matches posted spouse resumes to posted employer job openings. We are also instituting an electronic MSEP partner application and streamlining the vetting and approval process. These enhancements will allow companies to become partner employers more quickly. Webinars and online training resources are helping new schools and employers to improve their understanding and support for military spouse employees who seek employment continuity and upward career growth as they relocate to new duty stations.

- **Voluntary Education Opportunities:** During fiscal year 2011, our Voluntary Education program helped fund 866,788 enrollments by over 300,000 servicemembers, which resulted in 44,692 diplomas and 528 certifications/licensures. servicemembers are "blending" their course work, taking both traditional and online courses, with approximately 73 percent of servicemembers taking some courses online. Due to this, we now require all post-secondary institutions participating in the DOD Tuition Assistance program to follow certain standards of conduct; we are tracking compliance and monitoring to ensure there is continuous quality improvement.

- **Family Readiness Programs:** With budget and personnel reductions we can expect an increase in stress-related demand for support from our military families and we are prepared to meet that demand using the wide range of family support programs and partnerships. This includes developing virtual applications for the delivery of what has traditionally been in-person support, and providing surge capability. The Department is working closely with the Services to reduce redundancy and increase efficiency. For instance, we are in the process of developing a new community capacity-building toolkit and online professional development modules to streamline the training and development of our family support staff, and improve capacity. The last Military Family Readiness Council meeting was held in December 2011. We are identifying new members and working in coordination with the military Services to select spouses and/or parents to represent their Services. The next MFRC is projected to be during the third quarter of fiscal year 2012.

- **Non-Medical Counseling:** Demand for non-medical counseling continues to increase, and access to non-medical counseling is a Department focus area. We continue to enhance confidential non-medical counseling via two delivery systems, the Military Family Life Consultants (MFLC) and the Military One Source (MOS) Program. Non-Medical Counseling augments the military support programs currently in place, and is designed to help servicemembers and families cope with normal reactions to the stressful situations created by deployments, family separations, war, and reintegration. MOS non-medical counseling is offered by licensed clinicians who have private practices in the local community. The MFLC program began as a pilot in 2004, and today, more than 1,100 MFLCs provide confidential non-medical counseling support on 229 installations throughout the world. In fiscal year 2011, the program provided face-to-face counseling sessions to approximately 6.6 million people. At a commander's request, additional MFLCs may also be mobilized and deployed to provide "surge" counseling support. Non-medical counseling is provided by licensed clinicians who are deployed to installations and are assigned to work at the family centers, child development centers, youth centers, schools, and are embedded into brigades.

- **Military OneSource (MOS):** MOS provides call center and web-based information, referral, counseling, and educational materials. Services are available worldwide, 24 hours a day, at no cost to the user. In fiscal year 2011, MOS responded to almost a million telephone calls, received 3.6 million online visits and assisted servicemembers and families with over 200,000 Federal and State tax filings. Other MOS services include relocation assistance, document translation, child care and education resources, special needs consultation, elder care consultation, on-line library resources, and health and wellness coaching. Accessed via MOS, the Wounded Warrior Resource Center (WWRC) provides immediate assistance to wounded, ill,

and injured servicemembers, their families, and caregivers. In 2011, WWRC resolved 3,056 cases for wounded warriors, an increase from 2010.

- **Family Advocacy Programs (FAP):** The FAP addresses physical, sexual, and emotional abuse and neglect involving Active component military personnel and family members either as victims or abusers. We evaluate the effectiveness of FAP through rates of child abuse and neglect and spouse/intimate partner abuse and outcome measures for prevention and treatment. Through 10 years of high stresses on our families due to wartime deployments, our rates of such family maltreatment have remained relatively stable; however, we continue to monitor this carefully. For 2 consecutive years, 85 percent of those who participated in our New Parent Support Program for at least 6 months had no substantiated child abuse or neglect the following year, and 90 percent of substantiated spouse abusers who completed FAP treatment had no substantiated spouse abuse the following year.
- **Child Care:** The Department continues to expand child care capacity that supports RC families while the servicemember is deployed, geographically-dispersed active duty military families, and servicemembers living in areas in the continental United States where on-installation military child care is unavailable. Ongoing efforts are focused on ensuring the availability of child care options that meet quality standards, including health and safety standards and standards for developmentally-appropriate practices.
- **Youth Programs:** Faced with their own unique challenges, military youth aged 6–18 can turn to a number of quality programs serving more than 600,000 military youth around the world designed to prepare young people to meet the challenges of military life, adolescence, and adulthood. We have developed relationships with other Federal agencies and nationally-recognized organizations such as the Boys and Girls Clubs of America and the USDA's 4-H Youth Development Program. Through these relationships, we offer more than 300 camp opportunities each year for military youth, and are a vital component of our support to geographically-dispersed youth of the NG and RCs.

Special Needs

The Department and the Military Services continue to provide support to military families with special needs. During the last 2 years, 120 additional family support personnel have been hired and deployed to installations worldwide; we now have a total of over 400 providers who provide information, referral and education to families with special needs. The Exceptional Family Member Program (EFMP) family support component also provides non-clinical case management to those families who need additional assistance with accessing services on the installation and in their local communities. The Office of Community Support for Military Families with Special Needs developed a mobile website, accessible from smart phones; that website provides military families with information on the EFMP and contact information for enrollment and family support providers. The mobile website also provides podcasts and links to other materials available to military families with special needs.

The Department engages with military families with special needs by participating in the Congressional Military Family Caucus sessions and reviewing input from families during focus groups and online. We also established an EFMP family panel composed of ten families who represent all military Services, active duty, and RCs, and ranks. Family members with special needs are of all ages (children through adults) and with a wide variety of disabilities. Their issues range from access to medical care, availability of comparable services in the public schools, and lengthy waiting lists for Federal and State programs.

To address the needs of this population, the Office of Special Needs has partnered with the DOD children and youth programs to provide training through Kids Included Together® on the inclusion of children with special needs into children and youth programs. They have also partnered with the TRICARE Management Activity to communicate better with families about their benefits and accessing care, and to support them with portability of care during moves.

DOD-State Initiatives

The Department continues to work with State governments to educate policy-makers on the life-challenges faced by servicemembers and their families, and to ensure that State-level policies do not disadvantage military families due to their transient life style. States have addressed several key quality of life issues, to include the impact of frequent school transitions experienced by military children, the loss of income by spouses as a result of military moves, and enforcement of the Congress-

sionally-mandated DOD predatory lending regulation. The State responses have affirmed their commitment to the well-being of the Nation's fighting force. For example, 39 States have approved the Interstate Compact on Educational Opportunity for Military Children, 39 States (plus DC) now provide eligibility for unemployment compensation to military spouses, and 34 States (plus DC) enforce the DOD predatory lending regulation. The Department is continuing this effort in the 2012 State legislative sessions with strong emphasis on support of military families through the issues listed above. We are also promoting expedited occupational licensure processes to allow military spouses to resume their work faster in a new State, and provisions for separating servicemembers to receive credit for their military education, training and experience toward a State occupational license or an academic degree. The Department is continuing to partner with the Uniform Law Commission to inform State legislators of the Uniform Military and Overseas Voters Act which simplifies the absentee voting process by making it more uniform, convenient and efficient. This year we are advocating for States to consider establishing Veterans Treatment Courts for servicemembers and Veterans in the criminal justice system who are suffering substance abuse and mental health issues.

MWR Support to Troops in Combat:

Support is critical to allow servicemembers to communicate with family and friends, stay physically and mentally fit, and reduce stress. The Department now funds over 514 free MWR Internet Cafes in Iraq and Afghanistan and 135 portable satellite units (known as Cheetahs) to support remote locations. The DOD MWR Online Library offers free downloads of audio and e-books, and access to up-to-date recreation, education and career transition support databases.

The ability of injured servicemembers to engage in recreation and sports is a very important component of rehabilitation and reintegration. Under a contract with Penn State University, MWR specialists are trained to work with medical personnel, wounded warrior units, and community and non-profit organizations to ensure inclusive and adaptive sports and recreation are included in recreation programs. The DOD Paralympics Program continues to provide rehabilitation support and mentoring to injured servicemembers and veterans who have sustained various types of injuries.

We remain fully committed to supporting the All-Volunteer Force and their families, particularly in light of the unprecedented demands that have been placed on them in recent years.

The Department continues to pursue innovations, initiatives, and efficiencies that improve the quality of life of its military members and their families. With your continued support, our military force will remain ready, willing and able to serve this Nation with distinction.

Military Voting

The Department is well positioned for the 2012 election, building on its considerable success in the 2010 election efforts. Through direct-to-the-voter outreach programs, easy and quick online voting assistance tools, and aggressive communications and marketing programs, we experienced a 21 percent increase in military voter participation rates between 2006 and 2010. The Department is refining and expanding those programs for the 2012 election, as well as providing direct support to State and local election jurisdiction which deploy online ballot delivery systems, reducing ballot delivery time from 20 to 30 days to 20 to 30 milliseconds.

Department of Defense Education Activity

Ensuring excellence in the education of military children is a top priority for Secretary Panetta and the entire Department. A quality education is both a stabilizing influence in the lives of our children and their families and an overall recruitment, retention and morale element in the readiness of our Force. There are 1.2 million school-aged children with a parent serving in the military. Nearly 86,000 of these children attend one of the schools operated by the Department of Defense Education Activity (DODEA). Not unlike other parents, military families frequently say that the quality of their children's education is one of the most important criteria when selecting a place to live. The demands of extended conflict and frequent relocations add to the challenges faced by military families. While they are often described as a resilient group, the cumulative effects of multiple moves and significant parental absences can erode this resilience and, as the research suggests, diminish academic performance in school.

The DODEA schools offer a 21st century, student-centered learning environment that is tailored to meet the needs of military families. To this end, DODEA is leaning forward and providing military-connected children an educational experience that challenges each student to maximize his or her potential and prepares them

to be successful, productive and contributing citizens in today's global economy. DODEA also is mobilizing its knowledge, expertise, and resources to support military-connected children in the U.S. public schools.

The Department has made a number of sweeping commitments to improving the educational experience for military children. Some of these far-reaching commitments are highlighted below:

- DODEA has joined 46 States in the adoption of the Common Core State Standards. Today, the differences between State educational standards, including variances in graduation requirements, can and have negatively impacted achievement for military children. The Common Core State Standards will help mitigate this academic disruption and provide greater continuity in the educational experiences of our highly mobile children.
- DODEA has launched a vibrant Virtual Learning program which includes the use of tele-presence equipment in classrooms, to expand course offerings for students. No longer will small enrollments and limited course offerings at one DODEA school significantly drive the educational experience of students. Student interests and needs now have considerable influence. Through virtual learning, students have access to courses such as Advanced Placement, foreign language, and STEM-related courses that simply would not be possible in some locations.
- DODEA is adopting a 21st century teaching and learning framework, where technology is leveraged to improve the educational experience of children. Ten middle and high schools will be using a digital instruction platform on a pilot basis. As we leverage technology in our learning environments, we will need to make a significant investment in the professional development of our teachers and leaders.
- DODEA is modernizing and replacing school facilities to ensure that military children have school facilities that are safe, secure, in good repair and provide an optimal learning environment that supports current and future educational requirements. In fiscal year 2013, DODEA requested \$657 million for 11 school Military Construction projects.
- DODEA has ramped up its outreach to U.S. public schools to improve the educational experience for students in non-DODEA schools. Since 2008, DODEA has provided 146 grants totaling \$167 million to school districts, in over 900 schools. All grants focus on enhancing student learning opportunities, social-emotional support, and educator professional development.

As we move forward with Force structure changes, DODEA will continue to work with the Military Services to right-size schools in the affected communities, will keep students in the forefront, and will stay focused on delivering an excellent education and supporting our families. DODEA will ensure a "warm-hand off" to the U.S. public schools who may be receiving an influx of military-connected students. Further, we will leverage our civilian workforce shaping tools to provide continuity of employment for all those who wish to continue with their Federal careers.

The Department is charged with the responsibility and privilege of educating the children of our Nation's military. We know full-well the toll that war, conflict and frequent movements have exacted from our servicemembers and their families. The Department is committed to ensuring that the education of the children of servicemembers will not be among the many sacrifices our families must make to defend our great Nation.

Defense Commissaries

The commissary continues to be one of the most popular benefits with military members and families and is an efficient provider of non-pay compensation to our military personnel. Operated by the Defense Commissary Agency (DeCA), this integral element of the total compensation package significantly contributes to the financial readiness of our military families. An average family of four that consistently shops at the commissary will save nearly \$4,500 per year by taking advantage of the 32 percent savings on their overall purchases. The commissary further enhances financial readiness as a major employer of military spouses and family members. Last fiscal year, 39 percent of DeCA employees in the United States were military spouses or other family members; and the total rises to 63 percent when including military retirees, other veterans, and members of the Guard and Reserve. While enhancing military families' quality of life, the commissary also provides an excellent return on investment. Last fiscal year, the commissary provided direct savings to commissary customers of \$2.8 billion for a taxpayer cost of \$1.4 billion, a 2-for-1 return. DeCA implemented efficiency reductions in fiscal year 2012 and there are no plans for additional budget reductions at this time.

CONCLUSION

Putting together this year's budget request in a balanced package was a difficult undertaking, but I believe we have the right mix of programs and policies in place to shape the force we need in support of the strategic guidance. We will reduce the rate of growth of manpower costs, to include reductions in the growth of compensation and health care costs. But as we take those steps, we will continue to keep faith with those who serve.

During the past decade, the men and women who comprise the All-Volunteer Force have shown versatility, adaptability, and commitment, enduring the constant stress and strain of fighting two overlapping conflicts. They have also endured prolonged and repeated deployments. Some—more than 46,000 men and women—have been wounded, and still others—more than 6,200 members of the Armed Forces—have lost their lives. As the Department reduces the size of the force, we will do so in a way that respects and honors these sacrifices.

Senator WEBB. Thank you very much, Dr. Rooney.
Secretary Hale, welcome.

**STATEMENT OF HON. ROBERT F. HALE, UNDER SECRETARY
OF DEFENSE, COMPTROLLER, AND CHIEF FINANCIAL OFFI-
CER**

Mr. HALE. Thank you, Mr. Chairman, Senator Graham, members of the subcommittee. Let me underscore Dr. Rooney's thanks to all of you for the support of our men and women in uniform and the civilians who support them.

I am going to focus on some budget aspects of the personnel budget with just a few overall numbers.

We have asked Congress for \$525.4 billion of discretionary budget authority in fiscal year 2013. If you adjust that for inflation, it is a 2.5 percent real decline, the third consecutive year of real decline in the defense budget. As you look beyond fiscal year 2013, the budget is basically flat in real terms or slightly up.

To get to this request while also remaining consistent with title I, the non-sequestered title of the BCA, we reduced overall defense spending by \$259 billion in the next 5 years, our budget period 2013 to 2017, compared to the last year's plan. We took three steps to reduce our plan funding.

First, more disciplined use of defense dollars by eliminating lower priority programs and through efficiencies, including some cutbacks in contractor workforce.

Second, we propose force structure changes to carry out a new defense strategy, particularly important to this subcommittee. For example, our military will be smaller and leaner, especially our ground forces which will no longer be sized to carry out large, prolonged operations such as the one we undertook in Iraq. On the investment side, we made a number of decisions to fund high priority programs, cyber, special operations, for example, but also restructured and reduced investments for many weapons systems.

Third, and I know of particular importance to this subcommittee, the budget continues to fully support America's All-Volunteer Force even in the face of the BCA. We fully funded personnel, took a number of steps, funded family support programs fully.

But we also carefully reviewed and slowed the growth in military pay and benefits.

Let me expand on just two aspects of this budget in my oral statement.

The new 5-year budget plan calls for a reduction in end strength, Active end strength of about 100,000 and 20,000 in the Reserve components, mostly in our ground forces. To achieve these substantial end strengths, the Army will eliminate at least eight brigade combat teams; the Marine Corps, six battalions, four tactical air squadrons. There will be significantly smaller cuts in the Navy and the Air Force. Altogether these force structure reductions will save us about \$9 billion in fiscal year 2013 compared to last year's plan, \$53 billion over the FYDP, so we are about 20 percent with those on the way toward being consistent with the BCA.

We made substantial changes in investment—the cuts in this budget were disproportionately on the investment side—and pushed for more disciplined use of resources through streamlining and efficiencies. But it did not get us to where we needed to be.

In the end—and it was in the end—we made a decision to address military pay and benefits issues to avoid what we viewed as overly large cuts in force structure and investment. Our assessment took note of important trends in military pay and benefits. Pay and benefits, defined as military personnel and health care and some others, are up over 87 percent since 2001, 30 percent more than inflation, while the Active Duty end strength grew by only 3 percent during that period.

While we strongly believe that changes are needed in military pay and benefits, we also believe they must take into account some vital principles. The military compensation system has to recognize the unique stress of military life. We cannot simply copy the civilian system. It must enable us to recruit and retain needed personnel. We judged that it should be disproportionately small in terms of the amount of the savings. So our total savings were about 10 percent of the target we were working toward under the BCA, military pay and benefits more than a third of our budget. No one's pay can be cut. Growth can be slowed, but no pay cuts, no freezes.

Now, statements by other witnesses have described the proposals to reduce the size of our out-year pay raises, increase fees and deductibles for retirees, and raise pharmacy copays in ways that increase incentive to buy by mail order and to use generic drugs. I am not going to go over those again.

But I would like to do a couple of things, and I would like to correct first a misimpression we created. I am sorry Senator Ayotte is not here because I did not do a very good job. I did not have a chance really when I testified before the Senate Budget Committee, and she asked a question about what we were doing for fees of our civilian personnel—health care fees.

While the President's budget does not propose changes in the mechanism for fees charged to Federal civilian employees and retirees, those fees are tied to private sector insurance costs. Those fees have increased substantially over recent years, more than doubling for some large cuts over the last decade, and they are almost certain to continue to grow. Moreover, even when our proposed increases in military fees are fully in place, the military fees will remain substantially less than the ones charged to Federal civilian employees and retirees. So this budget does require increases for Federal civilian personnel and substantial ones.

Perhaps the most important point regarding our military compensation proposals is this, the proposals have the full support of our military leaders and that includes all the members of the Joint Chiefs, the senior enlisted, and advisors, and they have indicated that support in a formal letter sent to Congress earlier this year.

Several of our proposed compensation changes require legislative authority. None can be put into effect without your support. We fully recognize that. But if that support is not forthcoming—and you asked me to be candid, Mr. Chairman, so I will be—what keeps the CFO up at night—further cuts in forces and investment will be required of us to remain consistent with the targets of the BCA. Even if somehow we fit in changes in 2013, I have to worry about 2014 through 2018, and those cuts get bigger in that period.

If, for example, Congress turned down all of our compensation proposals and we offset that hole in our budget with additional force cuts, we would have to cut roughly another 60,000 troops by 2017. We might look at other ways and we probably would. But just to give you an idea of the magnitude, these additional cuts would surely jeopardize the new defense strategy that we have just recently put in place.

As this point suggests, our budget is a balanced, interconnected whole. I very much ask that you consider it as such.

Mr. Chairman, thank you again for your support of our troops and to all the subcommittee members for support of our troops and for the opportunity to testify today. When the witnesses are done, I welcome your questions.

[The prepared statement of Dr. Hale follows:]

PREPARED STATEMENT BY HON. ROBERT F. HALE

Mr. Chairman, Senator Graham, members of the subcommittee, thank you for the opportunity to join you this afternoon. I will not repeat the thorough statements presented by the Department's other witnesses. I would like to discuss selected personnel and readiness issues in the context of the Department's budget request for fiscal year 2013.

The fiscal year 2013 budget for the Department of Defense (DOD) responds to two broad factors. First, to be consistent with Title I of the Budget Control Act of 2011, it reduces defense funding for fiscal year 2013 to fiscal year 2017 by \$259 billion compared with last year's plans. We started by culling \$45 billion from our spending plans in fiscal year 2013, resulting in a request for \$525.4 billion in discretionary budget authority. Adjusted for inflation, that is a reduction of 2.5 percent compared to the enacted budget for fiscal year 2012—the third consecutive year of real decline in the Defense budget.

Second, our proposed budget for fiscal year 2013 reflects the new defense strategy that we announced in January. That strategy has been documented in a white paper issued in January. The budget implements this new strategy in four key ways:

- We seek to make more disciplined use of defense dollars. Key changes include streamlining in the Office of the Secretary of Defense and defense agencies, rephasing of military construction projects in view of force structure changes, further IT consolidations, efforts to improve our purchasing activities, and continued efforts to improve financial management and achieve audit readiness.
- Our budget proposes force structure and investment changes that are consistent with the new strategy. Our military will be smaller and leaner, but also ready and agile. We continue to invest in high priority areas such as Special Operations Forces, cyber, and unmanned aerial vehicles. However, reflecting strategy and good management along with budgetary limits, we propose to restructure and reduce investments in programs including the Joint Strike Fighter, shipbuilding programs, the Army Ground Combat Vehicle program, and the SSBN-X submarine program. We terminate six weapon programs in this budget proposal.

- We continue full support for America's All-Volunteer Force, which is the very foundation of our military strength. But we carefully review and slow the growth in military pay and benefits.
- Finally, we provide full support for our warfighters in combat through our request for funding for Overseas Contingency Operations.

Our budget proposal for fiscal year 2013 needs to be considered as a whole. It proposes changes that are balanced in order to be consistent with both our new strategy and good management. We hope that Congress will be cautious in making changes lest the revised version fail to fully support our new strategy or the current budgetary limits.

Finally, while this budget is consistent with Title I of the Budget Control Act, it does not accommodate the sequestration that could occur under Title III of that Act. Sequestration could have devastating effects on defense activities. It would force us to revisit our strategy and could lead to involuntary separations of personnel, reductions in readiness, and the disruption of numerous investment programs. We still have time to avert sequestration, and the President's fiscal year 2013 budget represents a path to doing so. We urge Congress to enact a large, balanced program of deficit reductions and then enact legislation to halt the sequestration.

In addition to this brief overview of our fiscal year 2013 request, I want to mention three specific considerations as they relate to personnel and readiness.

BUDGETARY IMPORTANCE OF FORCE STRUCTURE CUTS

The first of these involves force structure changes. Consistent with our strategy and budgetary limits, we assume there will be force structure cuts, primarily in ground forces. Our strategy envisions a force that is smaller and leaner and that no longer maintains forces sized for large, prolonged stability operations.

Specifically, the new 5-year budget plan calls for an end strength reduction of about 72,000 Army soldiers and about 20,000 marines by fiscal year 2017. This will result in an Army of 490,000 soldiers and a Marine Corps of 182,100 marines. To accommodate these reductions, the Army will eliminate a minimum of eight brigade combat teams, and the marines will disestablish six battalions and four tactical aircraft squadrons.

There will be smaller cuts in the Navy and Air Force. The Navy will be retiring 11 older vessels, and the Air Force will cut 7 TACAIR squadrons. By fiscal year 2017, the Navy's Active-Duty end strength will be reduced by 6,200 to a force of 319,500 sailors, and the Air Force will lose 4,200 airmen, to bring their total to 328,600.

We will also be reducing end strength in the Reserve components by 21,500 by fiscal year 2017. This will result in a total Reserve Force of 825,600, with Navy Reserve, Air Force National Guard, and Army National Guard components experiencing the greatest force reductions. There will be no reduction to the Marine Corps Reserve.

Altogether, compared to last year's plans, force structure reductions will save about \$53 billion over the FYDP and \$9 billion in fiscal year 2013 alone. Most of these savings reflect reduced operating costs but there are some investments savings as well.

These force structure changes mean that we need to consolidate our infrastructure. The President will ask Congress to authorize the Base Realignment and Closure (BRAC) process for 2013 and 2015. We recognize the political difficulty associated with the BRAC process, but it is the only effective way to achieve needed infrastructure savings.

BUDGETARY IMPORTANCE OF PAY AND BENEFIT CHANGES

The second item I want to mention is the budgetary importance of pay and benefit changes. Since 2001, the cost of military pay and benefits has grown by over 87 percent (30 percent more than inflation), while Active Duty end strength has grown by about 3 percent. We felt we had to review pay and benefits to avoid overly large reductions in forces and investments.

As my colleagues have noted, the military and civilian leadership considered changes in pay and benefits based on several guiding principles. To begin with, the military compensation system must take into account the unique stress of military life. It should not simply be a copy of civilian systems. The system must also enable us to recruit and retain needed personnel. We must keep faith with our military personnel. That means changes to the system of pay and benefits that do not cut anyone's pay. We propose to slow the rate of growth, not to institute pay freezes or pay cuts.

Changes affecting pay and compensation were designed to be disproportionately small when compared to the changes in forces and investments. While pay and benefits account for about one-third of the Defense budget, savings from the initiatives we are proposing will amount to about \$29 billion over the FYDP, which is slightly more than 10 percent of our savings target.

As our acting Under Secretary for Personnel and Readiness indicated, we plan military pay raises in fiscal years 2013 and 2014 consistent with the Employment Cost Index. In later years increases will be lower, but by then servicemembers and their families will have had time to plan. Over the 5 years of the FYDP, this approach will realize total savings of about \$16.5 billion.

We have also proposed changes in the cost-sharing formula for health care. This will mostly affect retirees and, especially, retirees who are under the age of 65 and are still in their working years. We have exempted those who are medically retired and survivors of those killed on Active Duty. Our proposed changes save about \$12.9 billion over the next 5 years. Dr. Rooney's statement expands on these changes, and I will not repeat them here.

However, I do want to emphasize one very important point that Dr. Rooney has made. Changes in cost sharing represent only one of the key steps that we are taking to improve health care and to hold down cost growth. We are also working to improve overall health care—moving from health care to health. We are reducing internal costs by cutting administrative overhead at headquarters and buying more effectively. We have significantly reduced payments to our civilian providers in order to slow the growth in health care costs.

I also want to note that, while our budget does not change the formula for enrollment fees for Federal civilian employees or civilian retirees, those fees have and are increasing. Fees for civilian employees and retirees are tied to private-sector plans and increase with increases in health care costs. It is important to note that fees paid by civilian employees and retirees will remain substantially higher than those paid by military retirees even after all of the changes proposed for military retirees have taken effect.

Our health care proposals, and all of our proposals for military compensation, have the full support of our military leaders—including both officer and enlisted leaders. These leaders have supported these changes in a letter to each of our oversight committees.

Several of our proposed changes in pay and benefits will require legislative authority. For instance, we need authority to exempt survivors of members who die while on Active Duty or military disability retirees and their families; to establish an annual TRICARE Standard enrollment fee for most retirees and their families; and to introduce an annual enrollment fee for TRICARE For Life beneficiaries. While these particular proposals require legislation, we need your support for all of these important changes.

If Congress does not provide us with needed support, we will face a major problem that would jeopardize our defense strategy. Without needed authority, we will face further cuts in forces and investment to be consistent with the Budget Control Act. Because our budget proposal already makes substantial reductions in the investment accounts, further cuts might fall mostly on forces. If, for example, Congress did not support any of our proposed changes to pay raises and health care, and we elected not to make further cuts in investment, we would be required to increase the size of our force reductions by roughly half. That could mean cutting roughly another 60,000 Active Duty and Reserve Forces by fiscal year 2017. Additional force cuts of this magnitude would jeopardize our ability to pursue the new defense strategy.

READINESS

The third and final concern that I would raise today is the matter of readiness. Our strategy calls for a force that is leaner and smaller, but also agile and ready.

Readiness is a complex topic. There is no single part of the budget that we could characterize as the "readiness" budget. That said, Operation and Maintenance (O&M) is the title most often associated with readiness. I would point out that O&M is the only title that would increase in the President's budget. Total O&M increases by 6 percent between fiscal year 2012 and fiscal year 2013 while the overall budget declines by 1 percent. We believe that we have made budgetary decisions designed to protect the readiness of our military forces.

When making our force structure decisions, we also favored the forces that are especially agile. Special Ops forces are a case in point. These forces, designed to be agile, continue to increase under this budget proposal. We also preferentially retained forces that can self-deploy. Accordingly, we maintained funding for a fleet

with long-term level of 11 aircraft carriers and 10 air wings. We also maintained funding for the bomber force.

CONCLUSION

In conclusion, I would emphasize again that our budget is an interconnected whole, and we ask that Congress consider it as such.

Thank you again for the opportunity to testify this afternoon. As always, thank you for the support of our men and women in uniform, and the civilian employees who support them. I welcome your questions.

Senator WEBB. Thank you very much, Secretary Hale.
Secretary Woodson, welcome.

STATEMENT OF HON. JONATHAN WOODSON, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS AND DIRECTOR OF TRICARE MANAGEMENT ACTIVITY

Dr. WOODSON. Thank you, Mr. Chairman, Senator Graham, members of the subcommittee. 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 coming year.

Over the last 10 years, the men and women serving in 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 world is unique among all military or non-military organizations on this globe. I am committed to sustaining this indispensable instrument of national security.

One of the most critical elements of our strategy is to ensure the medical readiness of the men and women in our Armed Forces. We are using every tool at our disposal to assess our servicemembers' health—before, during, and following deployment to the combat theaters. For those who return with injuries and illnesses, we continue to provide comprehensive treatment and rehabilitation services supported by medical research and development portfolios appropriately focused on the visible and invisible wounds of war.

Concurrent with our mission of maintaining a medically ready force, this ready medical force concept has many interdependent parts. It requires our entire medical team to be well-trained. It requires development of our physicians in active, accredited, graduate medical education programs. It requires our military hospitals and clinics to be operating at near-optimal capacity, and for our beneficiaries, it requires an active decision to choose military medicine as their preferred source of care.

To meet these readiness imperatives means we need to compete with the rest of American medicine to recruit and retain top talent, to provide state-of-the-art medical facilities that attract both patients and medical staff, and to sustain a high quality system of care.

The budget we propose provides the resources we need to sustain the system. As we maintain our readiness, we also must be responsible stewards of the taxpayers' dollars. The 2011 BCA required DOD to identify \$487 billion in budget reductions over the next 10 years. 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 to promote health, and reduce illness, injury, and hospitalization; and four, propose changes to beneficiary costsharing under the TRICARE program.

The military and civilian leaders in DOD developed these proposals and have publicly communicated their support for these proposals to you in writing and in person.

I want to identify the core principles to which we adhered when developing these proposals. We believe the TRICARE benefit has been one of the most comprehensive and generous health benefits in this country and our proposals keep it that way. In 1996, military retirees were responsible for about 27 percent of overall TRICARE costs. In 2012, the percentage share of costs borne by the beneficiary has dropped to about 10 percent of overall costs. If these proposals we have put forward are accepted, beneficiary out-of-pocket costs will rise to 14 percent of costs by 2017. This is about half of what beneficiaries paid in 1996.

Second, we have exempted the most vulnerable populations from our costsharing proposals. Medically retired servicemembers and families of servicemembers who have died on Active Duty are protected under this principle.

Additionally, we have introduced costsharing tiers based upon retirement pay, reducing the increases for those with lower retirement pensions. I would mention that that was led by the uniformed line leadership.

Mr. Chairman, we recognize the concerns of the members of this subcommittee and the beneficiary organizations have voiced regarding these proposals. I want to emphasize that these proposals are targeted to mitigate the burden on any one particular group of beneficiaries while simultaneously meeting our congressionally-mandated costsaving responsibilities under the BCA. We have recently submitted to Congress the Secretary's recommended path forward for how to organize the military health system. We have learned a great deal from our joint medical operations over the last 10 years. We recognize that there is much opportunity for introducing an even more agile headquarters operation that shares common services and institutes common clinical and business practices across the 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 in our national security.

I am proud to be here with you today to represent the men and women who comprise the military health system. I look forward to your questions.

[The prepared statement of Dr. Woodson follows:]

PREPARED STATEMENT BY HON. JONATHAN WOODSON

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 10 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 Congress, consistent with Section 716 of the National Defense Authorization Act for Fiscal Year 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 fiscal year 2012 enacted budget.

Figure 1: Fiscal Year 2013 Defense Health Program (DHP) Summary

[In millions of dollars]

Appropriation Summary	Fiscal Year 2011 ¹ Actual	Price Growth	Program Growth	Fiscal Year 2012 ² Enacted	Price Growth	Program Growth	Fiscal Year 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 Fiscal year 2011 actuals include Operation and Maintenance (O&M) funding of \$1,394.0 million and Research and Development funding of \$24.0 million from the fiscal year 2011 Overseas Contingency Operations (OCO), Title IX, Public Law 112–10.

² Fiscal year 2012 enacted (base), excludes O&M funding of \$1,215.3 million of OCO.

³ Fiscal year 2013 estimate excludes O&M funding of \$993.9 million for OCO. The Department of Defense projects \$135.6 million O&M funding should transfer in fiscal year 2012, and \$139.2 million in fiscal year 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 fiscal year 2011, fiscal year 2012, and fiscal year 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 servicemembers, 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, TX, 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 servicemembers, the Department has issued policy that servicemembers 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 servicemembers 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 servicemembers 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 50 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 frontline 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 fiscal year 2012, we have begun the process of embedding, over a 4-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 servicemembers.

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 servicemembers 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 servicemembers 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 servicemembers 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 nondeployed 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 fiscal year 2013 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 servicemembers 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 the health of deployed servicemembers 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 servicemembers 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 servicemembers—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 over-

weight 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 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 percent 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 fiscal year 2012, 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 5 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, MD, and the Fort Belvoir Community Hospital in Fort Belvoir, VA, 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 United States over the last 7 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 country 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 10 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 90 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 copayments 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 fiscal year 2013 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 4 years, with the full implementation of this policy set to occur in 2013. In fiscal year 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 servicemembers, and their families, who were medically retired from military service, as well as the families of servicemembers 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 copayments obtained outside of our MTFs. Prescription drugs distributed within MTFs will continue to be free of charge for all beneficiaries.

For over 15 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 copays 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 Congress' support for these proposals in the fiscal year 2012 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 copays 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 servicemembers and their families from between \$80–\$300 per year, based on the retirement pay of the servicemember, and continue to provide similar increases through 2016.
 - TRICARE Deductibles. We propose to increase deductibles for the TRICARE Standard program for retired servicemembers and their families beginning in fiscal year 2013. TRICARE deductibles have not been changed since before the TRICARE program was introduced, having last been adjusted over 20 years ago.
 - TRICARE Pharmacy Copays. 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 copay 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 servicemembers 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 percent 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 copayments or Medicare supple-

mental 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 fiscal year 2013.

- **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 copayments, 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 percent 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 percent 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 4- to 10-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.

Senator WEBB. Thank you very much, Secretary Woodson.
Secretary McGinnis, welcome.

**STATEMENT OF DAVID L. MCGINNIS, ACTING ASSISTANT
SECRETARY OF DEFENSE FOR RESERVE AFFAIRS**

Mr. MCGINNIS. Chairman Webb, Senator Graham, distinguished members of the subcommittee, thank you for the opportunity to appear before you today and discuss the Reserve and our National Guard.

Today, I can report to you that we have over 72,000 members of the Guard and Reserve on involuntary orders for mobilization supporting operations in U.S. Central Command (CENTCOM). In addition, we have another 86,000 on a snapshot. At the end of the month, we provided to the Secretary, 86,000 guardsmen and reservists deployed on 6 continents supporting our regional commanders in various duty statuses from annual training to mobilization. This is reflective of the emerging new role of our Reserve components described by many as the operational reserve.

The President's fiscal year 2013 budget supports this operational reserve providing funding and programmatic support to three key readiness imperatives: training, equipping, and recruiting and retention.

Training is focused on, first of all, maintaining capability and capacity identified within DOD for the particular organizations and leveraging available training technologies so we can make the maximum use of available time of our guardsmen and reservists when they are in training. We are focused on developing a common readiness standard across the components of each Service so we have standardized expectations on what we are looking for the Guard and Reserve to do.

Equipping within my office first focuses on transparency. That is a bumper sticker for assuring that the equipment that you authorize for the Reserve components gets to those Reserve components you expected in a timely manner. We have also expanded this program to now develop a life cycle view of that equipment and track it throughout the system.

We are also working very hard to ensure that the Guard and Reserve organizations have the right equipment to train with, including command and control and communications equipment, so they can integrate within the Total Force.

Recruiting and retention are obviously an essential element of a ready force, and our recruit quality remains high. We expect some shifts in that as we move forward with individuals leaving the Active component, as we mentioned earlier, and we are working very strongly to come up with ways to integrate them into the Reserve components as they leave Active service.

Retention currently is very solid, and we know that while we recruit the servicemember, we must maintain the family and retain the family. The Yellow Ribbon Reintegration Program (YRRP) is a wonderful tool that you provided us, that helps us do that. The use

of the Reserve components in an operational role is necessitating that we begin to move the YRRP, or at least portions of it, into the base budget. With Secretary Hale's help and the help of others, we have started to do that in 2013, and we are working on doing that as we develop the future defense program.

Continuing evolving requirements now also include employment programs, employment assistance, and training. We are working very hard at that. I will talk about that in a minute.

As we learned from our members and their families on multiple deployments, we are finding that the tension to pre-enduring deployment activities within the YRRP really enhances the post-deployment period. We are putting a lot of emphasis on that.

Hero2Hired (H2H) is a joint initiative between the YRRP and the National Committee on Employer Support to the Guard and Reserve which is focused on unemployment and under-employment of this distinct category of servicemembers within the Reserve components.

Second, this focuses on the reality that is really, unemployment of our guardsmen and reservists is a key element of individual military readiness. Successful guardsmen and reservists are established in the community and have good jobs. We know that.

Finally, sir, I could not appear before you without highlighting the 20-year history of the building of enduring international partnerships with the National Guard State Partnership Program. We currently have a total of 63 partnerships, but I would like to focus on the 22 in Eastern Europe and the 5 in CENTCOM. The 22 in Eastern Europe have helped us build the North Atlantic Treaty Organization (NATO) and expand NATO and also account today, as we speak, for about 9,500 Eastern European military members as part of the International Security Assistance Force (ISAF); and the 5 CENTCOM programs give us expanded access and understanding of the CENTCOM theater.

I thank you very much again. I look forward to your questions.
[The prepared statement of Mr. McGinnis follows:]

PREPARED STATEMENT BY DAVID L. MCGINNIS

INTRODUCTION

Chairman Webb, Ranking Member Graham, and members of the subcommittee; I thank you for your invitation to participate in this hearing. I welcome the opportunity to give you an overview of the issues we are addressing in the Reserve components.

The fiscal year 2013 budget supports the National Defense Strategy and will enable our Reserve components to continue to fulfill their vital national security role. The budget provides funding and programmatic support for the training, equipping, recruiting and retaining of the Guard and Reserve.

The Department's Ready Reserve totaling about 1.1 million members contributes 43 percent of total military end strength at a cost of 9 percent of the total base budget. The National Guard and Reserve provide trained, ready and cost-effective forces that can be employed on a regular operational basis, while also ensuring strategic depth for large-scale contingencies or other unanticipated national crises. Reserve component forces can:

- Provide critical capabilities for meeting national defense objectives
- Enable mitigation of strategic risk at lower cost than a large standing full-time force
- Provide cost effective returns on significant Department of Defense (DOD) investment
- Reduce stress on the Total Force

- Provide the capability to rapidly “reverse” given a change in our national strategic objectives

Prior to 2001, the Reserve components were primarily a strategic reserve with occasional operational missions as needed to augment Active Forces. Since 2001, Reserve component units and individuals have been heavily employed across the full spectrum of military operations ranging from combat missions overseas, to homeland emergencies, to National Special Security Events and have demonstrated their readiness and utility. The current National Guard and Reserve is, arguably, the most combat seasoned Reserve Force ever, and the Department seeks to capitalize on this significant investment to provide needed military capacity during current austere economic times.

To ensure the Reserve component can continue to provide both operational and strategic forces, the Department included funding and programs in its fiscal year 2013 budget request for their training, equipping, recruiting and retention.

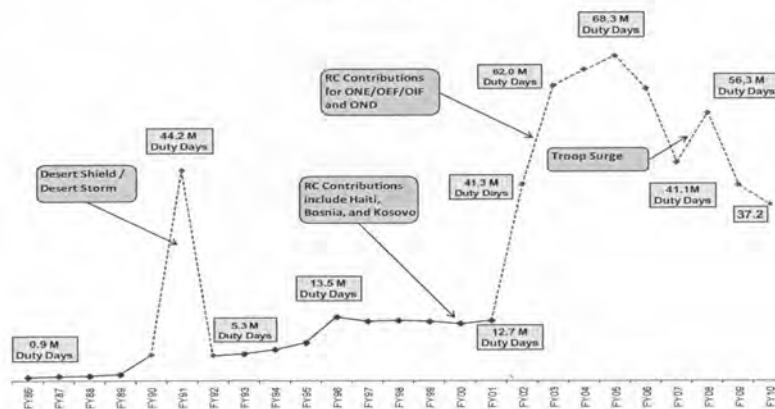
TRAINING AND UTILIZATION OPPORTUNITIES FOR THE MILITARY DEPARTMENTS

After a decade of sustained engagement in combat operations, the Reserve components of our Armed Forces continue to transform into a dependable operational force that provides full-spectrum capability to the Nation. As of 31 December 2011, 835,689 Reserve component members (809,913 Selected Reserve and 25,776 Individual Ready Reserve) have served in support of contingency operations since September 11, 2001 and 80 percent of those service men and women have deployed in the U.S. Central Command area of responsibility. Today there are over 85,000 National Guard and Reserve men and women on active duty around the world and at home, serving in missions ranging from combat in Afghanistan to defending the air space here in Washington and our borders in the southwest.

RC Utilization

The contribution of the Reserve components has increased dramatically in the last two decades, and during that time the Reserve component has become an integral part of the Nation’s military force participating in nearly every mission worldwide. The increased utilization of the Reserve components supports the recent Strategic Guidance, and the Department has managed the use of the Reserve component to help mitigate the stress on the Total Force.

Reserve Component Contributions (through October 2010)



Today’s Reserve component is a force multiplier which provides access and flexibility at an incredible value allowing the Services to utilize full capabilities in an operational capacity while retaining strategic depth. An optimal Active component/ Reserve component force mix will allow the department to not only preserve previous investments in readiness, capability, and capacity, but also protect the operational expertise of the force for future use while ensuring a rapidly expandable, trained, and ready military.

Innovative Readiness Training

The Innovative Readiness Training (IRT) Program is an outstanding volunteer training opportunity for our National Guard and Reserve. IRT's focus is to provide a varied and challenging menu of training opportunities that exercise the Mission Essential Task List (METL) requirements of combat support and combat service support units and individuals. Each year, new training opportunities are presented by Federal, State, or local government agencies or nonprofit organizations to the Services for their selection. Military units are provided METL training in a realistic, hands-on setting while providing quality services to communities throughout the United States and U.S. territories.

Examples of IRT activities include infrastructure development, constructing rural roads and runways, small building and warehouse construction and providing medical and dental care to medically underserved communities. These opportunities result in interoperability and readiness training ensuring our Nation always has a fully capable National Guard and Reserve. Historically, this office's IRT program budgets for, and executes a \$20 million fiscal year training program.

Cyber Workforce

Operating effectively in Cyberspace is vital to DOD and the Nation. "Cyber" as a Warfare Domain is newly organized and rapidly expanding. The need for personnel with cyber skills, the limited number of workers with those skills, and increasing competition within U.S. Government and the private sector for the same set of skills require a long-term and robust cyber workforce strategy. The Secretary of Defense has stressed the need for a flexible approach to attract, develop, and retain Cyber, and specifically Cybersecurity, professionals along with endorsing innovative use of the Reserve component for cyber missions.

Innovative use of the Reserve component as proposed by the Secretary is well underway, with forces assigned to the National Security Agency, U.S. Cyber Command (CYBERCOM), the Defense Information Systems Agency and to each of the four Service component commands supporting CYBERCOM. There are multiple Air and Army Guard units engaged in the cyberspace mission and Computer Network Defense teams are authorized in all 54 States and territories. The Reserve component offers very highly qualified individuals from the private sectors whose civilian skills may be maximized when supporting DOD.

State Partnership Program

The National Guard State Partnership Program (SPP) mission is to establish and sustain enduring relationships with partner nations of strategic value in conjunction with the National Security Strategy, National Military Strategy, Department of State and Combatant Command Theater Security Cooperation guidance to promote national objectives, stability, partner capacity, better understanding and trust.

Program partners engage in security cooperation activities to include homeland defense and security, disaster response/mitigation, consequence/crisis management, interagency cooperation, border/port/aviation security, combat medical, fellowship-style internships, and bilateral familiarization events that create training and exercise opportunities. SPP provides the ability to focus a part of DOD, a State's National Guard, with a single country or region in support of U.S. and partner country objectives. Currently, 48 States, 2 territories, and the District of Columbia are partnered with 63 countries around the world.

This program directly supports the Secretary's strategic goal of building innovative partnerships. The program has been funded at \$13.36 million for fiscal year 2012 and the President's fiscal year 2013 budget includes a request for \$16.5 million. Many of these partnerships have resulted in collaborative working relationships through police and military operational mentoring and liaison teams with our new NATO partners who are part of the effort in Afghanistan.

EQUIPPING THE RESERVE COMPONENTS

Equipment Procurement

There currently is no specific appropriation that provides equipment directly to the Reserve components. The Reserve component relies on the active procurement account to meet equipment requirements and provide adequate capabilities. Congress has been generous in providing additional support through the National Guard and Reserve Equipment Appropriation (\$1 billion for fiscal year 2012), which provides funding for Reserve component equipment modernization and critical dual-use equipment.

P-1R

We thank Congress for their continued generous support of the Guard and Reserve equipping (P1R fiscal year 2012 - \$4.6 billion/fiscal year 2013 - \$3 billion). The current challenge is that the P-1R has historically been treated as a non-binding projected subset of the Procurement Programs (P-1). In my view it is time to make the National Guard and Reserve equipment a sub-line within the P-1 and eliminate the P-1R. This will better ensure that Guard and Reserve component equipment is part of the Service plans throughout the entire procurement process.

Resetting

Currently, funding for reset of equipment returning from theatre for the Guard and Reserve comes from overseas contingency operations appropriations. As we prepare to move away from reliance on these supplemental funds, it is important to have a continued source of funding built into the base budget for Reserve component equipment reset. It is critical that the Guard and Reserves are able to continue to train on high quality equipment for which funds have already been allocated.

RC Equipment Transparency

Full transparency and accountability can only be achieved through a full life cycle, enterprise approach to reserve equipping. The life cycle includes requirements determination, budget requests, appropriation, purchase, and delivery of hundreds of thousands of pieces of equipment. The importance of transparency doesn't stop when an item is delivered to a Reserve component unit; the value of transparency in the life cycle approach to equipping continues beyond delivery. Plans to return borrowed Reserve component equipment are included as key deliverables in this process.

Military Construction

The fiscal year 2013 Reserve component budget includes \$1.02 billion, \$21 million less than fiscal year 2012, for military construction which will meet both current and new mission requirements for Reserve component operations, readiness, and training facilities. The budget also funds sustainment, which is essential to maintaining facilities at a level that supports readiness and preserves the substantial investment the country has made in infrastructure. However, with urgent Reserve component facilities deficiencies and funding constraints, we must work to exploit opportunities to utilize existing DOD facilities and continue to pursue the efficiencies of joint use construction opportunities. The benefits of doing this go far beyond cost savings by promoting cooperation, building trust, and providing opportunities for joint training.

Regional Integrated Training Environment

The Regional Integrated Training Environment (RITE) concept is a joint effort that identifies and matches Services' training requirements to a vast network of local training facilities and resources. The purpose of the RITE initiative is to help sustain the total force readiness posture and surge capability as determined by service rotational readiness models while reducing overhead training costs through innovative management of facilities, training assets, advance simulators and Joint Live Virtual and Constructive capability, pooled, shared equipment, and coordinated through a web-based scheduling/visibility program. As the concept matures, collaboration will expand with key internal and external DOD stakeholders.

RECRUITING AND RETAINING THE RESERVE COMPONENT FORCE

In approximate numbers, as of December 31, 2011, the Ready Reserve currently consists of the following end-strengths:

- Selected Reserve: 844,400
- Individual Ready Reserve: 220,000
- Inactive National Guard: 3,700

Continuum of Service, End Strength and Readiness Management

Meeting Reserve component end strength objectives is a priority of the Department. The following table depicts the current prescribed and actual end strengths for the Reserve components as of December 2011. The Department's Continuum of Service efforts have contributed to all six DOD Reserve components remaining within the variance allowed for their congressionally-mandated end strength objective. The Services have implemented recruiting, retention, and force shaping policies and programs to achieve end strengths for fiscal year 2012. We appreciate the congressional support of the fiscal year 2012 end strength levels and the legislative initiatives that assist in recruiting and retaining Reserve component servicemembers. Fiscal year 2013 end strength levels will provide the Reserve components with the

forces necessary to meet strategic and operational demands while maintaining a dwell consistent with Departmental policy.

Table 1. FY12 Reserve Component End Strength Objectives

Service	FY12 Objective	Actual as of December 2011	FY13 Request
Army National Guard	358,200	359,410	358,200
Army Reserve	205,000	204,949	205,000
Navy Reserve	66,200	63,971	62,500
Marine Corps Reserve	39,600	40,013	39,600
Air National Guard	106,700	104,832	101,600
Air Force Reserve	71,400	71,273	70,500

Of the end strength figures outlined above, there are Service members in the training pipeline for the Reserve Components who are not immediately available for mobilization.

Recruit Operational Ready Reserve Strength

Thus far, for 2012, Reserve recruiting efforts show continued success. Through January, five of the six Reserve Services are within tolerance for recruit quantity objectives. Also, all Reserve components have met recruit quality objectives. The Reserve components continue to exceed the DOD Benchmark of 90 percent of new recruits being High School Diploma Graduates, with 97 percent of Reserve component recruits holding that credential.

Table 2. Reserve Component Enlisted YTD Accessions (through JAN 2012)

Reserve Enlisted Recruiting Through Jan FY 2012	Quantity				Quality					
	Goal	Accessions	Percent of Goal		% High School Diploma Graduate (HSDG); DoD Benchmark ≥ 90 percent	% Scoring at / above 50th Percentile on Armed Forces Qualification; DoD Benchmark ≥ 60 percent	% Scoring at / below 30th Percentile on Armed Forces Qualification; DoD Benchmark ≤ 4 percent			
ARNG	16,596	15,548	94%	Y	96%	G	70%	G	0%	G
USAR	8,624	9,865	114%	G	98%	G	63%	G	0%	G
USNR	2,427	2,427	100%	G	97%	G	87%	G	0%	G
USMCR	2,880	3,149	109%	G	100%	G	76%	G	0%	G
ANG	2,671	2,591	97%	G	100%	G	100%	G	0%	G
USAFR	2,854	2,854	100%	G	99%	G	83%	G	0%	G
DoD Total	36,052	36,434	101%		97%		72%		1%	

It is important that we have a military that reflects the society it defends, both in the enlisted ranks and our commissioned officers. This is particularly important as less than 1 percent of the American public serves in uniform.

We continually review our recruiting programs to align funding and policies with current realities. Each of the Services has made significant adjustments to recruiting programs in light of our austere fiscal environment and draw-downs, and continues to look for additional cost savings but we must be cautious and resist the temptation to cut too deeply and too fast. Stable adequate investments in recruiting resources are necessary to maintain long-term success. Although enlistment incentives can be adjusted quickly to meet market fluctuations and force management needs, history has shown that the time required to redeploy advertising/marketing campaigns and/or qualified recruiters is significant.

Acknowledging and understanding these factors and the need to expand our recruiting areas for the Reserve components, we continue to enhance DOD influence in underserved communities by working with local school administrators, specifically from Title I school districts, and implementing programs like the DOD STARBASE Program that have potential long-term impacts on students' on-time high school graduation; college enrollment; and interest in learning science, technology, engineering and mathematics. DOD STARBASE is an outreach and educational program that focuses on science, technology, engineering, and mathematics (STEM). STARBASE provides students underrepresented in the STEM areas of study and careers with 25 hours of instruction through an inquiry-based curriculum with "hands-on, minds-on" experiential activities and exposing them to military's technological environment to solidify their attachment to and engagement with learning. The program's influence has resulted in former DOD STARBASE students being invited to attend and participate in the White House Science Fairs for the last 2 years.

My staff and I have been working with the Office of Management and Budget to challenge States, industries, and nonprofits to invest in intervention programs like the National Guard Youth Challenge Program. I am also working with General McKinley, Chief of the National Guard Bureau, to provide oversight and management of the Program by collaborating with Governors to eliminate State resident issues; and to ensure every qualified high school dropout has an opportunity to attend the program. The Challenge program is currently operating in 27 States and Puerto Rico. Its goal is to improve the education, life skills and employment potential of America's high school dropouts. We provide quasi-military based training, supervised work experience to advance the program's core components. The core components include obtaining a high school diploma or equivalent, developing leadership, citizenship, life coping and job skills and improving physical fitness, health and hygiene. Since the program's inception over 100,000 students have successfully graduated from the program. The average cost per Challenge student is approximately \$16,000. The fiscal year 2013 budget will support increasing annual enrollment and/or start up new programs in States that have the fiscal resources to match the cost-share funding requirements and to sustain the program's viability in States that have budget limitations.

These two successful DOD youth outreach programs provide the Department a unique connection to the American public and working with our most valued resource—our young people.

The Montgomery GI Bill-Selected Reserve (MGIB-SR) has been a cornerstone of our military recruiting efforts since 1985, and a major contributor to the success of the All-Volunteer Force. The new Post-9/11 GI Bill appears to enhance our recruiting efforts even more especially after signing the Post-9/11 Veterans Educational Assistance Improvements Act of 2010—providing additional benefit options that include the eligibility of National Guard and Reserve members who were inadvertently omitted from the original Bill, vocational and other non-college degree training, and living stipends for those enrolled in distance learning programs.

Individual Readiness

We understand that maintaining the highest level of individual readiness for our military manpower and civilian employees is a requirement for continuing to be utilized as a viable part of the operational force. Employing the Reserve components as operational forces requires modifications to training schedules and funding requirements. Ancillary training must be properly managed and prioritized in order to allow our members to focus on training for the skills that will be required of them when deployed or activated. Before DOD operationalized the Reserve component, the normal minimum training profiles consisted of training 2 days per month plus 14–15 days of active duty for training annually. While that training profile remains in-place for some types of units, current Department policy states that for those with planned deployments, training days prior to mobilization increases. This training profile, with more training pre-deployment and less post-deployment, minimizes mobilized time away from families and civilian. Increasing individual readiness by

modifying training profiles with resources and policies is a major focus area that will allow the Guard and Reserve to capitalize on the gains made during the last decade and enable the continued use of the Reserve component as an operational force.

Individual Medical Readiness

The Individual Medical Readiness of the National Guard and Reserve continues to be a priority for the Department to ensure availability of Ready Reserve component members for deployment. As of the fourth quarter of fiscal year 2011, the Reserve component has increased its Fully and Partially Medically Ready rate 5 percent over first quarter fiscal year 2011 rates, and reduced the Indeterminate population by 6 percent. Most notably, the Marine Corps Reserves improved their Fully Medically Ready status by 16 percent and reduced the Partially Medical Ready rate by 14 percent, over half of the fiscal year 2011 first quarter rates. The U.S. Coast Guard Reserve also made great improvements increasing their Fully Medically Ready rate by 9 percent, and reducing their Indeterminate and Not Medically Ready population by 4 percent and 6 percent respectively. While we continue to face challenges with Dental Readiness, all Services are over the 75 percent goal except Army Reserve and Army National Guard which are at 71 percent and 73 percent respectively. My office is working within P&R and across the Services to improve access to medical and dental services for Reserve component members. For example, the Army Reserve now budgets additional medical and dental services into their readiness accounts for Reserve component members.

TRICARE for the Reserve Components

The Department offers various health and dental coverage options to eligible members of the Reserve components and their families. Members of the Selected Reserve (SELRES) who actively participate in the Reserve component may purchase individual or family TRICARE Standard/Extra coverage under TRICARE Reserve Select (TRS). Members pay premiums that reflect 28 percent of the total cost of the coverage and incur cost shares after meeting an annual deductible (a government subsidy covers 72 percent of premium cost).

For Reserve component members who have been activated in support of a contingency operation, premium-free TRICARE coverage may begin up to 180 days before the member is activated (Early Identification) and continues for 180 days after the member is deactivated (Transitional Assistance Management Program (TAMP)) for the member and his/her family. After this period, qualified SELRES members may re-enroll and purchase TRS coverage again if desired. As of December 2011, there were a total of 81,465 TRS plans in effect: 29,204 TRS member-only plans and 52,261 TRS member and family plans with a total of 215,545 beneficiaries covered by TRS. Additionally, the Continued Health Care Benefit Program (CHCBP) is a premium-based health care program that offers temporary transitional health coverage for 18–36 months after TRICARE eligibility ends. CHCBP acts as a bridge between military health benefits and civilian health plans. Qualified members may purchase CHCBP within 60 days of loss of eligibility for either regular TRICARE or TAMP coverage.

TRICARE Retired Reserve (TRR) is a full cost (no government subsidy) premium-based, worldwide health plan that qualified retired Reserve members and survivors may purchase. TRR offers comprehensive health coverage from any TRICARE-authorized network or non-network provider. TRR members may receive care in military treatment facilities on a space-available basis. TRICARE Young Adult is a premium-based health care plan that qualified dependents may purchase. TRICARE Young Adult provides medical and pharmacy benefits, but dental coverage is excluded. TRICARE Young Adult allows dependent adult children to purchase TRICARE coverage after eligibility for “regular” TRICARE coverage ends at age 21 (or 23 if enrolled in a full course of study at an approved institution of higher learning) and are not yet age 26.

Collectively, these options for health care coverage provide a comprehensive and affordable health care plan for Reserve component servicemembers and their families. TRICARE insurance has provided servicemembers the opportunity to maintain their individual medical readiness requirements, increasing the overall readiness of our Reserve component units.

Yellow Ribbon Reintegration Program

The Yellow Ribbon Reintegration Program (YRRP) is a statutorily created, joint effort to support the Services in providing National Guard and Reserve servicemembers and their families with critical support, information, services, and referrals throughout the entire deployment cycle (pre, during, and post) to maximize successful transitions as servicemembers move between their military and civilian roles

and to create strong, resilient military families. The YRRP is also responsible for providing Reserve component members and those who support them with training in suicide prevention and community healing. In fiscal year 2013, the YRRP will continue collaborating with suicide prevention experts to develop a strategic approach in identifying promising practices, strengths, challenges and gaps. We in Reserve Affairs continue to work with the Services as well as the newly created Defense Suicide Protection Office within the Office of the Under Secretary of Defense for Personnel and Readiness to address this important issue. The Services, along with Reserve Affairs, have taken current suicide rates very seriously and have committed resources to significantly reduce this trend.

Guard and Reserve, Federal and State employees, volunteers and nonprofit organizations have worked tirelessly to ensure our servicemembers and those who support them have access to resources as they transition back into their communities. During the past 3 years, the YRRP has evolved into a successful, forward-leaning program providing essential readiness and resiliency training and resources to over 800,000 servicemembers and designees through direct-contact YRRP events. In fiscal year 2011, the Services conducted a total of 2,151 YRRP events across the country, providing vital information and resources to 309,753 servicemembers, their families and/or designated representatives. To support the use of the operational reserve in the future, we need to work towards YRRP funding in the base budgets to ensure continuation of these important programs.

In fiscal year 2011, Congress appropriated an additional \$16 million to the YRRP for enhanced outreach and reintegration activities which allowed the department to provide one-time support to various State led initiatives. Our Center of Excellence is working to collect data and metrics from these various programs to ensure we are funding the most effective outreach.

Employer Support of the Guard and Reserve (ESGR)

Employer Support of the Guard and Reserve engagement has grown significantly in recent years. The vision is “to develop and promote a culture in which all American employers support and value the military service of their employees with ESGR as the principal advocate within DOD.” ESGR has a footprint in all 50 States, U.S. Territories, and DC with over 4,800 volunteers assisting employers and servicemembers on a daily basis. The support of employers and families has never been more critical to our national defense. Through its network ESGR accomplished the following during the past year:

- Through Employer Outreach, ESGR volunteers briefed 153,062 employers regarding their rights and responsibilities in accordance with Uniformed Services Employment and Reemployment Rights Act (USERRA). Also, ESGR attained 45,140 Statements of Support. Employers signing a Statement of Support pledged support for their employees serving in the Guard and Reserve, while also focusing on opportunities to hire guardsmen, reservists, and veterans.
- Through Military Outreach efforts, ESGR volunteers briefed 473,891 servicemembers regarding their rights and responsibilities under USERRA. In turn, servicemembers recognized supportive employers with 4,049 nominations for the 2011 Secretary of Defense Employer Support Freedom Award and acknowledged 16,559 supervisors with ESGR’s Patriot Award.
- ESGR’s Ombudsman services are supported by over 600 trained USERRA experts spread across the country and by a National Customer Service Center. Together, the Ombudsmen fielded 29,727 USERRA inquiries and handled 2,884 cases. ESGR Ombudsmen provided free, neutral mediation to resolve nearly 80 percent of all cases, in less than 9 calendar days. For cases that cannot be resolved by the Ombudsman, servicemembers are informed of their option to file a complaint with the Department of Labor, where a formal investigation will be conducted as to the merits of the complaint.

Reserve Component Unemployment and Underemployment

The Department knows that civilian employment is an important piece of a Reserve component servicemember’s readiness, and the current high unemployment rate is a clear threat to the readiness of our force. The Bureau of Labor Statistics January 2012 report showed that the unemployment rate for all Veterans (including Guardsmen and reservists who previously served on active duty) was 7.5 percent nationwide. The unemployment rate among Gulf War era II veterans (those serving since September 11) was 9.1 percent. For reservists and guardsmen, the January 2011 Status of Forces Survey of Reserve Component Members shows a self-reported 23 percent unemployment rate among junior enlisted members in the grades of E-1 to E-4.

As a result of these unemployment rates, ESGR and YRRP launched an Employment Initiatives Program (EIP) in January 2011. Under the Office of the Assistant Secretary of Defense for Reserve Affairs (OASD (RA)) our ESGR volunteers increased their focused activities to address the unique unemployment needs of Reserve component servicemembers. Our ESGR Committees, representing the 54 States, Territories, and District, began focused efforts such as employment assistance workshops, job fairs, employment summits, and many other local community programs. ESGR conducted numerous workshops whereby servicemembers were trained on how to create civilian resumes, undergo mock interviews, dress for success, and received career counseling.

Beginning in March 2011, ESGR volunteers assisted the U.S. Chamber of Commerce in the launch of their mega-hiring fairs around the country. As of the latest Chamber report, there have been 88 events, connecting more than 84,000 Veterans, Reserve component members and military spouses, to over 4,300 different employers. As a result of the combined effort, the National Chamber reports that more than 7,300 veterans, servicemembers, military spouses, and 50 wounded warriors have gained employment.

This past December 2011, our office launched a comprehensive, multi-faceted program called "Hero2Hired", better known as H2H, using lessons learned from our own efforts this past year and from the U.S. Army Reserve Employer Partnership of the Armed Forces program. H2H was developed to address the gap in employment assistance services and support for Reserve component servicemembers who are not considered veterans in law and so are ineligible for VA employment programs. H2H focuses on helping Reserve component servicemembers connect to and find jobs with military-friendly companies that seek employees with specific training and skills. H2H is a powerful, comprehensive employment program with a powerful job search site (www.H2H.jobs) and online community that is made available at no cost to servicemembers and employers. It contains all the tools a job seeker needs to find a job: job listings, career exploration tools, education and training resources, advice and tips, hiring events, virtual career fairs, mobile phone app, and networking opportunities. In 2012, H2H is sponsoring and participating with the U.S. Chamber of Commerce in 40 job fairs in high Reserve component unemployment areas. H2H booths will be available and staffed by H2H, YRRP, and ESGR State Committee volunteers.

Together, YRRP and ESGR are delivering meaningful services to assist Reserve component servicemembers to transition and reintegrate into their civilian community through full spectrum assistance with employment and by promoting positive employer relations through USERRA education.

Individual and Family Support Policy (IFSP) is participating in DOD studies on Child Care Subsidy, Military Family Life Consultants, Effectiveness Tracking, Resilience Programs, Websites and Help-lines, State Liaisons, and Communication with Families. OSD Reserve Affairs will continue to be an active partner in the DOD process to ensure that as family support resources are realigned, the 1.1 million National Guard and Reserve members and their families are considered in the decisionmaking process and that family support functions at a level that sustains full mission readiness.

CONCLUSION

Secretary Panetta has recently testified on the need to maintain the tremendous expertise that has been developed in the Reserve components during the last decade of sustained engagement. The Department's recently released strategic guidance highlights the need for our National Guard and Reserves' continued capabilities and contributions as an agile, flexible and ready force in our national security. It is wise to build on the success and capitalize on these investments as we continue to develop the Reserve components to provide full-spectrum capability to the Nation. The Quadrennial Defense Review directed Comprehensive Review of the Future Role of the Reserve Component, released last year, provides a foundation upon which to build a cohesive execution strategy that preserves current Total Force competencies, efficiently integrates multiple capabilities, and leverages Reserve component value.

Additionally, the 2012 National Defense Authorization Act requires an assessment of Reserve component force structure and end strengths in total force structure, and we are working within the Department to complete this requirement. These analyses and others that are ongoing will support the Department's strategic guidance to examine the mix of Active component and Reserve component elements best suited to support the strategy while maintaining a balance between the available resources and our security needs for the next decade.

The fiscal year 2013 budget anticipates the Department will continue to use the Guard and Reserve as a vital part of the operational force, and where it makes sense, as a force of first choice. Today's Citizen Warriors have made a conscious decision to serve since September 11, with full knowledge that their decisions mean periodic recalls to active duty under arduous and hazardous conditions. To keep faith with their commitment, we will need your continued support of the funding requested for their training, equipping, recruiting, and retention. Thank you again for allowing me an opportunity to give you an overview of the issues we are addressing in the Reserve components.

Senator WEBB. Thank you, Secretary McGinnis.

I will start and I will also adhere to the 7-minute rule that I asked everyone else to adhere to at the beginning of my statement.

Actually, Secretary McGinnis, I would like to start with just where you ended up because when we look at the unemployment figures for those who served, we essentially, in my view, have three different groupings of people who have served. We have the one-term or non-career enlistees, which I think a lot of people up here misunderstand in terms of the size of that group. We tend to think if you have an all-volunteer system, you have an all-career system, and in truth and particularly in the Marine Corps and the Army, the majority of people leave before they enter their first enlistment. That group has one set of challenges in order to reassimilate into the civilian society.

Then we have the Guard and Reserve as a particularly difficult problem right now, and I want to get back to it.

Then third, we have the retirees who have another different set of circumstances when they leave.

But with respect to the Guard and Reserve, I had the position that you are acting in right now for 3 years and responsibility for the oversight of these programs. We never could have comprehended the rate that they are being called to Active Duty and the percentage of their professional career that they are actually spending in uniform. We are seeing some really disturbing data in terms of the unemployment rates. I understand there are a lot of complexities that go into the fact that the employment numbers are down, but could you give us a better description of what the challenges are?

Mr. MCGINNIS. Yes, sir. The first challenge is the group that has the biggest unemployment, going as high as 24 to 26 percent, depending on when you measured it, and that is junior enlisted personnel. We have increased the number of non-prior service enlistments over the last decade in the Guard and Reserves, especially Army components, and of course the Marine Corps has always had a high percentage. But in the Guard and Reserve, particularly in the Army Guard and Army Reserve, the numbers are now up to about 55 percent or more. They used to be lower than that by about 10 or 15 percent. We used to rely a lot more on prior service before stop-loss.

A lot of those individuals enlisted directly out of high school, came into the Guard, and went through their initial entry training and then deployed. Now they are coming back, and they have never been in the workforce before. So that is one unique group we are focusing on. That is why I mentioned in my opening statement that this is a unique group that we have to segment, as you explained, because then we have the individuals coming back who, because of

the economy and other reasons, may have lost their jobs for reasons that their employer could not help and that number is running about 12 percent.

So we are working with the Employer Support Committee in each State and their 4,800 volunteers with the Chamber and their effort and with H2H, which we have joined with the Army and the Army Reserve to focus on both of these groups in different ways. So we are getting a lot of momentum, and we have been working on it for about 18 months.

The initial problem we looked at was under-employment. We had some momentum working on under-employment for people coming back who were looking for better jobs based on their experience in theater. We did have some momentum.

But those are the two areas that we are focused on and they are two distinct areas.

Senator WEBB. Do you see any indication of a resistance in the employer community because of the deployment cycles?

Mr. MCGINNIS. No, sir. We have just completed a survey which is now being assessed of employers. The Employers Support Committee did that, and when it is available, we will make it available to you. But initial indications are while if you look at the groups who have to support us, the individual themselves, the families, the employers, the employers have the lowest level of support, but it is not below 50 percent. The employers on par have been very patriotic and very supportive of the efforts. We do not see a reluctance to hire. In fact, we see people who are coming to us who want to hire. The biggest issue we have—and it has been the issue since the program started—is the small employer and in some cases the medium employer. We need to continue to work with them. Hopefully from the survey we will figure out some ways that we can bring to you on how we can help them. But that is a large group of employers.

Senator WEBB. Secretary Hale, you mentioned the cross section of the Total Force when it comes to the reductions that we are looking at. Could you give us a comparative examination or a statement on the civilian employees and contractor employment?

Mr. HALE. The civilians are down slightly, roughly similar to the military from 2012 to 2013, down about 2 percent. In the out-years, our civilian employment drops not very much, just a couple more percent. In fact, we are looking at that now. I believe what happened is we were pretty busy in the last program budget review, and, I think, we did not have a chance to look at support personnel as much as we could or should beyond 2013. So I know it will be an issue as we look at the 2014 to 2018 program.

Regarding contractors, we struggle with good information. They are down in dollar terms from 2012 to 2013. Frankly, in the out-years, we do not have reliable data on contractors because we just do not formulate it in the same way. We are working to do that and I hope we will have better information, but they are down slightly from 2012 to 2013.

Does that answer your question?

Senator WEBB. Roughly, what would the percentages look like compared to the Active Force?

Mr. HALE. Similar. From 2012 to 2013, down 1 to 2 percent for both Active and civilians. Let me correct the details for the record. Similar for contractors in dollar terms, which is the best data I have.

Senator WEBB. Are the out-years the same?

Mr. HALE. Well, no. For Active Duty personnel, including Guard and Reserve together, about 5 percent over the FYDP period. More like 2 for civilians. As I said, I think we need to relook at that issue. I do not have contractor data beyond 2013. We keep track of how much we are going to spend in operation and maintenance buckets. We do not in the contractors, and we are trying to do a better job, but we are not there.

Senator WEBB. We may ask you a follow-on question on that.

Senator GRAHAM.

Senator GRAHAM. Thank you, Mr. Chairman.

Just to pick up with where the chairman left off, I think it is very important before we make a decision how to get to \$87 billion, that the civilian workforce, if it is going to be reduced just a fraction of the Active-Duty Forces and Reserve folks who wear the uniform, I would like to know more about how we could maybe shift some of this reduction, look at the civilian side a little bit harder, and make sure that we get to \$87 billion with as many people that are available to go to war if we have to have a war. So I just want to echo what the chairman said there.

Dr. Woodson, in 1996, I think you said the amount of money collected from people on the program through premiums for TRICARE was about 26 percent?

Dr. WOODSON. Sir, the cost share was about 27 percent.

Senator GRAHAM. 27 percent. So 27 cents of every dollar of cost came from the people on the program, right?

Dr. WOODSON. Correct.

Senator GRAHAM. It is down to 10 now. Is that right?

Dr. WOODSON. Correct.

Senator GRAHAM. Is that just because we have never adjusted the premiums and the costs have gone up?

Dr. WOODSON. Correct, and also remember we have added substantial benefits to the program over the last decade.

Senator GRAHAM. So what you are proposing is to try to get the premium cost share up to 14 percent?

Dr. WOODSON. Correct, on average.

Senator GRAHAM. Based on retirement benefits reschedules, based on how much money you make in retirement?

Dr. WOODSON. Correct.

Senator GRAHAM. In terms of overall budget, if it continues on the course that it is now, what percentage of DOD's budget would be consumed by health care?

Dr. WOODSON. Sir, that is a great question, Senator. If you look at the numbers right now and you look at a base budget of \$525 billion, our unified medical plan this year was \$53 billion. So we are at 10 percent now. If you look at the issue of a modest 5.3 percent growth in health care—and you can do the calculations—particularly the top line of DOD comes down. The implications of this, of course, are that health care will consume a greater percentage of the DOD budget, but it also produces a palpable tension, if you

will, between providing health care and training, manning, and equipping the force. I think that is what Secretary Hale was alluding to before.

Senator GRAHAM. I would just like to be on the record saying I would like to work with the administration to find some way to change this dynamic because the BCA requires \$87 billion. I do not know if that is set in stone. If we can change that number, I would be willing to. But we have to balance the budget. We are \$15 trillion in debt. Everything has to be on the table.

When it comes to the Guard and Reserve, Mr. McGinnis, the Air Guard seems to get hit pretty hard here. Are you familiar with the proposed cuts in the Air Guard?

Mr. MCGINNIS. Yes, sir. The Secretary of the Air Force is in the process of reorganizing his force and has presented this to DOD. I have made my recommendations to the Secretary, and the Secretary is in the process of reviewing that now.

Senator GRAHAM. I appreciate it.

Mr. MCGINNIS. Secretary Hale is very much a part of that, and hopefully in the near future, we will have a decision.

Senator GRAHAM. Secretary Rooney, if you allowed people who were 50 percent disabled to access commissaries and exchanges, could you get back to us later on and see what impact that would have? Because I think the rule is now that only 100 percent disabled people have commissary and exchange privileges. Is that correct?

Dr. ROONEY. I believe you are correct, sir.

Senator GRAHAM. Okay, if you could look at that. What I am getting at is our commissaries and exchanges are good deals for the members and their families, and we want to make it sustainable. If we are going to draw down the force, then you lose customers, and this might be one way of getting a larger customer base and reward people who have sacrificed for the country. I just want you to look at that and I will talk with Senator Webb about it.

Thank you all for your service, and we will see what we can do to work through this.

Mr. HALE. Senator Graham, could I add briefly to your opening, underscoring the chairman's point on civilian personnel? I agree we need to look at them. We need to look at contractors as well. But we need to remember that civilians run our acquisition, they run logistics, they run finance, they fix our ships and planes. We cannot fight effectively without them. So we need to be a little careful, in my view, about damning our civilian workforce which we sometimes, I think, lean toward doing. We just cannot work without them.

Senator GRAHAM. They are a very valuable part of the team, cannot do the job without them. But again, we are going to have to set our priorities in this country and figure out where we go.

Mr. HALE. We need to be careful.

Senator WEBB. Before I call on Senator Blumenthal, just let me first of all say I am looking for data here when it comes to civilian numbers and Active numbers. There is a reality that I think we all acknowledge that when you end a long period of sustained ground combat, you reduce your ground forces. So, it is not necessarily an

apples-to-apples comparison when you look at the civilian side. But my question really was to get the numbers.

Another thing, just from my own experience, Senator Graham, I was talking to staff on your question as to the percentage disability being able to use commissary and exchanges.

Senator GRAHAM. Am I wrong?

Senator WEBB. If you are medically retired from the military, it is 30 percent or above where you can use commissary and exchange. There is a different system if you go to the VA for a percentage. But I wanted to clarify that if you are retired, which is 30 percent or higher, then you are able to use those benefits.

Dr. ROONEY. Correct.

Senator WEBB. Senator Blumenthal?

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you for your leadership and Senator Graham's on this subcommittee. Thank you to the witnesses for the excellent work that you are doing in a very difficult time, perhaps more difficult than any within recent memory.

Many of the issues that have been raised both by my colleagues and by you in your testimony are of very great interest to me. I want to focus on one, though, that may not be directly related to the budget. I know the budget consumes a lot of time. You have discussed in your testimony, Secretary Rooney, the issue of sexual assault, which I know troubles you and the Secretary greatly, a great concern to you, and there is a zero tolerance policy. It is a leadership issue.

You say in your testimony that the estimates now are about 19,000 sexual assaults a year, which is down from the estimate of 34,000 in 2006. Are you suggesting that the rates or numbers of sexual assaults have been reduced over the last 6 years?

Dr. ROONEY. Sir, the way we get to that number is we look at the number of reported sexual assaults as a percentage of the overall force and then actually multiply it. The number appears to come down, but quite frankly, as you indicated, our concern is that there are any at all. 19,000 are 19,000 too many, or whatever the exact number is, because again, that was extrapolated from actual reported numbers. So while we believe that the attention being focused, the programs being put in place, and frankly the leadership taking this on as such a critical area to be able to address because it goes right to the heart of what our military believes in terms of their work and their respect for each other, that that number will come down. But we realize we have a great deal of work to do, sir.

Senator BLUMENTHAL. But it may not have come down in the last 6 years. Obviously, your objective is to make it come down. But I am just asking whether you have confidence in that number because, quite honestly, I am not sure that I do.

Dr. ROONEY. I believe that number indicates that we have a substantial problem. But again, it is not a specific number. It is extrapolated from those reports we have.

Senator BLUMENTHAL. Of the defendants who are reported—and in those incidents, 3,192 in fiscal year 2011—what percentage faced court martial?

Dr. ROONEY. Sir, I will take that question for the record and get back to you on the specifics.

Senator BLUMENTHAL. The information I have is fewer than 21 percent.

Dr. ROONEY. That percentage is correct.

Senator BLUMENTHAL. What is the reason that they are not brought to court martial?

Dr. ROONEY. Often, sir, it is many of the same challenges that we see on the civilian side, which is in order to go through the court martial, obviously, we need to be able to get the evidence and make sure that our folks are trained to be able to take and prosecute those particular cases. Those are specific areas we are working on now to make sure people are trained in the specific areas of how to be able to not only get the evidence, but to present that forward. That is often the roadblock.

Senator BLUMENTHAL. So you are upgrading the procedures for collection of evidence, and what about retention of evidence?

Dr. ROONEY. Yes, sir. We actually are retaining the evidence at this point, if it is an unrestricted report, for 50 years.

Senator BLUMENTHAL. Are you making efforts to speed up the process? In one instance that has been reported to me—and I can get you the name and perhaps you can get me more details—there was a 3-year gap. By the way, I am very familiar with the defects in the civilian area since I was involved in it.

Dr. ROONEY. I know you are, sir.

Senator BLUMENTHAL. So this is by no means to say that you should use it as a model necessarily, but I know the military sets its own standards for what excellence is and you have your own goals.

But that 3-year gap makes evidence, even if it is collected—that is, the eyewitness testimony that may be provided—more difficult to get. I just wonder what steps are being taken to make sure that these cases are brought to court martial and brought, in effect, to trial more quickly.

Dr. ROONEY. Actually, we are working directly with the Services on this, and the Joint Chiefs have been actively involved in looking at how do we not only streamline the actual court process, but also streamline from the point of reporting, we have such things in place as expedited transfers. So all through the process, making sure that we are able to still protect due process, if you will, for the accused, but move that through the system from the first report through. So that is something we are actually engaged, right now, with the Services to do.

Senator BLUMENTHAL. Do you have numbers as to the median or average length of time it has taken and what percentage involve eventual findings of guilt, culpability, and also what the eventual penalties are in those cases?

Dr. ROONEY. Sir, we do have those numbers, but if I could take that for the record and give them to you as opposed to trying to get them from memory, we do have them. I have seen them, sir.

Senator BLUMENTHAL. I would appreciate that.

Dr. ROONEY. We will.

[The information referred to follows:]

The length of time for the investigation and adjudication of sexual assault reports varies greatly with the facts of each case. Of the 2,439 Unrestricted Reports opened and investigated in fiscal year 2011, 66 percent (1,612) of investigations were com-

pleted by the end of the fiscal year. Based on past case flow, we would expect that the investigations and subject dispositions for over 90 percent of the remaining 827 Unrestricted Reports received in fiscal year 2011 should be completed in time for reporting in the fiscal year 2012 Annual Report on Sexual Assault in the Military.

In fiscal year 2011, 1,518 subjects investigated for sexual assault were military servicemembers. However, legal factors sometimes prevent disciplinary action from being taken against some subjects. For example, commanders were precluded from taking disciplinary action against 482 of these military subjects because there was insufficient evidence of an offense to prosecute, the victim declined to participate in the military justice process, or the statute of limitations had expired. These factors do not fall under the discretion of a military commander to remedy and precluded these military subjects from receiving disciplinary action. Commanders declined taking action against 47 military subjects because they determined the sexual assault allegations against those subjects were unfounded.

Of the 1,518 subjects investigated, commanders had sufficient evidence and the legal authority to support some form of disciplinary action against 989 subjects. Of the 989 subjects, 791 subjects had command actions taken against them for sexual assault: 62 percent (489 subjects) had courts-martial charges preferred (initiated) against them, 24 percent (187 subjects) received nonjudicial punishment under Article 15 of the UCMJ, and 14 percent (115 subjects) received a discharge or another adverse administrative action. For 198 subjects, evidence supported command action for other misconduct that came to light during the sexual assault investigation (such as making a false official statement, adultery, and other crimes under the UCMJ) but not a sexual assault offense. Of these, another 198 military: 9 percent (17 subjects) had court-martial charges preferred against them; 46 percent (92 subjects) received nonjudicial punishment; and 43 percent (85 subjects) received some form of adverse administrative action or discharge (no data was available for the remaining 2 percent of subjects).

As noted previously, of the 791 military subjects who had disciplinary action initiated on a sexual assault offense, 489 had court-martial charges preferred against them. The dispositions and the sentences imposed by courts-martial are for those subjects with at least one sexual assault charge adjudicated in fiscal year 2011. Of the 489 subjects who had courts-martial charges preferred against them in fiscal year 2011, 370 subjects' court-martial outcomes were completed by the end of the fiscal year. Of the 240 subjects whose cases proceeded to trial, 80 percent were convicted, and most convicted servicemembers received at least four kinds of punishment: confinement, reduction in rank, fines or forfeitures, and discharge (enlisted) or dismissal (officers) from service. Thirty-nine subjects were allowed to resign or were discharged instead of court-martial. Court-martial charges were dismissed against 91 subjects. However, commanders used evidence gathered during the sexual assault investigation to take nonjudicial punishment against 25 of the 91 subjects. Most of the 25 subjects who received nonjudicial punishment received three kinds of punishment: reductions in rank, fines or forfeitures, and restrictions on liberty.

Of the 791 military subjects who received disciplinary action on a sexual assault offense, 187 received nonjudicial punishment. Of the 168 subjects whose nonjudicial punishments were completed in fiscal year 2011, 93 percent of subjects were found guilty by the commander. Most subjects who received nonjudicial punishment received at least three kinds of punishment: reduction in grade, a fine or forfeiture of pay, and restriction of their liberty for a period of time. In addition, almost half of these subjects received extra duty or hard labor as part of their punishment. For 6 percent of subjects, the nonjudicial punishment served as ground for a subsequent administrative discharge.

Commanders administratively discharged 48 subjects investigated for a sexual assault offense. There are three types of administrative discharges: Honorable, General, and Under Other Than Honorable Conditions (UOTHC). Most of these 48 subjects received either a General or a UOTHC discharge.

In fiscal year 2011, commanders took adverse administrative actions against 67 subjects investigated for a sexual assault offense. These actions may consist of Letters of Reprimand, Letters of Admonishment, and Letters of Counseling. These actions may also include but are not limited to denial of reenlistment, the cancellation of a promotion, and the cancellation of new assignment orders. Adverse administrative actions are typically used when the misconduct alleged is of a lesser degree or when available evidence does not support more serious disciplinary action.

The sexual assault investigations conducted by the Military Criminal Investigative Organizations sometimes do not find sufficient evidence to support disciplinary action against the subject on a sexual assault charge. However, the investigations sometimes uncover other forms of chargeable misconduct. When this occurs, DOD

holds those servicemembers who have committed other misconduct appropriately accountable based on the available evidence.

DOD released the fiscal year 2011 Annual Report on Sexual Assault in the Military on April 13, 2012. The preceding information and supplementary charts and graphs detailing the subject case dispositions and punishments imposed are available on pages 42 through 49. The report is available at: <http://www.sapr.mil>.

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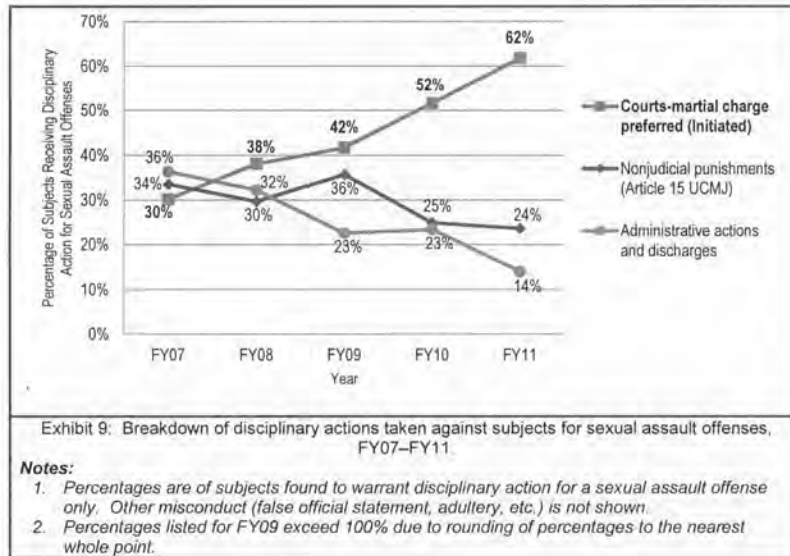
Table 3: Military subject dispositions in FY11.

Subject Disposition Category	Total Military Subjects in FY11	=	Subjects in Investigations Opened and Closed in FY11	+	Subjects in Investigations Opened Prior to FY11 and Closed in FY11
Military Subjects in Sexual Assault Cases Reviewed for Possible Disciplinary Action	1,518		856		662
Evidence-Supported Commander Action	989		590		399
<i>Court-Martial Charge Preferred (Initiated)</i>	<i>489</i>		<i>240</i>		<i>249</i>
<i>Nonjudicial Punishment (Article 15, UCMJ)</i>	<i>187</i>		<i>155</i>		<i>32</i>
<i>Administrative Discharge</i>	<i>48</i>		<i>32</i>		<i>16</i>
<i>Other Adverse Administrative Action</i>	<i>67</i>		<i>43</i>		<i>24</i>
<i>Probable Cause Only for Nonsexual Assault Offense</i>	<i>198</i>		<i>120</i>		<i>78</i>
Commander Declined Action	47		35		12
<i>Unfounded by Command</i>	<i>47</i>		<i>35</i>		<i>12</i>
<i>Commander Declined Action, per Rules for Courts-Martial 306(c)(1)</i>	<i>0</i>		<i>0</i>		<i>0</i>
Commander Action Precluded	482		231		251
<i>Victim Died</i>	<i>0</i>		<i>0</i>		<i>0</i>
<i>Victim Declined to Participate in the Military Justice Action</i>	<i>184</i>		<i>104</i>		<i>80</i>
<i>Insufficient Evidence to Prosecute</i>	<i>294</i>		<i>125</i>		<i>169</i>
<i>Statute of Limitations Expired</i>	<i>4</i>		<i>2</i>		<i>2</i>

MILITARY JUSTICE

This information that follows describes what happens once military subject's commander has decided to take disciplinary action. For sexual assault offenses, commanders have been relying upon the use of courts-martial for a growing proportion of military subjects involved in sexual assault offenses. Exhibit 9 shows that, from FY07 to FY11, commanders' use of courts-martial charges against military subjects for sexual assault offenses increased from 30% in FY07 to 62% in FY11. During the same time period, reliance upon nonjudicial punishment, adverse administrative actions, and administrative discharges decreased substantially.

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Courts-Martial

As noted previously, of the 791 military subjects who had disciplinary action initiated on a sexual assault offense, 489 had court-martial charges preferred against them (**Exhibit 1, Point R**). Exhibit 10 illustrates what happened to these subjects after their commanders preferred court-martial charges. The dispositions and the sentences imposed by courts-martial are for those subjects with at least one sexual assault charge adjudicated in FY11. Of the 489 subjects who had court-martial charges preferred against them in FY11, 370 subjects' court-martial outcomes were completed by the end of the FY. Of the 240 subjects whose cases proceeded to trial, 80% were convicted, and most convicted Service members received at least four kinds of punishment: confinement, reduction in rank, fines or forfeitures, and discharge (enlisted) or dismissal (officers) from service. Thirty-nine subjects were allowed to resign or were discharged instead of court-martial. Court-martial charges were dismissed against 91 subjects.

What percentage of Service member subjects tried for sexual assault charges were convicted in FY11, and what kind of punishment did they receive?

80% of Service members were convicted of at least one charge at trial of an offense ranging from Rape to Wrongful Sexual Contact within the Department's definition of sexual assault.

Most subjects received four kinds of punishment:

- Confinement
- A Fine or Forfeiture of Pay
- Reduction in Rank
- A Punitive Discharge or Dismissal

However, commanders used evidence gathered during the sexual assault investigation to take nonjudicial punishment against 25 of the 91 subjects. Most of the 25 subjects who received nonjudicial punishment received three kinds of punishment: reductions in rank, fines or forfeitures, and restrictions on liberty.

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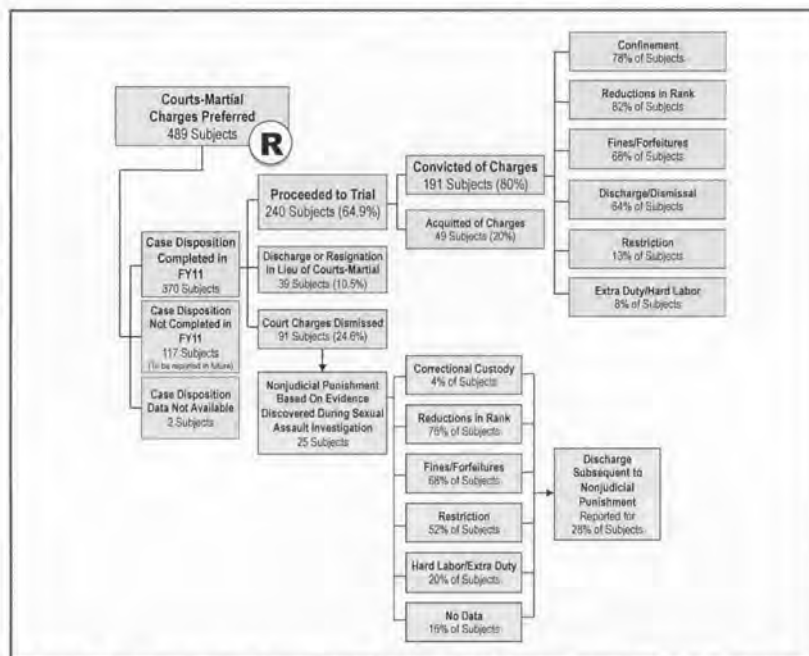
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Exhibit 10: Dispositions of Subjects Against Whom Courts-Martial Charges Were Preferred, FY11.

Notes:

1. The Military Services reported that 489 subjects of sexual assault investigations had court-martial charges preferred against them for a sexual assault offense.
2. Of the 489 subjects who had court-martial charges preferred against them, 117 subjects were still pending court action at the end of FY11. Disposition data was not available for 2 subjects.
3. Of the 370 subjects whose courts-martial were completed in FY11, 240 subjects proceeded to trial, 39 subjects were allowed to resign or received a discharge instead of trial, and 91 subjects had court-martial charges dismissed against them at some point in the justice proceedings.
4. In cases in which a resignation or discharge in lieu of court-martial is requested and approved, the characterization of the discharge is Under Other Than Honorable Conditions, unless a higher characterization is justified (See also the discussion of administrative discharge characterizations in the "Administrative Discharges and Adverse Administrative Actions" section of the report). Of the 91 subjects with dismissed charges, commanders imposed nonjudicial punishment on 25 subjects. Most of these 25 subjects received three kinds of punishment: a rank reduction, a fine or forfeiture, and restriction of their liberty for a period of time.
5. Of the 240 subjects whose cases proceeded to trial, 191 (80%) were convicted. Conviction by courts-martial may result in a combination of punishments. Consequently, convicted Service members could be adjudged one or more of the punishments listed. However, in most cases, they received at least four kinds of punishment: confinement, a reduction in rank, a fine/forfeiture, and a discharge. Discharges adjudged by courts-martial were either Bad Conduct Discharges or Dishonorable Discharges.

Nonjudicial Punishment

Nonjudicial punishment is administered in accordance with Article 15 of the UCMJ and empowers commanding officers to impose penalties on Service members when there is sufficient evidence of minor UCMJ violation. The member may demand trial by court-martial instead of accepting punishment by the commander. Nonjudicial punishment allows commanders to address some types of sexual assault and other misconduct by Service members that may not warrant prosecution in a military or civilian court. The DoD definition of sexual assault includes a wide range of offenses ranging from unwanted sexual contact to rape. With nonjudicial punishment a commander can take a variety of corrective actions, including demotions, fines, and restrictions on liberty. Nonjudicial punishment often serves as the grounds for discharging military subjects with a less than an honorable discharge.

Do military commanders use nonjudicial punishment as their primary means of discipline for sexual assault crimes?

No.

Less than a quarter of subjects who received disciplinary action for a sexual assault crime received nonjudicial punishment in FY11. Most subjects (62%) had court-martial charges preferred against them.

Of the 791 military subjects who received disciplinary action on a sexual assault offense, 187 received nonjudicial punishment (**Exhibit 1, Point R**). Exhibit 11 denotes the outcomes of nonjudicial punishment actions taken against subjects on a sexual assault charge in FY11. Of the 168 subjects whose nonjudicial punishments were completed in FY11, 93% of subjects were found guilty by the commander and issued punishment. Most subjects who received nonjudicial punishment received at least three kinds of punishment: reduction in rank, a fine or forfeiture of pay, and restriction of their liberty for a period of time. In addition, almost half of these subjects received extra duty or hard labor as part of their punishment. For 6% of subjects, the nonjudicial punishment served as grounds for a subsequent administrative discharge.

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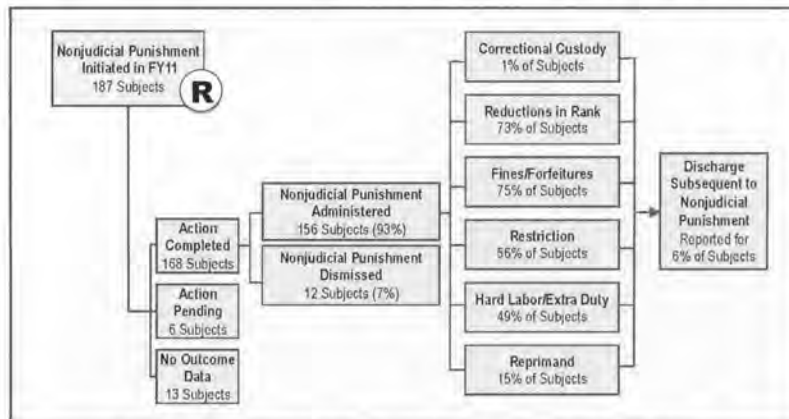
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Exhibit 11: Dispositions of Subjects Receiving Nonjudicial Punishment, FY11.

Notes:

1. The Military Services reported that 187 subjects of sexual assault investigations disposed in FY11 were considered for nonjudicial punishment.
2. Of the 168 subjects who were considered for nonjudicial punishment, 6 subjects were still pending action at the end of FY11. Nonjudicial punishment outcome data was not available for 13 subjects.
3. Of the 168 subjects whose nonjudicial punishments were completed in FY11, 156 subjects (93%) were found guilty by the commander and issued punishment. The remaining 12 subjects (7%) were found not guilty.
4. Nonjudicial punishment may result in a combination of penalties. Consequently, Service members found guilty can be administered one or more kinds of punishments. However, for most of the cases, convicted Service members received at least three kinds of punishment: a reduction in rank, a fine/forfeiture, and a restriction on their liberty for a period of time. Almost half of the subjects awarded nonjudicial punishment were given hard labor or extra duty.
5. For 6% of subjects, the nonjudicial punishment contributed to the rationale supporting an administrative discharge.

Administrative Discharges and Adverse Administrative Actions

Commanders administratively discharged 48 subjects investigated for a sexual assault offense (**Exhibit 1, Point R**). There are three types of administrative discharges: Honorable, General, and Under Other Than Honorable Conditions (UOTHC). General and UOTHC discharges may limit those discharged from receiving full entitlements and benefits from the DVA. Most of these 48 subjects received either a General or a UOTHC discharge.

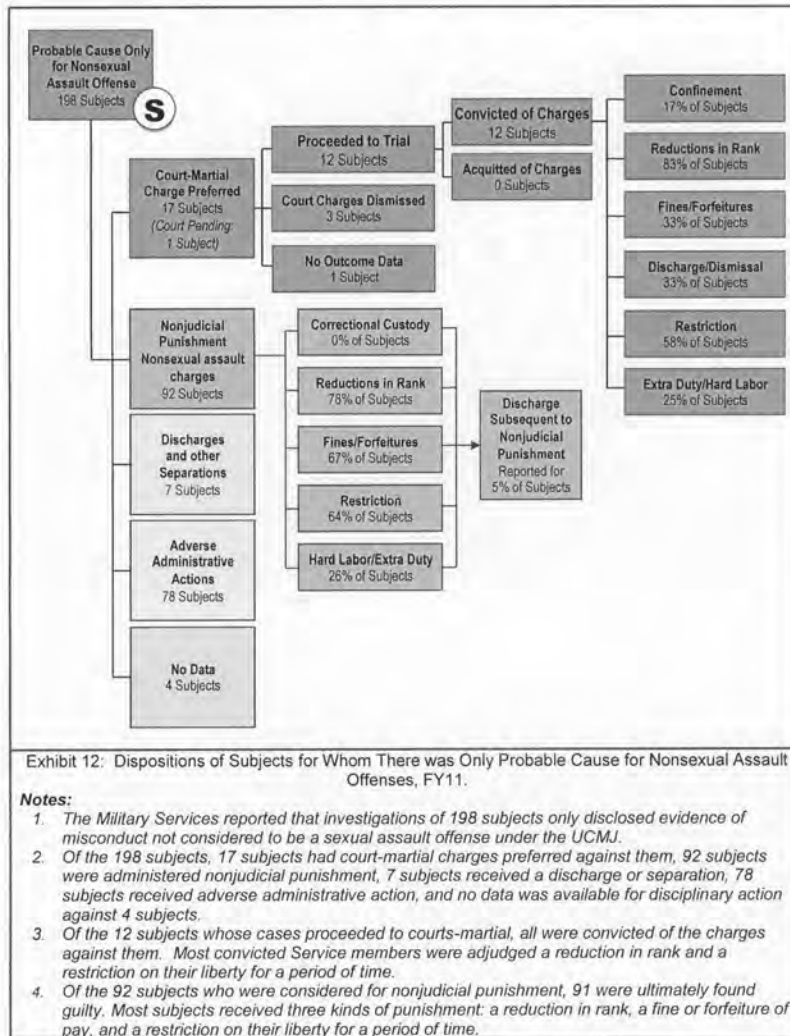
In FY11, commanders took adverse administrative actions against 67 subjects investigated for a sexual assault offense (**Exhibit 1, Point R**). These actions consist of Letters of Reprimand, Letters of Admonishment, and Letters of Counseling. These actions may also include but are not limited to denial of re-enlistment, the cancellation of

a promotion, and the cancellation of new assignment orders. Adverse administrative actions are typically used when the misconduct alleged is of a lesser degree or when available evidence does not support more serious disciplinary action.

Probable Cause Only for a Nonsexual Assault Offense

The sexual assault investigations conducted by the MCIOs sometimes do not find sufficient evidence to support disciplinary action against the subject on a sexual assault charge. However, the investigations sometimes uncover other forms of chargeable misconduct. When this occurs, the Department holds those Service members who have committed other misconduct appropriately accountable based on the available evidence. In FY11, commanders took action against 198 subjects who were originally investigated for sexual assault allegations, but evidence only supported action on nonsexual assault misconduct, such as making a false official statement, adultery, assault, or other crimes (**Exhibit 1, Point S**). Exhibit 12 denotes the outcomes of the disciplinary actions taken against subjects for nonsexual assault offenses in FY11.

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Senator BLUMENTHAL. Can you also provide percentages as to what numbers or in what rate you give defendants the option of a discharge or a resignation in lieu of court martial?

Dr. ROONEY. I will get the information as to what the eventual resolution was as to whether that was a negotiated plea or something in that regard. That will be a little harder, but I can certainly tell you article 15 and various steps of penalties.

[The information referred to follows:]

Of the 370 military subjects whose courts-martial action was completed in fiscal year 2011, 39 subjects (or 10.5 percent) were discharged (enlisted) or allowed to resign (officer) in lieu of court-martial. In cases in which a resignation or discharge in lieu of court-martial is requested and approved, the characterization of the discharge is usually Under Other Than Honorable Conditions, unless a higher characterization is justified.

Senator BLUMENTHAL. Finally on this subject, can you tell me when Secretary Panetta is going to be releasing the recommendations he is going to be having both administrative and legislative? Do you know?

Dr. ROONEY. Actually, we have been working on the possible legislative proposals as recently as today. So I am expecting those to be coming up soon, and within the next 3 to 6 months, we will also have some additional ways forward on specific recommendations coming out from the Services, as well as follow-up on the ones we mentioned with the expedited transfer and the document retention.

Senator BLUMENTHAL. Thank you.

On the issue—and you raise it in your testimony—concerning suicides, can you talk a little bit about what steps are being taken to address this issue more effectively?

Dr. ROONEY. Absolutely, and you are right that the numbers right now, despite many of our efforts, have not shown a significant decrease. But what we have done, in fact, is taken the task force that had their report forward. One of the recommendations was to create a specific suicide prevention office, which we have done in the last few months. The purpose of that office is not to create yet another layer, but it is to look across all of the Services and actually be the conduit for what are best practices, where are we missing some potential opportunities, getting rid of the redundancies. That has at this point a temporary staff, but in the fiscal year 2013 budget, we have the full appropriations we are requesting on that to have that staff stand up.

In addition to that, we are working directly with the Services in each of their component areas to see what practices they have in place.

The next thing—and I think you have seen it also from the medical side—is we are embedding behavioral health not only within the units but also making it available to the families through a number of our family programs. Again, we are continuing to monitor what has been the outreach and where have we seen some successes or not as it were.

Those are the steps at this point with many more coming forward.

Also, collecting data has been a big challenge that we have had, contemporaneous data. So we are working closely with the Department of Veterans Affairs (VA) in particular at this point to share information not only from the DOD side but also what the VA is getting. We are doing a lot of joint work with them. So we are getting data that is within 30 to 60 days old as opposed to a year or 2, which is what we had been getting, as the way the States are gathering it, and sharing that information and trying to trend directly with the VA.

Senator BLUMENTHAL. Thank you, thank you very much. My time has expired.

Thank you, Mr. Chairman.

We hear a lot and I profoundly agree with the statement that we have heard again and again that our most important asset is our people, and you are the folks who are dealing with that asset. So I want to thank you for your great work. Thank you for being here.

Thank you.

Senator WEBB. Thank you, Senator Blumenthal.

Senator Begich.

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

Thank you all for being here. I appreciate it.

Let me start with a couple of questions, but first, Mr. McGinnis, there is a piece of legislation that Senator Graham and I have sponsored on space availability for widows of combat veterans, as well as Guard and Reserves. To be very frank with you, we are not changing any of the prioritization. We are just making sure if there is a seat open and all the prioritization has occurred, then there is opportunity. The response we got informally was not very thoughtful in my view. I will not belabor it here, but I would like you, if you could, to take a look at that legislation and give your thoughts on it.

We have a lot of bipartisan support. As a matter of fact, a lot of people on this committee have sponsored it. We think it is a fair way to approach. It is like an airline industry. When there is a seat empty, there is no value to it, and if there is an opportunity, we should explore that. I think what we have tried to do is recognize the rules and regulations of prioritization of utilization of space available and recognizing that, but not overtaking that and leaving a lot of authority to DOD.

So if you could take a look at that bill, that would be great.

Mr. MCGINNIS. I will, sir.

Senator BEGICH. My staff will be happy to talk with your staff about that.

I will not belabor it more than that, to say the response was not as thoughtful as I thought it would be. I will leave it at that.

Mr. MCGINNIS. I will look at it.

Senator BEGICH. Thank you very much.

Secretary Hale, this might be to you and to Secretary Rooney also. I want to understand the process. You have to understand where I come from. I come from being a former mayor where if I have a CFO, they know all, and at the end of the day, they have to sign off on money things. No department can go do their own stuff, and even when personnel has stuff, someone has to sign off their savings or costs. So I do not necessarily say that is the way it all works in the military. I am not suggesting that.

But let me walk through an example and help me understand how you would be engaged in this or in your case, Secretary Rooney.

I am dealing with, and a lot of folks are dealing with, this around the country with bases that are being reviewed for potential reductions or reductions of services or personnel, may they be military and/or civilian. We are dealing with this at Eielson Air Force Base right now. Here is the scenario. The proposal was laid out.

It will save X amount of dollars. We then, of course, questioned this. Now they are sending a team up to analyze what the savings will be, which seems odd that you would propose a savings and then analyze it later, but I will leave that for a second.

First of all, I will start with you, Secretary Hale. When the Secretary of the Air Force—I am using them as an example, I do not mean to pick on them, but they are the ones we are dealing with with Eielson. They propose these savings that recognize a certain amount of money that will be saved. What is your interaction with those activities? Do you accept those based on that information? Then holding that thought, the question I would have for you, Secretary Rooney, is when they propose this—and it is basically a bulk of personnel savings—how are you engaged in that, in analyzing that number, may they be civilian and/or personnel or military active personnel? Secretary Hale, to the first question. What is that engagement?

Mr. HALE. We are dealing with one of the world's largest organizations, Senator Begich, and many of these proposals do work up through our Military Services and departments which have cost analysts and staff similar. They are not formally CFOs, but they have assistant secretaries for financial management and comptroller. My staff tends to review the ones that are in contention or perhaps cut across all the Services.

I do not know for sure on the Eielson one, but my guess is it was an Air Force estimate and reviewed by them.

Senator BEGICH. So you accept because they go through this kind of chain, to a certain extent, I am not saying all the time.

Mr. HALE. If we have reason to question it, no, but we do not review every single proposal that comes forward. I do not know on the particular one you are referring whether we did. I would need to find out.

Senator BEGICH. Let me ask then on the personnel. So when they recommend or suggest that it will save this amount of military personnel and X amount of civilian personnel, again recognizing they go through this chain, what happens at your level, if anything? I do not know.

Dr. ROONEY. Actually, it would. Two of the areas within personnel and readiness deal with military personnel policy and civilian personnel policy, but embedded in that is this idea of Total Force. Our role typically at that point is working with the Services to ask them what, in fact, are they going to use as tools, specific drawdown tools available potentially for the military, if they are seeing that the reduction would come from the personnel side, and walk through with them from a policy standpoint what exact shaping tools are they using and making sure they are understanding the costs or the implication of those.

The same with the civilian side. We have set processes and procedures to, hopefully, reintegrate the civilians within the workforce, and walk through whether, in fact, they are following those procedures and have considered that in cost estimates.

Senator BEGICH. I appreciate that answer. But I would have expected that from our personnel department in the city would have done that. The departments do their thing and then the personnel walks through it because sometimes departments will over-esti-

mate for the benefit of getting past the Office of Management and Budget (OMB). Getting past OMB, life is better. But in the mayor's office we always had to say, well, are these real, what does it mean?

In this situation, I am assuming they then submit to you something that says here is what we guess, here is how much civilian, here is how much Active, and then you walk through this process. Sometimes it is easy because it is clear, but sometimes more complicated. Is that a fair statement? Depending on what it is, is that fair?

Dr. ROONEY. A fair statement.

Senator BEGICH. Can I ask for the record—and again, I do not expect you to have it off the top of your head here—what role, maybe limited or extensive, that you might have had in this review within your area with regard to this redirection? It is a lot of people. Actually, they do not know how many. That is the challenge, to be very frank with you. They have estimated Active military, but they cannot give us an answer to this day on civilian. We have asked them four times. I know there is a document that exists that says here is what we anticipate because someone had to review it to say here is what it will save. I have not seen it. We have asked for it over and over and over again.

So is that something you could look at and respond? If your answer is, well, we did not get anything, okay. Or we did, and we cannot give it to you yet, okay. Or, yes, we have it, here it is. I would prefer the latter, to be very frank with you. I am hoping it is the latter.

Dr. ROONEY. What we will do is look at it. Based on what you are indicating, it is very possible it has not reached the level yet where we would see it fleshed out to the point to be able to give some feedback. But what I will do is check with our team, if they have been involved to this point, and if not, be able to check and see what work has been done, and then we can give you a better idea when it would, in fact, come to us for a review. But it usually has a little more detail than what you described before we would actually see it to be able to give some reaction.

[The information referred to follows:]

The fiscal year 2013 budget reflects a balanced workforce that decreases spending on military personnel, civilian full-time equivalents, and contracted services. It reflects our best judgment today, representing a carefully coordinated approach based on our strategy and policy, balancing operational needs and fiscal reality. Furthermore, we must budget for a future where we face a decreasing top line, and in order to help components do so, the Department of Defense (DOD) established civilian manpower targets at fiscal year 2010 levels, with certain exemptions and exceptions in critical growth areas. Individual components develop their workforces to meet their missions, tasks, and functions based on their operational requirements, workload needs, and available funding. At the departmental level, we do not prioritize the components' missions for them or tell them how to size their workforces. As such, we do not require the components to submit a report estimating civilian draw-down.

However, we are committed to ensuring the components have a balanced, flexible, responsive workforce that is the appropriate mix of military, civilian, and contracted support; efficiently mitigates risks, ensures continuity of operations, and promotes an organic knowledge base; and ensures mission requirements are met most cost effectively and efficiently.

In developing budget requests and making manpower determinations, Personnel and Readiness works together with other elements of the Secretary's and DOD's

leadership team to ensure that risk mitigation, continuity of operations, and mission attainment shall take precedence over cost of performance.

Senator BEGICH. My time is up.

I would have anticipated even the kind of detail you are talking about that you would expect I would expect when they make a reduction to a military base to shift 600-plus people plus more civilians, which we do not know of, that you would have more information to make those judgments because we have to make the decision that, okay, this is an okay budget and we have to check off. But if we do not understand how they got there, we cannot make a rational decision. So that is why I am in this quandary.

I will tell you there has been a lot of this—pointing—and I know the way it works, especially within the military. There are more forms about forms to have more forms. So somewhere in this mix someone wrote down in 2013 and 2014 and 2015 we anticipate this civilian reduction, this military reduction for the savings of X so that we can then get past OMB and the CFO. Someone did it somewhere. If they did not, then to be very frank with you, that is incompetency. But somewhere it is done. I just know it. That is how DOD works here, more reams of paper than paper can be produced every day, is my view. So that is just a thought there.

I have some other questions which I will submit for the record for generally all of you. They are broader in the sense of some policy issues, and I will submit those.

I thank you for you letting me have my rant. Thank you, Mr. Chairman, for letting me rant.

Senator WEBB. Thank you, Senator Begich. Actually, we will have another round if you want to come back and ask more questions.

Senator BEGICH. I will submit them.

Senator WEBB. Having spent 5 years in the Pentagon, I can say a lot of the reams of paper that grow around the Pentagon have been produced at the behest of the Senate and the House of Representatives. [Laughter.]

Senator BEGICH. The good news is I am not asking for more paper. I am just looking for a piece of paper that they produced.

Senator WEBB. Senator Ayotte?

Senator AYOTTE. Thank you, Mr. Chairman.

Speaking of paper, I wanted to ask Secretary Hale about where we are on audit because I was able to ask the Chief of the Air Force. I know that the Air Force may have the most difficulty in meeting Secretary Panetta's goal of a 2014 statement of budgetary resources. This is something I have been very interested in. In fact, I introduced an amendment to the National Defense Authorization Act (NDAA) in this past go-around wanting to codify that you meet the audit requirements.

Just wondering where we are. Are we going to meet the 2014 deadline for a statement of budgetary resources in each of our Services and within the overall DOD?

Mr. HALE. I am reasonably confident. This is a tough problem, tougher frankly than I anticipated. But we have several things going for us.

The first is the strong endorsement by Secretary Panetta which has opened doors wider than I expected, and we are doing every-

thing we can to leverage it. In particular, I think what we are doing that we have not been able to do in the past is get this out of being a comptroller issue and into being a commander issue. We absolutely have to do that because we have to change business processes, and only the commander can do that. We have the money. We have the governance process. We have interim goals which are critical. You probably heard me say before no one wakes up thinking, I really got to work hard today for a 2014, let alone a 2017, goal. So we have interim dates.

The Secretary convened a meeting of all the Service Secretaries and Service Chiefs. We had everyone there. Amazing to me. They get it that it is important now.

Senator AYOTTE. It is important. This is not just any paperwork.

Mr. HALE. So I am going to stop with reasonably confident.

Senator AYOTTE. Okay. I appreciate that.

We did talk about a lot of paperwork, but this is really important particularly when we are asked to make some very difficult decisions about DOD in terms of it being a management tool as well as an information tool for Congress. Would you agree with me on that?

Mr. HALE. I would. We have over-promised and under-delivered for a long time. So that is why the best you get is reasonably confident, Senator.

Senator AYOTTE. Reasonably confident. I will take it. How is that?

I wanted to ask Secretary Rooney, yesterday you and I had a chance to meet and talk about New Hampshire's deployment cycle support program within our Guard. It is one of the challenges that we have had that our guardsmen and women and our Reserves—we have really used them in these conflicts in Iraq and Afghanistan. They have been part of our Total Force. We would not be able to have fought in Iraq and Afghanistan without our Guard or Reserve. Yet, often the whole deployment cycle support is not there for them.

So, New Hampshire came up with a very strong public/private partnership. We partnered Federal Government resources with State government, as well as private organizations like Easter Seals. We have been keeping metrics on it so that we can measure the results, and, in fact, the results have been getting our veterans to work, reintegrated into work. We have actually saved someone's life in a suicide, which we are very proud of, and really serving our families.

So, I wondered Secretary Rooney, if you have had a chance to look at that after we talked yesterday, what are your impressions of it. I would also ask Mr. McGinnis as well, and then I would also love to invite both of you to New Hampshire to see firsthand how this program works.

Dr. ROONEY. Thank you, Senator. Starting with your last point, as I indicated to you yesterday, I would welcome the opportunity, particularly if I am back home in New England on the weekend, to join you and actually see the program.

I appreciate the additional information you did send over.

You hit upon a key aspect. When we talk about the challenges that we have in managing to leverage resources and be efficient,

it is how do we not only extend what we are doing in DOD, but reach out and form more of these public/private partnerships. It is going to be a way that we have to be very diligent about looking for those opportunities, finding those situations that work the best, and how can we replicate them.

After I left you, I was meeting with the senior enlisted, and we started talking about this, about how do we successful transition, and whether it is Guard and Reserve or Active, it is just how do we transition our folks from the military and reach out. They indicated to me too that they were aware of the New Hampshire program and also possibly another one in Oregon and maybe another State.

I think what all of us need the responsibility for doing, myself and Mr. McGinnis, is to look for those opportunities, learn more about how they work, and see if we can duplicate them so that we are addressing the issues, as we heard of, suicide and unemployment and transition. Our job can be to more tightly align with how do we translate military skills into skills that the civilian workforce can use. We can do a good job about that, but then really rely on those public/private partnerships. We are seeing in several cases that they work.

Senator AYOTTE. I think one of the reasons it works in New Hampshire is because we know there are limited resources, but we are leveraging those with the State and with the nonprofit community to take advantage of all the services in a way that is very proactive for those that return from overseas or return from deployment.

I do not know if you wanted to add anything, Mr. McGinnis?

Mr. MCGINNIS. Yes, ma'am. The funding that has been provided for these programs in the past has been congressional adds. There has been a number of State programs that have been supported. The appropriated dollars both to the Services and to DOD—and YRRP is focused on the long list of mandated requirements I have to make sure happens within the YRRP. We are focused on that.

However, our YRRP Center for Excellence (CFE) is putting together a process to be able to evaluate all these programs, as Dr. Rooney mentioned. We share a very similar problem with my colleague in military communities and families, Secretary Gordon, and we are working with him to put together a process where we can evaluate these programs. But like Secretary Rooney, I would very much want to come up and see your program.

Senator AYOTTE. We would love it. Come in the fall. It is gorgeous. We will have you sooner too.

Mr. MCGINNIS. Thank you.

Senator AYOTTE. I wanted to ask Dr. Rooney, certainly Secretary Woodson, where we are. Our All-Volunteer Force—I think you would all agree that our troops have done everything we have asked of them and more.

So last year, did we not increase TRICARE enrollment fees?

Dr. ROONEY. Modestly we did, yes.

Senator AYOTTE. But we did.

We tied it to cost-of-living adjustments, correct? Now you are back before us—I know, Secretary Hale, you certainly have an

opinion on this—to ask for additional TRICARE increases. These increases are very significant.

I know my time is up here, but I think this is a really important issue. So I will wait for another round.

But for some individuals, these are not trivial. For example, a retiree receiving between \$22,000 and \$45,000 a year—their annual fees will go from \$500 to \$1,500 a year, threefold in only about 4 years. So this is a pretty significant issue.

I think we have a duty, given what our servicemen and women have done, to really have a very hard discussion about this. I am really concerned about it.

I know my time is up. I will stick around to ask more questions and turn it back to the chairman.

Senator WEBB. Thank you, Senator Ayotte.

Actually, I am going to get into that. So I welcome your participating when I do.

I have one other little item that I would like to raise now, and there may be other questions that I or other members will submit for the record. They will have until close of business tomorrow in order to do so.

I want to follow on what Senator Ayotte just said.

Before I do that, Dr. Rooney, last year Secretary of Defense Gates made a decision to eliminate, reduce, or reallocate 140 general and flag officer positions. We held a hearing on that issue, as you may recall. Can you give us an update on the status of that?

Dr. ROONEY. Yes, sir. As of now, we have eliminated 49 of the positions. As you are aware, this is a process that we expect between now and 2016 to reach the number that you indicated. But right now we are at 49. We are expecting, as we continue the draw-down in our overseas operations, that we will continue to actually increase that number of those that have been eliminated or reduced.

Senator WEBB. So you are continuing the process that was begun when Secretary Gates initiated it?

Dr. ROONEY. Yes. In fact, Secretary Panetta was affirmative in his support for continuing that process.

Senator WEBB. All right.

Now, I would like to follow on to what Senator Ayotte said and add some of my own concerns here, as I did in the full committee hearing about a week ago.

First, I have said many times—I think all of you know that I believe whether there is a specific contractual obligation or not, when someone has served a full career, we have a moral obligation to provide them with lifetime medical care. Would you agree or disagree?

Dr. ROONEY. Sir, I believe we have to offer the best medical care possible in respect of their service, yes.

Senator WEBB. Secretary Woodson?

Dr. WOODSON. Yes, I do believe we have a responsibility, particularly for the wounded, ill, and injured, to provide long-term lifetime medical care.

Senator WEBB. What about for those who serve a career?

Dr. WOODSON. I think we have an obligation to provide them with a benefit package that is very generous and reflects their sacrifice and service.

Senator WEBB. Thank you. That defines the struggle that we all have here. I know how difficult it has been to put together these numbers.

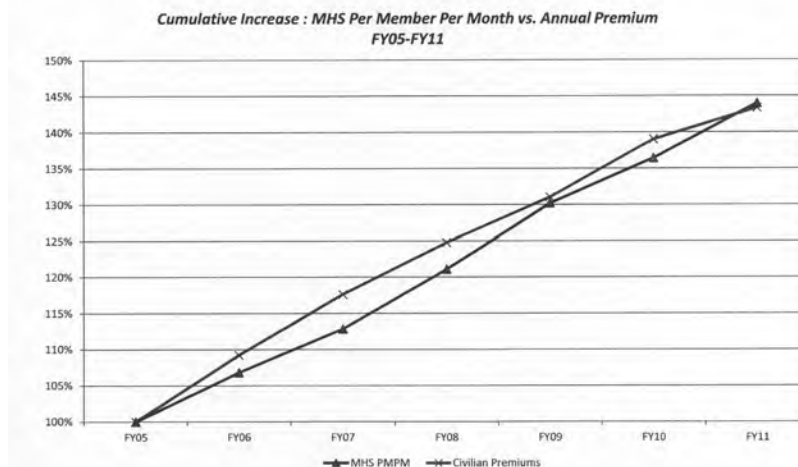
Secretary Woodson, I want to go back and examine the percentage that you raise with respect to 1996 versus today. I want to just have my staff take a look at that and get back to you. I may have some further questions about how that number was arrived at.

I would like to put up a chart that you had in your written testimony over here because this is another piece of the reality, and that is that if you look at cost per enrollee in the system, that cost has grown at pretty much the same pace as civilian health care. As I have said many times, our health care difficulties, as we have seen from the last 3 days in the Supreme Court, is a national problem. It is not a DOD problem. It is a challenge for all of us. But we are pretty much seeing the same percentage increase if you use 2005 as a baseline as we have seen nationally. Is that a correct statement?

Dr. WOODSON. That is correct. Thank you for putting up that chart because I have the very same chart.

[The chart referred to follows:]

Cost per Enrollee in the MHS Have Grown at Roughly the Same Pace as Civilian Health Care



Senator WEBB. I think it is a great starting point for this discussion.

Another clarification is, as far as I know, when we summarize the costs even for TRICARE For Life, we do not take the costs of Medicare Part B and apply it when you are looking at the health care costs inside DOD. Right?

Dr. WOODSON. Let me make sure I understand your question.

Senator WEBB. Let me be clearer. When a retired servicemember reaches the age of 65, they are required to sign up for Medicare Part B before they can get TRICARE For Life.

Dr. WOODSON. That is correct.

Senator WEBB. The cost of Medicare Part B—just to summarize, when you reach the age of 65, you are automatically entitled to Medicare Part A. But you have to elect to get Medicare Part B. It is wider coverage. But for a retired servicemember who wants TRICARE For Life, the DOD benefit, they are required to sign up for Medicare Part B.

Dr. WOODSON. That is correct.

Senator WEBB. When we look at the increase in the costs or the percentage increase in the costs inside DOD, we do not factor in Medicare Part B. That is a total separate account. Correct?

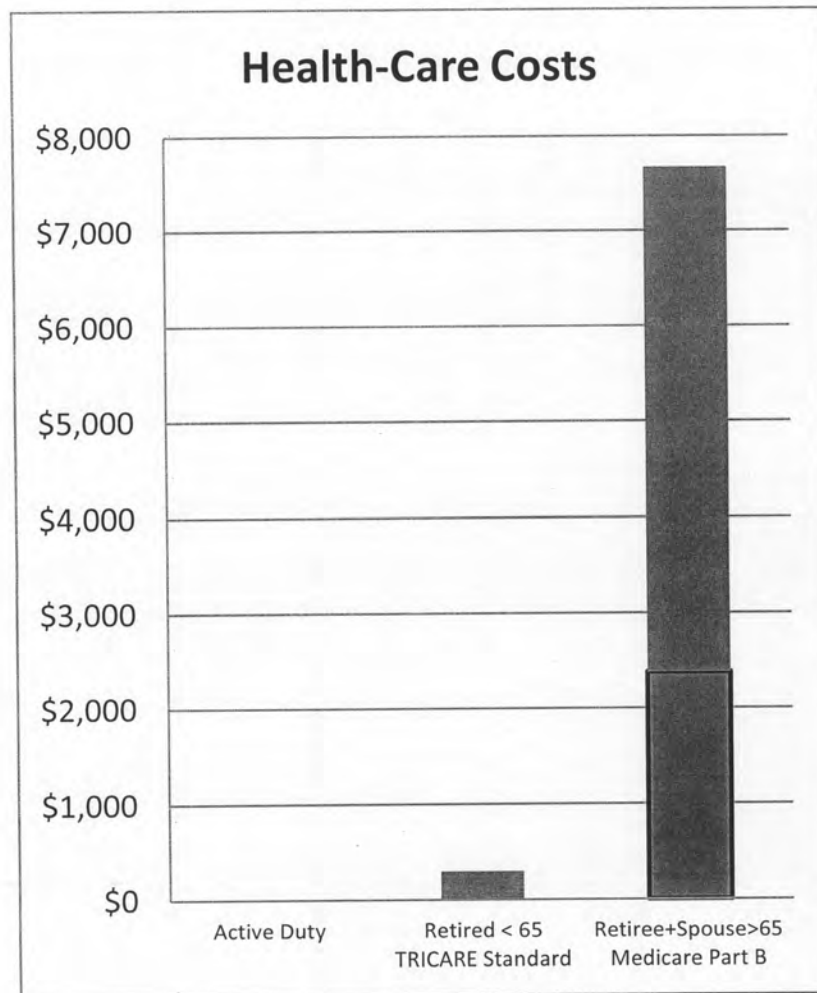
Dr. WOODSON. That is correct, but remember 90 percent of folks will and have taken Part B. TRICARE For Life represents that wraparound insurance for that other 20 percent, which includes a Part D, which is a pharmacy benefit. Remember prior to 2001 when TRICARE For Life came on board, many folks were paying independently for that wraparound insurance. So you are correct in your statement about Part B, but most folks will be paying Part B anyway.

Senator WEBB. Medicare Part B is a very expensive program, and we do not count that when we look at the cost of TRICARE in terms of DOD funding. Correct?

Dr. WOODSON. That is correct.

Senator WEBB. Can you put up this other chart?

[The chart referred to follows:]



Senator WEBB. If you are looking at this from the perspective of a retired servicemember—I spoke to this in a full committee hearing. But when you are on Active Duty, obviously all your medical care is provided for. When you retire before the age of 65, presently you are at where the red marks are on this line. You hit 65. You are where that far right bar is in terms of how much you are required to pay in. The blue represents the proposal from DOD for the increases in TRICARE fees.

So if you are somebody out there, having retired, looking at what it is going to cost you for health care, you are seeing, first of all, as Senator Ayotte pointed out, a significant jump with the proposals from DOD, but if you are over here past 65, you are seeing just a really large, sudden expenditure.

Dr. WOODSON. Yes. Thanks for bringing this up because this is an interesting chart. First of all, it does not include the average out-of-pocket costs. The figures you have given there, where you are looking at a premium of \$7,000 or a cost \$7,672, represents the upper tier of folks who pay Part B. They would have to be making \$428,000 a year in order to pay that premium.

Senator WEBB. The couple, not the individual. Actually, if you will see the first line there, that is the lowest tier. Also, let us remember if somebody is on that upper tier, they are also paying Medicare again for the money that they are making. They are paying three times. They are paying Medicare Part B. They are going to be paying TRICARE, and they are going to be paying for Medicare on the income that they are making.

Dr. WOODSON. Yes, but the important issue, in terms of the optics relative proportion, is that Medicare Part B—they do not start tiering until about \$170,000 a year. So you are really talking about an upper echelon.

The other thing about the chart is, again, you are not talking about total out-of-pocket costs. That is why the differential looks so wide there. If you looked at the other out-of-pocket costs, you would see that it would not be as—

Senator WEBB. Actually, that goes to another point, and then I am going to let Senator Ayotte follow on here, and that is that people who think that the TRICARE fee by itself is all that somebody is paying is not correct. For instance, if you are talking about TRICARE standard, you pay a 25 percent cost share after you pay your fee. So when people are talking about the notion that the amount that our retirees are paying for health care is very small, I agree with you that is not reflective of the amount that they are paying.

Dr. WOODSON. That is exactly why we talk about cost share because that takes into account the relative out-of-pocket costs, and so the statistics I gave you before were correct, that in 1996 the relative contribution cost share was 27 percent. It has dropped to about 10 percent, even less if you look at prime. What we are talking about is a rebalancing so that even in 2017 and beyond, the relative cost share is only going to be about 14 percent, which is about half of what it was originally. So you have to talk about out-of-pocket costs.

Senator WEBB. Right. We will look at your figures.

Dr. WOODSON. Oh, absolutely. We can provide you details on that.

Mr. HALE. Could I just add one more point that I think is important to this comparison? Although we should not copy the civilian system, we need to keep it in mind. Good Medigap coverage for a couple is probably \$4,000 a year. We are talking TRICARE For Life at the highest tier of \$900, at the lowest tier for \$22,000 and less, more junior retirees, \$300. It is meant to be generous. I think that is right. But I think we have to keep this in mind. This is a dynamic health care system, and we have to make some of those or—

Senator WEBB. Look, that is in addition and in addition to—

Mr. HALE. Yes, but it would be in addition for the civilians as well. They would be paying that \$2,000—

Senator WEBB. What we are talking about is an obligation to provide them medical care for the rest of their life based on a compensation package that begins the day that they enlist and is amortized over the rest of their life. It is not a direct comparison, in my view.

Now, we are going to continue this probably for the next 4 or 5 months. But I appreciate your views and you have heard mine.

Mr. HALE. Okay. I understand. May I add one more thought? That is, you keep this in the context that we owe them not only good medical care, we have to provide training and equipment for them, as you know a lot better than I do given your military service. We have to have a balanced package as we respond to the—

Senator WEBB. I totally agree with that, but what I am saying to you is you cannot renegotiate the front end once the back end is done. This is an obligation that has been made to people whose military careers are now done. If you want to reexamine the whole compensation package, that is something that actually is on the table.

Senator Ayotte.

Senator AYOTTE. I would agree very much with the chairman on this. Just in terms of what we are talking about, as far as a comparison, there is a reason that in President Lincoln's second inaugural address he said that we have a duty. Really, we have to "bind up our Nation's wounds to care for him who shall have borne the battle and for his widow and his orphan." This is different than the rest of the population in terms of what they have sacrificed and what they have put on the line for us and what they were promised. What is it that they expected in all this? So I think that that is what we are talking about here.

What bothers me about this is that the reason that you are here in this position is that—let's face it. Something like the BCA—you came with us last year to ask for TRICARE increases, and that was not easy, was it, Secretary Hale? That was a difficult question. I know you did not get everything you wanted.

Mr. HALE. We appreciate your support.

Senator AYOTTE. No, exactly. We supported you on that, and you are back before us this year.

In the context of what we are looking at with something like the BCA, you have been handed a number. You are under additional budgetary pressures. Health care costs are rising in every sector. But we have not, as a Congress, dealt with the 60 percent of the spending that is going up in Federal spending that includes Medicare, that includes Medicaid, that includes the mandatory programs. I understand why you are here before us.

I do not think, though, that we should put that, if we do not show the courage to deal with the entire budget—to really put a significant increase and burden after we just did an increase last year on this group of individuals who have served our Nation, given what they had as anticipation when they came into Service, as Senator Webb has said, and where we are making these changes. So that is one of the overall concerns I have about this.

I understand that you were handed a number in the BCA. Would you be here asking for these increases immediately after you got some last year but for the BCA?

Mr. HALE. I suspect the answer to that is no, but the BCA is a law that you passed and we do need to be consistent with it. My worry is that if we choose not to make these decisions, we will have to take it out of force structure and investment, and I believe that we have already, consistent with the strategy, done what we should there. It is actually quite disproportionate toward the investment side and very disproportionate on the low side for personnel. So if you do not support this, I am not sure where we go.

Senator AYOTTE. But my point in the bigger picture in all this, which is really not your fault that you are put in this position—is that because in Congress we are not looking at the whole picture, that you are in a position where you are handed the BCA, you are coming before us, you are going to ask for these health care increases after just having increased TRICARE last year. I think that we also on our end, to put this a little bit on us, that we have to take on the big picture here or we are going to be in a place like sequestration. We are going to be in a place where there is no question, reductions are going to happen to our military with withdrawal from Iraq and drawdown in Afghanistan. But you are here. It is troubling to me that we are going to take it out of that group first instead of dealing with the big picture of our budget problem.

Mr. HALE. I would love a grand budget deal.

Dr. WOODSON. But the truth of the matter is we are not taking it out of that group first. As Secretary Hale said in his opening statement, while personnel costs at 30 percent—when the Secretary laid out the policies and procedures for looking at the budget, 90 percent came from troops, weapons programs, ships, planes. 10 percent came from personnel costs, and the truth of the matter is these TRICARE fee adjustments represent only slightly less than 5 percent.

Senator AYOTTE. I do have one substantive question. You received the Government Accountability Office (GAO) report which recommended a consolidation among the Services of health care as a way of a significant cost saving measure. I do not see that in all of this. I do not see a significant move in terms of changing and consolidation in trying to look at other ways where we could save money in health care. In fact, GAO recommended that you could achieve between \$281 million and \$460 million in annual savings from that. Have we gone down that road at all?

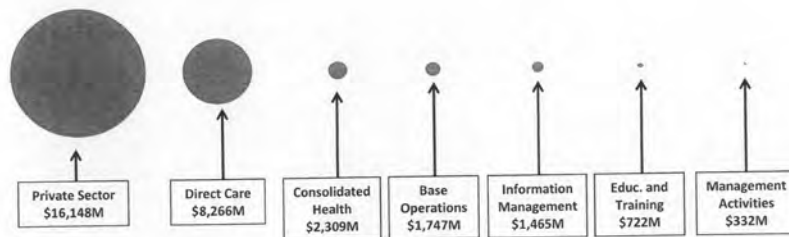
Dr. WOODSON. Yes. So you may be aware that we delivered to Congress the required report to Congress in the NDAA looking at the restructuring of the military health system. We were ready to move out on that last fall when at the 11th hour, we got a prohibition in the NDAA saying that we could not make any changes in the military health system. So we have gone down that path in terms of analyzing what we need to get the greatest amount of efficiencies by looking at common business practices and common service orientation.

I would suggest to you again that as much as we are bringing focus and energy to reorganizing the structure of the military health system—can we put up chart 1 please?

[The chart referred to follows:]

MHS Appropriation by Activity

(Operations and Maintenance PB2013 Request)



Size of Activity corresponds to width of circle.

Dr. WOODSON. You need to understand that headquarters functions actually represent only about 2 percent of budget, and we affectionately call this slide “the planet slide” because it shows the relative amounts of money in the budget. If you look to the far right, that really represents headquarters function, and where we spend the bulk of the money is actually in delivery of care and private sector care and maintenance—

Senator AYOTTE. I apologize. I will grab that report and look at it right away. So is this something you would still want to do?

Dr. WOODSON. Absolutely.

Senator AYOTTE. If you did it, could you also not have to ask for the increases that you are asking for?

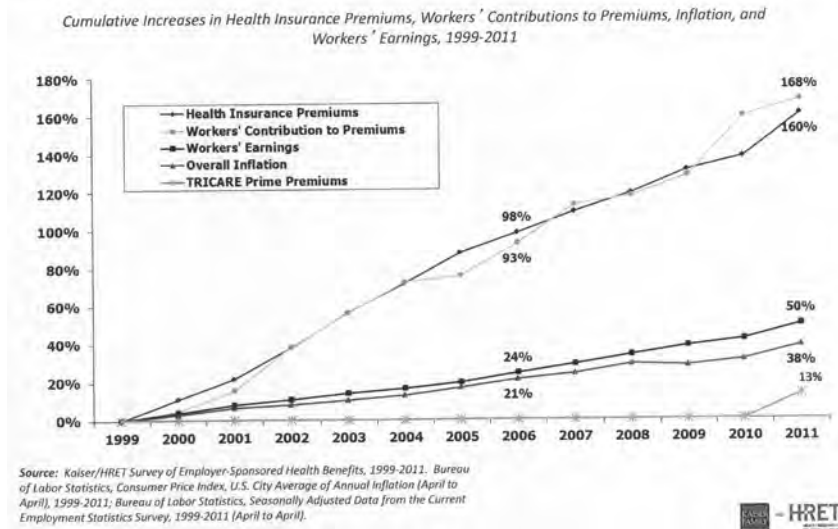
Dr. WOODSON. The answer is no because if you look at that slide, again headquarters function, while we want to squeeze that lemon very hard, only represents about 2 percent of really our costs. So the headquarters function is not going to get us to where we need to go.

The other thing that you have to remember is that it is about putting the program on a sustainable course so that it will be there for future generations and men and women who stand up and raise their right hand and say I will protect and defend, that a benefit will be there, a generous benefit will be there, to take care of their lifelong needs and medical care. The issue is that because we have had prohibitions for 16 years, we actually are far behind the curve and not on a sustainable course.

Put up number 4 there, please.

[The chart referred to follows:]

Private Sector Premiums Have Outstripped General Inflation & Wages
TRICARE Retiree Premium Increases Were Zero, Still Well Below Private Sector Experience



Dr. WOODSON. I want to show to you how dramatic this is. If you look at particularly the private sector—and I know we do not want to talk about comparisons—over the course of the last decade or so, contributions to premium costs in health care have gone up 168 percent. Premium costs have gone up 160 percent. If you look at the blue line at the bottom, you can see that there has been no increase until last year when we had these very modest increases of \$2.50 per month for singles and \$5 a month for families.

The issue is that we have not been on a sustainable course, and we need to certainly slightly rebalance it. With all of the proposals, we will not go back to what was the original agreed upon cost share. We will only be at half of that, but we will be on a more sustainable course. This is about a national security issue that goes on for decades.

Senator AYOTTE. This in my view—with all respect to the private sector, they do not endure what our soldiers do in battle—

Dr. WOODSON. I understand.

Senator AYOTTE.—or shot at—the things that they have to experience. So I do not find the comparison good.

I think that if we as Congress would actually say that this is a commitment we want to follow through on, that we could find a way to do it if we are willing to take on entitlements, if we are willing to take on the rest of the budget rather than you all trying to find a way to pass this on to our veterans in the first instance. That is my big-picture concern here.

But I understand that health care is going up everywhere, but I do not find the comparison the same.

Senator WEBB. Let me just have the final word here, seeing as I have the gavel. [Laughter.]

Just a couple of things. This is almost going the way that the lawyer hearing went when we had all the Judge Advocates General up here. It is going for another half hour.

We will have further discussion about this and we will actually want to come back to you again, Secretary Woodson. There are some data that I may want.

But let me just make three final points here in terms of where our concerns are.

First, I understand the hand that you are dealt. I spent 5 years in the building. I was on the Defense Resources Board for 4 years. I understand the hand you are dealt.

Second, I understand the notion of getting a sustainable course. The difficulty here is if you are going to look at the back end after someone has completed their career, that is a different situation than analyzing the whole context of the moral contract that goes into service. That is a concern.

Then third, the reason I put that chart up there with Medicare Part B is I do not think there are very many members up here who understand that a military retiree has to buy into Medicare Part B before they get TRICARE For Life. They do not understand that. They see the little bar at the very top, the red part of the bar. They do not understand the blue part. I think I got that right. So it is an important part of the decision process up here when people look at that because it does not show up in the DOD budget, but it does show up in somebody's bank account.

So we will continue this discussion. Again, I very much appreciate your all coming to testify today.

This hearing is adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR MARK BEGICH

TRICARE WEST

1. Senator BEGICH. Dr. Woodson, I understand you made a decision recently on the TRICARE contract in the West Region, which serves my home State of Alaska. As you know, Alaska is just beginning to move towards delivering military care in a somewhat similar manner as is done in the lower 48 States. It's been a long and challenging process. So, the decision on the contract award will have a substantial impact on my constituents. I understand this award went to the higher price bidder. The contract award process is more detailed than simply price, but price is pretty important these days. Is it accurate that the contract was awarded to a higher bidder?

Dr. WOODSON. Yes, the contract was awarded to the higher priced offeror. The source selection factors for this solicitation gave greater weight to technical and performance-related factors than to cost and price-related factors. The Source Selection Authority compared offers and, within the parameters of this authority, determined that the higher price was more than offset by the added value offered.

2. Senator BEGICH. Dr. Woodson, will you provide me with a full briefing on the decision from the Department of Defense (DOD) so I may better understand it, as it will have a tremendous impact on all men and women in uniform, but especially on constituents in Alaska, as we don't want to go backwards with progress that has been made in the State.

Dr. WOODSON. I would be happy to arrange for a briefing once this protest is settled. The decision in the West is under protest and a briefing prior to the outcome of that proceeding would be guide limited.

TRICARE INCREASES

3. Senator BEGICH. Secretary Hale and Dr. Woodson, in years past, DOD has proposed to increase TRICARE fees, and thereby achieve savings, that were based in part on the principle that beneficiaries would either opt out of TRICARE completely, or decrease the amount of health care they used. This year DOD's proposal for TRICARE Prime enrollment fees is for a first-year increase of 30 percent to 78 percent. That, plus other increases in health care costs to retirees, will result in \$12 billion in savings to DOD over 5 years. How much revenue does DOD expect to generate from the proposed fee increases?

Mr. HALE and Dr. WOODSON. The fiscal year 2013 health reform proposals are expected to save DOD a total of \$12.9 billion through fiscal year 2017. These savings are derived from four effects:

- First, we project some savings from stopping and reversing the increase in the number of retirees who use TRICARE as their primary health insurance vice using their employer-sponsored insurance. In fiscal year 2000, approximately 60 percent of retirees relied on TRICARE. Today, it is roughly 84 percent with projections that it will reach 90 percent by fiscal year 2017. Our estimate is that these proposals will reduce this reliance to 79 percent, roughly what it was in fiscal year 2008. For fiscal year 2013, these savings amount to \$201 million.
- Second, we project a minor decrease in health care utilization due to the higher fees.
- Third, we project that beneficiaries will use health care options that are less costly for DOD. We project more beneficiaries will use TRICARE Standard vice Prime, that they will use more generic prescriptions vice brand, and that they will use military treatment facility (MTF) and mail order vice retail pharmacies.
- Finally, there is the direct savings from increased fees that will offset DOD's cost of health care.

For fiscal year 2013–fiscal year 2021, we project that 25 percent of the savings will come from the increased reliance on employer-sponsored health care, 7 percent of the savings will come from the decrease in utilization, 28 percent will come from the use of less costly options, and that 40 percent will come directly from the increased fees.

4. Senator BEGICH. Secretary Hale and Dr. Woodson, how much does DOD expect to save from beneficiaries changing their behavior with regard to health care use?

Mr. HALE and Dr. WOODSON. The fiscal year 2013 health reform proposals are expected to save DOD a total of \$12.9 billion through fiscal year 2017. These savings are derived from four effects:

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PERSONNEL DECREASES

5. Senator BEGICH. Secretary Rooney, DOD is proposing a decrease of 8,000 personnel in fiscal year 2013. How did DOD determine 8,000 personnel decreases were feasible and will not undermine the workforce?

Dr. ROONEY. DOD's fiscal year 2013 budget request, including the proposed reduction in personnel, reflects a balanced workforce that decreases overall spending on military end strength and DOD's Federal civilian workforce, as well as on contract services. It reflects our best judgment today and represents a carefully coordinated approach based on DOD's strategy and policy that balances operational needs and fiscal reality without placing national security and our overall defense posture at risk. Proposed reductions in the military personnel levels reflect declines in our current overseas commitments; revised strategy, posture, and operational planning; and changes to our force structure. Reductions in civilian personnel are predominantly associated with ongoing organizational assessments and mission/function prioritization in an effort to reduce administrative workload. These reductions preserve DOD's civilian workforce's capability to perform key enabling functions for the operating forces, such as critical training and preparation to ensure readiness, equipment modernization and reset, medical care, family support, and base operating and infrastructure services—all vital services that support our men and women in uniform and help meet the Nation's security needs.

6. Senator BEGICH. Secretary Rooney, what assessment was conducted?

Dr. ROONEY. The reductions in the workforce reflect, in part, a continuation of DOD's efficiency initiative, directed by Secretary Gates and first included in the fiscal year 2012 budget. Specifically, they reflect the direction given to complete organizational assessments and mission/function prioritization, reflecting DOD's commitment to challenge workload requirements and more appropriately size the workforce to meet the most pressing and critical priorities with a focus on reducing administrative functions associated with headquarters staffs. Additional reductions planned and reflected in the fiscal year 2013 budget correlate to changes in DOD's force structure, strategy, posture, and operational tempo.

7. Senator BEGICH. Secretary Rooney, of the 8,000 civilian personnel reduction, please provide how many each Service will have to decrease by and in what areas—base support, et cetera.

Dr. ROONEY. Total U.S. Direct Hire (USDH) full-time equivalents (FTE) decreased by 7,367 from the fiscal year 2012 level of 751,172 to the fiscal year 2013 level of 743,805. There was a net decrease of USDH (reimbursable) FTEs of 12,194 (see charts by Service component and appropriation below), which were offset by a net growth of 4,827 USDH (direct) FTEs, resulting in the overall decrease of 7,367.

- The decrease in USDH reimbursable FTEs is primarily in the Military Departments' Operation and Maintenance and Revolving Funds accounts, as shown in the chart attached. Reimbursable functions include logistical support functions such as depot-level equipment/aircraft repair and maintenance and ship maintenance and operations.
- Of the Defense-wide reductions, 306 USDH reimbursable FTEs were converted to USDH direct FTEs. The remaining Defense-wide reductions were in the drug demand reduction and intelligence programs.

Table. USDH (reimbursable) FTE decreases by Service component and appropriation)

USDH (REIMB)	Operation and Maintenance				Revolving Funds			
	FY 2012	FY 2013	Difference	% Change	FY 2012	FY 2013	Difference	% Change
Army	63,673	55,250	(8,423)	-13.2%	23,059	23,537	478	2.1%
DoN	28,927	27,471	(1,456)	-5.0%	76,653	76,067	(586)	-0.8%
Air Force	16,244	15,769	(475)	-2.9%	31,731	30,648	(1,083)	-3.4%
Defense- wide	2,678	2,325	(353)	-13.2%	55,762	55,896	134	0.2%
Total	111,522	100,815	(10,707)	-9.6%	187,205	186,148	(1,057)	-0.6%

USDH (REIMB)	Family Housing				Military Construction			
	FY 2012	FY 2013	Difference	% Change	FY 2012	FY 2013	Difference	% Change
Army	0	0	-		5459	5398	(61)	-1.1%
DoN	4	4	-	0.0%			-	
Air Force			-					
Defense- wide			-					
Total	4	4	-	0.0%	5,459	5,398	(61)	-1.1%

USDH (REIMB)	RDT&E				MAP Federal Funds			
	FY 2012	FY 2013	Difference	% Change	FY 2012	FY 2013	Difference	% Change
Army	9441	9187	(254)	-2.7%	12	13	1	8%
DoN	558	557	(1)	-0.2%			-	
Air Force	1586	1466	(120)	-7.6%			-	
Defense- wide	333	338	5	1.5%			-	
Total	11,918	11,548	(370)	-3.1%	12	13	1	8.3%

USDH (REIMB)	TOTAL			
	FY 2012	FY 2013	Difference	% Change
Army	101,644	93,385	(8,259)	-8.1%
DoN	106,142	104,099	(2,043)	-1.9%
Air Force	49,561	47,883	(1,678)	-3.4%
Defense- wide	58,773	58,559	(214)	-0.4%
Total	316,120	303,926	(12,194)	-3.9%

JOINT BASING

8. Senator BEGICH. Secretary Rooney, you mention in your written testimony submitted for the record that there have been some exceptions for growth and increases to the civilian workforce—to include joint basing requirements for the Navy and Air Force. Why have these exemptions not also been extended to Air Force and Army joint bases—such as Joint Base Elmendorf-Richardson (JBER)?

Dr. ROONEY. When DOD directed its components to hold civilian funding to fiscal year 2010 levels, we recognized that some allowances had to be made for new missions or legislative requirements. One such allowance, as needed, was for implementing certain Base Realignment and Closure (BRAC) 2005 directed initiatives associated with selected joint basing agreements.

Joint basing generated civilian workforce transfers between the Services. As a result, both the Air Force and Navy increased, while the Army saw its civilian workforce decrease as joint basing was implemented. Therefore, the Army did not require a growth exception for joint basing. Based on workforce shifts of installation support realignments, the Navy and Air Force requested exceptions to their overall civilian workforce levels. Based on overall joint basing requirements, the Army did not request an exception.

9. Senator BEGICH. Secretary Rooney, I am concerned the Air Force, as the installation's executive agent, is not meeting joint basing requirements at JBER. JBER lost more than 220 civilian personnel billets previously identified as necessary to accommodate joint basing and the increase in Army end strength at the installation. Has the Air Force sought exceptions for joint bases where they are the lead or just the tenant? Why or why not?

Dr. ROONEY. The Air Force actively sought exceptions to protect civilian growth associated with joint basing, acquisition excellence, plus operations and maintenance in-sourcing. While some exceptions were granted, DOD had to also respond to the Budget Control Act (BCA) of 2011. As such, the Air Force focused on reductions in overhead and support areas while minimizing the impact to functions tied to joint basing, acquisition excellence, the nuclear enterprise, and its flying missions.

BRAC 2005 created joint basing as a means to identify, capture, and continue significant savings through consolidation thus freeing resources for other priorities. The joint bases for which the Air Force is the last Service are now in the process of reducing some of its previously planned growth by consolidating and centralizing many base support functions; examples include the "Tailoring Installation Support" and "Civil Engineer Transformation" initiatives. Their joint base commanders have the authority to, and will, reallocate manpower and dollars across their functions to maximize capabilities while mitigating impact to the services they provide. In spite of these fiscal challenges, Air Force remains committed to joint basing while meeting or exceeding the needs of our mission customers.

BASE SERVICES

10. Senator BEGICH. Secretary Rooney, as you know, to meet the fiscal year 2010 cap, the Services decreased civilian personnel primarily in base support services. Do you have any concerns the Services will take the additional reductions in base support services and thereby compromise quality of life and installation support?

Dr. ROONEY. No, I am not concerned that quality of life and installation support will suffer. The reductions in DOD's civilian workforce, including those in base support services, are correlated to workload and based on mission/function prioritization, reflecting the changes in DOD's strategy and force structure. DOD has established an internal, multi-level governance process for monitoring implementation of all efficiencies and associated budget reductions. Through such governance processes, the Service and Department's leadership ensures that base operating and infrastructure services, critical training to ensure readiness, equipment modernization and reset, medical care, and family support are delivered in a manner and with sufficient personnel to maintain quality of life and warfighting capabilities.

SEPARATION

11. Senator BEGICH. Secretary Rooney, I understand it is DOD's intent to utilize voluntary separation measures when implementing civilian personnel reductions. Yet, most applicants are being turned down when they apply for voluntary separation or retirement. In these economic times, a lay-off is unacceptable. Does DOD have the flexibility it needs to utilize voluntary incentives to the fullest?

Dr. ROONEY. Yes, these incentives have served DOD well in avoiding involuntary separations. In accordance with the governing statute, Voluntary Separation Incentive Pay (VSIP) and/or Voluntary Early Retirement Authority (VERA) can only be granted when a voluntary separation would avert an involuntary separation, or when the vacated position can be restructured to meet organizational needs. It is management's responsibility to determine when it is necessary to use these authorities and to determine who is in the eligible population. As a result, employees who do not work in areas targeted for VSIP/VERA are not eligible and they generally represent the group of applicants who claim they are being turned down.

To minimize involuntary separations, DOD has a statutory limit of 25,000 VSIP payments annually. We do not anticipate exceeding the statutory limit in the current environment. There is no ceiling on VERA, but the number may be limited by the 25,000 VSIP limit because most employees who apply for VERA also apply for VSIP. In fiscal year 2011, DOD approved 3,854 VSIPs and 712 VERAs (649 with VSIP). As of March 31, 2012, DOD has approved approximately the same number of VSIPs and VERAs as it did in fiscal year 2011.

If the use of voluntary separation incentives does not avoid the need for involuntary separations, DOD relies on the DOD Priority Placement Program (PPP), DOD's

civilian career transition assistance program. When employees are scheduled for displacement due to downsizing or organizational restructuring, they receive hiring preference for DOD job vacancies through the PPP. Almost 260,000 civilians have been successfully placed through this program, and it remains the centerpiece of DOD's overall efforts to maintain a stable workforce.

Voluntary Separation Incentive Pay Approved

	Fiscal Year			
	2009	2010	2011	2012 (1st and 2nd qtr)
Army	820	790	2,143	1,679
Navy	364	540	812	265
Air Force	496	236	247	1,107
Other DOD	313	463	652	427
Total	1,993	2,029	3,854	3,496

Voluntary Early Retirement Authorities Approved

	Fiscal Year			
	2009	2010	2011	2012 (1st and 2nd qtr)
Army	280	250	250	399
	(241 with VSIP)	(197 with VSIP)	(234 with VSIP)	(381 with VSIP)
Navy	149	150	186	71
	(102 with VSIP)	(125 with VSIP)	(175 with VSIP)	(60 with VSIP)
Air Force	157	107	142	247
	(151 with VSIP)	(99 with VSIP)	(136 with VSIP)	(241 with VSIP)
Other DOD	173	293	134	77
	(108 with VSIP)	(157 with VSIP)	114 with VSIP)	(74 with VSIP)
Total	759	800	712	794
	(602 with VSIP)	(578 with VSIP)	(659 with VSIP)	(794 with VSIP)

12. Senator BEGICH. Secretary Rooney, are there legal restrictions or barriers to more lenient use to avoid a reduction in force?

Dr. ROONEY. Yes. As explained in my previous response, VSIP and the VERA are governed by law. Section 9902 of Title 5 of the U.S. Code, imposes limits on the Secretary's independent authority to use these separation incentives. These tools may only be used for two purposes:

1. To reduce involuntary separations that would otherwise occur.
2. To restructure the workforce to meet mission objectives without reducing the overall number of personnel. We cannot approve VSIP or VERA requests unless the voluntary separations would achieve one of the two specified purposes.

FAMILY SUPPORT

13. Senator BEGICH. Secretary Rooney, family support programs are protected in the budget but indications are they will not see any growth in budget in the out-years. How does DOD intend to ensure funding of family support programs keeps pace with inflation?

Dr. ROONEY. To ensure that funding of family support programs keeps pace with inflation and family programs are not reduced, I emphasized the need for Services to safeguard and sustain funding levels for their family programs. This resulted in implementation of a Comptroller-mandated, in-depth, mid-year review of the Services' budgets. The Services are in the process of scrutinizing their budgets, tracking program funding, and disclosing discrepancies that could indicate diversion of funds from programs for which the funds were originally intended. Ongoing tracking of budgets and reporting on status of budgets supports the Secretary's position of "keeping faith" with servicemembers and their families to protect family assistance programs. Additionally, resourcing plans must maximize leveraging community-based organizations that offer legitimate resources to support and empower our

military families. DOD's ability to adapt programs and establish partnerships that more effectively and efficiently meet the needs of our military families are key to DOD's continued success in an ever more fiscally-constrained environment.

ASSIGNMENTS FOR WOMEN

14. Senator BEGICH. Secretary Rooney, I've long been an advocate for eliminating assignment restrictions for women in the military. Please describe the recent DOD changes with respect to women serving in the military.

Dr. ROONEY. On February 9, the Secretary of Defense notified Congress of his intention to remove the co-location restriction and permit an exception to policy that allows women to be assigned to the battalion-level of specific direct ground combat units. Co-located positions are not part of ground combat units, but by virtue of the duties or missions involved, must be co-located with the ground combat units. In addition, positions opened under an exception to the existing DOD policy permit assignment of women to specific direct ground combat battalions in select occupations open to women. The experience gained by assigning women to these select positions will help assess the suitability and contemporary relevance of the direct ground combat unit assignment prohibition and inform future policy decisions. In total, 14,325 positions are opening as a result of these changes. The Services will begin implementing these changes effective May 14, 2012.

15. Senator BEGICH. Secretary Rooney, what more is DOD doing to give women a larger role in the Services?

Dr. ROONEY. See response to question #14.

RESERVE COMPONENT

16. Senator BEGICH. Mr. McGinnis, I was pleased in your opening statement that you mention the Innovative Readiness Training (IRT) program. I am pleased to see this program's funding remained stable in the budget request at \$20 million. Please elaborate on the benefits of the program to our Reserve component and civilian and military partnerships.

Mr. MCGINNIS. The IRT program provides real world training opportunities for DOD servicemembers, which prepares them for wartime missions while supporting the needs of America's underserved communities, many in rural areas. Through this program, the National Guard and Reserve and various Active component military units refine their planning, logistical, engineering, health care, driving, and transportation skills by performing services and developing projects in and for communities that otherwise would not have the resources to conduct them on their own. In many cases, the community provides the materials and the military provides the manpower, equipment, and training to sustain the improvements.

This year, along with significant training in logistics, joint operational planning, coordination, and communication, Navy Seabees, Marine Combat Engineers, Army Reserve, and Air Force Red Horse teams will gain vertical and horizontal engineering experience. In West Virginia, over 1,300 Reserve component engineers and support personnel will build roads and helipads. In New Mexico, houses for homeless Navajos will be constructed, and in Arizona, a school for exceptional children will expand.

In Arkansas last year, 5 communities were provided much needed medical, dental, optometry, and veterinary care; over 6,000 residents received direct medical care. Just last month, over 10,000 residents of Kauai, HI received similar medical services and 3,500 pairs of glasses were fabricated. Currently, the Arctic Care mission is underway in 16 villages in partnership with the Norton Sound Health Corporation in Nome, AK. Next month, three rural communities in Alabama will provide the back drop for medical training and many residents will receive much needed health care. Over 300 military medical personnel train at each of these health care missions.

As overseas military operations wind down in the coming years, it is imperative to have sustainment training opportunities available to the Guard and Reserve. This program provides that unique niche of high-value mission essential training in support of the Nation's underserved and remote communities.

17. Senator BEGICH. Mr. McGinnis, you highlight the alarming Reserve component unemployment rate in your testimony. I understand the Army Reserves has a program called the Employer Partnership of the Armed Forces (EPAF). This program is having tremendous success ensuring members are trained and receive cre-

dentials for civilian work while staying qualified for their military work. The Army Reserves is working hand-in-hand with employers to understand what credentials and skill sets are required for employment, training the force, and then placing members into jobs. Are you familiar with this program?

Mr. MCGINNIS. Yes, my office is very familiar with this program. The EPAF was developed by the Office of the Chief, Army Reserve to work with employers to facilitate employment opportunities for Army reservists. After careful review of the success of EPAF, and with the concurrence of the Chief, Army Reserve, EPAF has transitioned to a multi-Service program known as "Hero2Hired (H2H)", which is administered by my office, and is available for use by servicemembers in all seven Reserve components. H2H, with a web site H2H.jobs, retains many of the great features and lessons learned in EPAF and has expanded tools designed to provide outreach, support, and mentorship to the unique Reserve component population. The tools help all unemployed and under-employed Reserve component servicemembers and spouses with employment assistance.

18. Senator BEGICH. Mr. McGinnis, how is DOD leveraging the lessons learned from successful initiatives such as this one?

Mr. MCGINNIS. The Yellow Ribbon Reintegration Program (YRRP) applies lessons learned to its operations on a continuous basis, constantly improving the quality of curriculum, materials, and resources provided to the Service components. H2H is a program provided by YRRP to address the needs of unemployed and under-employed Reserve component servicemembers. YRRP also made significant enhancements to the DOD YRRP Center for Excellence whose primary mission is to gather lessons learned, conduct analysis, and propagate the end results throughout the Services for their use.

19. Senator BEGICH. Mr. McGinnis, the 168th Air National Guard Wing at Eielson Air Force Base has a critical need for a communications facility. Unfortunately, funding for this facility has not been provided and funding for it continues to slip into the future years. Without construction and modifications to the existing facility, communications will fail for this wing. Would you please look into this issue and provide an update?

Mr. MCGINNIS. While my office provides policy oversight of the Reserve components, any final decisions on construction and funding for National Guard facilities falls within the purview of the Services. As such, my office did not play a direct role in any ultimate decisions related to the 168th. However, upon reviewing the matter, I was informed of the following information:

The communications facility is scheduled for design and subsequent construction in fiscal years 2012 and 2013. This facility requirement was reviewed and found to be better suited for accomplishment using a combination of minor construction and sustainment, restoration, and modernization (SRM) funds instead of military construction (MILCON) funds.

The project calls for a repair of the existing roof, construction of an addition, and renovation of the existing space. The roof was repaired in 2011. Construction of a 3,650-square-foot addition for \$2 million is under design for the fiscal year 2012 program and will be executed using minor construction funding. A companion project renovating 5,504 square feet for \$1.85 million is under design for the fiscal year 2013 program.

20. Senator BEGICH. Mr. McGinnis, I am especially concerned with the decreases proposed by the Air Force in Air Guard equipment and manning. What role did you play in the deliberations this year and what role did the States play?

Mr. MCGINNIS. The Assistant Secretary of Defense for Reserve Affairs serves as an advisor to the Secretary of Defense through the Under Secretary of Defense for Personnel and Readiness on all matters pertaining to the planning, programming, budgeting, and execution system for the Reserve components within DOD.

The budgets are developed by the Secretaries of the Services based on their views of the future of their Services. The role of Reserve Affairs is to advise the Secretary of Defense, but we do not play a direct role in development of these budgets. However, we did participate in the Office of the Secretary of Defense review of the Services' budget submissions.

I am not aware of whether the States Adjutants General were involved in the development of this budget. It is the responsibility of the Service Secretaries to communicate, through the National Guard Bureau, with the State Governors and representatives, and I fully support that interaction and communication. If that was done this year, my office would not necessarily have played a role.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

SEQUESTRATION

21. Senator GRAHAM. Secretary Hale, the BCA requires DOD to reduce all major accounts by a total of \$492 billion over 10 years. Secretary of Defense Panetta has said that this would have a catastrophic impact on our military and its ability to protect this country. What is the impact on military readiness, equipment, and training?

Mr. HALE. The initial impact of these reductions would come from a potential sequestration in January 2013. DOD is concerned that the sequestration process would have significant consequences due to the uncertainty surrounding the process and the rigid formula which Congress has prescribed for its application. Assuming the Fiscal Year 2013 Defense Appropriations Act Conference Report contains language similar to the Joint Explanatory Statement of the Committee of Conference accompanying Division A—Department of Defense Appropriations Act, 2012, DOD would be forced to reduce each line item within each procurement appropriation by the same percentage and each program element within each research and development appropriation by the same percentage. This percentage would be calculated based on the budgetary resources, primarily the enacted fiscal year 2013 appropriation and any unobligated balances carried forward at the end of fiscal year 2012. Some examples of the problems this method would cause are found in line items such as those for a ship, where it is not feasible to buy a fraction of a ship, or in a line item funding a multiyear contract where a fraction of the funding would not be sufficient to pay the negotiated cost of the multiyear contract. With over 1,500 individual line items in these accounts, DOD could not fix all of these issues with the transfer authority that Congress typically provides; this would leave broken programs across all of these accounts within DOD. Finally, sequestration would force an immediate percentage reduction in our operation and maintenance accounts which would impact readiness. Funding provided for overseas contingency operations is not excluded from sequestration.

The fiscal year 2014 and subsequent budgets will be developed using DOD's planning, programming, budgeting, and execution process. Changes to our budget required by revised caps on the defense budget will be managed through this process to best allocate potential reductions to the currently planned funding to protect our highest priorities. As changes of this magnitude will impact all aspects of DOD's budget, the process will be implemented in coordination with the White House and the Office of Management and Budget (OMB).

22. Senator GRAHAM. Secretary Rooney, if sequestration is allowed to go forward, are we creating a hollow force and diminished support for military families and schools?

Dr. ROONEY. I share your concerns about the devastating impact of further automatic cuts should Congress fail to enact additional deficit reduction measures.

As the Secretary testified on February 29 to the House Budget Committee, sequester would subject DOD to another roughly \$500 billion in additional cuts over the next 9 years. In fiscal year 2013, these cuts would have to be implemented with limited flexibility. These changes could hollow out the force and inflict severe damage to our national defense and programs that are vital to our quality of life.

23. Senator GRAHAM. Mr. McGinnis, I am concerned about the current cuts in the Reserve and National Guard. What greater catastrophe looms in the event of sequestration for the Reserve component?

Mr. MCGINNIS. The fiscal year 2013 budget submission supports the National Defense Strategy and will enable our Reserve components to continue to fulfill their vital national security role. The current budget provides funding and programmatic support for the training, equipping, recruiting, and retaining of the Guard and Reserve. Sequestration will have a direct impact on the operations, maintenance, and training of our Reserve components and can run the risk of preventing the ability of the National Guard and Reserve to provide trained, ready, and cost-effective forces that can be employed not only for unanticipated national crises, but also on a regular operational basis, providing strategic depth for large-scale contingencies. The extent of the impacts of sequestration will depend on congressional action or inaction, OMB guidance, and the measures each Service employs to implement those measures.

24. Senator GRAHAM. Dr. Woodson, will access and quality of medical care decline in the event of sequestration?

Dr. WOODSON. See response to question #22.

25. Senator GRAHAM. Secretary Rooney, Secretary Hale, Mr. McGinnis, and Dr. Woodson, are you currently conducting any planning in your areas of responsibility (AOR) for the impact of sequestration, and if so, how are you assessing and mitigating the risk of the potential cuts beginning in January 2013?

Dr. ROONEY, Mr. MCGINNIS, and Dr. WOODSON. The President's budget makes the necessary budget adjustments to avoid devastating DOD through sequestration. If sequestration becomes an inevitability, DOD will evaluate all options available to comply with the law.

Mr. HALE. Consistent with direction from OMB, DOD did not reflect the effects of the sequestration in its fiscal year 2013 budget submission. The President's budget proposes over \$4 trillion in balanced deficit reduction, which Congress could enact and avoid sequestration. DOD is not currently planning for sequestration. OMB has not directed agencies, including DOD, to initiate any plans for sequestration.

REDUCTIONS IN ACTIVE DUTY END STRENGTH

26. Senator GRAHAM. Secretary Rooney, despite ongoing combat operations, it seems clear that budgetary pressures are going to force reductions in the number of Active Duty military personnel: Army down 49,000; Navy down 9,000; and Marine Corps down 16,000. The Air Force will downsize to prevent exceeding its end strength limit, due to high retention. I am concerned about the need for advance planning to implement cuts like these, and particularly with respect to the ground forces, the effect this may have on morale and readiness in the present. How will cuts in the Army and Marine Corps affect dwell time, assuming we are still deploying units to Afghanistan?

Dr. ROONEY. In the near-term, the pace of the reductions will account for the completion of our mission in Afghanistan and provide the resiliency that comes with sufficient dwell times.

In the long-term, these reductions are consistent with our plan to transition to the new strategic guidance—to build a force that is smaller, more agile, and able to adapt to an uncertain future security environment.

The Services are shaping their future force structure in ways that protect their ability to maintain and regenerate capabilities needed to meet future, unforeseen demands, maintaining intellectual capital and rank structure that could be called upon to expand key elements of the force. For those critical skill sets, there will be a need to keep on hand some of the specialized infrastructure (people, facilities, training curricula), or seed corn, that will enable a new capability to be developed in a timely manner. Keeping experienced mid-grade officers and noncommissioned officers will also be key. The seed corn and the experience will need to be properly balanced between the Active and the Reserve components.

27. Senator GRAHAM. Secretary Rooney, if we are unable to find the mandatory spending authority for the force shaping legislation you would like to have (such as early retirement authority and more Selective Early Retirement authority), what measures would you have to use to achieve these reductions?

Dr. ROONEY. We currently have a limited number of force management tools we can use to achieve these reductions. They include, but are not limited to: Selective Early Retirement Board (SERB), Temporary Early Retirement Authority (TERA), Voluntary Retirement Incentive (VRI), and Voluntary Separation Pay (VSP).

The reinstatement of Enhanced SERB authority, the extension of Early Discharge or Reduction in Force (RIF) authority, and expanded Time-in-Grade waiver authority, combined with the use of the current authorities, will allow the Services to execute a very balanced drawdown. These additional authorities allow us to shape the force with greater flexibility and fidelity.

ARMY AND AIR NATIONAL GUARD

28. Senator GRAHAM. Mr. McGinnis, I'm interested in your views on the role of the Army and Air National Guard. There is no question that Guardsmen have been essential contributors in Iraq and Afghanistan. In the future, in an era of tight budgets, we need to have a clear understanding from the Army and Air Force about how the National Guard will and should best be employed. What is your view of the appropriate role of the National Guard? Stated differently, what does the term "operational reserve" look like for the National Guard as it's implemented over the Future Year Defense Program (FYDP)?

Mr. MCGINNIS. Missions that are predictable and long-lasting are particularly well suited to the Guard and Reserve. This was clearly established in the Comprehensive Review of the Future Roles of the Reserve Component approved by Secretary Gates on April 27, 2011. The legislation expanding authority in title 10, section 12304, that was passed last year, facilitates this type of utilization. The Guard and Reserve have proven themselves over the last 10 years. From a cost and readiness point of view, their continued use makes good sense. Placing Reserve component units and individuals in service force generation models with appropriate levels of resourcing makes full use of the Total Force. It also relieves stress on the Active Force, permits the Active Force to train for full spectrum operations, and maintains the readiness levels of the Reserve component.

29. Senator GRAHAM. Mr. McGinnis, data from the Air National Guard suggests that operating under today's deployment constraints, the Air Guard costs only 53 percent of an equivalent Active Duty Air Force Major Command. In light of the cost effectiveness of the Guard and Reserve, why do you support cutting the Reserve capability in the Navy and the Air Force?

Mr. MCGINNIS. The current National Guard and Reserve is, arguably, the most combat seasoned Reserve Force ever, and DOD seeks to capitalize on this significant investment to provide needed military capacity during current austere economic times. Since 2001, Reserve component units and individuals have been heavily employed across the full spectrum of military operations ranging from combat missions overseas to Homeland emergencies and national special security events. They have consistently demonstrated their readiness and enduring value.

To ensure the Reserve component can continue to provide operational reserve and strategic capabilities, DOD included funding and programs in its fiscal year 2013 budget request for their training, equipping, recruiting, and retention. I believe the service force generation models provide the best mechanism to maintain a ready Reserve component force that can routinely contribute to the operational force. As discussed in the recently released Comprehensive Review of the Future Role of the Reserve Component, I continue to strongly advocate for the value that the Guard and Reserve can bring to the force mix equation; value that leverage cost differentials, attainable readiness, and inherent strategic depth. I intend to continue to work closely with the Services and Joint Staff to ensure a ready Reserve component that contributes to the most efficient delivery of required capabilities of the Total Force.

30. Senator GRAHAM. Mr. McGinnis, why is this the correct strategy, either from a fiscal or readiness point of view?

Mr. MCGINNIS. Even as the pace of operations declines, placing the Reserve components in the Service rotational models expands readiness, permits the Active Force to reset and train, and provides an efficient use of the Total Force. There are currently ongoing studies that will provide further guidance on the appropriate force mix to achieve the right balance of Active and Reserve components to provide the necessary capabilities across the spectrum of operations to effectively support the national defense strategy.

CYBERSECURITY

31. Senator GRAHAM. Secretary Rooney, defense against cyberattacks is on every American's mind and DOD obviously has a big role to play and much at stake in this threat. What policies are being implemented to increase the skills and numbers of civilian and military personnel with cybersecurity skills?

Dr. ROONEY. To increase the cybersecurity skills of civilian and military personnel, DOD is updating its current information technology (IT) and information assurance workforce management guidance and enhancing training and education offerings. DOD is in the process of establishing policy and procedural requirements for the cyberspace workforce, leveraging the basic concepts of previous issuances, DOD Directive 8570.01, "Information Assurance Training, Certification and Workforce Management," and DOD 8570.01-M, "Information Assurance Workforce Improvement Program." In addition, under oversight of the DOD CIO, the Information Resources Management College (iCollege) of the National Defense University has restructured its cybersecurity certificate program and recently introduced a cyber leadership program.

DOD continues to explore optimal tools for recruitment and retention. Efforts include establishing a 2-year pilot program to use the DOD Information Assurance Scholarship Program to develop IT acquisition personnel with cybersecurity skill sets; working with the Office of Personnel Management to extend and enhance the

Cybersecurity Schedule A Hiring Authority (currently due to expire in December 2012); and developing a new cyberaptitude test to support military recruiting efforts.

32. Senator GRAHAM. Secretary Rooney, how are you avoiding duplication of efforts to train and recruit these specialists across the Federal Government as cited by the Government Accountability Office (GAO)?

Dr. ROONEY. In light of emerging cyberthreats, cyberworkforce roles, responsibilities, and skill requirements continue to evolve, not only in DOD, but across the Federal Government. DOD is working on Federal-wide efforts through the National Initiative for Cybersecurity Education (NICE) and Federal CIO Council to establish a common lexicon across government and the private sector; identify current and emerging cyberskill requirements; and develop relevant education, training, and recruitment strategies. Also, DOD is developing a directive to establish policy and guidance for the management of the workforce in the cyberspace domain which will include an American National Standards Institute (ANSI) accredited, commercial certification requirement, as appropriate. Collaborations with other Federal Government entities and the use of commercial certification providers reduce duplication by establishing a baseline that can be applied across the Government, while still allowing DOD, or component-specific training based on relevant threat or mission profiles.

33. Senator GRAHAM. Mr. McGinnis, how can the Reserve components be used creatively to enhance DOD's strength in this important area?

Mr. MCGINNIS. Many cybersecurity personnel in the Reserves are at the forefront of that industry in their employment as civilians. Within this evolving domain, Reserve components offer DOD the wide range of opportunity, flexibility, and depth of expertise that is difficult to capture within Active Forces. The Active component cyberworkforce and Active Duty missions are focused and scoped to meet the day-to-day Service-specific needs, limiting the ability to maneuver or plus-up in a crisis or a shift in threat.

This originates from the depth and currency of expertise that individual reservists bring from their civilian positions that is not now captured in the training and development of the Active component cyberforces. Changes in the cyberindustry are rapid and the capacity for those changes to be reflected in Service cyberschools is slower than it is in industry. Reservists bring to the fight depth and up-to-date information which is then rapidly shared and infused into the Active component mission.

DISABILITY EVALUATION SYSTEM

34. Senator GRAHAM. Secretary Rooney, do you agree that we have a large and growing problem for wounded and ill servicemembers who are in need of disability evaluation?

Dr. ROONEY. More than a decade of war has increased DOD's disability caseload but we are committed to ensuring that the evaluation and compensation of our wounded and ill servicemembers is fair, correct, and thorough. Many of these wounded and ill servicemembers suffer from highly complex injuries that take time to manifest, properly diagnose, and evaluate. DOD evaluated 18,393 servicemembers for disability during 2011, about the same number as in 2010 and about 22 percent more than in 2001. More than 50 percent of those DOD evaluated in 2011 went through the legacy process. Since November 2007, 49,478 servicemembers have entered and 19,518 have completed the Integrated Disability Evaluation System (IDES). Today, fewer than 2,000 servicemembers remain in the legacy process. At the same time, the inventory of servicemembers in the IDES has grown rapidly as installations complete their older, legacy cases and enter new cases in IDES. As of early May 2012, 27,371 servicemembers were in the IDES process (68 percent Army, 12 percent Marine Corps, 9 percent Navy, and 12 percent Air Force). DOD's number of servicemembers undergoing disability evaluation has grown since the beginning of the conflicts in Iraq and Afghanistan, and we project that it will continue to grow as servicemembers redeploy from Afghanistan and the Military Services reduce their end strength. Unfortunately, predicting the exact number of referrals into the IDES is complicated because many injuries and illnesses may take weeks, months, and years to manifest to the point where they prevent a servicemember from performing their duties. Nevertheless, we are committed to providing the necessary resources to accelerate IDES timeliness and improving all aspects of the Disability Evaluation System (DES) for our wounded and ill service-

members who are in need of disability evaluation. We are confident that we have the right measures in place to adequately staff and accelerate the IDES so it remains manageable for recovering servicemembers and the Military Services as they draw down and refit their forces.

35. Senator GRAHAM. Secretary Rooney, what is the solution to this problem?

Dr. ROONEY. DOD leadership is focused on improving the integrated disability evaluation process. DOD and the Department of Veterans Affairs (VA) leaders meet regularly to review progress toward that end. The Secretaries of DOD and VA have met to review progress multiple times in the last year and will receive monthly updates on progress toward this priority goal. Within DOD, the Military Services' disability agencies and medical and personnel communities are expected to execute the DOD portion of IDES in 175 days and do so in accordance with their 10 U.S.C. Chapter 61 responsibilities and authorities.

Under the IDES in March 2012, servicemembers averaged 395 days to complete both DOD and VA systems, significantly less than in the previous legacy system, but still short of our goal to have 60 percent of servicemembers complete the IDES in 295 days by the end of 2012. DOD is concentrating on accelerating the IDES to meet that goal and will not rest until all referred servicemembers experience the most efficient IDES possible, even in times of increased caseloads. DOD plans to accelerate the IDES by emphasizing the following themes.

Proper Staffing

The Services have planned their budgets to ensure proper staffing of the IDES. Their efforts are underway with the Army completing 1,218 of 1,400 (87 percent) hiring actions for additional IDES staff. The Navy has increased its Informal Physical Evaluation Board staffing by 47 percent and has reduced processing time from 50 days in January to 11 days in March 2012, well within the goal of 15 days. It is noteworthy that there has been growth in the number of soldiers in the IDES. Although the number of servicemembers in the IDES has grown since 2007, that growth is mainly a result of the transition between the prior legacy processes and the IDES. Although DOD expects some increase in the number of servicemembers requiring disability evaluation as servicemembers redeploy from Afghanistan and the Services reduce end strength, DOD believes the right measures are in place to staff and accelerate the IDES so the situation remains manageable.

Improving System Execution

DOD and the Services are focused on fine-tuning the IDES by identifying and implementing best practices in training and execution. For example, the Navy has made significant gains in accelerating their medical evaluation boards (MEB) at Camp Lejeune by using existing technology in DOD's Armed Forces Health Longitudinal Technology Application (AHLTA) to streamline the medical summaries. The Navy is now preparing to implement this improvement at all locations. The Air Force has improved their initial IDES referral screening process to prevent unnecessary referrals and added workload. The Army recently completed a review of its IDES process and is implementing an Execution Order (EXORD) to streamline and standardize their IDES operations. Each of the Services is taking positive steps to improve execution.

Senior Leadership Involvement

DOD and VA leaders meet regularly to ensure they oversee and drive progress within their commands. The Secretaries of DOD and VA meet quarterly to discuss IDES progress. The Vice Chief of Staff of the Army and the Navy's Bureau of Medicine leadership both meet monthly with VA senior staff to review IDES processes and direct attention to areas needing improvement. Recently, these top leaders convened joint VA and DOD teams to examine existing capabilities and implement by this summer an electronic, paperless, searchable IDES case file transfer system. This work is on track and will significantly reduce workload, accelerate the process by about 20 days, and save about \$600,000 in annual mailing costs.

DOD's goal is to continue to improve the IDES so that servicemembers will benefit from a process that is faster, fairer, and reduces the benefits gap. While this is appropriate, lasting improvement in disability evaluation requires a national dialogue and significant legislative work. DOD is in the beginning stages of exploring this strategic reform and envisions this to be a long-term project that will span several legislative and budgeting cycles. Any large-scale effort to revolutionize the IDES would eventually require your leadership and we look forward to working with you when and if we reach that point. Because soldiers comprise approximately 67 percent of the current IDES caseload, the Army bears most of that operational burden. To accelerate disability processing, the Army issued execution and operation orders

in the first half of fiscal year 2012. The orders direct staffing, standardization, and execution improvements. We are confident this effort will produce results for the Army and the DOD as a whole.

On the joint technology front, VA plans to release an improved version of the software DOD and VA use for disability evaluation in the third quarter of fiscal year 2012. These improvements will enhance case management capability and add electronic interfaces that will reduce labor-intensive data-entry requirements and free staff to focus on one core VA IT system. In the fourth quarter of fiscal year 2012, VA plans to implement an electronic case file transfer capability or paperless claim file to the available IDES IT support tools. VA, in partnership with DOD, is planning future veterans tracking application improvements, including synchronization of disability IT improvements with efforts to develop an integrated electronic health record and the planned virtual lifetime electronic health care record.

My Wounded Warrior Care and Transition Policy staff is also preparing updated IDES program guidance that will streamline and consolidate policy. DOD anticipates that this publication will ease execution of the IDES policy and procedural guidance and accelerate disability evaluation.

36. Senator GRAHAM. Secretary Rooney, what will this situation look like in a year or 2 if we don't come up with a solution?

Dr. ROONEY. Predicting the exact number of referrals into the IDES is complicated because many injuries and illnesses may take weeks, months, and years to manifest to the point where a member's fitness for duty maybe called into question. We project that DOD's number of servicemembers undergoing disability evaluation will grow as servicemembers redeploy from Afghanistan and the Services reduce their end strength. But, we are also confident we have the right measures in place to adequately staff and improve the process so the situation remains manageable for servicemembers as they recover from their wounds and prepare to transition back to their communities and the Services as they drawdown and refit their forces.

TRICARE REFORMS

37. Senator GRAHAM. Secretary Hale and Dr. Woodson, I've said that I support health care reform in DOD. Do you agree with me that if we don't control the growth in health care costs, we will pay for it through decreased personnel and readiness?

Mr. HALE and Dr. WOODSON. Absolutely. We project that the total medical care budget will grow to 10.7 percent of the DOD topline by fiscal year 2017 if we do not take additional measures to slow the growth in health care costs.

If Congress does not provide us with needed support for the health reform proposals included in the fiscal year 2013 budget, DOD will have to find about \$12.9 billion from other defense programs to meet its health care obligations. Such action would place the new defense strategy at risk. Without needed authority, DOD will face further cuts in forces and investment to be consistent with the BCA. DOD's budget proposal already makes substantial reductions in the investment accounts so further cuts might fall mostly on forces. This could mean cutting additional Active Duty and Reserve Forces by fiscal year 2017 at a magnitude that could jeopardize DOD's ability to pursue the new defense strategy.

38. Senator GRAHAM. Secretary Hale and Dr. Woodson, we received a 32-star letter embracing these proposals, so among the senior military leaders, there is no dissent, is that correct?

Mr. HALE and Dr. WOODSON. That is correct; these proposals have the full support of DOD's senior military leaders.

39. Senator GRAHAM. Secretary Hale and Dr. Woodson, how does this administration's proposal for fee increases compare with the proposal put forward in 2006, which we all felt was too much, too fast?

Mr. HALE and Dr. WOODSON. While there are some similarities between the 2006 and 2013 proposals, there are also significant differences. The 2006 proposal for Prime enrollment fees also involved three tiers and the enrollment fees for 2017 for each of the tiers are roughly the same as the 2006 proposals. However, the 2006 proposal was based on retired rank vice retired pay. In 2006, the tiers were split by junior enlisted (E-6 and below), senior enlisted (E-7 and above), and officers. Based on current data, roughly 24 percent of retired beneficiaries under the age of 65 would fall into the lowest category and 28 percent would fall into the highest category. With the 2013 proposal, 48 percent will fall into the lowest category and

only 12 percent will fall into the highest category. The 2006 proposals for Standard also involved implementing an enrollment fee and raising the deductible. The 2006 proposals had tiers with the lowest tier having a 2017 enrollment fee of \$410 and the highest tier, \$820. The 2013 proposal has no tiers for Standard and the proposed 2017 enrollment fee is \$250. The deductibles proposed in 2006 were also tiered with the lowest tier having a \$542 deductible in fiscal year 2007 and the highest tier having an \$820 deductible. The 2013 proposal, with no tiers, is for a 2017 deductible of \$580. There was no TRICARE For Life enrollment fee proposed in 2006. Finally, the 2006 pharmacy proposed copays were similar to the copays implemented in fiscal year 2012.

40. Senator GRAHAM. Secretary Hale and Dr. Woodson, from what I have heard, one of the most controversial elements of the reforms that you are seeking in health care is a three-tiered system that links the amount of the fee a retiree pays to his or her military retired pay. What is DOD's rationale in moving to means testing for military retiree health care benefits and why is it the right approach?

Mr. HALE and Dr. WOODSON. Where feasible, the proposed fee increases were tiered by military retirement pay, based on the principles of the December 2007 Task Force on the Future of Military Health Care. In its deliberations, the Task Force recognized that military retirement is not like most civilian retirement systems and that the entire military compensation system differs from the typical civilian salary system because much of the compensation is in-kind or deferred. Thus, changes in the health care benefit were examined in the context of this unique system and its compensation laws, policies, and programs. The Task Force believed that, for equity reasons, military retirees who earn more military retired pay should pay a higher enrollment fee than those who earn less. While this tiering approach is not commonly used in the private sector for enrollment fees, the Task Force believed that it made sense in a military environment.

41. Senator GRAHAM. Dr. Woodson, under current law, the TRICARE Prime benefit is supposed to be cost neutral—that is, the government costs for Prime should not exceed the government costs for Standard. Does the cost of TRICARE Prime today comply with this requirement? If not, what is the difference in government costs between TRICARE Prime and TRICARE Standard for retirees?

Dr. WOODSON. The Prime benefit is no longer cost neutral compared to Standard/Extra plans.

Section 731(c) of the National Defense Authorization Act (NDAA) for Fiscal Year 1994 required that the benefit that became known as TRICARE Prime “shall be administered so that the costs incurred by the Secretary under the TRICARE program are no greater than the costs that would otherwise be incurred to provide health care to the members of the uniformed services and covered beneficiaries who participate in the TRICARE program.” When TRICARE was implemented in 1996, the Prime enrollment fee was set to: (1) offset the substantially reduced out-of-pocket costs, including the elimination of the Standard deductible, the near-total elimination of the 25 percent Standard inpatient copay, and the substantial reduction of outpatient copays; and (2) make Prime cost neutral to the government. Subsequent enactments regarding TRICARE for Active Duty family members have superseded the NDAA for Fiscal Year 1994 requirement for Active Duty family members, but not for Prime-eligible retirees.

For a working retiree family of three, the cost to DOD of providing health care in fiscal year 2011: Prime—\$13,442; Standard—\$11,267. The disparity between Prime and Standard/Extra was recognized in 2005 and resulted in proposals to adjust cost shares to both Prime and Standard/Extra. DOD was largely prohibited from changing fees and copays until fiscal year 2012. The net result is that Prime is not cost neutral to the Standard/Extra plans.

42. Senator GRAHAM. Dr. Woodson, is cost neutrality of a managed care option like Prime compared to fee for service still desirable, still achievable?

Dr. WOODSON. Cost neutrality is a laudable goal and our efforts should try to move in that direction. However, we cannot get to complete cost neutrality without significantly increasing the cost shares under Prime above the levels proposed in the President's budget. The proposed increases in the Prime enrollment fee are one part. We also believe that increases in utilization management envisioned under the Patient Centered Medical Home concept that we are implementing will bring the cost of Prime closer to Standard/Extra.

43. Senator GRAHAM. Dr. Woodson, if you want to encourage more people to move from Prime to Standard, why make Standard more expensive?

Dr. WOODSON. DOD took a balanced approach to benefit reform with increases in cost shares for Prime, Standard, and to TRICARE For Life. Each program has not kept pace with the cost of medical care and thus DOD has been faced with funding a larger share of the total health care expenses. While Prime, with the fixed enrollment fee and relatively modest outpatient visit copay, saw the more significant change in the beneficiary share of the cost, Standard/Extra with no enrollment fee, fixed deductible, and especially the relatively low catastrophic cap also saw significant change. Both had to be adjusted and indexed so that the relationship between what DOD pays and what the beneficiary pays moves closer to what was originally intended and remains there.

44. Senator GRAHAM. Dr. Woodson, your reform proposals to TRICARE pharmacy will likely cause people to use mail order pharmacy instead of their local pharmacy, is that correct?

Dr. WOODSON. The copay changes included in the President's fiscal year 2013 budget proposal are intended to encourage beneficiaries to use the most cost-effective venue. Costs to both the government and to beneficiaries are lower in the military treatment facilities and the mail order pharmacy program than in the retail network pharmacy program. For example, review of recent DOD pharmacy data (fourth quarter of fiscal year 2011) show that moving 1 percent of the retail market of maintenance medication over to mail order would save approximately \$1 million in fourth quarter of fiscal year 2011 or \$4 million per year. It is worth noting that this 1 percent decrease in the retail market would have been a 1.8 percent increase in use at mail order pharmacies during the fourth quarter of fiscal year 2011 (because the retail market was larger than mail order). Also, these savings estimates assume the 1 percent moving over from retail to mail exactly matches the mix of maintenance medications that make up the retail market basket used in the study.

45. Senator GRAHAM. Dr. Woodson, can you explain the cost difference for DOD for prescriptions obtained at a local pharmacy versus those that come from mail order?

Dr. WOODSON. Based on DOD analysis of maintenance medications, which was comprised of 19.9 million prescriptions filled during the fourth quarter of fiscal year 2011 at all three points of service (military treatment facilities, retail, and mail order), the data show that the mail order and military treatment facility venues to be more cost-effective points of service. The results showed the mean cost per 90-day supply of a market basket of maintenance medications was 19 percent lower through either the mail order program or military pharmacies, compared to the retail pharmacy network.

46. Senator GRAHAM. Dr. Woodson, how much does DOD spend in pharmacy costs every year and where do you see that cost going in the future?

Dr. WOODSON. The table below highlights actual pharmacy costs for fiscal years 2009 through 2011. The table shows current projected costs for fiscal years 2012 and 2013. We have assumed slower growth in the future due to proposed copay changes and project that pharmacy expenses will increase at roughly the Consumer Price Index, Medical (3 to 5 percent per year). Failure to increase pharmacy copayments may result in higher actual expense.

[In millions of dollars]

	Fiscal Year				
	2009	2010	2011	2012	2013
Under 65 Pharmacy Expense	\$3.42	\$3.82	\$4.32	\$3.95	\$3.76
Medicare Eligible Pharmacy Expense	4.19	4.06	3.71	4.32	4.72
Total Pharmaceutical Expense	7.61	7.88	8.03	8.27	8.48

47. Senator GRAHAM. Dr. Woodson, what initiatives are underway, other than adjustments to cost sharing, to reduce the costs of the TRICARE pharmacy program?

Dr. WOODSON. Over the last several years, DOD has made significant efforts to control rising pharmacy benefit costs. The strategies and efforts pursued have been drawn from private sector best business practices, national trends, congressional mandates, professional consultants, and independent studies. Each effort has had an effect in controlling the rise in pharmacy costs. Many programs and policies sur-

rounding formulary management within TRICARE closely mirror what commercial plans do to manage drug benefits.

Implementation of section 703 of the NDAA for Fiscal Year 2008 granting DOD authority to obtain Federal discounts in the retail pharmacy venue has collected over \$3.5 billion in refunds as of March 30, 2012.

Publication of an Interim Final Rule in December 2009 covering seasonal flu, H1N1 flu, and pneumococcal vaccines followed by a final rule in August 2011 provided the authority for the TRICARE pharmacy benefit to cover all TRICARE-allowed vaccines within the retail pharmacy setting, significantly increasing accessibility of vaccines for the prevention of diseases. Over 700,000 vaccines have been administered through 45,000 retail pharmacies under this program since December 2009 at no copay for beneficiaries. In addition to the increased accessibility of vaccines for beneficiaries, the discounted price to the government was a factor in the decision for this effort.

The TRICARE Management Activity Beneficiary Education and Support Division in conjunction with the Pharmaceutical Operations Directorate implemented a comprehensive home delivery (mail order) marketing program in 2010. Over the course of 2 years this initiative has contributed to an overall increase of 23 percent in home delivery. In 2011, home delivery prescriptions totaled over 12 million. At the same time that the home delivery use increased, the growth in the more expensive retail use has slowed, declining for the first time in 2011. In the first quarter of fiscal year 2012 the government cost savings associated with this enhanced communication effort totaled \$17.2 million.

Substantial additional cost avoidance (over and above the standard retail rebate) is realized as a result of the ongoing clinical and cost effectiveness evaluations of drugs and drug classes for the TRICARE Uniform Formulary (first implemented mid-2005), which allowed for tiered formulary copays and the ability to negotiate with manufacturers for better pricing based on formulary status. As an example, the additional first-year cost avoidance for drug classes reviewed in fiscal year 2010 was estimated to be \$131 million. In fiscal year 2011, approximately \$161 million in cost avoidance was obtained over and above the mandatory retail refund. The recent copay changes have also added to our negotiation leverage with the pharmaceutical manufacturers.

Step therapy, requiring a trial of a preferred agent prior to covering a non-preferred agent—is among the formulary tools used to promote evidence-based and cost-effective drug therapy and to negotiate better pricing with manufacturers. We estimate that over 4 years (August 2007–June 2011), formulary decisions in four major drug classes with step therapy programs resulted in at least \$786 million in voluntary rebates over and above the mandatory retail rebate.

The NDAA for Fiscal Year 2007 directed implementation of an over-the-counter (OTC) demonstration project to allow selected OTC drugs to be included on the DOD Uniform Formulary thereby allowing access to less costly medications in place of the more expensive prescription products. The success of the program from both the beneficiary and government perspective has resulted in preparation of a legislative proposal requesting permanent authority for this program. Through November 30, 2011 the program has saved DOD \$48.5 million.

48. Senator GRAHAM. Dr. Woodson, TRICARE is a complex program that includes many benefit options. The administration's proposals will add to its complexity by creating a three-tiered copayment structure based on retired income. Did you take into consideration the increasing complexity of administering TRICARE in the development of your reform proposals?

Dr. WOODSON. Yes, we did consider the complexity in administering a pharmaceutical copayment structure based on retired income. For that reason, DOD's pharmacy copayment increase proposal is not linked to retirement pay. The proposed fees will be tiered, as they are today, based on the drug class status (i.e. generic, brand, or non-formulary). For Prime and TRICARE For Life enrollment fees, DOD's decision was to tier the premiums. This will add some complexity, which was taken into consideration, but it was determined to be achievable and worth the effort.

49. Senator GRAHAM. Dr. Woodson, what are the costs associated with the administration of the new benefit structure in fiscal year 2013 through fiscal year 2017?

Dr. WOODSON. The fiscal year 2013 fee proposals included an implementation cost of \$33 million in fiscal year 2012. The model assumed these costs in fiscal year 2012 on the assumption that contract modifications would need to be issued in fiscal year 2012 in order for the benefit changes to go into effect for fiscal year 2013. For subsequent years, starting fiscal year 2013, the budget also included annual administrative costs of \$16 million for ongoing administration of the enrollment fee process in

TRICARE Standard. All of these amounts should be viewed as rough order-of-magnitude placeholders, pending development and analysis of actual implementation details, timelines, et cetera.

50. Senator GRAHAM. Secretary Hale and Dr. Woodson, you and the military leadership have described the fiscal year 2013 budget request as an interconnected whole. What is the budgetary and programmatic impact on that whole if Congress fails to enact the reforms you have requested?

Mr. HALE. The reforms we requested are an essential element in meeting the fiscal controls mandated by the BCA of 2011. Therefore, any reduced savings from failure to implement DOD's TRICARE reform proposals will have to be replaced with commensurate reductions in other DOD accounts. This will undermine DOD's attempt to execute the new strategy as stated and raises the risk that readiness will suffer.

Dr. WOODSON. If Congress fails to enact the proposed health care reforms, DOD will be forced to shoulder the increasing cost of military health care, likely at the expense of force structure and in modernization. DOD's budget proposal already makes substantial reductions in the investment accounts, so further cuts could mean cutting additional Active Duty and Reserve Forces, which would impact DOD's ability to pursue the new defense strategy.

51. Senator GRAHAM. Secretary Hale and Dr. Woodson, how realistic are your health care savings targets for fiscal year 2013 in light of the timetable for completion of legislation for fiscal year 2013?

Mr. HALE and Dr. WOODSON. DOD will continue dialogue with Congress to identify options to achieve savings in fiscal year 2013. Our budget estimates are predicated on fee changes going into effect on October 1, 2012. DOD requires several months of lead time to make the appropriate contract and system changes to meet this timeline. Delays in the timetable for the completion of legislation will result in reduced savings in fiscal year 2013.

52. Senator GRAHAM. Secretary Hale and Dr. Woodson, what options does DOD have to achieve savings in fiscal year 2013 if the NDAA becomes law late in fiscal year 2012?

Mr. HALE. The fiscal year 2013 budget request assumes implementation of the TRICARE reform proposals on or about October 1, 2012. The projected fiscal year 2013 TRICARE savings are \$0.7 billion. Should the NDAA for Fiscal Year 2013 preclude the TRICARE reform proposals, DOD will most likely have to find commensurate savings in operational accounts with potential negative impact on readiness.

Dr. WOODSON. Our budget estimates are predicated on fee changes going into effect on October 1, 2012. DOD requires several months of lead time to make the appropriate contract and system changes to meet this timeline. Delays in the timetable for the completion of legislation will result in reduced savings in fiscal year 2013. DOD will continue dialogue with Congress to determine the appropriate course of action and implementation timelines.

INTERNAL EFFICIENCIES IN HEALTH CARE

53. Senator GRAHAM. Dr. Woodson, military family and veterans groups have urged that you exhaust internal efficiencies in health care before increasing fees. What progress are you making in internal reforms and how much money have they saved prior to going ahead with this year's proposal?

Dr. WOODSON. We completely agree. We have been working aggressively to reduce the administrative overhead of the military health system by reducing reliance on contract support; reducing the number of government staff; reducing the number of boards and studies conducted; implementing leading purchasing practices for buying the best medical products at the lowest cost; and simply doing more with less.

Health care savings initiatives—other than beneficiary cost sharing proposals—continue to be proposed and implemented, resulting in real cost savings. However, it is important to note that because the vast majority of the health care budget is spent on providing direct patient care, there is a limit on the amount of savings that can be achieved through internal efficiencies alone. As a result, changes in beneficiary cost sharing represent only one of the key steps that we are taking to improve health care and reduce the rate of growth in health care costs. We are also employing other approaches, including: (1) Moving from Healthcare to Health; investing in initiatives that keep our people well while promoting healthy lifestyle; (2) Maximizing Internal Efficiencies; that reduce the administrative overhead of our

military health system; and (3) Reforming Provider Payments; by responsibly paying private care providers and aligning with Medicare reimbursement levels, as required by law.

Over the past several years, we have made great progress in implementing changes that have resulted in real cost savings. Below is a summary of these efforts:

- **Federal Ceiling Price:** In 2008, with the support of Congress, DOD championed changes in law (known as Federal Ceiling Price) that require pharmaceutical manufacturers to provide DOD about \$800 million annually in discounts for drugs provided to TRICARE beneficiaries through retail network pharmacies. This authority will provide DOD over \$4 billion in collections over the next 5 years, representing substantial savings.¹
- **Outpatient Prospective Payment System:** In 2009, by aligning its payments with Medicare rates (known as the Outpatient Prospective Payment System), DOD instituted changes in the way it reimburses private hospitals for outpatient services provided to TRICARE beneficiaries. When fully implemented, these changes will save DOD over \$900 million annually. This new system will result in over \$4.6 billion in savings over the next 5 years.
- **Sole Community Hospital:** DOD is in the process of revising its payment rules to reimburse inpatient care claims at sole community hospitals by using Medicare rates; when fully implemented, this action will result in savings of about \$100 million annually.
- **Medical Supply Chain Optimization and Standardization:** To further reduce costs, DOD is changing the way it buys medical products, by leveraging the bulk buying power of the military health system. A series of strategic price reduction initiatives are being implemented, saving DOD on average \$60 million annually.
- **Reducing Administrative Overhead:** DOD is reducing administrative overhead in the military health system by streamlining its processes; reducing the number of unnecessary reports, studies, and commissions; and initiating other actions which will result in over \$200 million in reduced personnel and contract costs annually.
- **Reducing Fraud, Waste, and Abuse:** DOD is stepping up its efforts to detect fraud, waste, and abuse from fraudulent providers and institutions, and to recover overpayments. We expect these efforts will save DOD on average \$35 million annually over the next 5 years.
- **Investing in Health:** Finally, in effort to control long-term costs, DOD is pursuing a multifaceted strategy to invest in initiatives that keep beneficiaries well, promote healthy lifestyles, and reduce inappropriate emergency room visits and unnecessary hospitalizations while improving patient satisfaction. In the short term, we expect savings on average of over \$25 million over the next 5 years.

54. Senator GRAHAM. Dr. Woodson, how can Congress help you achieve them?

Dr. WOODSON. We appreciate Congress' support for past efficiency efforts. DOD continues to reduce the administrative overhead of its military health system by reducing reliance on contract support; reducing the number of government staff; reducing the number of boards and studies being conducted; implementing leading purchasing practices for buying the best medical products at the lowest cost; and simply doing more with less.

More is achievable with changes in the organizational structure of military medicine (report submitted to congressional committees). We look forward to Congress' support for these proposed changes.

TRANSITIONAL HEALTH BENEFITS

55. Senator GRAHAM. Dr. Woodson and Mr. McGinnis, if the administration's plan to reduce military personnel goes forward, some who have served may be involuntarily separated. What health benefits will those involuntarily separated from Active Duty receive?

¹\$1.5 billion in collections since 2009, based on data ending 31 January 2012; discretionary savings (DHP) and the reductions in outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF) since 2009 were approximately \$3.5 billion.

Dr. WOODSON and Mr. MCGINNIS. Active Duty servicemembers who are involuntarily separated from the Active component may² qualify for 180 days of premium free TRICARE coverage under the Transition Assistance Management Program (TAMP); (10 U.S.C. 1145(a)(2)(A)). TAMP offers comprehensive, premium-free TRICARE coverage to both the sponsor and eligible family members on the same basis as an Active Duty family member. At the conclusion of this transition period the individual and or his family is also eligible to purchase the Continued Health Care Benefit Program (CHCBP) plan, which is a premium based, temporary health care coverage program (18 months of eligibility) similar to better known COBRA program. It provides the Basic program benefits generally offered under the TRICARE Standard program. The premium rates are based on the Federal Employees Health Benefits program employee and agency contributions for a plan with similar benefits.

56. Senator GRAHAM. Dr. Woodson and Mr. McGinnis, what about for those involuntarily separated from the Reserve components?

Dr. WOODSON and Mr. MCGINNIS. "A member of a Reserve component who is separated from Active Duty to which called or ordered in support of a contingency operation if the Active Duty is Active Duty for a period of more than 30 days" may³ qualify for 180 days of premium free TRICARE coverage under the TAMP (10 U.S.C. 1145(a)(2)(B)). TAMP offers comprehensive, TRICARE coverage to both the sponsor and eligible family members on the same basis as an Active Duty family member.

If the Reserve component member is involuntarily disaffiliated from the Armed Forces altogether and the member had TAMP, TRICARE Reserve Select, or TRICARE Retired Reserve coverage at the time, the member and eligible family members may purchase premium-based coverage under the CHCBP.

57. Senator GRAHAM. Dr. Woodson and Mr. McGinnis, are these benefits fair and reasonable or should Congress consider some enhancement, particularly for the Reserve and Guard?

Dr. WOODSON and Mr. MCGINNIS. Congress recently enhanced the transitional health benefits for Reserve component members. Section 703 of the NDAA for Fiscal Year 2010 (P.L. 111-84) amended law and offered Active Duty dental coverage to the Reserve component sponsor (and sponsor only) in TAMP. This provision was implemented by the Final Rule published in the Federal Register December 28, 2011 (76 FR 81366-81368) and is fully operational as reported in the TRICARE news release <http://www.tricare.mil/mediacenter/news.aspx?fid=742>.

Comprehensive coverage under the CHCBP is now available for purchase by all individuals who lose coverage under TAMP or any TRICARE program under Chapter 55 of Title 10, U.S. Code.

This is further bolstered by the enhanced health care benefits eligibility from the VA enjoyed by combat veterans. This enrollment period was extended from 2 years to 5 years by section 1707 of the NDAA for Fiscal Year 2008 (P.L. 110-181, January 28, 2008), which amended 38 U.S.C. 1710(e)(3).

DOD has proposed a legislative change to extend eligibility for TRICARE Reserve Select and TRICARE dental coverage for a period of 180 days for members of the Selected Reserve who are involuntarily separated.

FAMILY SUPPORT PROGRAMS

58. Senator GRAHAM. Secretary Rooney, Secretary of Defense Panetta has assured Congress that support for family support programs is protected throughout DOD even in this austere budget. Yet, testimony provided by the National Military Family Association argues that "family programs are being short-changed," by reductions in child care and family support.

²Eligibility for the TAMP for sponsors and family members is determined by the sponsor's Service branch and information in the Defense Enrollment Eligibility Reporting System. TAMP categories are: members involuntarily separated from Active Duty and their eligible family members; National Guard and Reserve members, collectively known as the Reserve component, separated from Active Duty after being called up or ordered in support of a contingency operation for an Active Duty period of more than 30 days and their family members; members separated from Active Duty after being involuntarily retained in support of a contingency operation and their family members; and members separated from Active Duty following a voluntary agreement to stay on Active Duty for less than 1 year in support of a contingency mission and their family members.

³*Ibid.*

Our expectation is that the Secretary's pledge will be fulfilled. What are you doing in your oversight capacity to ensure that family programs are not reduced during this time of war?

Dr. ROONEY. To ensure that family programs are not reduced during this time of war, I emphasized the need for the Services to safeguard and sustain current funding levels for their family programs. This resulted in implementation of a comptroller-mandated, in-depth, mid-year review of the Services' budgets. The Services are in the process of scrutinizing their budgets, tracking program funding, and disclosing discrepancies that could indicate diversion of funds from programs for which the funds were originally intended. Ongoing tracking of budgets and reporting on status of budgets supports the Secretary's position of keeping faith with service-members and their families to protect family assistance programs.

QUESTION SUBMITTED BY SENATOR SAXBY CHAMBLISS

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

59. Senator CHAMBLISS. Secretary Rooney and Mr. McGinnis, the Uniformed Services Employment and Reemployment Rights Act (USERRA) protects millions of people, largely National Guard and Reserve members, as they transition between their Federal duties and civilian employment. USERRA is intended to eliminate or minimize civilian employment disadvantages resulting from service in the Reserve components and protect the rights of those members when they deploy. Since September 11, 2001, over 835,000 citizen soldiers have mobilized to fight the war on terrorism. Many American soldiers have served more than one tour of duty and may be required to serve more. As we downsize the Active Force and operationalize the Reserve Force, it is likely that Reserve soldiers will continue to mobilize to fill the gaps of the smaller Active Force. In light of this stress on the Reserve components, do you see the need for any changes to USERRA to provide additional protection to our Guard and Reserve members?

Dr. ROONEY and Mr. MCGINNIS. No changes to USERRA are required at this time. On balance, our Nation's employers have proven to be full partners in the 21st century Total Force. Moving forward, as we believe civilian employment is a key part of individual readiness, we are committed to ensuring strong protections for Reserve component servicemembers. As such, we will continue to review existing laws to ensure that they are keeping up with the needs of the servicemembers.

QUESTIONS SUBMITTED BY SENATOR KELLY AYOTTE

MEDICARE AND TRICARE

60. Senator AYOTTE. Dr. Woodson, the Centers for Medicare and Medicaid Services (CMS) are engaged with a number of States in seeking ways to enhance care and reduce costs for Medicare/Medicaid dual-eligible beneficiaries. The nearly 2 million TRICARE For Life beneficiaries are another large population that is dually entitled—to Medicare and TRICARE in this case. Have you explored with Medicare leadership the possibilities for interagency cooperation to evaluate potential approaches to coordinating benefits and enhancing care for TRICARE For Life beneficiaries?

Dr. WOODSON. TRICARE For Life provides Medicare wraparound coverage when health care is a benefit under both programs, as long as the beneficiary is enrolled in Medicare Part B. Medicare pays 80 percent of their allowed amount, and claims automatically cross over to TRICARE where TRICARE processes the remainder for payment.

Recently, TRICARE Management Activity staff met with representatives from the CMS' Innovation Center to discuss the Comprehensive Primary Care Initiative that CMS is developing. This initiative will use a managed care approach to providing preventive care and disease management for Medicare and other patients. It will reward providers when costs are reduced as participants in the initiative achieve desired health outcomes. Many TRICARE For Life beneficiaries are likely participants in the initiative, and TRICARE intends to monitor progress and results of the initiative to assess how and whether to apply the care approach to a broader segment of our TRICARE For Life population.

We have also instituted new management controls that are applicable when TRICARE becomes primary payer for a TRICARE For Life beneficiary's stay in a skilled nursing facility (SNF). This occurs after exhaustion of the 100-day SNF care coverage provided by Medicare. We have found that bills for SNF care are among

the largest of any that TRICARE For Life must cover. Now we require that SNF care beyond 100 days be preauthorized and base the decision upon review of medical records to ensure: (a) that skilled care truly is required; and (b) if skilled care is required, that it is of such intensity that it cannot be safely provided at a lower, less expensive, level than in a SNF.

61. Senator AYOTTE. Dr. Woodson, would this be a way to provide better care at a lower cost to the taxpayers for TRICARE For Life beneficiaries?

Dr. WOODSON. There is potential that Medicare's Comprehensive Primary Care Initiative will demonstrate an improvement in outcomes and will lower cost. That is why we are supportive of the initiative and intend to monitor its progress and results closely to determine if the approach is one that would have application to a broader set of our TRICARE For Life beneficiaries.

DEFENSE HEALTH PROGRAM

62. Senator AYOTTE. Secretary Hale, I understand that in their 2007 report, the Task Force on the Future of Military Health Care called on DOD to conduct an audit of financial controls on the DHP, to include establishment of a common cost accounting system. Did you serve on this task force?

Mr. HALE. Yes, I did serve on the Task Force on the Future of Military Health Care before assuming my current position. As noted above, the Task Force recommended: (1) the conduct of an external audit to ensure the proper financial controls with respect to health care eligibility and coverage, and (2) the establishment of a common cost accounting system to provide a more accurate level of accounting for costs across the Military Health System (MHS).

The Defense Manpower Data Center (DMDC), a component of the Defense Human Resources Activity (DHRA), provides the beneficiary data upon which eligibility for health care benefits is determined. The data is maintained in the Defense Enrollment and Eligibility Reporting System (DEERS) database. Both DMDC and DHRA understand and support the value of an independent, external audit of financial controls on the DHP.

DMDC is audited twice yearly by auditors external to the DHRA and the DHP. In that regard, the DOD Inspector General conducted an Audit of Beneficiary Data in the DEERS database (Project No. D2010-D000FR-0149.000) "to assess the completeness and accuracy of beneficiary data contained in DEERS used to estimate health care liabilities on DOD financial statements," and actions are underway to address the findings of the audit.

With respect to the establishment of a common cost accounting system, DOD is in the process of developing a statement of work to seek expert assistance in evaluating a set of alternatives for creating a common cost accounting structure and universal application across MHS. More specifically, DOD will evaluate the feasibility of overlaying a common cost accounting structure across the various disparate financial systems of the Service Medical Departments and the TRICARE Management Activity. In addition, DOD will evaluate the option of adopting a single financial system across the MHS, with special consideration to Service or Department systems further along in their development. We strongly believe that having a common cost accounting structure is a key component for improving financial transparency across the MHS and we are working on an aggressive schedule to accomplish this critical evaluation.

63. Senator AYOTTE. Secretary Hale, is that recommendation still valid today?

Mr. HALE. Yes, the recommendation is still valid today. As mentioned previously, both the DMDC and the DHRA understand and support the value of an independent, external audit of financial controls on the DHP, to include the establishment of a common cost accounting system. In addition, DOD is working aggressively to evaluate options for improving financial transparency across the MHS.

64. Senator AYOTTE. Secretary Hale, what actions are underway to achieve greater accountability and additional savings for the DHP, to include protection against fraud and recovery of payments from other health insurance?

Mr. HALE. DOD is employing a multi-prong approach for achieving greater accountability and additional savings for the DHP, to include: (1) Moving from Healthcare to Health; investing in initiatives that keep our people well while promoting healthy lifestyle; (2) Maximizing Internal Efficiencies; that reduce the administrative overhead of our MHS; and (3) Reforming Provider Payments; by responsibly paying private care providers. We are also stepping up our efforts to re-

duce fraud, waste and abuse and increase our recovery of payments from other health insurance. Specific strategies include utilizing third party entities to detect other health insurance coverage and prepare these cases for recovery; educating beneficiaries about legal requirements to disclose other health insurance coverage; and training MTF staff in proper patient intake procedures and tools available to increase recovery of payments.

[Appendices A through F follow:]

APPENDIX A



T H E M I L I T A R Y C O A L I T I O N

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STATEMENT OF THE MILITARY COALITION (TMC)

On

Military Health Care Issues

**SENATE ARMED SERVICES
SUBCOMMITTEE ON PERSONNEL**

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

Air Force Association
 Air Force Sergeants Association
 Air Force Women Officers Associated
 Army Aviation Association of America
 Association of Military Surgeons of the United States
 Association of the United States Army
 Association of the United States Navy
 Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
 Commissioned Officers Association of the U.S. Public Health Service, Inc.
 Enlisted Association of the National Guard of the United States
 Fleet Reserve Association
 Gold Star Wives of America, Inc.
 Iraq and Afghanistan Veterans of America
 Jewish War Veterans of the United States of America
 Marine Corps League
 Marine Corps Reserve Association
 Military Chaplains Association of the United States of America
 Military Officers Association of America
 Military Order of the Purple Heart
 National Association for Uniformed Services
 National Guard Association of the United States
 National Military Family Association
 Naval Enlisted Reserve Association
 Non Commissioned Officers Association
 Reserve Enlisted Association
 Reserve Officers Association
 Society of Medical Consultants to the Armed Forces
 The Retired Enlisted Association
 United States Army Warrant Officers Association
 United States Coast Guard Chief Petty Officers Association
 Veterans of Foreign Wars
 Wounded Warrior Project

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

*Executive Summary***FY2013 Budget Submission on TRICARE Fees**

The Coalition believes DoD's proposals for dramatic TRICARE fee hikes constitute a serious breach of faith with currently serving troops and families by cutting their future healthcare benefits. And if breaking faith with the currently serving is wrong, so is imposing a major "bait and switch" change on those who already completed 20-30 year careers, induced by promises of current benefits.

TRICARE Prime Fees: Reject any increase in TRICARE Prime fees that exceeds the COLA-based standard established in the FY2012 Defense Authorization Act.

TRICARE Standard Fees:

- The Coalition urges rejection of any TRICARE Standard enrollment fee unless and until the government provides guaranteed access to care for Standard beneficiaries
- The Coalition urges the Subcommittee to reject DoD's proposal to nearly double the TRICARE Standard deductible over the next five years.

TRICARE For Life Enrollment Fee: Sustain current law that avoids any enrollment fee for TRICARE For Life, consistent with Congress' determination in 2001 that the service and sacrifices extracted from military retirees and families over the course of their careers constituted a pre-paid premium for their TFL coverage as a Medicare supplement.

TRICARE Pharmacy Copays: Reject Administration-proposed pharmacy copayment increases that would inappropriately "civilianize" the military pharmacy benefit, dramatically raise costs for both retired and currently serving families, and deter beneficiaries from adhering to medication regimens that are essential to their long-term health as well as DoD's long-term cost containment.

TRICARE Proposals Raise New Inequities: The extremely limited categories of exemptions for survivors and disabled retirees disregard the similar or more severe situations of other survivors and disabled. The Coalition does not propose expanding the exemption, because that would imply a level of Coalition concurrence with the proposed fee hikes that does not exist. We raise this inequity issue as another reason why the proposed fee increases are grossly inappropriate for all grades and categories of beneficiaries.

TRICARE Fee "Tiering": Strongly oppose means-testing of military benefits, under which longer and more successful service would be penalized by progressive reduction of military healthcare benefits. The Coalition believes all retired servicemembers earned equal health care coverage by virtue of their service and that the proposed dramatic fee increases are inappropriate for servicemembers of all grades.

TRICARE Fee Indexing: Reject the DoD-proposed tying of annual increases in military health care fees to an index of health cost growth which would dramatically and disproportionately accelerate military healthcare fees over time.

Military Health Care Principles: The Coalition believes the law should be changed to explicitly acknowledge that:

- The healthcare benefit provided for members and families who endure to complete a military career should be among the very best available to any American;
- The decades of service and sacrifice rendered by career military personnel constitute a significant pre-paid premium toward their healthcare in retirement; and
- The large value of this pre-paid premium should be accounted for by minimizing fees payable in retirement and avoiding significant and arbitrary increases from year to year.

Leadership Accountability

The Coalition urges the Subcommittee to hold Defense leaders accountable for their own management, oversight, and efficiency failures before seeking to shift more costs to beneficiaries. Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.

Wounded, Ill, and Injured Servicemember Issues

The Coalition urges:

- Joint hearings by the Armed Services and Veterans Affairs Committees addressing the Joint Executive Council's (JEC) effectiveness in daily oversight, management, collaboration, and coordination of the Departments' wounded, ill, and injured servicemember programs.
- Permanent funding, staffing, and accountability for congressionally mandated Defense Centers of Excellence and associated mental-behavioral health, suicide prevention, caregiver, respite, and other medical and non-medical programs.
- Continued aggressive oversight of the Integrated Disability Evaluation and legacy disability evaluations systems to ensure preservation of the 30-percent threshold for medical retirement, consistency and uniformity of policies, ratings, legal assistance, benefits, and transitional services Defense-wide.

DoD – VA Seamless Transition

The Coalition urges:

- Joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved.
- Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.
- Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.

DoD-VA Integrated Disability Evaluation System (IDES)

The Coalition recommends:

- Preserving the statutory 30 percent disability threshold for medical retirement in order to provide lifetime TRICARE coverage for those who are injured while on active duty.
- Reforming the DoD disability retirement system to require inclusion of all unfitting conditions and accepting the VA's "service-connected" rating.
- Ensuring any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled service members.
- Eliminating distinctions between disabilities incurred in combat vs. non-combat when determining benefits eligibility for retirement.
- Revision of the VA schedule for rating disabilities (VASRD) to improve the care and treatment of those wounded, ill and injured, especially those diagnosed with PTSD and TBI.
- Barring designation of disabling conditions as "existing prior to service" for servicemembers who have been deployed to a combat zone.
- Directing DoD to re-engineer and redesign the front end of IDES to (1) better ensure medical evaluations are consistently based on a fully developed, accurate medical summary; (2) permit the servicemember's full participation; (3) afford each individual consistent, effective representation throughout the process; and (4) streamline the system by eliminating the redundancy of dual adjudication of disability.

Caregiver/Family Support Services

The Coalition recommends:

- Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely ill and injured personnel.
- Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for medically retired or separated members' caregivers.
- Extending eligibility for residence in on-base facilities for up to one year to medically retired or severely wounded servicemembers and their families (or until the medically retired or severely injured service member receives a VA compensation rating, whichever is longer).
-

Guard and Reserve Healthcare

The Coalition recommends:

- Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60
- Authorizing premium-based TRICARE coverage for members of the Individual Ready Reserve after being called to active service for a cumulative period of at least 12 months
- Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.
- Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.
- Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.

- Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.
- Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.

Additional TRICARE Prime Issues

The Coalition urges the Subcommittee to:

- Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.
- Require increased DoD efforts to ensure consistency between both the MTFs and purchased care sectors in meeting Prime access standards.
- Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas.

Additional TRICARE Standard Issues

The Coalition urges the Subcommittee to:

- Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future. Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation to meet the threshold.
- Require a specific report on provider participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.
- Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.

Overview

Mr. Chairman and distinguished members of the Subcommittee, The Military Coalition extends our thanks to you for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors.

Congress has improved retention and readiness by addressing a number of quality of life issues for the military community over the last decade including enactment of TRICARE For Life, TRICARE Senior Pharmacy coverage, and health coverage for the Guard and Reserve community, among many other important initiatives.

Now, ironically, critics decry the growth in health care spending over the last decade, ignoring that much of that cost was driven by wartime requirements and service organizational and readiness priorities rather than cost-efficient delivery of beneficiary care.

As Congress assesses how to fairly allocate necessary sacrifices among the various segments of the population, the Coalition urges that you bear in mind that:

- Assertions about personnel and health cost growth over the last decade are highly misleading, because 2001 (when nearly all older beneficiaries had been pushed out of military health coverage) is not an appropriate or reasonable baseline for comparison – 2001 was the “bottom” as far as military benefits were concerned. Congressional spending to fix that problem since then was a necessary thing, not a bad thing.
- DoD health costs remain well below the 16% share health care comprises of the national GDP.
- Assertions that cutbacks for retirees don’t affect the currently serving force are a delusion. Significant benefit cutbacks for retirees reduce incentives for the currently serving to complete a career. A currently serving member who will retire next month, next year, or next decade is definitely affected by such cutbacks.
- Retired servicemembers, their families and survivors have been no stranger to sacrifice. Nearly 600,000 of today’s retirees served on active duty during the current Iraq/Afghanistan wars. Hundreds of thousands more saw service in multiple hot and cold conflicts. Older retirees endured years when the government provided them no military health coverage, and those retired between 1985 and 2005 have forfeited an average 10% of earned retired pay because they retired under pay tables depressed by decades of budget-driven capping of military raises below civilian pay growth.
- Pentagon leaders’ insensitivity to this situation is perfectly illustrated by Secretary Panetta’s answer at a recent Senate Budget Committee hearing. When asked why the proposal focuses so much on raising fees for military retirees, he answered they would accept the changes because they’re used to doing what they’re told and used to a culture of sacrifice. In other words, they’re used to abuse so we can – and plan – to abuse them again.

- Military members' and families' sacrifices must not be taken for granted by assuming they will continue to accept the extraordinary personal and family sacrifices inherent in a multi-decade service career regardless of significant changes in their career incentive package.
- At a time when Congress is focused on lowering payroll taxes and avoiding any tax increases for other Americans, including millionaires and billionaires, it's grossly inappropriate to impose a \$1,000-\$2,000 new annual tax on the one group of citizens who already have sacrificed more for their country than any other.
- The Coalition is appalled that fully 60% of the projected savings associated with the proposed TRICARE fee increases accrue from the assumption that the fee increases will be so onerous as to drive many thousands of military beneficiaries away from using their service-earned coverage. When similar assumptions were highlighted about earlier DoD TRICARE fee proposals, Congress rightly deemed it grossly inappropriate to entice members to career service with promises of care and then consciously implement plans to drive them away from using that hard-earned care. That's no less true in 2012 than it was in 2007 and 2008.
- History shows clearly that there are unacceptable retention and readiness consequences for short-sighted budget decisions that cause servicemembers to believe their steadfast commitment to protecting their nation's interests is poorly reciprocated.

FY2013 Budget Submission

The President's proposed FY2013 budget has embraced the concept put forth by the Defense Department in past years that TRICARE benefits for retired beneficiaries should "trend toward market rates" by significantly increasing fees for retired beneficiaries and family members under 65.

The proposal would shift \$35 billion in costs to retired and some currently serving military families over the next 10 years through dramatic and disproportional healthcare fee increases. These fee levels are similar to those recommended by the Defense Department in past years, which the Subcommittee and Congress rejected as excessive on the basis that:

- Pentagon leaders need to demonstrate more effective cost management of their own before shifting significant additional costs to beneficiaries.
- Achieving savings by seeking to deter beneficiaries from using their service-earned benefits is inappropriate.

The budget proposes to raise beneficiary costs over the next ten years by:

- Raising annual fees by as much as \$1,500 or more for retired families under age 65.
- Establishing new annual enrollment fees of up to \$950 for retired couples over age 65.
- Imposing means-testing of military retiree health benefits – which no other federal employee experiences.
- Dramatically increasing pharmacy co-pays to approach or surpass the median of civilian plans.

- Tying future annual increases to an unspecified health cost index estimated to average 6.2% per year.

DoD leaders have made a great point of their intent to “keep faith with currently serving troops” by avoiding any retirement changes that would affect the current force.

But their concept of “keeping faith on retirement” doesn’t extend to retirement health care benefits, as the proposed changes would affect any currently serving member who retires the day after they were implemented. This has the same effect as reducing their retired pay by up to \$2,000 a year or more. Further, the pharmacy changes would affect hundreds of thousands of currently serving Guard/Reserve members and families, as well as the family members of currently serving personnel who don’t have access to military pharmacies.

The Coalition believes DoD’s proposals for dramatic TRICARE fee hikes constitute a serious breach of faith with currently serving troops and families by cutting their future healthcare benefits. And if breaking faith with the currently serving is wrong, so is imposing a major “bait and switch” change on those who already completed 20-30 year careers, induced by promises of current benefits.

TRICARE Prime Fees. The Administration’s TRICARE Prime Fee proposal for FY2013 is a radical departure from the new fee structure the Administration proposed and Congress accepted for FY2012.

Last year, finally acknowledging Congress’ long-standing concerns about the inappropriateness of dramatic increases in beneficiary fees, the Administration proposed a 13% increase in TRICARE Prime fees. In the absence of congressional objection, the increase was implemented as of October 1, 2011.

The new proposal for FY2013-2017 is a dramatic departure, proposing to triple or quadruple fees over the next five years, as indicated in the chart below.

Retired Pay**	DoD-Proposed TRICARE Prime Enrollment Fee for Retired Beneficiaries Under Age 65 (Family Rate)*					
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017***
\$0-22,589	\$520	\$600	\$680	\$760	\$850	\$893
\$22,590-\$45,178	\$520	\$720	\$920	\$1,185	\$1,450	\$1,523
\$45,179 or more	\$520	\$820	\$1,120	\$1,535	\$1,950	\$2,048

*Single rate is 50% of family rate
 ** Retired pay thresholds to be indexed to COLA increases
 *** Fees for FY18 and outyears to be indexed to health cost inflation

This proposal flies in the face of the specific language of the FY2012 Defense Authorization Act – signed into law less than three months ago – requiring that the percentage increase in TRICARE Prime fees for FY2013 and later years shall not exceed the percentage growth in military retired pay.

The logic behind the COLA cap has not changed in the last three months. Its purpose was to protect retirees against arbitrary, budget-driven initiatives to impose dramatic new fee increases.

The COLA cap was intended to help recognize that:

- Military retirees already pre-paid very large premiums for their health care in retirement through their decades of service and sacrifice in uniform, and that
- They shouldn't be subjected to a double penalty by having their fees raised dramatically after they've already rendered a career of service induced by long-standing government retirement and healthcare promises.

The Coalition urges the Subcommittee to reject any increase in TRICARE Prime fees that exceeds the COLA-based standard established in the FY2012 Defense Authorization Act.

TRICARE Standard Fees. The Administration proposes two changes to TRICARE Standard that are not authorized under current law: a new enrollment fee that would increase significantly over time, and a significant adjustment to the Standard deductible, which is set by current law at \$150 for a single person and \$300 for a family.

DoD-Proposed TRICARE Standard Annual Fees for Retired Beneficiaries Under Age 65 (Family Rate)*						
Enrollment Fee	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017**
	\$0	\$140	\$170	\$200	\$230	\$250
Deductible	\$300	\$320	\$400	\$460	\$520	\$580

*Single rate is 50% of family rate

** Fees for FY18 and outyears to be indexed to health cost inflation

The Coalition strongly opposes any enrollment fee for TRICARE Standard. An enrollment fee is only appropriate when the beneficiary is guaranteed a certain level of care. While the Defense Department has specified standards for TRICARE Prime, it's definitely not the case with TRICARE Standard.

According to DoD's own surveys, there are localities where finding a provider who will accept Standard patients is very difficult. This is particularly true for some high-demand specialties such as psychiatry.

In the absence of guaranteed access to care, there should be no enrollment fee.

Establishing an explicit enrollment requirement also would change the fundamental character of this service-earned healthcare benefit by forcing a choice between military health coverage and other available coverage. Many use TRICARE as a contingent coverage that is there as a fallback if they lose their civilian job, if their civilian insurance offers limited coverage, etc. Throughout their careers, they were told they would have this coverage. The Coalition objects to a system that backs them into a situation that implies it's a reasonable decision to forfeit that earned protection because they have other insurance that may or may not endure. In other words, their military ID card is and should continue to

represent their automatic enrollment in the default military healthcare option unless they choose to enroll in Prime or age into TRICARE For Life.

The Coalition also objects strongly to the proposal to nearly double the annual Standard deductible over the next 5 years. Standard-eligible retired beneficiaries who are able to find a participating provider already are absorbing a 25% copay, and so their costs have risen as allowable charges have risen.

The Coalition urges the Subcommittee to reject any TRICARE Standard enrollment fee unless and until the government provides guaranteed access to care for Standard beneficiaries

The Coalition urges the Subcommittee to reject DoD's proposal to nearly double the TRICARE Standard deductible over the next five years.

TRICARE For Life Fees. The Administration proposes a new TRICARE For Life (TFL) enrollment fee for beneficiaries age 65 and older, with successive annual increases as indicated in the chart below:

DoD-Proposed TRICARE-for-Life Annual Enrollment Fee (Per Individual Beneficiary Age 65+)						
<u>Retired Pay*</u>	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>FY2017**</u>
\$0-22,589	\$0	\$35	\$75	\$115	\$150	\$158
\$22,590- \$45,178	\$0	\$75	\$150	\$225	\$300	\$317
\$45,179 or more	\$0	\$115	\$225	\$335	\$450	\$475
** Retired pay thresholds to be indexed to COLA increases						
*** Fees for FY18 and outyears to be indexed to health cost inflation						

Again, the Coalition believes strongly that an enrollment fee is only appropriate when there is a guarantee of timely access to quality healthcare. While that is the case with TRICARE Prime, there is no such guarantee for TFL beneficiaries.

Because TFL is available only if the beneficiary enrolls in Medicare Part B and acts as second-payer to Medicare, it provides coverage only in the case of providers who accept Medicare patients.

In many localities around the country, more and more providers are limiting the number of Medicare patients they serve. In some localities, providers are refusing to accept any new Medicare patients.

In the event a provider refuses to accept Medicare, the beneficiary must absorb the full cost of the care, as Medicare will not reimburse the beneficiary for any share of the charges.

The reality is that Medicare patients already pay significantly more for their care than beneficiaries under 65 do because of the statutory requirement to enroll in Medicare Part B to be eligible for TFL. This means a TFL-eligible couple already is paying premiums of at least \$2,400 per year in 2012. Couples in higher income brackets may pay up to \$7,680 per year in Part B premiums alone.

Further, large numbers of these retired members already suffer severe and permanent financial penalties as a result of past government budget crises that caused depression of their annual pay raises while on active duty. Depression of military pay over time caused military pay scales to lag up to 13.5% behind private sector pay. Members who retired under those depressed pay scales already are being made to forfeit thousands of dollars per year, and those penalties will last through their lifetimes. Adding a TFL enrollment fee would add further financial insult to that grievous injury.

TFL was enacted in 2001 to rectify the previous decade's disenfranchisement of older military beneficiaries from virtually all military healthcare coverage in the wake of the BRAC-driven closure and downsizing of hundreds of military hospitals and clinics.

When Congress enacted TFL, it did so with the explicit acknowledgement that an enrollment fee for this program is inappropriate.

In passing the new law, Congress acknowledged that the premium for this Medicare-supplemental coverage already had been paid in full through decades of service and sacrifice.

The Coalition believes strongly that the experience of the last decade – during which the military community has been required to bear 100% of the nation's wartime sacrifice – only reinforces the rightness of Congress' 2001 acknowledgement that imposing an enrollment fee for TFL is inappropriate.

The Coalition urges strongly against imposing any enrollment fee for TRICARE For Life.

Proposed Fees Raise New Series of Inequities

The Coalition appreciates that some modest effort was made to accommodate human concerns by exempting medical (Chapter 61) retirees and survivors of members who died on active duty.

However, these very restricted exemptions create a whole new series of inequities that demonstrate a gross lack of appreciation for the circumstances of various beneficiary populations.

Limiting survivor exemption to cases of deaths on active duty ignores that other categories of survivors, most of whom are older, typically have far less resources than survivors of recent active duty deaths. Thousands of these older survivors have no income at all from the military or the VA, and received dramatically lower Servicemen's Group Life Insurance settlements than are available today -- yet they would be subjected to the higher TRICARE fees.

Among retirees, the sole exemption of chapter 61 (medical retirement) cases similarly ignores the realities of the disabled retiree population.

Medical retirees include not only the severely disabled, but also many with disability ratings of 30% (or lower in some cases, since members with 20+ years of service can be medically retired under chapter 61 with disability ratings as low as zero).

As the Subcommittee is only too well aware in the wake of multiple recent reviews and commissions in recent years, far larger numbers with significant disabilities were denied medical retirement under service policies and told to “see the VA for any disability issues.”

So a 20-year retiree with a zero-to-30% medical retirement would be exempted from the higher TRICARE fees that would be imposed on a similar 20-year non-medical retiree who is immediately acknowledged by the VA as 100% disabled.

The Coalition does not raise these inequity issues in order to propose expanding the exemption, because that would imply a level of Coalition concurrence with the proposed fee hikes that does not exist. We raise them as another reason why the proposed fee increases are grossly inappropriate for all grades and categories of beneficiaries.

Pharmacy Co-Payments. The Administration proposes dramatic increases in retail and other pharmacy copays, as shown in the chart below.

DoD-Proposed Pharmacy Co-Payments (For All Retirees, Survivors, Guard/Reserve and Active Duty Family Members)						
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017
Retail (1 mo fill)						
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 mo fill)	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY2017
Generic	\$0	\$0	\$0	\$0	\$0	\$9
Brand	\$9	\$26	\$28	\$30	\$32	\$34
Non-Formulary	\$25	\$51	\$54	\$58	\$62	\$66

* Non-Formulary pharmaceuticals will have limited availability in retail pharmacies

Again, these are dramatic increases from the copayment rates the Administration proposed for FY2012, and implemented on Oct 1, 2011 in the absence of congressional objection.

For FY2012, the Administration imposed increases of \$2 to \$3 (e.g., from \$9 to \$12 for retail brand-name drugs and from \$3 to \$5 for retail generics.)

Now, only a year later, the proposal would more than double the new retail rates and triple the mail-order rates for brand-name medications.

In subsequent years, copays would rise for generics in the retail venue, and the copay the Administration just eliminated for mail-order generic drugs last year would not only be restored, but tripled.

These purely budget-driven proposals are inappropriate on several levels.

- The current \$5 retail generic copay already exceeds the \$4 generic copay widely available to any civilian who walks through the door at dozens of retail pharmacies. Proposed further increases in the outyears only exacerbate the relative disadvantage for military beneficiaries.
- The proposed brand-name and non-formulary copays would make the TRICARE pharmacy benefit little or no better than the median of civilian employer plans. In 2011, for example, 56% of civilian plans provide brand-name medications for a copay of \$25 or less, compared to the DoD-proposed \$26.
- Contrary to DoD assertions about exempting currently serving personnel from fee hikes, the pharmacy copay increases would apply to hundreds of thousands of drilling Guard and Reserve personnel, as well as to active duty, Guard and Reserve family members who don't have access to military pharmacies.
- DoD has expended relatively little substantive effort to increase use of the mail order system other than seeking to impose an ever-bigger "stick" of higher fees on those who use other venues. The Coalition has urged DoD to create positive incentives such as eliminating copays for maintenance medications (see next paragraph) and work with the Coalition to develop better communication materials to address real-world concerns that deter beneficiaries from mail-order use, and will continue to do so even with higher copays. These initiatives could save DoD hundreds of millions a year, but Coalition offers to partner on such efforts have been rebuffed.
- Such dramatic pharmacy copay increases will only discourage adherence to medication regimens for chronic conditions like asthma, diabetes, and more. Studies show that even modest copayment increases deter use of maintenance medications that are essential to preserving wellness and holding down far more expensive care when the conditions deteriorate. The Coalition has endorsed reducing or eliminating copays for maintenance medications to hold down long-term costs. This new proposal would fly in the face of that objective, sacrificing long-term beneficiary health for short-term cost savings.

The Coalition believes strongly that the TRICARE pharmacy benefit should be a top-tier benefit, not merely one that approaches the median of plans offered by civilian employers, and that it should enhance wellness goals rather than posing a new impediment to them.

The Coalition urges the Subcommittee to reject Administration-proposed pharmacy copayment increases that would inappropriately "civilianize" the military pharmacy benefit, dramatically raise costs for both retired and currently serving families, and deter beneficiaries from adhering to medication regimens that are essential to their long-term health as well as DoD's long-term cost containment.

Means-Testing Plan Discriminates Against Military Retirees. The Administration proposal envisions establishing graduated enrollment fees for TRICARE Prime and TFL, based on the amount of the retired servicemember's retired pay, as indicated in the charts previously shown.

This proposal would impose blatant and dramatic discrimination against military retirees.

No other federal employee or retiree pays income-based fees for service-earned health coverage. The President, the Secretary of Defense, and the Speaker of the House pay the same premiums as the lowest-paid federal civilian retiree.

Means-tested fees also are rare in the private sector. This is because healthcare has long been recognized as a service-earned benefit.

Means-testing healthcare as DoD proposes would turn the concept of service-based benefits on its head, so that the longer and more productive the service, the less the earned benefit.

This need-based mentality may be appropriate for social welfare programs, but its application to benefits that are earned by service and sacrifice is inappropriate and counterproductive.

The proposal also discriminates against the military by failing to apply the same protections provided to VA healthcare programs and beneficiaries.

No such fee increases are envisioned for VA care, and Congress expressly exempted VA healthcare and other programs from any reduction under sequestration.

In past years, Congress has strongly rejected far smaller VA fee increases proposed for non-disabled veterans who had served as few as two years.

In those contexts, imposing fee hikes of up to \$2,000 a year for those who have served and sacrificed for two or three decades is grossly inconsistent and inappropriate.

The Coalition urges the Subcommittee to oppose means-testing of military benefits, under which longer and more successful service would be penalized by progressive reduction of military healthcare benefits. The Coalition believes all retired servicemembers earned equal health care coverage by virtue of their service and that the proposed dramatic fee increases are inappropriate for servicemembers of all grades.

Indexing of TRICARE Fees. The Administration's FY2013 budget request proposes to index, either immediately or following some transition period, a variety of TRICARE fees to a health care cost index.

The specifics of how that cost index would be calculated, what beneficiary population it would account for, and who would be responsible for calculating it, have not yet been revealed to us.

Last year, DoD sources indicated an expectation that such an index would yield annual adjustments on the order of 6.2% per year.

The Coalition objects strongly to tying TRICARE fee growth for military beneficiaries to any measure of healthcare cost changes.

Indexing fees to healthcare cost growth would far outstrip annual retired pay increases and greatly erode retired compensation value.

During congressional debate on this topic last year, Congress rejected the health cost growth index and capped year-to-year percentage increases in TRICARE Prime fees at the percentage growth in military retired pay, reflecting the belief that the latter measure was fairer considering the very large, up-front premium already extracted from career military personnel over decades of service and sacrifice.

The chart below shows how DoD-proposed increases in TRICARE Prime enrollment fees, tied in the outyears to the proposed health cost index, would vastly exceed the COLA-based standard approved by Congress last year, imposing large beneficiary losses that would continue and accelerate with each passing year.

Monetary Impact of DoD-Proposed Fee Adjustment Methodology

Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)	Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)
2012	\$520	\$520	\$0	2029	\$859	\$3,135	\$2,275
2013	\$536	\$720	\$184	2030	\$885	\$3,329	\$2,444
2014	\$552	\$920	\$368	2031	\$912	\$3,535	\$2,624
2015	\$568	\$1,185	\$617	2032	\$939	\$3,755	\$2,815
2016	\$585	\$1,450	\$865	2033	\$967	\$3,987	\$3,020
2017	\$603	\$1,523	\$920	2034	\$996	\$4,235	\$3,238
2018	\$621	\$1,617	\$997	2035	\$1,026	\$4,497	\$3,471
2019	\$640	\$1,718	\$1,078	2036	\$1,057	\$4,776	\$3,719
2020	\$659	\$1,824	\$1,165	2037	\$1,089	\$5,072	\$3,983
2021	\$678	\$1,937	\$1,259	2038	\$1,121	\$5,387	\$4,265
2022	\$699	\$2,057	\$1,359	2039	\$1,155	\$5,721	\$4,565
2023	\$720	\$2,185	\$1,465	2040	\$1,190	\$6,075	\$4,886
2024	\$741	\$2,320	\$1,579	2041	\$1,225	\$6,452	\$5,226
2025	\$764	\$2,464	\$1,701	2042	\$1,262	\$6,852	\$5,590
2026	\$787	\$2,617	\$1,831	2043	\$1,300	\$7,277	\$5,977

2027	\$810	\$2,779	\$1,969	2044	\$1,339	\$7,728	\$6,389
2028	\$834	\$2,952	\$2,117	2045	\$1,379	\$8,207	\$6,828

* Uses DoD actuaries' 3% long-term COLA assumption for military retirement trust fund

**DoD proposal assumes a 6.2% annual health cost inflation factor

The Coalition urges the Subcommittee to reject the DoD proposal to index military health care fees to an index of health cost growth.

Annual Financial Impact of Fee Hikes on Military Families

The following chart highlights how the cumulative impact of the DoD-proposed fee changes would roughly double or triple annual health costs for the bulk of the affected force (grades E-7 to O-4). Cost growth would be significantly larger for grades W-4 and O-5 and above.

This chart assumes average use of medications. Many older families and those with disabled or otherwise at-risk children require significantly more medications, and the proposed doubling and tripling of pharmacy copays would increase those families' annual expenses substantially above those shown in the chart.

The chart also highlights what many overlook – that Medicare-eligibles already are required to pay significant Medicare Part B premiums in addition to the proposed new TFL and pharmacy fees.

Impact of DoD-Proposed FY2013 TRICARE Fees on Military Families (E-7 to O-4) (Recommended by DoD in the President's Budget)

E-7 / O-4 Retiree* Under Age 65, Family of Three

TRICARE Prime**	Current	FY 2013 Proposed	FY 2017
Enrollment Fee	\$520	\$720	\$1,523
Doctor Visit Copays	\$60	\$60	\$60
Rx Cost Shares***	\$408	\$744	\$1,032
Yearly Cost	\$988	\$ 1,524	\$2,615

Retiree Under Age 65, Family of Three

TRICARE Standard	Current	FY 2013 Proposed	FY 2017
Enrollment Fee	\$0	\$140	\$250
Deductible	\$300	\$320	\$580
Rx Cost Shares***	\$408	\$744	\$1,032
Yearly Cost	\$708	\$1,204	\$1,862

* Enrolled in 2nd Retirement Income Tier (W-4s, O-5s and higher grades would pay even more)

**Enrolled to the network and assumes 5 doctor visits per year.

***Assumes 2 generic and 2 brand name prescriptions per month in retail pharmacy

E-7 / O-4 Retiree* Over Age 65 and Spouse

TRICARE For Life**	Current	FY 13 Proposed	FY 2017
Medicare Part B	\$2,398	\$2,494****	\$2,917****
Enrollment Fee*	\$0	\$150	\$634
Rx Cost Shares***	\$756	\$1,428	\$1,956
Yearly Cost	\$3,154	\$4,072	\$5,507

*Enrolled in 2nd Retirement Income Tier (W-4s, O-5s and higher grades would pay even more)

**Assumes lowest tier Medicare Part B premium for new enrollee in 2012.

***3 generic and 4 brand name prescriptions per month purchased at retail pharmacy

****Assumes Part B increases of 4% per year

Currently Serving Family of Four

TRICARE Standard*	Current	FY 13 Proposed	FY 2017
Enrollment Fee	\$0	\$0	\$0
Deductible	\$300	\$300	\$300
Rx Cost Shares**	\$264	\$432	\$624
Yearly Cost	\$564	\$732	\$924

* Spouse and 2 children use Standard.

**Assumes 2 generic and 1 brand name prescriptions per month at retail pharmacy.

Military vs. Civilian Cash Fees Is “Apple to Orange” Comparison

The Coalition continues to object strongly to simple comparisons of military vs. civilian cash fees. Such “apple to orange” comparisons ignore most of the very great price career military members and families pay for their coverage in retirement.

The unique package of military retirement benefits – of which a key component is a superior health care benefit – is the primary offset provided uniformed service members for enduring a career of unique and extraordinary sacrifices that few Americans are willing to accept for one year, let alone 20 or 30. It is an unusual and essential compensation package a grateful Nation provides to the small fraction of the population who agree to subordinate their personal and family lives to protecting our national interests for so many years.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year pre-payment plan that must be completed to earn lifetime health coverage. Once that pre-payment is already rendered, the government cannot simply ignore it and focus only on post-service cash payments – as if the past service, sacrifice, and commitments had no value.

DoD and the Nation – as good-faith employers of the trusting members from whom they demand such extraordinary commitment and sacrifice – have a reciprocal health care obligation to retired service members and their families and survivors that far exceeds any civilian employer’s.

The Coalition believes the TRICARE fee controversy is caused in part by the lack of any statutory record of the purpose of military health care benefits and the specific benefit levels earned by a career of service in uniform.

Current law gives the Secretary of Defense broad latitude to adjust fees for TRICARE Prime and the pharmacy systems. Absent congressional intervention, the Secretary can choose not to increase fees for years at a time or to triple or quadruple fees, as in this year's budget proposal.

Until a few years ago, this was not a particular matter of concern, as no Secretary had previously proposed dramatic fee increases.

The experience of the recent past – during which several Secretaries proposed no increases and then a new Secretary proposed doubling, tripling, and quadrupling various fees – has convinced the Coalition that current law leaves military beneficiaries excessively vulnerable to the varying budgetary inclinations of the incumbent Secretary of Defense.

It's true that many private sector employers are choosing to shift more healthcare costs to their employees and retirees, and that's causing many still-working military retirees to fall back on their service-earned TRICARE coverage. Fallout from the recession has reinforced this trend.

Efforts to paint this in a negative light (i.e., implying that working-age military retirees with access to civilian employer plans should be expected to use those instead of military coverage) belie both the service-earned nature of the military coverage and the long-standing healthcare promises the government aggressively employed to induce their career service.

The Coalition believes the law should be changed to explicitly acknowledge that:

- *The healthcare benefit provided for members and families who complete a military career should be among the very best available to any American;*
- *The decades of service and sacrifice rendered by career military personnel constitute a significant pre-paid premium toward their healthcare in retirement; and*
- *The large value of this pre-paid premium should be accounted for by minimizing fees payable in retirement and avoiding significant and arbitrary increases from year to year.*

DoD Should Fix Inefficiencies, Not Punish Beneficiaries

Unlike civilian healthcare systems, the military health system is built mainly to meet military readiness requirements rather than to deliver needed care efficiently to beneficiaries.

Each Service maintains its unique facilities and systems to meet its unique needs, and its primary mission is to sustain readiness by keeping a healthy force and sustaining capacity to treat casualties from military actions. That model is built neither for cost efficiency nor beneficiary welfare.

When military forces deploy, the military medical force goes with them, and that forces families, retirees and survivors to use the more expensive civilian health care system in the absence of so many uniformed health care providers. This shift in the venue of care and the associated costs are completely out of beneficiary control.

These military-unique requirements have significantly increased readiness costs. But those added costs were incurred for the convenience of the military, not for any beneficiary consideration, and beneficiaries should not be expected to bear any share of military-driven costs – particularly in wartime.

The Coalition strongly rejects Defense leaders' efforts to seek dramatic beneficiary cost increases as a first cost-containment option rather than meeting their own responsibilities to manage military healthcare programs in a more cost-effective manner.

Instead of imposing higher fees on beneficiaries as the first budget option, DoD leaders should be held accountable for fixing their own management and oversight failures that add billions to defense health costs.

- Decades of GAO and other reports demonstrate DoD cost accounting systems are broken and unauditible.
- More than a dozen reports have recommended consolidated oversight of three separate service medical systems, four major contractors, and innumerable subcontractors that now compete for budget share in counterproductive ways.
- DoD-sponsored reviews indicate more efficient organization could cut health costs 30% without affecting care or beneficiary costs
- DoD's inexplicable refusal to partner with associations to expand mail-order pharmacy above the current low level has cost hundreds of millions per year (each prescription switched from retail to mail saves DoD \$125).
- Improve and expand focus on management of chronic diseases.
- Reduce inappropriate and costly emergency room use by expanding clinic hours, urgent care venues, open access appointing, and phone/web-based access to providers after hours.
- Reform the TRICARE contracting and acquisition process.
- Base incentives to providers on quality-driven clinical outcomes that reward efficiency and value.
- Eliminate referral requirements that add complexity and inhibit timely delivery of needed care.
- Fix broken appointing system that inhibits beneficiary access to care.

These are only some of the examples demonstrating that more effective management, oversight and reorganization of military healthcare delivery could dramatically reduce defense health costs without affecting care or costs for beneficiaries.

The Coalition urges the Subcommittee to hold Defense leaders accountable for their own management, oversight, and efficiency failures before seeking to shift more costs to beneficiaries. Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.

Wounded, Ill, and Injured Servicemember Care

Though the war in Iraq has officially ended and the country seeks an exit strategy in Afghanistan, the Coalition has great and continuing concerns about the longer-term stability and viability of the policies, programs, and services intended to care and support our wounded, ill, and injured and their families-caregivers.

As the Pentagon marks a decade at war, seamless transition between the Departments of Defense (DoD) and Veterans Affairs (VA) continues to be problematic in many cases for our wounded, ill, and injured troops; disabled veterans; and their family caregivers.

Since 2007, every National Defense Authorization Act has built upon institutionalizing a seamless and unified approach to caring and supporting America's wounded, ill, and injured and their families-caregivers.

TMC acknowledges the significant progress that has been made in caring for our nation's heroes and thanks the Subcommittee for its leadership and oversight on these pressing issues, particularly in the last four years since the Walter Reed scandal that brought to light the flaws and inadequacies of both DoD and VA health care and benefits systems.

But complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

The Coalition looks forward to continued work with the Subcommittee to address the remaining issues and fully establish systems of seamless care and benefits that support our transitioning wounded warriors and family members.

TMC strongly urges:

- *Joint hearings by the Armed Services and Veterans Affairs Committees addressing the Joint Executive Council's (JEC) effectiveness in daily oversight, management, collaboration, and coordination of the Departments' wounded warrior programs.*
- *Permanent funding, staffing, and accountability for congressionally mandated Defense Centers of Excellence and associated mental-behavioral health, suicide prevention, caregiver, respite, and other medical and non-medical programs.*
- *Continued aggressive oversight of the Integrated Disability Evaluation and legacy disability evaluations systems to ensure preservation of the 30-percent threshold for medical retirement, consistency and uniformity of policies, ratings, legal assistance, benefits, and transitional services Defense-wide.*

DoD – VA Seamless Transition

Institutional Oversight – While many legislative changes have improved the care and support of our wounded, ill, and injured servicemembers, the Coalition is concerned that the sunset in law of the DoD-VA Senior Oversight Committee (SOC) poses significant risks for effective day-to-day leadership and coordination of DoD and VA seamless transition efforts. While an informal SOC exists, the Pentagon has relegated responsibility and authority to lower levels of the agency, making it difficult for senior official involvement and oversight on these matters and limiting the Department's ability to fully establish a synchronized, uniform and seamless approach to care and services.

Previously, the Coalition has expressed concern that the change of Administration posed a significant challenge to the two departments' continuity of joint effort, as senior leaders whose personal

involvement had put interdepartmental efforts back on track left their positions and were replaced by new appointees who had no experience with past problems and no personal stake in ongoing initiatives.

Unfortunately, those concerns were realized, as many appointive positions in both departments went unfilled for long periods, requiring reorganization of responsibilities and entry of new people with little or no background or authority to engage systems and continue to move forward.

While many well-meaning and hard working military and civilians are doing their best to keep pushing progress forward, leadership, organization, and mission changes have left many leaders frustrated with the process.

The Coalition urges joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved.

In addition, the hearings should focus on implementation progress concerning:

- *Single separation physical;*
- *Single, integrated disability evaluation system;*
- *Bi-directional electronic medical and personnel records data transfer;*
- *Medical centers of excellence responsibilities vs. authority, operations, and research projects;*
- *Coordination of care and treatment, including DoD-VA federal/recovery care coordinator clinical and non-clinical services and case management programs; and*
- *Consolidated government agency support services, programs, and benefits.*

Continuity of Health Care – Transitioning between DoD and VA health care systems remains challenging and confusing to those trying to navigate and use these systems. Systemic, cultural, and bureaucratic barriers often prevent the service member or veteran from receiving the continuity of care they need to heal and have productive and a high level of quality of life they so desperately need and desire.

Service members and their families repeatedly tell us that DoD has done much to address trauma care, acute rehabilitation, and basic short-term rehabilitation. They are less satisfied with their transition from the military health care systems to longer-term care and support in military and VA medical systems.

We hear regularly from members who have experienced significant disruptions of care upon separation or medical retirement from service.

One is in the area of cognitive therapy, which is available to retired members under TRICARE only if it is not available through the VA. Unfortunately, members are caught in the middle because of differences between DoD and VA authorities on what constitutes cognitive therapy and the degree to which effective, evidenced-based therapy is available.

Action is needed to further protect the wounded, ill, injured, and disabled. The Subcommittee has acted previously to authorize three years of active-duty-level TRICARE coverage for the family members of

those who die on active duty. The Coalition believes we owe equal transition care continuity to those whose service-caused illnesses or injuries force their retirement from service.

The Coalition recommends:

- *Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.*
- *Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.*

DoD-VA Integrated Disability Evaluation System (IDES) – One of the most emotional issues that emerged from the Walter Reed scandal was the finding that services were “low-balling” disabled servicemembers’ disability ratings, with the result that many significantly disabled members were being separated and turned over to the VA rather than being medically retired (which requires a 30% or higher disability rating)—a trend that continues today, especially for those in the Guard and Reserves.

Congress has taken positive steps to address this situation, including establishment of the Physical Disability Board of Review (PDBR) to give previously separated servicemembers an opportunity to appeal too-low disability ratings.

A jointly executed DoD-VA IDES pilot has been implemented and expanded, but experience under IDES has shown that the fundamental goals it was to achieve – to be more streamlined, faster, less complex, and non-adversarial -- have for the most part yet to be realized. The service member, typically without effective assistance, must navigate a still-complex adversarial system that is compromised by incomplete medical evaluations, overlooked conditions, and examinations omitting diagnoses – resulting in gaps in care, delays in decision-making, and lack of timely adjudication.

TMC was further encouraged that wounded, ill, and injured members would benefit from the Dec. 19, 2007 Under Secretary of Defense (Personnel and Readiness) Directive Type Memorandum (DTM) which added “deployability” as a consideration in the DES decision process – permitting medical separation/retirement based on a medical condition that renders a member non-deployable.

Unfortunately, several cases surfaced indicating the Services failed to incorporate the DTM in their DES process. In this regard, many members found “fit” by the PEB have been deemed by the service to be “unsuitable” for continued service – and administratively separated – because the member’s medical condition prevents them from being able to deploy or maintain their current occupational skill. The Coalition is grateful to the subcommittee for including provisions in both the FY2011 and FY2012 Defense Authorization Act prohibiting this practice.

Unfortunately, some services still use other loopholes, such as designating disorders as “existing prior to service” – even though the VA rated the condition as “service-connected” and the member was deemed fit enough to serve in a combat zone. The Coalition believes strongly that once we have sent a soldier,

sailor, airman or marine to war, the member should be given the benefit of the doubt that any condition subsequently found should not be considered as existing prior to service.

The Coalition believes strongly that all unfitting “service-connected” conditions as rated by the VA should be included in the DoD disability rating, and any member determined by the parent service to be 30 percent or more disabled should continue to be eligible for a military disability retirement with all attendant benefits, including lifetime TRICARE eligibility for the member and his/her family. We do not support efforts to disconnect health care eligibility from disability retired pay eligibility.

The Coalition also agrees with the opinion expressed by former Secretary Gates that a member forced from service for wartime injuries should not be separated, but should be awarded a high enough rating to be retired for disability.

The Coalition recommends:

- *Preserving the statutory 30 percent disability threshold for medical retirement in order to provide lifetime TRICARE coverage for those who are injured while on active duty.*
- *Reforming the DoD disability retirement system to require inclusion of all unfitting conditions and accepting the VA’s “service-connected” rating.*
- *Ensuring any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled service members.*
- *Eliminating distinctions between disabilities incurred in combat vs. non-combat when determining benefits eligibility for retirement.*
- *Revision of the VA schedule for rating disabilities (VASRD) to improve the care and treatment of those wounded, ill, and injured, especially those diagnosed with PTSD and TBI.*
- *Barring designation of disabling conditions as “existing prior to service” for servicemembers who have been deployed to a combat zone.*
- *Directing DoD to re-engineer and redesign the front end of IDES to (1) better ensure medical evaluations are consistently based on a fully developed, accurate medical summary; (2) permit the servicemember’s full participation; (3) afford each individual consistent, effective representation throughout the process; and (4) streamline the system by eliminating the redundancy of dual adjudication of disability.*

Caregiver/Family Support Services – The sad reality is that, for the most severely injured servicemembers, family members or other loved ones are often required to become full-time caregivers. Many have lost their jobs, homes, and savings in order to meet caregiver needs of a servicemember who has become incapacitated due to service-caused wounds, injuries or illness.

The Coalition believes the government has an obligation to provide reasonable compensation and training for such caregivers, who never dreamed that their own well-being, careers, and futures would be devastated by military-caused injuries to their servicemembers.

In 2009, the Subcommittee authorized a special payment to an active duty servicemember to allow compensation of a family member or professional caregiver. The authorized payment was in the same amount authorized by the VA for veterans' aid-and-attendance needs, reflecting the Subcommittee's thinking that caregiver compensation should be seamless when the member transitions from active duty to VA care, as long as the caregiver requirements remain the same.

The Coalition appreciates the Subcommittee's effort to sustain that principle in the FY2011 Defense Authorization Act in terms of caregiver support, and urges additional steps to ensure that non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage are provided health and respite care while the injured member remains on active duty, commensurate with what the VA authorizes for caregivers of wounded, ill, and injured veterans.

In a similar vein, many wounded or otherwise-disabled members experience significant difficulty transitioning to medical retirement status. To assist in this process, consideration should be given to authorizing medically retired members and their families to remain in on-base housing for up to one year after retirement, in the same way that families are allowed to do when a member dies on active duty.

Another important care continuity issue for the severely wounded, ill and injured is the failure to keep caregivers of these personnel involved in every step of the care and follow-up process. Again and again, we are told of clinicians and administrative people who seek to exclude caregiver participation and talk only to the injured member -- despite the reality that the injured member may not be capable of remembering instructions or managing their appointments and courses of care. In many cases, this occurs even when the caregiver has a medical power of attorney and other authorities documented in the member's records.

Congress, DoD and the VA have worked to get essential information to the wounded, ill, and injured and their caregivers. Similar efforts are urgently needed to educate medical providers and administrative staff at all levels that the final responsibility for ensuring execution of prescribed regimens of care for severely wounded, ill and injured servicemembers typically rests with the caregivers, who must be kept involved and informed on all aspects of these members' treatment, appointments, and medical evaluations.

The Coalition recommends:

- ***Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely wounded, ill, and injured personnel.***
- ***Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for eligible caregivers of medically retired or separated members.***

- *Extending eligibility for residence in on-base facilities for up to one year to medically retired or severely wounded, ill, and injured servicemembers and their families (or until the servicemember receives a VA compensation rating, whichever is longer).*

Guard and Reserve Health Care issues – The Coalition is very grateful for sustained progress in providing reservists' families a continuum of government-sponsored health care coverage options throughout their military careers into retirement, but key gaps remain.

For years, TMC has recommended continuous government health care coverage options for Guard and Reserve (G-R) families. Operational reserve policy during two protracted wars has only magnified that need.

DoD took the first step in the 1990s by establishing a policy to pay the Federal Health Benefits Program (FEHB) premiums for G-R employees of the Department during periods of their active duty service.

Thanks to this subcommittee's efforts, considerable additional progress has been made in subsequent years to provide at least some form of military health coverage at each stage of a Reserve Component member's life, including TRICARE Reserve Select for actively drilling Guard/Reserve families and TRICARE Retired Reserve for "gray area" retirees.

But some deserving segments of the Guard and Reserve population remain without needed coverage, including post-deployed members of the Individual Ready Reserve and early Reserve retirees who are in receipt of non-regular retired pay before age 60.

In other cases, the Coalition believes it would serve Guard/Reserve members' and DoD's common interests to explore additional options for delivery of care to Guard and Reserve families. As deployment rates decline, for example, it would be cost-effective to establish an option under which DoD would subsidize continuation of employer coverage for family members during (hopefully less-frequent) periods of activation rather than funding year-round TRS coverage.

TMC continues to support closing the remaining gaps to establish a continuum of health coverage for operational reserve families.

The Coalition recommends:

- *Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60*
- *Authorizing premium-based TRICARE coverage for members of the Individual Ready Reserve after being called to active service for a cumulative period of at least 12 months*
- *Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.*

- *Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.*
- *Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.*
- *Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.*
- *Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.*

Additional TRICARE Prime Issues – The Coalition is very concerned about growing dissatisfaction among TRICARE Prime enrollees – which is actually higher among active duty families than among retired families. The dissatisfaction arises from increasing difficulties experienced by beneficiaries in getting appointments, referrals to specialists, and sustaining continuity of care from specific providers.

Increasingly, beneficiaries with a primary care manager in a military treatment facility find they are unable to get appointments because so many providers have deployed, have been gone PCS, or are otherwise understaffed or unavailable.

The Coalition supports implementation of a pilot study by TMA in each of the three TRICARE Regions to study the efficacy of revitalizing the resource sharing program used prior to the implementation of the TRICARE-Third Generation (T-3) contracts under the current Managed Care Support contract program.

The Coalition strongly advocates the transparency of healthcare information via the patient electronic record between both the MTF provider and network providers. Additionally, institutional and provider healthcare quality information should be available to all beneficiaries so that they can make better informed decisions.

We are concerned about the impact on beneficiaries of the elimination of some Prime service areas under the new contract. This will entail a substantive change in health care delivery for thousands of beneficiaries, may require many to find new providers, and will change the support system for beneficiaries who have difficulty accessing care.

To date, largely because of the delay in award of the new contracts, beneficiaries who live in the areas where Prime service will be terminated have not received any information on this and how it may affect them.

The Military Coalition urges the Subcommittee to:

- *Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.*

- *Require increased DoD efforts to ensure consistency between both the MTFs and purchased care sectors in meeting Prime access standards.*
- *Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas.*

Additional TRICARE Standard Issues – The Coalition appreciates the Subcommittee’s continuing interest in the specific problems unique to TRICARE Standard beneficiaries. TRICARE Standard beneficiaries need assistance in finding participating providers within a reasonable time and distance from their home. This is particularly important with the expansion of TRICARE Reserve Select and the upcoming change in the Prime Service Areas, which will place thousands more beneficiaries into TRICARE Standard.

The Coalition is grateful that the FY2012 Defense Authorization Act extended through 2015 the requirement for DoD to survey participation of providers in TRICARE Standard.

However, we are concerned that DoD has not yet established benchmarks for adequacy of provider participation, as required by section 711(a)(2) of the FY2008 NDAA. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population, but could severely constrain access in other areas with higher beneficiary density.

The Coalition hopes to see an objective participation standard (perhaps based on the number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require intervention.

Further, the Coalition believes the Department should be required to take action to increase provider participation in localities where participation falls short of the standard.

A source of continuing concern is the TRICARE Standard inpatient copay for retired members, which now stands at \$708 per day or 25% of billed charges. The Coalition believes this amount already is excessive, and should be capped at that rate for the foreseeable future.

The Coalition urges the Subcommittee to:

- *Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.*
- *Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation to meet the threshold.*
- *Require a specific report on provider participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.*
- *Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.*

APPENDIX B



T H E M I L I T A R Y C O A L I T I O N

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STATEMENT OF

THE MILITARY COALITION (TMC)

before the

SENATE ARMED SERVICES
SUBCOMMITTEE ON PERSONNEL

concerning

Military Personnel and Compensation Issues

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning issues affecting the uniformed services community. This statement for the record provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

Air Force Association
 Air Force Sergeants Association
 Air Force Women Officers Associated
 AMVETS (American Veterans)
 Army Aviation Association of America
 Association of Military Surgeons of the United States
 Association of the United States Army
 Association of the United States Navy
 Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
 Commissioned Officers Association of the U.S. Public Health Service, Inc.
 Fleet Reserve Association
 Gold Star Wives of America, Inc.
 Iraq and Afghanistan Veterans of America
 Jewish War Veterans of the United States of America
 Marine Corps League
 Marine Corps Reserve Association
 Military Chaplains Association of the United States of America
 Military Officers Association of America
 Military Order of the Purple Heart
 National Association for Uniformed Services
 National Guard Association of the United States
 National Military Family Association
 Naval Enlisted Reserve Association
 Non Commissioned Officers Association
 Reserve Enlisted Association
 Reserve Officers Association
 Society of Medical Consultants to the Armed Forces
 The Retired Enlisted Association
 United States Army Warrant Officers Association
 United States Coast Guard Chief Petty Officers Association
 Veterans of Foreign Wars
 Vietnam Veterans of America
 Wounded Warrior Project

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

Executive Summary

Force Levels

Over the past several years, Congress has addressed the greater than anticipated requirements and resources to support the operational requirements and the resulting negative impact on the quality of life of uniformed servicemembers by boosting the Services' end strength resulting in increasing dwell time.

TMC remains concerned about the adequacy of strength levels in light of stress indicators including increased divorces, alarming suicide rates, and other symptoms.

Therefore, the Coalition urges the Subcommittee to:

- Ensure that the drawdown does not proceed at a rate which would adversely impact the required dwell time for the troops; that is, sustain force levels which are consistent with the mission.
- Ensure that the Services maximize the use of voluntary drawdown tools (including the temporary early retirement authority included in the FY2012 National Defense Authorization Act) before resorting to involuntary measures.
- Sustain adequate recruiting and retention resources to enable the uniformed services to sustain their continuing needs for top-quality personnel.
- Support a defense budget that funds both people and weapons needs.

Military Retirement

The purpose of the unique military retirement package is to offset the extraordinary demands and sacrifices inherent in a service career. These benefits provide a powerful incentive for top-quality people to serve 20-30 years in uniform.

The Administration's budget submission calls for a BRAC-like study to review the retirement system which has proven to be so critical to sustaining long-term retention and readiness. The program must not be subject to a short-circuited legislative process that denies due diligence and leaves this crucial program subject to the whims of a small group tasked to meet a political deadline.

The Coalition urges the Subcommittee to:

- Oppose initiatives that would "civilianize" the military retirement system, ignore the lessons of the ill-fated REDUX initiative, and inadequately recognize the unique and extraordinary demands and sacrifices inherent in a military career.
- Oppose a BRAC-like legislative process for military retirement reform that would short-circuit the opportunity for thorough Armed Services Committee deliberation.

Currently Serving Issues

Compensation – Congress has made great strides to restore military pay comparability over the past 12 years, including a statutory change that explicitly ties military pay raises to Employment Cost Index (ECI) growth.

Despite significant progress and retention problems associated with the “erosion of pay and benefits” abated, there are renewed calls to cut back on military raises, create a new comparability standard or substitute more bonuses for pay raises in the interests of deficit reduction.

The Coalition believes such proposals are exceptionally short-sighted in view of the extensive negative experience with military pay raise caps.

The Coalition urges the Subcommittee to sustain fully-comparable annual military pay raises based on the Employment Cost Index as specified in current law.

Wounded, Ill, and Injured Servicemember Compensation – Complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

The Coalition urges the Subcommittee to:

- Ensure any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled servicemembers.
- Oppose distinguishing between disabilities incurred in combat versus non-combat service when determining benefits eligibility for retirement.
- Support extending eligibility for residence in on-base facilities for up to one year to medically retired, severely wounded servicemembers and their families.

DoD Resale Operations – TMC strongly believes military commissary, exchange and Morale Welfare and Recreation (MWR) programs contribute significantly to a strong national defense by sustaining morale and quality of life for military beneficiaries both within the United States and around the globe.

The Coalition urges the Subcommittee to resist initiatives to civilianize or consolidate DoD resale systems in ways that would reduce their value to patrons.

Family Readiness and Support – A fully funded, robust family readiness program is crucial to military readiness, especially given the continuing demands of deployments and the uncertainty of the legacy of the effects of 10 years of war on servicemembers and their families.

The Coalition urges the Subcommittee to:

- Continue much-needed supplemental funding authority to schools impacted by large populations of military students.
- Direct DoD to report on MWR category programs.
- Fully fund effective programs.
- Ensure all National Guard and Reserve Yellow Ribbon Programs meet a standard level of family support within each State.
- Continue support for child care needs of the highly deployable, operational total force community.
- Encourage greater military spouse educational and career opportunities, and ensure existing programs are accessible and effective.
- Continue pressing the Defense Department to implement flexible spending accounts to enable military families to pay health care and child care expenses with pre-tax dollars.

Base Realignment and Closure (BRAC) Rounds – The Administration’s budget calls for two additional rounds of BRAC in order to garner savings. The Coalition is very concerned that these decisions are driven solely to save money.

The Coalition urges the subcommittee to proceed cautiously with additional BRAC rounds and verify DoD has accounted for all the implementing costs of their proposals.

National Guard and Reserve Issues

Operational Reserve Retention and Retirement Reform – The current law that credits only active service since January 28, 2008 disenfranchises and devalues the service of hundreds of thousands of Guard/Reserve members who served combat tours (multiple tours, in thousands of cases) between 2001 and 2008.

The Coalition urges the Subcommittee to:

- Eliminate the fiscal year limitation which effectively denies full early retirement credit for active duty tours that span the October 1 start date of a fiscal year.
- Modernize the reserve retirement system to incentivize continued service beyond 20 years and provide fair recognition of increased requirements for active duty service.
- Authorize early retirement credit for all Guard and Reserve members who have served on active duty tours of at least 90 days retroactive to September 11, 2001.

Yellow Ribbon Reintegration Program – Congress has provided increased resources to support the transition of warrior-citizens back into the community; however, program execution remains spotty from state to state and falls short for returning Federal Reserve warriors in widely dispersed regional commands.

The Military Coalition urges Congress to hold oversight hearings and direct additional improvements in coordination, collaboration and consistency of Yellow Ribbon services between States.

Reserve Compensation System – Related to this are demands on qualifications, mental skills, physical fitness, and training in conjunction with national security missions at home and abroad. The compensation system needs to be improved to attract and retain individuals into the Guard/Reserve.

The Coalition recommends Congress authorize:

- Credit for all inactive duty training points earned annually toward reserve retirement.
- Parity in special incentive pay for career enlisted/officer special aviation incentive pay, diving special duty pay, and pro-pay for reserve component medical professionals.
- Recalculation of retirement points after one year of activation. A recent law change allowed certain flag and general officers to recalculate retirement pay after one year of active duty. TMC believes this opportunity should be made available to all ranks.

Guard/Reserve GI Bill – Benefits for joining the Selected Reserve were not upgraded or integrated in the Post-9/11 GI Bill as TMC has long recommended. However, the Budget request proposes to reduce contributions into the DoD Educational Benefit Trust Fund.

The Coalition recommends the Subcommittee:

- Restore basic reserve MGIB benefits for initially joining the Selected Reserve to the historic benchmark of 47-50% of active duty benefits.
- Integrate reserve and active duty MGIB laws in Title 38.
- Enact academic protections for mobilized Guard and Reserve students, including refund guarantees and exemption of Federal student loan payments during activation.

Guard/Reserve Family Support Programs – We have seen considerable progress in outreach programs and services for returning Guard and Reserve warriors and their families. Family support programs promote better communication with servicemembers. Specialized support and training for geographically separated Guard and Reserve families and volunteers are needed.

The Coalition urges the Subcommittee to:

- Ensure programs are in place to meet the special information and support needs of families of individual augmentees or those who are geographically dispersed.
- Fund joint programs among military and community leaders to support servicemembers and families during all phases of deployments.
- Provide preventive counseling services for servicemembers and families.
- Authorize child care, respite care, family readiness group meetings and drill time.
- Improve the joint family readiness program to facilitate understanding and sharing of information between all family members.

Retiree Issues

Cost-of-Living Adjustments (COLAs) – COLAs are particularly important to military retirees, disabled retirees, and survivors because they start drawing their annuities at younger ages than most other COLA-eligibles and thus experience the compounding effects over a greater number of years. To the extent that COLAs fail to keep up with living costs, real purchasing power declines dramatically as long the longer a retiree lives.

The Coalition urges the Subcommittee to ensure continued fulfillment of congressional COLA intent, as expressed in House National Security (HNSC) Committee Print of Title 37, USC: "to provide every military retired member the same purchasing power of the retired pay to which he was entitled at the time of retirement [and ensure it is] not, at any time in the future...eroded by subsequent increases in consumer prices."

Concurrent Receipt – The Coalition strongly believes that career military members earn their retired pay by service alone, and that those who suffer a service-caused disability in the process should have any VA disability compensation from the VA added to, not subtracted from, their service-earned military retired pay and this remains a key goal in 2012.

The Coalition urges the Subcommittee to continue to seek options to:

- Expand Concurrent Retirement and Disability Payments (CRDP) to disabled retirees not eligible under the current statute, to include vesting of earned retirement credit for Chapter 61 retirees with less than 20 years of service.

- Resolve the so-called Combat Related Special Compensation (CRSC) "glitch" that causes combat-disabled members' compensation to decline when their VA disability rating is increased; or as an interim step.
- Pursue legislation specifying that a disabled retiree's CRSC disability compensation cannot be reduced when his or her VA disability rating increases until the retiree is afforded the opportunity to elect between CRSC and CRDP.

Fair Treatment for Servicemembers Affected by Force Reductions – Over the next five years, over 100,000 additional servicemembers will transition from wearing a uniform into the private sector as part of the force drawdown.

During any force reduction, servicemembers who intend to make the service a career are forced out. We believe the Nation should recognize their service and provide a "transportable" benefit for those that have their careers curtailed involuntarily short of 20 years.

The Coalition recommends enacting temporary legislation that would allow members separated during periods of significant force reductions to deposit part or all of their involuntary separation pay or VSP into their TSP account.

Survivor Issues

SBP-DIC Offset – The Coalition believes widows whose sponsors' deaths were caused by military service should not be last in line for redress.

The Coalition urges the Subcommittee to:

- Continue its leadership in seeking to eliminate the SBP-DIC offset.
- Authorize SBP annuities to be placed into a Special Needs Trust for disabled survivors who otherwise lose eligibility for Supplemental Security Income (SSI) and Medicaid.
- Reduce the age for paid-up SBP to age 67 to be fairer to those who joined the military at age 17, 18 or 19.
- Reinstated SBP annuities to survivors who transfer benefits to their children when the children reach majority, or when a second marriage ends.
- Exempt SBP-eligible children from being inadvertently penalized by the Alternative Minimum Tax (AMT), which treats SBP as unearned income and taxes it at the higher 26% AMT rate.

Final Retired Pay Check – Under current law, DFAS recoups from military widows'/widowers' bank accounts all retired pay for the month in which a retiree dies.

TMC urges the Subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

Overview

Mr. Chairman, The Military Coalition thanks you and the entire Subcommittee for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. Your efforts have had a significant and positive impact in the lives of the entire uniformed services community.

Presently, the Coalition has three major concerns with the Administration's proposed FY2013 Department of Defense (DoD) budget: health care fee increases, force level reductions, and the establishment of a commission to examine military retirement. This statement will focus on two of these areas as well as provide our collective perspective on other issues concerning the entire uniformed service community. We will address health care issues in a separate statement for the March 22 hearing.

The past few years have been exceptionally arduous, with our military winding down operations in Iraq while continuing operations in Afghanistan, all as the nation recovers slowly from the economic crisis. Congress and the Administration have had difficult choices to make as they worked to bolster the weak economy while facing record-breaking budget deficits.

We are grateful that DoD and Congress have given personnel issues top priority in the past few years. However, as we enter the eleventh year of intense wartime operations, the Coalition believes that critical personnel issues are being marginalized in the proposed FY2013 DoD budget.

Despite extraordinary demands, men and women in uniform are still answering the call – thanks in no small measure to the Subcommittee's strong and consistent support – but only at the cost of ever-greater personal sacrifices.

As you know, we have seen dramatic increases in suicide rates which reflect the long-term effects of requiring the same people to return to a combat theater again and again. In addition, there are reports that the military divorce rates are at the highest level since 1999.

In these times of growing political and economic pressures, the Coalition relies on the continued good judgment of the Armed Services Committees to ensure the Nation allocates the required resources to sustain a strong national defense, and in particular, to properly meet the pressing needs of the less than one percent of the American population – our men and women in uniform – who protect the freedoms of the remaining 99 percent.

In this statement, The Coalition offers our collective recommendations on what must be done to meet these essential needs.

Force Levels

Personnel Strength and Associated Funding – The Pentagon's budget submission includes a significant drawdown of over 100,000 troops, predominately affecting troops on the ground – the same troops that have endured repeated deployments over the past decade.

We understand that the Services are looking to reduce force levels as our troops return from the Middle East and the Coalition's primary concern is that the Pentagon's plan does not force additional burdens on our servicemembers and their families by continuing to fall short of dwell time goals.

For the last decade, servicemembers and their families have endured unprecedented sacrifices often having less than a year at home before returning for another year in combat.

Both Defense and Service leaders have acknowledged that minimum dwell time should be at least two years at home after a year deployment. That minimum goal has yet to be attained for all deploying servicemembers.

We are also concerned about sustaining a surge capacity for unexpected contingencies (as of Sept 10, 2011, no one anticipated the following decade-plus of war) and retaining combat experience by encouraging departing veterans to join the Guard and Reserve.

Cutting Guard/Reserve as well as active forces will make achieving these goals even more difficult.

The Coalition urges the Subcommittee to ensure adequate personnel strengths and funding are authorized to meet national security strategy requirements and dwell time goals.

TMC remains concerned about the adequacy of strength levels in light of stress indicators including increased divorces, alarming suicide rates, and other symptoms.

Therefore, the Coalition urges the Subcommittee to:

- *Ensure that the drawdown does not proceed at a rate which would adversely impact the required dwell time for the troops; that is, sustain force levels which are consistent with the mission.*
- *Ensure that the Services maximize the use of voluntary drawdown tools (including the temporary early retirement authority included in the FY2012 Defense Authorization Act) before resorting to involuntary measures.*
- *Sustain adequate recruiting and retention resources to enable the uniformed services to sustain the continuing needs for top-quality personnel.*
- *Support a defense budget that funds both people and weapons needs.*

Military Retirement

Uniformed Services Retirement System – The entire military compensation system, to include the retirement benefit, is based on principles outlined in the DoD's Military Compensation Background Papers and "should be designed to foster and maintain the concept of the profession of arms as a dignified, respected, sought after, and honorable career."

The purpose of the unique military retirement package is to offset the extraordinary demands and sacrifices inherent in a service career. Benefits provide a powerful incentive for top-quality people to serve 20-30 years in uniform, despite the burden of sacrifices as eloquently articulated by the Secretary of the Air Force during his January 18, 1978 testimony before the President's Commission on Military Compensation:

"The military services are unique callings. The demands we place on our military men and women are unlike those of any other country. Our worldwide interests and commitments place heavy burdens and responsibilities on their shoulders. They must be prepared to live anywhere, fight anywhere, and maintain high morale and combat efficiency under frequently adverse and uncomfortable conditions. They are asked to undergo frequent exposure to risk, long hours, periodic relocation and family separation. They accept abridgement of freedom of speech, political and organizational activity, and control over living and working conditions. They are all part of the very personal price our military people pay.

"Yet all of this must be done in the light of – and in comparison to – a civilian sector that is considerably different. We ask military people to be highly disciplined when society places a heavy premium on individual freedom, to maintain a steady and acute sense of purpose when some in society question the value of our institutions and debate our national goals. In short, we ask them to surrender elements of their freedom in order to serve and defend a society that has the highest degree of liberty and independence in the world. And, I might add, a society with the highest standard of living and an unmatched quality of life.

"Implicit in this concept of military service must be long-term security and a system of institutional supports for the serviceman and his family which are beyond the level of compensation commonly offered in the private, industrial sector."

There is no better illustration of that reality than the experience of the past decade of war. Absent the career drawing power of the current 20-year retirement system and its promised benefits, the Coalition asserts that sustaining anything approaching needed retention rates over such an extended period of constant combat deployments would have been impossible.

The crucial element to sustaining a high-quality, career military force is establishing a strong bond of reciprocal commitment between the servicemember and the government. If that reciprocity is not fulfilled, if we "break faith" with those that serve, retention and readiness will inevitably suffer.

The Coalition believes the government has a unique employer's responsibility to the small segment of Americans it actively induces to subordinate their interests to the America's for 20 to 30 years that goes far beyond any civilian employer's obligation to its employees.

The uniformed services retirement system has had its critics since the 1970s and even earlier.

In the 1980s, budget pressures led to amending retirement rules twice for new service entrants:

- Basing retired pay calculations on the high-36-month average of basic pay instead of final basic pay (1980), and
- Enacting the REDUX system that cut 20-year retired pay value by more than 25% (1986).

At the time the REDUX plan was being considered, then-Secretary of Defense Caspar Weinberger strongly (but unsuccessfully) opposed it (see attached letter), arguing the change would harm retention and degrade readiness. "It says in absolute terms," said Weinberger, "that the unique, dangerous, and vital sacrifices they routinely make are not worth the taxpayer dollars they receive."

When his prediction of adverse retention consequences proved all too accurate in the 1990s, Congress had to repeal REDUX in 1999 at the urging of the Joint Chiefs of Staff.

Subsequently, innumerable studies and task forces have recommended further dramatic changes, usually either to save money, to make the system more like those offered under civilian programs, or both.

Most recently, groups such as the National Commission on Fiscal Responsibility and Reform, the Debt Reduction Task Force, the Sustainable Defense Task Force, and the Defense Business Board's "Modernizing the Military Retirement" Task Group have all recommended dramatically revamping the system more on civilian lines, with significantly reduced and delayed military retirement compensation.

All too aware of the lessons of REDUX, Congress has wisely ignored and dismissed these ivory-tower recommendations, which propose far greater retirement cuts than REDUX entailed.

The existing retirement system is often characterized as "inflexible", limiting the ability of Service personnel managers to more precisely and effectively manage the force. The Coalition strongly disagrees.

The Services already have substantial authority to adjust high-year-of-tenure limits to enforce the unique military "up-or-out" promotion system. Other authorities exist, and the Services are currently exercising them, to incentivize voluntary separations and voluntary or mandatory early retirements.

The Services routinely tighten retention and reenlistment incentives and other restrictions when budget or other considerations create a need for additional separations and retirements. And when necessary, Congress has provided additional special drawdown authorities.

But the practical reality is that precisely planned force management initiatives are regularly tossed aside in the wake of world events which force dramatic reversals of those planned actions. Plans which envision delaying retirement eligibility until age 57 or 60 belie the reality that the Services don't want the vast majority of members to stay in uniform that long.

Service desires for unlimited flexibility to shape the force may be appropriate for management of hardware and other non-sentient resources. However, the Services are dependent upon attracting and retaining smart people who understand all too well when their leaders put no limits on the sacrifices that may be demanded of them, but also wish to reserve the right to kick them out at will....even while building a system that assumes they will be willing to serve under these conditions until age 60.

Servicemembers from whom we demand so much deserve some stability of career expectations in return.

We believe that "civilianizing" the military benefit package would dramatically undermine the primary military career retention incentive and would be disastrous for retention and readiness, as they increase the incentives to leave and reduce the incentives for career service.

Moreover, we believe it is irresponsible to focus on budget and “civilian equity” concerns while ignoring the primary purpose of the retirement system – to ensure a strong and top-quality career force in spite of arduous service conditions that no civilians experience and few are willing to accept.

The Coalition is particularly concerned that the Administration’s budget submission calls for a BRAC-like legislative strategy under which Congress would have to give a retirement study commission’s recommendations an “up or down” vote with only limited debate and no opportunity for amendments.

The Coalition is not opposed to a review of retirement pay, but we adamantly oppose a BRAC-like consideration process that would subvert thorough review, consideration, and determinations of propriety by the Armed Services Committees.

The military retirement program that has proven to be so critical to sustaining long-term retention and readiness, must not be subject to a short-circuited legislative process that denies due diligence and leaves this crucial program subject to the whims of a small group tasked to meet a political deadline.

The Coalition urges the Subcommittee to:

- *Oppose initiatives that would “civilianize” the military retirement system, ignore the lessons of the ill-fated REDUX initiative, and inadequately recognize the unique and extraordinary demands and sacrifices inherent in a military career.*
- *Oppose a BRAC-like legislative process for military retirement reform that would short-circuit the opportunity for thorough Armed Services Committee deliberation.*

Currently Serving Issues

Compensation – The Coalition is pleased that the Administration’s budget plan envisions proposes military pay raises for 2013 and 2014 that reflect the growth in private sector pay, as measured by the Bureau of Labor Statistics’ Employment Cost Index (ECI).

But we are very concerned that the proposal includes plans to break the tie to civilian pay growth by limiting military raises to .5%, 1%, and 1.5% for 2015, 2016, and 2017, respectively.

History has shown that capping military raises is an exceptionally slippery slope that has never ended well.

In the 1970s, a succession of annual pay raise caps contributed to serious retention problems that had to be addressed by two large “catch-up” raises in 1981 and 1982. But that lesson was quickly forgotten.

Throughout the 1980s and ‘90s, budget problems led to regular capping of military pay raises below private sector pay growth, eventually accumulating a “pay comparability gap” which peaked at 13.5% in 1998-99, and again contributed significantly to serious retention problems.

Congress has made great strides to restore military pay comparability over the intervening 12 years, including a statutory change that explicitly ties military pay raises to ECI growth.

Now that significant progress has been made and the “erosion of pay and benefits” retention-related problems have abated, there have been renewed calls to cut back on military raises, create a new comparability standard or substitute more bonuses for pay raises in the interests of deficit reduction.

The Coalition believes such proposals are exceptionally short-sighted in view of the extensive negative experience with military pay raise caps.

The Coalition is concerned that many in the Administration and some members of Congress are unaware of the history of past compensation changes and their unforeseen outcomes. Moreover, some view these vital programs simply as a source of savings without regard to the impact they may have on long term readiness in the All-Volunteer Force.

History indicates that, once military pay raise caps start, they tend to continue until they cause retention problems that then have to be addressed through significant pay raise plus-ups.

This is a significant irony, in that the whole purpose of sustaining pay comparability through good times and bad is to prevent retention and readiness problems from occurring, rather than going through an endless cycle of causing problems and then repairing them.

Additionally, the Pentagon has been advocating a new comparability standard under which each pay and longevity cell would represent the 70th percentile of compensation for similarly-educated civilians.

A 2010 Congressional Budget Office report asserted that, considering adjustments in housing allowances, many military people actually are paid somewhat more than their civilian counterparts in terms of Regular Military Compensation (RMC), composed of basic pay, food and housing allowances, and the tax advantage that accrues because the allowances are tax-free.

The Coalition believes such assertions are fundamentally flawed for three distinct reasons.

First, the RMC concept was developed in the 1960s, when all servicemembers received the same allowances, regardless of location, and the allowances were arbitrarily established. Congress has since transformed the allowances into reimbursements for actual food costs and median locality-based housing costs. Under the RMC comparability concept, a year in which taxes increase and average housing allowances rise (e.g., based on growth in high-cost areas) would yield a perverse requirement to cut basic pay to restore comparability.

Second, the Coalition is not convinced that the civilian comparison cohort or percentile comparison points as proposed by DoD are appropriate given that the military:

- Recruits from the top half of the civilian aptitude population;
- Finds that only about 25% of America’s youth qualify for entry;
- Requires career-long education and training advancement; and
- Enforces a competitive “up-or-out” promotion system to ensure progressive quality enhancements among those with longer service.

Third, the Coalition believes it is essential to recognize that compensation is not simply the amount one is paid. It is pay divided by what's required of the recipient to earn that pay. If we increase pay 25% but require 100% more sacrifice to earn it, that's not a pay raise.

In that context, today's conditions of service are far more arduous than anything envisioned 40 years ago by the creators of the All-Volunteer Force, who believed a protracted war would require reinstitution of the draft.

Moreover, a fundamental requirement for any pay comparability standard is that it should be transparent and understandable by all. The Coalition has sought, but has never been provided by DoD, any data on what civilian comparison cohort was selected and why, and what rationale was used to establish a specific percentile comparison point.

The Coalition agrees with the approach the Congress has consistently taken – that the best comparability measure is a comparison of the military basic pay raise percentage with the percentage growth private sector pay, as measured by the Bureau of Labor Statistics' Employment Cost Index (ECI). The government uses the ECI for every other measure of private pay growth, and it's transparent to government leaders and servicemembers alike.

The Coalition urges the Subcommittee to sustain fully-comparable annual military pay raises based on the Employment Cost Index as specified in current law.

Wounded, Ill, and Injured Servicemember Compensation – As the Pentagon enters the 11th year of war, the seamless transition between DoD and the Department of Veterans Affairs (VA) continues to be problematic in many cases for our wounded, ill, injured troops; disabled veterans; and their family caregivers.

TMC acknowledges the significant progress that has been made in caring for our nation's heroes and thanks the Subcommittee for its leadership and oversight on these pressing issues, particularly in the last five years since the Walter Reed scandal that brought to light the flaws and inadequacies of both DoD and VA health care and benefits systems.

But complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

There still exists a need to further streamline the Integrated Disability Evaluation System (IDES) and to improve the operational efficiency, effectiveness, consistency, and timeliness of the medical retirement process and DoD-VA coordination in the evaluation of disabilities. We also urge a greater alignment and correlation of federal programs such as TRICARE, Medicare, and Social Security Disability Insurance (SSDI) to ensure that severely wounded warriors who do not enroll in Medicare Part B do not lose TRICARE coverage.

The Coalition looks forward to continued work with the Subcommittee to address the remaining issues and fully establish systems of seamless care and benefits that support our transitioning wounded warriors and family members.

The Coalition urges the Subcommittee to:

- *Ensure any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled servicemembers.*
- *Oppose distinguishing between disabilities incurred in combat versus non-combat when determining benefits eligibility for retirement.*
- *Support extending eligibility for residence in on-base facilities for up to one year to medically retired, severely wounded servicemembers and their families.*

DoD Resale Operations – The Military Coalition strongly believes military commissary, exchange and Morale Welfare and Recreation (MWR) programs contribute significantly to a strong national defense by sustaining morale and quality of life for military beneficiaries both within the United States and around the globe.

The Coalition is very concerned about initiatives to curtail appropriated fund support for these activities.

Repeated studies have shown that military commissaries provide \$2 in compensation value to beneficiaries for each \$1 of appropriated funding. That constitutes a very significant retention “bang for the buck.”

Initiatives to civilianize commissaries or consolidate commissaries and exchanges to achieve budget savings would come only at the expense of devaluing their compensation and retention importance value for military patrons.

In order to be the best steward of our funds, we recommend that Congress direct the Pentagon to provide a report on all DoD and Service MWR Category A, B, and C Programs and Family Support/Readiness (Quality of Life [QoL] Programs). The report should include:

- A current listing of individual program funding levels by category, actual program expenditures vs. program requirement;
- An assessment of the effectiveness of each program including program standards and metrics; and
- A list of recommended changes to policy, including revisions in the current category program listings to more accurately support current war-time mission requirements and meet the needs of the 21st Century all-volunteer force.

The Coalition urges the Subcommittee to resist initiatives to civilianize or consolidate DoD resale systems in ways that would reduce their value to patrons.

Family Readiness and Support – A fully funded, robust family readiness program continues to be crucial to overall readiness of our military, especially with the demands of frequent and extended deployments.

Resource issues continue to plague basic installation support programs. At a time when families are dealing with continuing deployments, they often are being asked to do without in other important areas.

The Coalition urges the Subcommittee to continue to press the Defense Department to exercise its authority to establish flexible spending accounts (FSAs) for servicemembers so they can participate in the same pre-tax program available to all other federal employees for their out-of-pocket health and dependent care expenses.

Quality education is a top priority for military families. Servicemembers are assigned all across the United States and the world. Providing appropriate and timely funding of Impact Aid through the Department of Education with supplemental funding for highly impacted schools in the annual Defense Authorization Bill is critical to ensuring quality education military children deserve, regardless of where they live.

The Coalition urges the Subcommittee to:

- *Continue much-needed supplemental funding authority to schools impacted by large populations of military students.*
- *Direct DoD to report on MWR category programs.*
- *Fully fund effective programs.*
- *Ensure all National Guard and Reserve Yellow Ribbon Programs meet a standard level of family support within each State.*
- *Continue support for child care needs of the highly deployable, operational total force community.*
- *Encourage greater military spouse and surviving spouse educational and career opportunities, and ensure existing programs are accessible and effective.*
- *Continue pressing the Defense Department to implement flexible spending accounts to enable military families to pay health care and child care expenses with pre-tax dollars.*

Base Realignment and Closure (BRAC) Rounds – The Administration’s budget calls for two additional rounds of BRAC in order to garner savings. The Coalition is very concerned that these decisions are driven solely to save money.

Since the implementation of the 2005 BRAC, every GAO report has highlighted significant concerns about the process citing “concerns with DoD under reporting BRAC costs/savings and using non-BRAC accounts to fund requirements.” In fact, the long term impact of the 2005 BRAC has yet to be seen, as the deadline ended less than six months ago.

Therefore, the Coalition urges the subcommittee to proceed cautiously with additional BRAC rounds and verify DoD has accounted for all the implementing costs of their proposals.

National Guard and Reserve Forces

Since Sept. 11, 2001, more than 842,000 Guard and Reserve servicemembers have been called up, including over 300,000 who have served multiple tours. There is no precedent in American history for this sustained reliance on citizen-soldiers and their families. To their credit, Guard and Reserve combat veterans continue to reenlist, but the ongoing pace of routine, recurring activations and deployments cannot be sustained indefinitely.

Guard and Reserve members and families face unique challenges in their readjustment following active duty service. Unlike active duty personnel, many Guard and Reserve members return to employers who question their contributions in the civilian workplace, especially as multiple deployments have become the norm. Many Guard-Reserve troops return with varying degrees of combat-related injuries and stress disorders, and encounter additional difficulties after they return that can cost them their jobs, careers and families.

Despite the continuing efforts of the Services and Congress, most Guard and Reserve families do not have access to the same level of counseling and support that active duty members have. In short, the Reserve components face increasing challenges virtually across the board, including major equipment shortages, end-strength requirements, wounded-warrior health care, and pre- and post-deployment assistance and counseling.

Operational Reserve Retention and Retirement Reform – Congress took the first step in modernizing the reserve compensation system with enactment of early retirement eligibility for certain reservists activated for at least 90 continuous days served since January 28, 2008.

Congress authorized a historic expansion of operational reserve policy in the 2012 NDAA. Now up to 60,000 reservists may be called up for up to one year to perform non-emergency missions that are pre-planned and budgeted by the Services.

The Coalition believes this change only further underscores the need to ensure Guard and Reserve members' compensation keeps pace with the increased service expectations being imposed on them. The greater the demands placed on them, the greater the need to enhance inducements that are essential to sustain the operational reserve force over the long term.

Repeated, extended activations make it more difficult to sustain a full civilian career and impede Reservists' ability to build a full civilian retirement, 401(k), etc. Regardless of statutory protections, periodic long-term absences from the civilian workplace can only limit Guard/Reserve members' upward mobility, employability and financial security. Further, strengthening the reserve retirement system will serve as an incentive to retaining critical mid-career officers and NCOs for continued service and thereby enhance readiness.

As a minimum, the next step in modernizing the reserve retirement system is to eliminate the inequity inherent in the current fiscal year retirement calculation, which only credits 90 days of active service for early retirement purposes if it occurs within the same fiscal year. The current rule significantly penalizes members who deploy in July or August vs. those deploying earlier in the fiscal year to provide equal retirement-age-reduction credit for all activated service rendered since Sept. 11, 2001.

The current law that credits only active service since January 28, 2008 disenfranchises and devalues the service of hundreds of thousands of Guard/Reserve members who served combat tours (multiple tours, in thousands of cases) between 2001 and 2008.

Operational Reservists contributions to national security is demeaned by crediting a 90-day tour served from January through March, but only half credit for a 120-day tour served from August through November (because the latter covers 60 days in each of two fiscal years).

Moreover, the law-change authorizing early reserve retirement credit for qualifying active duty served after 28 Jan 2008 severed eligibility for TRICARE coverage until the reservist reaches age 60.

The Coalition urges the Subcommittee to:

- *Eliminate the fiscal year limitation which effectively denies full early retirement credit for active duty tours that span the Oct 1 start date of a fiscal year.*
- *Modernize the reserve retirement system to incentivize continued service beyond 20 years and provide fair recognition of increased requirements for active duty service.*
- *Authorize early retirement credit for all Guard and Reserve members who have served on active duty tours of at least 90 days retroactive to September 11, 2001.*

Yellow Ribbon Reintegration Program – Congress has provided increased resources to support the transition of warrior-citizens back into the community. But program execution remains spotty from state to state and falls short for returning Federal Reserve warriors in widely dispersed regional commands. Programs should meet a standard level of family support within each state. Military and civilian leaders at all levels must improve the coordination and delivery of services for the entire operational reserve force. Many communities are eager to provide support and do it well. But Yellow Ribbon efforts in a number of locations amount to little more than PowerPoint slides and little or no actual implementation.

DoD must ensure that state-level best practices – such as those in Maryland, Minnesota and New Hampshire – are applied for all operational reserve force members and their families, and that Federal Reserve veterans have equal access to services and support available to National Guard veterans. Community groups, employers and service organization efforts need to be encouraged and better coordinated to supplement unit, component, Service and VA outreach and services.

The Military Coalition urges Congress to hold oversight hearings and direct additional improvements in coordination, collaboration and consistency of Yellow Ribbon services between States.

Reserve Compensation System – The increasing demands of qualifications, mental skills, physical fitness, and training readiness on the Guard and Reserve to perform national security missions at home and abroad and increased training requirements indicate that the compensation system needs to be improved to attract and retain individuals into the Guard/Reserve. The added responsibility of returning to active duty multiple times over the course of a reserve career requires improvements to the compensation package and to make it more equitable with the active component.

The Coalition recommends Congress authorize:

- *Credit for all inactive duty training points earned annually toward reserve retirement.*
- *Parity in special incentive pay for career enlisted/officer special aviation incentive pay, diving special duty pay, and pro-pay for reserve component medical professionals.*
- *Recalculation of retirement points after 1 year of activation. A recent law change allowed certain flag and general officers to recalculate retirement pay after one year of active duty. TMC believes this opportunity should be made available to all ranks.*

Guard/Reserve GI Bill – The Coalition is most grateful to Congress for passage of the Post-9/11 GI Bill, which incorporates a number of major Coalition goals including benefits that match the cost of education, extension of the post-service usage period to 15 years, and cumulative credit for Guard-Reserve service on active duty. However, volunteers who join the Selected Reserve were left behind in this legislation.

Benefits for joining the Selected Reserve were not upgraded or integrated in the Post-9/11 GI Bill as TMC has long recommended. However, the Budget request proposes to reduce contributions into the DoD Educational Benefit Trust Fund. This could result in future cuts to this program.

The Coalition recommends the Subcommittee to:

- *Restore basic reserve MGIB benefits for initially joining the Selected Reserve to the historic benchmark of 47-50% of active duty benefits.*
- *Integrate reserve and active duty MGIB laws in Title 38.*
- *Enact academic protections for mobilized Guard and Reserve students, including refund guarantees and exemption of Federal student loan payments during activation.*

Guard/Reserve Family Support Programs – We have seen considerable progress in outreach programs and services for returning Guard-Reserve warriors and their families. Family support programs promote better communication with servicemembers. Specialized support and training for geographically separated Guard and Reserve families and volunteers are needed.

The Coalition urges the Subcommittee to:

- *Ensure programs are in place to meet the special information and support needs of families of individual augmentees or those who are geographically dispersed.*
- *Fund joint programs among military and community leaders to support servicemembers and families during all phases of deployments.*
- *Provide preventive counseling services for servicemembers and families.*
- *Authorize child care, including respite care, family readiness group meetings and drill time.*
- *Improve the joint family readiness program to facilitate understanding and sharing of information between all family members.*

Retiree Issues

Cost-of-Living Adjustments (COLAs) – In recent years, several commissions have proposed adjusting the Consumer Price Index (CPI) methodology to the so-called “chained CPI” calculation as a means of holding down COLA growth for military and federal civilian retired pay, Social Security and all other federal annuities over time.

Proponents of the chained CPI say it more accurately reflects changes in annuitants’ cost of living by recognizing that their purchasing behavior changes as prices change. If the price of beef rises, for example, consumers may purchase more chicken and less beef.

The real issue with the chained CPI is whether one is measuring changes in prices or changes in quality of life. If one continues the logical progression of the argument, consumers might find themselves substituting hot dogs or pasta for chicken, etc.

The Bureau of Labor Statistics has estimated that implementation of the chained CPI would depress COLAs by about one-quarter of a percentage point per year.

The DoD actuary estimates that inflation will average 3 percent per year over the long term.

Using those two estimates, applying chained-CPI COLAs for a servicemember retiring at age 42 would yield about 10 percent less in his or her retired pay check at age 80 relative to the current COLA system.

Additionally, some commissions have proposed delaying any COLAs on military retired pay until age 60 or later, barring COLAs on annuity levels above some set dollar amount, or reducing the CPI by one-half percent or a full percentage point per year.

The Coalition believes such initiatives would constitute a breach of faith with military people and constitute a disproportional penalty.

COLAs are particularly important to military retirees, disabled retirees, and survivors because they start drawing their annuities at younger ages than most other COLA-eligibles and thus experience the compounding effects over a greater number of years. To the extent that COLAs fail to keep up with living costs, real purchasing power continues to decline ever more dramatically as long as one lives.

The Coalition urges the Subcommittee to ensure continued fulfillment of congressional COLA intent, as expressed in House National Security (HNSC) Committee Print of Title 37, USC: "to provide every military retired member the same purchasing power of the retired pay to which he was entitled at the time of retirement [and ensure it is] not, at any time in the future...eroded by subsequent increases in consumer prices."

Concurrent Receipt – In the FY2003 and FY2004 NDAA, Congress acknowledged the inequity of the disability offset to earned retired pay and established a process to end or phase out the offset for many disabled retirees. The Coalition is extremely grateful for the Subcommittee's efforts to continue progress in easing the adverse effects of the offset.

We were very optimistic in 2009 and 2010 that another very deserving group of disabled retirees would become eligible for concurrent receipt when the White House included a concurrent receipt proposal in the Budget Resolution – the first time in history any Administration had ever proposed such a fix.

The Administration's proposal would have expanded concurrent receipt eligibility over a five year period to all those forced to retire early from Service due to a disability, injury, or illness that was service-connected (chapter 61 retirees).

The Coalition is dismayed that, despite the Subcommittee's leadership efforts and White House support, the provision has not yet been enacted – an extremely disappointing outcome for a most deserving group of disabled retirees.

We recognize only too well the challenges associated with adding new mandatory spending provisions in this difficult budget environment. But making at least some progress to address this grievous inequity (e.g., covering all 100-percent disabled retirees with less than 20 years of service) is an important goal.

Additionally, the Coalition is concerned that an inadvertent problem persists in the statutory Combat-Related Special Compensation (CRSC) computation formula causes many seriously disabled and clearly eligible members to receive little or nothing in the way of CRSC. The Defense Department has acknowledged the problem in discussions with the Subcommittee staff, and the Coalition urges the Subcommittee to correct this technical problem.

The Coalition believes strongly in the principle that career military members earn their retired pay by service alone, and that those unfortunate enough to suffer a service-caused disability in the process should have any VA disability compensation from the VA added to, not subtracted from, their service-earned military retired pay and this remains a key goal in 2012.

The Coalition urges the Subcommittee to continue to seek options to:

- *Expand Concurrent Retirement and Disability Payments (CRDP) to disabled retirees not eligible under the current statute, to include vesting of earned retirement credit for Chapter 61 retirees with less than 20 years of service.*
- *Resolve the so-called Combat Related Special Compensation (CRSC) "glitch" that causes combat-disabled members' compensation to decline when their VA disability rating is increased; or as an interim step.*
- *Pursue legislation specifying that a disabled retiree's CRSC disability compensation cannot be reduced when his or her VA disability rating increases until the retiree is afforded the opportunity to elect between CRSC and CRDP.*

Fair Treatment for Servicemembers Affected by Force Reductions – Over the next five years, over 100,000 additional servicemembers will transition from wearing a uniform into the private sector as part of the force drawdown.

Even though the President's budget includes additional funding for transition assistance for the Department of Labor, the Coalition remains concern over the adequacy of funding for DoD and the services based on what will be an ever increasing demand on transition services.

In addition, throughout the 1990s the services had several drawdown tools at their disposal to incentivize members to voluntarily leave the service: Voluntary Separation Incentive (VSI), Special Separation Benefit (SSB), and Temporary Early Retirement Authority (TERA). Voluntary Separation Pay (VSP) still exists and a recently reauthorized TERA will greatly aid the Services over the next five years.

During any force reduction, servicemembers who intend to make the service a career are forced out. We believe the Nation should recognize their service and provide a "transportable" benefit for those that have their careers curtailed involuntarily short of 20 years.

The Coalition emphasizes that this limited "vesting" initiative should be applied only during periods of significant force reductions and funding for it should not come at the expense of those who serve 20 years or more.

Authorizing separated servicemembers the ability to contribute part or all of their involuntary or voluntary separation pay into their Thrift Savings Plan (TSP) account would appropriately recognize their past service and provide a level of "transportable" career benefit under these difficult times.

The Coalition recommends enacting temporary legislation that would allow members separated during periods of significant force reductions to deposit part or all of their involuntary separation pay or VSP into their TSP account.

Survivor Issues

The Coalition is grateful to the Subcommittee for its significant efforts in recent years to improve the Survivor Benefit Plan (SBP), especially its major achievement in eliminating the significant benefit reduction previously experienced by SBP survivors upon attaining age 62.

SBP-DIC Offset – The Coalition believes strongly that current law is unfair in reducing military SBP annuities by the amount of any survivor benefits payable from the DIC program.

If the surviving spouse of a retiree who dies of a service-connected cause is entitled to DIC from the Department of Veterans Affairs and if the retiree was also enrolled in SBP, the surviving spouse's SBP annuity is reduced by the amount of DIC. A pro-rata share of the SBP premiums is refunded to the widow upon the member's death in a lump sum, but with no interest. This offset also affects all survivors of members who are killed on active duty.

The Coalition believes SBP and DIC payments are paid for different reasons. SBP is insurance purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the VA indemnity compensation should be added to the SBP annuity the retiree paid for, not substituted for it.

It should be noted as a matter of equity that surviving spouses of federal civilian retirees who are disabled veterans and die of military-service-connected causes can receive DIC without losing any of their federal civilian SBP benefits.

The reality is that, in every SBP-DIC case, active duty or retired, the true premium extracted by the service from both the member and the survivor was the ultimate one – the very life of the member. This reality was underscored by the August 2009 Federal Court of Appeals ruling in *Sharp v. U.S.* which found, "After all, the servicemember paid for both benefits: SBP with premiums; DIC with his life."

The Veterans Disability Benefits Commission (VDBC) was tasked to review the SBP-DIC issue, among other DoD/VA benefit topics. The VDBC's final report to Congress agreed with the Coalition in finding that the offset is inappropriate and should be eliminated.

In 2005 then-Speaker Pelosi and other House leaders made repeal of the SBP-DIC offset a centerpiece of their GI Bill of Rights for the 21st Century. Leadership has made great progress in delivering on other elements of that plan, but the only progress to date on the SBP-DIC offset has been the enactment a small monthly Special Survivor Indemnity Allowance (SSIA).

The Coalition recognizes that the Subcommittee's initiative in the FY2008 defense bill to establish the Special Survivor Indemnity Allowance (SSIA) was intended as a first, admittedly very modest, step in a longer-term effort to phase out the Dependency and Indemnity Compensation (DIC) offset to SBP.

We're very grateful for the Subcommittee's subsequent efforts to increase SSIA amounts as additional steps toward the goal of eliminating the offset.

While fully acknowledging the Subcommittee's good-faith efforts to win more substantive progress, the Coalition shares the extreme disappointment and sense of abandonment of the SBP-DIC widows who are forced to sacrifice up to \$1,195 each month and being asked to be satisfied with a \$80 monthly rebate.

The Coalition understands the mandatory-spending constraints the Subcommittee has faced in seeking redress, but also points out that those constraints have been waived for many, many far more expensive initiatives, including the recent extension of civilian unemployment benefits.

The Coalition believes widows whose sponsors' deaths were caused by military service should not be last in line for redress.

The Coalition urges the Subcommittee to:

- *Continue its leadership in seeking to eliminate the SBP-DIC offset.*
- *Authorize SBP annuities to be placed into a Special Needs Trust for disabled survivors who otherwise lose eligibility for Supplemental Security Income (SSI) and Medicaid.*
- *Reduce age for paid-up SBP to age 67 to be fairer to those who joined the military at age 17, 18 or 19.*
- *Reinstate SBP annuities to survivors who transfer it to their children when the children reach majority, or when a second marriage ends.*
- *Exempt SBP-eligible children from being inadvertently penalized by the Alternative Minimum Tax (AMT), which treats SBP as unearned income and taxes it at the higher 26% AMT rate.*

Final Retired Pay Check – Under current law, DFAS recoups from military widows'/widowers' bank accounts all retired pay for the month in which a retiree dies. Subsequently, DFAS pays the survivor a pro-rated amount for the number of days of that month in which the retiree was alive. This often creates hardships for survivors who have already spent that pay on rent, food, etc., and who routinely are required to wait several months for DFAS to start paying SBP benefits.

The Coalition believes this is an extremely insensitive policy imposed by the government at the most traumatic time for a deceased member's next of kin. Unlike his or her active duty counterpart, a retiree's survivor receives no death gratuity. Many older retirees do not have adequate insurance to provide even a moderate financial cushion for surviving spouses.

In contrast to the law governing military retired pay treatment of survivors, the title 38 statute requires the VA to make full payment of the final month's VA disability compensation to the survivor of a disabled veteran.

The disparity between DoD and VA policy on this matter is indefensible. Congress should do for retirees' widows the same thing it did ten years ago to protect veterans' widows.

TMC urges the Subcommittee to authorize survivors of retired members to retain the final month's retired pay for the month in which the retiree dies.

Summary

The Military Coalition again thanks the Subcommittee for your unfailing support of the entire uniformed service community and for taking our concerns and priorities into consideration as you deliberate on the future of the one weapon system that has never let our Nation down – the men and women who wear and have worn the uniform and their families.



THE SECRETARY OF DEFENSE
WASHINGTON, THE DISTRICT OF COLUMBIA

15 NOV 1985

Honorable Thomas P. O'Neill, Jr.
Speaker of the House of
Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The enclosed report complies with the requirements of section 567 of the Defense Authorization Act for fiscal year 1986.

Included in the report are drafts of the two pieces of legislation that would change the military non-disability retirement system. Each would result in a reduction in military retirement accrual funding of \$2.9 billion in fiscal year 1986 as mandated by the Congress. This is a 16 percent reduction in military retired pay from the current system and is in addition to the 13 percent reduction that was imposed by the Congress in the high-three-year averaging adjustment in 1980.

Although the Department of Defense has prepared the draft legislation as required by the Congress, I want to make it absolutely clear that such action is not to be construed as support for either of the options for change. To the contrary, the Department of Defense is steadfastly opposed to the significant degradation in future combat readiness that would result from the changes required to achieve the mandated reduction. I am particularly concerned about the potential loss of mid-level officers, NCOs and Petty Officers who provide the first-line leadership and technical know-how so vital to the defense mission. Unless offsetting compensation is provided, our model's conservatively indicates that our future manning levels in the 10 to 30 year portion of the force would drop below the dismal levels of the late 1970s when aviator shortages and shortfalls in Army NCO and Navy Petty Officer leadership seriously degraded our national security posture.

While the changes we have been required to submit technically affect only future entrants, we expect an insidious and immediate effect on the morale of the current force. No matter how the reduction is packaged, it communicates the same message, i.e., the perception that there is an erosion in support from the American people for the Service men and women whom we call upon to ensure our safety. It says in absolute terms that the unique, dangerous and vital sacrifices they routinely make are not worth the taxpayers' dollars they receive, which is not overly generous. I do not believe the majority of the American people support this view and ask that you consider this in your deliberations on this very crucial issue to our national security.

Sincerely,

Enclosure

Attachment

APPENDIX C



Statement for the Record

of the

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

**Subcommittee on
Personnel**

of the

**UNITED STATES SENATE
ARMED SERVICES COMMITTEE**

**Not for Publication
Until Released by
The Committee**

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

Association Volunteers in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteers are our "eyes and ears," bringing shared local concerns to national attention.

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

Our website is: www.MilitaryFamily.org.

Chairman Webb, Ranking Member Graham, and Distinguished Members of the Subcommittee, the National Military Family Association thanks you for the opportunity to present testimony for the record concerning the quality of life of military families – the Nation's families. After almost 11 years of war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate your recognition of the service and sacrifice of these families. Your response through legislation to the increased and ever-changing need for support has resulted in programs and policies that have helped sustain our families through these difficult times.

We recognize the emphasis the Administration is placing on supporting military families. The work of Mrs. Obama and Dr. Biden in raising awareness of the sacrifices military families make has been well-received by the Nation and appreciated by our families. The *Joining Forces* initiative calls the American people to action in supporting military service members and their families. It is helping more Americans understand how 1 percent of our population in the United States is being called upon to bear 100 percent of the burden of defending our Nation, giving up years of family life together, and how they need the support of the other 99 percent of Americans to continue carrying that burden. But all Americans must also understand that military service members and their families are still serving, in Afghanistan, in contingency operations throughout the world, and by maintaining readiness for unknown contingencies in the future.

We endorse the recommendations contained in the statement submitted by The Military Coalition on personnel issues and health care.

Our Nation's military is facing challenges after 11 years of war. As some of the troops come home, many will find realigning the work/life balance as a family may not be easy. Military families worry that budget cuts will affect the service member and erode the foundation of support they have relied on. Our Association believes that the Federal government has an inherent responsibility to provide support for military families and to ensure the readiness of the service member.

To address the challenges facing our Nation and its military families this year, our Association has identified critical priorities and will address them in the first pages of this statement. We also feel we have an obligation, as the only organization that speaks for the families of all components, retirees and survivors, to bring to your attention other issues of concern and, in some cases, let you know how legislation you have championed in the past has made an impact on their lives. We know our statement is lengthy. Military families love to share their stories. We want to share their stories with you.

Family Readiness

We remain a Nation at war. The readiness of service members and the families that support them needs to be at the forefront. Families rely on a foundation of support: accessible quality health care, responsive behavioral health support, spouse employment options, quality children's education, comprehensive child care, a secure retirement, and unwavering support when wounded, widowed, or orphaned. Military families should be able to access some level of this support no matter where they live – in the United States or overseas.

With the change in mission and expected reduction of forces, some families will be forced to make unexpected transitions. Some may enter a world filled with uncertainties, especially in the area of employment. Those who make the military a career also face uncertainties as they perceive threats to their retirement benefits. A review of the military retirement system must be made within the context of the entire military compensation package. It should recognize the service of those who don't or can't make the military a career.

Our Nation's warriors are returning to their families after multiple deployments and frequent separations. Our research shows children are especially affected by repeated separations from their mom or dad, and by how well their parent/caregiver has handled deployments. We cannot begin to anticipate the long-term impact on our families. The ability to achieve and maintain a work/life balance needs to include time for reintegration for all families, including those of the wounded, ill, and injured.

Reintegration Support

Military families have been living a revolving door existence for the past 11 years. They have experienced repeated deployments, each the same with the strains of separation, but unique with the dynamic of their family at that moment in time. They have had repeated reunions, honeymoons followed by the hard work of rebuilding their family. As they rebuilt, nagging in the back of their mind was the thought that soon their family would be doing this again. Family members of single service members can find themselves experiencing reintegration with their families long distance.

The Services have addressed reintegration needs by providing service members with resilience training through programs like the Army Comprehensive Soldier Fitness program, presently being adopted by the Air Force as well. The establishment of resilience centers on installation serves as a one-stop shop for access to counseling, chaplains and other wellness programs. The Army and Air Force are encouraging spouses to participate in the online evaluation and training sessions and have master trainers available at Family Support Centers. This may prove to be a good tool for the long term.

Reintegration programs become a key ingredient in the family's success. Our Association believes we need to focus on treating the whole family with programs offering readjustment information, education on identifying stress, substance abuse, suicide, and traumatic brain injury, and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. We appreciate the inclusion in the National Defense Authorization Act Fiscal Year 2010 (NDAA FY10) for education programs targeting pain management and substance abuse for families, especially as the Department of Defense (DoD) reports an increase in medication-related deaths and prescription-related substance use. We recommend Congress request DoD report on its outreach and the effectiveness of its educational programs in addressing this issue.

Successful reintegration programs will require attention over the long term, as well as a strong partnership at all levels between the various mental health arms of DoD, Veterans Affairs (VA), and State agencies. DoD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family, and for the couple to reconnect and bond must also be provided. Our Association has recognized this need and established family retreats under our *Operation Purple*® program in the National Parks, promoting family reintegration following deployment.

Expand and support strong and effective reintegration programs for families of all Services and Components.

Recommend Congress request DoD report on its outreach and the effectiveness of its educational programs in addressing readjustment information and services.

National Guard and Reserve

During the past 11 years of war, our Nation has relied on the services of the National Guard and Reserve more than ever before. Our Association appreciates the great strides made by both Congress and the Services to help support our Reserve Component families. We believe sustaining effective support programs

for our “Citizen Soldiers” and their families is essential at every stage of deployment. We ask Congress to provide funding for preventive and follow-up counseling and behavioral health services for mobilized Reserve Component members and their families.

Our Association also appreciates Congress authorizing travel and transportation for Uniformed Services members and up to three designees to attend Yellow Ribbon events. We appreciate the provision enhancing the Yellow Ribbon Program by authorizing Service and state-based programs to provide access to all service members and their families. We ask you continue funding this quality of life program for Reserve Component families.

Our Association has long recognized the unique challenges our National Guard and Reserve families face. They are geographically dispersed, live in rural areas, and have service members deployed as individual augmentees. Although family support programs have been strengthened, these programs may not be close enough to access. These families need more education on leveraging community resources with available military resources.

Provide funding for preventive and follow-up counseling and behavioral health services for mobilized Reserve Component members and their families.

Continue funding the Yellow Ribbon program and stress the need for greater coordination of resources supporting our Reserve Component families.

Behavioral Health Care

Our Nation must help returning service members and their families cope with the aftermath of war. DoD, VA, and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs, especially during transition from active duty to veteran status (voluntary or involuntary) and Permanent Change of Station (PCS) moves. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies' health care systems.

Full Spectrum of Care

As the war continues, the call from families who need a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical managed behavioral health services—is growing louder. The military offers a variety of psychological health services, both preventative and treatment, across Services, agencies, and a variety of programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative, and psychological health services will continue to rise. More importantly, this need will remain high even after military operations scale down.

Our Association applauds DoD and Senior leadership initiatives in addressing stigma around seeking behavioral health services for service members, Guardsmen, and Reserves. However, stigma still exists for spouses and their children. At a recent military spouse symposium, several spouses described their concerns with seeking treatment. They feared it would negatively impact their service member's promotion. Two spouses stated the Command was called by the counselor after they sought care at their Service's family support center. Spouses frequently tell us they don't know what is out there for help even though there are so many available programs. It is hard to find support when military families are having emotional difficulties or substance abuse issues because they live so far away from their loved ones who can assist with interventions. Stigma about seeking treatment is not openly discussed, but it exists and DoD needs to address it.

In the research they conducted for us, RAND found military children reported higher anxiety signs and symptoms than their civilian counterparts. A recent study by Gorman, et. al (2010), *Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints*, found an 11 percent increase in outpatient mental health and behavioral health visits for children from the ages of 3-8 during 2006-2007. Researchers found an 18 percent increase in pediatric behavioral health visits and a 19 percent increase in stress disorders when a parent was deployed. Additional research has found an increase in mental health services by non-deployed spouses during deployment. A study of TRICARE claims data from 2003-2006 published last year by the *New England Journal of Medicine* showed an increase in mental health diagnoses among Army spouses, especially for those whose service members had deployed for more than one year.

Our research also found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit as well as individuals. Communication is key in maintaining family unit balance. Our study also found a direct correlation between decreased communication and an increase in child and/or caregiver issues during deployment. Research is beginning to validate the high level of stress and mental strain our military families are experiencing. The answer is making sure our families have access to behavioral health providers.

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

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

Suicide

Our Association recognizes the action being taken by the Services and the VA to address the rising number of suicides in active duty, National Guard and Reserve members, and veterans. We appreciate the Army's suicide report and the *DoD Suicide Prevention Task Force* report. However, we are concerned that military and veteran families were not included when examining suicides. We have no data showing whether families are also experiencing a rise in suicides and outpacing their civilian counterparts. Therefore, we recommend Congress require a DoD report on the number of family members who committed suicide, made a suicide attempt, or reported suicidal thoughts.

We encourage Congress to direct DoD to include a brief mental health assessment of military families each time they visit their primary health care provider. Providers should inquire about whether or not the family is experiencing a loved one's deployment. We also recommend DoD offer a type of pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members).

Recommend Congress require a DoD report on the number of family members who have committed or attempted suicide.

Downsizing

While we are aware that the downsizing of the force has already begun, we want to highlight the effect on service members and their families whether they leave the service or stay. The editors of the March 19th editions of the various *Military Times* newspapers emphasized the toll these 11 years of war have taken on families. Quoting from their most recent *Military Times* Poll, active duty troops who say they are satisfied with their marriages, dropped 9 points since 2011 to 85%. The editorial also stated

The Marine Corps is shedding 20,000 people and fanning out to more deployment locations in the Pacific. The Navy is moving to longer sea tours. Places like the Philippines and Africa loom a new deployment destinations. To their credit, military leaders are trying to address dwell times between deployments and the need for stronger family support programs. A shrinking force will be a busier force – and that could prove tough on families.

Our Association agrees. It is another reminder that family support programs need to be sustained to support readiness. As the Army takes on a more expeditionary role to Europe and Korea, families left behind will need to rely on Family Readiness Groups (FRGs) and other support services. While service members will not be at war, they will be away from their families. The need for support programs will remain.

And what of those who are being asked to leave? While DoD and the Services talk about an upgraded Transition Assistance Program (TAP), more emphasis should be placed on attendance by the spouse of the separating service member at these sessions. Military spouses should be encouraged to take advantage of programs like the Military Spouse Employment Partnership to help with their employment planning. We hope that an appropriate lead time will be given to separating service members to help with planning. We also recommend that transitional compensation and health care coverage be made available to help ease the cross over to civilian life.

Provide compensation and transitional health care coverage for service members who are being released from service due to downsizing.

Encourage the Services to make TAPS training more accessible for military spouses.

TRICARE Cost Saving Strategies in the 2013 Budget

DoD's proposed TRICARE changes include a change in enrollment fees for TRICARE Prime for under age 65 retirees and the implementation of a first-ever enrollment requirement along with a fee for TRICARE Standard/Extra and TRICARE for Life (TFL). DoD also proposed additional changes to pharmacy co-pays and limited access to non-formulary retail medications. DoD states it will incur savings through better management of health care costs, but also highlights the "savings" it will gain through beneficiary fee increases. We believe, however, that the dramatic fee increases proposed for TRICARE Prime and the new fees for TRICARE Standard/Extra and TFL are not real "savings" at all, but simply a cost shifting to beneficiaries.

Moreover, as evidenced by last year's GAO Report "*Prohibition on Financial Incentives That May Influence Health Insurance Choices for Retirees and Their Dependents under Age 65*" (GAO-11-160R, Feb 16, 2011) and a February 22, 2012 report from the Congressional Budget Office, DoD has no clear indicator of what drives beneficiaries away from using their TRICARE benefit and choosing other insurance. When faced with increased costs to their employee health care and an ineligibility to use TRICARE standard as a second payer, both reports infer that many under age 65 retirees migrated to TRICARE Prime, resulting in higher costs to DoD. A TRICARE Standard enrollment fee combined with the cost of employer provided care or private TRICARE supplemental insurance and no managed care or guaranteed access to care, may drive more beneficiaries in this age category to Prime.

Our Association has always supported a mechanism to provide for modest increases to TRICARE Prime enrollment fee for retirees under age 65. TRICARE Prime, the managed care option for military beneficiaries, provides guaranteed access, low out of pocket costs, additional coverage, and more continuity of care than the basic military health benefit of TRICARE Standard/Extra and TFL. We have never

supported an enrollment fee for TRICARE Standard/Extra or TFL because these programs lack the same guarantees attached to TRICARE Prime. There is no added benefit to the beneficiary, just an added cost. It appears this is strictly a financial decision in order to bring in more revenue.

We oppose DoD's proposed tiered enrollment fees for TRICARE Prime and TFL based on retiree income. Civilian health care plans offer a variety of options at different premium levels. However in the civilian market, higher premium fees are tied to added benefits or coverage. DoD's proposal calls for TRICARE beneficiaries to pay a higher enrollment fee tied to their retirement income for identical TRICARE coverage. Again, it appears DoD's proposed tiered fees are simply a financial decision.

We appreciate that DoD did not propose any changes to the TRICARE benefit for active duty members, did not include a TRICARE enrollment fee for active duty family members, and ensures FY13 TRICARE enrollment fee changes will not apply to medically retired service members and survivors of active duty service member deaths.

While we have always supported a mechanism for modest TRICARE Prime increases, we have concerns regarding DoD's selection of a civilian-based index in determining TRICARE enrollment fee increases after October 2012. We object to DoD's proposed use of a civilian index because we believe health care experts cannot agree on an accurate index on which to base civilian health care yearly cost increases. Our Association has always supported the use of Cost of Living Allowance (COLA) as a yearly index tied to TRICARE Prime retiree enrollment fee increases. We believe if DoD thought the rate of \$230 for individual and \$460 for family was appropriate in 1995, then yearly increases tied to COLA would maintain that same principle. If DoD had used COLA from the beginning to increase TRICARE Prime enrollment fee for retirees and their families, it would have been \$339 for individual and \$678 for family in 2012, more than DoD's proposed Tier 1 fee. We applaud the Congressional mandate in NDAA FY11 to tie TRICARE Prime fees to COLA. We believe increases tied to COLA are the most fair to beneficiaries and predictable for DoD.

Recommend future increases to TRICARE Prime enrollment fees for working age retirees be indexed to retired pay cost of living adjustments as it is currently required by law.

Oppose an enrollment fee for TRICARE Standard/Extra for working age retirees and Medicare eligible TFL beneficiaries.

Recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program.

Include consideration of health care cost adjustments as part of a larger study of overall military compensation.

Other Cost Saving Proposals

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

- Require the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner
- Create a committee, similar in nature to the Medicare Payment Advisory Commission, to provide oversight of the DoD Military Health System (MHS) and make annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or within the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.

- Reform the Governance Structure of MHS. The Defense Health Board in 2006 and 2009 and the U.S. House Armed Service Committee's NDAA FY11 and FY12 proposed the establishment of a Unified "Joint" Medical Command, which our Association has supported as well.

Our Association believes right-sizing to optimize MTF capabilities through innovative staffing methods; adopting coordination of care models, such as medical home; timely replacement of medical facilities utilizing "world class" and "unified construction standards;" and increased funding allocations would allow more beneficiaries to be cared for in the MTFs. This would be a win-win situation because it increases MTF capabilities, which DoD asserts is the most cost effective. It also allows more families, who state they want to receive care within the MTF, the opportunity to do so. We support the *Task Force on the Future of Military Health Care* recommendations to make the DoD MHS more cost-efficient. They conclude the MHS must be appropriately sized, resourced, stabilized, and make changes in its business and health care practices. We encourage Congress to include the recommendations of the Task Force in the year NDAA FY13. These include:

- Restructure TMA to place greater emphasis on its acquisition role
- Examine and implement strategies to ensure compliance with the principles of value-driven health care
- Incorporate health information technology systems and implement transparency of quality measures and pricing information throughout the MHS (This is also a civilian health care requirement in the recently passed *Patient Protection and Affordable Care Act*.)
- Reassess requirements for purchased care contracts to determine whether more cost effective strategies can be implemented

We support TMA's movement toward a medical home model of patient and family-centered care within the direct and purchase care systems. An integrated health care model, where beneficiaries will be seen by the same health care team focused on well-being and prevention, is a well-known cost saver for health care expenditures. Our concern is with the individual Services' interpretation of the medical home model and its ability to truly function as designed. Our MTFs are still undergoing frequent provider deployments; therefore, the model must be staffed well enough to absorb unexpected deployments to theater, normal staff rotation, and still maintain continuity of providers within the medical home.

We support DoD's interest to reform the governance structure of MHS. The establishment of a Defense Health Agency and its ability to provide efficiencies is still being evaluated by the Government Accountability Office. However, we have some concerns with the governance reform chosen by DoD. We believe it has not gone far enough to include all of the needed changes to capture maximum efficiencies across the MHS. We look forward to discussing potential options with Members of Congress.

Military Compensation

In their recent testimony before the House Appropriations Committee's Military Construction, Veterans Affairs and Related Agencies Subcommittee, the Senior Enlisted Advisors of all Services spoke of a recent phenomenon they had all experienced. The Defense Business Board's presentation on *Modernizing the Military Retirement System* had prompted concerns among all levels of the enlisted and non-commissioned officer ranks. What they heard was "what's going on with my retirement?" They heard it everywhere they traveled. The Senior Enlisted Advisors passed that concern on to the members of the Subcommittee, stressing that the force did not need the added distraction in the field about whether the retirement system would be there for them after 11 years of war.

The Defense Business Board, which advises the Secretary of Defense, recommends eliminating the current retirement system that awards half of base pay for life to a service member who retires after 20 years of active service. Instead, the Board recommends a new defined-contribution plan for currently-serving and future service members, which would require service member and DoD contributions to the Federal Thrift Savings Plan (TSP). DoD contributions per service member could vary, with the prospect of larger contributions for personnel in risky assignments, on hardship tours, or in critical specialties. Under the Board's proposal, service members would be vested in the plan after 3 to 5 years and could take their TSP savings with them when leaving the military. But they would not be able to receive payouts from the TSP until age 60 or 65. Current retirees would not be affected by this proposal.

In an environment of defense budget cuts, military families wonder how soon this plan might be implemented and how they might be affected given their service member's time in the military. Among the most worried are the currently-serving members who've built their retirement planning on expectations about the existing system. We've heard several references to "promises broken" from members of the military community.

This reaction underlines the need for a broad review of the military retirement system. Our Association believes retirement is only one part of what must be a complex and comprehensive review of the military compensation system. That system and the benefits it provides must reflect the demands of service on service members and their families and enable DoD to recruit and retain the highly-skilled, dedicated people it needs to fight our Nation's wars and protect our security. We appreciate the Defense Business Board's recognition that most service members do not stay long enough to retire. Service members who have served five, ten, or 15 years should be able to leave service with some kind of start on their retirement savings, especially in times like the past 11 years of war with repeated deployments. With the plans to downsize, personnel who may want to stay to retirement may not be able to do so. Having a flexible compensation system that includes the option to provide retirement savings to people forced out because of periodic force strength reductions may provide a welcome retirement nest egg to these former service members and their families who must start over in another job.

This review will be complex. We disagree with the proposed BRAC-like legislative process proposed by the Administration. This would not allow the opportunity for thorough consideration by the Armed Services Committees.

Call for a comprehensive review of the military compensation system, including health care benefits.

Family Readiness and Support

Family Support

During deployments and often between deployments, military spouses have come to rely on the support from Family Support Centers. They've come to understand and make better use of benefits when they attend family support programs. In talking with the Services, we have heard of cuts in child care for volunteers, reduced curriculum materials for marriage enrichment programs, and significant reductions to chapel program budgets. We hear of other ways that family programs are being short-changed. Installation commanders may try to make up for budget shortfalls, either because of the Continuing Budget Resolutions of last year or in anticipation of cuts for FY13. Staff members have been cut from family service centers, causing reduction in services. Family members who have been trained and participate in family support programs have better experiences with deployment and have fewer problems. DoD and the Services talk of

eliminating the programs that are redundant and keeping the ones that work. Without a staff to run them, how will families access any of them?

Cuts to installation budgets affect the quality of life of service members and families in other ways. We are hearing from families and program staff that some families who have been waiting on housing lists for months must now pay for their own moving expenses when their turn finally comes up. This type of move had previously been provided through installation funds. Living an hour away from the installation, with added expenses for a short while, seemed a good trade-off for the opportunity to live in installation housing for the majority of their tour. The cost of moving may make it prohibitive to make the move to the installation. Will those families fall behind financially?

Installation commanders need to make the difficult choice of reducing hours or closing valued services such as libraries and gyms. These are services that consistently show up as highly valued by service members and their families.

Senior leadership recognizes family support is extremely important but continually reminds families of the need to “tighten our belts”. Families do not feel valued when their programs are cut. We know it will take time to fine tune the right mix of programs and the expectations of the families. We ask for funding to sustain effective family support programs critical to family readiness.

Fund family support programs to address the changing needs of military families.

Child Care

Our Association appreciates the efforts of Congress and the Department of Defense (DoD) to ensure that military families have access to high quality child care. Child care concerns used to be the number one complaint we heard from families. This is no longer true. Our military families enjoy a plethora of choices including drop-in and 24-hour care, and choose between care in Child Development Centers or in Family Care homes. We also have several services available to help us find child care in our local communities through the National Association of Child Care Resource and Referral Agencies (NACCRRA) and SitterCity. The Department of Defense (DoD) and the Services continue to take innovative steps to address concerns as they arise.

The Department of Defense is running a pilot initiative in thirteen states aimed at improving the quality of child care within communities. This investment translates into increased child care capacity for military families living in geographically dispersed areas. DoD is contracting with SitterCity.com to help military families find caregivers and military subsidized child care providers. The military Services and NACCRRA continue to partner to provide subsidized child care to families who cannot access installation based child development centers.

In February, the GAO released the report required by the National Defense Authorization Act (NDAA) Fiscal Year 2010 (FY10) on financial assistance provided for child care costs across the Services and Components to support the families of service members deployed in support of a contingency operation. The report details the steps DoD and the Services are taking to address family concerns with regards to accessibility and quality.

The Mental Health Needs of Military Children

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

Our study on the impact of the war on caregivers and children found deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not “rock the boat.” They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve members face unique challenges since most do not live near a military installation. Our research finds they have more difficulty with deployments and reintegration than their active duty counterpart.

Our study respondents stated their communities did not understand what it was like to be military, and youth reported feeling misunderstood by people in their schools. We hear that school systems are generally unaware of this change in focus within these family units and are ill prepared to spot potential problems caused by these deployments or when an injury occurs. The National Guard and Reserve must partner with their deployed families' schools and educate them about available services and programs.

We appreciate the inclusion of a study on the mental health needs of military children in the NDAA FY10. However, we are still waiting for the study's findings.

Prompt DoD to release the study on the mental health needs of military children called for in NDAA FY10.

Education of Military Children

We strongly urge Congress to ensure appropriate and timely funding of Impact Aid through the Department of Education. We also ask that you allow school districts experiencing high levels of growth, to apply for Impact Aid funds using current student enrollment numbers rather than the previous year. In addition, we thank Congress for authorizing and funding DoD Impact Aid annually. We ask you to authorize \$50 million for schools educating large numbers of military connected students. These funds help local school districts to meet the education needs of our military children in an era of declining state budgets. Our Association has long believed that both Impact Aid programs are critical to ensuring school districts can provide quality education for our military children.

Our Association wishes to thank Congress for providing additional funding to civilian school districts educating military children through DoDEA's Educational Partnership Grant Program. We are very pleased the *National Defense Authorization Act for Fiscal Year 2012* provided a three-year extension to the DoD authority that was set to expire in 2013. Since 2008, DoDEA has awarded 146 grants, totaling \$167 million to school districts, for more than 900 schools. We believe DoDEA's expanded authority to provide grant assistance to local education agencies is an important step in strengthening education for all of the 1.2 million school-aged children.

We also thank Congress for appropriating additional funding to construct, renovate, repair, or expand elementary and secondary public schools on military installations. We appreciate that schools with the most serious capacity or facility condition deficiencies will be given priority consideration.

Ensure appropriate and timely funding of Impact Aid through the Department of Education.

Allow school districts experiencing high growth to apply for Impact Aid funds using current student enrollment numbers.

Authorize and appropriate \$50 million in DoD Impact Aid funding for schools educating large numbers of military connected students.

Support for Special Needs Families

The Office of Community Support for Military Families with Special Needs (OSN) was created in the NDAA FY10 to enhance and improve DoD support around the world for military families with special needs, whether medical or educational. Last year our Association expressed concern that the needs of our special needs families were not being addressed in a holistic manner. Our Association is pleased OSN is now regularly meeting with the Department of Defense Office of Health Affairs to address the medical resources our special needs families require. We are also pleased the OSN has twice convened the Advisory Panel on Community Support for Military Families with Special Needs created in the NDAA FY 11 to get input from families on the medical, educational, relocation, and family support resources our special needs families require. Progress has been made, but our Association still has some concerns.

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

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

The Office of Community Support is studying Medicaid availability for special needs military family members. Our Association is anxiously awaiting this study's findings. We will be especially interested in the types of value-added services individual State Medicaid waivers offer their enrollees and whether state budget difficulties are making it more difficult for military families to qualify for and participate in waiver programs. This information will provide yet another avenue to identify additional services ECHO may include in order to help address our families' frequent moves and their inability to often qualify for these additional value-added benefits in a timely manner.

There has been discussion over the past several years by Congress and military families regarding the ECHO program. The ECHO program was originally designed to allow military families with special

needs to receive additional services to offset their lack of eligibility for state or federally provided services due to frequent moves. We suggest that, before making any more adjustments to the ECHO program, Congress should request a GAO report to determine if the ECHO program is working as it was originally designed and if it has been effective in addressing the needs of the population it was intended to serve. We also hear from our ECHO eligible families that they could benefit from additional programs and health care services to address their special needs. We request a DoD pilot study to identify what additional services, if any, our special needs families need to improve their quality of life, such as cooling vests, diapers, and some nutritional supplements. We recommend families in the pilot have access to \$3,000 above what is provided by ECHO to purchase self-selected items, programs, and/or services not already covered by ECHO. DoD would be required to authorize each purchase to verify the requested item, program, or service is appropriate. This pilot study could identify gaps in coverage and provide DoD and Congress with a list of possible extra ECHO benefits for special needs families. More information is needed so the correct solutions can be applied to meet the needs of these families. Our Association believes the Medicaid waiver report, the GAO report, along with the pilot study will provide DoD and Congress with the valuable information needed to determine if the ECHO program needs to be modified in order to provide the right level of extra coverage for our special needs families. We also recommend a report examining the impact of the war on special needs military families.

The Reserve Component (RC) has unique challenges with their special needs family members. They only qualify for ECHO when they are on active duty status. The population is relatively small, but our Association is concerned with the coordination of care and seamless transition of services as the special needs family member becomes eligible to receive ECHO benefits and then loses them when the member is deactivated. We request Congress ask GAO to examine ECHO benefits during the activation and deactivation cycle, and its impact on the RC family and the special needs family member.

Require GAO reports to determine if the ECHO program is working as it was originally designed, and to examine the impact of almost 11 years of war on our special needs families.

Create a DoD pilot study to identify what additional service(s), if any, our special needs families need to improve their quality of life.

Ask GAO to examine the impact of ECHO benefits during the activation and deactivation cycle on the RC family and the special needs family member and if it has been effective in addressing the needs of this population.

Spouse Education and Employment

In February 2012, the First Lady and Dr. Biden urged state action to support military spouses with state licenses by unveiling the joint report from the Departments of Defense and Treasury. *Supporting our Military Families: Best Practices for Streamlining Occupational Licensing Across State Lines* outlines best practices that states can adopt to support military spouse employment and license portability. We believe Congress can also support military spouse license portability. We recommend Congress pass the *Military Spouse Job Continuity Act*, (H.R. 3046 or S. 697) or similar legislation. This legislation provides a tax credit to a military spouse to offset the cost of a new state-required license after a government ordered move.

Military spouses who require a state license for their profession are financially disadvantaged by Permanent Change of Station (PCS) orders. Many military spouses maintain career licenses in multiple states, costing hundreds of dollars. For example, a pharmacist can only reciprocate to another state from their original license, which requires a military spouse pharmacist to maintain a license in more than one

state. State legislation can expedite the employment process and Congress can alleviate the financial burden with a tax credit.

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

We thank you for your strong support of military spouse education by continuing to fund the Military Spouse Career Advance Account (MyCAA) program. We are disappointed DoD has not reopened the program to all military spouses. Many military spouses delay their education to support the service member's career. Since 2004, our Association has been fortunate to sponsor our Joanne Holbrook Patton Military Spouse Scholarship Program. Of particular interest, 33.5 percent of applicants from our 2011 scholarship applicant pool stated their education was interrupted because of the military lifestyle (frequent moves, TDYs, moving expenses, etc.) and 12.2 percent of those directly attributed the interruption to deployment of the service member. In 2012, there were nearly 9,000 applicants and 40 percent were not eligible for the MyCAA program. Military spouses remain committed to their education and need assistance from Congress to fulfill their educational pursuits.

In FY11, DoD did not use all of the funds allocated for the MyCAA program. We ask Congress to push DoD to reinstate the MyCAA program to include all military spouses, regardless of their service member's rank. We also ask Congress to work with the appropriate Service Secretaries to extend the MyCAA program to spouses of the Coast Guard, the Commissioned Corps of NOAA, and the U.S. Public Health Service.

We look forward to the military spouse employment report required by the NDAA FY12. This report will complement the Congressional mandated military spouse education report released in 2011.

Recognize the value of military spouses with a tax credit to offset state license and credential fees (H.R. 3046/S. 697) and expand the Work Opportunity tax credit (H.R. 687).

Fully fund the MyCAA program for all military spouses.

Commissary and Exchange

Our Association is committed to protecting the Commissary and Exchange benefits vital to the quality of life of our military families. This past year, our Association worked tirelessly to defeat attacks to the Commissary and Exchange benefits:

- The Senate Veterans' Affairs Committee voted to eliminate the federal subsidy for military commissaries and recommended the Department of Defense (DoD) consolidate the operations of the commissaries and exchanges in order to pay for the *Caring for Camp Lejeune Veterans Act of 2011* (S.277).
- An amendment proposed to the NDAA FY12 to consolidate commissaries and exchanges and increase prices.
- Senator Tom Coburn's (R-OK) "Back to Black" report recommended consolidation of commissaries and exchanges into a single, nonsubsidized retail system over five years.
- The Congressional Budget Office continues to recommend consolidation of commissaries and exchanges, price increases, and commercially redeemable vouchers for only certain commissary patrons.

Our Association is very pleased that the DoD FY13 Budget does not call for additional reductions to the Defense Commissary Agency (DeCA). We believe the commissary benefit is a vital part of the compensation package for service members and retirees, and is valued by them, their families, and survivors. Military families consistently tell us that they consider the commissary one of their most important benefits. Here are just a few of the many comments we received:

- "The commissary is a great benefit that helps us stretch our paycheck while helping us put food on the table. I was in shock recently when I went to a grocery store and saw the prices! I know that it would be much harder to feed my family within our budget if there wasn't a commissary."
- "Making it on junior enlisted pay means we have a strict budget and there isn't a lot left over. Every penny counts and living in an overseas location makes things even tighter. One of the ways we are able to make ends meet is shopping at the commissary. We simply cannot afford to shop off post. Taking away the savings we get at the commissary would catastrophically hurt our standard of living."
- "Our family chooses to shop at the commissary and the PX because so many of the items are less expensive than retail. It is hard to feed a family of 4 boys on retail rates. My husband and I figured out we save approx. \$300.00 a month. The other reason why we shop at the PX and the Commissary is that the money that is made is put back into military programs via MWR..."

Commissaries provide an average savings of more than 32 percent over local supermarkets. They also employ military family members. According to the Honorable Jo Ann Rooney, Acting Under Secretary of Defense for Personnel and Readiness, in her statement before the House Armed Services Committee Military Personnel Subcommittee, "Last fiscal year, 39 percent of DeCA employees in the United States were military spouses or other family members; and the total rises to 63 percent when including military retirees, other veterans, and members of the Guard and Reserve."

Commissaries also provide military families a sense of community. Commissary shoppers gain an opportunity to connect with other military families and are provided with information on installation programs and activities. Commissary patrons also receive nutritional information through commissary promotions and campaigns, as well as the opportunity for educational scholarships for their children.

In addition to commissary benefits, military families also save over 20 percent by shopping in the Exchanges. The \$300 million in annual dividends are used to support essential Moral, Welfare and Recreation (MWR) programs that support service members and their families. Our Association strongly believes that every effort must be made to ensure this important benefit and MWR revenue is preserved, especially as facilities are down-sized or closed overseas.

According to this year's American Customer Satisfaction Index (ACSI) survey, the Exchange scored higher than ever before as its operations equaled the industry of excellence. The Exchange also relies on a Customer Service Index (CSI) to provide feedback on how well facilities improve the value of support provided to Soldiers, Airmen, and their families. The CSI score for 2011 was a 77, another all-time high score for the Exchange. These customer satisfaction indexes prove that military families value the benefit of the Exchange more than ever.

Protect the Commissary and Exchange benefits from future budget cutting measures.

Military Housing

Privatized housing expands the opportunity for families to live on the installation and is a value for military families. With more joint basing, the Services must work together to create consistent policies not only within their Service, but across the Services. Pet policies, deposit requirements, and utility policies are some examples of differences across installations and across Services. How will Commanders address these variances under joint basing? Military families face many transitions when they move, and navigating the various policies and requirements of each contractor is frustrating and confusing. It's time for the Services to increase their oversight and work on creating seamless transitions by creating consistent policies across the Services. We ask Congress to push the Services to develop joint basing policies.

The Government Accountability Office (GAO) report, *Military Housing: Enhancements Needed to Housing Allowance Process and Information Sharing among the Services* identified four key areas of improvement. Our Association is especially concerned with the lack of available housing at growth installations. As service members return from deployments and families move back to installations, we will have a housing shortage. According to the GAO Military Housing report there is a housing shortage at DoD installations impacted by growth. Further, installation officials expect such housing challenges to continue or worsen.

Congress must look for solutions to provide housing to growth impacted installations. The Services need flexibility to enter into housing partnerships in local communities and to adjust allowances for families who may need to live in temporary housing for longer periods of time as they wait for housing to become available.

Adopt the recommendations from the GAO Military Housing report.

Find additional flexible solutions for housing needs at growth installations.

Voting Support for Military Service Members and their Families

The passage of the *Military and Overseas Voter Empowerment (MOVE) Act of 2009* was a significant step toward alleviating many of the voting issues faced by military service members and their families. Our Association greatly appreciates Congress passing this important legislation and holding subsequent hearings to evaluate its effectiveness. Many improvements have been made to strengthen the absentee voting process for military families. However, according to DoD's 2010 Post Election Survey Report to Congress, 29 percent of military voters still did not receive their ballots in the 2010 election. In light of this fact, we urge you to continue your oversight of the MOVE Act implementation.

Our Association is proud of the role we played in helping to pass the MOVE Act. We work with the DoD State Liaison Office to support the passage of the *Uniform Military and Overseas Voters Act (UMOVA)*. This legislation would assist states in meeting the statutory mandates of the MOVE Act and expand these important protections and benefits to cover state and local elections. To date, forty-seven states and the District of Columbia have passed state-specific laws resulting in better protection for military and overseas voters. Our Association remains committed to advocating for military families' right to vote wherever they are stationed, and to have their vote counted.

Continue oversight of the MOVE Act implementation to improve voting rights for military service members and their families.

Financial Readiness

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

The DoD financial literacy program should be expanded to transitioning service members and their families. The program currently focuses on new and junior service members. Transitioning families must be financial prepared for life outside the military and the financial literacy program is the right resource to provide this training.

Our Association is pleased the Office of Servicemember Affairs (OSMA) within the Consumer Financial Protection Bureau (CFPB) elevated financial concerns of military families and connected government and nongovernment organizations. We look forward to the further development of the complaint process.

We remain concerned about the impact of the housing crisis on military families. The funds from the expanded Homeowners Assistance Program (HAP) are gone and other solutions are limited. In September 2011, Members of Congress sent letters to Departments of Treasury and Housing and Urban Development, the Federal Housing Finance Agency, and the Securities and Exchange Commission, after hearing concerns from service members about the difficulties they face when receiving Permanent Change of Station (PCS) orders and attempting to qualify for home foreclosure prevention programs. Service members and their families are often unable to sell their homes quickly at prices that will enable them to pay off their mortgages, and they cannot generate enough rental income to cover their mortgage payments or retain their homes until housing prices return to normal values.

The Department of Treasury responded by providing updated guidance to its Home Affordable Foreclosure Alternatives (HAFA) Program. Under the new guidance, service members who cite a Permanent Change of Station (PCS) order as a basis for their financial hardship under HAFA are now eligible even if their income has not decreased. Unfortunately, the new guidance does not address a military homeowner who is a landlord and is underwater. Government agencies must continue to provide solutions to assist underwater military homeowners. Service members must relocate where ordered and cannot ride out the housing market.

We remain a Nation at war and must continue to support the families of our forward deployed war fighters. The Family Separation Allowance (FSA) has not increased in more than ten years. We ask that the Family Separation Allowance be indexed to the Cost of Living Allowance (COLA) to better reflect rising costs for services.

Press federal agencies to formulate solutions to assist underwater military homeowners.

Increase the Family Separation Allowance by indexing it to COLA.

Flexible Spending Accounts

Congress has provided the Armed Forces with the authority to establish Flexible Spending Accounts (FSA), yet the Service Secretaries have not established these important tax savings accounts for service members. We are pleased H.R. 791 and S. 387 have been introduced to press each of the seven Service Secretaries to create a plan to implement FSAs for uniformed service members. FSAs were highlighted as a

key issue presented to the Army Family Action Plan at their 2011 Department of the Army level conference. FSAs would be especially helpful for families with out-of-pocket dependent care and health care expenses. Civilians who work for the Department of Defense have access to FSAs, it is time for service members to have access to a similar benefit.

It is imperative that FSAs for uniformed service members take into account the unique aspects of the military lifestyle, such as Permanent Change of Station (PCS) moves and deployments, which are not compatible with traditional FSAs. We ask that the flexibility of a rollover or transfer of funds to the next year be considered.

Require DoD to create Flexible Spending Accounts for uniformed service members that account for the unique aspects of military life including deployments and Permanent Change of Station moves.

Healthcare

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

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

Improving Access to Care

Our Association continues to monitor the experience of military families with accessing care within both the direct care and purchased care segments of the MHS. We are concerned our MTFs are stressed from 11 years of provider deployments, which directly affects the quality, access, and cost of health care. We consistently hear from families that their greatest health care challenge is getting timely care in both the direct and the purchased care systems. Their main challenges with the direct care system are:

- access to their Primary Care Managers (PCM)
- availability of after-hours and weekend routine care
- availability of urgent care and additional same-day appointments
- having appointments available in MTFs for next day or week, along with 60, 90, or 120-day follow-ups recommended by their providers

Beneficiaries' main challenges with the purchased care system, according to TRICARE's *Health Care Survey of DoD Beneficiaries 2009 Annual Report*, are difficulty in accessing personal doctors and specialty care.

Our Association hears frequent complaints by families regarding the referral process. Families are often unfamiliar with the process at their MTF and in their TRICARE region. They frequently report difficulties in obtaining an appointment within access standards. Families often find that a provider on the TRICARE Managed Care Support Contractor's (MCSC) list is no longer taking TRICARE or taking new patients. The difficulties sometimes cause the beneficiary to give up on the referral process and never obtain the specialty appointment their PCM believes they need. Our Association is concerned with the impact these delays or the lack of even getting the referral is having on the quality of care and beneficiary outcome. We cannot stress enough how continuity of care is important to maintain our families' quality of care. We recommend Congress require a DoD report on the management of the referral process—both within the

direct care system and between the direct care and purchased care sectors--and the impact on beneficiaries' access to care.

We see even more issues ahead that could affect beneficiary access. The TRICARE Management Activity (TMA) has rolled out the new TRICARE Third Generation (T3) contract in the TRICARE North Region and will be rolling out T3 in the TRICARE South Region beginning April 2011. At that time, the remaining TRICARE West Region will still be operating under the existing TRICARE Next Generation (T-Nex) contract. Full T3 implementation will remain in a holding pattern, preventing contractors' renegotiation with approximately 33 percent of our civilian TRICARE providers. With the demands and uncertainties to providers in regards to health care reform's added requirements and expenses along with looming Medicare reimbursement rate changes, we are beginning to hear from providers their lack of a long-term willingness to remain in the TRICARE network and impact TRICARE MCSCs' ability to recruit new providers. Thus, the combination of factors may result in a decreased access to care for military families, especially mental health.

We applaud DoD building "world class" MTFs that utilize evidence-based design. Ft. Belvoir Community Hospital and the National Military Medical Center Bethesda are two examples. Ten more MTFs are being built using similar design concepts. Our Association wants to make sure that the inner workings of the hospital are also "world class." Reasonable pharmacy wait times, professional attitudes with a customer focus, medical home designed clinics, quality care, and access standards met for all appointments are hallmarks of a "world class" system. Given the recent discussion of high health care costs and budget concerns, beneficiaries are going to wonder why DoD spent so much money on facilities that look great, but conduct business as usual. Congress needs to make sure that DoD's new facilities meet "world class" definitions both in brick and mortar and in customer services and policies and procedures.

Require a DoD report on the impact on beneficiaries of the MHS referral process.

National Guard and Reserve Member Family Access to Care

We remain especially concerned about access to care for National Guard and Reserve families. These families also need increased education about the multiple types of TRICARE health care benefits in which they are eligible to participate. We recommend Congress request a report to assess the coordination and continuity of health care services for National Guard and Reserve families as they frequently move from activated TRICARE Prime coverage to non-activated status and TRICARE Reserve Select (TRS) or their employer civilian health care insurance plans. We continue to believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the service member is mobilized may work out better for many families in areas where the TRICARE network may not be robust. This will hold true as well when the beneficiary population in remote areas decreases as mobilizations decline with the end of conflicts.

Require a report assessing the coordination and continuity of health care services for National Guard and Reserve families as they transition from one TRICARE status to another.

Allow reserve component families to be given the choice of a stipend to continue their employer-provided care during the deployment of the service member.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. We are pleased Congress passed the *Temporary Payroll Tax Cut Continuation Act of 2011* (P.L.112-78), which provided a one-year extension of current Medicare

physician payment rates until December 31, 2012. When Congress takes up Medicare legislation this year, we ask you to consider how this legislation will impact military health care. We are especially concerned about our most vulnerable population, military families living in rural communities and those needing access to mental health services.

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

Pharmacy

For several years, our Association has cautioned about DoD generalizing findings of certain civilian pharmacy plans changing beneficiary behaviors and automatically applying them to the military population. As part of the President's FY13 Budget proposal, DoD recently announced it would adjust certain pharmacy co-payments. DoD's intent is to drive beneficiaries away from retail pharmacies and toward TRICARE Mail Order Pharmacy (TMOP) utilization, which should lower government costs and increase DoD savings. Our Association long championed a zero co-payment for generic Tier 1 medications in TMOP and we applaud DoD's proposal and Congressional approval to implement this measure as one of their cost-saving measures.

The rationale behind DoD's recent proposed pharmacy changes is concerning. The proposed increase in co-payments and the loss of access to retail non-formulary medications starting in 2013 will have the biggest impact on beneficiaries who have no choice but to rely on the retail pharmacy for urgent formulary and non-formulary non-maintenance medications. For example, young families of deployed National Guard, Reserve members and recruiters usually do not live close to an MTF pharmacy. When their child needs an antibiotic for an urgent medical condition, such as pneumonia, they have no other option than the retail pharmacy. Beneficiaries who need certain medications not suited for TMOP, such as a narcotic or a chemical compound not suitable for home delivery, would find themselves paying more or not able to even fill the non-formulary prescription without first acquiring a Prior Authorization (PA) or Medical Necessity (MN) from their provider. We fear this requirement of a PA or MN will become so confusing and difficult to achieve by everyone involved (beneficiary, provider, and pharmacist), the beneficiary will simply walk out without the needed medications. The end result will impact beneficiary compliance and decrease desired quality outcomes. If this is implemented, DoD will need to educate the beneficiary and TRICARE network providers on the PA and MN requirement process to ensure the process is seamless and successful.

We are also concerned about the effect of the proposed co-pay changes and access to non-formulary medication at retail will have on our wounded, ill, and injured service members and those already medically retired. This population may be adversely affected because of the frequent alteration to their medication protocols by their health care providers in order to achieve optimum medical benefits for their often-changing medical conditions. Their medications may appear to be maintenance drugs, but are actually intended to be used only for short-term relief. Sending them to TMOP for a 90-day supply just because the

co-payment is less may in fact cost the beneficiary and the government more because of frequent changes in doses. Many of the prescriptions needed by the wounded, ill, and injured are for newly FDA-approved medications, which will most likely place them in non-Formulary Tier 3 status. This may place an unfair financial burden and lack of access to these medications on this population because they tend to utilize a higher number of formulary and non-formulary medications.

Beneficiaries who have no choice in where they must obtain their medications should not be subjected to co-payment increases and barriers to non-formulary retail access simply aimed at changing the behavior of those who do have choices. DoD must consider the possible effects of its co-payment changes and access barriers as it plans for implementation and may need to devise alternative co-payment adjustments to protect beneficiaries during these situations. We look forward to discussing potential options with Members of Congress and DoD.

We believe there are additional ways DoD could experience increased pharmacy savings. These include:

- Provide medications treating chronic conditions, such as asthma, diabetes, and hypertension, at the lowest level of co-payment regardless of brand or generic status
- Implement *The Task Force on the Future of Military Health Care* recommendation to include over-the-counter (OTC) drugs as a covered pharmacy benefit, thus eliminating the need for more costly pharmaceuticals that have the same efficacy as over-the-counter options
- Make all newly FDA approved medications non-formulary status until reviewed by DoD's Pharmacy and Therapeutics Committee's (P&T Committee) within 9 months of approval.

The new T3 contract will provide TRICARE MCSCs and the pharmacy contractor with the ability to link pharmacy data with disease management. This will allow for better case management, increase adherence/compliance, and decrease cost, especially for beneficiaries suffering from chronic illness, co-morbidities, and multiple conditions. However, this valuable tool is only available starting April of this year in the TRICARE North and South Regions because the T3 contract still remains under protest in the remaining TRICARE West Region.

Require DoD to report on how proposed pharmacy changes may impact beneficiary behavior and health care quality outcomes.

U.S. Family Health Plan (USFHP)

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

be another mechanism in which beneficiaries would be allowed to continue in this patient-centered program after becoming Medicare eligible.

Recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program.

National Health Care Reform

Our Association is cautious about the changes contained in the *Patient Protection and Affordable Care Act* (P.L. 111-148) and their potential impact on TRICARE and CHAMPVA. We thank Congress for including a provision in the NDAA FY11 to allow TRICARE Standard/Extra and Prime coverage for TRICARE eligible young adult beneficiaries up to the age of 26. Military families had been asking for this added benefit. However, we still need Congressional action to allow CHAMPVA coverage for eligible young adults up to the age of 26. This lack of coverage for eligible survivor dependents is causing an unnecessary financial burden on a population already economically challenged.

Provide health care coverage to young adults, up to the age of 26, who are eligible for CHAMPVA.

Access to Behavioral Health Care

The body of research focusing on the increased levels of anxiety and utilization of mental health services and medication causes our Association to be even more concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network.

While TMA reports significant progress by the TRICARE contractors in adding to the numbers of mental health providers in the networks, these numbers do not automatically translate into a corresponding increase in access. A recently published report in the March 2011 issue of *Military Medicine*, "Access to Mental Health Services for active duty and National Guard TRICARE Enrollees in Indiana," found that only 25 percent of mental health providers listed in the TRICARE contractor's provider list were accepting new TRICARE beneficiaries. Researchers stated the number one barrier to active duty and reserve component service members and their families, in obtaining mental health care in Indiana, was the accuracy of the TRICARE mental health provider list. Our Association hears from families about the number of times they contact network providers using the TRICARE provider list only to find the providers cannot meet access standards, are no longer taking TRICARE, or are not taking new TRICARE patients. Provider lists must be up-to-date in order to handle real time demands by military families.

While families are pleased more military mental health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families report they are being turned away from obtaining appointments at their MTFs and clinics and told to seek services elsewhere. The military fuels the shortage by deploying its mental health providers, even its child and adolescent psychology providers, to combat zones.

Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to service members, veterans, and their families of available mental health resources through DoD and VA with providers who inherently understand military culture. We appreciate the VA allowing family member access to Vet Centers; however, we encourage them to develop more family-oriented programs and offer internet based chat and Skype grouped meetings. DoD must also look beyond its own resources to increase mental health access by working with other government agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), especially SAMHSA's Military Families Strategic Initiative and Service member, veteran, and family Policy Academy States and Territories, and encourage State agencies to provide their already established services and programs to service members, veterans, and family members. Our

Association has been actively working with SAMHSA, providing valuable input on military families and military culture to these initiatives. DoD must also educate these other agencies about military culture to make the providers more effective in their support.

Frequent and lengthy deployments create a sharp need in mental health services by family members and service members as they get ready to deploy and after they return. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. Embedding mental health providers in medical home modeled clinics will allow easier access for our families. DoD must maintain a flexible pool of mental health providers that can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants (MFLC) and Military OneSource counseling are providing this type of preventative and entry-level service for military families. The web-based TRICARE Assistance Program (TRIAP) has been offering another vehicle for non-medical counseling, especially for those who live far from counselors. The TRIAP program will be absorbed by Military OneSource beginning 30 March. Project FOCUS (Families Over Coming Under Stress) is a family psychological health and resiliency building program to help families deal with deployment(s) and high-operational tempo. The military Services, along with military family members, need to be more aware of resources along the continuum of mental health support. Families need the flexibility of support in both the MHS and Service family support arenas, as well as coordination of support between these two entities.

There are other barriers to access for some in our population. Many already live in rural areas, such as our National Guard and Reserve members, or they will choose to relocate to rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, National Guard and Reserve, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, military installation based support programs, VA facilities, Community-Based Outpatient Centers, and Vet Centers. The National Guard Bureau's Psychological Health Services (PHS) has been established to address mental health issues. We applaud the provision in NDAA FY11 promoting the use of telemental health and removing geographic practice barriers that prevent mental health providers from participating in telemental health services. Our Association looks forward to working with DoD on implementation of this new policy. However, we encourage Congress to do more by: increasing mental health reimbursement rates for rural areas; developing a standardized military culture curriculum; and educating civilian network mental health providers about our military culture.

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

Recommend the "inTransition" program be expanded to provide the same benefit to active duty family members.

Recommend the use of alternative treatment methods, such as increasing mental health reimbursement rates for rural areas; developing a standardized curriculum; and educating civilian network mental health providers about our military culture.

TRICARE Policy Barriers to Behavioral Health Care

TRICARE's policies contribute to a lack of adequate access to behavioral health care. TRICARE is not part of the Mental Health Parity and Addiction Equity Act of 2008 (P.L.110-343); therefore, our families have a yearly cap on how many days they can receive inpatient behavioral health services. Some families try to enroll their child into Medicaid in order to continue receiving treatment. TRICARE should meet the provisions of the Mental Health Parity law. TRICARE requires Partial Hospitalization Programs (PHP) and Substance Use Disorder Rehabilitation Facilities (SUDRFs) to become a National Quality Monitoring contractor (NQMC). There is no incentive for PHP and SUDRFs to comply since it is not required by commercial programs. TRICARE's policy excludes the utilization of Intensive Outpatient Program (IOP), which is considered a best clinical and business practice that allows for the continuum of care. Also, DoD needs to incorporate clinical best practices across the Services.

Caregiver Burnout

Many health care and behavioral health providers have just returned home after completing a combat tour, only to be overwhelmed by treating active duty members, retirees, and their families. It can lead to provider compassion fatigue and create burnout. Our Association would like to be assured DoD is allowing these providers adequate dwell time and time to reintegrate with their families before returning to work. Beneficiaries rely heavily on MTF providers for their care, especially mental health, and need them to be fully ready to care for them. Providers must also be provided the opportunity to sharpen their practice skills, which may have not been used while serving in a combat zone. If they are not adequately addressed, this situation has the potential to negatively impact both the provider's ability to provide quality care and the beneficiary to receive quality care. We recommend Congress ask for a study to examine the impact the war is having on our MHS active duty providers and their families.

Ask for a study to examine the impact the war is having on our MHS active duty providers and their families.

Educating Those Who Care for Service Members and Families

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

The DoD, VA, and State agencies must educate their health care and mental health professionals of the effects of mild Traumatic Brain Injury (mTBI) in order to help accurately diagnose and treat the service member's condition. They must be able to deal with polytrauma--PTS and PTSD in combination with mTBI and multiple physical injuries.

DoD, working with the TRICARE Managed Care Support Contractors (MCSC) and Service medical leadership, must reach out to educate civilian health care providers on how to identify signs and symptoms of mTBI, PTS, and PTSD. They must also educate them about our military culture. We recommend a course on military culture be required in all health care and behavioral health care college curriculums and to offer a standardized DoD approved military culture Continuing Education Unit (CEU) for providers who have already graduated. TMA should incentivize providers to take these courses.

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Transition

Families on the Move

Travel allowances and reimbursement rates have not kept pace with the out-of-pocket costs associated with today's moves. In a recent PCS survey conducted by our Association, more than 50% of survey respondents identified uncovered expenses related to the move as their top moving challenge. Military families are authorized 10 days for a house hunting trip, but the cost for the trip is the responsibility of the service member. Families with two vehicles may ship one vehicle and travel together in the second vehicle. The vehicle will be shipped at the service member's expense and then the service member will be reimbursed funds not used to drive the second vehicle to help offset the cost of shipping it. Or, families may drive both vehicles and receive reimbursement provided by the Monetary Allowance in Lieu of Transportation (MALT) rate. MALT is not intended to reimburse for all costs of operating a car but is payment in lieu of transportation on a commercial carrier. Yet, a TDY mileage rate considers the fixed and variable costs to operate a vehicle. Travel allowances and reimbursement rates should be brought in line with the actual out-of-pocket costs borne by military families.

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

Address the out-of-pocket expenses military families bear for government ordered moves.

Wounded Service Members Have Wounded Families

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

DoD and VA are working together on the Integrated Disability Evaluation System (IDES). Our Association applauds this cooperation. Many of our wounded, ill, and injured are members of the Reserve Component. They often do not reside where the IDES is taking place. We recommend DoD and VA pilot the IDES using a Community Based Warrior Transition Unit (CBWTU). This would allow the wounded, ill, and injured Guardsman or Reservist to be home with their family while going through the IDES process. Currently, they are held at the demobilization site, assigned to the MTF, and proceed through the IDES. This recommendation is also supported by the National Guard Association of the United States (NGAUS), The Retired Enlisted Association (TREA), and Association of United States Navy (AUSN).

Reintegration programs become a key ingredient in the family's success. For the past three years, we have held our *Operation Purple® Healing Adventures* camp to help wounded, ill, and injured service members and their families learn to play again as a family. We hear from the families who participate in this camp that many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury/illness. Each member needs to understand the unique aspects the injury/illness

brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes everyone must focus on treating the whole family, with DoD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process. DoD, the VA, and non-governmental organizations must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

DoD and the VA must do more to work together both during the treatment phase and the wounded service member's transition to ease the family's burden. They must break down regulatory barriers to care and expand support through the Vet Centers, the VA medical centers, and the community-based outpatient clinics (CBOCs). We recommend DoD partner with the VA to allow military families access to mental health services throughout the VA's entire network of care using the TRICARE benefit. Before expanding support services to families, however, VA facilities must establish a holistic, family-centered approach to care when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran. Family members are a key component to a service member's psychological well-being. They must be included in mental health counseling and treatment programs for service members, reserve component, and veterans.

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

Wounded, ill, and injured service members and their families should be allowed to remain enrolled in their MTF when they are medically retired. Our Association has been hearing from families that this is not always the case. The family may be re-enrolled, but the medically retired service member is not and told to enroll in the VA health system of care instead. Many are having difficulty obtaining timely specialty care for service connected disability medical conditions, such as PTS. Medical retirees are using their TRICARE benefit to receive their care, paying co-pays, and having to navigate the TRICARE purchased care network for specialty providers without the assistance of a case manager. This can be a daunting task for a medically retired service member with a mild to moderate Traumatic Brain Injury and PTSD. We request Congress ask the GAO to design and conduct a study to determine the accessibility and timelessness of VA primary and specialty care, particularly for those conditions most prevalent among returning veterans. The study should take into account of such factors as waiting times relative to patient acuity, travel times, barriers to provisions of fee basis care and variability among VA networks; should identify what alternative treatment avenues veterans/medically retirees are using when confronting barriers at VA; and should provide not only a quantitative analysis but an analysis of other factors that account for or contribute to lack of access and timelessness, where it exists. This Congressional request is also supported by Iraq and Afghanistan Veterans of America (IAVA), Wounded Warrior Project (WWP), AMVETS, and Veterans of Foreign Wars (VFW).

Allow medically-retired service members and their families to maintain the active duty family TRICARE benefit for a transition period of three years following the date of medical retirement, comparable to the benefit for surviving spouses.

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

Case Management

Our Association still finds families trying to navigate a variety of complex health care systems alone, trying to find the right combination of care. Our most seriously wounded, ill, and injured service members, veterans, and their families are often assigned multiple case managers. Families often wonder which one is the “right” case manager. We believe DoD and the VA must look at whether the multiple, layered case managers have streamlined the process or have only aggravated it. We know the goal is for a seamless transition of care between DoD and the VA. However, we continue to hear from families whose service members are still on active duty and meet the Federal Recovery Coordinator (FRC) requirement, who have not been told FRCs exist or that they qualify for one. The GAO FRC report found there were many areas of concern, one being limitations on sharing of information between the Services’ case managers and the VA’s FRCs, which impacts care coordination. The Congressionally mandated Recovering Warrior Task Force (RWTF) has also been looking into the issue around case management. We look forward to their report to determine how case management is working within each Service and government agency caring for our wounded, ill, and injured service members, veterans, and their families.

Caregivers of the Wounded

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

We have observed from our own *Healing Adventure Camps* the lack of support and assistance to the spouse/caregiver of our wounded, ill, and injured. Many feel frustrated with not being considered part of the care team and not included in long-term care decisions. The level of frustration displayed by the spouses/caregivers at our recent *Healing Adventure Camp* at Ft. Carson about lack of information and support was disturbing. Even the RWTF discovered the same level of frustration during their site visit and raised their concerns to the MTF and Warrior Transition Unit (WTU) Commanders. DoD needs to make sure the spouse/caregiver and the family are also cared for and provided them the support they need to perform their role as a caregiver and provide them with the tools to care for themselves as well. WTU Commanders need to establish spouse/caregiver support groups and mentoring opportunities. Spouses/caregivers need a platform where they can voice their concerns without the fear of retribution. Evoking HIPAA (*Health Insurance Portability and Accountability Act of 1996*) privacy is not an excuse to limit spouses/caregivers from receiving health care information about their loved one. Wounded warrior commands must remember that they are an integral part of the health care team and their input is invaluable.

The VA has made a strong effort in supporting veterans’ caregivers. Our Association still has several concerns with the VA’s interpretation of P.L.111-163. The VA’s eligibility definition does not include illness,

which means it does not align with DoD's *Special Compensation for Service*. We believe the VA is waiting too long to provide valuable resources to caregivers of our wounded, ill, and injured service members and veterans who served in Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND). The intent of the law was to allow caregivers to receive value-added benefits in a timely manner in order to improve the caregiver's overall quality of life and train them to provide quality of care to their service member and veteran. Another area of immediate concern is the potential gap in financial compensation when the service member transitions to veteran status. The VA's application process and caregiver validation process appear to be very time intensive. The DoD Special Compensation benefit expires at 90 days following separation from active duty. We recommend DoD's remove the 90-day limit and allow the Special Compensation benefit to be extended until the VA's caregiver benefit is instituted.

The VA's decision to delay access to valuable training may force each Service to begin its own caregiver training program. Thus, each Service's training program will vary in its scope and practice and may not meet VA's training objectives. This disconnect could force the caregiver to undergo two different training programs in order to provide care and receive benefits.

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

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

Spouses/caregivers of the wounded, ill, and injured Reserve Component face unique challenges. They are often not located where their loved one is assigned by their Services' wounded warrior commands. They must travel using their own money to visit them while they are receiving medical treatment for service connected conditions or going through the Medical Evaluation Board process. DoD should pay for their travel and lodging during this timeframe. If the family decides to relocate in order to be closer to their loved ones treatment at the MTF, DoD should pay for their move. Services should allow wounded, ill, and injured Reserve Component the opportunity to receive treatment as close to home as possible. When they receive care in TRICARE's purchase care network for service connected conditions, TRICARE MCSC should case manage their treatment.

Encourage DoD to establish spouse/caregiver support groups and mentoring opportunities.

Recommend DoD remove the 90-day limit and allow the Special Compensation benefit to be extended until the VA's caregiver benefit is instituted.

Relocation Allowance and Housing for Medically-Retired Single Service Members

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

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

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

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

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

Medical Power of Attorney

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

Require each deploying service member to execute a Medical Power of Attorney and a Living Will.

Senior Oversight Committee

The Recovering Warrior Task Force report recommended the Senior Oversight Committee functions be consolidated into the Joint Executive Council (JEC). Even though the Services have stated to the RWTF that SOC initiatives are progressing, there are still frequent instances where processes are working at cross-purposes, resulting in misaligned DoD and VA benefits and programs. The JEC has a history of not getting things done, which is why the SOC was created in the first place. Pushing responsibilities of creating seamless transition of benefits and programs back onto the JEC in our minds is moving the process backward rather than forward. DoD and VA senior leaders must play an active role, which means meeting on a regular basis, developing goals, and implementing strategies to address issues at every meeting. We request Congress hold DoD and VA Secretaries accountable for getting the job done right.

Office of Wounded Warrior Care and Transition Policy

DoD established the Office of Wounded Warrior Care and Transition Policy to take over responsibility for three SOC Line of Action items for wounded ill, and ill service members. The Office has

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

Defense Centers of Excellence

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

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

Survivors

The Services continue to improve their outreach to surviving families. In particular, the Army's SOS (Survivor Outreach Services) program makes an effort to remind these families they are not forgotten. We appreciate the special consideration, sensitivity, and outreach to the families whose service members have committed suicide. We do have some concerns about the effect federal civilian employee downsizing will have on this program when certain expectations for survivors have been established. We would like to acknowledge the work of the Tragedy Assistance Program for Survivors (TAPS) in this area as well. They have developed unique outreach to these families and hold support conferences to help surviving family members navigate what is a very difficult time with many unanswered questions. DoD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need through all of VA's venues. We believe Congress must grant authority to allow coverage of bereavement or grief counseling under the TRICARE behavioral health benefit. The goal is the right care at the right time for optimum treatment effect.

We are grateful the extended TRICARE Active Duty Dental benefit for survivors has finally been implemented. We were disappointed that TRICARE chose to use the date of implementation instead of the date the legislation was passed as the effective date for these families.

The need for designated bereavement leave has been brought to our attention. Service members, especially those married to other service members, many times are not allowed the administrative leave necessary to finalize paperwork and other operations that may be required after the loss of a loved one, never mind the need to grieve. While this should seem to be straightforward, the recent introduction of non-chargeable adoption and paternity leave demonstrates the gentle nudge that some commanders need to allow their service members the time to complete administrative tasks. The service member may then return to duty without the distraction of important tasks left undone. This leave would be at the discretion of the commander, as are the other two designated leaves.

Recommend that grief counseling be more readily available to survivors as a TRICARE benefit.

Establish a designated bereavement leave policy to allow the surviving service member to complete required administrative tasks in a timely manner and fully return to duty more quickly.

Our Association still believes the benefit change that will provide the most significant long-term advantage to the financial security of all surviving families would be to end the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). Ending this offset would correct an inequity that has existed for many years. Each payment serves a different purpose. The DIC is a special indemnity (compensation or insurance) payment paid by the VA to the survivor when the service member's service causes his or her death. The SBP annuity, paid by DoD, reflects the longevity of the service of the military member. It is ordinarily calculated at 55 percent of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure that their family has a guaranteed income should the retiree die. If that retiree dies due to a service-connected disability, their survivor becomes eligible for DIC.

Surviving active duty spouses can make several choices, dependent upon their circumstances and the ages of their children. Because SBP is offset by the DIC payment, the spouse may choose to waive this benefit and select the "child only" option. In this scenario, the spouse would receive the DIC payment and the children would receive the full SBP amount until each child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (23 if in college). Once the children have left the house, this choice currently leaves the spouse with an annual income of \$13,848, a significant drop in income from what the family had been earning while the service member was alive and on active duty. The percentage of loss is even greater for survivors whose service members served longer. Those who give their lives for their country deserve more fair compensation for their surviving spouses.

We believe several other adjustments could be made to the Survivor Benefit Plan. Allowing payment of the SBP benefits into a Special Needs Trust in cases of disabled beneficiaries will preserve their eligibility for income based support programs. The government should be able to switch SBP payments to children if a surviving spouse is convicted of complicity in the member's death.

We believe there needs to be DIC equity with other federal survivor benefits. Currently, DIC is set at \$1,195 monthly (43 percent of the Disabled Retirees Compensation). Survivors of federal workers have their annuity set at 55 percent of their Disabled Retirees Compensation. Military survivors should receive 55% of VA Disability Compensation. We are pleased that the requirement for a report to assess the adequacy of DIC payments was included in the NDAA FY09. We are awaiting the overdue report. We support raising DIC payments to 55% of VA Disability Compensation. When changes are made, we ask Congress to ensure that DIC eligibles under the old system receive an equivalent increase.

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

Eliminate the DIC offset to SBP to recognize the length of commitment and service of the career service member and spouse. We support H.R. 178 and S. 260, which both provide for that elimination.

Allow SBP benefits to be paid to a Special Needs Trust in cases of disabled family members.

Increase DIC to 55 percent of VA Disability Compensation.

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

Former Spouses, Abandoned Spouses

On September 10, 2001, DoD released a report containing recommendations for improvements to the Uniformed Services Former Spouse Protection Act (USFSPA). While Congress has addressed one or two of the recommendations from the report in the ensuing 11 years, none of them have been passed. We endorse the TMC recommendation for a hearing on this important issue.

We have also heard from a number of spouses who have been abandoned physically and financially. There can be many reasons for this, some related to behavioral health, some to inability of the families to reintegrate after many deployments. We intend to pursue this issue with DoD and the Services since it appears not to need a legislative fix. However, we do feel it is important enough to mention as a symptom of how our families and marriages are suffering after 11 years of war.

Our Association recommends that legislative action be taken to implement recommendations of the DoD Report on the Uniformed Services Former Spouse Protection Act including:

- Base the award amount to the former spouse on the grade and years of service of the member at time of divorce (not time of retirement);*
- Prohibit the award of imputed income while on active duty, which effectively forces active duty members into retirement;*
- Extend 20/20/20 benefits to 20/20/15 former spouses;*
- Permit the designation of multiple Survivor Benefit Plan (SBP) beneficiaries with the presumption that SBP benefits must be proportionate to the allocation of retired pay;*
- Eliminate the "10-year Rule" for the direct payment of retired pay allocations by the Defense Finance and Accounting Service (DFAS);*
- Permit SBP premiums to be withheld from the former spouse's share of retired pay if directed by court order;*
- Permit a former spouse to waive SBP coverage;*
- Repeal the one-year deemed election requirement for SBP; and*

Assist DoD and the Services with greater outreach and expanded awareness to members and former spouses of their rights, responsibilities, and benefits upon divorce.

Implementation of the Repeal of "Don't Ask, Don't Tell"

We are very pleased with the implementation of the repeal of "Don't Ask, Don't Tell". We have heard from many gay and lesbian service members and their families about how accepted and welcomed they have felt by the military community. They are participating in support activities and accessing resources where they can. Our Association is pleased at the ongoing efforts by the DoD and the Services to monitor the implementation. We were heartened to read in the recent statement by Dr. Jo Ann Rooney, Acting Under Secretary of Defense for Personnel and Readiness about the formal monitoring process and the feedback they continue to get back from all service members. We are pleased DoD is engaged in a comprehensive review of the possibility of extending eligibility for additional benefits, when legally permitted, to same-sex

partners. The success of this implementation underlines the importance of careful planning and training when instituting controversial new policies. We congratulate DoD and the Services on its success.

Military Families – Our Nation's Families

Bringing the troops home does not end our military's mission or the necessity to support military families, especially their children, dealing with the long-term effects of more than a decade at war. Downsizing and budget cuts will present new challenges. The government should ensure military families have the tools to remain ready. Effective support for military families must involve a broad network of government agencies, community groups, businesses, and concerned citizens.

Our Nation must continue to fund what works to support military families, protect the most vulnerable, and, above all, value their service.

APPENDIX D



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

Statement
Of
The National Association of Chain Drug Stores
For
U.S. Senate
Armed Services Committee
Personnel Subcommittee
Hearing on
FY2013 Defense Authorization
232-A Russell Senate Office Building

National Association of Chain Drug Stores (NACDS)
413 North Lee Street
Alexandria, VA 22314

NACDS Statement for the Record
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Introduction

Chairman Webb, Ranking Member Graham, and members of the Military Personnel Subcommittee. The National Association of Chain Drug Stores (NACDS) thanks the committee for the opportunity to submit a statement for today's hearing on the FY2013 Defense Authorization.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States.

Community Pharmacies are the Most Readily Accessible Healthcare Providers

Ninety-two percent of Americans live within five miles of a community pharmacy, making pharmacies among the most accessible healthcare providers. Local pharmacists play a key role in helping patients to take their medications as prescribed and offer a variety of pharmacist-delivered services to improve health quality and outcomes. With preventive immunizations and appropriate medication use, it is possible to reduce utilization of costly medical services such as emergency department visits and unnecessary physician visits. The proximity of community pharmacies to each and every American and pharmacists' exceptional knowledge and training renders pharmacies uniquely positioned to provide care for the American public.

Pharmacist-Administered Vaccinations Improve Public Health

Increasingly, local pharmacies are not only a reliable, convenient source for obtaining prescription drugs, but also a healthcare destination. For example, retail network

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pharmacies now provide vaccinations to TRICARE beneficiaries. Recognizing the cost effectiveness of pharmacist-provided vaccinations, the Department of Defense (DoD) authorizes TRICARE beneficiaries to obtain vaccinations at a retail network pharmacy for a \$0 co-payment. In its final rule expanding the authority of retail pharmacies to provide vaccinations, DoD estimated that in the first six month of the immunization program, it had saved over \$1.5 million by having vaccinations provided through the pharmacy rather than the medical benefit (*Federal Register*, Vol. 76, No. 134, p. 41064). This cost savings did not take into consideration the savings from medical costs that would have been incurred in treating influenza and other illnesses, if TRICARE beneficiaries had not been vaccinated. In addition, DoD also noted in the final rule that “adding immunizations to the pharmacy benefits program is an important public health initiative for TRICARE, making immunizations more readily available to beneficiaries. It is especially important as part of the Nation’s public health preparations for a potential pandemic, such as was threatened last fall and winter by a novel H1N1 virus strain. Ensuring that TRICARE beneficiaries have ready access to vaccine supplies allocated to private sector pharmacies will facilitate making vaccines appropriately available to high risk groups of TRICARE beneficiaries” (*Federal Register*, Vol. 76, No. 134, p. 41063).

Medication Therapy Management Improves Health Outcomes and Reduces Spending

Medication therapy management (MTM) is a distinct service or group of services that optimize therapeutic outcomes of medications for individuals based on their unique needs. MTM services increase medication adherence, enhance communication and collaboration among providers and patients, optimize medication use, and reduce overall healthcare costs. Increasingly, MTM services provided face-to-face by retail pharmacists is proving to be the most effective. For example, a recent study published in the January 2012 edition of *Health Affairs* demonstrated the key role retail pharmacies play in providing MTM services to patients with diabetes. The study found that a pharmacy-based intervention program increased patient adherence and that the benefits were greater

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for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study also suggested that an integrated, pharmacy-based program, including interventions such as in-person, face-to-face interaction between the retail pharmacist and the patient, contributed to improved behavior with a return on investment of 3 to 1.

Preserving Patient Access and Choice in the TRICARE Program

As the Congress considers FY2013 Defense Authorization, NACDS urges consideration of policies that control spending while protecting patient choice and preserving access to local pharmacies.

NACDS was disappointed to learn that the President's Budget proposed further changes to co-payments and other policies that would further drive TRICARE beneficiaries out of their local pharmacies and to the TRICARE Mail Order Pharmacy (TMOP). There are strong incentives in place to encourage beneficiaries to use mail order. Additional changes were put in place in October 2011. Currently TRICARE beneficiaries can receive a 30-day supply of medication at a local pharmacy for co-payments of \$5 (generic), \$12 (brand) or \$25 (non-formulary brand), versus co-payments of \$0 (generic), \$9 (brand) or \$25 (non-formulary brand) for a 90-day supply of medication from TMOP.

The President's FY2013 budget includes even more draconian changes. In most cases, TRICARE beneficiaries will be unable to obtain non-formulary medications at their local pharmacy. Furthermore, cost sharing will increase to as much as \$34 for a 30-day supply of a formulary medication at retail, and as much as \$66 for a 90-day supply of a non-formulary medication at TMOP.

In addition to unfairly penalizing TRICARE beneficiaries who prefer to use local pharmacies, NACDS believes this proposal is penny wise and pound foolish. Failure to take medications as prescribed costs the U.S. health system \$290 billion annually, or 13%

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of total health expenditures. Threatening beneficiary access to prescription medications and their preferred healthcare provider will only increase the use of more costly medical interventions, such as physician and emergency room visits and hospitalizations.

NACDS supports cost savings initiatives that preserve patient choice. For example, the utilization of generic medications by TRICARE beneficiaries is low in comparison with other plans. According to Wolters Kluwer Health, in 2010, generic drugs were dispensed 71.2% of the time by community pharmacies, compared with 56.1% by mail order. In contrast, for the TRICARE program, generic medications were dispensed 69.7% by community pharmacies, and 51% by TMOP. Modest increases in generic utilization by TRICARE beneficiaries would have a dramatic impact on the DoD budget.

We also urge DoD to conduct a demonstration project on the effectiveness of medication therapy management (MTM) in improving patient medication adherence and reducing healthcare costs. The demo should target TRICARE beneficiaries with at least one chronic condition that accounts for high spending in TRICARE. Targeted beneficiaries should be eligible for MTM services at a TRICARE retail network pharmacy. Services should include a face-to-face comprehensive medication review as well as quarterly follow-up reviews as deemed necessary. Beneficiaries may opt-out of the MTM program, but those who elect to participate and comply with program recommendations will have cost sharing for maintenance medications waived while participating.

Finally, we encourage Congress to consider the use of a “drug-stock replacement” program for retail pharmacies, similar to the program currently in use by the TRICARE mail order pharmacy. NACDS believes using depot pricing for covered prescription drugs provided through the retail pharmacy network would assist DoD in negotiating additional discounts from drug manufacturers, beyond the Federal Ceiling Price (FCP) discounts currently required by law.

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Potential savings for the TRICARE program through these initiatives are significant. For example, use of a drug stock replacement program using depot pricing for retail prescriptions could result in savings of up to 30%. Since the Department of Defense spends an estimated \$5 billion annually on prescription medications dispensed by retail pharmacies, the resulting savings could be as much as \$1.5 billion.

Conclusion

Thank you for the opportunity to share our views. We look forward to working with you on policies that control costs and preserve access to local pharmacies.

APPENDIX E

**Reserve Officers Association of the United States
And
Reserve Enlisted Association**

Written Testimony on Health Care

for the

**Senate Armed Services Committee
Subcommittee on Personnel**

March 28, 2012



"Serving Citizen Warriors through Advocacy and Education since 1922."™



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

The Association's 58,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security. ROA is represented in each state plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state. ROA has more than 450 chapters worldwide.

ROA is a member of The Military Coalition where it co-chairs the Tax and Social Security Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans and family support organizations.

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

Executive Director	
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DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers and Reserve Enlisted Associations are member-supported organizations. Neither ROA nor REA have received grants, sub-grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.



INTRODUCTION

The Reserve Officers Association and the Reserve Enlisted Association thank the Personnel subcommittee for the chance to present written testimony on behalf of the 1.1 million Ready Reservists affected by medical readiness, and for the retirees of the National Guard and Reserve who continue to be entitled to health care. The Associations also thank the Senate Armed Services committee as a whole for limiting adjustments to TRICARE Prime enrollment to only an increase at the same percentage as the retiree's cost-of-living (COLA) rate.

Yet, the Department of Defense (DoD) was not satisfied with last year's increase to TRICARE, and has revisited this topic by proposing further increases. The challenge this year is reviewing these increases to TRICARE fees, prescription co-payments and the catastrophic caps, and the establishment of new enrollment structures for TRICARE Standard, and TRICARE for Life at a time when there is also a proposal to cut defense budgets.

Both ROA and REA are disappointed that the Pentagon continues to make these recommendations unilaterally and to neither discuss cost sharing with the beneficiary associations, nor heed the sense of Congress as to what direction to take in making adjustments.

We commend your committee on proactively working these health care issues ahead of proposed DoD language. Open communication is key to reducing the angst felt by the beneficiaries that would be directly affected. Further, the serving force is watching how the retirees are being treated to see how this or any administration "keeps the faith" with those who serve.

ROA and REA also appreciate the reassurances that the serving members of the Reserve and National Guard who are TRICARE Reserve Select beneficiaries are excluded from any fee increases being considered just the same as active duty members and their families.

EXECUTIVE SUMMARY

Increasing the cost-share of DoD health care beneficiaries is admittedly an emotional issue. The nation and the Department of Defense are faced with ever increasing health care costs, but this is not simply a budgeting exercise. Because of the dynamics involved, this is an issue that should be resolved by involving all those who are concerned. Here is a summary of the key points as seen by the Reserve Officers Association (ROA) and the Reserve Enlisted Association (REA).

Congress must maintain an oversight over DoD health care, preventing capricious fee increases to beneficiaries.

TRICARE:

- Do not change the Catastrophic Cap of \$3000.
 - o If indexed, at no more than COLA adjustments.

TRICARE Prime:

- Continue any adjustment to Prime enrollment based on COLA rates.
- Independently verify the current total cost of DoD health care benefits. Such an audit will permit Congress to validate proposals based on cost-sharing percentages.
- Do not link annual increases to the market-driven national health costs inflation rate, nor Federal Employee Health Benefits Plan (FEHBP).

On Pharmacy Co-payments:

- Any higher retail pharmacy co-payment should not apply on initial prescriptions, but on maintenance refills only.
- To keep co-payments lower, ROA and REA support a mandatory mail-order prescription refill, if an opt-out is permitted.

TRICARE Standard:

- No annual enrollment fee for DoD beneficiaries.
 - o Should an enrollment fee be instituted - limit such an enrollment to only a one-time nominal administrative fee.
- No increase to Standard deductible.
 - o Higher cost share is already being made by automatic increases to TRICARE Standard through the 25 % copayment as health care costs increase.
 - o For individuals or families relying on Standard for medical treatment, it is a more expensive health plan than TRICARE Prime.
 - o Should the Standard deductible be increased; by no more than COLA.
- Do not link annual increases to the market-driven national health costs inflation rate, nor Federal Employee Health Benefits Plan (FEHBP).
- Decouple changes to TRICARE Standard deductible from TRS as Reservists pay more upfront.

Reserve Health Care Initiatives:

- Improve continuity of health care for all drilling Reservists and their families by:
 - o Permitting active members in the Individual Ready Reserve (IRR) to buy-into TRICARE Reserve Select.
 - o Allowing demobilized Retirees and Reservists involuntarily returning to IRR to qualify for subsidized TRS coverage.
 - o Providing TRS coverage to mobilization ready IRR members; levels of subsidy would vary for different levels of readiness.
 - o Improving post deployment medical and mental health evaluations and access to care for returning Reserve Component members.
 - o Providing an option for Reservists where DoD pays a stipend to employers.
- Extend military coverage for restorative dental care following deployment to 90 days.
- Permit beneficiaries of Federal Employee Health Benefit plan the option of subscribing to TRICARE Reserve Select.
- Should any TRICARE fees be “tiered” do so by annual military retirement, as
 - o Reserve Component member are paid about 1/3 less than active duty.

TRICARE Retired Reserve (TRR)

- Premiums are too high; to keep TRR viable, premiums must be reduced.
- GAO should audit the assumptions used for TRICARE Retired Reserve premiums.

TRICARE for Life:

- Implement no enrollment fee.
- Do not link annual increases to the market-driven national health costs inflation rate, nor Federal Employee Health Benefits Plan (FEHBP).

TFL beneficiaries are already paying Medicare Part “B”, which adds up to more than any other TRICARE beneficiary pays (except for gray area Reservists). In addition, there is means testing, which increase the expense for a number of retirees over age 65.

DISCUSSION**MILITARY HEALTH CARE – a shaky foundation.**

For a number of years, the Pentagon has spoken out about the rising costs of health care and the need for reform. This can be noted by statements illustrating that military health costs have increased such as “DoD medical costs have shot up from \$19 billion in FY 2001 to \$52.5 billion in FY 2012,” as made by Deputy Secretary of Defense William J. Lynn, III at a Senate Budget hearing last year.

Health care costs now consume about nine percent of the DoD budget. Yet comparisons of health care costs are distorted by beginning with a peacetime starting point followed by a decade of war. Still judging from what has been said to both Congress and the press, it would seem that many in the Pentagon are attributing the increases in military health care to its retirees, especially those working second careers. A break out of beneficiary medical expense totals have not been provided by the Pentagon.

This is why DoD needs to publish a breakdown of its OCO and baseline health care costs. The department has said it will cost a billion dollars to perform such an audit and won’t have anything before 2014.

Congress needs to continue to ask the Pentagon for a financial breakdown. An independent audit by the Government Accountability Office (GAO) or another agency would allow Congress an opportunity to validate proposals based on financial benchmarks rather than DoD speculation.

DoD officials continue to tout that “working-age retirees” (those younger than 65) should use their employer’s health care. The Congressional Budget Office predicts that if TRICARE fees go up, 60 percent of the savings would be from beneficiaries leaving TRICARE, providing the Pentagon with long sought after savings. There is fallacy in this argument. Recent changes to the TRICARE structure have only driven beneficiaries to TRICARE Prime which is more expensive for the Government.

The Pentagon’s public campaign for health care reform has undercut its credibility with serving members, retirees and beneficiary associations in what has been said, what has been budgeted, and what still might be planned.

The Reserve Officers Association was among the first associations to be open to a relook on cost sharing for TRICARE beneficiaries. Unfortunately, ROA’s position has grown less flexible as DoD demands have grown more costly to beneficiaries.

HEALTH CARE COST DISCUSSION

The Reserve Officers Association and the Reserve Enlisted Association would like to thank Congress for its continued involvement on DoD health care issues and hope it remain a leading partner on these issues.

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

It is important to sustain the DoD health care as a deferred benefit for our serving Active and Reserve Component members and their families. While retired, these beneficiaries have accepted risks and made sacrifices in their earlier military careers that have not been asked of the remaining 99 percent of the nation's population. TRICARE fulfills an on-going promise by the government for continued health care to those who have served or are serving.

ROA and REA are committed to our membership to sustain this health care benefit. DoD, Congress and the beneficiary associations need to work together to find a fair and equitable solution that protects our beneficiaries and ensures the financial viability of the military health care system for the future. ROA and REA remain open to discussions on cost-sharing.

Of concern is a proposal to index future increases. DoD suggests that cost indexing be based on the national health costs inflation rate. Military retirees face different health issues than the national average. Twenty to thirty years of physical training requirements makes it a healthier population than the nation as a whole.

ROA and other associations are advocating that no change be made to the adjustments of the annual TRICARE Prime enrollment fee, allowing only an increase at the same percentage as the retiree's cost-of-living (COLA). Cost of living is actually rising higher than what COLA adjusts for.

The actual inflation rate is higher than how COLA is calculated. While COLA adjustment increased by 3.6 percent, everyday prices rose 7.2 percent in past year, according to the independent American Institute for Economic Research. The annuity pay for military retirees continues to fall behind inflation.

Another proposal has been to adjust annual fees to what they would be if COLA adjustments had been made annually since 1996. While this would make it almost 22 percent higher in FY-2012 than the adjusted \$560, it should be remembered that DoD did not seek fee increases for almost ten years, which is why ROA and REA don't support such an adjustment. Retired beneficiaries should not be penalized for DoD's inaction.

Congress has already agreed to a COLA increase concept. It should not be tempted, as DoD did in the past, by a one year catch-up. Any retroactive COLA "catch-up" would need to be done over a period of years, but should also be adjusted for those years when COLA did not keep up with inflation. Taking all factors into account, Congress should seek a quick fix.

ROA and REA share the concern that any process used should be a fair and equitable approach where retiree's won't be overburdened.

RESERVE COMPONENT HEALTH CARE DISCUSSION

The Pentagon views TRICARE as a health care plan, and Reserve TRICARE as a health care insurance. Because words create paradigm, Reserve health care is treated by DoD entirely different than active duty health care. The differences are easily noted: Active duty members enroll in a benefit with deductibles and co-payments; Guard and Reserve members "purchase" a premium based health plan. The following are suggested improvements.

1. ROA and REA still hold concerns over the implementation of TRICARE for gray area retirees. Because DoD treated Reserve gray area retirees as a separate health care risk group, health care premiums proved higher than expected. Because of the expense, enrollment is low. It is likely just being used by those with health care problems, who can't afford health care from other sources. If the program is not changed it will have a similar success to mobilization insurance.

ROA and REA hope that the committee will request a Government Accountability Office review of the process that determined the published premium levels.

2. Seamless Transition. Service members should not have to navigate through bureaucracy to receive care or benefits. Every time a Reserve Component member transitions into a new category of health care, he or she is required to reenroll in the new program. Even those who are beneficiaries of TRICARE Reserve Select (TRS) need to do an administrative transition between TRS, TRICARE once mobilized, into Transitional Assistance Management Program (TAMP) and back onto TRS. And once retired, there is additional transition into TRICARE Retired Reserve, and the latter TRICARE retiree health care. Add to this the additional health care provided by the Department of Veteran Affairs, and there are gaps in health care as a Reserve Component or family member moves between programs.

3. Employer health care option: DoD could pay a stipend to employers of deployed Guard and Reserve members to continue employer health care during deployment. G-R family members are eligible for TRICARE if the members' orders to Active Duty are for more than 30 days; but some families would prefer to preserve the continuity of their own health insurance. Being dropped from private sector coverage as a consequence of extended activation adversely affects family morale and military readiness and discourages some from reenlisting. Many G-R families live in locations where it is difficult or impossible to find providers who will accept new TRICARE patients. This stipend would be equal to DoD's contribution to Active Duty TRICARE.

ROA and REA continue to support an option for individual Reservists where DoD pays a stipend to employers

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

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

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

Because there are inadequate dental assets at Military Treatment Facilities for active members, active families, and reservists, **ROA and REA further recommend that dental restoration be included as part of the six month TAMP period following demobilization.** DoD should cover full costs for restoration, but it could be tied into the TRICARE Dental program for cost and quality assurance.

5. IRR Access to TRS: Not everyone who drills is eligible for TRS. All services offer drilling for points without pay. These members are in the IRR. The Navy has Voluntary Training Units that drill monthly. The Air Force and Army have non-paid Individual Mobilization Augmentees (IMA). The Army also has a group within the IRR body that has agreed to mobilization during their first two years.

The Army, the Marine Corps and the Navy have mobilized Reservists out of the Individual Ready Reserve. Under current law, unless these RC members are given an opportunity to join the Selected Reserve, they are not eligible to purchase TRS.

ROA and REA feel that IRR members should be eligible for TRS (not TRR.) They could qualify if they sign an agreement of continued service and complete a satisfactory year of training and satisfy physical standards. A satisfactory year could be defined either by points or by training requirements, as defined by each Reserve Chief.

ROA and REA recommend legislation to allow IRR buy-in to TRICARE Reserve Select.

CONCLUSION

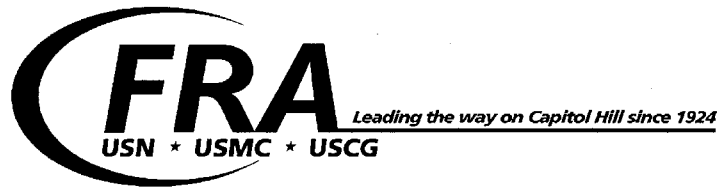
ROA and REA reiterate their profound gratitude to the personnel subcommittee for addressing the health care issues. The process that we develop and what we decide upon this year for TRICARE fees and sustained benefits reflects not only our recognition of retired members for their service to the nation, but is a dedication to the warriors of the future.

Service members deserve the best medical care that the nation can offer. Health care services are vital to keeping the nation's military force strong and ready. As a deferred benefit, it serves as a recruiting as well as a retention tool, as the willingness of the young to serve will depend on how they perceive the treatment and appreciation given to earlier veterans.

When a nation puts members of its military at physical risk from disease and traumatic injury, it absolutely owes them health care not health insurance.

ROA and REA strongly urge that when all cost-sharing is finally taken into account, our beneficiaries must receive the DoD provided health care for which they are entitled.

APPENDIX F



Statement of
The Fleet Reserve Association
on
Military Personnel Policy, Benefits, and Compensation

Submitted to:
Senate Armed Services Committee
Personnel Subcommittee

by
Master Chief Joseph L. Barnes, USN (Ret.)
National Executive Director
Fleet Reserve Association

March 28, 2012

THE FRA

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

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

FRA's mission is to act as the premier "watch dog" organization on Capitol Hill in maintaining and improving the quality of life for Sea Service personnel and their families. The Association also sponsors a National Americanism Essay Program and other recognition and relief programs. In addition, the FRA Education Foundation oversees the Association's scholarship program that presented awards totaling over \$120,000 to deserving students last year.

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

FRA celebrated 87 years of service in November 2011. For nearly nine decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, (now TRICARE Standard) was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (USSBP). More recently, FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for service members and their dependents.

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

**CERTIFICATION OF NON-RECEIPT
OF FEDERAL FUNDS**

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

SYNOPSIS

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

INTRODUCTION

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

STOP DOD SEQUESTRATION

As mandated by the 2011 Budget Control Act, failure of the Super Committee in 2011 to develop a bipartisan plan to contain the growth of the national debt will force implementation of "sequestration" in January 2013 unless Congress intervenes. Failure to act will trigger across-the-board cuts with half coming from the Defense budget. FRA agrees with Secretary of Defense, Leon Panetta, who said these cuts "would do catastrophic damage to our military, hollowing out the force and degrading its ability to protect the country." Defense counts for 17 percent of the federal budget but will receive 50 percent of the Sequestration cuts.

With the American military out of Iraq and the conflict in Afghanistan winding down, some are suggesting the possibility of a "peace dividend." Although there have been victories in the War on Terror, there has been no peace treaty with terrorism and the additional \$500 billion defense cuts beyond the cuts in the FY 2013 budget request could jeopardize essential military pay and benefit programs, which would negatively impact recruiting, retention and overall military readiness. For these reasons, FRA strongly supports the "Down Payment to Protect National Security Act" (S. 2065) sponsored by Senator Jon Kyl and a House bill (H.R. 3662) sponsored by HASC Chairman, Rep. Howard P. "Buck" McKeon. These proposals would amend the Budget Control Act by excluding the DoD budget from the first year of sequestration (2013).

DoD has already identified over \$450 billion in budget cuts over the next 10 years. While operations are winding down in Iraq and Afghanistan, the Nation however, is still at war and slashing DoD's budget further will not reduce the associated threats.

Less than one percent of the population is shouldering 100 percent of the burden of maintaining our national security, and the punitive reductions mandated by sequestration would force major across-the-board cuts to all programs and could potentially threaten the All-Volunteer Force.

BUDGET DEVALUES MILITARY SERVICE

FRA's membership is especially concerned about the Administration proposed FY 2013 budget which includes plans to drastically increase existing TRICARE Prime enrollment fees, implement new fees for TRICARE Standard and TRICARE-for-Life beneficiaries, and increase pharmacy co-pays. If approved, fees would be tiered based on the beneficiary's retired pay. These increases are a major concern to the entire military retiree community and since mid-February that concern has prompted nearly 11,000 messages to Capitol Hill via FRA's web site Action Center. Our members are also concerned that the budget calls for the fees to be increased based on health care inflation after FY 2017.

The budget also calls for a commission to study and propose changes to the military retirement system. This BRAC-like process would bypass the expertise of the Senate and House Armed Services Committees and only allow Congress an up-or-down vote on the commission's recommendations. All Reservists responding to a recent FRA survey, and 97 percent of active duty participants ranked retirement benefits as a very important benefit. More than 1,000 current and former service members participated in the survey. As Congress considers plans to reduce DoD costs by revamping the military retirement program, that benefit is particularly relevant to active duty and Reserve component personnel. Many current service members have expressed concern about the future of the retired pay and healthcare benefits they've been promised after they complete a career of military service. FRA appreciates SecDef Panetta assuring those currently serving that they will come under the current retirement system, but wonders why there is no similar commitment for those who served in the past?

The budget also requests an active duty and Reserve pay hike that is equal to the Employment Cost Index (ECI) only for FY 2013 and FY 2014, and makes deep cuts in Army and Marine Corps end strengths.

FRA supports a defense budget of *at least* five percent of GDP that will adequately fund both people and weapons programs, and is concerned that the Administration's spending plan is not enough to support both, particularly given ongoing operational commitments associated with the new defense strategy.

Future spending on national defense as a percentage of Gross Domestic Product (GDP) will be reduced despite significant continuing war related expenses and extensive operational and national security commitments. *Wall Street Journal* editorial writers noted, "Taken altogether, the (defense) budget could shrink by over 30% in the next decade. The Administration projects outlays at 2.7% of GDP in 2021, down from 4.5% last year (which included the cost of Iraq and Afghanistan). That would put U.S. outlays at 1940 levels – a bad year. As recently as 1986, a better year, the U.S. spent 6.2% of GDP on defense with no detrimental economic impact. What's different now? The growing entitlement state. The Administration is making a political choice and sparing Social Security, Medicare and Medicaid, which are set to hit nearly 11% of GDP (without health care reform costs) by 2020."

Make no mistake about the importance of these entitlement programs, however, DoD and VA benefits are also important and essential to maintaining that All Volunteer Force and our national security.

TRICARE FEE INCREASES

Health care benefits are important to every segment of FRA's membership. The continued growth in health care costs is not just a military challenge but a challenge for the entire country. FRA believes that military service is a unique profession and notes minimal projected savings associated with DoD management efficiencies and other initiatives in FY 2013 and beyond, while retirees are targeted for major fee hikes. These proposed hikes follow the 13-percent military retiree TRICARE Prime increase imposed this year.

Our members are also very concerned about a proposed new TRICARE-for-Life (TFL) enrollment fee beginning in FY 2013. This is viewed as another failure to honor commitments to those who served past careers in the military. These personnel pay Medicare Part B premiums and have not benefited from the significant pay and benefit enhancements enacted since 2000.

The Association believes that military retirees have earned their TRICARE benefits with twenty or more years of arduous military service with low pay. As you know, many retirees believe that they were promised free health care for life.

FRA strongly opposes premium increases for TRICARE beneficiaries' based on health care inflation. The Consumer Price Index (CPI) is the basis for military retiree annual cost-of-living-adjustments (COLAs), the purpose of which is to maintain purchasing power for the beneficiary.

Deputy Secretary of Defense Ashton B. Carter recently announced a plan to reform the Department of Defense's (DoD) governance structure of the Military Health System (MHS) in an effort to improve efficiency and reduce costs, per provisions of the FY 2012 National Defense Authorization Act. This is a step in the right direction, however, FRA continues to advocate for more extensive management reform and other department efficiencies as alternatives to shifting costs to retired TRICARE beneficiaries.

RETIREMENT COMMISSION

The Administration has proposed the creation of a BRAC-like commission to review and "reform" the current military retirement system. Numerous studies and commissions have focused on the military retirement as an opportunity to reduce overhead costs for the Pentagon. The latest is the Defense Business Board (DBB) proposal to replace the current system with a 401(k) plan similar to what corporations offer their employees. This concept has created significant anxiety in the career active duty community as noted above per a recent FRA online survey. As Congress considers plans to reduce DoD costs by revamping the military retirement program, that benefit is particularly relevant to active duty and Reserve component personnel. Many current service members have expressed concern about the future of the retired pay and healthcare benefits they've been promised after they complete a career of military service.

Since last October, FRA has noted strong opposition responses to its survey regarding proposals to “civilianize” the current military retirement system. More than 1,700 current and former service members responded and nearly 95 percent believe retiree benefits offer the most appeal if they were joining today. More than 80 percent of active duty and Reserve component respondents said they’d shorten their term of service if retirement benefits were changed to conform with the recommendations.

FRA believes that military service is unlike any other career or occupation, and requires a unique retirement system. Career senior NCOs are the backbone of our military and their leadership and guidance are invaluable and a result of many years of training and experience.

WOUNDED WARRIORS

FRA believes post traumatic stress should not be referred to as a “disorder.” This terminology adds to the stigma of this condition, and the Association believes it is critical that the military do all it can to reduce the stigma associated with PTS and TBI.

FRA also believes the Armed Services and Veterans Affairs Committees should remain vigilant regarding their oversight responsibilities associated with ensuring a “seamless transition” for wounded warriors transitioning from DoD’s Military Health System (MHS) to the Department of Veterans Affairs (VA). FRA strongly supports efforts to create a Joint Virtual Lifetime Electronic Record (VLER) for every service member and believes this would be a major step towards the long-standing goal of a truly seamless transition from military to veteran status for all service members and would permit a DoD, VA, or private health care provider immediate access to a veteran’s health data.

According to *Navy Times* editors, “Even before sequestration takes effect budget cuts have impacted the Office of Wounded Warrior Care and Transition Policy with the elimination of 40 percent (44 positions) of the staff, and all 15 contract employees in the transition policy section that leaves only two full-time civilian employees.”¹ Budget cuts have also resulted in the cancellation of the Virtual Transition Assistance Program (VTAP) website that was scheduled to replace the current Turbo TAP website. FRA is concerned that these cuts could negatively impact transitioning wounded warriors.

The Association also notes the importance of the Navy’s Safe Harbor Program and the Marine Corps Wounded Warrior Regiment (WWR) that are providing invaluable support for these personnel.

SUICIDE RATES

Suicide in the military is a serious concern for FRA and the Association notes that active duty suicides have been reduced or at least leveled off, but suicides for non-active duty Reserve Component personnel are increasing. “More than 2,000 service members killed themselves in the past decade, including 295 in 2010 compared with 153 in 2001.”²

¹ *Navy Times* Editorial, January 16, 2012, Page 4

² ABC News, [Rising Suicides Stump Military Leaders](#), September 27, 2011, Kristina Wong

Master Chief Petty Officer of the Navy (MCPON) Rick West testified on February 16, 2012 before the House Military Construction, Veterans Affairs Appropriations Subcommittee (Mil-Con/VA) and stated that in 2011 there were 51 Navy active duty suicides and seven Navy Reserve suicides which represents an increase from 39 active duty suicides and six Reserve suicides in 2010. To reduce the suicide rate the Navy has implemented a multi-faceted approach with communication, training, and command support, designed to reduce individual stress and strengthen psychological health of Sailors. The Navy efforts fall within the scope of their broader family readiness programs.

At the same hearing, Sergeant Major of the Marine Corps Micheal Barrett stated that in 2011 there were 33 Marine suicides and 171 failed suicide attempts. During the previous year, 37 Marines committed suicide and there were 172 failed attempts. The Marines have deployed peer-to-peer suicide prevention training and are working with the DoD Suicide Prevention Office to implement the recommendations of the DoD Joint Task Force on the Prevention of Suicide. Despite these initiatives, suicides continue and efforts to address the reasons for suicides must continue to be a top priority. FRA appreciates the provision in the FY 2012 Defense Authorization Act that requires pre-separation counseling for Reservists returning from successful deployments. In addition, FRA supports Rep. Thomas Rooney's bill (H.R. 208) that authorizes reimbursement for mental health counseling under TRICARE.

COLA ADJUSTMENTS

Under current law, military retired pay cost of living adjustments are rounded down to the next lowest dollar. For many of these personnel, particularly enlisted retirees, their retired pay is sometimes the sole source of income for them and their dependents. Over time, the effect of rounding down can be substantial for these personnel and FRA supports a policy change to rounding up retiree COLAs to the next highest dollar.

RESERVE EARLY RETIREMENT

A provision of the FY 2008 NDAA reduces the Reserve retirement age requirement by three months for each cumulative 90-days ordered to active duty. This is effective upon the enactment of the legislation (January 28, 2008) and NOT retroactive to October 7, 2001 and the Association supports "The National Guardsmen and Reservists Parity for Patriots Act" (H.R. 181) sponsored by the House Personnel Subcommittee Chairman, Rep. Joe Wilson, to authorize Reservists mobilized since October 7, 2001, to receive credit in determining eligibility for receipt of early retired pay. Since 09/11/2001 the Reserve Component has changed from a strategic Reserve to an operational Reserve that now plays a vital role in prosecuting the war efforts and other operational commitments. This has resulted in more frequent and longer deployments impacting individual Reservist's careers. Changing the effective date of the Reserve early retirement would help partially offset lost salary increases, promotions, 401(k) and other benefit contributions. The Association urges support for this important legislation.

RETENTION OF FINAL FULL MONTH'S RETIRED PAY

FRA urges the Subcommittee to authorize the retention of the full final month's retired pay by the surviving spouse (or other designated survivor) of a military retiree for the month in which the member was alive for at least 24 hours. FRA strongly supports "The Military Retiree Survivor Comfort Act" (H.R. 493), introduced by Rep. Walter Jones.

Current regulations require survivors of deceased armed forces retirees to return any retirement payment received in the month the retiree passes away or any subsequent month thereafter. Upon the demise of a retired service member in receipt of military retired pay the surviving spouse is to notify the department of defense of the death. The Department's financial arm (DFAS) then stops payment on the retirement account, recalculates the final payment to cover only the days in the month the retiree was alive, forwards a check for those days to the surviving spouse (beneficiary) and, if not reported in a timely manner, recoups any payment(s) made covering periods subsequent to the retiree's death. The recouping is made without consideration of the survivor's financial status.

The measure is related to a similar pay policy enacted by the VA. Congress passed a law in 1996 that allows a surviving spouse to retain the veteran's disability and VA pension payments issued for the month of the veteran's death. FRA believes military retired pay should be no different.

CONCURRENT RECEIPT

FRA supports legislation authorizing the immediate payment of concurrent receipt of full military retired pay and veterans' disability compensation for all disabled retirees. The Association strongly supports Senate Majority Leader, Harry Reid's "Retired Pay Restoration Act" (S. 344) and Rep. Sanford Bishop's "Disabled Veterans Tax Termination Act" (H.R. 333). Both proposals would authorize comprehensive concurrent receipt reform, and Rep. Gus Bilirakis' "Retired Pay Restoration Act" (H.R. 303) would authorize current receipt for retirees receiving CRDP with a disability rating of 50 percent or less.

FRA also strongly supports House Personnel Subcommittee Chairman Joe Wilson's bill (H.R. 186), that expands concurrent receipt for service members who were medically retired with less than 20 years of service (Chapter 61 retirees) and would be phased-in over five years. This proposal mirrors the Administration's proposal from the 110th Congress. In 2008, Congress voted to expand eligibility for Combat-Related Special Compensation (CRSC) coverage to Chapter 61 retirees and the proposed legislation would, in effect, extend eligibility for Concurrent Retirement and Disability Pay (CRDP) to all Chapter 61 retirees over five years. A less costly improvement to pursue in an austere budget year would be fixing the so-called "glitch" for CRSC that result in compensation declining when the VA disability rating increases.

CHILD CARE

Access to affordable, quality child care must be a high priority for all the military services. Adequate and reliable child care helps reduce stress on a military family that has one of the parents deployed. Sergeant Major of the Marine Corps Micheal Barrett testified before the House Mil-

Con/VA Appropriations Subcommittee on February 16, 2012 and stated that child care remains a high priority for that service. The Marine Corps provided 15,927 child care spaces in FY 2011, which reflects an 18 percent increase in capacity from FY 2010. The service developed a Child Development Program and Facility Master Plan, which reviewed child care capabilities and costs. The report will assist the Marine Corps in providing this benefit in a more efficient manner. MCPON Rick West stated at the same hearing that at the end of this year the Navy will complete its expansion efforts by adding 7,000 new child care spaces to meet the Office of Secretary of Defense (OSD) guidance to provide 80 percent of potential child care needs. This expansion has reduced waiting times to three-months or less.

UNIFORMED SERVICES FORMER SPOUSES PROTECTION ACT (USFSPA)

According to *USA Today*, “At the end of FY 2011, the military divorce rate reached its highest level since 1999, as nearly 30,000 marriages were dissolved. The overall military divorce rate of 3.7 percent edged out the most recent civilian (divorce) rate.”³ FRA urges Congress to review the USFSPA with the intent to amend the language so that the Federal government is required to protect its service members against State courts that ignore the Act.

The USFSPA was enacted 30 years ago; the result of Congressional maneuvering that denied the opposition an opportunity to express its position in open public hearings. The last hearing, in 1999, was conducted by the House Veterans’ Affairs Committee rather than the Armed Services Committee which has oversight authority for USFSPA.

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

There are other provisions that weigh heavily in favor of former spouses. For example, when a divorce is granted and the former spouse is awarded a percentage of the service member’s retired pay, the amount should be based on the member’s pay grade at the time of the divorce and not at a higher grade that may be held upon retirement.

FRA believes that the Pentagon’s USFSPA study recommendations are a good starting point for reform.

HOUSING

FRA supports reform of enlisted housing standards by allowing E-7s and above to reside in separate homes, track the Basic Allowance for Housing (BAH) to ensure it is commensurate with ac-

³ USA Today, Dec. 14, 2011, Military Divorce Rate at Highest Level Since 1999, Gregg Zoroya

tual housing costs, ensure adequate housing inventory and that housing privatization programs are beneficial to service members and their families.

The Marines are the youngest and least married of the four services. FY 2012 was the last year of a five year barracks construction effort to replace and update facilities. The FRA notes that Marines have 100,000 bachelor enlisted housing units. These projects were developed to meet 90 percent of the housing requirements of 202,000 and will meet just less than 100 percent of the projected reduced end strength force.

According to MCPON West during the above referenced testimony, the Navy is continuing to invest in Homeport Ashore Program to provide off-ship housing for junior Sailors who would otherwise live aboard ships. Despite multi-year efforts to address this issue, there are still 5,400 single Sailors E-1 through E-4 living abroad ships while at their home ports. This program will finally eliminate aboard ship living at home port by FY 2016.

The Navy has 3,500 family housing units that are inadequate and the service plans to reduce inadequate housing from the current 36 percent to 10 percent by FY 2017. The Marines have 24,000 family homes (including PPV) and the FY 2013 budget provides \$20 million to restore 44 family homes. The Navy and the Marines have privatized 97 percent of their family housing and when their Public Private Venture (PPV) is complete the Navy will own less than 100 homes.

MILITARY RESALE SYSTEM

FRA strongly supports adequate funding for the Defense Commissary Agency (DeCA) to ensure access to the commissary benefit for all beneficiaries. Since 2000, DeCA's budget has remained flat in real dollars, meaning the agency has done more with less for the past 11 years. The Association also strong supports the military exchange systems (AAFES, NEXCOM and MCX), and urges against revisiting the concept of consolidation. FRA instead urges a thorough review of the findings of an extensive and costly (\$17 million) multi-year study which found that this is not a cost-effective approach to running these important systems

MILITARY VOTING

In the past two years, 47 states and the District of Columbia enacted laws to protect the voting rights of military and overseas citizens, according to a report recently released by the Pew Center on the States. These changes are associated with a provision in the FY 2010 NDAA that requires all states to provide military voters with ballots no later than 45 days prior to each election, to ensure adequate time to complete and return them. The provision also allowed states and D.C. to transmit ballots to voters electronically and eliminated requirements for notarization and witnesses. FRA wants to express its appreciation for helping all deployed service members to be afforded the opportunity to vote. The Association recommends that this distinguished Subcommittee periodically conduct oversight hearings to ensure that deployed service members are not being disenfranchised.

CONCLUSION

FRA is grateful for the opportunity to provide these recommendations to this distinguished Subcommittee.

[Whereupon, at 3:39 p.m., the subcommittee adjourned.]

**DEPARTMENT OF DEFENSE AUTHORIZATION
FOR APPROPRIATIONS FOR FISCAL YEAR
2013 AND THE FUTURE YEARS DEFENSE
PROGRAM**

WEDNESDAY, APRIL 25, 2012

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

**CONTINUATION OF TESTIMONY ON THE ACTIVE,
GUARD, RESERVE, AND CIVILIAN PERSONNEL PRO-
GRAMS**

The subcommittee met, pursuant to notice, at 1:07 p.m. in room SR-232A, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, Blumenthal, Graham, Brown, Ayotte, and Vitter.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

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

Minority staff member present: Richard F. Walsh, minority counsel.

Staff assistant present: Jennifer R. Knowles.

Committee members' assistants present: Gordon Peterson, assistant to Senator Webb; Ethan Saxon, assistant to Senator Blumenthal; Brad Bowman, assistant to Senator Ayotte; Sergio Sarkany, assistant to Senator Graham; and Joshua Hodges, assistant to Senator Vitter.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. The hearing will come to order.

The subcommittee meets today to continue to receive testimony from the military Services on military and civilian personnel programs contained in the administration's Defense Authorization Request for Fiscal Year 2013 and the Future Years Defense Program (FYDP).

I would like to begin this hearing by thanking everybody for adjusting their schedules. As you have been informed, we have a series of votes that will begin in approximately 1 hour. So I am going to summarize my statement, at the end of which I will have my full statement entered into the record. Then I think we previously

asked that the civilian assistant secretaries give a brief overview of theirs. All of the written statements will be entered into the record, and hopefully we can allow enough time for members who wish to ask questions to use this next hour in a fruitful manner.

As always, the hearing record will be open until close of business tomorrow if there are written questions for the record for any of those of you who are here today.

We have today the senior leaders responsible for military and civilian personnel matters within the Services. We will discuss, as always, the plans and programs for fiscal year 2013 and also specific budget items in furtherance of this subcommittee's oversight responsibilities.

We have Hon. Thomas R. Lamont, Assistant Secretary of the Army for Manpower and Reserve Affairs; Hon. Juan M. Garcia III, Assistant Secretary of the Navy for Manpower and Reserve Affairs; Hon. Daniel B. Ginsburg, Assistant Secretary of the Air Force for Manpower and Reserve Affairs; Lieutenant General Thomas P. Bostick, USA, Deputy Chief of Staff G-1, U.S. Army; Vice Admiral Scott R. Van Buskirk, USN, Chief of Naval Personnel, U.S. Navy; Lieutenant General Robert E. Milstead, Jr., USMC, Assistant Commandant for Manpower and Reserve Affairs, U.S. Marine Corps; and Lieutenant General Darrell D. Jones, USAF, Deputy Chief of Staff for Manpower, Personnel and Services, U.S. Air Force.

We had originally scheduled this hearing for a few weeks ago. At that time, General Milstead was recovering from some very serious surgery. We are pleased that you have successfully recuperated, although you might have been better off being able to avoid this hearing a couple of weeks ago. But we are very happy to have you with us today, General.

As I stated at our oversight hearing with the Office of the Secretary of Defense (OSD) witnesses in March, we have some very serious challenges here. General Schwartz, Air Force Chief of Staff, called these challenges with personnel programs "the monumental defense issue of our time." These challenges, as everyone knows, have been made more difficult by the Budget Control Act (BCA).

Much of the subcommittee hearing last month was devoted to the TRICARE fee issue. I am not going to go into that in any detail today. Just suffice it to say that it is an issue of great concern to me and some other members on this subcommittee.

We are concerned about the planned reduction of large numbers of military personnel, more than 120,000 across Service components. I have been able to have personal discussions with a number of you about that issue. It may come up again today.

The Integrated Disability Evaluation System does not seem to be working. I have been able to have discussions again out of this hearing room with people about that. It is being implemented worldwide. There are some 23,000 servicemembers in the system, that at least by our count, are still awaiting some sort of resolution.

We are interested in examining the roles and opportunities for service by women. The Marine Corps, particularly, has had an interesting week in that regard. We will have a discussion about that.

Sexual assault prevention and response remain a priority, as always, for our subcommittee.

Another priority is the many discussions we have had regarding total force mix of military personnel, Department of Defense (DOD) civilian personnel, and contractors. This has come up a number of different times. It was a major part of our hearing last year. It will come up again today.

Lastly, we continue to be interested in the DOD's and the Services' efforts to eliminate, reduce, and reallocate 140 general flag officer positions and 150 Senior Executive Service positions.

At the outset of the hearing, I think it is important for those of us who are on this end of the table to express our great appreciation to all of you for what you and the people who serve alongside you do every day to make our country more secure and also to make DOD a better functioning place.

At this time, I will enter my full statement for the record.

[The prepared statement of Senator Webb follows:]

PREPARED STATEMENT BY SENATOR JIM WEBB

The subcommittee meets today to receive testimony from the Military Services on military and civilian personnel programs contained in the administration's Defense Authorization Request for Fiscal Year 2013 and the Future Years Defense Program.

With us today are the senior leaders responsible for military and civilian personnel matters within the Services. We will discuss not only their plans and programs for fiscal year 2013, but also specific budget items in furtherance of this subcommittee's oversight responsibilities. We will begin marking up the 2013 defense bill in the next few weeks. Your statements and testimony today are extremely important as we prepare for that important activity.

Our witnesses today are:

- The Honorable Thomas R. Lamont, Assistant Secretary of the Army for Manpower and Reserve Affairs;
- The Honorable Juan M. Garcia III, Assistant Secretary of the Navy for Manpower and Reserve Affairs;
- The Honorable Daniel B. Ginsberg, Assistant Secretary of the Air Force for Manpower and Reserve Affairs;
- Lieutenant General Thomas P. Bostick, USA, Deputy Chief of Staff G-1, U.S. Army;
- Vice Admiral Scott R. Van Buskirk, USN, Chief of Naval Personnel, U.S. Navy;
- Lieutenant General Robert E. Milstead, Jr., USMC, Assistant Commandant for Manpower and Reserve Affairs, U.S. Marine Corps; and
- Lieutenant General Darrell D. Jones, USAF, Deputy Chief of Staff for Manpower, Personnel and Services, U.S. Air Force.

Lieutenant General Milstead, I understand you tried to avoid this hearing the first time by scheduling surgery. I am pleased that your plan failed, and we are happy to see you back in good health.

As I stated at our oversight hearing with the Office of the Secretary of Defense witnesses in March, this subcommittee faces a very clear challenge this year as we address the need to control the increasing costs of personnel programs. General Schwartz, the Air Force Chief of Staff, called this challenge "the monumental defense issue of our time."

This challenge is made more difficult by the funding limitations imposed by the Budget Control Act. To comply with the discretionary funding caps, the administration has made several proposals to reduce military personnel costs, including end strength reductions of more than 120,000 military personnel, limiting pay raises beginning in 2015, establishing a BRAC-like commission to conduct a comprehensive review of military retirement, and increasing TRICARE fees for military retirees and their families.

Much of this subcommittee's hearing last month was devoted to the TRICARE fee issue, and I won't rehash that here. Suffice to say, I believe we have made a moral contract with servicemembers past and present to provide them a lifetime of medical care in exchange for a career of military service. The Department's proposal to insti-

tute fees for TRICARE for Life, in my view, does not fully take into account other fee requirements that already are in place.

We are also very concerned about the planned reduction of large numbers of military personnel—more than 120,000—across all Service components. I want to hear from the personnel chiefs in particular about their plans to reduce the size of their forces, how they will ensure adequate dwell time, and how they will avoid the need to involuntarily separate soldiers, sailors, airmen, and marines. Our witnesses today are well aware that our men and women in uniform have sacrificed much on behalf of our Nation during the past decade. I specifically would like to know what force-shaping tools the Services must have in place to achieve force reductions in a compassionate and sustainable manner.

In a related issue, the Integrated Disability Evaluation System (IDES) does not seem to be working as initially planned. It is bureaucratic and timeconsuming. It has been fully implemented worldwide for some 15 months, and yet there are more than 23,000 servicemembers in the system according to the latest data provided to the committee. For the Army alone, its IDES population would equal six brigade combat teams. I would like to hear from the personnel chiefs their view of how this new evaluation system is progressing and what we can do to make it more efficient and fair.

Many of us on the committee continue to be interested in examining the roles and opportunities for service by women. The Department recently proposed to Congress policy changes that would open more than 14,000 positions to women. Additionally, last week the Marine Corps announced opening a limited number of training slots in combat specialties to women, a significant departure from current restrictions. As our witnesses know better than anyone, for a variety of reasons, more than 75 percent of the Nation's youth do not qualify for enlistment in the military. Maintaining unnecessary barriers to service of those who are qualified and motivated to serve magnifies the challenge in recruiting the most qualified individuals for service in the All-Volunteer Force. At the same time, this subcommittee has an obligation to ensure policy changes continue to move us in the right direction. I look forward to learning more from our witness today.

Sexual assault prevention and response remain a priority for this subcommittee. Last year, we enacted a number of legislative provisions to assist victims of sexual assault. Additionally, Secretary Panetta recently announced several initiatives in this area, some of which may require legislation. I would like to hear what the Services are doing to reduce incidents of sexual assault in the military, prosecute offenders, and provide greater assistance to victims of such crimes.

Another continuing priority is accounting for the total force mix of military personnel, DOD civilian personnel, and contractors. At last year's hearing, with all the same witnesses except for Admiral Van Buskirk, I asked how you account for civilian contractors when you build your manpower models. There was a good deal of difficulty in pinning down actual numbers. I would like to know how we have progressed on addressing this issue since last year.

Lastly, this subcommittee continues to be interested in the Department of Defense and the Services' efforts to eliminate, reduce, and reallocate 140 general and flag officer positions and 150 Senior Executive Service positions. I would like to know what progress has been made in executing these reductions.

I'm sure that we all agree that there is no greater responsibility for Congress and our military leaders than to care and provide for our servicemembers and their families. That includes making careful, deliberate, and sometimes painful budget choices necessary to protect the viability of the All-Volunteer Force and to ensure our military remains the finest in the world. Tradeoffs must be made between what is nice to have and what we must have—not just in terms of weapons, planes, and ships, but most importantly in terms of our people. We must have the right number with the right qualifications and skills.

I look forward to hearing your testimony about the health of your Services, military personnel and their families, and your assessment and counsel concerning the difficult choices ahead. As always, I encourage you to express your views candidly. Let us know how we can best assist our servicemembers and their families to ensure that our military remains steadfast and strong.

We will now hear opening statements from our witnesses. Given the number of witnesses, I ask that the witnesses keep their oral statements to 3 to 5 minutes. Their complete prepared statements will be included in the record. Following the opening statements, we will limit our questions to 7 minutes per round. I am going to call witness by Service, starting with the Army.

Finally, I would like to note that this will be the last subcommittee hearing for Dick Walsh, minority counsel to the committee. Dick has been with the committee

for over 10 years and has made innumerable contributions always in a bipartisan fashion. We will miss him, and we wish him luck.

We have received a statement from the Reserve Officers Association. If there is no objection, it will be entered into the record.

Senator WEBB. With that, Senator Graham, welcome.

Senator GRAHAM. Thank you, Mr. Chairman. I will just forgo an opening statement and look forward to receiving the testimony.

Senator WEBB. Thank you.

We have received a statement from the Reserve Officers Association, and if there is no objection, that will be entered into the record.

[The information referred to can be found at Appendix A:]

Senator WEBB. With that, we will start with Secretary Lamont. Hopefully, you can summarize your statement in about 3 minutes or so.

STATEMENT OF HON. THOMAS R. LAMONT, ASSISTANT SECRETARY OF THE ARMY FOR MANPOWER AND RESERVE AFFAIRS; ACCOMPANIED BY LTG THOMAS P. BOSTICK, USA, DEPUTY CHIEF OF STAFF G-1, U.S. ARMY

Mr. LAMONT. I will try to do it in half of that, if you do not mind. I have truncated my lofty words and will rely upon our written statement.

Senator WEBB. Your written statement in full will be entered into the record.

Mr. LAMONT. Thank you.

Chairman Webb, Senator Graham, and members of this subcommittee, thank you for taking the time to explore the issues that are so critical to the men and women in our All-Volunteer Army and to our national defense both today and in the future.

It is an honor to serve as the Army's Assistant Secretary for Manpower and Reserve Affairs.

After a decade of war, the Army is poised to draw down both our military and civilian forces. We must do this smartly and compassionately. Thousands of individuals will transition out of military and civil service after serving faithfully and honorably. They will need the support of the Nation and deserve quality transition assistance.

Wartime experiences over the past decade have taught us that we must have a total Army. The Army National Guard and Army Reserve provide 51 percent of the Army's military end strength for around 16 percent of the base budget. We look forward to working with you to transform the Army National Guard and Army Reserve into an operational force that provides not only ready access to 1 million trained soldiers but also an historic opportunity for our Nation to achieve the most cost-effective use of its Army.

We are increasingly aware of the physical and emotional toll a decade of war has taken on our force, and we are committed to providing quality assistance to soldiers and family members who are struggling with issues such as substance abuse, depression, post-traumatic stress disorder (PTSD), and sexual harassment and abuse. These issues affect readiness and weaken our force. The Army continues to take aggressive action to promote health, identify and reduce risky behaviors, and prevent suicides. Further, at

all levels of the Army, we are reinforcing the Army value of respect in order to establish a climate where sexual harassment, sexual assault, and hazing will not be tolerated.

While we transform to a smaller Army, we remain dedicated to improving readiness and building resilience in our soldiers, civilians, and families. The Army must not and will not sacrifice readiness as it draws down. We will emerge from the forthcoming budget reductions a leaner force but one still capable of and committed to meeting our obligations to the Nation, the American people, and the dedicated men and women who serve. Although our Army will become smaller in the coming months and years, we will preserve the quality of our All-Volunteer Force. This fighting force will retain the confidence and pride of the American people as it has for more than 236 years.

I appreciate the support of the committee and your commitment to taking care of our soldiers, civilians, and families. The well-being of our force, regardless of its size, is absolutely dependent upon your tremendous support.

Thank you very much. I look forward to your questions.

Senator WEBB. Thank you, Secretary Lamont. General Bostick, your written statement will be entered into the record as well. I know you will be receiving some questions during the question period.

[The joint prepared statement of Mr. Lamont and General Bostick follows:]

JOINT PREPARED STATEMENT BY HON. THOMAS R. LAMONT AND LTG THOMAS P. BOSTICK, USA

INTRODUCTION

Chairman Webb, Senator Graham, distinguished members of this committee, thank you for the opportunity to appear before you on behalf of America's Army. The U.S. Army is a values-based organization that exists to serve the American people, to defend the Nation, to protect vital national interests, and to fulfill national military responsibilities. We are now poised to execute an historic drawdown of both our military and civilian personnel, and we are proposing to do it in a deliberate and careful manner. Thousands of individuals will transition out of military and civil service and deserve quality transition assistance.

While the future Army will be smaller, the Army is implementing a number of improvements in force structure and other capabilities to ensure it remains the best led, best-trained, and best-equipped land force in the world today and in the future. Our soldiers have performed superbly over the last 10 years of war, displaying the values, character and competence that make our Army second to none. We must not waver on our commitment to support all those who have served with courage, pride, and honor.

Thank you for your steadfast commitment to ensuring that the needs of our soldiers, their families, and our civilian workforce are met by supporting our personnel initiatives to ensure growth, sustainment and well being of our All-Volunteer Force.

STRATEGIC OVERVIEW

America's Army, our soldiers, families, and civilians are strained by nearly a decade of persistent conflict. More than 1.1 million soldiers have deployed to combat, impacting not only the soldiers, but their families as well. Additionally, Army civilians shoulder a majority of the Generating Force mission, and 30,000 civilians have deployed into harm's way. Now we will transition to a smaller force, while continuing to remain vigilant of new threats and prepare for new capabilities and requirements.

To maintain an All-Volunteer Force of the highest quality soldiers and achieve our end-strength goal, the Army must responsibly balance force shaping across accessions, retention, promotions, voluntary and involuntary separations, and natural

losses. We should assist our soldiers and civilians who will transition from their military and civil service careers to employment in the private sector.

One of the challenges we face is the nondeployable population. The disability system is not effective and we must continue to work on an efficient solution between the Services, DOD, and the Veterans Administration to streamline the disability system and improve coordination for health care, compensation, and benefits. The Army also continues to focus on assisting our soldiers and family members struggling with depression, substance abuse, and other Health of the Force issues.

With the continued support of the American people and Congress, we remain committed to the readiness, health and well being of our soldiers, civilians, and family members. As part of this effort the Army is also focused on wisely managing our resources in the health care arena. The Department of Defense (DOD) has also put forward a set of 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. Most importantly, DOD continues to provide resources that improve the overall health system for our soldiers and their families.

The American soldier is the centerpiece of everything we do in the Army. Our efforts must remain focused on the preservation of our most precious resource, our people.

DRAWDOWN/END STRENGTH

In keeping with the National Defense Strategy, the Army is building our future force to meet the Nation's requirements. The Army is reducing its Active component end strength to 490,000 soldiers by fiscal year 2017. Based on Total Army Analysis of future requirements, the force structure effective in fiscal year 2017 requires an additional decrease of ~24,000 enlisted soldiers and ~5,000 officers beyond our current rate of attrition over this same period. The Army continues to reduce the additional temporary end strength increase (TESI) of 22,000 soldiers, approved in 2009 by the Secretary of Defense, and is on target to be at an Active component end strength of 552,100 by the end of fiscal year 2013. In fiscal year 2014, the Army will begin to take further steps to significantly shape the force toward the 490,000 fiscal year 2017 goal.

Our projected drawdown ramp allows for funding 490,000 of end strength in the base budget starting in fiscal year 2014 and beyond, with all other end strength supported by Overseas Contingency Operations (OCO) funding. This ramp allows for a steady enlisted accession mission of ~57,000 and an Active Competitive Category officer mission of ~4,300. Our strength projections incorporate additional soldier inventory, Temporary Endstrength Army Medical (TEAM), to mitigate impact of the Disability Evaluation System (DES) nondeployable soldiers. This TEAM end strength is assumed in fiscal year 2013 and fiscal year 2014 and fully eliminated by end of fiscal year 2015.

In order to achieve expected end strength reductions, the Army expects to use various types of separation authorities across all elements of the force (officer, enlisted, and civilian). In order to maintain America's Army as an All-Volunteer Force of the highest quality, we are planning to execute the upcoming force reductions in a responsible and targeted fashion while maintaining a ready force. Our soldiers have performed superbly over the last 10 years of war and have displayed the values, character and competence that made us successful. We value their service and sacrifices, and will use precision, care, and compassion in achieving the end strength goal without jeopardizing combat operations. Under current loss rates, the Army will not be able to reach its end strength goal over the fiscal year 2013–2017 period. We are making use of reduced accession levels, promotion selectivity and tightened retention standards to help shape our force naturally. Through these processes, we expect to lose combat seasoned soldiers and leaders, but our focus will be on retaining the best individuals in the right grades and skills.

The National Defense Authorization Act (NDAA) for Fiscal Year 2012 provides several incentive authorities that will help the Army encourage soldiers to separate over the drawdown period, along with the flexibility to apply them to meet specific grade and skill needs. We are developing cost data for potential use of Voluntary Separation Pay (VSP), Temporary Early Retirement Authority (TERA), and Voluntary Retirement Incentive (VRI) pay, but will need to realign or request re-

programming of funds to support execution of these now existing authorities. Unfortunately, there is no single force shaping method among the choices of accessions, retention and separations, that will achieve the Army's end strength goals, and there will be good soldiers who we will not be able to retain. As soldiers depart our active duty formations, the Army is committed to assisting them and their families as they transition to the Army Reserve, National Guard, or civilian life.

To maintain an All-Volunteer Force of the highest quality soldiers and achieve our end strength, the Army must responsibly balance force shaping across accessions, retention, promotions, voluntary separations, involuntary separations, and natural losses.

Total Military Personnel Resources – Base and OCO Funding

Military Personnel Account (\$M)*	FY 2011	FY 2012	FY 2013
Personnel (AC, NGB & USAR)	64,953.5	62,882.8	63,300.6
Medicare-Eligible Retiree Health Care	5,163.0	5,085.4	3,226.7
Total	70,116.4	67,968.2	66,527.3

Temporary End Strength Increase Request (\$M)**	FY 2011	FY 2012	FY 2013
Military Personnel, Army	\$1,616	\$1,076	\$288

* Includes Base Budget and OCO Funding

**TESI funding included in Military Personnel total

TRANSITION ASSISTANCE STRATEGY

Our Nation entrusts its best and brightest to the Army to support the All-Volunteer force. Therefore, the Army has a responsibility to help our transitioning personnel prepare for post-Army life by providing the training and tools to enable their success. We must help them use their Army training, education and experience to successfully return to civilian life and to become gainfully employed. Support through this transition process demonstrates the Army's commitment to its soldiers and their families beyond their years of service.

Some of the more than 130,000 soldiers who transition from the Army annually have difficulty finding employment. As of January 2012, 21 percent of our Gulf War II Veterans between the ages of 20 and 24 are unemployed while the national unemployment average for the same age group is 14 percent. Since 2001, the Army's annual unemployment compensation costs have increased from \$90 million to \$574.5 million in fiscal year 2011. As the Army executes force shaping in the 2014–2017 timeframe, the number of personnel requiring transition training and counseling is expected to increase.

Consequently, the Army is transforming the way we transition soldiers in order to give them the greatest opportunity for success after their military service. On August 29, 2011, the Army published a new Transition Policy, which encompasses transitions throughout the entire lifecycle of Service (e.g. permanent change of station, component change, promotion, schooling, deployment, demobilization and separation/retirement). In particular, this policy establishes Transition as a commander's program; ensures every soldier begins mandatory transition counseling and planning no later than 12 months before separating or demobilizing; mandates building a tailored plan for an individual's needs which will have measurable outcomes; and expands virtual services for career and education counseling before, during, and after deployment. On December 29, 2011, the Army published an Execution Order focused on transition policy actions which will have an immediate and positive impact on soldiers preparing to separate from Active Duty, demobilizing Reserve component soldiers, and their families.

The Army supports the White House Employment Initiative and the DOD/Department of Veterans Affairs (VA) Veterans Employment Initiative Task Force to develop reforms to ensure all transitioning servicemembers maximize their career readiness prior to separation in line with the newly enacted Veterans Opportunity to Work to Hire Heroes Act of 2011. With the Army's new proactive approach to transition, we are connecting soldiers and veterans with career private industry employment opportunities. The Army is working with the DOD/VA Task Force to help identify the best information technology application and functional capability to support this employment initiative.

CIVILIAN REDUCTIONS AND HUMAN CAPITAL MANAGEMENT

The Army is reducing civilian on-board strength, where necessary and appropriate, in order to meet funded targets. This reduction will draw down civilian on-board strength in order to hold to fiscal year 2010 civilian funding levels. Headquarters, Department of the Army Staff and all Army commands and agencies have conducted exhaustive reviews of programs and functions in order to identify specific functions, activities, and workload for elimination and/or reduction.

On February 2, 2011, the Department of the Army suspended civilian employment offers for Operation and Maintenance, Army (OMA)-funded positions, with exceptions for positions related to medical, law enforcement, safety, health, welfare, and contingency operations. Other exceptions to fill vacancies were approved at the Department of the Army headquarters level. The suspension was lifted on April 29, 2011, and commands and agencies were directed to manage civilian and contracted workload within their targeted fiscal constraints.

The Secretary of the Army issued implementation guidance to Army commands on July 11, 2011, informing them of their funded civilian authorization levels and an implementation order was issued on August 3, 2011. The \$834 million reduction in OMA funding is associated with 8,741 reductions in direct hire civilian authorizations. Commands and agencies will take immediate action to reduce civilian on-board strength as rapidly as possible, but no later than the end of fiscal year 2012. Our reshaping efforts are already assisting commanders and directors with reshaping efforts.

The Assistant Secretary of the Army (Manpower and Reserve Affairs) and the Assistant Secretary of the Army (Financial Management and Comptroller) have established business processes and reporting mechanisms to effectively align requirements, authorizations, on-board strength and associated funding execution for the civilian workforce. Commands and agencies report monthly on the status of their civilian workforce reduction plans, the number of civilian reductions effected each month, the total number of reductions to date and the amount of OMA funding expended on civilian payroll. In accordance with statutory restrictions and the Secretary of the Army's instructions, service contracts will not be initiated in lieu of reduced civilian manpower, nor will existing contracts be modified to accommodate work formerly performed by civilian employees.

To the maximum extent possible, the Army is relying on voluntary departures and attrition to achieve the personnel reductions. Reshaping tools to effect voluntary departures include Voluntary Early Retirement Authority (VERA) and Voluntary Separation Incentive Pay (VSIP). Other non-voluntary reshaping tools short of Reduction In Force (RIF) may include release of temporary employees, separation of Highly Qualified Experts (HQE), separation of re-employed annuitants, management-directed reassignments and furloughs. If these measures do not achieve the required civilian personnel levels, then a RIF may be considered.

Several commands are releasing temporary employees, re-employed annuitants and HQEs. Many have also instituted internal hiring freezes, with recruitment outside of the command requiring higher headquarters approval. Commands have offered VERA to employees willing to retire and/or VSIP to those willing to separate from the Federal Government. If further reductions are necessary, a RIF will be the last resort. As conditions change with regard to the size of the workforce, marginal adjustments will be made to these planned reductions at installations where such adjustments are warranted.

Civilian Pay	FY 2011	FY 2012	FY 2013
(\$B)	23.8	24.3	22.9
Full-Time Equivalents (FTE)	FY 2011*	FY 2012*	FY 2013*
Army funded	180,107	157,670	156,346
External funded	57,267	87,783	76,299
Revolving fund	27,947	24,734	23,537
TOTAL	265,321	270,187	256,182

*Civilians funded by OCO and Civil Works appropriations which are not captured as any part of the Army's budget submission.

RECRUITING AND RETENTION (OFFICER AND ENLISTED)

Our soldiers are the Army's most important resource, and our ability to meet the challenges of the current and future operational environment depends on our ability to sustain the All-Volunteer Force. Even as we drawdown the Army, we must continue to bring high quality men and women into the force to grow our future leaders. We must also ensure that the Army retains the most talented soldiers with the skills necessary to meet our future needs.

Despite the challenges of an ongoing conflict, the active Army and the Army Reserve once again exceeded their enlisted recruiting and retention missions in fiscal year 2011. The Army National Guard intentionally under accessed in fiscal year 2011 to avoid exceeding their congressionally mandated end strength limits. The active Army accessed the highest percentage of high school diploma graduates since fiscal year 1992—increasing from 94.7 percent in fiscal year 2009 to 98.7 percent in fiscal year 2011. The Army met its skill-set needs, achieving over 99 percent Military Occupational Specialty (MOS) precision. The Army's percentage of new enlisted soldiers with a high school diploma was well above historic rates for all three components. In addition, recruits scoring (50–99 percent) exceeded the DOD standard of 60 percent, while recruits who scored in the lower range (30 and below) on the Armed Forces Qualification Test decreased by 30 percent (from 281 to 199). Ineligibility waivers granted for enlistment and appointments declined by 4.45 percent from fiscal year 2010 to fiscal year 2011 as a result of being more selective and the improved recruiting environment. We are currently on track to achieve our fiscal year 2012 mission and expect to recruit half of the fiscal year 2013 annual mission into the entry pool by the end of fiscal year 2012.

In fiscal year 2011, Combined Active Army (AC) and Army Reserve Component (RC) enlistment and reenlistment incentives (bonuses and education), totaled slightly over \$1.39 billion. Entering fiscal year 2012, the combined Active and Reserve components will spend slightly over \$1.19 billion (AC recruiting; \$406 million), AC retention (\$231 million), Army National Guard recruiting and retention (\$455 million), USAR recruiting and retention (\$274 million). A large part of the fiscal year 2012 incentives budget is a result of obligations for enlistment bonuses occurring from fiscal years 2007–2010. As a result of lower recruiting missions and the favorable recruiting environment, average Regular Army recruiting bonuses dropped from over \$13,000 in fiscal year 2009 to \$2,500 in fiscal year 2012. Enlistment and reenlistment bonuses are only used to incentivize longer-term enlistments in a small percentage of critical skills. These incentives ensure the success of the total Army recruiting and retention missions and shape the force to meet specific grade and skill requirements. The amount budgeted for contractual payments is anticipated to decrease until at least fiscal year 2015.

Program Description (\$M)	FY 2011 ^a	FY 2012	FY 2013
AC Enlisted Army Incentives (EB, SRB, Ed Ben)	557.9	481.2	443.1
NGB Enlisted Army Incentives	394.6	449.6	364.1
USAR Enlisted Incentives	271.2	256.2	199.6
Total Army Enlisted	1,223.8	1,187.0	1,006.7

^aTotals may not add due to rounding

Over the years through research, the Army has improved personnel assessment measures to more fully assess an individual's potential to serve and predict a soldier's success in job performance, attitudes, and career intentions. One valuable measure is the Tailored Adaptive Personality Assessment System (TAPAS). TAPAS was developed to enhance the selection of soldiers with Tier 1 credentials by screening out low motivated, high attrition risk applicants. To date, more than 320,000 Army and 96,000 Air Force applicants have tested on TAPAS. The Navy also started testing their applicants in late fiscal year 2011. Preliminary results in operational testing indicate that soldiers who pass the TAPAS screen have better retention and training outcomes than soldiers in the same Test Score Category who fail the TAPAS screen.

Recruiting success is expected to continue in fiscal year 2012; however, the Army and the Nation still face challenges such as rising obesity rates and decreasing high school graduation rates as we recruit the All-Volunteer Force. As the pool of qualified 17–24 year old Americans continues to decline due to growing rates of obesity and decreasing rates of high school graduation, it will become more important for parents, teachers and business leaders to support a youth's decision to join the Army. In today's environment fewer than one in four 17–24 year-olds are eligible

to serve in the Army. More than 20 percent of high school students fail to graduate and 1 in 5 youths, 12–19 years old, are currently overweight, compared to 1 in 20 in the 1960s. This trend is projected to grow to 1 in 4 by 2015.

The Army must retain the flexibility to offer incentives to attract and retain talent. The continued funding of these programs by Congress is absolutely critical to the Army. These incentives assist in shaping the force for both quality and specific talent required.

The Army continues to retain soldiers at unprecedented levels, while engaged in the longest period of conflict for our All-Volunteer Force. The Army has surpassed its retention goal, every year since 2002. Soldiers reenlist for three top reasons: current command climate, job satisfaction, and the quality of life in the Service. Additionally, retention rates within the last 24 months have been slightly higher than anticipated.

In fiscal year 2011, the Active Army reenlisted 43,626 soldiers towards an annual mission of no less than 40,000 and no more than 45,000. Soldiers extending to complete deployments with their units represented an additional 7,346 extended contracts. The Army Reserve reenlisted 12,934 soldiers, exceeding their annual goals by 11 percent. The Army National Guard accomplished their mission as well by achieving 116 percent of their assigned mission, reenlisting 39,750 soldiers.

During fiscal year 2011 and into fiscal year 2012, retention bonuses were carefully monitored and adjusted to ensure that the Army met its retention goals while remaining fiscally responsible. As we posture for future reductions in the size of our force, the Army is using lessons learned from past reductions to ensure that today's decisions maintain the viability of tomorrow's All-Volunteer Force. Retention policies will emphasize retention of soldiers with high potential coupled with appropriate force alignment and structure.

The Army's programs to recruit and retain both officers and enlisted soldiers with critical skills have been effective. For enlisted soldiers, the Enlistment Bonus, the Selective Reenlistment Bonus, Critical Skills Retention Bonus, and the Student Loan Repayment Program are proven tools that remain effective for filling critical skills.

DIVERSITY

The diversity of our Army is a continuous source of strength as we recruit soldiers and Army civilians from an increasingly diverse America. We must take full advantage of opportunities to bring new ideas and expanded capabilities to the mission by reaching out to communities and building relationships that will support the Army's human resource requirements. To this end, we have developed and implemented our first strategy for conducting outreach activities on an Army-wide basis. In this first year of execution, 9 commands are responsible for coordinating 25 outreach events for the Total Army. The Army staff will coordinate an additional 10 events for a total of 35 during 2012. Additional organizations and events will be added to the strategy in the future.

Our ability to be inclusive of the Nation's diverse citizenry while sustaining a high performance Army requires the engagement of senior leaders and continuous diversity education throughout the Force. The Army Diversity Roadmap, published in December 2010, outlines a unique approach to an enterprise-wide diversity initiative over the coming years and will guide our actions in the areas of leadership, people, structure and resources, training and education, and inclusive work environments. Within the Roadmap, we are implementing an intra-Army council of senior leaders to advise the Secretary and provide a forum for collaboration and sharing ideas in connection with implementation of the Army Diversity Roadmap and execution of related initiatives. In addition, the Council will facilitate delivering the diversity and inclusion message throughout the Army.

Our initial diversity training and education efforts have focused on practitioners who support our commanders and other leaders. We have completed initial training for 560 Military Equal Opportunity (MEO) and Equal Employment Opportunity professionals, and followed up with materials to support unit-level instruction. Over the past 2 years, 300 general officers and civilian senior executives have completed a diversity education program. In this program Senior executives are presented with Army demographics and participate in experiential exercises that facilitate awareness and perspective.

We will continue to invest in diversity education and inclusive leadership by seamlessly integrating the training for senior leaders into their initial leader development programs. Ultimately, we will also reach every soldier and Army civilian through the Army's institutional professional development system.

We must position the Army to recruit, develop and retain the most talented people our Nation has to offer. Critical to our global mission is an understanding of the cultures, languages and social norms of the people in locations where we deploy as well as in our own ranks. This diversity initiative is integral to the Army's long-term vision for human capital and our understanding of the human dimension of leadership and global engagements.

OPERATIONALIZING THE RESERVES

The wartime experiences of the past decade validate the need to institutionalize the policies, procedures and legal authorities conducive to achieving the most efficient utilization of the Total Force through maintaining the Army's Reserve components as an "operational force." Additionally, recent DOD strategic guidance advocates maintaining key capabilities within the Total Force by shifting certain capabilities to the Reserve components where they can be maintained at a high readiness level at lower overall cost. This strategy requires we continue to regularly employ National Guard and Reserve Forces in support of our national strategy.

To support an Operational Reserve, the Army included resources for the National Guard and Army Reserve within the fiscal year 2013 base budget, including additional resources for collective training, full-time manning and medical/dental readiness. This required investment in readiness ultimately allows the Army to manage our Reserve components as an operational force.

Towards that end, the NDAA for Fiscal Year 2012 provided the authority for Service Secretaries to place limited numbers of their Reserve component units on active duty as an operational force for certain preplanned missions in support of the combatant commands where the costs associated with such usage are contained in that year's Defense budget. Additionally, the Secretary of the Army promulgated the Army's Deployment Period Policy which established a common, 9-month period of deployment for General Purpose Forces at division-level and below. The policy also mandates common processes and procedures for validating pre-deployment readiness across the Total Force with a view towards integrating Active and Reserve Forces at the tactical level consistent with the Secretary of Defense's policies for utilization of the Total Force.

The Army National Guard and Army Reserve provide 51 percent of the Army's military end-strength for around 16 percent of the base budget. Transforming the Army National Guard and Army Reserve into an operational force provides not only ready access to 1 million trained soldiers, but also an historic opportunity for our Nation to achieve the most cost-effective use of its Army.

NONDEPLOYABLE CAMPAIGN PLAN

As a result of more than a decade of war, the Army has experienced a dramatic increase in the number of soldiers who are unable to deploy. During the 4-year period from 2007 through 2011, the nondeployable rate for Brigade Combat Teams (BCTs) increased by nearly 60 percent, from ~10 percent in fiscal year 2007 to greater than 16 percent in fiscal year 2011. The corresponding decrease in the overall deployable rate has required us to over-man deploying units so that BCTs deploy with the required combat strength. This has directly impacted the Army's ability to properly man the generating force. As a result, the Army developed a comprehensive nondeployable campaign plan to analyze the three categories representing the highest percentage of nondeployable soldiers: Medical, Separations [Expiration Term of Service/retirements], and Legal Processing.

With the support of this Congress, we made significant strides this past year in the administrative categories; driving the overall rate down to 14 percent. Legislation passed in 2011 authorizing 365-day early separation will enable the Army to increase the readiness of our deploying units as we backfill those separating with deployable soldiers. Soldiers with medical conditions remain a challenge, comprising nearly half of our nondeployable population. This population will continue to grow as we draw down, decreasing the overall population while retaining these non-deployable soldiers as they undergo medical evaluation. Our soldiers continue to be the cornerstone of our combat formations and as we draw down the force, we remain committed to providing top quality service to our soldiers and their families. Therefore, we have focused our efforts to reduce the number of medically nondeployable soldiers by creating a Disability Evaluation System (DES) Task Force that will represent both medical non-deployable and DES initiatives. Through the collaboration of this multi-faceted Task Force, we can continue to man an expeditionary Army with soldiers who are deployable, while preserving the All-Volunteer Force.

THE ARMY DISABILITY EVALUATION SYSTEM

The DES has made improvement over the last 4 years, as legislative changes and the new Army Disability Evaluation System (DES) have made the system less adversarial; provided greater consistency between Military and VA ratings; and reduced the time it takes to start receiving VA benefits after separation. However, we are committed to improving the complex process.

The current process takes almost 400 days to complete. Even if the Army were meeting DOD's goal of 295 days, 10 months is simply too long for our soldiers and their families to wait while their future hangs in the balance. Currently the Army has more than 19,000 soldiers tied up in this process of disability adjudication; the equivalent of 5 Brigade Combat Teams sitting on the bench, not available or deployable, who must be replaced from other elements to meet operational and tactical requirements. As a result of the lengthy processing times, the DES continues to have a significant impact on Army readiness. More than 95 percent of these soldiers depart from the Army once through the process.

The Army is committed to doing everything it can to improve the current process. Our Senior Leadership meets monthly with our partners in the Department of Veterans Affairs to focus on the execution of the Army DES down to the installation level, identify performance issues, and share best practices in order to streamline the process. More recently the Army completed a Senior Leader assessment of the execution of the Army DES at installations across the Army. This assessment identified specific actions required to enhance and standardize performance across the Army. Combined, these actions and standards will ensure our soldiers receive the needed support in a timely manner; provide the leadership at all levels visibility in order to adjust resourcing and assess efficiency; and help us improve Army Readiness by moving soldiers through the Army DES more expeditiously.

We are working with DOD leadership, the other Services, and our partners in the Department of Veterans Affairs on improving the system and look forward to collaborating with Congress on this issue.

QUALITY OF LIFE/FAMILY PROGRAMS

The strength of our Nation is our Army. The strength of our Army is our soldiers. The strength of our soldiers is our Families. Because of the tremendous sacrifices soldiers and families make every day, the Army is resolute in sustaining the important programs that enhance their strength, readiness, and resilience.

The Army Family Covenant institutionalized the Army's commitment to provide soldiers and their families with a quality of life commensurate with their level of service to the Nation. Army Senior Leadership signed the first Family Covenant in October 2007 and reaffirmed its tenets in October 2011. The Covenant represents our commitment to provide programs and services to soldiers, both single and married, and their families, regardless of component or geographic location. The Covenant recognizes the strength and commitment of soldiers and their families and establishes a lasting partnership with Army families to enhance their strength, readiness, and resilience.

We are committed to improving soldier and family readiness by continuing to build resiliency through strengthened soldier and family programs that are simple and easier to access; maintaining accessibility and quality of health care; sustaining high-quality housing for soldiers and families; maintaining excellence in school support, youth services, and child care; promoting education and employment opportunities for family members; sustaining recreation, travel, and quality of life opportunities for single soldiers; and joining forces with communities to inspire support for soldiers and families.

Covenant Program \$M	FY 2011	FY 2012	FY 2013
Family MWR Command (FAPC)	38.9	35.1	37.9
Army Community Service (QACS/VFRA/QPSG)	449.7	414.2	368.9
Child Care Services (QCYS)	392.1	408.3	441.0
Youth Programs (QCYS)	137.8	152.5	156.2
Community Recreation (QDPC)	269.8	245.2	288.0
Family Programs	1,288.3	1,255.3	1292.0
Voluntary Ed/Tuition Asst (VACE/VATA)	399.9	353.4	368.7
Supplemental/OCO	49.1	127.4	57.3
Total Family Programs	1,737.3	1,736.1	1718.0

ARMY MILITARY EQUAL OPPORTUNITY POLICY

The Army is the leader in MEO policy and practice. Commanders at all levels are responsible for sustaining positive MEO climates within their organizations, thus enhancing Army Readiness. To remain relevant within the ever-changing environment in which we operate, the Army is revising its MEO policy by integrating and institutionalizing equal opportunity goals, objectives and training practices. This effort will strengthen the foundation of the Army's Human Capital Strategy. Since fiscal year 2009, the Army has invested \$3.2 million to include \$0.8 million in fiscal year 2011, and expects to invest another \$2.1 million in fiscal year 2012 for MEO personnel services support, database and survey systems, outreach support, and training for implementation.

WOMEN IN THE ARMY

On January 13, 1994, the Secretary of Defense issued the Direct Ground Combat Definition and Assignment Rule. The rule remains in effect today and prohibits the assignment of women to units below the brigade level whose primary mission is to engage in direct combat on the ground.

The Army's current assignment policy (Army Regulation 600-13, 27 Mar 92) allows women to serve in any officer or enlisted specialty or position except in those specialties, positions, or units (battalion size or smaller) which are assigned a routine mission to engage in direct combat, or which collocate routinely with units assigned a direct combat mission.

On March 2, 2010, in the context of a changing operational environment, with emerging requirements and missions, the Army initiated a routine cyclic review of its assignment policy for female soldiers. The purpose of the review was to assess the current Army policy alignment with DOD policy. The Army completed the cyclic review in March 2011 and submitted the results and recommendations to Army Senior Leadership for decision. Prior to making that decision, the NDAA for Fiscal Year 2011, section 535, directed the Secretary of Defense, in coordination with the Services, to review laws, policies, and regulations that restrict female servicemembers an opportunity to excel in the Armed Forces.

The DOD review was completed in late January 2012 and released February 9, 2012. The Army concurred with the other Services in the revision of the Direct Ground Combat Assignment Rule that eliminates gender-based assignment restrictions to units and positions that are required to physically collocate and remain with direct ground combat units that are closed to women and to further align Army assignment policy with that of DOD. In doing so, the Army opened approximately 13,139 positions for the assignment of women. Additionally, we opened six MOS: three in Field Artillery and the remaining three closed specialties in the Logistics career field. We also requested and were granted a DOD exception to the Direct Ground Combat Assignment Rule that will authorize the Army to assign females to direct ground combat units below the brigade level. This limited exception allows assignment of female soldiers in select open specialties to serve in the battalion headquarters of select direct ground combat units. Each of these activities will take effect in late spring 2012.

Women in the Army have and continue to serve this Nation with honor and distinction in the roles, positions, units, and specialties in which they are allowed to serve. They have proven their ability to serve in expanded roles throughout the Army both on and off the battlefield. This review marks the beginning of a careful and deliberate effort to apply lessons learned by commanders over more than a dec-

ade of persistent conflict. The Army will continue to review positions and requirements to ensure that all soldiers are provided opportunities to reach their full potential and that we accomplish our missions with the most capable and qualified soldiers.

SEXUAL HARASSMENT/ASSAULT RESPONSE AND PREVENTION PROGRAM (SHARP)

The Army's goal is to eliminate sexual assault and sexual harassment through cultural change, thereby, creating a professional climate where every member of the Army family (soldiers, civilians, family members, and contractors) trusts their leaders to treat them with dignity and respect.

The Army SHARP Program reinforces the Army's commitment to reducing incidents of sexual violence while promoting sensitive care and confidential reporting for victims of sexual assault, and accountability for those who commit these crimes.

The Army continues to implement a comprehensive "I. A.M. (Intervene, Act, and Motivate) Strong" Sexual Harassment/Assault Prevention Strategy and Campaign.

The campaign is based on the same strategic framework and guiding principles used to execute a successful military initiative—Prevent, Shape and Win. The Army's goal is to "Prevent" sexual assault and harassment before it occurs; "Shape" an Army culture that promotes dignity and respect; and "Win" an environment that improves prevention, investigation, and prosecution while reducing the stigma of reporting.

The program consists of a comprehensive policy that centers on awareness and prevention; training and education; victim advocacy; and response, reporting, accountability and program assessment.

The Secretary of the Army and the Chief of Staff of the Army are strong advocates for the implementation of the SHARP Program. They consider SHARP an integral part of the "Profession of Arms" in developing individual character and supporting the Warrior Ethos.

In 2008 the Army launched a comprehensive sexual assault prevention strategy, which incorporates the ethical principles of the "Profession of Arms" and requires leaders to establish a positive command climate that clearly communicates sexual assault's negative impact on the force and family members. The strategy further encourages soldiers to engage in peer-to-peer intervention, and not tolerate behavior that could lead to sexual assault.

This strategy consists of four integrated, cyclical phases that are designed to achieve true cultural change as we work to be the Nation's leader in sexual harassment and sexual assault prevention:

Phase I (Committed Army Leadership) provides training on best practices and allows commands the opportunity to develop prevention plans to support the Army strategy.

Phase II (Army-wide Conviction) includes educating soldiers to understand their moral responsibility to intervene and stop sexual assault and harassment.

Phase III, which launched April 2011, is dedicated to "Achieving Cultural Change" and fosters an environment free from sexual harassment and sexual assault.

Phase IV, the final phase is "Sustainment, Refinement and Sharing." This phase will be implemented beginning April 2013. Here, the prevention program will continue to grow while motivating national partners—governmental and nongovernmental organizations—to support our efforts in changing generally accepted negative social behaviors.

The goal will be the reduction of sexual assault through primary prevention by creating an environment where people are not afraid to intervene as soon as conditions exist that could lead to sexual misconduct if left unchecked.

The Army's campaign commitment includes integrating sexual harassment and sexual assault prevention efforts; executing the SHARP transformation plan; providing policies; training and education support to commands; and establishing prevention partnerships.

The SHARP Program transition is occurring throughout the Army. Building on previous training, SHARP Mobile Training Teams (MTTs) have trained approximately 7,900 of 17,000 command-selected program personnel on a prevention-focused 80-Hour Program Certification Course. The course was approved by the National Organization for Victim Assistance in December 2011 and credentialed under the National Advocacy Credentialing Program.

The Army applied \$40 million from fiscal year 2009–fiscal year 2011 to increase investigative and prosecutorial capabilities by hiring 12 highly qualified experts in the field of prosecution and investigations and 23 additional special investigators.

The Judge Advocate General designated 16 special victim prosecutors and 5 Trial Counsel Assistance Program attorneys. Additionally, there are plans to add another seven Special Victim Prosecutors in fiscal year 2012.

The U.S. Army Military Police School Special Victims Unit Course, Fort Leonard Wood, MO, has been selected as the DOD school house. In essence, the Army will serve as the DOD executive agent for sexual assault investigator training and the U.S. Army Military Police School will serve as the proponent for sexual assault investigations training for DOD.

The Army's school house employs a unique advanced interview technique in its Special Victims Unit (SVU) Training Course. This technique is called the Forensic Experiential Trauma Interview, or FETI, which was developed by the Army SVU lead instructor. This new interview technique combines the best of child forensic interview techniques along with the principles of critical incident stress debriefings and new neurobiology research to obtain not just the who, what, why, when, where, and how of the incident, but also the three dimensional experiential aspect of the crime. This process solicits and documents critical forensic physiological evidence. Based on feedback from the field this new technique has already shown to be substantially more effective in obtaining information and substantially more beneficial evidence which enhances our ability to prosecute sexual assault cases. The FETI technique is also being trained by our Army trainers to Federal, State, and local civilian agencies and has been embraced as a promising best practice.

The SVU course is not only taught by USAMPS and USACIDC experts, but is also augmented by other nationally recognized experts as well as legal instructors from the Army Trial Counsel Assistance Program. Agents from DOD Inspector General, Naval Criminal Investigative Service, and Air Force Office of Special Investigations have already begun training at the SVU course. Army prosecutors will also begin attending the SVU course in April of this year to foster additional synergy and understanding between our CID Special Agents and prosecutors. We have developed a plan to include prosecutors from other DOD Services beginning in fiscal year 2013.

Additionally, the Army is continuing in its efforts to ensure attorneys in the Judge Advocate community are receiving the most up-to-date training so they are properly equipped to investigate/prosecute sexual assault cases. Judge Advocates who are selected to serve as Special Victims Prosecutors based on their skill and experience in the courtroom, are required to attend a 2-week Career Prosecutors Course at the National District Attorneys Association in South Carolina; a 1-week Essential Strategies for Sexual Assault Prosecutions; and 2-weeks of on-the-job training with a designated civilian district attorney's office, special victims in various other locations.

The Army is currently providing \$3.5 million to support Judge Advocate prosecution and defense capability improvements, to include policy development, case management, training and education. DOD is supporting the Army's investigation/prosecution training efforts with an additional \$1.3 million in funding.

Based on recent congressional, Office of the Secretary of Defense, and Army directives, the Army is revising its policy and program requirements to effectively expand the program to additional beneficiaries such as family members 18 years of age or older, DOD civilians serving overseas and Deployed DOD contractors deployed into combat zones, while finalizing a plan to meet the NDAA for Fiscal Year 2012 requirements. Concurrently, the Army is revising its comprehensive training and education program that began in fiscal year 2004 and remains flexible to meet new legislative and military direction.

The Army is working with DOD leadership to ensure the manpower and funding required to address the programmatic changes stipulated in the NDAA are adequately addressed.

\$M	FY 2011	FY 2012	FY 2013
SHARP (Sexual Harassment)	28.6	25.3	46.3

HEALTH PROMOTION, RISK REDUCTION AND SUICIDE PREVENTION

The Army continues to take aggressive actions to promote health, identify and reduce risky behaviors, and prevent suicides. Utilizing a holistic approach, increased emphasis has been placed on developing and implementing targeted training programs as well as funding for support programs that impact the entire Army Family.

The key elements of the Army's approach are: ensuring that all soldiers have prompt access to quality behavioral health care; increased screening and docu-

mentation of mild traumatic brain injuries; and improved leader awareness of high-risk behavior. As conclusions are derived from ongoing studies, such as the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), the largest BH epidemiological study that the Armed Forces has ever undertaken, appropriate leadership decisions will follow to capitalize on the outcomes. The Army has increased screening efforts to improve diagnosis and treatment for soldiers through the Post-Deployment Health Assessments, standardized screening protocols for those exposed to concussive events and implemented the "Pain Management Task Force" to appropriately manage the use of pain medications and adopt best practices Army-wide.

The dramatic increases in suicides experienced from 2006 to 2010 leveled off in calendar year 2011 and were down slightly from their record year in 2010. It is important to note, however, that suicides by soldiers on Active Duty increased while those by soldiers not on Active Duty decreased. There were 165 suicides by Active-Duty soldiers during 2011, an increase from 159 suicides in 2010. However, a significant decrease was observed for Not-on-Active Duty members of the Army Reserve and National Guard, with 115 suicides during 2011 compared to 146 in 2010. This represents a decrease of 25 suicides over the 2010 report.

The Army released the Army 2020 Generating Health and Discipline in the Force Ahead of the Strategic Reset Report 2012. Referred to as the Army Gold Book, the report is an update to the Army Health Promotion, Risk Reduction, Suicide Prevention Report, 2010. It summarizes the progress made in enhancing the health, discipline and readiness of the Force and it represents the next phase in the Army's ongoing campaign to counter the stress associated with more than a decade of war. The Gold Book is designed to educate leaders, illuminate critical issues that still must be addressed, and provide guidance to those grappling with these issues on a day-to-day basis. It candidly addresses the challenges that leaders, soldiers and families currently face, while providing a thorough assessment of what the Army has learned with respect to physical and behavioral health conditions, disciplinary problems, and gaps in Army policy and policy implementation. The Army is committed to ensuring the entire Army Family has access to the training and resources necessary.

\$M	FY 2011	FY 2012	FY 2013
HP/RR/SP (suicide)	41.038	45.480	53.736

ARMY SUBSTANCE ABUSE PROGRAM

More than a decade of war has created symptoms of stress for our soldiers, including an increase in alcohol and drug abuse. The Army Substance Abuse Program (ASAP) is a commander's program that uses prevention, education, deterrence, detection, and rehabilitation, to reduce and eliminate alcohol and drug abuse. It is based on the expectations of readiness and personal responsibility.

In March 2010, the Army conducted a counselor requirements analysis based on each installation's average daily client census with a ratio of 1 counselor for 30 patients. Patient caseload was as high as 60 patients per counselor at some installations. The 1:30 ratio is an accepted ratio based on literature and counselor input. Applying this ratio yielded a requirement of 563 counselors assuming a 20 percent growth in number of patients.

An Army priority in this area includes the hiring of more counselors. There is a finite pool of qualified substance abuse counselors nationwide and the Army is competing for this scarce talent with private industry, the Veteran's Administration and State and local governments. As of January 1, 2012, the Army has hired 500 of the 563 counselors needed. The Army is increasing the use of recruiting, relocation, and student loan reimbursement incentives to attract more qualified candidates, and is developing a ASAP Counselor Internship Program which will allow students with Masters degrees to work in a supervised internship for up to 2 years as they attain their licenses and substance abuse counselor certifications.

The Confidential Alcohol Treatment and Education Program (CATEP), began in July 2009 and offers confidential alcohol treatment to qualified soldiers. For these soldiers, the chain of command is not informed of the soldiers enrollment as was previously customary. This pilot program was initially offered at Fort Lewis, Fort Richardson, and Schofield Barracks. An initial assessment was conducted in March 2010, and the Secretary of the Army directed that the pilot be expanded to include Forts Carson, Riley, and Leonard Wood.

The initial assessment showed moderate success in attracting soldiers and placed more career NCOs and younger officers into treatment. Soldiers who participated in CATEP were very positive about the opportunity to take care of their issues without commander knowledge and were more motivated as patients. Some soldiers informed their commanders about their enrollment and these commanders had a high acceptance of the program. The program was assessed again during July 2011. The results showed that many soldiers with an alcohol abuse or dependency diagnosis had walked away from treatment when asked to change their behaviors. After careful consideration, the VCSA directed implementation of several improvements to the pilot and consideration of the use of a contract for soldiers interested in CATEP, with the proviso that non-compliance with treatment would result in mandatory placement in the Command ASAP. The pilot will be assessed again in April and May 2012, after which the Secretary will decide whether to expand the CATEP to the remainder of the Army. To date 1,129 soldiers sought CATEP treatment and 784 were/are enrolled.

\$M	FY 2011	FY 2012	FY 2013
ACSAP	36.4	109.5	11.0

CONGRESSIONAL ASSISTANCE

As the Army prepares for reductions in the force, we will need congressional support to drawdown accurately and efficiently while maintaining readiness. The Army continues to work with the various parties to improve the physical disability system, so that our servicemembers receive the transition they deserve. The continued support of Congress for competitive military benefits and compensation, along with incentives and bonuses for soldiers, their families, and for the civilian workforce is critical in helping the All-Volunteer Army continue to recruit, retain, and support the highest caliber of individuals.

CONCLUSION

We have invested a tremendous amount of resources and deliberate planning to preserve the All-Volunteer Force. People are the Army, and our enduring priority is to preserve the high quality, All-Volunteer Force—the essential element of our strength.

While we transform to a smaller Army, we remain dedicated to improving readiness, and building resilience in our soldiers, civilians, and their families. The Army will not sacrifice readiness as it draws down. We must draw down wisely to preserve the health of the force or prevent breaking faith with the brave men and women who serve our Nation. The Army has gained the trust of the American public more now than at any other time in recent history, while fulfilling our responsibilities toward those who serve.

The well-being of our force, regardless of its size, is absolutely dependent upon your tremendous support. The Army is proud of the high caliber men and women whose willingness to serve, is a credit to this great nation. To conclude, I wish to thank all of you for your continued support, which has been vital in sustaining our All-Volunteer Army through an unprecedented period of continuous combat operations and will continue to be vital to ensure the future of our Army.

Chairman Webb, and members of the subcommittee, I thank you again for your generous and unwavering support of our outstanding soldiers, civilian professionals, and their families.

Senator WEBB. Secretary Garcia, welcome.

STATEMENT OF HON. JUAN M. GARCIA III, ASSISTANT SECRETARY OF THE NAVY FOR MANPOWER AND RESERVE AFFAIRS; ACCOMPANIED BY VADM SCOTT R. VAN BUSKIRK, USN, CHIEF OF NAVAL PERSONNEL, U.S. NAVY; AND LT.GEN. ROBERT E. MILSTEAD, JR., USMC, ASSISTANT COMMANDANT FOR MANPOWER AND RESERVE AFFAIRS, U.S. MARINE CORPS

Mr. GARCIA. Thank you, Senator. I also will be short.

Chairman Webb, Senator Graham, and distinguished members of the subcommittee, thank you for the opportunity to speak about the sailors, marines, and civilians who comprise the Department of the Navy.

There have been many successful changes in the Department of the Navy since I testified before you last spring. We have 23 female officers assigned to submarines, with more being assigned in the very near future.

Last year I spoke of new Navy Reserve Officers Training Corp (ROTC) units at Arizona State University and Rutgers. This year I am pleased to report that we are expanding our ROTC presence at Harvard, Yale, and Columbia as part of our goal to make naval service a viable option for the young men and women from all regions and all segments of society.

In addition to ensuring our manpower and personnel policies meet our country's security requirements, it is my honor and privilege to represent and advocate for the more than 800,000 sailors, marines, and civilian employees. We are always prepared to respond to the needs of our Nation.

Both sea services will strive to meet their operational requirements with as an efficient a force as possible. For the Navy, this means continuing to move sailors from shore support functions to sea duty to enhance operational readiness. Such a shift not only means fewer sailors will be available for important work ashore, but also that sailors will, on average, spend more time at sea away from their families. For the Marine Corps, the reduction of nearly 20,000 in end strength coincides with the planned withdrawal from Afghanistan.

Our highest priority remains the care and recovery of our wounded, ill, and injured servicemembers. The Department of the Navy is leading the way in innovative, therapeutic treatments of our wounded warriors. At the National Intrepid Center of Excellence, the Department of the Navy is pioneering research into diagnosis and treatment of traumatic brain injury and PTSD, but more work remains in this area.

I wish to thank the subcommittee members for your continuous and unwavering commitment to support the Navy and Marine Corps and the brave men and women who as sailors and marines serve bravely in Afghanistan, spend months at sea apart from their families, combat pirates in the Indian Ocean, board drug runners in the Caribbean, guard embassies throughout the world, conduct humanitarian missions whenever and wherever needed, and perform countless other missions, often under unimaginably demanding conditions and circumstances. Thank you.

Senator WEBB. Thank you, Secretary Garcia.

[The prepared statement of Secretary Garcia follows:]

PREPARED STATEMENT BY HON. JUAN M. GARCIA

Chairman Webb, Senator Graham, and distinguished members of the subcommittee, thank you for the opportunity to speak about the Department of the Navy's personnel programs and about the sailors, marines, and civilians who comprise the Department of the Navy.

There have been many successful changes in the Department of the Navy since I testified before you last spring. By the end of March we will have 23 to 25 female officers assigned to submarines, with more being assigned in the very near future. The repeal of "Don't Ask, Don't Tell" is fully implemented across the force with no

significant problems or incidents. National Naval Medical Center, Bethesda, has transformed into the new joint Walter Reed National Military Medical Center. Navy personnel comprise 27 percent of the hospital's staff.

In addition to ensuring our manpower and personnel policies meet our country's security requirements, it is my honor and privilege to represent and advocate for the more than 800,000 sailors, marines, and civilian employees who are always prepared to respond to whatever our Nation demands.

Vice Admiral Van Buskirk and Lieutenant General Milstead will address their respective Service's personnel plans in detail, but I would like to touch on some common challenges the Department of the Navy faces as a whole.

Recently, the Secretary of the Navy unveiled the 21st Century Sailor and Marine Initiative, which is designed to place an increased focus on the resiliency and fitness of our servicemembers. With so much of our defense strategy dependent upon our Navy and Marine Corps, we must ensure that our resources support the most combat effective and the most resilient force in our history. We must set high standards, but at the same time provide individuals with the services and training needed to meet those standards. The 21st Century Sailor and Marine Initiative consists of five "pillars": readiness, safety, physical fitness, inclusion and continuum of service.

Readiness will ensure sailors, marines, and their families are prepared to handle the mental and emotional rigors of military service. Both Services are introducing campaigns this year to deglamorize use, and treat and track alcohol abuse. We will also develop new means to deter Spice use, reduce suicides and increase our family and personal preparedness programs. This includes zero tolerance for sexual assault. We are continually working to improve the reporting, investigation and disposition of sexual assault cases, ensuring that commanders, investigators, and prosecutors receive sufficient training and appropriate resources.

We will also increase our efforts to ensure the safest and most secure force in the Department's history, including a reinvigoration of our efforts to encourage the safe use of motor vehicles and motorcycles.

Physical fitness is an important central pillar that resonates throughout the 21st Century Sailor and Marine Initiative. Personal fitness standards throughout the force will be emphasized. We will also improve nutrition standards at our dining facilities with the introduction of "Fueled to Fight", which ensures that healthy food items will be available at every meal.

The Department of the Navy will be inclusive and consist of a force that reflects the Nation it defends in a manner consistent with military efficiency and effectiveness as it serves its primary function of defending the Nation. The Department will also reduce restrictions to military assignments for personnel to the greatest extent possible consistent with our mission and military requirements.

The final pillar, continuum of service, will provide the most robust transition support in the Department's history. Individuals selected for either separation or retirement will be afforded myriad of assistance programs and benefits that are available to them as they transition to civilian life. These programs, which include education benefits, transition assistance, career management training, counseling, life-work balance programs, and morale, welfare and recreation programs have been recognized by human resource experts as some of the best corporate level personnel support mechanisms in the Nation.

The budget process requires a careful balancing of resources and assessment of risk. Within in the President's fiscal year 2013 budget and the Future Years Defense Plan are the results of several other difficult decisions and tradeoffs. The final product meets mission requirements while providing appropriate compensation and benefits for our Active Duty, Reserves, civilian employees, and military retirees.

Both sea services will strive to meet their operational requirements with as efficient a force as possible. For the Navy this means continuing to move sailors from shore support functions to sea duty to enhance operational readiness. Such a shift not only means fewer sailors will be available for important work ashore, but also that sailors will, on average, spend more time at sea away from their families. For the marines, the reduction of nearly 20,000 end-strength coincides with the planned withdrawal from Afghanistan.

Our highest priority remains the care and the recovery of our wounded, ill, and injured servicemembers. The Department of the Navy is leading the way in innovative therapeutic treatments of our Wounded Warriors. At the National Intrepid Center of Excellence the Department of the Navy is pioneering research into diagnosis and treatment of Traumatic Brain Injury and Post-Traumatic Stress Disorder, but more work remains in this area.

There are other initiatives that deserve mention. We continue to emphasize civilian hiring of veterans and of wounded warriors in particular, through both competitive and non-competitive hiring authorities. Similarly, the Department is continuing

our participation in the Military Spouse Employment Partnership both as a resource for our members' spouses and as an employer.

Last year I spoke of new Navy Reserve Officers' Training Corps (ROTC) units at Arizona State University and Rutgers. This year I am pleased to report that we are expanding our ROTC presence to Harvard, Yale, and Columbia as part of our goal to make naval service a viable option for young men and women from all regions and all segments of society.

As many of you are aware, the Navy has recently closed a number of Junior ROTC programs at units that failed to meet the statutorily required participation numbers. To minimize the effects of these closings, I authorized the creation of National Navy Defense Cadet Corps (NNDCC) units at a number of these schools. The NNDCC program is virtually identical to Navy Junior ROTC, except there is only a 50 student minimum enrollment requirement and the schools must provide the majority of the funding.

We continue to search for innovative ways to improve the efficiency and capability of our forces as well as the quality of life of our members and their families. Modernization of the military retirement system could provide greater fairness and equity to servicemembers with, perhaps, some savings to the defense budget.

We wish to thank the committee members for your continuous and unwavering commitment to support the Navy and Marine Corps and the brave men and women who, as sailors and marines, serve bravely in Afghanistan, spend months at sea apart from their families, combat pirates in the Indian Ocean, thwart drug runners in the Caribbean, guard embassies throughout the world, conduct humanitarian missions whenever and wherever needed, and perform countless other missions, often under unimaginably demanding conditions and circumstances.

The following service specific information is provided for the committee. We look forward to your questions.

APPENDIX A

Military Personnel	FY11	FY12	FY13	Delta
Total DoN	\$41,477M	\$42,345M	\$42,068M	(\$277M)
Military Personnel, Navy	\$27,425M	\$28,051M	\$27,966M	(\$85M)
Military Personnel, Marine Corps	\$14,052M	\$14,294M	\$14,102M	(\$192M)

Service Member and Family Support	FY11	FY12	FY13	Delta
Total DoN	\$913.8M	\$875.0M	\$935.2M	\$60.2M
Navy Sailor and Family Programs*	\$510.9M	\$507.2M	\$589.1M	\$81.9M
Marine Corps Family Community Support Programs	\$402.9M	\$367.8M	\$346.1M	(\$21.7M)

* Includes Warfighter and Family Services, Child and Youth, and Morale, Welfare and Recreation

Training	FY11	FY12	FY13	Delta
DoN Total	\$2,828.9M	\$2,723.9M	\$2,662.8M	(\$61.1M)
Navy Accession Training	\$288.1M	\$306.5M	\$297.5M	
Navy Basic Skills Training	\$976.1M	\$951.7M	\$962.7M	
Navy Recruiting and Other Training/Education	\$537.2M	\$556.1M	\$507.1M	
Navy Total	\$1801.4M	\$1814.3M	\$1767.3M	(\$47.0M)
Marine Corps Accession Training	\$16.6M	\$19.1M	\$19.1M	
Marine Corps Basic Skills Training	\$696.0M	\$642.8M	\$631.0M	
Marine Corps Recruiting and Other Training/Education	\$314.9M	\$247.7M	\$245.4M	
Marine Corps Total	\$1027.5M	\$909.6M	\$895.5M	(\$14.1M)

**Funding includes OCO.

Senator WEBB. Admiral Van Buskirk and General Milstead, your full statements will be entered into the record at this time. We will also get back to you during questioning.

[The prepared statements of Admiral Van Buskirk and General Milstead follow:]

PREPARED STATEMENT BY VADM SCOTT R. VAN BUSKIRK, USN

I. INTRODUCTION

Chairman Webb, Ranking Member Graham, and distinguished members of the Senate Armed Services Committee, thank you for the opportunity to review Navy's fiscal year 2013 manpower, personnel, training, and education budget request. I am honored to be here to represent the outstanding men and women of the U.S. Navy, and their families, in this my inaugural appearance before the committee as the 56th Chief of Naval Personnel.

In developing our budget request, we recognized that our Nation is at an historic inflection point, that we are shaping a Navy that will be more agile, flexible, ready and technologically advanced. As we continue our presence in the Middle East, maintain our commitments in Europe, add emphasis and focus in the Asia-Pacific region, Navy has continued to prove itself in providing a truly adaptive force capability and capacity, at sea, on land and in the air. While Navy's operations in Iraq and Afghanistan have been both sea and land based, the shift in focus toward the Asia-Pacific region will likely increase demands upon Navy's maritime role, even as the Nation works to address the national security imperative of deficit reduction through a lower level of defense spending.

As we move into this new era, Navy is well positioned to recruit, develop, retain, and provide the American people the best and most capable maritime fighting force in history. Navy has worked to become a "Top 50" organization, an employer of choice, providing world-class benefits and opportunities. Moreover, as an All-Volunteer Force, we must adapt to changing economic times, while continuing to implement force management policies focused on incentivizing, encouraging and rewarding high performance. We will continue to strive for a Navy that attracts and retains top-performing sailors who possess the critical skills necessary for our mission. Further, we are making hard choices on sailor retention as Navy continues to transition, but we are committed to doing so in a fair, transparent and compassionate manner using performance as our benchmark.

Our fiscal year 2013 budget request enables us to continue to meet the operational demands of the Fleet and the Joint Force while optimizing personnel readiness. As we look to the future, Navy is mindful that:

- The All-Volunteer Force is the foundation of our Navy and vital to the security of our Nation.
- Navy life involves unique challenges and stresses as a global, full spectrum sea service.
- War related deployments since September 11 have placed extraordinary demands on many sailors and their families.

We believe our request appropriately balances risk in supporting the readiness requirements of the Fleet and Joint Force, changing strategic mission focus, and essential programs that provide for the care of our sailors and their families.

II. A READY AND CAPABLE GLOBAL NAVY

Shortly after assuming office as the Nation's 30th Chief of Naval Operations (CNO) last September, Admiral Greenert issued his inaugural guidance to the Fleet, the CNO's Sailing Directions. Coupled with our Navy Total Force Strategy for the 21st Century, it charts a course for Navy to deter aggression, and, when necessary, decisively win our Nation's wars. We will employ global reach and persistent presence through forward-stationed and rotational Forces to protect our Nation against direct attack, assure Joint Operational Access, and retain global freedom of action. With our global partners, we will protect the maritime freedom that is the basis for global prosperity. We will foster and sustain cooperative relationships with our allies and international partners as we enhance global security in a constantly changing environment.

Informed by the Sailing Directions and our Navy Total Force Strategy for the 21st Century, we have crafted our focus areas ...

Warfighting First: We will manage military personnel strength to deliver an affordable, sustainable and resilient force that meets mission needs. We will deliver a Force that is operationally ready—assignable and deployable. To remain operationally effective, we will deliver a career-continuum of technical training and advanced education.

Operate Forward: We will deliver "fit" and balance to the Fleet—not only the right number of sailors, but also the right skills and experience for the job. We must also anticipate fleet and combatant commander priorities to meet operational needs and provide the regional skills required for theater security and cooperation of our Joint and coalition partners.

Be Ready: We will attract, recruit, and retain a high-quality Force through recruiting and outreach efforts—we must be competitive for the best talent in the Nation. Most importantly, we will continue to care for sailors and their families ... the foundation upon which our Navy is built.

III. END STRENGTH

Our fiscal year 2013 Navy budget request appropriately balances risk, preserves capabilities to meet current fleet and joint requirements, fosters growth in emerging

mission areas, and provides vital support to sailors and Navy families. The request supports active end strength of 322,700, and selected Reserve end strength of 62,500. These levels will allow us to meet Fleet and the Joint Force operational demands while optimizing personnel readiness as articulated in the recently released Sustaining U.S. Global Leadership: Priorities for 21st Century Defense. The President's \$28.9 billion request for Active Navy Manpower, Personnel, Training and Education seeks \$27.1 billion in Military Personnel, Navy (MPN) appropriations and \$1.8 billion in related Operation and Maintenance, Navy (O&MN). The Reserve request includes \$1.9 billion for Reserve Personnel, Navy (RPN) and \$24.7 million in related Operation and Maintenance, Navy Reserve (O&MNR).

In fiscal year 2013, there is no OCO funding requested for Active component end strength in support of non-core Individual Augmentee (IA) mission. Following an assessment of the Reserve component's funding, and ability to cover previous Active component-sourced non-core IA requirements, 5,900 man-years of OCO funding was requested to support 4,500 Reserve IA billets throughout the fiscal year. We will continue to fill IA requirements, when possible, with Reserve component personnel funded through OCO appropriations.

As we work to stabilize Navy end strength with emphasis on achieving warfighting wholeness, we continue to shift billets from shore duty to sea duty while preserving nearly 600 critical shore billets in sea-centric ratings, including regional maintenance centers, afloat training groups, Fleet electronic warfare training and Ballistic Missile Defense AEGIS billets. We expect last year's sea/shore-flow requirements changes to result in reduced at-sea gaps this year and in fiscal year 2013. We continue to apply Sea Duty Incentive Pay to encourage and reward sailors for extended or repeat sea duty service to help further mitigate our gaps at sea.

Navy will continue to size, shape, and stabilize the Force while carefully monitoring personnel and Fleet readiness. As required, we will apply, evaluate and adjust existing and new force-shaping tools designed to retain the right skills, pay grade, and experience-mix necessary to provide mission-ready Naval Forces, as required.

IV. FORCE MANAGEMENT: ACHIEVING BALANCE, MAXIMIZING INVESTMENTS

We must always remember that the men and women of the All-Volunteer Force in our Navy have remained versatile, adaptable and committed to the Nation during a time of unprecedented, sustained combat operations, and at tremendous personal sacrifice. As we take the necessary steps to properly size and shape the Navy to meet current and emerging requirements, we must be vigilant to ensure the readiness of the All-Volunteer Force, while maintaining trust with those who serve in our Navy.

We expect to finish fiscal year 2012 below end strength controls, largely due to effective force management policies within the enlisted force. At the same time, we are over-executing our officer strength. To remedy this imbalance, we plan to stabilize enlisted strength while gradually reducing officer strength. Our strategy focuses on rebalancing the Force to achieve the right mix of officers and enlisted personnel by increasing enlisted accessions over time, reducing officer accessions in a controlled manner through judicious application of force management tools to address officer overages in specific skills. We will achieve proper force balance while respecting the sacrifices of sailors and their families by using voluntary measures to the extent possible before resorting to involuntary actions. Through careful combination of both, we will meet dynamic force management challenges and maximize investments in our people.

Our use of force management tools will be continuously evaluated as end strength and force structure is reduced. We will keep a watchful eye on indicators of shifting behavior and on economic trends and act quickly to preserve our ability to attract and retain the highest-quality sailors while achieving and then maintaining the right balance of seniority, skills, performance, and experience to deliver optimum military personnel readiness to the Fleet.

Perform-to-Serve (PTS) remains our primary, and most effective, enlisted force-balancing tool, allowing us to manage enlisted continuation behavior by rating. Based on performance ranking, PTS identifies sailors at career decision points, up to 14 years of service, who are best qualified for in-rate reenlistment, conversion from overmanned to undermanned specialties, or separation from the Navy. In fiscal year 2011, we converted 1,052 sailors, narrowing critical manning gaps, while 6,765 sailors identified by PTS separated at their End of Active Obligated Service. We plan to separate another 6,650 sailors through PTS in fiscal year 2012, and fewer in fiscal year 2013. PTS has significantly improved enlisted manning balance per-

mitting us to offer in-rate reenlistment to significantly more sailors while returning advancement opportunity to historic norms.

To further assist in rebalancing the Force and relieve pressure on sailors in a PTS reenlistment window, Enlisted Retention Boards (ERB) were implemented as an additional force management tool. The ERB was necessary to ensure we could reduce inventory within overmanned ratings in cases in which converting sailors to undermanned ratings was not a viable option. Unlike PTS, the ERB looked at all eligible sailors in 31 overmanned ratings, not just the ones in a PTS window. This past summer, ERB examined the records of approximately 16,000 sailors in pay grades E4–E8, with at least 7 and less than 15 years of service, who are serving in overmanned ratings, and identified 2,947 for separation in fiscal year 2012. Approximately 300 of these sailors, who will have at least 15 years of service by September 1, 2012, are being offered the opportunity to apply for early retirement under Temporary Early Retirement Authority (TERA) enacted in the National Defense Authorization Act for Fiscal Year 2012. We do not intend to use ERB authority in fiscal year 2013.

We have used, and continue to use, a host of other tools to contribute to ongoing force management efforts for both officer and enlisted sailors, including:

- High-Year Tenure separations in select pay grades and years of service. We separated 912 sailors in fiscal year 2011, and plan an additional 909 in fiscal year 2012, and slightly more in fiscal year 2013, through recent changes to High Year Tenure policy.
- Early Transition. In fiscal year 2011, we allowed 1,541 sailors to separate up to 24 months before the end of their enlistments, and anticipate authorizing a similar number of separations in fiscal year 2012, but fewer in fiscal year 2013.
- Annual performance-based continuation boards. We reduced the number of active duty sailors in pay grades E7–E9 with over 20 years of service by 187 and expect an additional 50 losses in fiscal year 2012 and fiscal year 2013.
- One-year time-in-grade (TIG) retirement waivers for select senior enlisted and officers. We executed 37 officer TIG waivers in fiscal year 2011 and expect approximately 45 for fiscal year 2012 and fiscal year 2013.
- Monthly probationary officer continuation and redesignation boards. These boards authorize release or redesignation of probationary officers (with <6 years commissioned service). We separated 242 officers in fiscal year 2011 and anticipate separating 270 in fiscal year 2012.
- Permitting voluntary retirement of officers with prior enlisted service after 8, vice 10, years commissioned service. Enacted in the NDAA for Fiscal Year 2011, we expect to authorize approximately 60 retirements in fiscal year 2012 and fiscal year 2013.
- Selective Early Retirement (SER). SER Boards selected 124 unrestricted line captains and commanders for early retirement in fiscal year 2012. In fiscal year 2013, we may select approximately 40 Restricted Line and Staff Corps officers for early retirement.
- Voluntary Retirement Incentive (VRI). An authority that allows Navy to precisely target specific commanders (O–5) and captains (O–6) with between 20–29 years of service in certain specialties and warfare areas to separate and retire voluntarily.
- Temporary Early Retirement Authority (TERA). In fiscal year 2012, we are offering early retirement to approximately 300 sailors as an alternative to early separation required by Enlisted Retention Boards. We are evaluating options for further targeted use of TERA in fiscal year 2013.

Despite significant progress, additional force management actions are necessary to maintain mandated end strength and officer levels with the right mix of skills and experience due to high retention and low attrition. For example, we will soon implement two new policies to facilitate further enlisted force management:

- In fiscal year 2012 and fiscal year 2013, we will apply Initial Training Separation Authority to separate fewer than 500 sailors per year who do not satisfactorily complete their training pipeline, but for whom no suitable vacancy exists.
- We will adjust High Year Tenure thresholds to separate fewer than 1,000 sailors in pay grades E2–E3 in fiscal year 2013.

We are contemplating whether additional authorities may be necessary to enhance our ability to properly shape and balance the Force. A range of broad, flexible, options to properly size and shape the Force remains vital to Navy military personnel readiness. We appreciate Congress enacting flexible authorities that provide

voluntary means to effectively manage the Force in a way that preserves a positive tone across the Navy.

V. SAILOR AND FAMILY SUPPORT

Our fiscal year 2013 budget request of \$131.7 million for sailor and family care coupled with the items in the Secretary of Defense and Defense Health Care budgets sustains or enhances our comprehensive continuum of care. The health care proposals in the President's budget are consistent with our efforts in identifying processes that are more efficient, incentivizing positive health behaviors, promoting overall wellness and keeping our sailors fit and ready to deploy on a moment's notice. This budget keeps faith with those who serve and those who have served, and responsibly meets the demands dictated by the Federal budget crisis. With continued congressional support, Navy is committed to retaining funding levels necessary to address the medical, physical, psychological, and family readiness needs of sailors and their families. I hope you will agree, and support our efforts.

Comprehensive Continuum of Care

Through a comprehensive continuum of care, we place the highest priority on the medical, physical, psychological, spiritual and family readiness needs of sailors and families. Navy's Operational Stress Control Program, Navy Reserve Psychological Health Outreach Program, Warrior Transition Program, Returning Warrior Workshop, Navy Safe Harbor, and our Medical Home Port Program are critical continuum of care elements.

- The Operational Stress Control (OSC) program is our proactive approach to address the personal readiness of our sailors and their families. OSC is comprised of training, assessment, policy, and tools to support and build sailor, family, and unit resilience. It enables leaders to foster a climate in which sailors use available resources to stay fit and ready without stigma. OSC, with complementary and integrated support from the Navy Chaplain Corps, provides assistance for stress reactions before they become stress problems. A 2011 Behavioral Health Quick Poll found most sailors reported using positive methods to cope with stress.
- The Navy Reserve Psychological Health Outreach program improves the psychological health and resiliency of Reserve Component (RC) sailors and families. Teams of psychological health outreach coordinators and outreach team members, located at the five regional Reserve commands, provide psychological health assessments, education, and referrals to mental health specialists.
- The Warrior Transition program provides Individual Augmentees the opportunity to decompress and transition to life back home. Through small group discussions, chaplains and medical personnel prepare sailors to resume family and social obligations, return to civilian places of employment, and reintegrate into the community.
- Returning Warrior Workshops help remove stigma that may prevent sailors from seeking support during demobilization and reintegration.
- Navy Safe Harbor supports the non-medical needs of wounded, ill, and injured sailors, coast guardsmen, and their families. This network of recovery care coordinators and non-medical care managers, at 18 locations across the country, provides individually tailored assistance to 748 enrolled sailors, 43 enrolled coast guardsmen, and an additional 777 sailors considered assist cases. The fiscal year 2013 budget request supports our enduring goal to provide the highest quality care to our wounded, ill, and injured.
- Medical Home Port program is a team-based primary care model focused on optimizing relationships between patients, primary care providers and other health care professionals to enhance health and readiness. Beginning this year, mental health providers will be embedded within Medical Home Ports alongside the rest of the care team, and will facilitate regular assessment and early behavioral intervention for sailors and families. This will enable treatment in settings in which patients feel most comfortable and will reduce stigma associated with seeking care. Early detection and intervention in the primary care setting reduces the demand for time-intensive intervention in behavioral health specialty clinics. The presence of behavioral health within the Medical Home Port promotes increased comfort among primary care providers in treatment of behavioral health issues within their scope of practice in collaboration with the embedded specialists.

Behavioral Health

The Navy Behavioral Health program goal is to develop an organizational climate that encourages psychologically healthy, resilient and mission-effective sailors. It provides Navy-wide resources for suicide awareness and prevention, intervention skills, and risk mitigation procedures. We track and analyze data on suicide-related behaviors and deaths to identify trends and develop additional policy, training and outreach to prevent suicide risk. A 2011 Behavioral Health Quick Poll reflects positive trends in the percentage of sailors attending Suicide Prevention Training and who recognize proactive suicide-prevention efforts occurring at their commands.

Suicide Prevention: All Hands, All of the Time

Every Navy suicide represents a tragedy that affects command cohesiveness and the loss of a valued shipmate; a loss the Navy is determined not to accept. Our comprehensive strategy to combat suicide incorporates four pillars: Education and awareness; Operational Stress Control; Intervention; and Post-intervention support; a leadership-led effort with a foundation built on a comprehensive array of education and outreach.

Navy's suicide prevention approach builds combined sailor, family, and command resilience with a goal of changing behavior through personal resilience; peer to peer support; leadership intervention throughout the chain of command; enhancing family support; and fostering a command climate where help-seeking behaviors, when required, are expected in order to restore personal readiness.

We have implemented a year-round strategic communication plan focused on Navy's "Ask-Care-Treat" model, or ACT, which emphasizes the value of peer-to-peer support. Additionally, targeted suicide assessment training is provided for primary care providers at large Medical Treatment Facilities as another viable means to identify at-risk sailors.

The Suicide Prevention Coordinator network is growing with the addition of webinar training that has trained more than 500 new suicide prevention coordinators in 18 webinars since December 2011 and additional webinar training is planned for members of the Public Affairs community. We are also continuing to make progress in implementing recommendations of the DOD Task Force on Prevention of Suicides Among Members of the Armed Forces. Moreover, in fiscal year 2013, we will provide targeted chaplain training, guidance and tools for leaders, to facilitate successful reintegration of sailors into their units following behavioral health or other medical treatment. We will improve integration of suicide prevention into the broader array of resilience and prevention efforts to provide a coherent approach to comprehensive wellness, resilience and prevention.

Sexual Assault: Not in my Navy

There is no place for sexual assault in the U.S. Navy. We are committed to eliminating sexual assault completely; to ensuring compassionate support for sexual assault victims; to investigating all cases thoroughly; and to holding perpetrators accountable within the full extent of the law. Since 2005, we have worked to build a robust Sexual Assault Prevention and Response (SAPR) program, and we are already engaged in a number of new initiatives to combat sexual assault. These collectively are critical investments in both individual sailors and in Force readiness. In addition to other direct measures, we will use a proven process of tiered training for sexual assault prevention and response and provide Navy's SAPR-Leadership training to all E-7 and above leaders and every sailor through SAPR-Fleet training. This process served us well in the repeal of Don't Ask Don't Tell and we anticipate this will resonate in our campaign to eliminate sexual assault from our Navy.

Our immediate goal is to measurably reduce the frequency of sexual assaults involving sailors. Our first and perhaps most important tool has been a strong, consistent, top-down leadership message of intolerance for sexual assault. We are pleased to already be seeing Department-level leadership forums translating into special workshops and other sessions conducted by regional commanders and commanding officers. Our second core strategy involves updated training tools for Navy-wide use. We have already worked with civilian experts to review relevant content in a broad range of Navy training curricula spanning the full continuum of leadership development. We are developing special new video programs for all sailors to emphasize the criticality of sexual assault issues, and the responsibility of every sailor to actively intervene in protecting shipmates in vulnerable situations. In addition, we have undertaken special initiatives focused on those most at risk—our youngest sailors just out of recruit training. Our "Bystander Intervention" program uses locally trained instructors in small-group sessions to educate and mentor sailors at "A-Schools" Navy-wide. At TSC Great Lakes, we have combined this effort with a number of simultaneous other initiatives—and we have developed a process of peri-

odic anonymous surveys to assess our impact. After a year of progressive effort, it is still too early to speak of definitive outcomes, but the initial signs are encouraging. In 2011, over 67,000 sailors participated in an anonymous, web-based sexual assault survey conducted by the Navy Secretariat. We plan to repeat that process every 2–3 years worldwide to help us understand issues and trends in the underlying incidence of sexual assault. If it is necessary along the way, we will use our best accumulated data and insight to adjust course in combating sexual assault. Civilian experts, including researchers at the Centers for Disease Control, tell us this kind of approach is cutting-edge and breaking new ground. However, that is not all we are doing.

In just the past 2 years, we have conducted site visits and special training at Navy sites worldwide. We have talked to stakeholders including senior commanders, SAPR program managers, sailor focus groups, and even individual sexual assault victims. We have brought Sexual Assault Response Coordinators and installation commanders together from across the Navy for programs civilian experts on sexual assault prevention summits. We have given special training to NCIS agents and JAG lawyers on the unique aspects of sexual assault cases. NCIS recently hired new criminal investigators with extensive civilian backgrounds in sexual assault cases for every major Navy (and Marine Corps) installation. We are working on tool kits for commanding officers to help them make the right decisions in complex cases.

In summary, there is no place for sexual assault in the U.S. Navy. We take the challenge seriously, we are engaged on numerous fronts, and we are committed to a sustained effort.

VI. RECRUITING

Navy has worked hard to achieve strong recruiting success over the past 4 years by projecting the Navy as an employer of choice and attracting the Nation's very best men and women for America's Navy. Our brand, "America's Navy—A global force for good", captures the diversity of our Navy missions while also appealing to our target recruiting market. In fiscal year 2011 and through fiscal year 2012 to date, Navy's "total force" recruiting achieved accession recruiting goals for officers in the Active component (AC) and enlisted recruiting goals in both the Active and Reserve components (RC). Additionally, we attained the best quality future sailors in history with 98.7 percent of accessions entering as high school diploma graduates (HSDG) and 88.2 percent of accessions scoring in the upper 50th percentile on the Armed Services Vocational Aptitude Battery (ASVAB).

Adapting to the current challenges of the recruiting environment and in anticipation of an improving economy, Navy recruiting is investing in the future with improvement of its Information Technology (IT) systems and streamlining its processes as part of its innovative Recruiting Force 2020 strategy. This strategy will provide an agile, mobile and highly responsive capable recruiting force.

Looking ahead, we will continue to aggressively attack specific recruiting areas, particularly in the healthcare profession where all military services have had difficulty in attaining specialized medical professionals. An additional challenge is RC General Medical Officer recruiting where we achieved nearly 80 percent of our fiscal year 2011 goal primarily due to the high retention of active duty officers in the unrestricted line communities. We continue to work closely with the Office Chief of Naval Reserve (OCNR) and BUMED on several aggressive initiatives to address both challenges as we keep Medical and RC General Medical Officer recruiting as our top officer recruiting priorities.

The fiscal year 2013 budget requests \$276.0 million for recruiting programs including accession incentives, advertising, and support for our Active and Reserve recruiters. This represents a reduction of \$34.1 million from fiscal year 2012 mainly due to adjustments in marketing and advertising. Our budget request ensures that the recruiting force remains appropriately sized and resourced for success.

Accession bonuses remain critical to meeting our goals for recruiting health professionals, nuclear operators, and special warfare/special operations personnel. We maintained bonus levels for nuclear officers and health professionals, and continue to offer enlisted accession bonuses to special warfare/special operations and other critical ratings to meet increased demand. A favorable recruiting environment has enabled us to reduce the number of ratings eligible for an accession bonus from 67 in 2008 to 6 in 2012. The fiscal year 2013 active budget request for bonuses, special pays, and incentives, represents a \$22.1 million reduction from fiscal year 2012.

An integral component of achieving our force management goals include competing for the best talent in our Nation's colleges and universities. Our Naval Reserve Officers Training Corps (NROTC) program has 61 units located at 75 host institutions with 87 cross-town institution agreements. While the NROTC program

has more than sufficient capacity for our current requirements, Navy recognizes the value of engagement and presence on the campuses of America's elite colleges and universities and appreciates the high quality educational experience provided to future military leaders at these institutions. The highest quality applicants ever for our NROTC program in fiscal year 2011 further reflected Navy's recruiting success.

To broaden outreach efforts and generate recruiting leads, and to offset reductions in paid media advertising, we are expanding our use of social media and other technologies. Navy Recruiting Command has over 100,000 active followers across 19 prominent social media sites, including 15 Facebook communities of interest. However, face-to-face contact with recruits in the field remains the cornerstone of our sustained success in attracting high quality, diverse individuals.

VII. RETENTION

We continue to closely monitor retention behavior across the Force and project we will meet our fiscal year 2012 overall officer and enlisted retention goals. While we have been able to make selected reductions in retention bonuses, sailor retention behavior indicates we must continue to apply bonus programs to critical skill areas that are less responsive to changes in the economic environment and which require significant investments in training and education.

Enlisted Retention

Despite a decade at war, Navy continues to experience high levels of retention among enlisted personnel across the force, due in large part to Navy's efforts to provide a quality lifework experience, increases in basic pay and housing allowances, and contributing economic conditions. Additionally, we experienced higher retention among female servicemembers, especially within critical technical and warfighting skilled areas. fiscal year 2011 aggregate enlisted retention was 63.9 percent, which is elevated relative to historical norms, even though we utilized several force management tools to suppress reenlistments.

Active Navy Retention	Fiscal Year 2011 Achievement	
	Reenlisted (Percent)	Expected (Percent)
Zone A (0–6 yrs)	66.0	59.0
Zone B (6–10 yrs)	67.0	66.0
Zone C (10–14 yrs)	72.7	72.0

Our new and existing policies encourage longer-term career behavior as sailors commit sooner to stay for longer periods. While affording increased predictability of future personnel readiness, higher retention also contributes to increased competition for reenlistment.

This past year, 14,544 sailors were discharged before the end of their contracts, slightly above the projected attrition of 14,300; we project similar attrition in fiscal year 2012. Misconduct-related discharges this year are within 1 percent of misconduct discharges in fiscal year 2011. Reserve enlisted attrition rates continue to trend lower than the historical average, evidence of the high quality Force we have recruited.

Demand in civilian industry for highly trained nuclear-qualified sailors challenges our ability to meet nuclear retention goals. We are committed to retaining sailors with critical skills in high demand in the civilian sector, as well as sailors in specialties that continue to experience high operational tempo in support of OCO, such as special warfare/special operations and independent duty corpsmen. Selective Reenlistment Bonus (SRB) remains the most important tool in our efforts to retain these highly-skilled sailors.

By our close monitoring of retention behavior, we apply adjustments to SRB levels on a semi-annual basis, or as required. We have adjusted SRB levels five times in the past 18 months, reducing the number of eligible skill areas by 26 percent compared to fiscal year 2011. In fiscal year 2012, 33 of 84 ratings will receive SRB; the pool of eligible sailors is 2.3 percent of our Active Enlisted Force, representing a 60 percent reduction compared to fiscal year 2011. Our SRB plan targets high-demand skill sets unaffected by slowing or down economy, to include special warfare/special operations, information technology, medical, cryptology, and nuclear ratings. The fiscal year 2013 budget request includes \$107.3 million for new SRB contracts for Active Duty sailors, a slight reduction from fiscal year 2012. The fiscal year 2013 SRB budget for selected Reserve sailors is 13 percent less than fiscal year 2012, a reduc-

tion achieved by realignment of resources within the Navy Reserve Comprehensive Bonus Strategy to target the most critical specialties.

Officer Retention

Active and Reserve officer retention rates remain high due, in large part, to targeted incentive pays, improved mentoring, flexible career options, and increased emphasis on lifework integration initiatives and current economic conditions. Retention of female unrestricted line (URL) officers beyond initial minimum service requirement (MSR) has increased in the last 4 years in both the surface warfare community (19 percent for Year Group 2001 to 33 percent for Year Group 2004) and aviation community (14 percent for Year Group 1998 to 27 percent for Year Group 2001).¹ Initiatives to improve retention of Selected Reserve (SELRES) officer communities by 2014 include targeted officer affiliation and retention bonuses, increased accession goals, and Continuum of Service programs.

Although the overall loss rate for junior officers increased slightly from fiscal year 2009 to fiscal year 2010, economic conditions have contributed to surface and submarine communities meeting retention goals for the third consecutive year. With signs of an improving economy, we are closely watching junior officer retention since retention through the operational department head tour is a critical metric for monitoring the health of these communities.

After a decade of war, we are seeing signs of increased operational stress on Naval Special Warfare (SEAL), Special Warfare Combatant-Craft Crewmen (SWCC), Combat Support and Combat Service Support personnel; increased operational tempo, decreased dwell time, and deployment unpredictability have contributed to a decrease in junior officer retention, particularly at the lieutenant commander (O-4) level. Mentorship and increased access to family support programs and operational stress control resources are primary tools to mitigate the effects of stress on these officers and their families. The fiscal year 2013 budget request includes \$7.6 million for targeted incentive pays to retain these critical officers.

We have experienced slight improvement in medical community retention, largely due to competitive incentives and bonuses. Select subspecialties, including dentistry, psychiatry, clinical psychology, clinical social work, physician assistants, general surgery, preventive medicine, family medicine, mental health nurse practitioner, perioperative, and nurse anesthetists, continue to require attention. The fiscal year 2013 budget request includes \$76.4 million for special and incentive pays to retain these critical medical professionals.

Retention and Compensation Going Forward

The Budget Control Act of 2011 mandates reductions in Federal spending at levels that require every area of the budget to be scrutinized for efficiencies to produce cost savings. With the current budget situation, the Navy believes that every area of the budget, to include personnel costs, should be examined for efficiencies that could lead to cost savings. However, before any changes are made, complete understanding of the impact those changes might have on the servicemember and the Navy should be understood. The current compensation system, to include incentive pay, retirement and other benefits, is a major factor in retention for servicemembers. Any changes to this compensation package must be examined to ensure that Navy retention requirements are met.

We routinely review special and incentive pay and bonus programs, adjusting bonus levels and eligibility in response to manning levels, in addition to reducing enlisted accession bonuses, Assignment Incentive Pay (AIP) and SRB. Over the past year, we have reduced officer bonuses in the aviation, and intelligence communities. Additionally, we restructured the Submarine Support Incentive Pay program to efficiently address shortfalls at specific career points and reduced total program costs by over 58 percent since fiscal year 2009. We will continue monitoring retention rates in fiscal year 2012 to determine the need for further adjustments for select officer communities.

The current military compensation system, including retired pay and other monetary and non-monetary benefits, is a major factor in the success and quality of the All Volunteer Force. Navy strongly supports protecting the retirement benefits of those who currently serve by grandfathering their benefits; Navy is working closely with the Office of the Secretary of Defense (OSD) and other Services on this effort. Any changes to compensation, especially the retirement system, must be fair to the

¹ Because Minimum Service Requirement (MSR) is different for Surface Warfare (5 years) and Aviation (7 years), 2 comparable year groups (i.e., includes women who are past their initial service obligation) were examined to more accurately capture overall URL female retention. YGs 98 and 01 which both had only 7 year MSRs for prop/helo and 8 years for jets (10 U.S.C. 653).

sailor and suitably reward the individual and their family for their service. As we examine the personnel budget, we must carefully consider, before imposing any cuts, the potential impact on sailors and Navy military personnel readiness.

VIII. LEARNING AND DEVELOPMENT

Education and training are strategic investments that enable our highly-skilled force to meet the demands of CNO's Sailing Directions and the Navy Total Force Strategy for the 21st Century. In response to the demands of our increasingly diverse and technologically complex world, we have increased our focus on Science, Technology, Engineering and Math (STEM) in our accessions and education programs. The \$1.5 billion fiscal year 2013 education and training budget invests in innovative training technologies and increases our investment in simulators, curricula, and instructors targeted at critical mission areas.

Accessions Training and Education

We continue to invest in the Navy's ROTC program as an essential contributor to a diverse work force and diversity of thought and, in concert with appropriately-sized U.S. Naval Academy and Officer Training Command accessions, we have the officer accessions capacity we need to meet USN and USMC requirements. New investments in cyber education at USNA will ensure our flagship institution produces officers with the technical education and core competencies necessary to excel in this area as 21st century warriors.

We have no plans to close Navy ROTC units, and in fact have recently restored the historic Navy ROTC presence at Harvard, Yale, and Columbia, and have opened host units at Arizona State University and Rutgers. Although the Navy's Junior ROTC program has included closures, they have occurred in accordance with Federal guidelines, and the bulk of the affected units have substituted Navy National Defense Cadet Corps (NNDCC) units in their stead. We are evaluating re-opening some JROTC units previously closed under Federal guidelines, but which have restored student enrollment above the statutory minimum enrollment threshold. Recruit Training Command (RTC) is appropriately sized to support current enlisted accession requirements and prepared to meet the increases associated with economic changes.

Technical Training and Skills Development

The Navy continues to adjust staffing and student throughput of our accessions pipeline schools in response to the changing size, missions, and make-up of the Force. We have initiatives in progress to optimize the efficiency and responsiveness of the supply chain that takes a sailor from "the street to the fleet". For 2013 we made critical targeted investments in our technical training schoolhouses focused on improving readiness in key mission capabilities areas including Integrated Air & Missile Defense; Anti-Submarine & Surface Warfare; Command, Control, Communications, Computers, Combat Systems, and Intelligence; and Ballistic Missile Defense.

The fiscal year 2013 budget request supports additional investments in simulators, trainers, and new technologies that allow us to deliver sailors to their commands with the skills needed to perform their missions faster and at reduced cost. Coupled with training aboard ships, simulators increase training opportunities and effectiveness across the Fleet while minimizing stress on equipment, operating costs and risk to our sailors. Examples of our fiscal year 2013 simulator investments include the Integrated Air & Missile Defense Advanced Warfare Trainer for our Ballistic Missile Defense platforms and the Aegis Ashore Team Trainer for shore based Ballistic Missile Defense. The Littoral Combat Ship (LCS) training program is based on the Virtual Ship Centric Training Strategy, which uses virtual simulators in the ashore LCS Training Facility to cover the full breadth and depth of ship operations and maintenance training.

We continue to invest in the development and application of innovative training technologies that offer tremendous potential to provide our sailors the best technical training in less time with improved understanding and retention. The field of intelligent tutoring is a focus area for the Future Naval Capabilities Capable Manpower science and technology program, and our enlisted cyber-warriors are currently participating in a very promising Digital Tutor pilot course that combines classroom, instructor led training with advanced computer-based one-on-one tutoring to increase a student's motivation and problem solving skills.

Joint and Professional Military Education

In the past year, the Navy has held education summits to examine the role of joint education, professional education and technical education in the career paths

of our unrestricted line, restricted line and staff officer communities. The results of these summits, combined with a thorough review of the education requirements coded to all Navy officer billets, are informing an ongoing review of the Navy's education strategy. A review of Naval Post Graduate School (NPS) curricula is underway to examine ways to reduce time required to complete in-residence degrees, which, in conjunction with expanded distance learning opportunities, will better align with our officer career tracks and allow greater flexibility in meeting the Navy's Joint, and professional education requirements. In the past year, we have also begun new masters degree programs at the NPS for cyber operations and for energy management.

A progressive continuum of professional military education, including degree opportunities, also exists for enlisted personnel. Junior enlisted pursue professional military education through distance learning hosted by the Naval War College, while senior enlisted personnel are afforded the opportunity to attend the Senior Enlisted Academy (SEA), which graduated 505 senior enlisted sailors from its 6-week resident course in fiscal year 2011.

Voluntary Education

The Navy's on-line Virtual Education Center (VEC) website and counseling service has proven very successful in providing centralized management of Tuition Assistance (TA) requests, sailors' academic transcripts and virtual counseling. The VEC has enabled the Navy to reduce operating costs by downsizing or eliminating local Navy College Offices at some bases while also reducing paperwork and processing time and increasing accessibility to educational opportunities for our sailors.

Navy continues to maximize education opportunities through programs specifically tailored to meet the needs of our sailors and their families. The Navy College Program for Afloat College Education (NCPACE) makes college courses available to sailors assigned to ships and submarines deployed around the world. The Navy College Program Distance Learning Partners (NCPDLP) program offers both associate and bachelor degree programs through partnerships with accredited civilian institutions. These institutions provide maximum credit for military training and experience for every Navy rating and combine those credits with courses they offer to meet degree requirements. Sailors may use Tuition Assistance to offset their education costs in both NCPACE and NCPDLP.

The Tuition Assistance (TA) program is the primary means for Navy personnel to pursue their off-duty education goals. The TA program management controls we implemented in 2010 require sailors to have a plan with clear educational goals to emphasize both professional development and academic success. These controls have helped us remain within our established funding limitations while providing a more equitable opportunity to use the program. Our management controls have improved academic success as evidenced by the reduction in the non-completion rate of TA-funded courses from 16 percent in fiscal year 2009 to 7.5 percent in fiscal year 2011.

Credentialing

The demand for credentialing examinations continues to be very high, indicating the significant value sailors place on gaining professional recognition for their training and experience. In fiscal year 2011, we funded 19,762 certification exams, a 43 percent increase over fiscal year 2010. The Navy Credentialing Opportunities Online (COOL) website experienced 497,002 visits, a 65 percent increase over fiscal year 2010, and 30,460,627 hits, an 11 percent increase. Sailors in all 83 ratings have applied for funding, and 94.2 percent of those completing voluntary certification examinations via Navy COOL funding passed, far exceeding the national average pass rate of 75–85 percent, and represents a positive return on investment. In 2011, Navy COOL and Navy's Credentialing Program was awarded "Best Workforce Development Program" by Human Capital Management Defense, and the Navy COOL program was recognized through the Training Top 125 Award for the second consecutive year.

In 2012, work has already begun to implement several improvement recommendations from the President's Employment Initiatives DOD/VA Veterans Employment Task Force and to develop Navy COOL pages to display credentialing opportunities for Navy's 198,000+ civilian employees. In addition, we will waive the time-in-service prerequisites to make COOL available to all sailors affected by the ERB to help posture them for success as they transition to the civilian workforce.

Navy Language, Regional Expertise, and Culture (LREC)

Cultural, historical, and linguistic expertise remains essential to fostering strong relationships with global partners and to enhance our ability to execute missions in multinational environments. Over the past year, LREC efforts paid dividends in every geographic area of operations, including support for Operation Tomodachi in

the Far East, Operation Odyssey Dawn in the Mediterranean, and Operation Continuing Promise in Latin America. Navy's LREC program in fiscal year 2011 provided language and cultural training and products to over 67,000 sailors and officers, 49 flag officers and 46 senior leaders heading to overseas assignments.

We recently expanded the Navy Reserve Language Culture and Pilot Program to include all selected Reserve personnel. In fiscal year 2012, we are increasing opportunities for overseas study, language and cultural immersion, as well as professional exchanges with foreign navies for U.S. Naval Academy midshipmen. We are also pursuing full implementation of in-country language immersion training for Foreign Area Officers (FAOs), and transitioning the Personnel Exchange Program (PEP) to redefine long-standing agreements with traditional allies and partners, while realigning towards nations in regions of increasing strategic importance. In anticipation of the shift in focus outlined in Secretary Panetta's Sustaining U.S. Global Leadership: Priorities for 21st Century Defense, LREC product development emphasis is transitioning from Central Command (CENTCOM) to the Asia-Pacific region, Indian Ocean perimeter, and West Africa.

This past year we participated in Maritime Security Cooperation activities and supported the Joint Force in Afghanistan and Pakistan with enhanced language and cultural capabilities through the Afghanistan-Pakistan (AFPAK) Hands Program. We also provided timely, tailored language, and Afghanistan/Pakistan training and culture products to 3,695 Navy Individual Augmentees (IAs) and to sailors assigned to units deploying to the CENTCOM Area of Responsibility.

IX. BUILDING FOR THE FUTURE

As we navigate through a period of change, Navy must take action now to posture itself for success in the future. Evolving missions, shifting workforce demographics, and increased competition for skills will require new and innovative approaches to attracting, recruiting, and retaining the Nation's best talent. Mission success starts and ends with a highly skilled, highly capable workforce. To build an effective future force, we remain focused on developing and sustaining a diverse workforce, providing our sailors with opportunities for greater work-life balance, and promoting open, frequent communication with families.

Diversity Initiatives

Diversity is a Navy strategic imperative. By 2020, demographic projections indicate that minorities will comprise nearly 40 percent of the Navy's recruitable market, with minority representation continuing to increase over time. Navy's ability to access and retain the talents of varied sectors in our society has a direct impact on mission success at home and abroad.

We recognize the value of diverse ideas, perspectives, and experiences to remain competitive in an increasingly global environment; our Navy draws strength and innovation from this diversity. Navy continues to effectively execute our accession strategy of "moving the needles," maintaining a high number of diverse applicants and enrollments in both NROTC and U.S. Naval Academy class of 2015. In recognition of our efforts, Navy received the 2011 Diversity MBA Magazine's Best Places for Diverse Managers to Work, ranking number 26 on the list of the top 50 organizations for Diversity Leadership, and the only government organization included on the list of Fortune 500 companies. Additionally, the Association of Diversity Councils recognized the Navy's Strategic Diversity Working Group (SDWG) as the nation's number one diversity council for 2011.

Expanding Opportunities for Women

Gender diversity remains an important focus area for Navy, 23 percent of our enlisted accessions were women in fiscal year 2010 and fiscal year 2011, and we are on-track to bring in a similar number of women in fiscal year 2012. We are exploring ways to further increase the number of women in the Navy in the future. With few exceptions in which the combat exclusion applies, the vast majority of billets (93 percent) are available to women, including ship, aviation squadron, afloat staff, naval construction force units and most recently, specific submarine platform billets.

In fiscal year 2011, Navy began the integration of female officers into the submarine force. Five of the eight crews being integrated during the first round are successfully integrated and the remaining three will be by the end of March 2012. Our second round will include one additional SSGN and SSBN (i.e., four additional crews); women are currently in the training pipeline for integration in November 2012. We will continue to integrate women on submarines in a brisk yet responsible manner, while leveraging the insights from the studies and the lessons learned from initial integration efforts.

Life-Work Integration

In an All-Volunteer Force, life-work integration and flexible career options are key to attracting, recruiting, and retaining the talent of a new generation just entering the workplace. With 75 percent of Fortune 500 companies reporting a chronic "talent shortage" among mid-level employers, Navy continues to address the imperative to retain talent and provide a work environment that is personally and professionally rewarding. Navy's ability to recruit and retain the talents of varied demographics has a direct impact on mission success. We are actively creating programs to enhance personal and professional development while providing life-work balance.

Sailors and their families continue to benefit from comprehensive parental support programs including paternity and adoption leave, extended operational deferment for new mothers, and expanded childcare. We continue to support life-work integration while meeting mission requirements through initiatives such as Career Intermission, telework, and other flexible work options.

Communication with Navy Families

Navy recognizes that social networking and the Internet can greatly facilitate communication efforts with sailors and their families. We continue to promote open, frequent communication with our sailors and their families and encourage development of social networking accounts, mobile applications, public websites, and publishing newsletters to sailors and their families via email.

The Navy Recruiting Command "Navy for Moms" website received a 2011 Workforce Management Magazine Optimas Award for "Service." Through this award-winning website, families of current sailors can share information with families of future sailors and answer many questions about Navy life. Since its establishment in March 2008, more than 36,000 members have used the website to discuss issues with others who share common concerns. "Military OneSource" provides information on many topics, including parenting and childcare, educational services, financial information and counseling, civilian legal advice, crisis support, and relocation information. This free, 24/7 information and referral service offers practical solutions, background information and advice via the telephone, email, or the web to all Active Duty and Reserve sailors, and their families.

Social media venues such as Facebook have quickly become a primary and effective means of communicating with a wide audience, including family members. Additionally, in cooperation with Navy's Chief of Information's social media team, we are able to connect to a much broader audience by taking advantage of the U.S. Navy official Facebook page, which currently has more than 400,000 fans.

Recognized for Results

Our efforts have culminated in Navy's recognition as a Top 50 organization. Top 50 organizations encourage innovation and focus on performance, while taking care of their people through programs and policies that support a culture of trust, respect, and collaboration. In October 2011, Navy received several awards for Business Excellence in Workplace Flexibility from the Alfred P. Sloan Foundation. These awards recognize initiatives introduced at six different organizations across the Navy that promote flexible work options while still achieving business goals. For the third year in a row, Navy received the prestigious Workforce Management Magazine's Optimas Award. This marked the first time in the award's 21-year history an organization has won 3 consecutive years.

Navy continues to earn recognition for its high quality training and development programs. In the 3 years since Navy began participating in the American Society for Training and Development (ASTD) awards program, no other organization has won more awards for "Excellence in Practice." Most recently, Navy was honored with an ASTD BEST Award, ranking third out of 32 best training organizations from a prestigious list of recipients from 6 nations. For the second year, Training Magazine recognized Navy as one of the premier training organizations in the country, ranking seventh out of 125 organizations recognized. We remain committed to seeking out best practices across industry and benchmarking our programs against the best in the Nation.

X. CONCLUSION

The President's fiscal year 2013 budget request supports critical programs that will ensure Navy's continued success in delivering the personal component of CNO's Sailing Directions, the Navy Total Force Strategy for the 21st Century, and key capabilities in support of Sustaining U.S. Global Leadership: Priorities for 21st Century Defense. I look forward to working with you as we continue to shape the Navy to meet current and emerging requirements, while confronting the challenges that lie ahead. On behalf of the men and women of the U.S. Navy, and their families,

I extend our sincere appreciation for your leadership, commitment and unwavering support. Thank you.

PREPARED STATEMENT BY LT. GEN. ROBERT E. MILSTEAD, JR., USMC

Chairman Webb, Ranking Member Graham, and distinguished members of the subcommittee, it is my privilege to appear before you today to provide an overview on Marine Corps personnel.

I. YOUR MARINES

The Marine Corps is our Nation's expeditionary force in readiness. We are ready to respond to today's crisis—with today's force—TODAY! Currently, approximately 27,000 marines are forward-deployed in operations supporting our Nation's defense. Our individual marines are the Corps' most sacred resource, and the quality of our force has never been better.

II. END STRENGTH

New strategic guidance issued by the President and the Secretary of Defense provides the framework by which the Marine Corps will balance the demands of the future security environment with the realities of our current fiscal environment and the lessons learned from 10 years of combat. The new strategy includes a reduction in our Active component end strength from 202,100 to 182,100 by the end of fiscal year 2016, while maintaining our Reserve component at 39,600 marines. Although reshaping the Marine Corps to a force of approximately 182,100 marines entails some risk relative to current and anticipated capacity requirements, we believe that it is manageable. Your new Corps will have fewer infantry battalions, fixed wing, aviation squadrons, and general support combat logistics battalions than we had prior to September 11. However, it adds cyber warfare capability, special operators, wartime enablers and higher unit manning levels—all lessons gleaned from recent combat operations.

Our intent will be to conduct our drawdown in a measured way beginning in fiscal year 2013. Our plan is to reduce our end strength by approximately 5,000 marines per year and will be accomplished by some accession cuts, natural attrition, and voluntary separation and retirement authorities. The drawdown cannot be accomplished by accession cuts alone—that is a lesson learned from the last drawdown in the 1990s. In addition, we have no plan to conduct a reduction-in-force (RIF) of our marines; they will be allowed to complete their current period of service. Our all-volunteer system is built upon a reasonable opportunity for retention and advancement; wholesale cuts undermine the faith and confidence in service leadership and create long-term experience deficits with negative operational impacts. Such an approach would no doubt do significant long-term damage to our ability to recruit and maintain a quality force.

Our overarching goal must be to keep faith with our marines and their families.

III. MARINE CORPS RESERVE

Our Reserve component continues to make essential contributions to Total Force efforts in Overseas Contingency Operations. In 2011, we continued to refocus our recruiting and retention efforts on meeting our Reserve component authorized end strength. These efforts included increases to the non-prior service recruiting mission, lowering rates of attrition, and discreet targeting of those marines eligible to receive an incentive. As a result, we achieved over 99.8 percent—39,527—of authorized end strength in fiscal year 2011 (not including reservists who served on active duty at least 3 of the prior 4 years).

Our incentives budget is \$5.4 million in fiscal year 2012, and we project an end strength of 39,249, approximately 1 percent below our authorized level. For fiscal year 2012 and beyond, we have refined the use of incentives to strengthen manning in specialties and grades where we remain critically short. In particular, the recruitment of company grade officers and aviators remains most challenging. Targeted incentives and transition assistance outreach programs help us to attract junior officers who are leaving the Active component. While transitioning officers from the Active component provide the majority of our company grade officer leadership, we have had considerable success commissioning officers directly into the Reserve. The Reserve Officer Commissioning Program, which includes Officer Candidate Course-Reserve (OCC-R)—has produced a total of 431 lieutenants for the Marine Corps since its creation in 2006 and has increased company grade officer fills from 21 to

46 percent. More importantly, it enables the Marine Corps Reserve to place officers in critical small unit leadership positions at the platoon and company level.

To complement outreach efforts and the use of incentives, and to address the challenges of geographic constraints, we offer occupational specialty retraining. The Prior Service Military Occupational Specialty Retraining Program is crucial in our efforts to join enlisted marines to units that are located in areas of the country where it is geographically challenging to recruit. This training has helped us to build positive trends with respect to recruiting and retention and are integral to our future success.

This year we increased efforts to fully staff Reserve aviation squadrons. To achieve this goal, we developed a number of Reserve aviation manpower initiatives designed to encourage transitioning Active component aviators to affiliate with Reserve units. Since there are a limited number of Reserve squadrons, the use of travel reimbursement, incentives, and aviator retraining programs are critical to achieving our staffing goals. Altogether, these programs, combined with our prior service recruiting efforts, should provide for at least 90 percent manning of critical combat arms and company grade officer billets by the end of fiscal year 2014, with Reserve squadrons reaching this mark 1 year later.

IV. RECRUITING

The Marine Corps is unique in that all recruiting efforts (officer, enlisted, regular, Reserve, and prior-service) fall under the direction of the Marine Corps Recruiting Command. Operationally, this provides us with tremendous flexibility and unity of command, allowing us to meet accession requirements.

To meet future challenges in the recruiting environment, it is imperative that we maintain our high standards both for our recruiters and those who volunteer to serve in our Corps. Recruiting quality youth ultimately translates into higher performance, reduced attrition, increased retention, and improved readiness for the operating forces. Our actions, commitment, and investments today in recruiting ensure a high state of readiness in our Corps tomorrow.

In fiscal year 2011, we achieved over 100 percent of our enlisted and officer recruiting goals for both the Active and Reserve components. On the enlisted side, we accessed over 99 percent Tier 1 high school diploma graduates and over 74 percent in the upper Mental Groups of I-IIIAs, both exceeding Department of Defense quality standards. Our fiscal year 2012 Mission for enlisted marines is 28,500 regulars (Active component) and 5,450 reservists. In fiscal year 2012, we expect to meet our annual recruiting mission to include all quality goals. Additionally, we expect to have a strong population of qualified individuals ready to ship to recruit training as we enter fiscal year 2013. The fiscal year 2013 mission forecast is 28,500 regulars and 5,800 reservists.

The Marine Corps seeks to reflect the diversity of the Nation and be representative of those we serve. Diversity remains a strategic issue that raises our total capability by leveraging the strengths and talents of all marines. In fiscal year 2011, a tremendous amount of effort and resources was placed into communicating the Marine Corps diversity message through community outreach, recruit marketing, training and education. This enduring challenge requires the Corps to strategically evaluate our current efforts in order to drive toward improved capabilities.

Our officer accessions mission for fiscal year 2012 is 1,450 Active Duty and 125 Reserve officers. Historically, the Active component has been the exclusive source of lieutenants and captains for the Reserves. As previously noted, filling company grade officer billets for our Selected Marine Corps Reserve units is traditionally our greatest challenge, but the success from the OCC-R program is proving to help in remedying this shortfall.

Our recruiting command is taking a hard look at its advertising budget. It is imperative that we maintain the momentum within a competitive media environment and still provide the basic awareness level when reaching out to an increasing number of critical audiences (prospects and their influencers, officer candidates, and multicultural audiences) to include our diversity outreach. It is important that we acknowledge that today's successes are dividends from the investments made in recruiting and advertising 4 to 5 years ago.

Our greatest asset is the individual marine and recruiting remains the lifeblood to the Corps and our bedrock to "Make Marines, Win Battles, and Return Quality Citizens." We thank you for the generous support you have provided to us and look forward to working with you to ensure continued success in the future.

V. RETENTION

In fiscal year 2011, the Marine Corps achieved both its accession and retention missions and completed the year with a 201,497 Active component end strength (including 340 reservists who served on active duty at least 3 of the prior 4 years). For fiscal year 2012, we will continue to assess all recruiting and retention missions, enabling the Marine Corps to successfully meet our mission requirements and poise the force for the impending drawdown.

Even with our successes in recruiting, retention, and overall end strength, the Marine Corps must continue to shape our force to meet continuing mission requirements and fill critical military occupational specialties (MOSs) with the most qualified marines. Incentive pays remain critical to this effort, allowing the Marine Corps to fill hard to recruit positions, such as crypto linguists and reconnaissance. Enlistment bonuses also allow us to ship new recruits at critical times to balance recruit loads at the depots and meet school seat requirements. It is important to note that only 8 percent of new Marine Corps recruits receive an enlistment bonus; the Marine Corps budget for enlistment bonuses has decreased from \$75 million in fiscal year 2008 to \$14.7 million in fiscal year 2012.

Selective Reenlistment Bonuses (SRBs) similarly allow us to shape our career force. SRBs target critical MOSs and allow us to laterally move marines to these MOSs. There are currently 6 of 205 occupational specialties where the on-hand number of marines is less than 80 percent of what is required. Our SRB funding has decreased from \$468 million in fiscal year 2009 to \$108.6 million in fiscal year 2012.

VI. WOMEN IN SERVICE REVIEW

As directed by the National Defense Authorization Act for Fiscal Year 2011, the Marine Corps, alongside the other Services, conducted a review of the laws, policies and regulations regarding the service of female members. The findings were delivered to Congress in February 2012. The Marine Corps requested an exception to policy that would allow for the assignment of Active component female company grade officers and staff noncommissioned officers (E-6 and E-7) into select Ground Combat Element (GCE) units (Artillery, Tanks, Assault Amphibian, Low Altitude Air Defense, Combat Engineer and Combat Assault) down to the battalion level, in military occupational specialties (MOSs) already open to female marines. This will open 97 officer billets and 274 staff noncommissioned officer billets for assignment of female marines during 2012.

Concurrent with the exception to policy, the Marine Corps will conduct responsible research to generate data that can be used to make informed decisions and potentially develop appropriate gender neutral tests to screen males and females prior to assignment to the GCE. We must ensure that all marines assigned to the GCE have the required physical aptitude. This research will include a force survey and a research study that will assess the potential impact on recruiting, MOS classification, entry level training, and promotions in order to inform future assignment decisions. We will report back to the Secretary of Defense with an initial assessment in November 2012.

The Marine Corps is committed to utilizing the skills and abilities of our marines to achieve the highest levels of unit readiness and focus on mission accomplishment. We are proud of the contributions that women make across the Marine Corps and want to ensure female marines continue to have opportunities to be successful.

VII. DIVERSITY

The Marine Corps is committed to attracting, mentoring and retaining the most talented men and women who bring a diversity of background, culture and skill in service to our Nation. In both representation and assignment of marines, diversity remains a strategic issue. Our diversity effort is structured with the understanding that the objective of diversity is not merely to strive for a force that reflects a representational connectedness with the rich fabric of all the American people, but to raise total capability through leveraging the strengths and talents of all marines.

We are near completion of a new comprehensive campaign plan to focus our diversity effort in areas where improvement is most needed and anticipate release of this roadmap this year. This is an effort facilitated through our standing Diversity Review Board and a Diversity Executive Steering Committee chartered to establish the foundations for diversity success in the Total Force. In addition, since 2010, we have conducted leadership seminars that introduce diverse college undergraduates to Marine leadership traits and leadership opportunities in the Marine Corps; we are actively seeking new communities within which to continue this effort.

The Marine Corps has established minority officer recruiting and mentoring as the highest priority in our recruiting efforts. Because we acknowledge the accession and retention of minority officers has been a challenge for our Corps, we are committed to taking steps to further facilitate the mentoring and career development of all our officers with emphasis on our minority officers in order to encourage the retention of our best officers no matter their background.

Overall, we seek to communicate the Marine Corps diversity mission through community outreach and recruit marketing; to ensure continued opportunities for merit based development and advancement; and to optimize training and education to increase the understanding for all marines of the value that diversity brings to the Total Force.

VIII. TAKING CARE OF MARINES, SAILORS, AND FAMILIES

Marine families are America's families and a model for the Nation. The Marine Corps will continue to take care of its marines and families through enhanced family readiness and family care programs. Marine communities are a team, and our programs promote increased socialization and community connection through official unit communication, readiness preparation and information, and referral opportunities. These programs seek to improve resiliency by training marines and families how to cope with the rigors of life in the Marine Corps, whether at home or deployed.

Family Readiness

The Marine Corps has 380 Family Readiness Officers, who connect marines and families at the grassroots level to critical information and referrals and assist families during all phases of deployments. We recently completed an overhaul of our Marine Corps Family Team Building Training to ensure we are providing relevant, standardized and timely support and information to our families. In fiscal year 2011, we provided 5,869 Marine Corps Family Team Building training sessions.

Family readiness also benefits from dependable yet innovative communication tools that help families effectively manage their lives in times of stress. eMarine, a secure website, delivers readiness information to marines and their families whether they are on active duty stationed at large installations or in the Reserves living in remote locations. It gives family members access to documents, photos and videos, discussion forums, and vital information about their marine's unit from anywhere in the world, 24/7.

The Marine Corps conducted a full review during fiscal year 2011 of its Family Readiness programs to ensure they adequately support the mission and operational requirements of the Marine Corps. While our programs conform to the Commandant's guidance and congressional direction, we are developing program plans and supporting resource requirements to maintain capabilities at appropriate levels.

Family Care

Family care programs support the care and development continuum of Marine Corps children from birth into their teens. Family care includes our school liaisons, who provide approximately 70 school districts with information about the needs of Marine Corps families and access to beneficial training and counseling services to support teachers and students. Marine parents are comforted by the support of a local education expert, who provides meaningful insight to new transfers and those with questions on local education policies.

Child care services remain a high priority. In fiscal year 2011, we provided 15,927 child care spaces, which reflects an 18 percent increase in capacity from fiscal year 2010. The Marine Corps opened five new child development centers in fiscal year 2011 and plans to open eight more in fiscal year 2012. The Marine Corps has completed a Child Development Program and Facility Master Plan, which reviewed child care capabilities and costs across the Marine Corps. This plan will facilitate efforts to build multi-capable, adaptable services, reexamine structure, and ensure that our programs are prepared to deliver child care in an efficient manner. We will continue to standardize our processes in fiscal year 2012 and will work to enhance child care for marines and families serving on independent duty or at locations that are isolated from military bases and stations. We are also expanding our staffing model to include nurses at our Child Development Centers and behavioral health specialists at our installations across our family programs.

Families enrolled in our Exceptional Family Member Program (EFMP) strongly endorse our focus on providing a continuum of care and the improvements made to their level of support. Two years of increasing enrollments and a reduction in issues experienced by families relocating to new duty stations demonstrate this approval. EFMP had only 4,500 enrolled family members in fiscal year 2008; it has over

10,000 today. The Marine Corps continues to underwrite the cost of up to 40 hours of short-term respite care per month for enrolled families, providing more than 450,000 hours of respite care in fiscal year 2011. We continue to transform our program, which the Department of Defense (DOD) and our sister services continue to recognize as a premier program. Marine Corps policy ensures that the assignment and relocation process is sensitive to EFMP family needs and allows marines to remain competitive for promotion while maintaining a continuum of care for exceptional family members.

Personal and Professional Development

We recognize and encourage all marines and their spouses to pursue and achieve their life goals while serving in the Marine Corps or beyond as veteran marines. Our Personal and Professional Development (P&PD) program supports marines and their spouses with their education, employment, financial fitness, and transition readiness goals. This program integrates the efforts of several formerly-disparate programs (education services, transition assistance, spouse employment support, personal financial management, relocation assistance, library programs and the Marine For Life network) to ensure we provide our marines and spouses holistic education and support.

One of our most significant initiatives is to revise and improve our Transition Assistance Management Program (TAMP) to better meet the needs of our transitioning marines and their families. TAMP is being integrated and mapped into the lifecycle of a marine from recruitment, through separation or retirement, and beyond as veteran marines. The Marine Corps efforts will comply with the multi-agency initiative, led by OSD and VA, to help improve employment prospects of veterans, as well as with implementing the provisions of the recently enacted Veterans Opportunity to Work (VOW) Act.

The integration of our Marine For Life program in the P&PD Program has improved our ability to work with the civilian community to find opportunities for our transitioning marines and their spouses. Marine For Life also provides an avenue for marine veterans to reach back for assistance or to volunteer their services to assist transitioning or veteran marines in their communities.

Regarding spouse employment opportunities, we see that tying these programs more closely with formerly marine-focused programs, such as transition assistance and on-base education, creates significant synergy. Many of the same employers who seek marine veterans are also interested in employing marine spouses. We look forward to working with the Joining Forces Initiative, which seeks to streamline certification and licensure procedures for marine spouses. We also support parallel efforts to qualify marines for certifications based upon military training and experience.

Our P&PD Program includes personal finance counseling efforts to help marines make responsible financial decisions. We have created a new personal financial management curriculum that covers 34 major topics including saving and investing, credit and debt management, and smart home buying, selling and renting. These efforts help ensure that we are not focusing solely on those in financial distress but also on preparing marines and their families to be financially stable and prepared.

Bringing all of these programs together to offer an integrated set of personal and professional development services will enable marines and their families to be more effective, and more ready. At the same time, these services will help marines be better prepared to make the transition back to civilian life whether it be after a 4-year enlistment or a 30-year career.

Behavioral Health Integration

The integration of our behavioral health programs seamlessly weaves our efforts in sexual assault, suicide, combat and operational stress, substance abuse and family advocacy/domestic violence into the larger support network of command structures and the health and human services across the Marine Corps. We focus on evidence-based practices to ensure we are providing effective support in these critical areas and utilize our Behavioral Health Information Network, which is a web-based clearinghouse, for the latest information on behavioral health. This integration further benefits from our Behavioral Health Advisory Committee, a committee chartered for the purposes of examining promising practices and making recommendations on our behavioral health programs. A universal prevention training module, which is in development, will reduce redundancy in our training efforts by integrating all behavioral health program information. This training will discuss common risk and protective factors across all behavioral health programs.

Sexual Assault Prevention and Response

Our Sexual Assault Prevention and Response Program follows a holistic approach to prevention and response, utilizing a top-down leadership message of support and an emphasis on bystander intervention. Marines have an inherent responsibility to step up and step in to prevent sexual assault. Our priority is to reduce the number of incidents as well as reduce the number of unreported sexual assaults by utilizing a consistent and focused emphasis on command climate. The Marine Corps has revitalized our curriculum for noncommissioned officers to include a new video-based bystander training, entitled "Take a Stand," designed to reduce stigma by stimulating conversation and engaging marines with a more personalized message about sexual assault prevention.

We are revitalizing our Command Team training module, updating our annual training and enhancing our training for all first responders. We have staffed our installations with subject matter experts, positioned to have the greatest impact on victims and victim care. In addition, 24/7 Helplines are available at all major installations and Reserve headquarters to provide resources and advocacy for victims. These Helplines are answered by victim advocates who are trained to provide immediate services to victims of sexual assault.

We continue our focus on accountability for those who violate the Uniform Code of Military Justice. The Marine Corps Trial Counsel Assistance Program (TCAP) trained 118 Judge Advocates in sexual assault investigation and prosecution best practices in fiscal year 2011. TCAP will continue this training in fiscal year 2012 and plans to train approximately 125 Judge Advocates and 75 enlisted paralegals. The DOD-wide release of the Defense Sexual Assault Incident Reporting Database will enhance current case management capabilities.

Suicide Prevention

In calendar year 2011, we lost 33 marines to suicide, and we preliminarily recorded 171 suicide attempts. While we have seen 2 consecutive years of decreased suicides and evidence of change in marine attitudes toward behavioral health, we still have much work to do. Leaders prevent suicide by strengthening all marines and encouraging marines to engage helping services early, when problems are most manageable. We continually encourage marines to recognize, acknowledge and seek help for stress reactions, and we deploy evidence-based prevention practices such as peer-to-peer suicide prevention training. The Marine Corps will work closely with the DOD Suicide Prevention Office to implement recommendations of its Joint Task Force on the Prevention of Suicide. Our award-winning "Never Leave a Marine Behind" suicide prevention program, which is peer-led and continually updated to reflect emerging evidence-based practices, is tailored to reflect the culture and values of the Marine Corps. We will continue to forge strong relationships with Federal agencies, academia, and private industry in order to further our understanding of suicide prevention.

Combat and Operational Stress Control

Combat and Operational Stress Control (COSC) helps Marine leaders maintain their warfighting capabilities by addressing the negative impacts of stress. COSC enhances force preservation, readiness and the long-term health and well-being of marines and their families. Every battalion or equivalent unit across the Total Force will have an Operational Stress Control and Readiness (OSCAR) team by mid-2012. OSCAR teams are comprised of mentors (selected unit marines and leaders), extenders (unit medical and religious personnel), and mental health professionals, who provide a network of support. As of March 2012, the Marine Corps had trained over 10,000 marines as OSCAR mentors, who help reduce stigma and act as sensors for the commander by noticing small changes in behavior and taking action early before stress becomes a medical issue. COSC is incorporating lessons learned into new courses in COSC fundamentals for all levels of enlisted professional military education.

Our DSTRESS Line, which will have a global capacity by mid-2012, addresses the full spectrum of behavioral health needs, whether they are problems arising from the everyday stressors of life or a suicidal crisis. DSTRESS Line is a "by Marine/for Marine" counseling center for marines, attached Sailors, and families, who can call, chat online, or Skype with a veteran marine, Fleet Marine Force corpsman, or Marine Corps family member.

Substance Abuse

Our Substance Abuse Program works to reduce substance abuse and dependency disorders that negatively affect the operational readiness and health of the force. The program's tenets are prevention, treatment and drug demand reduction. We are

executing an Alcohol Abuse Prevention Campaign throughout the Marine Corps this year to reduce the negative impact that alcohol abuse and misuse has on the Marine Corps' readiness and health.

Marine Total Fitness

In fiscal year 2012, we will also continue to develop our Marine Total Fitness concept to develop marines of exemplary physical, psychological, spiritual and social character. Marine Total Fitness, which will support the Department of the Navy's 21st Century Sailor and Marine Initiative will infuse resilience-based information and concepts into all aspects of a marine's training and readiness. A totally fit marine exhibits exemplary physical, mental, spiritual, and social character and is prepared to successfully operate in and respond to the rigors, demands, and stressors of both combat and garrison. The four pillars of Marine Total Fitness—physical, psychological, social, and spiritual—provide an avenue to deliver programs, initiatives and resources.

Casualty Assistance

The Marine Corps Casualty Assistance Program is committed to ensuring that families of our fallen marines are treated with the utmost compassion, dignity, and honor. Always seeking to improve survivor assistance and demonstrating a record of quick, effective action, our Casualty Assistance Program is a 24-hour-per-day operation manned by marines and civilians trained in casualty reporting, notification and casualty-assistance procedures. Casualty Assistance Calls Officers assist the next-of-kin with burial arrangements, applications for benefits and entitlements, contact with benevolent and philanthropic organizations, and obtaining reports of investigation. Within days of the incident, families are connected to representatives from the Tragedy Assistance Program for Survivors, a nationally-recognized provider of comfort and care to those who have suffered the loss of a military loved one. The Marine Corps reaches out to the next-of-kin approximately 60 days after the loss to help resolve any remaining issues and to let the families know that they are still part of the Marine Corps family. We will remain steadfast in our support of our Marine Corps families who have paid so much in service to our Nation.

IX. SEMPER FIT & EXCHANGE SERVICES

I want to thank Congress, especially this subcommittee, for your continued support for our Marine Corps Semper Fit and Exchange programs. In the National Defense Authorization Act for Fiscal Year 2012, you and your colleagues included a provision which allows us to access credit for business operations through the Federal Financing Bank and thereby lock-in the best possible interest rates. Thank you for your hard work on that bill.

The Commandant continues to stress that the Marine Corps will keep faith with our marines, our sailors, and our families. We repeat this theme in all that we do as we strive to deliver capability-based programs all the way down to the unit level.

Semper Fit & Recreation

Our Semper Fit and Recreation programs support the readiness, resiliency, and retention goals of your Marine Corps. Our efforts are primarily focused on the areas of fitness, sports, health promotion, and recreation, as they are essential in maintaining a fit marine. We recently introduced High Intensity Tactical Training (HITT), a comprehensive strength and conditioning program geared towards optimizing physical performance and combat readiness. HITT is designed to reduce the likelihood of injury while in theater; initial feedback from marines is positive and Corps-wide rollout of the program, including use in Afghanistan, began in February and will be completed at all installations by June 2012.

Social resilience is linked with unit cohesion and we are identifying unit-driven recreational activities to provide at Marine Corps installations. Operation Adrenaline Rush, currently offered at two installations, assists marines in reintegration by empowering small unit leaders, maintaining combat readiness, and reinforcing unit cohesion. The program offers opportunities for outdoor recreation activities such as whitewater rafting and deep sea fishing.

Overall, Semper Fit makes every effort to deliver high quality programs and services to marines and their families. Our programs are vital to the continued success and development of your marines and your Corps.

Marine Corps Exchange and Temporary Lodging Facilities

The Marine Corps Exchange (MCX) is inextricably linked to our mission of taking care of marines and their families and is an important part of the overall non-monetary benefits package. Our success is measured on the program's value and con-

tributions to the readiness and retention of our marines, as well as our ability to provide unparalleled customer service, premier facilities, and valued goods and services at a savings. With MCX, unlike any other retail store, marines can rely upon a high quality product at a fair price and know that the proceeds are returned to their community, creating a stronger Marine Corps. Like other Marine Corps Community Services (MCCS) facility master planning efforts, MCX is executing branding strategies, and our aggressive re-investment into our main stores is near completion. We are also expanding the branding strategies to focus on our Marine Marts and Temporary Lodging Facilities. All Marine Corps design standards are focused on energy efficiency and sustainability.

Deployed Support

Deployed support is one of the most important services we provide. Our Exchange, Recreation and Fitness, Communication, and MCCS Amenity Wi-Fi services not only boost and maintain morale, but also help to reduce mission-related stress.

Exchange

Ongoing missions in Afghanistan include the operation of two Direct Operation Exchanges Tactical at Camps Leatherneck and Dwyer, one Tactical Field Exchange at Camp Delaram II, one Imprest Fund Site at Forward Operating Base (FOB) Edinburgh, and numerous Warfighter Express Services Teams operating out of Camps Leatherneck, Dwyer, and FOB Edinburgh.

Recreation and Fitness

We assist in providing sports, recreational, and fitness equipment to units throughout Helmand Province. This transportable equipment includes sports/recreation cooler kits filled with sports gear and board games, electronic game kits, Theater-in-a-Box kits, and functional fitness equipment for use in austere environments. Reading materials, both electronic and paperback, are also available.

Communication

Morale Satellite services are available to forward operating bases, combat outposts, and other austere locations. We have delivered 13 satellite communications systems to units in Afghanistan. Each system has 2 phones which each provide 6,000 free minutes per month and 5 laptops that allow internet access, social networking, and chat/video capabilities to deployed marines. In 2011, we provided over a half-million minutes of telephone air time. In addition, approximately 23,683 marines were able to use the Morale Satellite services at several different FOBs, including over 2,100 telephone calls over the Thanksgiving and Christmas holidays.

MotoMail, supported by Marine and Family Programs and first offered in December 2004, is another form of communications support which continues to serve marines and families. MotoMail allows friends and family members to submit letters and pictures online to deployed marines. A marine will receive their letter within 24 hours of submission. Since implementing this free service, over 4.1 million letters have been created and delivered.

MCCS Amenity Wi-Fi Solution

The Marine Corps Community Services Amenity Wireless Fidelity (Wi-Fi) Solution program deploys Wi-Fi capability at no cost to marines and families. This morale and welfare initiative helps marines stay in contact while separated from their families. The Wi-Fi is conveniently located at temporary lodging facilities, exchange food courts, libraries, education centers, child and youth centers, clubs, and Wounded Warrior Program facilities. Since its inception, our Wi-Fi program has been popular with marines and their families. As of the first of this year, the program is available on 19 Marine Corps installations with 240 buildings receiving Wi-Fi coverage.

X. WOUNDED WARRIOR REGIMENT

The Marine Corps is grateful for this subcommittee's recognition of the service and sacrifices of wounded, ill, and injured (WII) marines and their families. Your marines continue to sustain wounds on the battlefield, including catastrophic injuries that present significant quality of life challenges. Marines also continue to be injured in training accidents, become ill, and experience other tragedies that require a wide range of interconnected non-medical care. Through our Wounded Warrior Regiment (WWR), we provide this care—from the point of injury or illness through return to duty or reintegration to civilian communities.

Our WWR is a single command with a strategic reach that provides non-medical care to the total Marine force. The Regimental Headquarters in Quantico, VA, commands the operation of two Wounded Warrior Battalions (at Camp Lejeune, NC,

and Camp Pendleton, CA) and multiple detachments in locations around the globe, including at major Military Treatment Facilities and Department of Veterans Affairs Polytrauma Centers. All WWR elements function as a cohesive team to allow for consistent, top-notch services for WII marines, their family members, and caregivers.

The Marine Corps approach to wounded warrior care is to return recovering marines to their parent units as quickly as their medical conditions permit. Allowing marines to “stay in the fight” is what makes our care model unique and successful. When WII marines remain with their parent units, they are supported by their regular command structure with the full assistance of our WWR’s comprehensive assets. WII marines with medically acute cases (typically when their recoveries are more complex and medical treatment or rehabilitation is expected to exceed 90 days) are joined to a WWR element where they are enrolled in programs to not only heal them medically, but also strengthen their mind, body, spirit, and family during recovery and rehabilitation.

There is no one-size-fits-all approach to warrior care. Each case is unique based upon the marine’s phase of recovery, their location and family situation. Care does not lend itself to a process, but rather, it is a relationship between the WWR and the WII marine. As leadership is an integral part of the healing process, our WWR assigns specially-trained Marine Section Leaders to various locations where WII marines are joined to maintain good order and discipline and ensure that these WII marines are provided leadership, mentorship, and encouragement on a daily basis.

Assets and Capabilities

Now in its fifth year of operation, our WWR continues to refine its programs and services. Many program improvements are based upon sound feedback from WII marines, their family members and caregivers. Our fundamental assets and capabilities are available to WII marines whether they are joined to the WWR or remain with their parent command.

Recovery Care Coordinators (RCCs)

We currently provide 49 RCCs to approximately 1,220 WII marines, 60 percent of whom are joined to the WWR and 40 percent remain with their parent command. Our RCCs are located at 14 sites and serve as the WII marine’s central point of contact to help them set and meet their recovery and transition goals. RCCs work in coordination with other members of the marine’s recovery team (Marine leadership, medical case managers, non-medical case managers, and others) to ensure recovery and transition actions are fully coordinated. Recent improvements to the RCC program include standardizing Comprehensive Recovery Plans (CRPs), the WII marine’s “life map,” by implementing a quality assurance program for consistent CRP development and documentation. We have also developed a robust training program that provides RCCs with the critical skills necessary to identify WII marines’ needs, translate those needs into concrete goals, and then provide actionable steps to help the marine meet their goals. To facilitate a smooth transition process, the RCCs have instituted a practice whereby they hand-off cases of marines who leave the Marine Corps to other WWR assets for post-transition monitoring and to provide for any ongoing or residual care coordination requirements. Our RCCs coordinate with the Department of Veterans Affairs’ Federal Recovery Coordinators (FRC) on cases where WII marines have been assigned an FRC to ensure a smooth transition to VA services.

Warrior Athlete Reconditioning Program

When a marine is wounded, ill, or injured, our WWR helps focus them on their abilities through the Warrior Athlete Reconditioning Program (WAR-P). WAR-P provides activities and opportunities for marines to train as athletes, to increase their strength so they can continue with military service or develop healthy habits for life outside of the Marine Corps. WAR-P, which is mandatory for marines joined to the WWR, does more than help WII marines maintain a healthy body; it counters declining self-perception, depression and stress that may be associated with their injury. Under WAR-P, WII marines have more than 20 activities to choose from, including swimming, cycling, running, wheelchair basketball, and strength and conditioning.

Sergeant Merlin German Wounded Warrior Call Center

The Marine Corps continues to honor its commitment to keep faith with WII marines through our WWR’s Call Center, a Department of Defense Best Practice, which renders resource and referral assistance to WII marines and Marine veterans. Our trained Call Center staff includes retired marines, other Marine veterans, and family members of marines augmented by a small staff of psychological health pro-

professionals. They not only receive calls on a 24/7 basis, but also conduct outreach efforts to check on the well-being of WII marines. Combat-wounded marines who remain with their parent units are contacted at prescribed intervals to determine if they have any needs or issues. If needs are identified, the marine is referred to a non-medical care manager for resolution. These calls can result in assignment to a Wounded Warrior Battalion or the assignment of a Recovery Care Coordinator, or both. This Call Center also serves as the WWR's hub for its new social media efforts, which includes Facebook, Twitter, and a new WWR App that can provide fact sheets, news updates, and other WWR-specific information.

Strategic Communication

Clear, consistent, and accurate information regarding services and eligibility must reliably reach WII marines, their family members, and caregivers. To address this need, the WWR continually disseminates information on its programs and services to various audiences, including Marine Corps leaders, to ensure the Marine Corps total force, including all wounded warriors and commanders are aware of the WWR's services.

Community Reintegration

As the vast majority of WII marines reintegrate to their communities, our WWR has taken steps to ensure they are highly competitive in a difficult job market. We provide specialized transition support through Transition Cells, located at WWR Headquarters and Wounded Warrior Battalions. Transition coordinators, both Marine Corps and civilian employees (including representatives from the Departments of Labor and Veterans Affairs), work closely with marines to reach their employment and education goals. Based on the WII marine's ultimate goals, the transition coordinators determine their needs, develop pathways, provide coaching and resources, and help network for employment and careers. For WII marines who are joined to the WWR, their transition to civilian life begins as soon as their medical conditions allow (typically at outpatient status). They must start an education program, participate in an internship, or return to work (ideally in a military occupational field commensurate with their established goals).

Integrated Disability Evaluation System Support

The Marine Corps supports the current Integrated Disability Evaluation System (IDES) process as it enables the recovering servicemember and family to continue to receive our support and transition smoothly to VA benefits from active duty status. While not a universal concern, some marines have expressed dissatisfaction with the IDES process due to the variance in their final DOD compensation package and their VA compensation based on the same VA disability rating determination. This is because DOD compensates for medical conditions that are determined to be military unfitting by the service Physical Evaluation Board (PEB), whereas VA compensates for all disabling medical conditions incurred or aggravated during a period of active duty. Although the Marine Corps does not own the IDES process, we own the marine and it is our responsibility to be their advocate. Over the past year, we have taken several actions to improve IDES performance. These actions include:

- providing Marine Corps leadership with detailed IDES case processing information, resulting in their ability to work closer with the Regional Medical Commanders on specific issues impacting IDES performance;
- enhancing the PEB administrative staff and bolstering manning to perform field-level counseling and case processing assistance;
- providing Marine Corps disability evaluation attorneys with a list of marines entering the IDES process for proactive advocacy prior to the Medical Evaluation Board (MEB) referral; and
- ensuring all marines referred into the IDES receive a pocket-sized information pamphlet on the IDES process which provides detailed information on the establishment of the DOD and VA compensation based on the VA determined disability rating. It also identifies all actors (PEBLOs, VA Military Service Coordinators, DES Attorneys, and Independent Medical Reviewers) in the IDES process and describes how the marine can work with that actor to achieve a better outcome.

These initiatives have reduced case backlogs and improved case processing timeliness in the MEB and improved customer satisfaction.

Program Assessment

The WWR recognizes the importance of sound data to measure program effectiveness and inform changes in the way we serve WII marines and their families. Since the WWR was established in 2007, several surveys have been conducted. The most

recent survey was administered to WII marines joined to or supported by the WWR and posed questions relating to our various care coordination assets: Section Leaders, Recovery Care Coordinators, the Wounded Warrior Call Center and Battalion Contact Cells, Family Readiness Staff, and District Injured Support Coordinators. Findings reveal that satisfaction levels have increased for marines injured prior to 2007 and are now consistent with WII marines injured post 2007. Much of this equalization can be attributed to the reach-back capability that the Call Center possesses, conducting outreach calls to offer assistance. There was also an increase in satisfaction levels in the following areas: WWR personnel; the level of information provided/ability to provide information; and ability to provide support to family members. One of the most important data points from the survey: 81 percent of respondents agreed or strongly agreed that WWR personnel do a good job of coordination with each other to make things easier.

Our WWR has also been assessed by the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Services. We are pleased to point out that we were recognized for several best practices, including our Hope and Care Centers, customization and delivery of the Keeping It All Together Handbook to families at detachments, and our IDES Pocket Guide for Marines.

WII marines and their family members and caregivers have sacrificed much and I can assure this subcommittee and Congress that we will fully honor their sacrifices by continuing to provide them quality care and support to posture them for success, whether they return to duty or transition back to civilian life.

XI. CIVILIAN MARINES

Our civilian marines support the mission and daily functions of the Marine Corps and are an integral part of our Total Force.

In recognition of the need to study and clearly define our civilian workforce requirements in light of civilian labor budget reductions, we proactively conducted a full review of the civilian workforce in late 2010. This measure resulted in a self-imposed hiring freeze from December 2010 to December 2011, but allowed time to prioritize requirements within affordable levels and align resources with capabilities. It also ensured the civilian labor force was shaped to support the mission of the Corps today and for the future. As a result of our efforts, the Marine Corps avoided drastic reductions of civilian personnel and was able to reduce from a planned level of 21,000 personnel in direct funded Full-Time Equivalencies to 17,501.

Our fiscal year 2013 civilian personnel budget reflects efforts to restrain growth in direct funded personnel. By establishing budgetary targets consistent with current fiscal realities, we will be able to hold our civilian labor force at fiscal year 2010 end-of-year levels, with some exceptions for critical workforce growth areas such as acquisition, intelligence (National Intelligence Professionals), information technology, security (Marine Corps Civilian Law Enforcement Personnel), and cyber.

The civilian labor budget represents less than 5 percent of the Marine Corps' fiscal year 2012 budgetary submission, demonstrating that our "best value" for the defense dollar applies to our civilians as well as our marines.

XII. HEALTH CARE EFFICIENCIES

The Marine Corps supports the reforms in military compensation programs included in the President's fiscal year 2013 budget. The President's budget acknowledges the reality that military pay, allowances, and health care costs cannot be ignored in our comprehensive effort to achieve savings. The compensation reforms are sensible. Modest pay raises continue—no reductions, no freezes. TRICARE care enrollment and deductibles fees increase for retirees, but they are comparatively moderate and tiered based on retirement income. Pharmacy co-pays trend toward market rates and encourage the use of generic drugs and mail-order delivery. In all cases, costs remain substantially less than those in the private sector.

XIII. CONCLUSION

To continue to be successful, we must always remember that our individual marines are our most precious asset, and we must continue to attract and retain the best and brightest into our ranks. Marines are proud of what they do. They are proud of the "Eagle, Globe, and Anchor" and what it represents to our country. With your support, a vibrant Marine Corps will continue to meet our Nation's call.

Thank you for the opportunity to present this testimony.

Senator WEBB. Secretary Ginsberg, welcome.

STATEMENT OF HON. DANIEL B. GINSBERG, ASSISTANT SECRETARY OF THE AIR FORCE FOR MANPOWER AND RESERVE AFFAIRS; ACCOMPANIED BY LT. GEN. DARRELL D. JONES, USAF, DEPUTY CHIEF OF STAFF FOR MANPOWER, PERSONNEL AND SERVICES, U.S. AIR FORCE

Mr. GINSBERG. Thank you very much, Mr. Chairman.

Chairman Webb, Ranking Member Graham, and members of the subcommittee, General Jones and I would like to thank you for the opportunity to testify today on behalf of more than 700,000 airmen—Active, Guard and Reserve, and civilian, who make up the most capable aerospace and cyberspace force the world has ever known. We know that you and members of the subcommittee are keenly interested in the well-being and support of our airmen. We must start by thanking you all for everything that you have done to support them each and every day.

In the past year, our Nation's airmen have performed magnificently, carrying out operations precipitated by Arab Spring, major natural disasters, Homeland defense missions, and ongoing overseas contingencies in Afghanistan and the conclusion of our Iraq operations.

It is vital to visit our airmen firsthand and see their contributions and challenges they face every day, and we can assure you that from Japan to Florida, from Wyoming to Kandahar, your members of the U.S. Air Force are laying it on the line for the Nation every single day.

It is due to the quality of our All-Volunteer Force that your Air Force can project focused military power to achieve strategic, operational, and tactical objectives globally in support of our national security interests.

We have no higher priority than taking care of our airmen and ensuring that they have the resources and support that they and their families need to stay focused and ready to perform the demanding missions we assign to them.

As this subcommittee already is well aware, the Air Force had to make very hard choices in this year's budget submission. We had to reconcile top-line reductions with our requirement to fulfill our global commitments and maintain acceptable levels of readiness while still sustaining key quality of life and core services for our people. Despite a difficult budget situation, the Air Force is committed to providing cost-effective medical care services and programs to maintain a healthy and resilient force. We must support our people to meet the demands of high operational tempo and persistent conflict. Developing and caring for our airmen will remain a key focus as we continue to become more efficient and develop smarter and more agile approaches to our achieving security objectives.

Again, on behalf of Secretary Donley and General Schwartz and all of our airmen, we thank you for your commitment and support to our Air Force. We look forward to answering your questions.

Senator WEBB. Thank you very much, Secretary Ginsberg.

General Jones, both of your full statements will be entered into the record at this time.

[The joint prepared statement of Mr. Ginsberg and General Jones follows:]

JOINT PREPARED STATEMENT BY HON. DANIEL B. GINSBERG AND LT. GEN. DARRELL D. JONES, USAF

The airmen of our great Air Force serve the Nation with distinction. They have performed valiantly during more than 20 continuous years of combat operations dating back to Operation Desert Storm, while simultaneously supporting multiple broad-spectrum operations across the globe. Committed to meeting the requirements of the President's Defense Strategic Guidance, while confronting the realities of the current and future constrained fiscal environment facing our Nation, the Air Force remains committed to recruiting, developing and delivering to the battlefield innovative airmen who can smartly and skillfully meet any task or mission. Our commitment as the Air Force's Assistant Secretary for Manpower and Reserve Affairs and Deputy Chief of Staff for Manpower, Personnel and Services is to align the Air Force's greatest resource, our airmen, to support the national security strategy. We must do so with fiscal responsibility, making extremely difficult resource priority decisions while at the same time demonstrating that we fully support our airmen and their families. As we prioritize missions, it is critical we balance capabilities between our Active and Reserve components to maintain a robust national security posture in a dynamic global environment.

CONTINGENCY OPERATIONS

Our airmen remain at the forefront of today's conflicts and contingency operations around the globe, serving proudly alongside our soldier, sailor, and marine counterparts. Today there are more than 80,000 airmen either forward deployed or stationed abroad worldwide in our Nation's defense with an additional 134,000 airmen providing direct support to our joint warfighters from the continental United States on a daily basis. That means 43 percent of our Total Force is directly supporting combatant commander requirements every day. In late 2010, the Air Force began a transition to a 6-month baseline deployment length. This will increase at-home time for airmen between deployments and use pre-deployment training resources more efficiently. We are on track to complete this transition by October 2012. At the same time, Air Force 365-day deployment taskings have increased to 2,300, up from 689 in 2005, and now represent 7 percent of the Air Force's total deployments.

MILITARY AND CIVILIAN PERSONNEL BUDGETS

The Air Force is committed to maintaining and sustaining the appropriate size and force mix to align with the new defense strategy, ensuring we meet mission requirements with acceptable personnel tempo and associated stress on the force. Detailed assessments of future conflict scenarios and deployment rotation requirements drove force structure adjustments resulting in the corresponding personnel reductions. By the end of fiscal year 2013, end strength will be reduced a further 9,900 from 510,900 to 501,000. This will result in an Active Duty military end strength reduction from 332,800 to 328,900. Our Air Force Reserve (AFR) military end strength will decrease by 900 (increase in 200 full-time; decrease in 1,100 part-time, including 700 associated technician positions) to 70,500, and Air National Guard (ANG) military end strength will decrease by 5,100 (500 full-time; 4,600 part-time, including 1,400 associated technician positions) to 101,600. Approximately 80 percent of these reductions were driven by force structure changes.

During the development of the fiscal year 2012 President's budget, the Secretary of Defense released efficiency guidance to improve the effectiveness and efficiency of business operations. As part of this guidance, the Department of Defense (DOD) civilian end strength funding was targeted at fiscal year 2010 levels. For the Air Force, this action effectively removed funding for 16,500 civilian positions that were planned growth between fiscal year 2010 and fiscal year 2012. To meet the DOD-directed civilian funded targets, the Air Force conducted an enterprise-wide review of efficiency initiatives, reducing overhead and eliminating redundancies, while protecting areas of strategic importance such as the nuclear enterprise, intelligence, reconnaissance and surveillance. The reductions ultimately resulted in the Air Force divesting 3,000 positions of planned civilian growth and approximately 13,500 established positions, primarily from management and support staff areas.

The fiscal year 2013 budget includes a total budget authority request of \$34.2 billion for Active Duty, ANG and AFR military personnel. Included in this budget is a 1.7 percent military base pay increase, a 4.2 percent increase in the housing allowance and a 3.4 percent increase in subsistence allowance. We also project an 11.4 percent decrease in Overseas Contingency Operations (OCO) funds. In addition, the civilian personnel budget requested for fiscal year 2013 is \$12.4 billion for a pro-

grammed total force civilian strength of 185,900, and includes a 0.5 percent pay raise following a 2-year pay freeze.

COMPENSATION REFORM

We support the President's plan to establish a military retirement commission, undertaking a thorough review of the current retirement system and make recommendations to modernize that system with input from the Department. We also support the recommendation that any changes be grandfathered. The costs for military pay, allowances and health care have risen significantly in the last decade. As part of a DOD-wide effort, we are participating in the development of multiple proposals to meet deficit reduction targets and slow cost growth. The adjustments to the TRICARE benefits 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.

MILITARY FORCE MANAGEMENT

The Air Force will continue to sustain excellence with a smaller, more agile and modernized force. We continue to realize record high retention and remain focused on tailored force management efforts as we continue to size and shape the force to meet congressionally mandated end strength. The Force Management Program is a targeted, multi-year program managing the force along the 30-year continuum of service, which leverages voluntary measures first, incentivized programs where needed, and implements involuntary measures as required to yield sustained support for combatant commanders across the globe.

The fiscal year 2012 voluntary force management programs include active duty service commitment waivers; time-in-grade waivers; reduced enlistment contract waivers; 8 versus 10 commissioned years of service waivers for prior-service officer retirement, as granted in the National Defense Authorization Act (NDAA) for Fiscal Year 2011; voluntary separation pay; and Palace Chase transfers to the Air Reserve components. We plan to utilize the Temporary Early Retirement Authority granted in the NDAA for Fiscal Year 2012 by targeting a very limited and specific number of enlisted airmen in selected skills.

The fiscal year 2012 officer involuntary force management program resulted in 610 losses through use of a force shaping board for probationary officers with less than 6 years Total Active Federal Commissioned Service (TAFCS), a reduction in force board for captains and majors, and lieutenant colonel and colonel selective early retirement boards. The fiscal year 2012 enlisted involuntary force management program currently only calls for date of separation rollbacks.

In fiscal year 2013, the Air Force's voluntary programs are similar to those in fiscal year 2012 and the only involuntary action is a projected force shaping board for probationary officers with less than 6 years TAFCS. Additionally, the Air Force will continue use of limited selective continuation and reduced promotion opportunities to captain (95 percent) and major (90 percent).

While we must take proactive measures to manage the force to remain within end strength, the Air Force is also committed to ensuring an effective transition to civilian life for our airmen. We have increased our focus on improving Transition Assistance Programs and are actively participating with the White House Veterans Employment Initiative Task Force, in an effort to reduce veteran unemployment. We are committed to providing appropriate resources towards increased transition assistance and veteran employment efforts as we continue to collaborate with the Office of the Secretary of Defense (OSD), the Department of Veterans Affairs (VA), the Department of Labor, the Department of Education, and other government partners.

CIVILIAN FORCE MANAGEMENT

The Air Force has initiated programs to achieve the necessary civilian force reductions while ensuring mission continuity to comply with the fiscal year 2010 funding levels as directed by DOD. The Air Force has implemented force management programs such as hiring controls, a 90-day hiring freeze, and two rounds of voluntary separation initiatives (Voluntary Early Retirement Authority (VERA) and the Voluntary Separation Incentive Pay (VSIP)). More than 2,900 civilian employees have accepted VERA/VSIP incentives. A third round of voluntary separation initiatives are planned to begin 1 May and conclude on 31 August. During this time of reductions and reshaping the force, the Air Force's primary goal is to minimize the number of involuntary separations to the greatest extent possible.

RETENTION, RECRUITMENT, BONUSES, AND INCENTIVE PAYS

The Air Force accesses, retains and grows motivated and uniquely qualified airmen to meet the security threats of today and the future. We must carefully tailor accessions to meet current needs, while also considering the future, as not bringing in enough new recruits can impact the force for 30 years to follow. Therefore, while our force management plan includes reducing some officer and enlisted accessions, those reductions are considered against future requirements. We project reducing enlisted accessions for fiscal year 2012 and fiscal year 2013 by 1,030 and 1,232, respectively, and reducing officer accessions by 30 in fiscal year 2012, but no planned reductions in fiscal year 2013.

The Air Force seeks the highest quality recruits to fill our ranks as current airmen retire or separate through programmed attrition. To support these efforts, we have included \$82 million in the budget for the Air Force Recruiting Service to support Total Force recruiting operations, and an additional \$97 million for fiscal year 2013 advertising, a slight reduction in the total recruiting budget from fiscal year 2012. In 2011, the Air Force experienced great recruiting success, meeting all enlisted and officer recruitment goals for the Active Duty and Reserve components. Just as notably, the quality of recruits entering the Air Force greatly increased. For our CAT I to IIIA recruits, the average score on the Armed Services Vocational Aptitude Battery increased from 90.5 percent in 2010 to 98.5 percent thus far in fiscal year 2012, and we anticipate continued overall recruiting success in fiscal year 2012 and fiscal year 2013. However, there are nine Air Force career fields, to include linguist, special operations, and explosive ordnance disposal specialties where critical shortages remain due to high operational demand, manning shortages, or lengthy training pipelines. We budgeted \$14.5 million in Initial Enlistment Bonuses in fiscal year 2013 to attract airmen into these critical skill areas. Active duty, non-line officer recruiters met 99 percent of their 2011 goal. We increased our efforts to recruit Fully Qualified Health Professionals (FQHP), meeting the goal of 25 FQHP officers in fiscal year 2011 while increasing our fiscal year 2012 goal to 55.

The ANG met their fiscal year 2011 enlisted recruiting goal and are on track for fiscal year 2012. However, ANG officer recruitment fell short in fiscal year 2011 in both line officer and health professional areas. In response, the ANG is executing precision recruitment efforts in fiscal year 2012 towards officer candidates using a standardized processing system, focused lead generation, and a heightened advertising campaign to help meet officer recruiting goals by fiscal year 2013.

The Air Force Reserve continues to attract and retain qualified prior service and nonprior service recruits. For the 11th straight year, the AFRC Recruiting Service has led DOD in meeting recruiting goals. The Air Force's ability to attract and retain trained Active component airmen into the AFR greatly reduces training costs, and enhances the repository of talent and expertise available to meet the Air Force's surge and steady state requirements.

Retention remains at an all-time high in the Air Force as a whole, contributing to the need for multi-year force management programs to remain within authorized end strength. However, retention is still problematic for some skill sets and year groups, and we need investment to counter low accession year groups of the past and to retain critical warfighting skills for the future. Bonuses have proven the most effective, responsive, and measurable tool for retention to encourage airmen to remain in or retrain into career fields with high demand requirements. Training and replacement costs far exceed the amount invested in bonus programs, so the Air Force has allocated \$420.4 million in fiscal year 2013 for Special and Incentive bonus pay. The Air Force has portioned \$232 million of this amount for Selective Reenlistment Bonuses (SRB) for 78 Air Force specialties, down from 89 in fiscal year 2011. SRB investments have shown to improve retention up to 1 to 8 percent per SRB increment, depending on the enlistment zone, and have proven to be a critical tool in retaining our needed specialties for the future. Retention of senior non-commissioned officers (SNCO) in certain high-demand specialties such as combat control and pararescue is also challenging. critical skills retention bonuses (CSRB) remain a vital tool to target specific year groups within specialties experiencing low retention, manning shortfalls, and high operational demand. Therefore, the Air Force targeted \$2.9 million in enlisted CSRB towards retaining these SNCOs beyond retirement eligibility. Additionally, we are investing \$10 million in CSRB towards officer specialties with retention and manning problems including contracting, special tactics, combat rescue officers and health professionals.

AIRMAN DEVELOPMENT

One of our primary initiatives in developing the force is an effort to better define, identify, and track institutional, occupational, and cross-functional competencies.

During fiscal year 2013, we will continue to institutionalize a process allowing force development stakeholders at all levels to quantify and measure specific skills on both an individual and aggregate basis. Doing so will allow us to develop our Total Force airmen more deliberately by matching training, education, and experiential opportunities to real-world requirements. The Air Force is developing cross-cultural competence for all airmen, in order to prepare them to deliver the global vigilance, global reach and global power our Nation expects. To support this requirement, we will focus our efforts on: (1) building expertise in foreign language, regional, and cultural skills; (2) recognizing joint experience in an airman's career; and (3) ensuring our educational offerings address current and anticipated requirements for language and regional expertise.

SUPPORT TO AIRMEN AND THEIR FAMILIES

Quality-of-life programs continue as one of our highest priorities. As our force changes, we must adapt our programs and services to ensure we meet the needs of today's airmen and families. Additionally, we must tailor our offerings based on the utilization of services and the availability of suitable alternatives.

We recently completed the second generation of our Caring for People Survey. More than 100,000 Total Force airmen voiced their opinions in this online survey conducted from December 1, 2010 to January 3, 2011. The survey measured satisfaction with quality of life across the Air Force community, to include airmen, spouses, Air Force civilians, and retirees across multiple areas like medical care, housing and support for families. The respondents expressed satisfaction with housing, installation schools, military benefits, dining facilities, fitness centers, child development centers and youth programs. Information, Tickets and Travel, along with the Air Force Food Transformation Initiative were standouts, competing with comparable industry leaders in the travel and food service industries. Some areas of concern include a sense of Air Force community, financial issues, medical care for families and job satisfaction.

We have a project team developing base prototypes, technological innovations and efficiencies to address concerns not just from the Caring for People Survey, but a variety of other surveys and focus groups as well. The team will provide installation commanders with tools to help them determine how to shape quality of life programs according to the needs of their local Air Force community. In that vein, another key focus area is strengthening partnerships within local communities to take advantage of the services they provide. In the end, we will consolidate or divest quality of life activities that are not financially viable or not well utilized in order to redirect resources to the places where they matter most to airmen, their families and the mission.

Our successful Food Transformation Initiative (FTI) continues as a high priority through fiscal year 2012 and fiscal year 2013. A customer satisfaction rating of 75 at the 6 FTI installations, compared to 67 at other facilities, indicates we are on the right path as we work to improve the delivery of meal choices, food quality, speed of service, and the overall dining experience for our personnel. As another indicator of success in our first year, we served an additional 530,000 customers and provided 133,000 more meals to our junior enlisted members at FTI installations as compared to the previous year. Based on the initial success of this program and with congressional support, we anticipate expanding FTI to seven additional installations in fiscal year 2013.

It is important to recognize the contributions of non-pay programs in enhancing the quality of life for our airmen and their families. The Defense Commissary Agency operates as a nonprofit organization and can save a family of four an estimated \$4,500 a year. Providing groceries and household items at cost saved patrons a total of \$2.7 billion last fiscal year. Additionally, the Army Air Force Exchange Service (AAFES) provides merchandise and services to military members and their families at competitively low prices. The 3,100 facilities located in over 30 countries provided an average 24 percent savings to customers compared to comparable retail stores. Additionally, AAFES gives back to the military community through significant dividend contributions, which amounted to \$90.6 million going back to the Air Force communities AAFES serves in fiscal year 2010. AAFES also offers employment benefits as 31 percent of employees are military family members.

We continue to strengthen our Air Force community by meeting childcare needs through a robust construction effort to increase the number of available childcare spaces and reduce our shortfall by the end of fiscal year 2012. We are also adding 74 accessible childcare playgrounds and 26 community nature parks in support of Air Force families with special needs. The Air Force Expanded Child Care program assists airmen who need child care for unusual shifts, extended duty hours and drill

weekends. Additionally, we funded our new respite childcare program for special needs children at seven bases and we will expand it to other locations throughout the upcoming year.

We are also expanding our Exceptional Family Member Program (EFMP) to support more than 18,400 Air Force families with special needs members, a 10 percent increase since the end of fiscal year 2010. To do so, we placed 35 EFMP Family Coordinators at installations with the highest concentrations of families enrolled in the program. We are also adding 36 EFMP Medical Coordinators through fiscal year 2016 to support families needing specialized medical care and included \$3 million starting in fiscal year 2013 to fund respite care and other EFMP related programs.

The Air Force also recognizes the important role and sacrifices of our ANG and AFR airmen and their family members. While many of the same family support programs are offered to our Reserve components, we realize that ANG and AFR families have difficulty sometimes accessing those available resources. As a result, we have supported ANG and AFR unique programs such as the Home Community Care program, which provides fee-assisted, in-home quality childcare during scheduled drill weekends. Returning Home Childcare for deployed personnel is another ANG/AFR family program benefit, funding 16-hours of no-cost care per child following deployments of 30 days or more. Finally, a Defense Management Data Center survey administered to ANG/AFR families highlighted the high satisfaction with the congressionally-supported Yellow Ribbon Reintegration Program (YRRP), with 83 percent of respondents expressing high satisfaction with the YRRP events. Additionally, 77 percent said the information presented increased their confidence in their ability to find and utilize vital resources that would prepare them and their loved ones for continued military service.

MILITARY HEALTH SYSTEM (MHS) GOVERNANCE

The Air Force fully supports the MHS Governance Task Force recommendations. They are important because they represent the intense and informed deliberation of both line and medical professionals who were seeking the best solutions to maintain exceptional care for our servicemembers while finding more effective and efficient ways to deliver that care.

The Air Force believes implementation of the task force recommendations will ensure the sustainment of this high level of mission success. We agree that a more effective and efficient joint medical solution can be attained without the expense of establishing a unified medical command. The Services should—and will—continue integrating common medical platforms to reduce redundancy and lower costs. The task force recommendations will move us quickly to a construct that curtails expenses and achieves savings to the greatest extent possible while meeting our deeply important mission; providing quality health care to the military member and their families, while being good stewards of American taxpayer dollars.

AIRMAN AND FAMILY RESILIENCY

A key factor in maintaining the health of our Air Force is to increase the resiliency of our airmen. Our efforts include a number of programs in the Comprehensive Airman Fitness (CAF) model designed on four pillars of resilience: Mental, Physical, Social and Spiritual. This program provides tools to help Total Force airmen and their families withstand, recover or grow in the face of stressors and changing demands. It is our goal to expand education and training of the CAF model to our accession and professional military education units first. Next, we will provide Master Resilience training Air Force-wide to individuals who provide face-to-face resilience skills training at the installation level. Further, the Leadership Pathway is a program incorporating basic resilience and life skills for airmen and family members in utilizing existing resources offered at the Airman and Family Readiness Center, Health and Wellness Center, Air Force clinics/hospitals and base chapels.

The Deployment Transition Center (DTC) at Ramstein Air Base, Germany, was established to provide valuable decompression, reintegration and resilience training for returning servicemembers who were exposed to significant danger and stress in combat zones. Since calendar year 2010, over 3,000 airmen have completed the center's 2-day program and have reintegrated with their home units and families. The Air Force fiscal year 2012 budget includes \$7 million for DTC operations, research, curriculum development, materials and intervention training.

SUICIDE PREVENTION

Suicide prevention remains a top Air Force leadership priority. The Air Force uses an integrated public health approach to suicide prevention, emphasizing leadership

involvement, a supportive Wingman culture, and access to evidence-based care provided by Air Force helping agencies. The Air Force Suicide Prevention Program is one of only 15 evidence-based programs listed by The Substance Abuse and Mental Health Services Administration. Recent suicide prevention initiatives include requiring face-to-face suicide prevention training for all frontline supervisors in the three career fields with the highest suicide rates in 2010. Since implementation in November 2010, the suicide rates in these career fields dropped significantly.

Other initiatives include developing the Airman's Guide for Assisting Personnel in Distress, a new web-based resource to assist all airmen with strategies and resources for a variety of behavioral concerns. We are also sponsoring a RAND study on the use of social media and its impact on relationships and emotional wellbeing, as well as research by the University of Rochester on specific clusters of risk factors associated with suicide. The Air Force Community Action Information Board/Integrated Delivery System (CAIB/IDS) links leaders and helping professionals at every level of the Air Force organization and monitors all our suicide prevention initiatives for continuity and completeness. An audit of its effectiveness will provide guidance on enhancing the functioning of these organizations and provide areas of further improvement in our evidence-based program.

Proper public messaging on suicide prevention is important. Public messages must avoid the impression that suicide is common, so the Air Force has revised memorial service and public affairs guidance shifting the focus toward the positive message of resilience, stressing the benefits of early help-seeking and effective Wingmanship.

Finally, the Air Force is working closely with our sister Services to implement recommendations made by the Defense Health Board's Task Force on Suicide Prevention and to clarify roles and responsibilities within the Department regarding suicide prevention.

SEXUAL ASSAULT PREVENTION AND RESPONSE

The Air Force strongly supports the Secretary of Defense's commitment, focus, and initiatives aimed at eradicating sexual assault. Eliminating sexual violence is everyone's responsibility. Leaders, commanders and supervisors set the tone and must model zero tolerance and behaviors supporting zero tolerance. The goal of our Air Force Sexual Assault Prevention and Response (SAPR) program is to prevent and respond to sexual assault through a balance of focused education, compassionate advocacy and accountability, promoting respect and dignity throughout the Air Force.

Prevention of sexual assault continues to be a high priority. Career long education and training creates a foundation for prevention. This education begins with accessions, continues through all phases of professional military education, and is refreshed during annual training. In February, we released a wing commander guide, *An Opportunity to Lead*, containing five core elements to help commanders provide immediate impact. The guide addresses personal leadership, climate and environment, community leadership, victim response, and offender accountability. In addition, Bystander Intervention Training has been established as a requirement for all airmen, focusing on the importance of recognizing signs of inappropriate or unsafe situations and intervening appropriately.

The NDAA for Fiscal Year 2012 contained significant mandates addressing sexual assault including a requirement for full time Sexual Assault Response Coordinators (SARCs) and victim advocates at brigade or equivalent level. The Air Force SAPR program has included full time SARCs at installation level since 2005, including the six primary U.S. Central Command area of responsibility AF locations. Air Force SARCs receive training that meets national advocacy credentialing standards. Victim advocates are military and Air Force civilian volunteers who receive comparable training. Currently, 3,159 fully trained volunteers are available to assist victims. The Air Force projected \$31.8 million to execute the SAPR program in fiscal year 2013. The budget funds full-time SARCs, 24 dedicated investigative agents specializing in sexual assault investigations, and operational program expenses for all first-responder agencies and field level activities. To meet the new NDAA for Fiscal Year 2012 requirement for full time Sexual Assault victim advocates at brigade or equivalent level, the Air Force will need to add 89 new positions (60 DOD civilians and 18 officers from the Active Duty component, and 11 traditional Reserve officers from the Air Reserve component). The associated cost is \$7.5 million in fiscal year 2013, increasing to \$8.4 million by fiscal year 2017.

Prevention and response are critical elements of the SAPR program. Holding those who commit the crime of sexual assault accountable is equally important. The Air Force is committed to accountability through effective investigations, knowledge-

able staff judge advocate advice, and strong commander and senior enlisted support. The Air Force has 24 Air Force Office of Special Investigations investigators dedicated to sexual assault investigations and funds 10 DNA analyst salaries at the U.S. Army Criminal Investigations Laboratory to analyze Air Force sexual assault case evidence. Investigators and judge advocates participate in combined training and attend courses specifically addressing sexual assault crimes. The recent Air Force Judge Advocate General Keystone annual leader summit provided a 4-hour session for staff judge advocates facilitated by subject matter experts on investigation and evaluation of sexual assault cases. Executive Order MRE 514 provides victim advocate privilege against disclosure of certain communications by victims, SAPR victim advocates and family advocacy program victim advocates, and we feel certain this provision will encourage more victims to come forward and report sexual assaults and incidents of domestic violence.

In March, the Air Force launched the Defense Sexual Assault Incident Database (DSAID). The Air Force has worked closely with OSD from concept development to DSAID system design, so we look forward to implementing this valuable tool for enhanced reporting to Congress and to our leaders and commanders and we appreciate Congress's continued support in addressing this crime.

WOUNDED WARRIORS

The Air Force continues to strengthen its support for our wounded, ill and injured population through our Warrior and Survivor Care Division. Our wounded, ill and injured airmen deserve our very best and the Warrior and Survivor Care Division is committed to providing them individualized and focused non-clinical support. Through the Recovery Care Coordinator (RCC) program, we have strategically placed 33 non-clinical care managers around the country and in Germany. This RCC network provides dedicated support and coverage from the moment Air Force Casualty reports that an airman is placed in a seriously or very seriously ill or injured status; serving as independent advocates for each airman and working to ease the burden of administrative and personal requirements as they navigate through their continuum of care.

Our Family Liaison Officers (FLO) also provide an invaluable service to the families of our seriously or very seriously wounded, ill and injured airmen. The Air Force has taken the concept used to support families of the fallen and applied it to our wounded warrior families as well. The FLO coordinates all logistical support for family members to include arranging lodging, securing transportation, and seeing to the comfort and other arising needs of the family.

While we provide excellent care for all our wounded, ill, and injured with RCCs and FLOs, the Air Force Wounded Warrior Program (AFW2) focuses exclusively on our combat wounded airmen. This program provides long-term, non-clinical care management for combat wounded who must meet a Medical Evaluation Board or Physical Evaluation Board to determine whether they are fit for duty. Focused, personal care from AFW2 allows our combat wounded airmen the opportunity to make informed decisions when their future career path changes due to their injuries.

INTEGRATED DISABILITY EVALUATION SYSTEM

The Air Force has collaborated with OSD and the VA to simplify the Integrated Disability Evaluation System (IDES) process for servicemembers by increasing transparency and reducing processing time to improve the transition for servicemembers from DOD to VA. Overall, the IDES monthly progress report for February 2012 indicates Air Force Active component case processing is averaging 360 days, down from an average of 540 days in recent years.

The Air Force Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) are working diligently to meet timeliness goals and ensure quality outcomes. We have directed considerable leadership attention and resources targeting improved MEB and PEB decision timeliness and are on target to meet review and decision guidelines by October 2012. These focused efforts will ensure our wounded, ill and injured personnel receive timely reviews and adjudications of their cases. Along with the Army and the Navy, the Air Force is working with the Wounded Warrior Care and Transition Policy Office to identify a methodology for accurately tracking each step associated with the transition phase.

Another venue of disability appeals administered by the Air Force is the DOD Physical Disability Board of Review (PDBR). As the lead component operating this Wounded Warrior Board, the Air Force recently partnered with the VA in its outreach efforts to ensure every PDBR-eligible veteran is made aware of their opportunity to have their service assigned disability ratings reviewed. The goal of this interdepartmental effort is to reach all 77,000 eligible veterans within the year.

OPERATIONAL RESERVE

We appreciate the opportunity to also share information about the highest quality, most cost efficient Reserve component in history. As the new DOD strategy is implemented and planning occurs to conform with an increasingly austere budget environment, the Air Force Reserve and Air National Guard will continue to maximize the advantages of Associations. Associate units have proven themselves as a solid solution that exploits the strengths each component offers. They ensure that the experience and cost effectiveness of the Air Force Reserve and Air National Guard reach their full potential. This effort is critical to mission success in an environment wrought with fiscal challenges.

Recently, Congress passed much-needed legislation allowing Service Secretaries to involuntarily mobilize up to 60,000 members of the Reserve component without a national emergency. The use of this authority still needs to be planned, programmed and budgeted before it can be implemented. The Air Force is working with OSD to develop the policies and procedures to offer the fastest, most enduring support to not only the combatant commanders around the world, but to all our members; balancing their time between service to our country, their families, and their employers.

The Air Force Reserve and Air National Guard are currently sustaining combat operations in conjunction with our active duty colleagues on five continents—lengthy operations which have produced strains on our airmen and our equipment. We will continue to define the most efficient mix of Active, Air Force Reserve, and Air National Guard forces best suited to the strategy in terms of cost, operational requirements, surge or regeneration capability, and employment of Total Force assets. By ensuring optimal mix between the Regular Air Force, the Air Force Reserve, and the Air National Guard the Total Force will not only preserve previous investments in readiness, capability, and capacity, but also protect the operational expertise of the force for future use while ensuring a rapidly expandable, trained and ready military.

MILITARY PERSONNEL APPROPRIATION (MPA) MAN-DAYS

The MPA man-day resource enables the Air Force to leverage Air Reserve Component capabilities supporting military missions beyond the Active component's level of capability. In late 2009, a decision was made to implement a requirements-based MPA man-day process as part of the Air Force Corporate Structure (AFCS) fiscal year 2012 Program Objective Memorandum (POM) development process. Since the fiscal year 2012 POM build, Air Force Major Commands have worked closely with the combatant commanders to identify requirements. Once submitted, requirements are staffed, verified and vetted through the AFCS based on priorities established in the Annual Planning and Programming Guidance. Additional criteria such as mission impact, critical skills, active duty manning and level of support are also weighted to finalize the prioritization. The Air Force is committed to continuing this transparent process, which is designed to ensure appropriate deployment of Reserve Component forces, enabling the Total Force to properly respond to combatant command requirements.

INTEGRATION OF AIR FORCE COMPONENT PERSONNEL MANAGEMENT

We are committed to fully integrating personnel management policies, organizations, systems and processes across the Air Force enterprise, with the outcome of providing more effective and improved service to our airmen, reducing barriers to continuum of service, and increasing emphasis on unified Total Force decision-making. This is not only the right thing to do for our Air Force; it will drive greater operational efficiencies and allow transfer of resources from tail to tooth.

Since the Secretary of the Air Force directed the integration of the three Air Force Component Personnel Management Systems into one, personnel from across the Air Force headquarters have been working to facilitate the integration and standardization of human resource management with Total Force directives and instructions. As of this date, analysis is underway on more than two dozen human resource activities, with the high-level policy analysis phase on track for completion in May 2012. We are looking closely at existing policy guidance to standardize or consolidate management across components wherever practical and where allowed by law. This effort has a targeted implementation work plan of calendar year 2012, with follow-on actions through the Future Years Defense Plan (FYDP).

DIVERSITY

Diversity remains a top priority of Air Force senior leadership. The Air Force recognizes that a diverse force is a military necessity, and we continue on a strategic path to attract, recruit, develop and retain a diverse and inclusive workforce of highly qualified individuals who reflect the rich tapestry of the Nation we serve. In October 2011, a Declaration on Diversity signed by the Secretary of the Air Force, Chief of Staff of the Air Force and Chief Master Sergeant of the Air Force was distributed across the Air Force to highlight the importance of diversity to the mission. Additionally, we increased senior leader involvement in the Air Force Diversity Committee by adding the Major Command Vice Commanders, who provide invaluable insight on best practices throughout their respective commands. We are well on the way to institutionalizing our Strategic Diversity Roadmap, A Journey to Excellence throughout the Total Force.

Results from our 2011 Internal Communication Assessment Group Diversity survey indicated 75 percent of airmen agreed it is important for the Air Force to attract, recruit, develop, and retain a qualified, diverse workforce as a way to maintain our edge as a superior military organization. Furthermore, 88 percent of airmen surveyed believe the Air Force is doing a good or excellent job creating diversity within the Total Force.

Focus on Air Force outreach programs remains central to attracting and recruiting diverse talent. To that end, in partnership with OSD's Office of Diversity Management and Equal Opportunity, the Air Force plans, coordinates and oversees national-level diversity outreach programs supporting our diversity goals and objectives. Further, to maximize resources, we utilize a Total Force perspective to determine which events and opportunities provide the best return on investment. We have 80 outreach events planned for 2012, including the Black Engineer of the Year Awards, Joint Women's Leadership Symposium and the Hispanic Engineer National Achievements Award Corporation Conference. We continue to place emphasis on education, health, and mentoring in the Science, Technology, Engineering, and Mathematics disciplines through our community engagements, and feedback from community influencers has proven very positive thus far.

Finally, the Air Force supports the Military Leadership Diversity Commission recommendations and is poised to support Executive Order 13583, Establishing a Coordinated Government-wide Initiative to Promote Diversity and Inclusion in the Federal Workforce. Upon OPM's release of the government-wide Diversity and Inclusion Strategic Plan, we will work with OSD to develop a plan of action and milestones to support the President's goal of using the talents of all segments of society by enhancing our ability to recruit, hire, promote, and retain a more diverse workforce and creating a culture that encourages collaboration, flexibility, and fairness to enable individuals to participate to their full potential.

U.S. AIR FORCE ACADEMY

The U.S. Air Force Academy (USAFA) continues to provide an exceptional environment for educating, training and inspiring men and women to become outstanding officers, motivated to lead the U.S. Air Force in service to our Nation in a challenging global environment. Senior Air Force leadership continues to energetically engage in the Academy's oversight, ensuring cadet train, study and live in a safe and productive environment. We continue our close working relationship with the USAFA Board of Visitors (BOV), enjoying frequent interactions with Ambassador Susan Schwab, USAFA BOV Chair, who is keeping the BOV vitalized and actively engaged in providing external Academy oversight.

In the past year, USAFA cadets received numerous accolades for their undergraduate work, including one Rhodes scholar and two Marshall scholars, recognition by U.S. News & World Report as having the #2 Aerospace/Aeronautical/Astronautical Program in the Nation and #1 undergraduate-only institution in research funding-over \$70 million, and being ranked by Forbes #10 of 610 of America's Best Colleges. In addition to outstanding academics, the cadets have also excelled in athletics, being #2 of 120 NCAA Division I football programs in academic progress rates, #1 of 9 academically in the Mountain West Conference, and for the second consecutive year, the Academy's football team will visit the White House to receive the Commander in Chief's Trophy from the President. The President will also give this year's commencement address at the Academy.

Respect for human dignity is at the core of the USAFA environment. USAFA is a leader in developing programs for the prevention of and responding to incidents of sexual assault and sexual harassment, gender relations issues, and religious tolerance. The Academy is currently conducting Religious Respect Training, which involves cadets, faculty and staff, using training scenarios designed to spur critical

thinking on religious tolerance and actions. While the Academy had an uneventful "Don't-Ask/Don't-Tell" transition, it is unfortunately in the midst of investigating several cases of alleged sexual assault and illegal drug use.

USAF is working hard to preserve an outstanding training and educational environment in a fiscally challenging environment. As part of the AF response to the requirements of the Secretary of Defense's August 2010 Efficiency Memorandum, USAF is reducing its civilian workforce by 67 positions (~4 percent of its current workforce). The Academy is currently in the process of selecting members for the Class of 2016 while focusing efforts to ensure the size of that class supports the 1 Oct 2012 cadet wing end strength target of 4,000.

CONCLUSION

The hallmark of the U.S. Air Force's success has always been, and will remain, our people. Nearly 2 decades of sustained combat, humanitarian, and stability operations have imposed extraordinary demands on our forces. Yet our airmen continue to contribute significant capabilities to the joint team and do so with the integrity and excellence familiar to the global community. We will continue to size and shape the force through all necessary means while retaining an intrinsic value that attracts and keeps the highest quality airmen. We are a smaller force, but a ready force. By sustaining accessions for the long-term and balancing the total force to meet operational requirements, your U.S. Air Force, with its joint partners, provides unmatched capabilities across the spectrum of operations.

Senator WEBB. Thank you very much, Secretary Ginsberg,

I am going to ask three questions, and then I am going to move along to whichever other Senators on the subcommittee wish to ask questions.

First, Secretary Ginsberg, let me ask for your clarification on something. When I was in the Pentagon, the way the budget process worked was, first, the Services got together with their different components. They got the budget submissions. They argued against a top line. They figured out their budget. Then the different Services presented their budgets to OSD, and I sat on the Defense Resources Board (DRB) for 4 years. The DRB would examine the Service budgets. They would challenge different components of it. You came up with a DOD budget signed off by the Deputy Secretary of Defense and eventually by the Secretary. That was then brought to the Office of Management and Budget (OMB). OMB scrubbed it. Then you had a DOD budget, and it came over here to Congress. Once it came over to Congress, DOD as a whole was expected to support that budget.

Is that the way things work?

Mr. GINSBERG. Yes, sir. I think that is fundamentally the basic outline of the way it works today. We develop our budgets through what we call the corporate process. What that really does is bring together every component of the Air Force, every office that has equity in the budget, and we develop a program that is, of course, meeting the strategic guidance the President lays out then within the fiscal realities and we submit it to OSD. The other Services have a chance to look at it. We develop a program and then we submit it up through OMB.

Senator WEBB. It is a corporate process?

Mr. GINSBERG. Yes, sir.

Senator WEBB. For instance, a little more than 20 years ago, there was an Air Force Chief of Staff named Larry Welch who I had served with in the Pentagon and who was widely expected to become Chairman of the Joint Chiefs of Staff. He went over to the House side and had a discussion with Les Aspin about a tradeoff at that time between Minuteman and Midgetman missile pro-

grams, how much money would go into one or the other. He made a statement that he would personally support—in his opinion, he could personally support something that had not been in the budget. By the time he got back to the Pentagon, he was reprimanded by the Secretary of Defense.

There was an article in the New York Times yesterday about the Air National Guard lobbying the Hill against budget cuts that were in a scrubbed budget. Are you aware of that effort?

Mr. GINSBERG. No, sir. I read that article. I do not know specifically what that was referring to. No, sir.

Senator WEBB. It said for 2 months the Air National Guard, with the help of Governors from every State, has been battling the Active Duty Air Force over proposed budget cuts. I can hear Senator Graham wanting to get to the mic here. [Laughter.]

What do you think about that?

Mr. GINSBERG. Sir, I do not know exactly what that is referring to again. So, of course, there you have the adjutants general of the States who are the chief military advisors in the State role to their Governors. When they are the adjutants general, they are——

Senator WEBB. What if they are over here in uniform?

Mr. GINSBERG. What is that?

Senator WEBB. What if they are over here in uniform?

Mr. GINSBERG. It depends on what business they are carrying out, sir.

Senator WEBB. If they are carrying out this particular business mentioned in this particular article.

General Jones, do you have a thought on that?

Mr. GINSBERG. I cannot comment on a specific hypothetical. Sir, I do not know exactly again specifically the specific situation.

Senator WEBB. General Jones, do you have a comment on that?

General JONES. Senator, I am familiar with the article you are speaking of. When we prepared the budget, it was a budget that was designed to look at the new strategy, a balanced approach, and that is certainly what the Chief and the Secretary feel like they need to bring forward that balances the requirement for the Guard, the Reserve, and the Active Duty to coexist to support each other in a role that allows us to use each to their strengths. I feel like that is the proposal that was laid out by the Chief. Obviously, some people have opinions of the proposals and the details of it. But I really feel like the budget was something that was put together. The proposals were vetted. They were discussed, and it was a collaborative effort or a cooperative effort. Not every decision was agreed upon 100 percent, but when you have to make decisions, they will not all be agreed upon.

Senator WEBB. We may end up coming back to that or someone may end up coming back to that.

General Milstead, you and I had a discussion about this. This is the front page of the Marine Corps Times this week. Grunt training for women starting now, infantry school admissions, new combat tests, et cetera. The Internet is abuzz with this decision. There are a lot of people wondering what the inception of it was, what the plan is. I think this is an opportunity maybe for you to explain how this decision took place, how you project this moving into the future as well.

General MILSTEAD. Yes, sir. It is important to put that story and the story that was in the New York Times as well in context. It is also important to make sure that folks understand what it is and, more importantly, what it is not.

Assignment policy for women has not changed. We are not training women to be infantry officers. We do not have that authority. That authority resides with Congress.

What we are doing is deliberate research. If I may, the National Defense Authorization Act (NDAA) for Fiscal Year 2011 directed OSD and the Services to review the policies and the laws and the regulations that pertain to women in the Service and to report back. They stood up a working group with members from all the Services and they reported back in February. That report included a request from Congress to conduct an exception to policy and what we call a pilot program. It also asked for the authorities. It stated that they were removing the collocation restriction, and then the Secretary further directed—

Senator WEBB. Just for clarification, what was that request? What was the nature of that request when you said the report included a request for a pilot program? All Military Occupational Specialists (MOS)?

General MILSTEAD. Thank you, a request to take open MOSs and to establish them at a lower level. For instance, in the Marine Corps, we did not have women below the division level in certain MOSs. So it was a request for an exception to policy to take a woman in an MOS that she is already authorized to serve in and put her down to the battalion level. We intend to do that as part of the research.

The Secretary further tasked the Commandant and the other Service Chiefs to come back to him in 6 months and give him their personal recommendation. So what we are doing is we are doing a measured, responsible, and deliberate research, a comprehensive plan, so that the Commandant, when he does give his recommendation to Secretary Panetta, it will be based on an analyses. It will be based on quantitative information and on research, and it will be an informed recommendation.

Senator WEBB. To clarify the record, because there are a lot of people who are following this, what I understand that you are saying is that this is pursuant to a request by the Secretary of Defense. The opening up of infantry schools, et cetera, is pursuant to a request by the Secretary of Defense for the Commandant to give him a report in 6 months on feasibility.

General MILSTEAD. That decision was ours. We felt that we could take volunteers—and they are volunteers. They have to be volunteers under the protocols—take women officers when they come out of the basic school, women volunteers, subsequent to the MOS that they will be going to, to attend the Infantry Officer Course (IOC), not to become infantry officers, but to see how they do and to capture data which will be given to the Commandant which will allow him to make an informed recommendation to the Secretary how we proceed.

Senator WEBB. We need to understand the origins of this experiment. That is why I am trying to get it clear for the record. The NDAA gave a broad recommendation, as I understand what you

are saying. Then the Secretary of Defense gave a further request that within 6 months certain recommendations from the Services come to the Secretary of Defense?

General MILSTEAD. That is correct.

Senator WEBB. This is pursuant to that request?

General MILSTEAD. The decision being within our own wire. It is the Marine Corps. He did not tell us to open IOC. The Commandant—we came to him with a research plan and said we want to push people down to the battalion level, assess that. We want to take some women. We want to put them into IOC, see how that comes up. We want to come up with common gender-neutral standards. We want to do a test based on physical fitness for both men and women to see what the level playing field is. It is all to come to the Commandant and allow him to make an informed recommendation to the Secretary of Defense on the way he thinks that we should proceed.

Senator WEBB. So when a male officer finishes IOC, is he automatically entitled to one of two MOSs? Right?

General MILSTEAD. Yes, sir. That is correct.

Senator WEBB. So, if a female officer finishes IOC?

General MILSTEAD. If a female volunteer attends IOC, it is not for the purpose of getting the 03, 02, or 02, 03 MOS. She will not receive that MOS.

Senator WEBB. But if she successfully concludes—

General MILSTEAD. Even if she successfully completes. This is not to make female infantry officers.

Senator WEBB. You are going to get a lot of comment on that.

General MILSTEAD. Yes, sir.

Senator WEBB. Secretary Lamont, very quickly, because I wanted to ask a question of each of your Service representatives. Eight years ago this week, I spoke at the Army Infantry School on a lessons-learned package that they had talking about my experiences in Vietnam. That night, we had a reception at the commanding general's house, and they informed us that Pat Tillman had been killed. I think, first of all, it is a little sad that we are not remembering what this individual did for the respect of the military, leaving millions of dollars behind and voluntarily enlisting and going over and serving.

But what happened after that, the way that his death wrongly characterized, apparently even when the Army knew it was a friendly fire incident, and the existence of private communication inside the general officer corps warning the Army that this was a friendly fire incident—even his family did not know it—was a really tragic circumstance for the family, and I think a stain on the Army's reputation.

We then had an incident at Wanat where certain commanding officers were held accountable by a U.S. Central Command (CENTCOM) investigation and then their accountability was removed by the Department of the Army subsequently.

We just had an incident not too long ago with a soldier who apparently was shot by his own platoon leader accidentally during a night engagement but was left on the battlefield when others were evacuated, and there does not seem to have been a lot of accountability.

Maybe, General Bostick, you would like to comment on it, either or both of you. What is the Army doing in terms of reinforcing the notions of the accountability of senior leadership?

Mr. LAMONT. I am certainly aware of the situation with that captain, as I recall. Actually, I think he may have been a 1st lieutenant at the time. As I understand it, it was at night. They did not have awareness of where the fallen victim was until later. I do know he was reprimanded. Unfortunately, I also understand he was subsequently promoted. But I do recall that there was a significant review, and, in fact, the Secretary, as recently as 3 weeks ago, I think, met with the father of the young victim.

General BOSTICK. First, our heart goes out to all of the loved ones that have lost soldiers on the battlefield.

We realize that in our Army and the way we fight, we place huge responsibilities on the shoulders of young sergeants and lieutenants and captains. They have to make on-the-spot decisions that sometimes are life-threatening-type decisions. We count on them to do that every day.

We also count on leaders to train them and to be accountable for their behaviors. When things go wrong—and they always will in war—then we expect to thoroughly investigate each one of these incidents. That is what happened in each of these.

I can tell you in the case of Wanat, my wife taught that young man when he was in elementary school. So for us, it had special meaning, and I know the parents very well. I know Hondo Campbell, who was asked to review the situation by the senior leadership of the Army, took in the new evidence that came on board, and he made his decisions, and the Secretary of the Army stood by those decisions.

But I think in each one of these cases, our responsibility is to make sure that if an investigation is due, it is thorough, it is proper, and that we report back to the families and we provide the care and compassion that they need to get through it.

Senator WEBB. Thank you.

Senator GRAHAM.

Senator GRAHAM. Thank you, Mr. Chairman.

Secretary Lamont, you mentioned efforts to deal with sexual harassment and sexual assaults in the Army and the military, in general. Is there anything this subcommittee can do or tools we can provide or money we can appropriate or recommend to be appropriated that we are not doing?

Mr. LAMONT. I would hesitate ever to say you do not need to give us any more money. But on the whole—

Senator GRAHAM. You do not have to give a definitive answer today.

Mr. LAMONT. Right, and I appreciate the opportunity to do that.

I think we are making every effort, frankly, to create the kind of professional climate that gives to every soldier the dignity and respect that he or she deserves. I do not know that it is a money question. Although under the new NDAA requirements that we shall have sexual assault counselors and victim advocates at the brigade level, we understand that our numbers would suggest roughly 980 personnel. The fact that we are under a civilian cap now at OSD will in itself create some problems because we will

have to have a mix of both civilian and military to meet those requirements. I think right now that is the only thing that I would suggest that we would need from this committee.

Senator GRAHAM. Can I ask the same question of the Navy and the Air Force?

Mr. GARCIA. Senator, I would say that we believe we have the resources and the commitment and the emphasis on the issue, that we do not need any extra tools. You asked this question. At the end of our "sexual assault awareness month" where every unit in the Department of the Navy has just had four separate stand-downs over the course of this month to emphasize the priority that our leadership has in ending this scourge of sexual assault and harassment across the force.

I am certain you are familiar with the Secretary of Defense's new guidance on convening special courts martial at the O6 level.

Prior to this across the Navy, we have trained our Naval Criminal Investigation Service personnel to be dedicated field experts in capturing and sustaining and protecting evidence in crime scenes. Our Judge Advocates General and our Staff Judge Advocates are trained in the most effective prosecution strategies where appropriate, expedited transfer for members who request it within 72 hours. That is all on the response side.

If I could take one more second to speak to the prevention side. Every new sailor or marine in our department right now, when they go to their A school, their first training school, will receive bystander training, bystander intervention training. Every leader, enlisted leader and officer leader, will be trained in ensuring their command environment eliminates the stigma for an individual, preventing an individual from being willing to report such an incident.

You may have followed—I guess it has been about 3 weeks now. Our Secretary, our Commandant, our Chief of Naval Operations rolled out our new 21st Century Sailor and Marine Initiative, and a key cornerstone of that, the readiness piece, includes an effort to end sexual assault and acknowledge the undeniable correlation, the link between irresponsible alcohol use—close to 50 percent of our sexual assaults involve it in some way or another, and that is why we are introducing the use of breathalyzers that I suspect you are familiar with.

So I think we have the tools to combat this.

Mr. GINSBERG. Senator, there is absolutely no place in the Air Force for sexual assault. This is really everyone's responsibility. It is a command responsibility. It is every airman's responsibility to not just go after those who perpetrate this action but also to create a climate that reduces the likelihood of this occurring. We are not just following up the direction, of course, that of Secretary Panetta who has, as Secretary Garcia laid out, mentioned later a whole series of actions from elevating the level for a disposition of case to the O6 level, but we are also taking a number of steps on our own, including putting \$2.4 million for additional Office of Special Investigations investigators.

As Secretary Lamont mentioned, though, there is going to be an additional resource requirement with the additional full-time victim advocates, and we are going to address that in the fiscal year 2014 budget.

Senator GRAHAM. I think the committee would appreciate in writing anything that you need from us, Uniform Code of Military Justice changes, regulatory changes, funding requirements, new positions, so that we can say in Congress we have done everything within our power to help you do a job that needs to be done and, quite frankly, has to be dealt with more seriously. So if you could do that in the next week or 2, we would appreciate it.

Senator Webb brought up the conflict between the Reserve component and Active Duty component in the Air Force. I just want to say I have not been visited by anybody from the Air Guard to tell me what to do or not do about the proposed force structure. I have decided that on my own, right or wrong, that 5,000 out of the Air Guard and Air Reserve and less than 1,000 out of the Active-Duty Force is probably not the right mix. Some of the airframes that we will be retiring—I am not so sure that is wise. In a down-sized world, you have to have the right mix of Active Duty, Air Reserve, and Air Guard personnel.

The Council of Governors entity—what is the latest on that?

Mr. GINSBERG. Sir, I think you have received—

Senator GRAHAM. Yes, I think we got it yesterday.

Mr. GINSBERG.—some correspondence, but their proposal from Secretary Panetta is basically to put back 24 C-130 and about 2,200—

Senator GRAHAM. Right.

Mr. GINSBERG. Sir, if I could just talk about that. Obviously, we talked about hard choices in my opening statement. This is, of course, one of the many hard decisions that the Air Force had to make. We had a new Strategic Guidance that came from the President that talked about being more flexible, agile, told the Air Force that we were going to have a very high operational tempo over the long term.

At the same time, we had the BCA, \$487 billion off the DOD top line over 10 years. For the Air Force, that meant about \$54 billion over a 5-year period over our FYDP.

So in order to meet the strategy and to be responsive with the limited resources, we had to feed in overseas presence. We had to maintain rotational demand and make sure that the operational tempo was manageable across not just the Guard and Reserve and Active. So we were really concerned about balancing the budgets on the backs of our people.

Senator GRAHAM. I got you. I met with General Breedlove and Secretary Donley and had a real good discussion about what went into the decisionmaking process.

The question for me and I think Members of Congress is \$487 billion, given the threats we face—is that too much? I think certainly we need to do north of \$400 billion, but when it comes to the Air Force, the Reserve component got hit pretty hard.

This Council of Governors negotiation, I think, is an appropriate thing for you to be doing because they are affected by the decisions. Hopefully, we can find some compromise that people will feel comfortable that we have the right mix particularly in the Air Force. I do not think it is really a concern in the other Services.

But my final question is as we go forward in a down-sized environment of having to reduce the military, the Army by 80,000,

what should the Nation know about future conflicts in terms of how we meet future land engagements? Hopefully we do not have another Iraq, Afghanistan war anytime soon, but the possibility of a large land force being deployed is not unheard of or impossible to imagine in the future.

General Odierno told the Appropriations Committee that if we had another Iraq-like conflict where you had a large number of forces deployed over a fairly significant period of time, that with the reduction of Active-Duty Forces of 80,000, that 50 percent of that combat power and support power, personnel, would have to come from the Reserves and the Guard. Does that surprise you, Secretary Lamont?

Mr. LAMONT. Not greatly. Clearly we are going to be in need of a significant operational Reserve. To the extent that we have the trained and ready forces to support a smaller Active component, it is absolutely essential.

Senator GRAHAM. The only reason I mentioned that is, I think, that probably is true, and that does mean the Air Guard and the Air Reserve who do the fighting and the refueling and the transport—we have to look at the Guard and Reserve anew. If our Active Duty component is going to be reduced to the point, at least on the Army side and probably to the Air Force side too, where the next major engagement will be one out of two people will be a Guard member or a reservist for a very long period of time, we will have to come to grips with that as a Nation. Is that where we want to go? If we want to go, we will have to plan for it because I do not think anyone has ever planned for that before.

Mr. LAMONT. I think we have to be very careful because as we reduce the Active component of the Army, we may very well find it necessary to shift further capabilities into the Guard and Reserve. If we are going to do that, then we better make sure they are trained and ready to go. So as we get into the budget process, we have to ensure from our standpoint that we have sufficient funds for not only full-time support to assist the Guard and Reserve, but to also have the training monies. We are very good right now on the equipping level, but we are a little concerned that we have sufficient and adequate funding to train them at the readiness level that we know we will need to do.

Senator GRAHAM. Thank you. Mr. Chairman.

Senator WEBB. Thank you, Senator Graham.

Just as an aside on your very important question, when I was responsible for the Guard and Reserve programs in the 1980s before this current evolution that we see in Iraq and Afghanistan, the way that the total force was designed at that time was approximately half of the combat support and about two-thirds of the combat service support, as I recall, in the Army was in the Guard and Reserve. They wanted to keep the immediate deployers, the combat units, fully manned up to, I think, 18 divisions at the time. We are probably going to end up with a similar formula as we draw down.

General Bostick, what was the Army's Active Duty strength on September 11? Do you recall? The point being, just to get to it, is that the number you are going down to now is slightly above where it was on September 11. Is that not correct?

General BOSTICK. Yes, Senator. It was about 482,000–483,000. We are going to come down to 490,000.

Senator WEBB. Are you comfortable with that number? Is the Army comfortable with that number?

General BOSTICK. I think, Senator, given the strategy that has been laid out, we are comfortable given the assumptions that we can make. We are never very good in the assumptions that we make about the future, but given the assumptions that we have made, given the strategy that we have outlined, we are comfortable that if we stay on the ramp that we are on in terms of drawing down the Army end strength, that we can do this in a reasonable way and take care of soldiers and families as we come down and still meet the missions that we have been asked to do.

Senator WEBB. Thank you.

Senator Ayotte.

Senator AYOTTE. Thank you, Mr. Chairman.

General Bostick, if I can just follow up on the end strength reductions on a couple of different fronts. First of all, with the 72,000 in end strength reductions in the Army, how much—call it what you want, how much latitude did you build in there? How much contingency did you build in there? Where are we in terms of being on the edge of a position where we could put ourselves in a place where we would hollow out our force? As we think about 72,000, how much did we build in there that we may have made a mistake in terms of future contingencies that we are asked to respond to?

General BOSTICK. From an operational standpoint, Senator, I would say again, given the strategy that has been outlined from the President, we look at that strategy, develop a force structure, and then our job is to man that force structure. So based on the strategy and the assumptions that go into that strategy, if we can stay on the ramp that the Secretary and the Chief have asked us to stay on through the end of 2017, there will be risks there but we believe we have mitigated the risk as best we can.

Where we can get hollow is in a number of areas. A lot of folks think about hollowness of a force in terms of people. But the Chief and the Secretary have said that they need a balanced force, and we are not going to retain force structure to hurt ourselves in readiness, and readiness could be in training readiness, it could be in the quality of life for our soldiers and families, it could be in modernization. So currently the biggest portion of our budget, 45–46 percent of our budget, is in personnel and it is in manning. So we have put the risk in other areas beyond personnel.

Senator AYOTTE. What are our current dwell times and where would the end strength reductions—where will we be with dwell times? Also, can you tell me what the dwell times are in particular for the military occupational specialties?

If what you have told us thinking about we have an unanticipated contingency because, as you have noted, we have been particularly bad at predicting our next conflict, where does that bring us in terms of needing to reverse the Army's end strength reductions?

I know that is a series of questions, but if you can help me where we are with dwell times, where does this bring us with the end

strength reductions. It is one of the concerns I have about the readiness of our forces.

General BOSTICK. The dwell times—and it is a difficult question to answer simply because dwell is an individual metric. If you add it all up, when I testified last year, the dwell was about 1 to 1.5. Today it is about 1 to 2. But there are MOSs like our aviators, our infantry, and those low-density MOSs that have much lower dwell times. It varies on grade. So if you are a young junior enlisted, then your OPTEMPO and your dwell is lower than a senior officer or a senior non-commissioned officer (NCO). But if you add it up across the Army, it has been a long time that it has taken a reach of 1 to 2 dwell, but we are there now except for some of the key MOSs that I talked about later.

We are very concerned on end strength as we come down. If we come out of Afghanistan as planned in 2014, that is when the majority of—our bigger end strength reductions will happen in 2014 and beyond. So the temporary end strength increase of 22,000 that Congress and the Secretary of Defense have authorized us to have is helping us meet the demands of our deployers. So we have no issues with meeting our deployer strengths at their late arrival dates, have had no issues with ensuring that they are able to have end strength in addition to compensate for their disability evaluation system, the soldiers that are involved in that. So from an end strength perspective and the glide path that we are on, I feel fairly comfortable as long as we are able to maintain the Overseas Contingency Operations (OCO) dollars. Everything above 490,000 is not in our base. It is an OCO. So that is something that we have to fight for each year.

In terms of your last point on reversibility, we have asked Congress for the ability to increase the affiliation bonus from Active component to Reserve component from \$10,000 to \$20,000, and we think that will allow us to put more of our NCOs and officers that are leaving the Active Force into the Reserves. What the Chief and the Secretary have asked us to do is put some of our young captains and senior NCOs in drill sergeant status and recruiting, more of them in those positions and more on the platform in our institutional Army, if you will, so that if we had to grow the Army quickly, the part that we cannot grow is our mid-grade officers, our mid-grade NCOs. So if we have them in some of our school locations where we have pulled them out or converted it to civilian positions, we would have some flexibility to grow the Army.

Senator AYOTTE. How many are going to receive involuntary termination in terms of officers and NCOs with the drawdown, the 72,000 drawdown?

General BOSTICK. I do not have a specific number on that. We have asked Congress for the authorities to have involuntary separations. There will be some officers and there will be some very good NCOs that will want to stay in the Army and will probably not.

What the Secretary of the Army and the Chief have said is that is our last resort. They want to do this without involuntary separations. Also on the voluntary separations like we had in the 1990s, we open it up to everyone, and a lot of our very best folks would leave.

We think we can manage it, but there will be some especially in the 2014–2015 timeframe that on this ramp will have to leave by other than natural causes.

Senator AYOTTE. General, I would really very much appreciate if you could get us an estimate of how many involuntary terminations there will be both in the commissioned and then the NCOs.

Also, I think it is really important for people to understand, as I understand it, that some of those people that are going to get involuntary terminations have done multiple tours for us in these conflicts that we have been fighting.

Mr. LAMONT. Could I just very quickly address a couple of your issues? You have mentioned the dwell time, but I want to let you know, we are moving our deployment cycle down to a 9-month cycle. So we hope that will help reduce some of our stress on the force and maybe even eventually, as we reduce in Afghanistan, our dwell time will then rise.

As you say on the hollowing out of the force and our concern with our assumptions, the problem is the enemy always gets a vote. We never know what the enemy is going to do. We do not know what contingencies are going to arise, and we must be extremely careful in how we plan for reversibility and expandability as necessary.

Just on some of the numbers, I hate to throw out numbers, but I have seen numbers that will approach in the enlisted category perhaps as high as the mid-20s, 23,000, 24,000, and on the officer contingent—again, these are very rough numbers and all based gain on assumptions and attrition rates, but officers may go up to 4.5 to maybe 5,000.

Senator AYOTTE. That is a very significant number for many who have done multiple tours for us. So I think the American people need to understand that in terms of some of the choices that we are making.

I very much appreciate all of your being here. I have some follow-up questions that I will probably submit for the record on other issues. Thank you.

Senator WEBB. Thank you, Senator Ayotte.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman.

Thank you all for your excellent work in a time of great challenge, and thanks to all the men and women who serve under you.

I have some questions that really relate to the responsibilities that will be increasingly important placed on our Reserve and National Guard and in particular on the transition assistance that we give them as they come, many of them, off Active Duty to go into the Reserve, which has been a focus of mine, and also on the employment opportunities once they return to civilian life.

I am troubled by reports—and you may want to comment on them—that there are instances of discrimination. I do not know how to put it any more politely, but discrimination against reservists or National Guard because of the possibility that they may be deployed and therefore unavailable in their workplaces, number one.

Number two, whatever transition assistance we can give them while they are in the military but also afterward when they are in civilian life, a Transition Assistance Program (TAP) type of assist-

ance. I know that many of the Services—I am most familiar probably with the Marine Corps and what it is doing to expand the TAP.

I would ask you to comment on those areas of transition assistance and employment opportunity when our Reserves and National Guard come off Active Duty and also the kinds of help we are giving to our veteran services.

Secretary Ginsberg?

Mr. GINSBERG. Senator, thank you. There are a couple issues there that you really raised that are very critical for our Air Force and our future. There is a very key readiness concern there that if our Guard and Reserve airmen do not feel like they have the support of their employers, they are not going to be raising their hands to volunteer for the missions, whether a pop-up contingency or some type of steady state action. So we need to make sure, in addition to the family support and the direct support we provide them, that we have the backing of their employers. So this is absolutely vital for our Air Force, and what we have been trying to do is communicate across the force to the families, to the employer partners that we are going to really need our Guard and Reserve over the long term.

Of course, if an airman does have a problem, we encourage them to file a real complaint, obviously, to be investigated by the Department of Labor. So very vital there.

But the other issue there, sir, is the one you mentioned about the transition support, and that is a realm where the President has made it a very top priority. We are going to be working to make TAP available to our Guard and Reserve in a way that really has not been available to them over the long term. So any Guard and Reserve member who goes on a deployment over 180 days is going to be eligible for a full range of transition programs, counseling, resource databases. That is all going to be put at their fingertips. But we are moving out on that and it is a key concern to us.

Senator BLUMENTHAL. Thank you.

Secretary Garcia?

Mr. GARCIA. Senator, thank you for your question.

We too have heard anecdotally accounts of our reservists having difficulty in employment and coming back to returning employers. We have run each case to ground.

But I think I would have to point out as well the other side of that coin, that on the Navy side alone, we have mobilized 67,000 reservists for year-long mobilizations over the course of this war. The Navy reservist model is a little bit different. They tend to follow their Active Duty service. They tend to be a little bit older demographic. The overwhelming evidence is that supporters, especially against the backdrop of a struggling economy, with these Navy personnel have accommodated in many cases voluntarily paying the differential between their mobilized salary and that which they have made in their civilian capacity, and it is real patriotism.

Our Marine Reserve model is a little bit different. Those cases that have run up against the regulations and the law, and those cases—we have run each one to ground.

Secretary Ginsberg mentioned the work we are doing with our counterparts at Labor, OMB, and the Department of Veterans Af-

fairs (VA) in fleshing out the details of the Veterans Opportunity to Work to Hire Heroes Act of 2011, known as the “VOW to Hire Heroes Act.”

But above and beyond that, the TAP reform that both Services are doing, initiatives like the American Corporate Partners, where heads of a stunning number of companies across America have reached out to serve as mentors for our separating personnel as they go through TAP. Within the Department of the Navy, every separating member, to keep them on the team to the maximum extent possible—for example, at Naval Sea Systems Command which is our largest civilian hiring entity, we set a goal of hiring 365 departing members last year, one a day, and we have hired 500. We have set a goal for 300 this year.

So the transition process is receiving full priority.

Senator BLUMENTHAL. I do not mean to disparage employers in general. I think that the instances of alleged discrimination or non-hiring are a small minority, but as Secretary Ginsberg said, they create disincentives that may have a ripple effect or ramifications beyond that. I agree with you. My impression is the vast majority of employers want to do the right thing.

I am very interested, I know Senator Graham has asked about sexual assault, and I commend the Secretary of Defense and all of you who have taken a really increasingly hard line on that issue. But I want to ask about an unrelated issue—and I would like to follow up in questions because I want to give my colleagues a chance to ask some questions and that is, suicide prevention. How are we doing? Any progress to report? Any comments for us?

Mr. GARCIA. I had the opportunity to respond to Senator Graham’s question earlier. General, do you want to start this one off?

General MILSTEAD. Of course, one is too many, and nobody is dancing in the end zone, but we are doing better. If you look at the numbers, calendar year 2009 was the dark year for us. We were at 52. The next year we came down to 37, and this past year we were at 33. So the glide slope is right, but again, until you get a zero—and so far this year we are at 12, a little bit ahead of where we were last year, but I am not sure what that means.

We continue to work this. In the Marine Corps, we have given this to our NCOs. We continue with our training. Now we have a training program for our junior marines, for our NCOs, and then for our young officers and staff NCOs, our platoon sergeants and our platoon commanders. But the NCOs—those are the guys that have their fingerprints all over the guys and gals, where we see this, the young ranks.

So we are optimistically hopeful, but this is something that we will continue to work at until we have zero. As you are well aware, Senator, this is a national problem. It is just not within the military. But it has the Commandant’s attention. It has all the Services’ attention.

Admiral VAN BUSKIRK. Senator, I would like to add we are also putting more resources towards it, and just recently we have added—we have operational stress training teams out in the fleet concentration areas that can be out there among our sailors, our men and women, out there so they can help train our leadership to identify the signs of increased stress with our servicemembers

and then additionally be a resource that they can actually go on board the ships to help counsel our people as well.

24/7 hotlines as well that we are manning to ensure we have the people available to counsel at any time a person has some indication that they may have some problems.

So I think adding that and adding additional leadership focus to this is critical. But certainly we do not like the trends we are seeing across the Services and we want to continue to combat and put the resources against it, sir.

Senator BLUMENTHAL. Thank you.

Mr. GARCIA. If I could just punctuate that point, Senator. I think in some part what makes this such an agonizing problem, each of us reviews the operations reports each morning from the night before, and to try to discern a pattern in these cases is so difficult. Across the Department of the Navy, we will typically see about five and a half suicide events per day, that is, ideation, attempts, or in the worst case, the act. It is not rare to have days, five and a half more incidents, where the members involved have never deployed. It is difficult to make the correlation, the formal link, between the operational tempo and the deployment piece.

It took me a while to get to this point. What I take some comfort in is that an ideation event, if it does not culminate in an attempt, or, God forbid, the actual act, I want to believe is a sign that we are making progress in that a sailor or marine knows the resources to go to. His shipmates, his fellow marines, are recognizing the tell-tale signs and are reaching out and getting information to the right people.

Senator BLUMENTHAL. Thank you, all. I really appreciate your excellent answers. Thank you.

Thank you, Mr. Chairman.

Senator WEBB. Thank you, Senator Blumenthal.

Senator Vitter.

Senator VITTER. Thank you, Mr. Chairman, and thanks to all of you for your service. In that vein, by the way, we just had Navy Week in New Orleans associated with commemoration of the War of 1812, and I got to meet a number of servicemembers. They happened to all be Navy. But I tell you what. We have a lot of problems and a lot of challenges, but it is not the young people in the military. So thanks for your leadership and thanks for them.

I have some questions focused on some concerns I have with the cuts and proposals as it affects Louisiana. Let me put it in context. Look, these are very tough budget times. There are going to be a lot of decisions that are not popular to different States, and we all get that.

I think what frustrates me and some other Members are two things.

Number one, in a lot of these cases, we are not given and we do not see, even after digging, a clear metric and a clear justification and rationale.

Number two, in a lot of these cases, I see jointness going out the window at a time when greater jointness, including greater efficiency, is more necessary than ever. In some of these decisions, I personally see the stovepipes hunkering down and sacrificing jointness and through it, greater efficiency.

So that is the context of some of these concerns and questions. Specifically the Air Force—and I will ask you, Mr. Secretary—is recommending to cut out the 917th Fighter Group at Barksdale, the A-10s there. Now, when we looked into that, when we asked the folks on the ground in Louisiana, including the Army folks at Fort Polk who they help train, those folks on the ground said that about 70 percent of all of the joint Air Force/Army training at Joint Readiness Training Center (JRTC) at Fort Polk use that 917th Fighter Group during the Green Flag East exercises. So there was tremendous appreciation of that participation in that joint training.

When we asked the Air Force—I just got a letter from the Secretary, and his response was that the same 197th group has only fulfilled its requirement, meaning that training, once over the last 3 fiscal years.

Now, this is not a 10 percent difference of opinion. This is different planets, and so it is very concerning to me when you get wildly different statistics and numbers behind a decision. How am I to reconcile those wildly different statistics?

Mr. GINSBERG. Senator, I certainly will reconcile the numbers for you. We will go back and validate and we will certainly get back to you on that.

I will say a couple of things. One is on the decision to retire the A-10s, that was based on our force planners' assessment of what the future demand was going to look like, what was the range of scenarios that the Department of the Air Force would have to support the joint war fight in and what was the overall capacity of aircraft that were needed for that. A decision was made to take down more A-10s than F-16s because the F-16 is a multi-role aircraft versus the A-10 which is more single purpose. So that was the decision to take down—that was the approach to take down the capacity.

In terms of where the specific units were in the distribution among the Guard and Reserve, it was similar to what I talked about. The thought was similar to what I mentioned before, that in order to maintain the overseas presence and to maintain an acceptable level of operational tempo across our force, to do more of those reductions in the National Guard and Reserve. So that was the overall thought process there.

Sir, I would just like to highlight that. If there is a unit at JRTC that is in the box, ready to go deploy, whether it is the 917th or an A-10 unit from Moody Air Force Base in Georgia, that is a valid requirement, and in the same way that the Air Force plugs in with its Service counterparts down range, it will do so here in order to make sure that our comrades are ready to go and that we can train like we fight every day. So that is something we will be working through.

But, sir, I do want to make sure we are providing you all the information that you need.

Senator VITTER. Certainly, I would like that follow-up and reconciliation.

More broadly we have asked for specific savings numbers and analysis for that, as well as Louisiana National Guard 259th Air Traffic Control Squadron from DOD. The only thing we have gotten are conclusory statements or the decision or a letter with a para-

graph explanation. We have constantly, many times over, asked for a specific cost savings assessment. If you can get that to us more broadly.

[The information referred to follows:]

The new Defense Strategic Guidance states that U.S. forces will no longer be sized to conduct large-scale, prolonged stability operations. Analysis based on scenarios consistent with the Strategic Guidance resulted in a reduced requirement for tactical combat aircraft and a preference for multi-role fighters to provide the most flexible capability within each scenario. As a result, A-10 retirements were selected in lieu of other combat aircraft and the Air Force made the difficult choice to retire five A-10 squadrons comprised of 102 A-10 aircraft. Previous reductions in fighter force structure shifted the Total Force ratio toward Reserve component forces, and Air Force decisions in the fiscal year 2013 President's budget request (20 A-10s from Active Duty, 61 from the Air National Guard, and 21 from the Air Force Reserves) rebalanced that ratio to create a more sustainable force structure over the long term.

Before I explain how we determined where to take the A-10 reductions out of the Air Force Reserve, I'd like to clarify the discrepancies you noted in the A-10 taskings for the 917th Fighter Group and their support of the Joint Readiness Training Center (JRTC) at Fort Polk. The Air Force has formally tasked the 917th Fighter Group one time through the Air Combat Command Consolidated Planning Schedule. However, due to their proximity to Fort Polk, the 917th Fighter Group routinely accepts ad-hoc requests from the JRTC for close air support training outside of Air Combat Command Consolidated Planning Schedule.

The Air Force Reserve reduction of 21 A-10 aircraft required a decision between two unit-equipped bases, Barksdale and Whiteman AFB. The Air Force Reserve employed four realignment strategy principles that influenced the selection of specific locations for aircraft reductions. It first ensured aircraft reductions would not negatively impact operational support to the combatant commands. Second, it considered if force structure movements would create any new Air Force bills. Third, it attempted to minimize risk by optimizing crew ratios to exploit expected increase in mission capability rates. The final principle considered locations that continued to have an Air Force mission due to the presence of another Air Force component. In addition, although not stated as one of the four guiding principles, our sphere of influence also factored in and allowed for maximum reversibility at minimum cost.

The decision between Barksdale and Whiteman Air Force Base (AFB) Reserve A-10 units was difficult, as both units are tenant organizations on Active Air Force installations, have excellent recruiting capabilities, sound track records of performance, and provide support to joint warfighting and training. Ultimately, the Air Force Reserve determined that the B-52 classic association at Barksdale AFB would be best positioned to absorb some of the adverse impact of closing the A-10 squadron at Barksdale. Conversely, the A-10 unit at Whiteman AFB is a stand-alone tenant unit. Closing the Whiteman unit would make it difficult to absorb the personnel. The Air Force will continue to provide support to joint warfighters at the JRTC through the Air Combat Command Consolidated Planning Schedule system.

By divesting the A-10 squadron at Barksdale AFB, the Air Force expects to save approximately \$336 million over the Future Years Defense Program. The savings account for operations and maintenance personnel, flying hours, aircraft modifications such as wing replacements, and depot sustainment funding.

The decision to divest the 259th Air Traffic Control Squadron (ATCS) was based on the lack of an Air National Guard flying mission assigned to the Alexandria International Airport. The cost savings to the Air Force will include cost avoidance for the purchase of a next generation deployable radar and deployable instrument landing system as well as non-flying and depot level repair cost savings that exceed \$500,000 per year. Additionally, the manpower saved by divesting the ATCS allowed the Air National Guard to realign the corresponding end strength towards bolstering readiness in areas such as aircraft maintenance, intelligence, surveillance, and reconnaissance, and domestic operations.

Senator VITTER. On the 917th, if it is true that they have participated in a big number, a majority—folks on the ground say 7 percent of that training at Fort Polk—what will be the replacement for that type of training?

General JONES. Senator, I think it is important that when they talk about what will be the replacement, not that they ask for what

type, what specific aircraft, but what capability. That is where we were stuck with the tough decision to have to eliminate single capability aircraft to go with multi-role aircraft so we could bring in something that could do more than just one thing. So what we would be providing them is a multi-role aircraft that could perform the same function the A-10 was performing.

Sir, if I could just go back and comment on one thing you said earlier about jointness, the question of Services hunkering down and trying to back away from jointness—I really do not agree with that. I would have to tell you that having served in the U.S. European Command when I was a younger officer, having been the J-1 at CENTCOM during much of the conflict when General Abizaid was the commander, we are all so bought into jointness that it would be impossible for us as a department to walk away from how we fight now. We fight as a joint, integrated team. Our leadership teams are integrated. Our relationships across the Services have been solidified, and that is the only way we will be going to war in the future.

Senator VITTER. Okay. To follow up on that thought, regarding this A-10 decision, let me ask your Army colleagues when in the process was the Army consulted regarding the impact of this A-10 decision? How early or late and who was consulted about that on the Army side?

Mr. LAMONT. I frankly cannot respond to that. I will have to take that for the record and find out. I assume it would be within our G-3 staff, our training and operational concerns.

General BOSTICK. Senator, we will go back and find out, but I would agree with my Air Force colleague. We will never walk away from jointness, and any opportunity that we have to train is going to be a good opportunity for the country. So just like we cannot walk away from the Reserve component, we cannot walk away from jointness and the combined nature of how we fight is the only way that we can do this.

Senator VITTER. If you would follow up because I think it would be an interesting test of this debate to see when in time and at what level the Army was actively in a meaningful way consulted on this decision.

Mr. LAMONT. We will find out.

Senator VITTER. Okay. I will look for that follow-up, and I appreciate it.

[The information referred to follows:]

The Air Force did not consult with the Army regarding moving the A-10 mission out of Barksdale. The Air Force made difficult choices to closely align with the new Department of Defense strategy. In doing so, it favored aircraft with multi-role capabilities versus those focused on niche missions. The Air Force Reserve was faced with a fair share reduction of A-10 fleet and had to make a decision between two unit-equipped bases, Barksdale and Whiteman Air Force Base (AFB), to reduce 21 A-10s. Both units are tenant organizations on Active Air Force installations, have excellent recruiting capabilities, sound track records of performance, and provide support to joint warfighting and training. The Air Force Reserve determined that the B-52 classic association at Barksdale AFB would be best positioned to absorb some of the adverse impact of closing the A-10 squadron at Barksdale. Conversely, the A-10 unit is a stand-alone tenant unit on Whiteman AFB. Closing the unit would make it difficult to absorb the personnel.

Mr. GINSBERG. Senator, could I just say that during the development of our budgets, each Service's plan is vetted through the

other Services, and of course through our Office of Secretary of Defense overseers. So there are smaller forums and larger forums. We have our programmers, plans, and programs. We call them the "eights." They regularly review the budget submissions towards the tail end, once each Service is developed, and then our budgets go through something they call the Defense Management Action Group, and that is where the Services can look before it is submitted to Congress, before it goes to OMB. Every Service gets to peer into what each other Service is doing. Also, there are lots of communications back and forth where we highlight some of the big issues that are going to be coming forward in the year ahead.

Senator VITTER. Secretary Ginsberg, again on the Air Force side, Global Strike Command is a relatively new command at Barksdale.

Senator WEBB. Senator Vitter, I am going to have to interrupt you because we are on a 7-minute clock, and a vote has been called. I know Senator Brown wants to ask a question. You could submit that question for the record as can anyone else on the subcommittee before close of business tomorrow night.

Senator VITTER. I will submit that for the record. Thank you, Mr. Chairman.

Senator WEBB. Senator Brown.

Senator BROWN. Thank you. I will be brief. Thank you.

How much time do we have before the vote?

Senator WEBB. The vote has been called.

Senator BROWN. I will be done long before then. Thank you.

General Milstead, first of all, I am encouraged to hear that General Amos is opening up some slots for the training of women at Marine Corps Infantry School right down the road in Quantico. I want to commend him for that.

I read a quote from General Gray who said every marine is first and foremost a rifleman. All other conditions are secondary. I agree with that also. I am a strong proponent of women in combat, providing they fit the qualifications.

Where do you think the perception comes from that somehow female servicemembers could, "compromise the mission"? Have you heard that? Do you think it is relevant? Do you think it is something that is being handled appropriately?

General MILSTEAD. Sir, again, I do not believe the Senator was in here when I first responded to Senator Webb's response that this is research so that the Commandant can make an informed recommendation to the Secretary.

But we have approximately a little over 13,000 women marines. I have been in combat twice with them. They are in combat. That is a misunderstanding of a lot of people. Our women are in combat. I am a Cobra pilot. We have women Cobra pilots. But we are talking a difference between closed and open MOSs. Our women marines, just like our women sailors and our women soldiers and our women airmen, make a great contribution and have made a great contribution, and we have no inclination at all in turning our back on that.

Senator BROWN. It means a lot. I appreciate the effort and I will convey that to General Amos.

I know that Senator Graham and I and others are deeply concerned about the Air Force, and I think the Army has struck a good

balance between Guard and Reserves and regular Army. The Air Force—I have to tell you I am not quite happy with the way things are shaking out. I feel that the Guard and Reserves are getting the short end of the stick. A lot of the input that has been given, I feel, has fallen on deaf ears.

I am deeply concerned about the fact that the Air Force has taken all the toys and is holding them and then really having a difficult time sharing and especially because I feel we get a very good value for the dollar in the Guard and Reserves especially in Massachusetts. Some of the units are at 70–80 percent mission-capable and yet we are going to take away that—destroy some of those teams and shift and adjust. It is deeply, deeply concerning to me. So if we were to make these irreversible cuts to the Guard based on disputable facts or flawed assumptions, could that be reversed? Could those actions be reversed, do you think?

Mr. GINSBERG. Senator, we really have struck a balance, given again the strategic demands—

Senator BROWN. You have been given guidance from Secretary Panetta, but then you have gone and done it how you felt it was appropriate. Is that a fair statement?

Mr. GINSBERG. Yes, sir.

Senator BROWN. The Army has done the same thing, but they have a different model.

Mr. GINSBERG. Sir, we just looked at what the demands were going to look like over the future, what were the war plans that we would have to fulfill, what are the rotational requirements, and then we had to, again, balance those considerations with the fact that there was a very significant change in our resourcing over the fiscal year plan.

Senator BROWN. Yes, but you are going to get a better value for your dollar with the Guard and Reserves. You know that the OSD Reserve Affairs report basically said the method of calculating the baseline costs and capabilities of the Guard and Reserves—without having the appropriate information, is it possible the Service Chiefs are assuming key data that would show how to preserve the greatest amount of military capability at the lowest cost or not?

Mr. GINSBERG. Sir, there has been a lot of discussion about the costs, of course. If there is a way to do a mission more cheaply and to get it done, we are going to do that, sir. The challenge has been when you are using the Guard and Reserve in a very high operational intensity, that some of the cost benefits become more ambiguous.

Senator BROWN. But if you shift some of the Active components to some of the Reserve bases like has been done in the past, you are going to get that good value for the dollar and also stretching out the mission.

Mr. GINSBERG. We foresee a very intense deployment schedule for the Guard, Reserve, and the entire force, and like I said, as you are using them more intensely, again the cost differences among the various components become more ambiguous.

In the meantime, sir, we also have to be, of course, concerned about what is the demand that is placed on the force and what is the stress level that we put on everybody. We are concerned that if we get these balances wrong, that a member of the Guard or Re-

serve is going to have to deploy at an intensity that will just be unacceptable to them, and our airmen are going to walk with their feet not just on the regular Air Force side but across our entire force.

Senator BROWN. I do not know if I agree with that assumption. I have been in 32 years. I have met with all the Guard and Reserve air components in Massachusetts and throughout, and I will tell you what, this conversation is not over. If it is not going to be addressed by you guys keeping and staying at the table, we will handle it in committee and we will do it for you. I do not know how else to say it. We will make sure we play a very active role.

Unfortunately, we do have to go vote, but I do have a question or two for the record I will submit.

Thank you, Mr. Chairman.

Senator WEBB. Thank you, Senator Brown.

Again, all members of the subcommittee will have until the close of business tomorrow to submit any further questions for the record.

I thank all of you for your testimony and for your continued service to our country.

This hearing is adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR KELLY AYOTTE

INTEGRATED DISABILITY EVALUATION SYSTEM

1. Senator AYOTTE. Secretary Lamont and General Bostick, while speaking at the Warrior Care and Transition Program Training Conference in Orlando, Florida, in 2011, the former Vice Chief of Staff for the Army, General Chiarelli, said that the current Army Disability Evaluation System (DES) is "complex, disjointed, hard to understand, and it takes too long to complete." How long does it take for the average soldier to complete the DES process?

Secretary LAMONT and General BOSTICK. Active component soldiers who completed the Integrated Disability Evaluation System (IDES) in April 2012 averaged 396 days from referral through notification of the Department of Veterans Affairs (VA) benefits decision, Reserve component soldiers averaged 401 days.

2. Senator AYOTTE. Secretary Lamont and General Bostick, what is the Department of Defense's (DOD) goal for completing the DES process?

Secretary LAMONT and General BOSTICK. The goal for completing the IDDES is 295 days for Active component soldiers and 305 days for Reserve component soldiers, measured from date of referral to the IDDES through notification of the VA benefits decision.

3. Senator AYOTTE. Secretary Lamont and General Bostick, how long does this process take and why is it taking so long?

Secretary LAMONT and General BOSTICK. Active component soldiers who completed the process in April 2012 averaged 396 days and Reserve component soldiers averaged 401 days. The Army is enduring the effects of 10 years of war and lacks sufficient capacity to efficiently process the increasing number of soldiers now in the IDDES.

4. Senator AYOTTE. Secretary Lamont and General Bostick, how many soldiers are currently enrolled in the Army's DES?

Secretary LAMONT and General BOSTICK. As of April 23, 2102, there were more than 24,000 soldiers enrolled in the DES, including over 18,800 who are enrolled in the IDDES and over 5,100 who are enrolled in the legacy DES.

5. Senator AYOTTE. Secretary Lamont and General Bostick, would it be correct to say that as these soldiers progress through the 400-day process, they are obviously nondeployable and count toward the Army's overall end strength?

Secretary LAMONT and General BOSTICK. Yes, these soldiers are nondeployable and do count against the overall Army end strength. The purpose of the DES is to maintain a fit and ready force. Soldiers going through that process are being evaluated to see if they are fit enough to continue to serve in the Army. Approximately 5 percent of those who begin the process are deemed fit and continue to serve. The remainder are evaluated for disability ratings and are separated.

6. Senator AYOTTE. Secretary Lamont and General Bostick, what can we do to fix this?

Secretary LAMONT and General BOSTICK. The Army is aggressively working to improve performance of the DES. We are currently implementing a number of initiatives designed to improve the performance, including: adding over 1,100 in staffing; publishing guidance to standardize the process across the Army; enhancing our training; and establishing procedures that will enhance the sharing of information with the VA. However, the Army believes we need to fundamentally change the DES; and remain convinced statutory reform is the only way we can achieve a sustainable system worthy of the sacrifices of our volunteer force in this era of persistent conflict.

The Army is looking at several different options to improve the DES—one of which would be a process where DOD determines a disabled servicemember's fitness for duty, and if found unfit, provide a lifetime annuity based on the member's rank and years of service. The VA would then establish compensation for service-connected injuries, disease, or wounds. We believe this type of system would achieve an average disability process outcome in less than 90 days: improved readiness; reduced complexity; decreased impact on limited medical resources; and less adversarial.

7. Senator AYOTTE. Secretary Lamont and General Bostick, is part of the problem the dual DOD/VA adjudication systems?

Secretary LAMONT and General BOSTICK. The IDES was designed to eliminate the duplicative elements of the separate disability processes previously operated by VA and the military. It employs a model that features a streamlined exam process using VA protocols and a single disability rating to be issued by VA. One of the principal goals of the new system was to ease servicemembers' transition to veteran status so they can quickly access VA benefits to reduce the risk of financial hardship. From this perspective IDES was successful.

IDES allowed for a move toward a single process with a single examination and a single source for all disability ratings. However, soldiers continue to receive two ratings. The Services can only compensate for military unfitting (fit for duty) service-connected conditions, while the VA compensates for all service-connected conditions. This duality creates confusion, and the belief the Services are not being loyal to or fair with servicemembers; it is also wasteful and time consuming.

We need to move to a system where the Services determine a disabled servicemember's fitness for duty, and if found unfit, provides benefits based on the member's rank and years of service and let VA establish compensation for disabling service-connected conditions. We believe this type of system would achieve an average disability process outcome in less than 90 days, improve readiness, while decreasing the impact the system currently has on our limited medical resources. It would be a less adversarial system.

8. Senator AYOTTE. Secretary Lamont and General Bostick, could these two systems be combined into one in order to streamline the process, help our troops, and save taxpayers' money?

Secretary LAMONT and General BOSTICK. The Army believes there is a need to clarify the objectives of each respective system. The current DES is over 60 years old and was designed for a draft-based military, in an industrial/agricultural economy. Its focus on disability and compensation reduces incentives or creates conflicting incentives to participate in rehabilitation or to return to work and is not adequate for the needs of today's professional all volunteer military.

The Army believes the system requires reform. We recommend a simpler process where DOD determines a disabled servicemember's fitness for duty, and provides benefits based on the member's rank and years of service. VA continues to determine disability benefits as it does now using one of its predischARGE programs. We believe this type of system would achieve an average disability process outcome in less than 90 days and ensure that VA benefits were available to soldiers immediately after separation.

DWELL TIME

9. Senator AYOTTE. General Bostick, what is the impact on readiness when there is insufficient time at home between deployments?

General BOSTICK. Over the past 11 years, the Army has successfully satisfied the high demand for conventional ground forces throughout two conflicts. The Army works hard at ensuring that our deploying units are adequately manned and ready to meet operational demands. The price of meeting the increase in the operational demand has significantly stressed our military personnel and their families. To fully reconstitute our units, soldiers and their families must be given the time and resources they need to reintegrate and reverse the effects of the sustained operational tempo. A study completed in 2009 confirmed what we already intuitively knew: soldiers require more than 2 years to fully recover, both mentally and physically, from the rigors of combat deployment. The Army's goal is to achieve and maintain a dwell time of at least 2 months at home for every month deployed for the Active component soldier and 4 months at home for every month mobilized for the Reserve component soldier.

The withdrawal of forces from Iraq will assist the Army with restoring its operational depth and returning strategic flexibility in our formations and among our leaders. In the second quarter of fiscal year 2012, the median Active component Army individual boots-on-the-ground (BOG):dwell reached the goal ratio of 1:2. The ongoing drawdown of forces in Afghanistan will continue to improve the BOG:dwell ratio of the force, and as dwell times increase, the Army will be able to focus on sustaining the rotation rates of 1:2 as envisioned. This will ensure the force's long-term health, and will, once again, allow the necessary time to train units to perform missions across the full spectrum of operations.

10. Senator AYOTTE. General Bostick, what impact does insufficient dwell time have on families?

General BOSTICK. Most families focus on the quality of the dwell time rather than the length. But it does take time to adjust and become reacquainted with what it's like to be together again. Soldiers' reintegration with their families is an individual process. It is important for soldiers to spend quality time with their families in the reset period following deployment. With less dwell time, returning members may not have enough time to reconnect with their families and fit back into the home routine before they have to deploy again. Children worry about the next deployment, which impacts their ability to get to know their parent again. To help families with this process, the Army is educating family members about reintegration, helping them recognize changes in family structure and functioning, and the importance of establishing expectations before the soldier returns.

11. Senator AYOTTE. General Bostick, what impact does insufficient dwell time have on the Army's ability to train for full spectrum operations, including major combat operations?

General BOSTICK. The amount of dwell time required for a redeploying unit to progressively build readiness for a broad range of military operations (including major combat operations) depends on complexity of the unit's design, functions, interaction with external organizations, and degree the unit will be employed in harm's way or employ deadly force. Whether or not dwell time is sufficient depends on a number of factors, primarily how quickly the Army is able to reset the unit with personnel and equipment and how much training resources and venues are available to support the unit's progressive training strategy. If dwell time proves insufficient for the unit to fully prepare before expected to be available for contingency operations, then the Army must accept either more training time or risk before deploying the unit, as allowed by exigencies of the situation.

Risk associated with insufficient dwell time is somewhat mitigated by developing unit leaders throughout their career in professional military education and through participation in Army training venues like Combat Training Centers; by providing training support capabilities that allow unit components to sharpen skills using virtual/constructive/gaming venues through iterative execution of increasingly complex tasks, conditions, and enabler integration—complexity which is simply infeasible to create for live training at the unit's home station due to constraints on maneuver space, airspace, joint/interagency/multinational availability; by training on fundamentals first and progressively building the proficiency of individuals, crews, sections, small units, then larger formations; and by integrating adaptability into training, which enables a professionally disciplined force to apply their mastery of fundamentals to any assigned mission and adapt to circumstances. Units deploying with insufficient dwell may not have had opportunity to perform as a large forma-

tion, to fully integrate external enablers required of unified operations, or to practice against the full arrange of threats presented by contemporary operating environments.

12. Senator AYOTTE. General Bostick, what are the Army's current goals for dwell time between deployments for the Active and Reserve components?

General BOSTICK. Because individuals follow a variety of deployment patterns, we measure dwell as a ratio of time spent deployed (boots-on-the-ground (BOG)) to time spent not deployed (dwell). Our near-term goals are for Active component soldiers to have 2 months of dwell for every 1 month deployed (a 1:2 BOG:dwell ratio) and for Reserve component soldiers to have 4 months of dwell for every month deployed (1:4 ratio).

13. Senator AYOTTE. General Bostick, what military occupational specialties and types of units are receiving the least time at home between deployments?

General BOSTICK. Because individuals and units follow a variety of deployment patterns, we measure dwell as a ratio of time spent deployed BOG to time spent not deployed following the deployment (dwell). In terms of this ratio, aviation units and aviation-related specialties have been the most taxed. This is especially true among junior enlisted soldiers and warrant officers, who have seen slightly more than 3 months of dwell for every 2 months deployed. Other units such as civil affairs, intelligence, military police, psychological operations, engineers, and special forces have also been heavily taxed and remain just above the mandated 1:1 BOG:dwell ratio for units. However, the soldiers in these units tend to have better median individual BOG:dwell ratios than aviation soldiers, suggesting a wider variety of assignment opportunities or partial-unit deployments.

14. Senator AYOTTE. General Bostick, what are the current dwell times for individuals with these specialties and for these types of units?

General BOSTICK. Because individuals and units follow a variety of deployment patterns, we measure dwell as a ratio of time spent deployed BOG to time spent not deployed following the deployment (dwell). As previously stated, aviation units and aviation-related specialties have been the most taxed. This is especially true among junior enlisted soldiers and warrant officers, who have seen slightly more than 3 months of dwell for every 2 months deployed, a 1:1.5 ratio. This ratio is highly correlated with the unit ratios, as these soldiers do not have many assignment opportunities outside of these units. More senior noncommissioned officers and commissioned officers have been experiencing ratios better than 1:1.8, largely because they have more assignment opportunities.

15. Senator AYOTTE. General Bostick, do you believe the Army should be reducing its end strength before achieving its dwell time goals?

General BOSTICK. For the last several years, the Active Army has enjoyed the benefits of a temporary end strength increase that was as much as 22,000 soldiers above its 547,000 permanent end strength. Because of this increase, the Active component was able to achieve its median 1:2 individual BOG:dwell goal in second quarter of fiscal year 2012. With the expected decrease in demand for deployed forces, we do not anticipate that the median individual BOG:dwell will worsen.

16. Senator AYOTTE. General Bostick, if future unanticipated contingency operations emerge and the Army's dwell time predictions turn out to be too optimistic, at what point would you recommend pausing or reversing the Army's end strength reductions?

General BOSTICK. Once the Army is no longer able to sustain the 1:2 BOG:dwell ratio assigned to it in the Guidance for Employment of the Force, the senior Army leadership would need to assess the risk to the force and recommend to the Secretary of Defense that he pause or reverse the end strength reductions.

TRAUMATIC BRAIN INJURY

17. Senator AYOTTE. Secretary Lamont, Secretary Garcia, Secretary Ginsberg, General Bostick, Admiral Van Buskirk, General Milstead, and General Jones, can you give me a sense as to how many of your servicemembers have suffered from a traumatic brain injury (TBI)?

Secretary LAMONT and General BOSTICK. Since 2000, there have been 233,425 DOD servicemembers including 134,938 U.S. Army soldiers diagnosed with TBI.

Secretary GARCIA and Admiral VAN BUSKIRK. From 2000 through 2011, Navy has had 32,379 TBI cases among Active and Reserve sailors while Marine Corps has had 33,989 such cases among Active and Reserve marines. In 2011 alone, Navy had 2,825 instances of TBI while Marine Corps had 4,747. Mild TBI accounts for approximately 77 percent of TBI cases documented across the Services since 2000, and 84 percent of all TBIs occur in garrison.

Secretary GINSBERG and General JONES. The Air Force accounts for 14 percent of the total TBI cases in the military, with 32,119 cases from 2000 through 2011 (deployed and nondeployed, all severity). There are approximately 2,500–3,500 total cases per year, with the majority not being associated with deployment. According to the Medical Surveillance Monthly Report, there were 242 cases of deployment-associated TBI in airmen in calendar year 2010 (0.56 percent of Air Force deployments). Of the total cases, 81.8 percent were mild, defined by the duration of alteration of consciousness, loss of consciousness, or post-traumatic amnesia at the time of injury. As reported in the civilian TBI literature, 85–90 percent of those who sustain mild TBI recover fully within 3 months, often sooner. Early identification, education, rest, and symptom management facilitate recovery. Those who sustain recurrent concussions and/or have co-morbid conditions such as Post-Traumatic Stress Disorder (PTSD) may take longer to recover.

General MILSTEAD. The official TBI data for DOD is reported through the Defense and Veterans Brain Injury Center (DVBIC). Current DVBIC data indicate 233,425 total TBI cases throughout DOD from 2000 through 2011. In that same time period, the Navy has had 32,379 TBI cases within Active and Reserve components, while the Marine Corps, Active and Reserve components, has had 33,989 such cases. In 2011, the Navy had a total of 2,825 TBIs while the Marine Corps had 4,747. Mild TBI accounts for approximately 77 percent of TBI cases documented across the Services since 2000, and 84 percent of all TBIs occur in garrison.

18. Senator AYOTTE. Secretary Lamont, Secretary Garcia, Secretary Ginsberg, General Bostick, Admiral Van Buskirk, General Milstead, and General Jones, what is your Service doing to address this problem and care for our servicemembers who have sustained a TBI?

Secretary LAMONT and General BOSTICK. The Army has instituted a comprehensive program to better detect, diagnose, treat, and track TBI. This program contains four essential elements: (1) baseline neurocognitive testing of all deploying soldiers; (2) a comprehensive in-theater policy for assessing and treating soldiers exposed to potentially concussive events, who may have been exposed to a traumatic event; (3) establishment of an expansive garrison clinical care program to meet the medical and rehabilitation needs of patients with all severities of TBI; and (4) an aggressive research program looking at ways to better diagnose and treat TBI.

Army policy directs that all soldiers who have been exposed to possible concussive events are screened for TBI and are given mandatory recovery time. The Army has improved provider education and training with regard to screening, evaluation, and management of concussion in both the deployed setting and the garrison environment. Research is being conducted to find possible biomarkers of TBI, to improve accurate and timely diagnosis of TBI, and to increase the treatment options for individuals with a positive diagnosis of TBI.

Secretary GARCIA, Admiral VAN BUSKIRK, and General MILSTEAD. TBI care on the battlefield has improved significantly since the beginning of Operations Enduring Freedom and Iraqi Freedom. Most improvements have targeted early screening and diagnosis followed by definitive treatment. In 2010, the Deputy Secretary of Defense issued Directive-type Memorandum 09–033, “Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting,” which has resulted in improved diagnosis and treatment of battlefield concussion.

For Navy and Marine Corps, the primary treatment site for concussed servicemembers has been the Concussion Care Restoration Center (CRCC) at Camp Leatherneck in Afghanistan. Since its opening in 2010, the CRCC has treated over 964 servicemembers, resulting in a greater than 98 percent return-to-duty (RTD) rate and an average of 10.3 days of duty lost from point-of-injury to symptom-free RTD. There is also a Concussion Specialty Care Center (CSCC) at the North Atlantic Treaty Organization (NATO) Role III Hospital in Kandahar, with a neurologist on staff.

Upon return from deployment, enhanced screening methods for TBI and mental health conditions are being piloted at several Navy and Marine Corps sites. These efforts include additional screening and follow-up for any servicemember noted to have sustained a concussion in theater. Efforts are underway to increase use of the National Intrepid Center of Excellence (NICoE) across DOD, and development of

NICoE satellite sites, to provide state-of-the-art evaluation and treatment for patients who do not improve with routine clinical care.

Secretary GINSBERG and General JONES. Of the total TBI cases from 2000 to 2011, 81.8 percent were mild, defined by the duration of alteration of consciousness, loss of consciousness, or post-traumatic amnesia at the time of injury. As reported in the civilian TBI literature, 85–90 percent of those who sustain mild TBI recover fully within 3 months, or often sooner. Early identification, education, rest, and symptom management facilitate recovery. Those who sustain recurrent concussions, and/or have co-morbid conditions such as PTSD may take longer to recover.

As outlined in the 2009 Department of Veterans Affairs/Department of Defense Clinical Practice Guideline (CPG) for Management of concussion/mild TBI, most of the initial management of mild TBI can be accomplished by primary care in the patient-centered medical home, with referral to specialty services when needed. In addition to the CPGs, providers also have tools produced by the Defense Centers of Excellence for Psychological Health and TBI, such as the Pocket Guide for Management of TBI and the Co-Occurring Disorders Toolkit. The Air Force has one stand-alone multidisciplinary TBI clinic at Joint Base Elmendorf-Richardson. This TBI clinic stood up in 2008 and was started to support the local Army units who account for over 90 percent of the patients treated. Additional efforts to standardize mild TBI care are in place for higher risk units in the Air Force, such as explosive ordnance disposal. One example is a provider-to-provider video teleconsult pilot project that brings together primary care providers with a TBI team of experts using video teleconference capability to allow exchange of knowledge and de-identified case discussion.

A theater system of TBI care has evolved since the release of Directive Type Memorandum (DTM) 09–033: “Management of Concussion of mild TBI in the Deployed Setting.” Leadership’s responsibility to identify and report servicemembers involved in mandatory events (within 50M of blast, direct blow to head, and motor vehicle crash) ensures early identification of TBI. Medics and providers standardize care by using clinical algorithms for evaluation and management of mild TBI, including mandatory rest periods. Located throughout Afghanistan, 11 concussions care centers, which are overseen by the theater neurology consultant, allow servicemembers sufficient time to rest and recover, resulting in an over 95 percent return to duty rate. Clinical history and examination, together with post-injury neurocognitive testing in theater, aids in return to duty decisionmaking.

19. Senator AYOTTE. Secretary Lamont, Secretary Garcia, Secretary Ginsberg, General Bostick, Admiral Van Buskirk, General Milstead, and General Jones, do you have all of the resources and authorities you need to care for our servicemembers with TBI?

Secretary LAMONT and General BOSTICK. While resources are adequate for current efforts, continued congressional support of the Army’s TBI clinical and research efforts will ensure improved screening and delivery of care.

Secretary GARCIA, Admiral VAN BUSKIRK, and General MILSTEAD. Caring for sailors and marines who have sustained a TBI remains a top priority. While we are making progress, we recognize that there is much work ahead of us to determine the acute and long-term impacts of TBI on our servicemembers. Our strategy must be both collaborative and inclusive, by actively partnering with the other Services, our Centers of Excellence, the VA, and leading academic medical and research centers, to make the best care available to warriors afflicted with TBI.

We are grateful to you and your colleagues for your outstanding support of our efforts in improving the care of our sailors and marines and their families. We believe we have both the resources and authorities required for the diagnosis, treatment, and recovery of our servicemembers who have sustained a TBI. While we are resourced well, we should continue our vigilance in the area of TBI policies that support tracking and surveillance efforts. We need to ensure sailors and marines receive the optimal care at all points in the continuum from point of injury to reintegration.

Secretary GINSBERG and General JONES. At this time, the Air Force has sufficient resources and authority to provide care for airmen who sustain TBI. In addition to the steps taken to identify and care for airmen with TBI, the Air Force has support from our sister Services, the Defense Centers of Excellence for Psychological Health and TBI, the Defense and Veterans Brain Injury Center, and the NICoE.

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

APPENDIX A

Statement for the Record

**Reserve Officers Association of the United States
And
Reserve Enlisted Association**

for the

**Senate Armed Services Committee
Subcommittee on Personnel**

**ACTIVE AND RESERVE COMPONENT
PERSONNEL ISSUES**

April 25, 2012



"Serving Citizen Warriors through Advocacy and Education since 1922."™



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**RESERVE STRENGTH.
RESERVE LIFE.**

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

The Association's 58,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen, who frequently serve on Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic and Atmospheric Administration, who often are first responders during national disasters and help prepare for homeland security. ROA is represented in each state with 54 departments plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state. ROA has more than 450 chapters worldwide.

ROA is a member of The Military Coalition, where it co-chairs the Guard and Reserve Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans, and family support organizations.

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

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DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers Association and Reserve Enlisted Association are member-supported organizations. Neither ROA nor REA have received grants, sub-grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.



INTRODUCTION

On behalf of our members, the Reserve Officers Association and the Reserve Enlisted Association thank the committee for the opportunity to submit testimony on personnel issues affecting serving members, retirees, their families, and survivors.

The Title 10 Reserve and National Guard are no longer just a part-time strategic force but are an integral contributor to our nation's operational ability to defend itself, assist other countries in maintaining global peace, and fight against overseas threats. They are an integrated part of the Total Force, yet remain a surge capability as well. At a time that the Pentagon and Congress are examining our nation's security, it would be incorrect to discount the Reserve Components' abilities and cost efficiencies. Instead, these part-time warriors provide a cost savings solution and an area to retain competencies for missions not directly embodied in the administration's new strategic policy, *Sustaining U.S. Global Leadership: Priorities for a 21st Century Defense*.

ROA and REA are concerned that as the Pentagon strives to achieve the administration's goals for this new strategic policy, it is not seriously considering the available assets and cost efficiencies of the Reserve Component, and that it views the Reserve and National Guard as a bill payer instead. Congress, starting with the leadership of this subcommittee, should insist on a methodical analysis of suggested reductions in missions and bases before authorizing such changes. Haste creates mistakes.

Each association would like to thank Congress and this committee for amending Title 10 USC, Chapter 1209 of section 12304a that allows Title 10 Reservists to provide assistance during a time of major disaster or emergency, and for amending Section 515 of Chapter 1209 that now authorizes service secretaries to activate Guard and Reserve members at times other than war or emergencies to augment the Active component. These two provisions should help prevent the Reserve Component from being placed back into Armories and Reserve Centers as just a strategic asset. ROA and REA hope that the administration makes use of these new authorities by providing necessary funding.

PROVIDE AND EXECUTE AN ADEQUATE NATIONAL SECURITY

The Reserve Officers Association is chartered by Congress "to support and promote the development and execution of a military policy for the United States that will provide adequate national security."

Requested Action

- Hold Congressional hearings on the new policy of "Sustaining U.S. Global Leadership: Priorities for the 21st Century Defense."
- Seek exemption or delay in Defense Sequestration budget cuts.
- Study the impact of manpower cuts to Army and Marine Corps on National Security.
- Avoid parity cuts of both Active and Reserve Components without analyzing rebalance.
- Maintain a robust and versatile all-volunteer armed forces that can accomplish its mission to defend the homeland and U.S. interests overseas.

The Defense Budget, including current war expenses, is close to 5 percent of the Gross Domestic Product, yet as a percentage of the overall Federal budget it continues to decline. With defense expenses representing less than 20 percent of the federal budget, it seems inappropriate to take half of the budget reduction from National Security.

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ROA and REA question the current spending priorities that place more importance on the immediate future, rather than first doing a short and long term threat analysis. The result of such a budget-centric policy could again lead to a hollow force whose readiness and effectiveness is degraded.

The administration proposes cutting 100,000 troops. End strength cuts need to be made cautiously. The deployment of troops to Iraq and Afghanistan proved that the pre-9/11 end strengths left the Army and US Marine Corps undermanned, which stressed the force.

ROA and REA share concerns about reductions in the Department of Defense, while budgets for other federal agencies increase. An example of this is the \$13.4 billion budget increase for the Department of Veteran Affairs. Of this, \$10.6 billion is an increase in mandatory funding. When ROA asked the VA's Chief Financial Officer, Todd Grams, what offset is being made to allow this increase, his response was that no offset was needed as all but \$1 billion were for existing programs.

While some VA increase is obviously needed with the ever increasing number of service-connected veterans who are disabled, injured, or ill, every agency should be fiscally responsible to help balance the budget and reduce the ever growing deficit.

Serving members, retirees, families, and survivors are in effect being taxed by defense reductions to be the dollar offsets for other departments. Not only is this unfair, but by making cuts to national security, it puts future warriors at a greater risk.

BASE CLOSURE OR DEFENSE REALIGNMENT?

The President's Budget recommends two more rounds of base closures. **ROA and REA don't support such a BRAC recommendation.**

- 1) BRAC savings are faux savings as these savings are outside the accounting cycle; with a lot of additional dollar expenses front loaded into the defense budget for infrastructure improvements to support transferred personnel.
- 2) Too much base reduction eliminates facilities needed to support surge capability. Some surplus is good.

Instead, **ROA and REA recommend that Congress consider an independent Defense Realignment Commission** that would examine the aggregate national security structure. It could examine:

- 1) Emerging Threats.
- 2) Foreign defense treaties and alliance obligations.
- 3) Overseas and forward deployment requirements.
- 4) Foreign Defense Aid.
- 5) Defense partnerships with the State Department and other agencies, as well as NGO's.
- 6) Requisite missions and elimination of duplicity between the Services.
- 7) Current and Future weapon procurement and development.
- 8) Critical Industrial base.
- 9) Surge capability and contingency repository.
- 10) Best utilization and force structure of Active and Reserve Components.
- 11) Regional or centralized training, and dual purpose equipment availability.
- 12) Compensation, recruiting and retention; trends and solutions.

In a time of war and force rebalancing, it is wrong to make cuts to the end strength of the Reserve Components. We need to pause to permit force planning and strategy to take precedence over budget reductions.

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MILITARY RETIREMENT MODERNIZATION

Another recommendation in the President's budget is a commission to review deferred compensation. **As structured, ROA and REA do not support this proposal either**, but if considered:

- 1) This should not be a BRAC-like commission. Congress should not give up its authority.
- 2) In one section of the President's Budget, it suggests that the President will appoint all of the members on the commission. Congress should share in appointments.
- 3) While alternatives to current military retirement should be explored, ROA and REA don't support a two tiered system where two generations of warriors have different benefit packages.
 - 3.1) An incentivized retirement option could be offered, rather than making any new mandatory system.
- 4) Should a task force be appointed, ROA and REA recommend that individuals with experience in Reserve Component compensation be among those appointed, as the administration has suggested that both regular and non-regular (reserve) retirement should be the same.

RESERVE STRENGTH

"The challenges DoD has to face are not going to be handled by circling the wagons here at home," Dennis McCarthy, then-Assistant Secretary of Defense for Reserve Affairs told ROA at its national meeting in 2011. "We're going to continue to need a force that can deploy worldwide ... for the full spectrum of missions."

"With roughly 1.4 [million] active-duty service members, 1.2 million reserve-component members and likely future missions worldwide," McCarthy added, "the military will need to continue to rely on reserve strength."

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

Yet, as discussions occur in both Congress and the Pentagon on how to reduce the budget and the deficit, the peril of lowering defense spending is that the Reserve Components will become a bill payer. The Air Force and the Navy are already making drastic cuts to their Reserve Components.

A further risk exists where Defense planners may be tempted to put the National Guard and Title 10 Reserve on the shelf, by providing them "hand me down" outmoded equipment and by underfunding training. In the 2005 BRAC, Reserve and National Guard facilities were closed, reducing the risk of closure to active duty facilities.

Rather than be limited by historical thinking, and parochial protections, creative approaches should be explored. The Reserve Component needs to continue in an operational capacity because of cost efficiency and added value. The cost of the Reserve and National Guard should not be confused with their value, as their value to national defense is incalculable.

The Reserve Components remain a cost-efficient and valued force. It is just a small percentage of the total services budget:

Army Reserve – 7 percent of the Army budget; 18 percent of the force
 Army National Guard – 14 percent of the Army budget; 32 percent of the force

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Marine Forces Reserve – 6 percent of the USMC budget; 16.5 percent of the force
 Navy Reserve – 7 percent of the USN budget; 17 percent of the force
 Air Force Reserve – 4 percent of the AF budget, 14 percent of the force, and 20 percent of the capability
 Air National Guard – 6 percent of the AF Budget and 21 percent of the force.

“Differences in the cost of the active and reserve components relate primarily to three factors,” writes Jennifer Buck, former Director, Programs and Budgets, Reserve Affairs at Office of the Secretary of Defense. “First, the guard and reserve have lower operating and training tempo. Second, they receive part-time pay and benefits, [and only accrue personal leave when mobilized.] Third, the guard and reserve incur smaller infrastructure costs—such as, for example, in family housing.”

Admittedly a member of the reserve who is engaged in operational missions will cost more than one who is used strategically, but even in an operational mode, the tempo for a reservist will be less frequent, bringing down the costs. With a dwell time of four years at home and one year activated, that reflects a cost of about 23 percent when compared to a full time active duty member.

If it assumed that members of the Reserve components mobilize four times during the course of a career, and members of the active component are sent to an operational conflict seven times during the course of a career a career cost per deployment can be calculated. *In The Cost of the Reserves, Chapter 10*, Jennifer Buck determined that based on differences in pay and follow-on retirement, an active member “costs” the government almost \$2.4 million over a lifetime of service while reserve members cost about \$790,000. In terms of “usage,” it can be calculated at \$336,000 per deployment “opportunity” for the active member and \$198,000 for a member of the reserves.

Value, on the other hand, is more intangible to calculate. The Reserve Component fills an ongoing need for a surge capability as an insurance policy against worse-case scenario’s. Reserve and National Guard members give the armed forces access to civilian skills that would prove too expensive for the uniformed services to train and maintain. With less than one percent of the U.S. population serving in uniform, the Reserve Component also provides a critical link to American communities.

The Reserve and National Guard should also be viewed as a repository for missions and equipment that aren’t addressed in the administration’s new Strategic Policy. They can sustain special capabilities not normally needed in peacetime.

Part of the President’s budget includes planned end-strength reductions for both the Army and Marine Corps, by 80,000 and 20,000, respectively. It should be remembered that individuals cannot be brought quickly on to active duty on a temporary basis, as it is an accumulation of experience and training that is acquired over years that becomes an asset for the military. The Reserve is also a repository for these skills.

A strong Reserve is needed for a strong national defense. For the last 73 years, America hasn’t gone to war without its Reserves. According to the Congressional Research Service, Reserve and Guard members were involuntarily ordered to active duty for military operations 10 times since World War II:

• Korean War (1950-1953)	857,877
• Berlin Crisis (1961-62)	48,034
• Cuban Missile Crisis (1962)	14,200
• Vietnam War (1968-1969)	37,643*
• Persian Gulf War (1990-91)	238,729
• Haiti (1994-1996)	3,680
• Bosnian peacekeeping mission (1995-2000)	19,324

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- Iraqi [Operation Northern Watch] conflict (1998-2000) 2,038
- Kosovo conflict, peacekeeping mission (1999-2000) 5,933
- Iraq and Afghanistan (2001-present) over 843,000 activations

* As in many conflicts, newly affiliated Reserve Component members on their initial active duty tour served in Vietnam, but were not included in the above statistics. In Vietnam, 5,857 reservists were killed, which extrapolates to about 260,000 Reserve Component members in theater.

The Reserve Component also contributed to ending the Cold War, because Soviet war planners had to account for the U.S. Reserve strength as well as its Active Duty numbers. The added military costs to prepare for all contingencies against the U.S. proved overwhelming to Soviet war planners.

To maintain a strong, relevant, and responsive Reserve Force, the nation must commit the resources necessary to do so. Reserve strength is predicated on assuring the necessary resources—funding for personnel and training, equipment reconstitution, and horizontal fielding of new technology to the RC, coupled with defining roles and missions to achieve a strategic/operational Reserve balance.

National Guard and Reserve Equipment Allowance (NGREA)

The Reserve and National Guard are faced with ongoing challenges on how to replace worn out equipment, equipment lost due to combat operations and legacy equipment that is becoming irrelevant or obsolete. The National Guard and Reserve Equipment Allowance provide critical funds to the Reserve Chiefs and National Guard Directors to improve readiness throughout procurement of new and modernized equipment. Continued receipt of NGREA and congressionally added funding will allow the Reserve Components (RC) to continue to close the Active/Reserve Component modernization and interoperability gap.

Air Force – An Example of a Rush to Make Cuts

The Air Force has recommended cuts in personnel and equipment, with disproportionate cuts taken from the Reserve Components. Proposed budget cuts has the Air Force planning to retire 286 aircraft as part of the president's new defense strategy over the next 10 years. A large number of these aircraft will be cut from the Reserve Component with most of the cuts "upfront" between Fiscal Years (FY) 2013 and 2017.

The proposed cuts heavily impact the Reserve Component, affecting 32 states and one territory, 75 reserve component units, and the military careers of thousands of Air Force Reserve and Air National Guard members.

There is only a 35 percent savings when a Reserve Component officer or enlisted is cut when compared to the cost of keeping an individual on active duty. Certain missions can be performed by either the National Guard or the Reserve for much less than maintaining a fully staffed active duty unit.

Air Force Chief of Staff, General Norton A. Schwartz has said that the Air Force is going to get smaller, and all of the components, Active, Guard and Reserve, are going to get smaller. An earlier statement by the Department of the Air Force indicated that the reductions would be balanced. Unfortunately, under the Air Forces plan, the majority of the end strengths cuts will come from the Reserve Components.

The Air Force announced at the beginning of March that FY 13 manpower cuts would be:

3,900	Active Air Force
5,100	Air National Guard
900	Air Force Reserve*



It should be also noted that the Air Force ended fiscal year 2011 about 1,200 Airmen over active duty end strength. The net reduction would be 2,700 from authorized active duty end strength. The Reserve Component is be reduced by 2.2 times that of the active force.

* Even though the AF announced that the Air Force Reserve will be reduced by 900 personnel in FY-2013 over 3000 jobs will be realigned. There will be a risk of further reductions at some locations not shown on the chart attached to this testimony. There are 2,093 Reserve and 734 full time staff (FTS) reductions shown in Air Force announcements at six Air Force Reserve flying locations. These include:

- 563 Lackland, Texas (-385 reserve/-178 FTS in C-5s)
- 580 Barksdale, La. (-409/-171 closing AFR A-10 unit)
- 53 Homestead, Fla. (-40/-13 reducing F-16s)
- 1448 Pittsburgh, Penn. (-1122/-326 closing Wing and Base)
- 53 Fort Worth, Texas (-40/-13 from the NAF)
- 130 Youngstown, Ohio (-97/-33 reducing C-130s).

Then in FY 14 and out, the plan to close the entire C-130 wing at Maxwell, Ala. ; the entire C-130 wing/base at Minneapolis-St Paul, Minn.; a C-130 flying squadron at Keesler, Miss.; and the C-130 wing/base at Niagara, N.Y.

While some billets may not be lost, but simply transferred to other locations, individuals will be impacted by these changes. Some Air Force reservists will have to move or travel to new jobs. Career choices will be aggravated by a poor economy and civilian job availability, and will push attrition rates higher. In these proposed reductions, the Air Force does not seem to understand the importance of population/reserve demographics to cost-effective reserve unit locations.

Some question the basis of the Air Force analysis. For example the Air Force identified Pittsburgh Joint Air Reserve Station for closure, claiming that the ARS is below the BRAC threshold of 300 full time civilian jobs enabling them to close the ARS unilaterally. Locals disagree, demonstrating that 317 DoD personnel are employed at Pittsburgh. Rebuttal position papers suggest that the Air Force is purposely misinterpreting Title 10 USC, "disregarding" DoD publications, and OPM definitions. This paper further suggests that the Air Force disregards infrastructure savings by having an Air Reserve Station at a shared civilian facility such as Pittsburgh International Airport.

The Council of Governors also question the Air Force's proposal, suggesting that the new budget "shift the Active Duty/Reserve Component mix back to the Cold War ration of the early 1990's when reserve components were strategic rather than combat-tested operational reserve forces." The report also highlights a shift of a 4 percent of combat aircraft and 3 percent of mobility aircraft into the active force. This actually raises the operational expense. The Council of Governors recommending returning the AC/RC mix to near the Fiscal Year 2012 ratio.

The Council of Governors report includes offsets and recommendations for end strength cuts, but the report is National Guard centric, again highlighting that it would be ill-advised to react without a comprehensive review of the Active, Reserve and National Guard missions and assets for true budget savings.

This risk is parochial infighting as active and reserve components "lobby" for dwindling financial resources. It didn't help when Air Force Chief of Staff Gen. Norton Schwartz General said, "The active component has been cut to the point at which capacity cannot be reduced further without harmful effects to...readiness, increased capacity and the ability to surge and rotate at a sustainable tempo," while

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speaking at the Air Force Association's annual air warfare symposium, seeming to justify cuts to the Air National Guard and drilling Air Force Reserve.

There needs to be a referee to keep the armed forces focused on emerging threats rather than squabbling amongst ourselves. ROA and REA are confident that Congress will remind the Pentagon what is important.

RESERVE LIFE

Reserve and Guard members have provided unprecedented service and sacrifice for the past decade. Congress should make a commitment to them to provide lifelong support for them through career growth, civilian employment, seamless health care, family support and deferred compensation that has been promised to them upon retirement. This will be an incentive to continue to serve.

Continuum of Service

A continuum of service influences the way the nation uses individual service members and the way it employs its Active and Reserve forces. It enables an effective use of our most important national security asset: the men and women who are willing to serve in the armed forces. It allows them and their families to continue to serve throughout predictable life-status changes, and leverages their skills throughout a career that is unencumbered with unnecessary barriers.

By consolidating Active and Reserve personnel procedures and policies, and permitting seamless transition between the Active and Reserve components, individuals can gain better control of their own careers, while the services maximize the efficiency of force structure. A continuum would allow for a flexibility and optimization of the Total Force by allowing special skills and functions to be activated as needed and returned to the Reserve Component when not.

Continuum of service is a human capital strategy that views active (full-time) and reserve (part-time) military service not as two elements of valuable service but as a continuation of service where a qualified individual can serve in different capacities and durations during his or her career. A continuum of service strategy recognizes the tremendous cost of accessing and training each service member and seeks to avoid unnecessary replication of such costs by accessing those skills rather than replacing them.

Taken to its full potential, a continuum of service would require a re-examination of how service is credited and compensated, but would also allow for a more efficient management of our forces in a resource constrained environment.

Reserve Life Issues supported by the Reserve Officers and Reserve Enlisted Associations include:

Changes to retention policies:

- Permit service beyond current mandatory retirement limitations.
- Retain serving members for skill sets, even when passed over for promotion.
- Support incentives for affiliation, reenlistment, retention and continuation in the Reserve Component.
- Advocate against cuts in Reserve Component; support Reserve commissioning programs
- Reauthorize yellow ribbon program to support demobilized Guard and Reserve members.

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Pay and Compensation:

- Reimburse a Reserve Component member for expenses incurred in connection with round-trip travel in excess of 50 miles to an inactive training location, including mileage traveled, lodging and subsistence.
- Eliminate the 1/30th rule for Aviation Career Incentive Pay, Career Enlisted Flyers Incentive Pay, and Diving Special Duty Pay.
- Simplify the Reserve duty order system without compromising drill compensation.

Education:

- Include Title 14 Coast Guard Reserve duty in eligibility for the Post 9/11 GI Bill.
- Exempt earned benefit from GI Bill from being considered income in need based aid calculations.
- Increase MGIB-Selected Reserve (MGIB-SR) to 47 percent of MGIB-Active.
- Include 4-year reenlistment contracts to qualify for MGIB-SR.

Spouse Support:

- Expand eligibility of surviving spouses to receive Survivor Benefit Plan (SBP)-Dependency Indemnity Clause (DIC) payments with no offset.
- Provide family leave for spouses and family care-givers of mobilized Guard and Reserve for a period of time prior to or following the deployment of the military member.

Deferred Benefits and Retirement:

- Extend current early retirement legislation retroactively to Sept. 11, 2001.
- Change US Code to eliminate the Fiscal Year barrier toward full credit toward early retirement.
- Promote improved legislation on reducing the Reserve Component retirement age.
- Permit mobilized retirees to earn additional retirement points with less than two years of activated service, and codify retirement credit for serving members over age 60.
- Modify US Code that requires repayment of separation bonuses if an individual receives a Uniformed Service retirement annuity.
- Continue to protect and sustain existing retirement benefits for currently retired.

Voting:

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

Joint Military Professional Education – a need to expand.

A deep bench of Joint Qualified Officers (JQO) is essential to military planning and operations in today's national security environment. The architects of the Goldwater-Nichols Act recognized this and attempted to codify standards and career milestones to build a robust cadre of Joint officers. Although this act makes no distinction between the Services' Active and Reserve Components, obtaining Joint Qualified Officer (JQO) Level III status, which requires both joint experience and education, has proven much more challenging for members of the Reserve Components (RC) to achieve.

The primary reason is that opportunities for members of the RC to attain JPME Phase II credit or attend Senior-Level Education in residence are more limited than for the Active Component (AC). Members of the RC typically complete Senior-Level Service School through their respective services' distance education program.

However, graduates of the Distance Education Programs (DEP) do not receive the JPME Phase II credit required to achieve the coveted JQO Level III status. So, in addition to completing a 12 to 24 month DEP, RC members aspiring to achieve JQO status must complete the Advanced Joint Professional Military Education (AJPME), a 10-month blended course, through Joint Forces Staff College. Altogether this can potentially add up to 34 months of education to achieve what most members of the AC do in 10 months at in-residence programs—despite the fact that nearly the same curricula standards apply to both the DEP and the resident education program (REP). To both provide equal access to achieve Level III status, and to better position the RC to continue to function as an Operational Force, barriers to educational achievement must be creatively addressed while not lowering standards.

Solution - Amend Title 10 USC and adjust policy to provide that nonresident graduates of accredited senior-level service school programs receive the same JPME credit as resident graduates. It is acceptable to also require that a certain amount of the non-resident curricula also deal with joint issues. Further, the laws should be amended that provide that graduates of the Joint Forces Staff College (JFSC) Advanced JPME course receive Phase II credit.

Permit flexibility in the student and faculty ratios now required by Title 10 USC to permit the nonresident programs to adjust and validate other ratios that would still yield a proper joint education. The waiving of the current ratios would be solely within the control of the Secretary of Defense although his discretion should be limited to permitting a maximum ratio of 80% faculty and students coming from the host institution to ensure cross-culturalization.

ROA has suggested language to amend Title 10 USC, and will work with the committee to make these improvements.

CONCLUSION

ROA and REA reiterate our profound gratitude for the bipartisan success achieved by this committee by improving parity on pay, compensation and benefits between the Active and Reserve Components. The challenges being faced with proposed budget cuts are going to make this committee's job that much harder.

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



[Whereupon, at 2:20 p.m., the subcommittee adjourned.]

**DEPARTMENT OF DEFENSE AUTHORIZATION
FOR APPROPRIATIONS FOR FISCAL YEAR
2013 AND THE FUTURE YEARS DEFENSE
PROGRAM**

THURSDAY, JUNE 21, 2012

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

**DEPARTMENT OF DEFENSE PROGRAMS AND POLICIES
TO SUPPORT MILITARY FAMILIES WITH SPECIAL NEEDS**

The subcommittee met, pursuant to notice, at 2:35 p.m. in room SD-106, Dirksen Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, Begich, Gillibrand, and Blumenthal.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

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

Minority staff member present: Diana G. Tabler, professional staff member.

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

Committee members' assistants present: Brian Burton, assistant to Senator Lieberman; Lindsay Kavanaugh, assistant to Senator Begich; Elana Broitman, assistant to Senator Gillibrand; Ethan Saxon, assistant to Senator Blumenthal; and Lenwood Landrum, assistant to Senator Sessions.

OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN

Senator WEBB. The subcommittee will come to order. The subcommittee meets today to receive testimony on the Department of Defense (DOD) programs and policies to support military families with special needs in review of the National Defense Authorization Act (NDAA) for Fiscal Year 2013 and the Future Years Defense Program.

At the outset, let me say a few things. First, I know that this is a hearing that was supposed to have been held yesterday. Some of you have been required to stay over a day in order to testify. I want you to know I appreciate that, and I think everybody here is aware of what we have been doing on the Senate floor for the past

3 days. We had the Farm Bill up and we entertained more than 70 amendments in 3 days.

Having spent 4 years as a committee counsel on the House side, I can tell you it is a lot different on the Senate side in terms of how we address amendments because each of these amendments is debated. There is a time for a vote, and each senator has to personally present themselves when they vote. It is a very timeconsuming process, and I think there is actually a pretty good bipartisan feeling right now that we were able to get through such a complex piece of legislation, nearly a \$1 trillion piece of legislation during that time period.

But I do apologize for not having been able to have held this hearing yesterday. We thought about trying it, but quite frankly, we would have been in and out of here constantly, and I do not think it would have been the best use of the time of the people who have come here to testify.

I would also like to acknowledge Senator Gillibrand, who is, I have heard, on her way, for having expressed an interest in a couple of these issues, which resulted in Senator Levin and Senator McCain suggesting that we hold a hearing on these issues. So this is what we are doing. This was during the recent markup of the Defense Authorization bill. She requested that some specific special needs programs be examined in an open subcommittee hearing. We are doing that today and very pleased to be doing that today.

We are fortunate to have with us today a diverse panel. Our witnesses are Dr. Karen S. Guice, Principal Deputy Assistant Secretary of Defense for Health Affairs, and Principal Deputy Director of TRICARE Management Activity; Dr. Rebecca L. Posante, Deputy Director of DOD's Office of Community Support for Military Families with Special Needs; Dr. Vera F. Tait, Associate Executive Director, and Director of the Department of Community and Specialty Pediatrics of the American Academy of Pediatrics; Mr. Jeremy L. Hilton, a military spouse, a veteran, and a military family advocate, as well as the 2012 Armed Forces Insurance Military Spouse of the Year as voted by his fellow military peers in Military Spouse Magazine; Dr. Geraldine Dawson, Chief Science Officer of Autism Speaks, and Professor of Psychiatry at the University of North Carolina at Chapel Hill; and Mr. John O'Brien, Director of Healthcare and Insurance for the U.S. Office of Personnel Management (OPM).

This panel represents a variety of interests and viewpoints: the Federal Government, clinicians, the military family community, non-profit organizations, and academia. We look forward to hearing from each of you today.

I have said in many previous hearings that ensuring that our uniformed personnel and their families receive first-rate healthcare is one of the critical elements in what I view as the military's moral contract with those who volunteer to serve our Nation. I say that as someone who grew up in the military, who had the honor of serving as a marine rifle platoon and company commander during Vietnam, whose son served as a marine infantryman in Iraq, whose brother served, and both my sisters married military professionals. I care deeply about this, as I am sure everybody on this panel does also.

Families play a significant role in maintaining our volunteer force, and this is true now more than ever. Our servicemembers must know that their families are receiving timely and professional medical care, especially when they are so frequently deployed. This can be even more imperative in cases where military family members have special needs.

We are mindful that the term “special needs” is very broad. For some families, “special needs” may mean obtaining necessary care and treatment for complex medical issues. For others, it means gaining access to resources necessary to accomplish goals set out in a child’s individual education program at school. For many, it can mean a combination of medical treatment, educational services, and systems of support for caregivers.

Given the unique challenges inherent to military life, including frequent relocations to new homes and schools, and having a new team of medical providers with each permanent change of station (PCS), not to mention deployments, it is no wonder that DOD felt it necessary to establish the Exceptional Family Member Program (EFMP). This program provides support to our military families with special medical and educational needs through identification and enrollment, assignment coordination, and family support. Currently, more than 120,000 servicemembers are enrolled in this program.

Beyond support through EFMP, DOD reports that in fiscal year 2011, more than 10,000 beneficiaries were enrolled in the Extended Care Health Option (ECHO) program, which supplements basic TRICARE coverage. This program provides eligible Active Duty families with up to \$36,000 a year to help cover the costs of services and supplies necessary for qualifying medical and physical conditions.

Data for the ECHO program provides us with a sense of the scope of conditions that some military families face today. For example, DOD tells us that more than 6,000 dependents have been diagnosed with autism. More than 1,000 have infantile cerebral palsy. Another 2,700 have disorders including epilepsy, hearing loss, digestive disorders, spina bifida, or muscular dystrophy. These are just the major categories of medical conditions military families with special needs must address.

Today, we aim to increase our awareness of the challenges facing our military special needs families. Some examples: we recently heard of the need for better outreach to military families with special needs, some of whom may be unaware of resources that are available to them, continued effort to provide more uniform support through EFMP from installation to installation, and assisting our servicemembers and their families to navigate the various medical and educational services available from State to State.

We have also been informed that OPM recently determined that applied behavior analysis (ABA) therapy for autism spectrum disorders is considered medical therapy for purposes of offering it to beneficiaries under the Federal Employees Health Benefits (FEHB) program. DOD has been offering ABA therapy for several years, but not under its basic TRICARE program as it has determined that ABA is an educational intervention and not a medical therapy.

We are interested in hearing the thoughts of today's witnesses about this distinction.

We appreciate the breadth of knowledge the panel before us today possesses. I hope that our witnesses can help us to identify the key issues and concerns facing military families with special needs, the steps DOD has taken to address those concerns, and where DOD and Congress can do a better job.

We look forward to your testimony. I encourage all of you to express your views candidly, to tell us what is working and what is not, and to raise any concerns and issues you may want to bring to this subcommittee's attention.

I would also point out at this time that we have received written statements from the National Military Family Association and the National Council on Disability. These statements will be included in the record at the end of the testimony of the witnesses that we have today.

[See Annexes A and B]

Senator WEBB. We will now hear brief opening statements from each of our witnesses. I would like to say to each of our witnesses that your full prepared statements will be entered into the record in their entirety at the end of your opening statements. I would ask that you look to keeping your opening statements to about 5 minutes.

We have six witnesses, so that is going to take us probably a little more than a half hour to do that.

Please proceed. Dr. Guice, welcome.

STATEMENT OF DR. KAREN S. GUICE, PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS AND PRINCIPAL DEPUTY DIRECTOR, TRICARE MANAGEMENT ACTIVITY

Dr. GUICE. Mr. Chairman, members of the subcommittee, as you can tell, I have laryngitis. I would like to beg your indulgence in letting me talk a little over the 5 minutes, if I have to.

Thank you for the invitation to discuss the military health system—

Senator WEBB. Very convenient, Dr. Guice, that you would have laryngitis when we have called you to this hearing. [Laughter.]

You are getting a lot of empathy right now, so if you want to make your statement briefer, that is fine. We can do it any way possible to accommodate you.

Dr. GUICE. Thank you. Military service brings unique challenges to anyone who wears the uniform. Those servicemembers who have special needs children have additional challenges.

DOD is proud of the programs and services we offer to these families in conjunction with other support services provided by State and local governments and the private sector. Dr. Rebecca L. Posante will talk about those services provided by the Office of Community Support for Military Families with Special Needs. I will briefly touch on the health benefits and supplemental services we provide through our basic medical plan and the ECHO program.

DOD offers a comprehensive and uniform medical benefit for military beneficiaries delivered worldwide through our military treatment facilities or purchased care. For our beneficiaries, these

medical benefits include access to a variety of providers, including specialists, inpatient and outpatient care, as well as prescription medication.

In addition to the basic health plan, the military health system offers the ECHO program. This program provides additional beneficiaries not otherwise available under the basic health plan to eligible Active Duty servicemembers with special needs. By ensuring our Active members have access to these services, we support military retention and readiness for DOD.

One example of the services covered under the ECHO program is ABA treatment for patients with autism spectrum disorders (ASD). Since 2001, DOD has covered ABA services for qualifying members. Because many of our Active Duty families found it difficult to access certified ABA providers under the traditional ECHO program's criteria, we implemented a demonstration project in 2008, to determine if we could expand the availability of providers.

Under the demonstration program, we cover ABA services when provided by tutors who are under the direct supervision of certified ABA therapists. This demonstration project has succeeded in expanding access to services, and participation in the demonstration project has grown by average of 3 to 5 percent per month per year. We are now in the process of converting the demonstration project into a permanent part of the ECHO program.

Military families also asked us to help sustain continuity of care and service during reassignments and relocations. We work closely with our TRICARE regional offices and TRICARE contractors to ensure that there is a smooth transition for families with children who have special needs when they relocate.

I understand that one of the primary purposes of this hearing is to address medical coverage decisions by OPM for the FEHB Plan and TRICARE relative to ABA for patients with ASD. In 2010, DOD conducted an assessment to determine if ABA qualified as medically necessary and appropriate under existing TRICARE law and regulation. Through robust analysis, peer review literature, and independent technical analyses, ABA was determined to be an educational intervention, and as such, did not meet the criteria for coverage under the basic medical program.

Our determination is consistent with the 2011 Agency for Healthcare Research and Quality's Comparative Effectiveness Review, Therapies for Children with Autism Spectrum Disorders. In this review, the investigators found the literature to be highly variable in quality, limited in those specific areas, and inconclusive. They identified the need for more research to determine which children benefit from a particular intervention or combination of interventions.

In the same report, the investigators clearly separated education and behavioral interventions for medical interventions. They did not consider ABA to be a medical intervention, which is consistent with DOD's 2010 review. However, we also understand that OPM has recently reviewed evidence that they believe now meets their threshold for determining ABA as a covered medical service. We have formally requested that OPM provide us this evidence so we can evaluate it against our coverage criteria.

Medical care evolves over time, and we continuously evaluate new medical interventions or treatments for effectiveness and safety prior to a coverage determination. Our coverage determinations are strictly governed by statute and regulations, and require an extensive assessment of reliable medical evidence. Our determinations are also based on what is medically or psychologically necessary to diagnose and treat disease or injury.

DOD is committed to providing comprehensive services for military families who have children with special needs. By providing robust medical care for our Active Duty members and their families, along with supplemental services to further support those with special needs, we contribute to a stronger warfighter.

I am proud to be here with you today to represent the military health system and our exceptional health providers who provide exceptional service to exceptional people. I look forward to answering your questions.

[The joint prepared statement of Dr. Guice and Dr. Posante follows:]

JOINT PREPARED STATEMENT BY DR. KAREN S. GUICE AND DR. REBECCA L. POSANTE

Mr. Chairman, members of the subcommittee, it is a privilege for both of us to appear before you today, and we appreciate the opportunity to testify on our efforts to support military families that include a member with special medical or educational needs.

The Department of Defense is proud of the programs and services we provide to military families with special needs. We have been providing specialized services to families for decades. In response to the landmark legislation for military families with special needs (Sec. 563 of the National Defense Authorization Act, Pub. L. No. 111-84), the Secretary of Defense established the Office of Community Support for Military Families with Special Needs (OSN) in October 2010. This office is leading efforts to streamline processes that can be improved, to develop policies that guide the provision of support by the military departments, and to generally help families identify, understand and navigate the systems they will encounter. This office is closely linked with our colleagues in the Office of the Assistant Secretary of Defense (Health Affairs) and the TRICARE Management Activity (TMA) within the Office of the Under Secretary of Defense (Personnel & Readiness).

Support to military families with special needs is an especially important task for the Department. Military families with special needs are first military families. They have the same challenges any other military family may encounter in the face of periodic moves, deployments, and separation from family. Further, they face additional challenges, navigating often complex systems to obtain the services and benefits their families need to help their loved one function to their maximum potential. Each time a military family moves the process starts over, and they face questions such as: Who provides early intervention services in this State? Am I going to the local school system, public health or a regional board to get help? What do they call their programs here? Is there a waiting list for Medicaid, or perhaps, how long is the waiting list? Where do I sign up for the women, infants, and children program, and will they accept the certification from my current state? What will we do when we can no longer take our non-verbal child to the dentist who has finally achieved his trust? Will there be anyone at the new location who will understand what we need? What school district can best meet the needs of my child?

We recognize that these military families need assistance with these questions, and we have worked to make this process less challenging wherever possible.

THE CURRENT STATE OF THE EXCEPTIONAL FAMILY MEMBER PROGRAM

For over 30 years, the Military Services have administered the Exceptional Family Member Program (EFMP), which identifies family members who have special medical or educational needs, documents their needs and ensures they are considered when the servicemember is being considered for the next assignment. Since the NDAA for Fiscal Year 2010, the EFMP has been expanded to include a requirement for family support and to extend the coordination of assignments based on the fam-

ily member's special needs to permanent change of station (PCS) moves within the United States as well as overseas.

Currently, over 400 EFMP family support personnel serve military families with special needs. All installations have either a full- or part-time staff person, or (in smaller locations) a point of contact for military families with special needs. Installations with greater numbers of families with special needs may have multiple EFMP family support personnel. All providers have been trained in their roles, the agencies with which they will work, and the requirements of supporting military families with special needs.

The OSN developed an EFMP Family Support Reference Guide and disseminated it to all EFMP family support providers (to include Reserve and Guard Components) as a guide to providing family support and networking with community support systems. Through a Memorandum of Understanding with the U.S. Department of Agriculture (USDA), the OSN partnered with Cornell University and the University of Kansas to conduct a benchmark study identifying the concerns of military families with special needs, the support they require, and the systems that have been effective in providing services. The research team conducted focus groups with military families from all branches of Service and with civilian populations. This study will generate recommendations for the military in refining our support programs including staffing models, metrics, evaluation standards, and a family satisfaction scale.

The OSN is working closely with the Military Services to standardize the EFMP across Services. Military families want consistency, and we are improving their ability to navigate internal processes more easily by having standard forms, terms, and procedures. The OSN embarked on a multi-year project to analyze current systems (medical, personnel and family support) that make up the EFMP (identification/enrollment, assignment coordination and family support) to even more closely integrate service delivery. We have concluded the first year of the functional analysis. Over the longer term, we will create an integrated, longitudinal electronic record that works across all military departments. This system will prevent families from reinventing paperwork with every PCS, allow the medical command to alert the personnel command about availability of medical services, and regardless of Service affiliation the family will receive a warm handoff to the receiving location. This is a detailed, iterative process involving multiple data and case management systems. The end result, however, will offer an important enhancement to the families we serve.

LISTENING TO OUR MILITARY FAMILIES

In the last 2 years, we have held two EFMP family panels representing military families of all ranks, Service affiliation, Active Duty and Reserve components, and ages and disabilities of the family member with special needs. We have conducted three studies on access to special education in the public schools, access to Medicaid, and a benchmark study on what makes a support system work. The lack of State and local data identifying military-connected families who use public sector programs, including special education, remains a gap.

We have also consulted with non-governmental agencies on their knowledge of the relevant issues regarding special needs families, and participated in several of the Military Family Caucus sessions. These Caucus sessions pertained to special needs, and military family members who advocate for families with special needs were invited to discuss issues in our office. We have read the National Council on Disability's report, *How to Improve Access to Health Care, Special Education, and Long-Term Support and Services for Family Members with Disabilities*, and met with the researchers who developed the report. The same issues for our families emerge in each forum: access to special education, access to Medicaid, transition problems with access to TRICARE when families change locations, and a request for inclusion of applied behavior analysis as a medical benefit within TRICARE rather than through the Extended Care Health Option.

We have focused on providing the information military families with special needs members need, particularly during critical transition moments; we work to educate them about what is available to them and assist them with obtaining resources and benefits within the scope of the law. Our efforts have been directed at identifying the problems families encounter, addressing those we have the authority to address (such as consistency across the military departments) and collaborating with the agencies/programs responsible for services not within our control.

EDUCATING OUR FAMILIES

While the Department does not have authority over programs in other governmental agencies or programs administered by the States, we have the responsibility

to educate our families on how to identify resources available to any American citizen and obtain benefits. We can provide information about special education and the Individuals with Disabilities Education Act (IDEA) and all its requirements and protections. Many military family children benefit from special education and the families must know how these systems work. Our military families need and benefit from programs such as Medicaid, Supplemental Security Income, and early intervention, too.

The OSN has created a wealth of information for military families available online at the MilitaryOneSource.mil website or by calling Military OneSource. These include written guides for families whose children have disabilities and a new guide for families where there is an adult family member with special needs. Both guides will be accompanied by a facilitator's manual, which can be used by EFMP staff (or families) to conduct training sessions on special education, early intervention, TRICARE, and much more. We conduct monthly webinars utilizing the talents of leaders in our field on such subjects as care giving, assistive technology, guardianship and estate planning, and advocacy. We have produced a series of podcasts available on smart phones and a mobile website that allows families to access EFMP providers, EFMP enrollment forms, and all of our online content. Several e-learning modules have been developed to increase parents' knowledge about special education and how to collaborate with school personnel, about the EFMP and about other Federal and State programs.

We are in the process of revising the content and presentation on the Military OneSource website and anticipate completion of this revision by September 1. From one landing page families with special needs will be able to learn about military and community programs, access an EFMP provider, sign up for a webinar or view archived webinars, request materials, or make an appointment for a specialty consultation with a Military OneSource consultant who is a professional in special needs.

SUPPORTING DOD PROGRAMS TO SERVE FAMILY MEMBERS WITH SPECIAL NEEDS

OSN has created an internal coalition of Defense organizations to address issues of access for our military families with special needs. Through effective collaboration with the military departments, the EFMP and Morale, Welfare and Recreation, we have built over 200 accessible playgrounds for children with disabilities and installed pool lifts in all military swimming pools. We have developed online tools for families who are moving with a special needs family member to help them plan their move. For the past 2 years in cooperation with the military children and youth programs, we have funded ongoing training and support to enable those programs to integrate children and youth with disabilities. The OSN purchased and distributed books and electronic subscriptions to all military departments' installation libraries and family centers to create an EFMP library. The set of references is intended to assist professionals and family members in accessing materials on disability-related topics. In addition, special education law resources were provided to military department legal offices and selected medical offices. We work closely with the DOD Education Activity to ensure the 9,700 children with special needs attending a DOD schools receive appropriate special education services.

ACCESS TO SPECIAL EDUCATION

Military families are concerned about access to special education services. Obtaining comparable services from one assignment to the next is the most consistently reported obstacle for military families and often reflects differences in eligibility and services between States. For example, the American Association for Employment in Education (AAEE) has reported shortages of special education teachers, speech-language pathologists, school psychologists, vision and hearing specialists, school nurses, physical therapists and occupational therapists, with many regions of the country reporting considerable shortages for several years in a row (AAEE, 1996–2010). There are wide disparities in school nurse staffing ratios; some exceed 1:4,000. Only 75 percent of schools have a full or part time nurse; 25 percent have no registered nurse. Seventeen percent of schools with more than 750 students have no registered nurse on duty (National Association of School Nurses (NASN)). Forty-eight States and the District of Columbia identified special education teaching and/or at least one of the related service provider categories as an official "shortage area" for the 2011–2012 school year (Teacher Shortage Areas Nationwide Listing, U.S. Department of Education, Office of Postsecondary Education, March 2011). Given well-documented fiscal pressures on State budgets, it is likely that discrepancies in which resources are available between school districts and among States will persist.

To address family member information needs in this area, OSN has initiated multiple efforts including establishing a resource clearinghouse to help families with relocation; identifying and promulgating effective support practices among service branches; and sponsoring research studies on evidenced-based educational practices. OSN developed an online Education Directory to inform families of points of contact, resources, and procedures in public school districts in the States with the highest number of military assignments. The project continues and by the end of fiscal year 2014, we will publish a directory that includes all 50 States and the District of Columbia.

Through the USDA MOU previously mentioned, we are partnering with Ohio State University and Pennsylvania State University to collect more detailed data about the extent and types of issues impacting families as they attempt to access comparable special education services in their new duty station. This project will support the identification of special education issues for which parents and family support providers need additional training and assist in determining if a formal military complaint documentation system should be explored in collaboration with the U.S. Department of Education.

ACCESS TO MEDICAL SERVICES—TRICARE, EXTENDED HEALTH CARE OPTION (ECHO) AND MEDICAID

In managing health and health benefit issues, we first ensure we are faithfully following public law regarding what is a covered medical benefit. We also seek to align our initiatives to the Military Health System (MHS) strategic plan, the Quadruple Aim, which is comprised of four interrelated missions—Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care. We consider “family readiness” as an essential element of our Readiness strategy.

The MHS has long been a leader in offering benefits and services to military families with special needs. We have directed considerable effort in formulating policy for coverage of effective therapies under the TRICARE Basic Program and the Extended Care Health Option (ECHO) program.

TRICARE Basic Program

The TRICARE Basic Program—whether TRICARE Prime, TRICARE Extra, or TRICARE Standard—offers a comprehensive health benefit that covers any medically or psychologically necessary care for special needs beneficiaries, to include physician visits, immunizations, psychological testing and medical interventions such as speech therapy, physical therapy and occupational therapy. TRICARE offers exceptionally comprehensive coverage with very low out of pocket costs to our beneficiaries. For active duty families enrolled in TRICARE Prime, the out of pocket costs are almost non-existent, and families are further protected by a \$1,000 out of pocket catastrophic cap, after which DOD pays 100 percent of allowable costs. By law, the TRICARE Basic Program may not cover non-medical services such as Applied Behavior Analysis (ABA).

Extended Care Health Option

The ECHO program, established under Title 10 U.S.C. Code 1079, provides additional benefits not otherwise available under the TRICARE Basic Program to certain eligible active duty family members with special needs. As established by law (National Defense Authorization Act for Fiscal Year 2009, Public Law 110-417), the government will cover up to \$36,000 per beneficiary per year in ECHO benefits.

As we noted at the beginning of our testimony, similar to other military families, our active duty families with special needs members must move frequently from one location to another. To ensure continuity of care for ECHO participants when they move, our TRICARE contractors have established case management hand-off processes so that the receiving contractor will be prepared to maintain for a family the set of ECHO services it had been receiving before moving. Because of the complexity and diversity of the services required to effectively address the special needs of many participants in ECHO, TRICARE requires its regional managed care support contractors to provide case management services to ECHO participants. Applied case management ensures access to a comprehensive, coordinated set of required treatments and services.

Each of the three TRICARE contractors is required to deliver a uniform TRICARE benefit. Consequently, a family can expect to receive the same ECHO services upon arrival at the new duty station. However, families may notice some differences in the administration of these services by our regional contractors. The Department does permit some variation in administrative practices in order to permit the use of contractor best practices. In the unlikely event a family should be denied coverage

under either TRICARE Basic or ECHO it had been receiving in another TRICARE region, there is a well-designed appeal process beneficiaries may use, and the contractors are required to assist them in understanding and exercising their appeal rights.

Examples of benefits not available through the TRICARE Basic Program, but available through ECHO include: assistive services, expanded in-home medical services, institutional care when a residential environment is required, and other services that the Director of TMA determines are capable of reducing the disabling effects of a qualifying condition. These “qualifying conditions” include Autism Spectrum Disorders (ASD). At the end of fiscal year 2011, DOD had over 10,000 TRICARE beneficiaries registered in the ECHO program.

The Department has worked to ensure our special needs families with ASD have access to the most widely-accepted educational intervention, known as ABA. Since 2001, the Department of Defense has covered ABA services for eligible active duty family members under the ECHO program (and its predecessor, the Program for Persons with Disabilities). Originally, we covered ABA services only if provided by a Board Certified Behavior Analyst (BCBA). We found there were not enough of them available to satisfy the demand from Active Duty family members for services. So, in 2008 we constructed a demonstration to increase access to ABA services by permitting tutors, under the supervision of BCBAs, to provide the services. Even today, ECHO enrollees with an ASD who want ABA services but who do not want to participate in the demonstration may obtain the services directly from a BCBA, if available from that source.

This demonstration has succeeded in expanding access to services—and we continue to witness increased participation by ABA supervisors, tutors and TRICARE beneficiaries. As of March 31, 2012, there were 3,783 beneficiaries enrolled in the demonstration—a number that has grown by 3–5 percent annually, on average, since the program was first introduced in 2008. Just as importantly, a recent DOD survey of military parents of dependent children with autism reported that the improved access to ABA services contributed to improved military family readiness and retention.

The Department is now moving beyond a demonstration program and seeking to embed the supervisor-tutor model of ABA provision as a permanent element of the ECHO program. We published a proposed rule in the Federal Register on December 29, 2011, to establish coverage of this ABA provision under ECHO for eligible beneficiaries with ASD. Upon final implementation of this rule, we intend to categorize ABA as an “Other Service” under the ECHO statute and permanently adopt a more robust ABA services delivery and reimbursement methodology.

While we are pleased that we have been able to broaden access to these services, we do recognize that some families experience additional out-of-pocket costs when needed services exceed the government’s statutory limit of \$36,000. Based on our own claims data from 2011, 207 beneficiaries using the ECHO program had expenditures above \$35,000 per year. Another 489 beneficiaries had expenditures between \$30,000 and \$35,000. Thus, in 2012, we estimate that approximately 86 percent of TRICARE beneficiaries with an ASD diagnosis and using the ECHO program have had 100 percent of their expenses covered within the \$36,000 government maximum.

Several Members of Congress have inquired about the feasibility of categorizing ABA services as a medical benefit covered under the TRICARE Basic Program. The Department conducted a thorough technical assessment of ABA in 2010 to determine whether ABA met the requirements for inclusion as a TRICARE covered service.

Our technical assessment looked at the following: Does the reliable evidence, as that standard is defined in law and regulations for TRICARE Basic Program coverage determinations, 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 Sec. 199.4. Can ABA be covered as a TRICARE benefit under Chapter 55 of Title 10, 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?

We found that ABA is an “educational intervention” and does not meet the TRICARE definition of medically or psychologically necessary care. The majority of the reliable evidence characterizes ABA as not being a medical treatment, as that standard is defined in law and regulations for TRICARE Basic Program coverage

determinations, but instead as involving non-medical, behavioral intervention services.

Consequently, the Director, TRICARE Management Activity has concluded that ABA is not medically or psychologically necessary or appropriate medical care within the meaning of the law and regulations governing coverage of medical benefits under the TRICARE Basic Program. However, the assessment indicates that TRICARE has authority to pay for ABA to reduce the disabling effects of ASD for ECHO-registered dependents with an ASD diagnosis, and this assessment helped guide our decision to make ABA services a permanent part of the ECHO program. The assessment and Director's conclusion serve as the administrative record of the agency's decision and is reflected in the proposed rule. The TMA's Medical Benefit & Reimbursement Branch reviews information about Medicare's and other payers' coverage, regular medical technology updates available through a subscription to Hayes, Inc. reports (a medical technology assessment firm), data/evidence submitted by beneficiaries and providers on appeal, evolving practice information from the Office of the Chief Medical Officer, and TRICARE Managed Care Support Contractors' evolving practice reports. TMA decides on the basis of these information sources whether it is warranted to conduct a formal review to determine if a medical technology can be confirmed by the hierarchy of evidence specified in 32 CFR 199.2 to be considered medically safe and efficacious.

Medicaid. Some military families with special needs beneficiaries also qualify for Medicaid. There are select services that TRICARE does not cover that are available through this Federal-State medical program. Example of items and services that TRICARE (and most civilian health insurance) does not cover includes long-term care, custodial care (assistance with daily living), adult day services, or expendable items such as diapers.

Because Medicaid is State-administered, military families that include member(s) with special needs face difficulties each time they move and they are required to reapply for Medicaid eligibility. In some cases, this includes placement on waiting lists. Because of the frequency of military rotations, some families do not move off the waiting list before they once again relocate.

The Department has contracted with West Virginia University to study the problems military families face with accessing Medicaid. Preliminary findings of the West Virginia study indicate that families and EFMP providers need more training on how to access Medicaid. The final report from this study will be available in fall 2012.

The DOD State Liaison Office held an open meeting recently to discuss adopting this as one of the issues to address with States much as they have addressed the transition of school-aged children. We will provide an update on the outcome of this recommendation in the near future.

The Department recognizes the enormous challenges that military families with special needs beneficiaries experience, and we have aggressively sought to meet their needs with targeted programs and services. As we stated earlier—family readiness is a military readiness issue. We have made tremendous progress over the past several years, consistent with the law that Congress has established.

In the case of military children with special needs, we have crafted programs that have only been enhanced and improved over the last 10 years—in the areas of education, special education, community wide information and education. In the medical arena, we have successfully expanded programs that allow for the delivery of services beyond the traditional medical services authorized under TRICARE. We have continuously worked to expand both service delivery and reduce their out of pocket expenses. Congress has also expanded the government's maximum cost-share for the ECHO program from \$2,500 monthly maximum to \$36,000 annually.

We are committed to maintaining our passion for excellence and service to these very special families. We are proud of what we have accomplished to date, and we are optimistic about our ability to continue to meet family member needs for the long-term.

Again, we thank you for inviting us to be here today, and we look forward to your questions.

Senator WEBB. Thank you very much, Dr. Guice.
Dr. Posante, welcome.

STATEMENT OF DR. REBECCA L. POSANTE, DEPUTY DIRECTOR, OFFICE OF COMMUNITY SUPPORT FOR MILITARY FAMILIES WITH SPECIAL NEEDS, DEPARTMENT OF DEFENSE

Dr. POSANTE. Thank you, Senator Webb, for inviting me to testify today. Supporting individuals and families with special needs has been a passion of mine for over 30 years. I really appreciate the attention being paid to this topic today.

When I brief the NDAA for Fiscal Year 2010 to military audiences, I always refer to it as landmark legislation. It established the Office of Community Support for Military Families with Special Needs, for which it has been my pleasure to serve as the Deputy Director for nearly 2 years. It served as a catalyst for our efforts to streamline processes that can be improved, to raise issues that need to be raised, to develop policies that guide the provision of support by the military departments, and to generally help families identify, understand, and navigate the systems they will encounter.

Military families with special needs are military families first. They face the same challenges that other military families face due to periodic moves, deployments, and separation from their extended families. But in addition, our families with special needs face the challenge of navigating often complex, stovepiped, and confusing educational, medical, and community support systems. Our families have children with intellectual, physical, communication, and emotional disabilities. In about a third of our families, it is the adult member that has a special need.

The good news is that there are a myriad of systems, military, State, and local community systems, available to support them. The bad news is there are a myriad of systems. Our office has been charged with bringing order to this chaos and helping our families access the support they need.

Currently, over 400 family support personnel serve military families with special needs. All of our installations, depending on their sizes, have a full or part-time staff person or, in some very small locations, a point of contact for military families with special needs. Over the last 2 years, all of our providers have been trained on their roles, on the agencies with which they should be working, and on the requirements of supporting military families with special needs.

Communicating with our families is important. Educating them on programs, benefits, and resources is crucial. Working jointly with the military departments, we have provided a wealth of information to military families with special needs, including materials available online and through Military OneSource.

My written testimony outlines our ongoing work in greater detail, where we are succeeding, and where we have more work to do. Thank you so much for your support.

Senator WEBB. Thank you, Dr. Posante. Again, I would remind the witnesses that your full written statements will be entered into the record at the end of your opening statements. Also, just for the subcommittee, that the hearing record will remain open until close

of business tomorrow in case there are written questions that anyone would like to present to you.

Senator WEBB. Dr. Tait, welcome.

STATEMENT OF DR. VERA F. TAIT, ASSOCIATE EXECUTIVE DIRECTOR, DEPARTMENT OF COMMUNITY AND SPECIALTY PEDIATRICS, AMERICAN ACADEMY OF PEDIATRICS

Dr. TAIT. Thank you. Chairman Webb and members of the subcommittee, thank you for holding today's hearing on such an important topic: military families who have children with special healthcare needs. I am Dr. Vera Fan Tait, and I represent the American Academy of Pediatrics (AAP), a professional organization of more than 60,000 primary care pediatricians and pediatric subspecialists. I am honored to join this panel, which includes such extraordinary advocates and experts.

I am a pediatric neurologist and an Associate Executive Director at the AAP. Prior to joining the AAP, I was in practice for more than 25 years with my major areas of expertise including children and youth with special healthcare needs, traumatic brain injury, neurodevelopmental disabilities, and neurologic rehabilitation. Caring for our Nation's military families and their children has always been of paramount importance for AAP. I am proud to say that one of the oldest sections in our academy is the section on uniform services.

The impacts of long or multiple deployments on all military families can be significant. For families with children who have neurodevelopmental disabilities or disorders, these impacts are often significantly exacerbated. The AAP believes that the optimal health and well-being of all infants, children, adolescents, and young adults, including those in military families, is best achieved with access to appropriate and comprehensive health insurance benefits. These benefits must be available through public health insurance plans, like Medicaid, the Children's Health Insurance Program (CHIP), and TRICARE, as well as the private health insurance plans.

AAP policy recommends that minimum health benefits for infants, children, and youth should provide all medically necessary care within the medical home. We believe that medical and other services must be delivered and coordinated, as you said, Senator Webb, in a comprehensive patient- and family-centered medical home, which is the quality setting where physicians who are known to the family and to the child have developed a partnership of mutual responsibility and mutual trust.

The health insurance plan that most military families use is TRICARE, and services, as we have heard, covered by TRICARE provided by pediatricians who are Active Duty military, but also community pediatricians and pediatric sub-specialists, who provide care near military facilities. Military families often face challenges navigating the TRICARE program, many times struggling to find the appropriate pediatric providers or have certain pediatric services covered.

One area of particular concern among military families, and the reason we are here today, is to look at children with special healthcare needs and the coverage of services for children with

neurologic disorders, especially the ASD. Unfortunately, there is often no simple solution for families whose children must receive care often from numerous providers. A coordinated approach to intervention and treatment among the medical home, the educational institutions, and the family is really critical for success.

One demonstrated effective treatment for autism is ABA. The symptoms associated with autism are directly addressed by ABA methods, which have proven effective in addressing the core symptoms of autism, as well as helping children develop skills and improve and enhance functioning in other areas that affect health and well-being.

The effectiveness of ABA-based interventions and autism has been well-documented through a long history of research. Children who receive early intensive treatment have been shown to make substantial gains in cognition, language, academic performance, and adaptive behavior, as well as social behavior. Their outcomes have been significantly better than those of children who have no access to these interventions. Though more research and ongoing research is needed, ABA has both long-term empirical and research data to demonstrate its effectiveness in helping children who are diagnosed with ASD.

The AAP has endorsed the use of ABA treatments when determined appropriate by physicians within a medical home in close consultation with families.

Thank you for allowing me to testify before the subcommittee today. We must do all that we can to support our military families, but especially those who have the added challenge of raising children with special healthcare needs. Thank you, and I look forward to the questions.

[The prepared statement of Dr. Tait follows:]

PREPARED STATEMENT BY DR. VERA F. TAIT MD, FAAP

Chairman Webb and Ranking Member Graham, thank you for holding today's hearing on such an important topic—the programs and policies that the Department of Defense has in place to support military families with children with special needs. My name is Vera Fan Tait, MD, FAAP, and I am representing the American Academy of Pediatrics (AAP), a nonprofit professional organization of more than 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

I am a pediatric neurologist and am an Associate Executive Director at AAP, as well as the Director of AAP's Department of Community and Specialty Pediatrics. In addition to my role with the American Academy of Pediatrics, I am also a member of the Child Neurology Society and the Association of Maternal and Child Health Programs. Prior to joining the AAP, I was in practice for more than 25 years and my major areas of expertise include children and youth with special health care needs, traumatic brain injury, neurodevelopmental disabilities, and neurological rehabilitation. It was my privilege to care for families with children with autism spectrum disorders and other neurodevelopmental disabilities.

I have personally experienced the struggle that many pediatricians face every day when trying to access needed medical, educational and other services for children with special health care needs. Finding needed services can be difficult even when they are adequately covered by health insurance. It is only more difficult when a primary care pediatrician or subspecialist can locate care only to find it is not covered by a family's insurance.

Caring for our Nation's military families and their children has always been of paramount importance for the Academy. I am proud to say that one of the oldest sections we have at the Academy is the Section on Uniformed Services. Created in 1959, the AAP's Section on Uniformed Services has helped direct the Academy's leadership on the health and well-being of our Nation's military children and adoles-

cents. The Section is comprised of over 900 members who are active duty or retired military, as well as civilian pediatricians who serve military beneficiaries. The section works closely with the pediatric consultants to the surgeon general of each branch of the military.

An example of one of the Section's most recent accomplishments is the development of the Military Youth Deployment Support Video Program, which is designed to help children and adolescents cope with the deployment of one, or sometimes even both, of their parents or guardians to other countries around the world. The video was initially designed by the Section on Uniformed Services and was subsequently utilized by the U.S. Army Medical Command. So far more than 20,000 copies of the program have been distributed worldwide to military families, various military youth serving professional agencies, and primary care offices.

The health and well-being of children in America's military families ranks as one of the top priorities of the Academy, and that is why I am honored to represent AAP here today. The impacts of long or multiple deployments on all military families can be significant and for families with children with autism spectrum disorders, neurodevelopmental disorders or other disabilities, these impacts are often significantly exacerbated.

The American Academy of Pediatrics believes that the optimal health and well-being of all infants, children, adolescents and young adults through 26 years of age—including those in military families—is best achieved with access to appropriate and comprehensive health care insurance benefits. These benefits must be available through public insurance plans like Medicaid, the Children's Health Insurance Program and TRICARE, as well as private health insurance plans.

AAP policy recommends that minimum health benefits for all infants, children, and youth should provide all medically necessary care, and include such services as:

- preventive care
- hospitalization
- ambulatory patient services
- emergency medical services
- maternity and newborn care, and
- mental health and substance abuse disorder services.

Also included in the set of benefits should be:

- behavioral health
- rehabilitative and habilitative services and devices
- laboratory services
- chronic disease management, and
- oral, hearing and vision care.

In short, all children must have a medical home. AAP believes that medical and other services should be delivered and coordinated in a comprehensive, patient and family-centered, physician-led medical home—the quality setting for primary care delivered or directed by well-trained physicians who are known to the child and family, who have developed a partnership of mutual responsibility and trust with them, and who provide accessible, continuous, coordinated, and comprehensive care.

The health insurance plan that most military families use is TRICARE. Services covered by TRICARE are provided by pediatricians who are active duty military but also community pediatricians and pediatric subspecialists who provide care near military bases and other military facilities. AAP members providing care to children and families covered by TRICARE face unique challenges compared to other public and private programs and plans. For example, one of the challenges that military families with children face is that the TRICARE program is largely based on Medicare, a health system designed to provide coverage for senior adults. Because of this program alignment, military families often face challenges navigating the TRICARE program, many times struggling to find appropriate pediatric providers or have certain pediatric services covered. This is especially true for parents of children with special health care needs. AAP has worked closely with TRICARE programs to ensure needed services are available from routine immunizations to highly specialized and acute pediatric care.

One area of particular concern among military parents of children with special needs is the coverage of services for children with autism spectrum disorders or other neurological disorders. Recently released data from the Centers for Disease Control and Prevention confirms that the prevalence of children with autism spectrum disorder (ASD) is growing, as is the need for effective services to help children with ASD maximize their potential.

Autism spectrum disorders, similar to other neurodevelopmental disabilities, are generally not “curable,” and complex care is required for the child along with services for the family. Unfortunately, there is often no simple solution for families and

effective, family-centered care will include numerous providers. A coordinated approach to intervention and treatment among the medical home, educational institutions and the family is critical for success.

Optimizing medical care and therapy can have a positive impact on the habilitative¹ progress and quality of life for the child. Medically necessary treatments ameliorate or manage symptoms, improve functioning, and/or prevent deterioration. Thus, in addition to routine preventive care and treatment of acute illnesses, children with ASD also require management of sleep problems, obsessive behaviors, hygiene and self-care skills, eating a healthy diet, and limiting self-injurious behaviors.

Effective medical care and treatment may also allow a child with ASD to benefit more optimally from therapeutic interventions. Therapeutic interventions, including behavioral strategies and habilitative therapies, are the cornerstones of care for ASD. These interventions address communication, social skills, daily-living skills, play and leisure skills, academic achievement, and behavior.

An example of a demonstrated, effective treatment for ASD is Applied Behavior Analysis (ABA). ABA uses behavioral health principles to increase and maintain positive adaptive behavior and reduce negative behaviors or narrow the conditions under which they occur. ABA can teach new skills, and generalize them to new environments or situations. ABA focuses on the measurement and objective evaluation of observed behavior in the home, school, and community.

ASD is a medical/neurodevelopmental condition with behavioral symptoms that are directly addressed by applied behavior analysis methods. ABA has proved effective in addressing the core symptoms of autism as well as developing skills and improving and enhancing functioning in numerous areas that affect the health and well-being of people with ASD.

The effectiveness of ABA-based interventions in ASD has been well documented through a long history of research in university and community settings.² Children who receive early intensive behavioral treatment have been shown to make substantial gains in cognition, 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.

Late last year, TRICARE proposed to extend coverage under the Extended Care Health Option for Applied Behavior Analysis interventions for Active Duty servicemembers who have family members with autism spectrum disorders. AAP commented on the proposed rule and commended the Department of Defense for undertaking the important task of proposing measures to make it easier for Active Duty servicemembers with children with ASD to better access needed health care services for their children.

In short, though more research is needed, ABA has both long-term empirical and research data to demonstrate its effectiveness in helping children who are diagnosed with ASD, and AAP has endorsed the use of ABA treatments when determined appropriate by physicians within a medical home, in close consultation with families. ABA remains an active subject of research and we encourage the Department of Defense to maintain flexibility in the provision of ABA services as new data may emerge.

Beyond just ABA services, one way to make it easier for military parents with special needs children would be to examine how TRICARE currently works for its beneficiaries. The Academy supports legislation introduced in the House—the TRICARE for Kids Act,³ which could begin the process of making TRICARE work better for all parents, but especially those with children with ASD or other special health care needs.

TRICARE for Kids would require TRICARE to establish a working group of relevant stakeholders to review TRICARE policies and practices and develop a plan to ensure that TRICARE meets the pediatric-specific needs of military families, including those children with chronic and special health care needs. We believe this is an excellent collaborative model to ensure that TRICARE policies work for all children in military families.

¹“Habilitative or rehabilitative care” means professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual.

²“Management of Children With Autism Spectrum Disorders,” Scott M. Myers and Chris Plauche Johnson, *Pediatrics* 2007; 120; 1162; originally published online October 29, 2007; DOI: 10.1542/peds.2007-2362

³The TRICARE for Kids Act was subsequently included as an amendment to the House’s National Defense Authorization Act for Fiscal Year 2013.

Thank you for allowing me to testify before the subcommittee today. As I said earlier, caring for our Nation's military families and their children has always been of paramount importance for the American Academy of Pediatrics. We must do all that we can to support our military families, especially those who have the added challenge of raising children with special health care needs.

I look forward to your questions.

Senator WEBB. Thank you very much, Dr. Tait.

Mr. Hilton, welcome.

**STATEMENT OF MR. JEREMY L. HILTON, MILITARY SPOUSE,
VETERAN, AND MILITARY FAMILY ADVOCATE**

Mr. HILTON. Mr. Chairman and distinguished subcommittee members, thank you for allowing me to discuss our military families impacted by disabilities.

I am a Navy veteran. My wife is Active Duty Air Force. When our daughter, Kate, was born in 2002 with significant disabilities, I resigned my commission to take care of her. This year I was honored as Military Spouse of the Year by my peers in Military Spouse Magazine. It is an amazing privilege to be able to represent a million-plus military spouses and their families.

A recent National Council on Disability Military Families study concluded, "Far reaching systemic changes are needed in our Nation's health, education, and long-term service systems to address the significant barriers faced by exceptional family members." This hearing is a critical step in addressing and acting on these extraordinarily important issues to our military families.

Caring for a child with a disability can be exceptionally expensive and remarkably stressful. We have higher medical bills, therapy bills, home modification and equipment bills, and other large expenses. Many families will need Medicaid waiver assistance for their children, but State Medicaid waiver wait-lists are very long, lasting for years. Every time a military family moves, they go to the bottom of the next State's wait-list. They rarely reach the top before moving again. Those that do lose their Medicaid when the military moves them.

There are a variety of ways in which this problem could be rectified, including a military Medicaid waiver, an interstate compact addressing Medicaid portability, allowing servicemembers to maintain wait-list eligibility based on their home of record, or extending the ECHO benefit into retirement. In the end, we ask that our children are not penalized for the service their mother or father renders to the Nation.

The extended care health option was created to bridge the needs of families unable to access the State Medicaid waiver programs. But experience shows it fails to come close to replacing Medicaid waiver benefits. We are grateful for this benefit, but we would like to see it updated and made more flexible so it better fulfills its purpose.

We support the Senate report language directing DOD to explore more flexible ECHO options. We respectfully ask that EFMP families are included on any working groups considering this and other issues that impact our families.

While we look forward to enhanced functionality and flexibility of the ECHO program, the treatment of autism for our military children is one area that I do not believe requires further study.

It requires action. TRICARE currently segregates ABA, the standard of care, and the treatment of autism into ECHO as a non-medical educational service. TRICARE's classification of ABA as non-medical allows TRICARE to limit care to dependents of Active Duty servicemembers, and places a financial cap on treatment services which fall far below recommended standards. There is no other disease, disability, or chronic health condition which is treated similarly as autism and its segregation of treatment outside the basic TRICARE benefit.

Because the ECHO benefit is only available for dependents of Active servicemembers, dependents of our retirees are not able to access ABA treatments under TRICARE. Prior to the hearing, we supplied 80-plus stories to the subcommittee. Many are heart-breaking, but inspiring at the same time. I am going to read from a letter written by Lance Corporal Hardy Mills, U.S. Marine Corps, Retired.

"In 2004 while serving with the 1st Marine Expeditionary Force in Fallujah, Iraq, I was wounded severely by a rocket propelled grenade. Because of my injuries, I retired medically from the Marine Corps in 2006 with full disability benefits. I am blessed with a supportive wife, and we have two beautiful children.

Our son, Shane, has autism. As a retired Marine and disabled veteran, my family depends on the military healthcare system, TRICARE, for coverage of medical services and interventions. Unfortunately because of my retired status, Shane's medically recommended autism treatment, ABA, is not covered by TRICARE. My family faces out-of-pocket costs of \$4,600 a month associated with this vital service because of current TRICARE policy deficits. We have sold our home to provide Shane the care he requires, but we are running out of funding and ask for your intervention."

The other letters are no less important and show the struggles our military families have gone through to be able to provide therapy to their children. In the end, many of these families are still coming up significantly short, particularly those with younger children and our retirees.

You will hear Dr. Tait and Dr. Dawson testify on the scientific evidence that proves ABA is effective. Many other reputable organizations and members of the medical community have endorsed ABA therapy as the standard of care for autism. I sincerely hope that the Senate Armed Services Committee will take this into consideration and support an amendment to the 2013 NDAA to help our military kids impacted by autism.

These military families are remarkable Americans who endure exceptionally trying circumstances in addition to their service in an already stressful military lifestyle. I would encourage you to take a moment and get to know each of them. As I am certain you realize after reading these stories, we have much work left to do in order to provide the appropriate level of medical care, services, and support these military families deserve.

I would like to personally thank the subcommittee members and the professional staff for their leadership in providing much-needed oversight to these issues. Thank you to this subcommittee for not forgetting our military families. I look forward to your questions.

[The prepared statement of Mr. Hilton follows:]

PREPARED STATEMENT BY MR. JEREMY L. HILTON

Mr. Chairman, Senator Graham, and distinguished members of the subcommittee, thank you for the opportunity to discuss the issues facing our military families impacted by disabilities and your consideration of actions and initiatives that I submit need to be accomplished to ensure our Nation honors its obligations to our military families. By doing so, I believe we enhance the readiness of our All-Volunteer Force and improve the lives of our military children.

INTRODUCTION

I am a 1995 U.S. Air Force Academy graduate that cross-commissioned into the Navy and served 8 years in the submarine force. In 2002, while on shore duty at the Washington Navy Yard, our daughter, Kate, was born with a number of significant disabilities. Seven months later, I resigned my commission and have been taking care of our children ever since. Since Kate's birth we have moved six times, five of those within a 5-year timeframe due to deployments, training, and military Permanent Changes of Station (PCS). Kate has undergone nine surgeries and received thousands of hours of therapy, provided by our family and outside therapists. Our primary goal is to ensure she lives life to her fullest and is educated and lives in the community to the greatest degree possible. My wife remains Active Duty Air Force, and we are currently stationed at Andrews AFB where she is the commander of an AFOSI squadron. We have a 1-year-old son, Jackson.

In May 2012, I had the distinct honor of being selected as the Military Spouse of the Year, based on my advocacy for military families. I started as an advocate for our daughter. That advocacy expanded within the Air Force, then the Department of Defense (DOD), and then to the larger disability population. I quickly discovered there are so many unmet needs in the disability world. Our families are overwhelmed. There is little to no time to be advocates because many families are simply surviving. We don't have the defense industry or unions to ensure our programs receive the funding they require. We have a very small group of volunteer parents that do their best to raise these tough issues when they happen to be stationed in the DC Metro area. What I have learned from being part of this process is that our families do have a voice, but many times it is very quiet, at least relative to the normal buzz in DC. However, what we lack in volume, we make up for with passion. In the short amount of time we've had since the hearing was announced, these amazing families have provided me the most astonishing and personal insights into their lives and the hope they have for their children. I hope the Committee finds their stories instructive (see attachments after written testimony).

This committee plays an integral role in both legislation and oversight on the issues that enable our families to support our servicemembers while they protect our country. Your support continues to be instrumental in making needed changes to the DOD infrastructure, policy, and procedures which will allow our special needs military families to deal with the significant stresses associated with service; PCS, multiple deployments, and the high operational tempo that has marked these past 10 years of war.

There are a number of areas that I will be discussing today: Medicaid Waivers, the Extended Care Health Option (ECHO), TRICARE, Autism, Education, the Exceptional Family Member Program (EFMP), Survivor Benefits, and Legal Issues. Each of these programs and issues has a substantial impact on the health and wellbeing of our military families with disabilities and it is critical that the Committee understand what areas require improvement.

Many of these areas were considered in a recent National Council on Disability (NCD) study on Marine Corps EFMP families (transmittal letter included as Attachment A). In the preamble to the study, the NCD Chairman, Jonathan Young stated:

"However, many of the changes necessary to improve the supports available to military families with [Exceptional Family Members] are beyond the control of the Marine Corps and may require statutory and regulatory changes to meet these needs.

NCD has concluded that far-reaching systemic changes are needed in our Nation's health, education, and long-term service systems to address the significant barriers faced by EFMs. NCD thus seeks support from Congress, the military, and the administration to build the critical Federal partnerships necessary to effect systemic change and ensure that the men and women serving our country can do so knowing their family members with disabilities will have the supports and services they need."

This hearing is the first step in addressing these extraordinarily important issues to our military families.

MEDICAID WAIVERS

Caring for a child with a disability can be exceptionally expensive and remarkably stressful. We have higher medical bills, therapy bills, home modification, equipment and supply bills, and other large expenses. Many, if not most, families impacted by disabilities will come to rely on public assistance programs in some fashion for our children who are disabled. The majority of such programs relate to State-run Medicaid waiver programs which provide short and long term benefits that TRICARE does not. Examples of such supports include incontinence supplies, respite, employment supports, housing, and more flexible medical coverage. Most of the Medicaid waiver programs run by the States have significant waiting lists for citizens to access these benefits because the need is simply much greater than the available benefits. It is not uncommon for a family to place a 1-year-old on the State Medicaid waiver waitlist with the hope the child will receive benefits by the time they are a teenager or an adult, depending on the type of waiver and the State in which they reside. For our highly mobile military families, that means our children constantly remain at the bottom of any given State's waitlist. If by chance they get off the waitlist and receive services in one State, they will lose their eligibility once they PCS, and they will find themselves back on the bottom of the next State's waitlist. Upon retirement after a career of service, our children, yet again, find themselves on the bottom of waitlist at their new and final home.

There are a variety of ways in which this problem could be rectified, including a military Medicaid waiver, an Interstate Compact addressing Medicaid portability, allowing servicemembers to maintain list-eligibility based on their home of record, or extending the ECHO benefit into retirement. Given the cross-committee jurisdictional nature of this issue, Medicaid reform may seem like a bridge too far, but it is one that will have a significant impact on our families.

Parent advocates are currently working with a variety of partners on finding a fix that addresses the problem. The DOD has funded a grant for West Virginia University to study this issue and we expect findings this summer. We would ask that this committee remain engaged on this issue moving forward to ensure State Medicaid services for our military children are provided for equally in comparison to their civilian counterparts.

EXTENDED CARE HEALTH OPTION PROGRAM

The ECHO, created in 2005, was originally designed to bridge the needs of families due to the inability to access State-run Medicaid programs. Our experience has been that it does not replicate those benefits because of the lack of flexibility in the ECHO program. Military families strongly support the Senate report language that directs the DOD:

“to assess participation in the ECHO program by eligible dependents with special needs, and to explore options to provide more flexible benefits.” [sec. 703]

Our families are grateful for the ECHO benefit. However, it is time to reassess its effectiveness to meet the requirements for which it was created. As one is considering the benefits typical families might need, it is imperative that DOD consider best practices as applied by the States. Please understand that while these studies are taking place, children may be very well going without necessary items or therapy. We would hope for an aggressive timeline for dissemination and prompt action on the basis of the results from the study.

There are two helpful resources when considering both Medicaid and ECHO issues:

- United Cerebral Palsy's annual “Case for Inclusion” which ranks the 50 States and DC on its Medicaid waiver programs: <http://www.ucp.org/the-case-for-inclusion/2011/>
- Medicaid's Web based resources: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915%28c%29#wavers>

One striking item included in the Medicaid website highlights that there are 423 different Medicaid waiver programs and demonstration projects throughout all 50 States and the District of Columbia. There must be a way we can find to serve the military family appropriately.

TRICARE

As most parents are quite aware, children are not simply little adults. It is why the children's hospital model exists, to provide for a child's unique health care

needs. This is why TRICARE, being based on Medicare, sometimes doesn't provide the best possible care for our military children, particularly those who have special health care needs. It is also why military families support the TRICARE for Kids Amendment (Attachment B) included in the National Defense Authorization Act (NDAA) for Fiscal Year 2013 recently passed by the House. This bi-partisan amendment was co-sponsored by Representative Steve Stivers (R-OH15), Representative Susan Davis (D-CA53), and Representative Bobby Schilling (R-IL17) and has been endorsed by the Military Officers Association of America (MOAA), the National Association of Children's Hospitals (NACH), the National Military Family Association (NMFA), and the March of Dimes.

From a recent endorsement letter by the March of Dimes (Attachment C), they noted:

- "Unfortunately, because TRICARE utilizes a reimbursement structure based on Medicare, it often adopts policies and practices from Medicare that do not address the unique health care needs of children. Moreover, despite the best efforts of the Department of Defense, military families with children with special health care needs and chronic conditions often have difficulty accessing resources and services from local or regionally specialized providers. This problem is further exacerbated by the mobility of military families, who must repeatedly locate and obtain specialized health care service in unfamiliar geographic regions as their assignments change or they are deployed.
- The TRICARE for Kids Act seeks to better shape the policies and practices of TRICARE to meet the needs of children, including those with special health care needs or chronic illnesses."

Our hope is to ensure that the final NDAA includes the Tricare for Kids amendment, section 723 in the House bill, and that the conference committee report will mirror the Section 703 report language provided by the Senate, thus providing a specific panel to address children's health needs, and adding ECHO to DOD's ongoing evaluation and reporting of cost, access, and quality.

AUTISM

While we look forward to enhanced functionality of the TRICARE program, the treatment of autism for our military children is one area that I do not believe requires further study; it requires action.

TRICARE currently segregates Applied Behavioral Analysis (ABA), the standard of care in the treatment of autism, into ECHO, which is an entirely separate arm of TRICARE, as a "non-medical educational" service. TRICARE's classification of ABA as "non-medical" allows TRICARE to limit care to dependents of Active Duty servicemembers and places a financial cap on treatment services which falls far below recommended standards. There is no other disease, disability or chronic health condition which is treated similarly as autism in its segregation of treatment outside the basic TRICARE benefit. Families are forced to make the difficult decision of paying thousands of dollars out of pocket to address these deficits or forgo medically recommended care. Because the ECHO benefit is only available for dependents of active-duty servicemembers, dependents of our retirees (including Wounded Warriors retired due to injuries sustained in combat) are not able to access ABA treatments under TRICARE and Guard/Reserve families receive intermittent care.

Contrary to DOD's stated position, in April of this year, the U.S. Office of Personnel Management (OPM) concluded that ABA treatment for autism is a "medical therapy." In a letter dated 19 April 2012 (Attachment D), OPM stated [bottom of page 5]

- "The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy."

The previous findings are instructive as well as they point to what level of evidence was required to overcome OPM's original objection. In a 2006 letter to Representative Christopher Smith (R-NJ4) (Attachment E), the Director of OPM, Linda Springer, stated

- "It is OPM's most sincere hope that one day randomized trials will demonstrate ABA to be an effective course of treatment for autism and no longer be considered investigational. OPM has great empathy for the fami-

lies affected by this tragic disorder, and regret our decision could not be more favorable”.

Coverage of ABA care in the civilian sector also exceeds that of TRICARE. Currently, 30 States have laws requiring private insurers to cover autism-related therapies, including ABA, as a medically necessary service. TRICARE’s position that ABA therapy is “non-medical” is now contrary to the Federal Government and laws in 30 States.

We now stand at a point where, without action by Congress, we will soon see Federal workers provided medically prescribed autism therapy for their children while military families receive either an inferior level of care or, as in the case of the retired veteran’s child, receive no care. Our families simply cannot imagine that Congress would find that appropriate.

With strong bipartisan leadership, the House’s 2013 version of the NDAA includes important language clarifying that military dependents with autism, regardless of duty status, have access to medically necessary behavioral health treatments including ABA through the TRICARE basic program. Our military families ask that you work to ensure comparable language is included with the Senate version of the NDAA.

EDUCATION

Special education as a career is truly a calling and the vast majority of teachers who instruct our children are competent professionals whose greatest desire is to see our children succeed. However, with the pace, length, and number of deployments over the past 10 years, as well as the normal structure of the military lifestyle, military families whose children require special education have struggled to receive a free appropriate public education.

According to the Military Child Education Coalition, the average military child will transfer schools 6 to 9 times between grades K to 12. For the special needs military family, the frequent moves present additional challenges: reestablishment of medical care, educational services, and necessary therapies each time they move to a new location. For many of our families, this means the primary caretaker parent will devote countless hours ensuring their child’s needs are met. In the event the spouse is employed outside the home, or in the case of a dual active duty couple, there is little time to digest the changing special education laws and regulations required to ensure a child receives a free, appropriate public education. In many situations, military families either go into debt to hire advocates or lawyers to ensure their child is receiving an appropriate education or they go without and watch their child regress in an inappropriate placement without proper supports.

In the event that a school district does not provide appropriate services for a military child, the family must weigh the following before attempting to hold a school district accountable under the Individuals with Disabilities Education Act (IDEA):

1. Legal fees, many lawyers no longer will take a case on contingency
2. Expert witness fees (not reimbursable even if you win your case)
3. Length of time left in the current assignment
4. Family and life considerations (financial and medical stress, spouse deployed, wounded, or otherwise unavailable).

Military families have little control over where they will be stationed, sometimes as part of a normal base reassignment, and sometimes when a spouse and child(ren) have to live close to family when a member deploys for a year or more.

Some school districts take advantage of military families, calculating how long they will likely spend at a current base, and the families’ emotional, physical, and financial abilities to utilize their procedural safeguards under IDEA.

The average due process case to hold a school district accountable lasts a number of years, making IDEA’s procedural safeguards essentially meaningless for the large majority of military families, particularly when confronted with an aggressive, cost-cutting school administration. Most school districts have law firms retained from taxpayer funds with unlimited time to run out the clock against a military family. Military families have few resources to hire lawyers or retain experts to ensure our children receive an appropriate education.

Included in the 2011 NDAA was a directive to DOD to consider these issues for study (sec 583). The DOD’s response was that the evidence was anecdotal therefore they could not make any conclusions without appropriate data. This lack of data has been a consistent issue for all military connected children as evidenced by the DOD report as well as two GAO reports sparring over the last 5 years (GAO study entitled “Military Personnel: Medical, Family Support, and Educational Services Are Available for Exceptional Family members” (2007) and GAO study entitled “Education of Military Dependent Students, Better Information Needed to Assess Stu-

dent Performance" (2011)). Over the last 5 years, we could have been collecting data to take action, but for some reason, we haven't. It seems clear to me that a data element is needed to identify our military connected students so we can access and evaluate their needs.

In August 2011, four Service representatives wrote a letter to the Assistant Secretary for Special Education and Rehabilitative Services, Ms. Alexa Posny, for clarification and guidance on issues specifically related to military families (Attachment F). To date, no response has been provided. While many of the educational challenges facing our military connected special needs students involve cross jurisdictional issues, we desperately need this committee's strong leadership to ensure our children our appropriately take care of.

Finally, the new Post-September 11 or Bill offers a terrific option to transfer educational benefits to dependents; expanding these benefits to cover more options beyond traditional degree-granting education would be a welcome improvement for our special needs dependents.

EXCEPTIONAL FAMILY MEMBER PROGRAM

DOD support for families with special needs has been a work in progress for many years. The 2010 NDAA included the creation of the Office of Special Needs (OSN) within the Military Community and Family Policy Office. The next year's NDAA provided for the creation of the Military Exceptional Family Member Panel, which includes military family members and adults impacted by disability. The goal of the panel is to provide specific real world input to the OSN on issues facing our families. Each of these has been a forward step in improving our family member's ability to access a life that any parent would want for their child. We thank the committee for taking legislative action to improve DOD support for military families with special needs. However, the proof is in the implementation of these directives.

The specific mandate provided to the OSN included "The development and implementation of a comprehensive policy on support for military families with special needs". Two years later, this hasn't been completed. Without appropriate policy to review, it is not clear where we stand with many of the other mandates assigned to the OSN.

Our families ask that appropriate oversight be provided to ensure that the Office of Special Needs has the funding and personnel to carry out its mandates and then ensure that they are completed in a reasonable amount of time.

To consider best practices within DOD, one need look no further than the Marine Corps, which is universally lauded as providing the best care for its exceptional family members. Attached you will find a recent brief provided by the head of the USMC Family Programs branch, Rhonda LaPorte, which provides an immediate overview of the current EFM Program as well as future direction. (Attachment G). We believe the other Services should follow the lead of the Marine Corps as they review their EFMP programs.

SURVIVOR BENEFITS

Today, servicemembers with permanently disabled children face an unfortunate dilemma. Under current law, the servicemember can only direct survivor benefits to that child, and not a trust of any sort. Because the Survivor Benefits Plan (SBP) annuity cannot be placed into a special needs trust this survivor benefit ironically will make the beneficiary ineligible to receive the Medicaid waiver which allows many individuals with a disability to survive. One example of a consequence includes a disabled adult being removed from a group home or other long-term care facility provided by Medicaid because the SBP amount exceeds State income thresholds for Medicaid waiver programs and disqualifies the individual from that program. Please see Attachment H for a more detailed analysis of this issue by a lawyer who specializes in special needs trusts.

Civilian families are able to create special needs trusts for their pennanently disabled children that preserve their access to Medicaid while providing them additional supports that enable them to live in their communities. We believe that members of the military should have the assurance that their surviving family members with disabilities will have the same opportunities after they are gone.

The Disabled Military Child Protection Act, H.R. 4329, was introduced in this Congress to correct this disparity. Unfortunately, because of a very modest cost and lack of a means to pay for it, the measure was not included in the House version of the NDAA. We request the Committee to file an amendment to be added to the Senate NDAA in order to resolve this issue.

LEGAL ISSUES

There are a whole host of issues our military families face when trying to access the legal system. For military families with special needs, these primarily include issues related to guardianship, wills, trusts, and special education. Each one of these issues create significant out of pocket expenses above and beyond that of a typical military family. The issues are not ones that the on-base JAG officers are qualified to provide counsel on, and most JAG officers do not have the connections required to even provide a referral.

Our families are encouraged by the Senate language regarding its support for the American Bar Association's Military Pro Bono Project. We would encourage the Secretary of Defense and the DOD's General Counsel to consider the unique issues of our military families impacted by special needs as they are investigating the report request by the Senate (detailed in Senate Report 112-173).

DISABILITY ISSUES

There are a variety of issues which impact the disability community as a whole, including our active duty military families, our veterans and retirees, and particularly our Wounded Warrior community. The Senate will soon consider the Convention on the Rights of Persons with Disabilities. The Senate Health, Education, Labor, and Pensions Committee will hold a hearing on restraint and seclusion in our public schools on June 30. While the Senate Armed Services Committee does not specifically play a role in these issues, please appreciate the fact that these issues are ones that our families care about and your support in ensuring these issues are resolved significantly impacts our military community.

CONCLUSION

- "Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society."

These are the congressional findings from the IDEA, the Federal law that ensures children with disabilities are provided a public education. If the concept that having a disability is a natural part of our world is foreign to you, you are not alone. But like so many things in our world, your perception can change in a millisecond. For some of us, this will happen in a split second, whether that is an IED explosion or from the doctor telling you something is wrong with your baby. For others, it will be the shocking realization of the road you are about to travel as you deal with your MS, cancer, or Alzheimers. Smart disability policy is the right thing to do, both for our military families and for its positive impacts on our force's readiness. Short-term thinking and budgeting will in fact have significant long term cost, whether we are talking about the rehabilitation of a young airmen with traumatic brain injury or a child with cerebral palsy or autism. Our entire society as a whole has made significant strides in the last four decades in supporting people with disabilities. The strides our society as a whole has made have been mirrored in many of the programs within the Department of Defense and the VA. However, there continue to be significant stovepipes within DOD, the VA, Tricare, the individual services as well as individual States as opposed to an appropriate sharing of best practices and implementing changes needed. What we need is leadership at all levels of the chain of command, within Congress, and within our local communities to make change reality.

I've attached a number of stories of individual military families immediately after this written testimony. [See Attachment I]. These are amazing Americans, who endure exceptionally trying circumstances and somehow find ways to serve their nation and many times try to help others. I would encourage you to take a moment and get to know each of them. If you look "hero" up in the dictionary, you'd see the faces of these moms, dads, and their children.

We don't pretend to think that there are any easy tasks in front of us as a nation. How we deal with these tough issues will define us as a Nation. Our families appreciate the opportunity and leadership demonstrated by holding this hearing. Thank you to this committee for not forgetting our military families.

List of Attachments

Attachment A	NCD Transmittal Letter on USMC EFMP Study
Attachment B	TRICARE for Kids Amendment
Attachment C	March of Dimes Endorsement Letter
Attachment D	OPM FEHB Program Carrier Letter
Attachment E	2006 OPM Ltr to Rep. Christopher Smith
Attachment F	2011 Ltr to Assistant Secretary Posny
Attachment G	USMC Family Programs Briefing
Attachment H	SBP Legal Analysis
Attachment I	Stories of Individual Military Families, Provided by Mr. Jeremy L. Hilton

Attachment A

NCD Transmittal Letter on USMC EFMP Study



National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

Letter of Transmittal

November 28, 2011

The President
The White House
Washington, DC 20500

Dear Mr. President:

The National Council on Disability (NCD) is pleased to submit the enclosed report, "United States Marine Corps Exceptional Family Members: How to Improve Access to Health Care, Special Education, and Long-Term Supports and Services for Family Members with Disabilities." NCD conducted this study at the request of the Marine Corps, which has a longstanding commitment to providing support for its Families with disabilities. This report is based on a study conducted within the Marine Corps interviewing Marines and Families that have dependents that meet the requirements to qualify for the Exceptional Family Member Program (EFMP).

The lifestyle of the Marine Corps Family is challenging under the best of circumstances. Among the challenges that military Families face are separation from their extended families, Service Member absences, permanent changes of station moves, and the stresses of combat and noncombat deployments. These challenges are compounded for Families with disabilities, referred to in the Marine Corps as "Exceptional Family Members" (EFMs).

The Services have recently passed the marker of 10 plus years of armed conflict across the world, but most specifically in Afghanistan and Iraq. Multiple deployments to these theaters have increased stress on all military Families, but even more on those with EFMs.

The objectives for this study were to:

- 1) Document the experiences of USMC EFMP participants in accessing appropriate and effective services in health care, special education, related services, long-term supports, and services;
- 2) Identify barriers impeding access to appropriate resources and services; and
- 3) Develop recommendations to improve access.

NCD conducted focus groups and interviews of Caregivers, Family Members with disabilities, and service providers between January 2010 and March 2010 at Marine Corps Base Quantico, Camp Lejeune, and Camp Pendleton.

NCD findings indicate that EFMs and their Families face barriers that span the domains of health care, education, and long-term supports and services. Key findings include:

- For Caregivers, navigating the health, education, long-term services systems, and obtaining and maintaining disability-related services require

relentless hard work—a process they have to start over every time the Family moves. For some—particularly young parents, Families with more than one EFM, Families with a dependent with significant disabilities, parents who are themselves EFMs, and Families with a deployed sponsor—it can be an overwhelming prospect and can be so time-consuming that it becomes impossible for the spouse of an active-duty Marine to work outside the home.

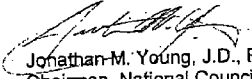
- Many Families lamented the lack of qualified health care specialists near their installations, and they struggle to obtain timely referrals and appointments and make long trips to medical specialists.
- For Family Members in need of special education services, having to make frequent moves to a new school system results in substantial gaps in critical education and therapeutic services.
- The lack of Medicaid portability across states is a significant barrier to obtaining necessary long-term supports and services for Families with EFM dependents. Each time the Family moves, they have to start over on a Medicaid waiver waiting list and often do not live in one place long enough to qualify. Tricare does not cover the same services provided under a Medicaid waiver.
- Many families are dependent on the disability-related services typically covered by ECHO, a Tricare supplemental insurance, and they worry about how they will pay for these services when they retire and ECHO is no longer available to them.

These findings reveal that prompt action must be taken to improve health, education, and long-term services for Marine Corps Families with EFMs. NCD commends the Marine Corps for making significant improvements to their EFM program during the time this study was being conducted (many of which are highlighted in this report). However, many of the changes necessary to improve the supports available to military Families with EFMs are beyond the control of the Marine Corps and may require statutory and regulatory changes to meet these needs.

NCD has concluded that far-reaching systemic changes are needed in our nation's health, education, and long-term service systems to address the significant barriers faced by EFMs. NCD thus seeks support from Congress, the military, and the Administration to build the critical federal partnerships necessary to effect systemic change and ensure that the men and women serving our country can do so knowing their Family Members with disabilities will have the supports and services they need.

NCD commends your Administration for focusing on the needs of military Families, particularly the launch of Joining Forces, and would welcome the opportunity to work with you on behalf of military Families with EFMs.

Sincerely,


Jonathan M. Young, J.D., Ph.D.
Chairman, National Council on Disability

Attachment B
TRICARE for Kids Amendment



I

112TH CONGRESS
2D SESSION

H. R. 4341

To direct the Secretary of Defense to establish a working group to review TRICARE policy with respect to providing health care to children and determine how to improve such policy, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 29, 2012

Mr. STIVERS (for himself, Mr. SCHILLING, and Mrs. DAVIS of California) introduced the following bill; which was referred to the Committee on Armed Services

A BILL

To direct the Secretary of Defense to establish a working group to review TRICARE policy with respect to providing health care to children and determine how to improve such policy, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SENSE OF CONGRESS.

4 It is the sense of Congress that—

5 (1) children of members of the Armed Forces
6 deserve health-care practices and policies that—

7 (A) are designed to meet their pediatric-
8 specific needs;

2

1 (B) are developed and determined
2 proactively and comprehensively; and

3 (C) ensure and maintain their access to pe-
4 diatric-specific treatments, providers, and facili-
5 ties;

6 (2) children's health-care needs and standards
7 of care are different and distinct from those of
8 adults, therefore the TRICARE program should un-
9 dertake a proactive, comprehensive approach to re-
10 view and analyze its policies and practices to meet
11 the needs of children to ensure that children and
12 their families receive appropriate care in proper set-
13 tings and avoid unnecessary challenges in seeking or
14 obtaining proper health care;

15 (3) a proactive and comprehensive review is
16 necessary because the reimbursement structure of
17 the TRICARE program is patterned upon Medicare
18 and the resulting policies and practices of the
19 TRICARE program do not always properly reflect
20 appropriate standards for pediatric care;

21 (4) one distinct aspect of children's health care
22 is the need for specialty care and services for chil-
23 dren with special-health-care needs and chronic-
24 health conditions;

1 (5) the requirement for specialized health care
2 and developmental support is an ongoing and serious
3 matter of day-to-day life for families with children
4 with special or chronic-health-care needs;

5 (6) the Department of Defense and the
6 TRICARE program, recognizing the special needs of
7 certain children, have instituted special-needs pro-
8 grams, including the ECHO program, but there are
9 collateral needs that are not being met, generally be-
10 cause the services are provided in the local commu-
11 nity rather than by the Department of Defense, who
12 may not always have the best tools or knowledge to
13 access these State and local resources;

14 (7) despite wholehearted efforts by the Depart-
15 ment of Defense, a gap exists between linking mili-
16 tary families with children with special-health-care
17 needs and chronic conditions with the resources and
18 services available from local or regional highly spe-
19 cialized providers and the communities and States in
20 which they reside;

21 (8) the gap is especially exacerbated by the mo-
22 bility of military families, who often move from
23 State to State, because special-needs health care,
24 educational, and social services are very specific to

1 each local community and State and such services
 2 often have lengthy waiting lists; and

3 (9) the Department of Defense will be better
 4 able to assist military families with children with
 5 special-health-care needs fill the gap by collaborating
 6 with special-health-care needs providers and those
 7 knowledgeable about the opportunities for such chil-
 8 dren that are provided by States and local commu-
 9 nities.

10 **SEC. 2. ESTABLISHMENT OF TRICARE WORKING GROUP.**

11 (a) **ESTABLISHMENT.**—

12 (1) **IN GENERAL.**—The Secretary of Defense
 13 shall establish a working group to carry out a review
 14 of the TRICARE program with respect to—

15 (A) pediatric health care needs under para-
 16 graph (2); and

17 (B) pediatric special and chronic health
 18 care needs under paragraph (3).

19 (2) **PEDIATRIC HEALTH CARE NEEDS.**—

20 (A) **DUTIES.**—The working group shall—

21 (i) comprehensively review the policy
 22 and practices of the TRICARE program
 23 with respect to providing pediatric health
 24 care;

1 (ii) recommend changes to such poli-
2 cies and practices to ensure that—

3 (I) children receive appropriate
4 care in an appropriate manner, at the
5 appropriate time, and in an appro-
6 priate setting; and

7 (II) access to care and treatment
8 provided by pediatric providers and
9 children's hospitals remains available
10 for families with children; and

11 (iii) develop a plan to implement such
12 changes.

13 (B) REVIEW.—In carrying out the duties
14 under subparagraph (A), the working group
15 shall—

16 (i) identify improvements in policies,
17 practices, and administration of the
18 TRICARE program with respect to pedi-
19 atric-specific health care and pediatric-spe-
20 cific healthcare settings;

21 (ii) analyze the direct and indirect ef-
22 fects of the reimbursement policies and
23 practices of the TRICARE program with
24 respect to pediatric care and care provided
25 in pediatric settings;

1 (iii) consider case management pro-
2 grams with respect to pediatric complex
3 and chronic care, including whether pedi-
4 atric specific programs are necessary;

5 (iv) develop a plan to ensure that the
6 TRICARE program addresses pediatric-
7 specific health care needs on an on-going
8 basis beyond the life of the working group;

9 (v) consider how the TRICARE pro-
10 gram can work with the pediatric provider
11 community to ensure access, promote com-
12 munication and collaboration, and optimize
13 experiences of military families seeking and
14 receiving health care services for children;
15 and

16 (vi) review matters that further the
17 mission of the working group.

18 (3) PEDIATRIC SPECIAL AND CHRONIC HEALTH
19 CARE NEEDS.—

20 (A) DUTIES.—The working group shall—

21 (i) review the methods in which fami-
22 lies in the TRICARE program who have
23 children with special-health-care needs ac-
24 cess community resources and health-care
25 resources;

1 (ii) review how having access to, and
2 a better understanding of, community re-
3 sources may improve access to health care
4 and support services;

5 (iii) recommend methods to accom-
6 plish improved access by such children and
7 families to community resources and
8 health-care resources, including through
9 collaboration with children's hospitals and
10 other providers of pediatric specialty care,
11 local agencies, local communities, and
12 States;

13 (iv) consider approaches and make
14 recommendations for the improved integra-
15 tion of individualized or compartmentalized
16 medical and family support resources for
17 military families;

18 (v) work closely with the Office of
19 Community Support for Military Families
20 with Special Needs of the Department of
21 Defense and other relevant offices to avoid
22 redundancies and target shared areas of
23 concern for children with special or chron-
24 ic-health-care needs; and

1 (vi) review any relevant information
2 learned and findings made by the working
3 group under this paragraph that may be
4 considered or adopted in a consistent man-
5 ner with respect to improving access, re-
6 sources, and services for adults with spe-
7 cial needs.

8 (B) REVIEW.—In carrying out the duties
9 under subparagraph (A), the working group
10 shall—

11 (i) discuss improvements to special
12 needs health care policies and practices;

13 (ii) determine how to support and pro-
14 tect families of members of the National
15 Guard or Reserve Components as the
16 members transition into and out of the rel-
17 evant Exceptional Family Member Pro-
18 gram or the ECHO program;

19 (iii) analyze case management services
20 to improve consistency, communication,
21 knowledge, and understanding of resources
22 and community contacts;

23 (iv) identify areas in which a State
24 may offer services that are not covered by

1 the TRICARE program or the ECHO pro-
2 gram and how to coordinate such services;

3 (v) identify steps that States and
4 communities can take to improve support
5 for military families of children with spe-
6 cial health care needs;

7 (vi) consider how the TRICARE pro-
8 gram and other programs of the Depart-
9 ment of Defense can work with specialty
10 pediatric providers and resource commu-
11 nities to ensure access, promote commu-
12 nication and collaboration, and optimize
13 experiences of military families seeking and
14 receiving health care services for their chil-
15 dren with special or chronic health care
16 needs;

17 (vii) consider special and chronic
18 health care in a comprehensive manner
19 without focus on one or more conditions or
20 diagnoses to the exclusion of others;

21 (viii) focus on ways to create innova-
22 tive partnerships, linkages, and access to
23 information and resources for military
24 families across the spectrum of the special-
25 needs community and between the medical

10

1 community and the family support commu-
2 nity; and

3 (ix) review matters that further the
4 mission of the working group.

5 (b) MEMBERSHIP.—

6 (1) APPOINTMENTS.—The working group shall
7 be composed of not less than 14 members as follows:

8 (A) The Chief Medical Officer of the
9 TRICARE program, who shall serve as chair-
10 person.

11 (B) The Chief Medical Officers of the
12 North, South, and West regional offices of the
13 TRICARE program.

14 (C) One individual representing the Army
15 appointed by the Surgeon General of the Army.

16 (D) One individual representing the Navy
17 appointed by the Surgeon General of the Navy.

18 (E) One individual representing the Air
19 Force appointed by the Surgeon General of the
20 Air Force.

21 (F) One individual representing the re-
22 gional managed care support contractor of the
23 North region of the TRICARE program ap-
24 pointed by such contractor.

11

1 (G) One individual representing the re-
2 gional managed care support contractor of the
3 South region of the TRICARE program ap-
4 pointed by such contractor.

5 (H) One individual representing the re-
6 gional managed care support contractor of the
7 West region of the TRICARE program ap-
8 pointed by such contractor.

9 (I) Not more than three individuals rep-
10 resenting the non-profit organization the Mili-
11 tary Coalition appointed by such organization.

12 (J) One individual representing the Amer-
13 ican Academy of Pediatrics appointed by such
14 organization.

15 (K) One individual representing the Na-
16 tional Association of Children's Hospitals ap-
17 pointed by such organization.

18 (L) One individual representing military
19 families who is not an employee of an organiza-
20 tion representing such families.

21 (M) Any other individual as determined by
22 the Chief Medical Officer of the TRICARE pro-
23 gram.

24 (2) TERMS.—Each member shall be appointed
25 for the life of the working group. A vacancy in the

1 working group shall be filled in the manner in which
2 the original appointment was made.

3 (3) TRAVEL EXPENSES.—Each member shall
4 receive travel expenses, including per diem in lieu of
5 subsistence, in accordance with applicable provisions
6 under subchapter I of chapter 57 of title 5, United
7 States Code.

8 (4) STAFF.—The Secretary of Defense shall en-
9 sure that employees of the TRICARE program pro-
10 vide the working group with the necessary support
11 to carry out this section.

12 (c) MEETINGS.—

13 (1) SCHEDULE.—The working group shall—

14 (A) convene its first meeting not later than
15 60 days after the date of the enactment of this
16 Act; and

17 (B) convene not less than four other times.

18 (2) FORM.—Any meeting of the working group
19 may be conducted in-person or through the use of
20 video conferencing.

21 (3) QUORUM.—Seven members of the working
22 group shall constitute a quorum but a lesser number
23 may hold hearings.

24 (d) POWERS.—

1 (1) HEARINGS AND TESTIMONY.—The working
2 group may, for the purpose of carrying out this Act,
3 hold public or private hearings, sit and act at times
4 and places, take written or oral comments or testi-
5 mony, and receive evidence as the working group
6 considers appropriate.

7 (2) OFFICIAL INFORMATION.—The working
8 group may secure directly from any department or
9 agency of the United States information necessary
10 to enable it to carry out this Act.

11 (3) MAILS.—The working group may use the
12 United States mails in the same manner and under
13 the same conditions as other departments and agen-
14 cies of the United States.

15 (e) CONSULTATION.—

16 (1) ADVICE.—With respect to carrying out the
17 review of the TRICARE program and pediatric spe-
18 cial and chronic health care needs under subsection
19 (a)(3), the working group shall seek counsel from
20 the following individuals acting as an expert advisory
21 group:

22 (A) One individual representing the Excep-
23 tional Family Member Program of the Army.

24 (B) One individual representing the Excep-
25 tional Family Member Program of the Navy.

1 (C) One individual representing the Excep-
2 tional Family Member Program of the Air
3 Force.

4 (D) One individual representing the Excep-
5 tional Family Member Program of the Marine
6 Corps.

7 (E) One individual representing the Office
8 of Community Support for Military Families
9 with Special Needs.

10 (F) One individual who is not an employee
11 of an organization representing military families
12 shall represent a military family with a child
13 with special health care needs.

14 (G) Not more than three individuals rep-
15 resenting organizations that—

16 (i) are not otherwise represented in
17 this paragraph or in the working group;
18 and

19 (ii) possess expertise needed to carry
20 out the goals of the working group.

21 (2) COMMENTS.—With respect to carrying out
22 the review of the TRICARE program and pediatric
23 special and chronic health care needs under sub-
24 section (a)(3), the working group shall invite and ac-
25 cept comments and testimony from States, local

15

1 communities, national special needs advocacy
 2 groups, educators, pediatric-health-care providers,
 3 and military family advocates.

4 (f) REPORTS REQUIRED.—

5 (1) REPORT.—Not later than 12 months after
 6 the date on which the working group convenes its
 7 first meeting, the working group shall submit to the
 8 congressional defense committees a report includ-
 9 ing—

10 (A) any changes described in subsection
 11 (a)(2)(A)(ii) identified by the working group
 12 that—

13 (i) require legislation to carry out, in-
 14 cluding proposed legislative language for
 15 such changes;

16 (ii) require regulations to carry out,
 17 including proposed regulatory language for
 18 such changes; and

19 (iii) may be carried out without legis-
 20 lation or regulations, including a time line
 21 for such changes; and

22 (B) steps that States and local commu-
 23 nities may take to improve the experiences of
 24 military families with special-needs children in

1 interacting with and accessing State and local
2 community resources.

3 (2) FINAL REPORT.—Not later than 18 months
4 after the date on which the report is submitted
5 under paragraph (1), the working group shall sub-
6 mit to the congressional defense committees a final
7 report including—

8 (A) any additional information and up-
9 dates to the report submitted under paragraph
10 (1);

11 (B) information with respect to how the
12 Secretary of Defense is implementing the
13 changes identified in the report submitted
14 under paragraph (1); and

15 (C) information with respect to any steps
16 described in subparagraph (B) of such para-
17 graph that were taken by States and local com-
18 munities after the date on which such report
19 was submitted.

20 (g) TERMINATION.—The working group shall termi-
21 nate on the date that is 30 days after the date on which
22 the working group submits the final report pursuant to
23 subsection (f)(2).

24 (h) DEFINITIONS.—In this Act:

1 (1) The term "children" means dependents of a
2 member of the Armed Forces who are—

3 (A) individuals who have not yet attained
4 the age of 21; or

5 (B) individuals who have not yet attained
6 the age of 27 if the inclusion of such depend-
7 ents is applicable and relevant to a program or
8 policy being reviewed under this Act.

9 (2) The term "congressional defense commit-
10 tees" has the meaning given that term in section
11 101(a)(16) of title 10, United States Code.

12 (3) The term "ECHO program" means the pro-
13 gram established pursuant to subsections (d)
14 through (e) of section 1079 of title 10, United
15 States Code (commonly referred to as the "Extended
16 Care Health Option program").

17 (4) The term "TRICARE program" means the
18 managed health care program that is established by
19 the Department of Defense under chapter 55 of title
20 10, United States Code.

Attachment C

March of Dimes Endorsement Letter

March of Dimes Foundation

Office of Government Affairs
1111 K Street, NW, Suite 900
Washington, DC 20004
Telephone (202) 638-1600
Fax (202) 296-2964

marchofdimes.com
nacersano.org

June 13, 2012

The Honorable Steve Stivers
U.S. House of Representatives
Washington, DC 20515

The Honorable Susan Davis
U.S. House of Representatives
Washington, DC 20515

The Honorable Bobby Schilling
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Stivers, Davis, and Schilling:

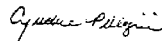
The March of Dimes, a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 51 chapters representing every state, the District of Columbia and Puerto Rico, is pleased to endorse H.R. 4341, *the TRICARE for Kids Act*, a bill to ensure that all military families and children receive the essential health care services they need.

The TRICARE program covers 9.6 million lives, including children and families of active duty soldiers. Unfortunately, because TRICARE utilizes a reimbursement structure based on Medicare, it often adopts policies and practices from Medicare that do not address the unique health care needs of children. Moreover, despite the best efforts of the Department of Defense, military families with children with special health care needs and chronic conditions often have difficulty accessing resources and services from local or regionally specialized providers. This problem is further exacerbated by the mobility of military families, who must repeatedly locate and obtain specialized health care service in unfamiliar geographic regions as their assignments change or they are deployed.

The *TRICARE for Kids Act* seeks to better shape the policies and practices of TRICARE to meet the needs of children, including those with special health care needs or chronic illnesses. If enacted, the bill would convene a working group with a wide range of expertise in children's health and health care to systematically review TRICARE's policies and practices and make recommendations for improvements. The working group would also work with specialty providers of children's health care and support services to better connect military families to state resources for children with special and chronic health care needs.

Our nation's soldiers and their families have made tremendous sacrifices for the sake of our country. It is our duty to ensure that these families receive the health care that best meets their needs. The *TRICARE for Kids Act* will help make this possible. We look forward to passage of this important bill.

Sincerely,



Cynthia Pellegrini
Senior Vice President, Public Policy & Government Affairs

march of dimes

Attachment D

OPM FEHB Program Carrier Letter

FEHB Program Carrier Letter
All Fee For Service Carriers

U.S. Office of Personnel Management
 Healthcare and Insurance

Letter No. 2012-12(c)

Date: April 19, 2012

Fee-for-service [11] Experience-rated HMO [n/a] Community-rated HMO [n/a]

Subject: 2013 Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2013 through December 31, 2013. Please refer to our annual Call Letter (Carrier Letter 2012- 09) dated March 29, 2012 for policy guidance. Benefit policies from prior years remain in effect unless otherwise noted.

This year's deadlines are as follows:

- **No later than May 31, 2012:** Please send your complete proposal for benefit changes and clarifications to your contract specialist on a CD-ROM (or other electronic means) in addition to a hard copy. Your proposal should include corresponding language describing all proposed brochure changes. Your OPM contract specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.
- **Within five business days following receipt of close-out letter or by date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2013 brochure. See Attachment VI: Preparing Your 2013 Brochure.

Carriers are strongly encouraged, as always, to follow our guiding principles of affordability and value based benefit design when preparing proposals. This year you will see an increased focus on quantitative data which we need to measure each plan's overall performance. For some items, we ask for historical data to establish a baseline for performance reviews. In addition, we appreciate your continued timely efforts to submit benefit and rate proposals and to produce and distribute brochures.

Enclosed is a checklist (Attachment XVI) showing all the information to include with your benefit and rate proposals. Please return a completed checklist with your submission.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

John O'Brien
 Director
 Healthcare and Insurance

Preparing Your 2013 Benefit Proposal

Your benefit proposal must be complete. Timeframes to conclude benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

- A signed contracting official's form (Attachment I);
- A plain language description of each proposed change (Attachment II) and revised language for your 2013 brochure; and
- A plain language description of each proposed clarification (Attachment III) and revised language for your 2013 brochure.

If you anticipate significant changes to your benefit package, please discuss them with your OPM Contract Specialist before preparing your submission.

As stated in the 2013 Call Letter, our three primary initiatives this year are:

- Implementing additional requirements under the Affordable Care Act;
- Improving the delivery and cost efficiency of prescription drugs; and
- Advancing quality of care principles.

I. CALL LETTER INITIATIVES

A. Implementing the Affordable Care Act

1. Lifetime and Annual Limits on Essential Health Benefits

FEHB plans have historically not imposed lifetime limits and we will continue to enforce this requirement.

In addition, FEHB plans are expected to eliminate annual limits on essential health benefits (EHB), regardless of grandfathered plan status.

On December 16, 2011, the Department of Health and Human Services (HHS) released a Bulletin (http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) describing its approach to define EHB under the Affordable Care Act. On February 17, 2012, HHS issued a FAQ (<http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>) to provide additional guidance on the subject.

Information Required for Proposal: Attachment IV- Lifetime and Annual Limits on Essential Health Benefits

2. Clinical Trial Coverage

FEHB plans are expected to comply with certain coverage requirements for clinical trials next year, in advance of required implementation for 2014, regardless of grandfathered status. The requirements are described in detail in Attachment V.

Information Required for Proposal: Attachment V- Clinical Trial Coverage

3. Preventive Services

Last year, we requested FEHB plans to eliminate cost-sharing for all recommended in-network preventive services, immunizations, screenings, tobacco cessation services and medications. Please check the latest posting by the Advisory Committee on Immunization Practices (ACIP) at <http://www.cdc.gov/vaccines/pubs/ACIP-list-by-date.htm> for the full list of required vaccinations as some have changed. Note that, unless otherwise specified, plans must cover these requirements no later than the start of the plan year which follows the year in which the recommendation becomes effective.

Plans must submit proposals that cover preventive services, including birth control, with no cost-sharing, regardless of grandfathered status. The Affordable Care Act adds new preventive services requirements for 2013 that go beyond recommendations of the United States Preventive Services Task Force. See <http://www.hrsa.gov/womensguidelines/>.

Information Required for Proposal: Attachment VI- Preventive Services

4. 2013 Brochure

FEHB plans are required to provide a "Summary of Benefits" for 2013, in advance of required implementation for 2014, regardless of grandfathered status. To evaluate our "Going Green" goals to help reduce FEHB administrative costs, please provide your cost savings information on the worksheet provided. You will receive additional guidance in a forthcoming carrier letter.

Information Required for Proposal: Attachment VII-Preparing Your 2013 Brochure

5. Grandfathered Plans

You only need to complete the certification for options that you anticipate will remain grandfathered for plan year 2013, based on benefit changes. Please read the certification carefully as it lists specific regulatory requirements that allow a plan to remain grandfathered under the Affordable Care Act. We will confirm requested grandfather status once final benefits and rates are negotiated.

Note: If one or more of your plan options was grandfathered in 2012, but will no longer meet regulatory requirements for 2013 then all Affordable Care Act requirements for non-grandfathered plans must be met in 2013.

Information Required for Proposal: Attachment VIII-Grandfathered Status Certification

B. Improving the Delivery & Cost Efficiency of Prescription Medications

OPM continues to explore innovative methods to reduce pharmacy spending and to develop effective prescription drug management without cost shifting or burdening members. The rate proposal, which you will receive separately, has our pharmacy data request.

Information Required for Proposal:

- Describe effective prescription drug management without cost shifting or burdening enrollees;
- Describe proposals to implement specialty drug programs that manage these costs;
- Describe how you are managing the control of drug administrative costs such as dispensing fees; and
- Complete Attachment IX for four issues below.

(1) Generic Medications

OPM's target for 2013 is to achieve an overall FEHB average generic dispensing rate of at least 75 percent. The Generic Dispensing Rate (GDR) is defined as the percentage of total prescriptions filled with generic drugs.

(2) Specialty Pharmacy

OPM's target is to stabilize the growth and cost of specialty drugs by keeping cost trends below the industry average of 14 to 20 percent.

(3) Pharmacy Benefit Managers Accreditation

FEHB plans should provide the highest quality pharmacy services to Federal employees, retirees and their families as demonstrated by the accreditation status of their pharmacy benefit managers (PBMs) or pharmacy components.

(4) Control of Dispensing Fees

Carriers will provide OPM with baseline data on the administrative fees in their current PBM contracts and describe how they intend to mitigate inflation in those fees. Examples are dispensing fees for generic drugs, brand name drugs, and for specialty drugs.

C. Advancing Quality of Care

1. Quality

OPM supports enhanced care coordination and the principles underlying patient centered medical homes (PCMH). To the greatest extent possible, we encourage participation in pilots offered by states or other Federal agencies, including the Comprehensive Primary Care (CPC) initiative sponsored by the Centers for Medicare and Medicaid Innovation Center. Read about this important initiative at

<http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html>
We invite you to propose arrangements through which your FEHB members can participate in the new CPC activities.

Information Required for Proposal: Attachment X-Quality of Care: PCMH

Additionally, we support the goals of the HHS' *Partnership for Patients, Better Care, Lower Costs* to reduce hospital readmissions by 20 percent and decrease preventable hospital acquired conditions by 40 percent when compared with 2010. We expect that you will make concerted efforts to improve the quality and safety of health care by addressing both those concerns.

Note: Plans will receive separate guidance in a forthcoming Carrier Letter describing how to measure applicable rates for FEHB populations.

We seek to eliminate elective deliveries before 39 weeks' gestation to reduce prematurity and adverse neonatal outcomes. We encourage you to describe initiatives supporting this goal in your benefit proposal, including those in place through your plan, participating hospitals or network providers.

Note: The forthcoming Carrier Letter regarding readmission and preventable conditions will include data requests reflecting maternity care and prematurity.

2. Wellness

In your proposal, please describe all wellness programs you intend to offer - including any quantitative data or other measures of their effectiveness - that can improve employee productivity, enhance healthy lifestyles and lower long-term healthcare costs.

FEHB plans are expected to continue programs to manage obesity as part of their focus on members' health and wellness. Your 2013 benefit proposal should update weight management coverage to ensure that enrollees receive all appropriate support to achieve and sustain a healthier weight.

Information Required for Proposal: Narrative information on all wellness programs with outcome data and Attachment XI-Weight Management

II. BENEFITS & SERVICES

A. New Guidance: Coverage of Applied Behavior Analysis (ABA)

The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy. Accordingly, plans may propose benefit packages which include ABA.

Information Required for Proposal: Describe what benefit package you intend to offer and describe how you will deliver these services through appropriate providers.

B. Benefit Changes

Your proposal must include a narrative description of each proposed benefit change. Please use Attachment II as the template to submit benefit changes. You must show all changes, however small, that result in an increase or decrease in benefits, even if there is no rate change.

We expect you to answer each of the following questions in worksheet format for each proposed benefit change. Indicate if a particular question does not apply and use a separate page for each change you propose. We will return any incorrectly formatted submissions.

Information Required for Proposal:

- Describe the benefit change completely. Show the proposed brochure language, including the "How we change for 2013" section in "plain language" using the active voice and written from the member's perspective. Show clearly how the change will affect members and the complete range of the change. For instance, if you propose to add inpatient hospital copays, indicate whether the change will also apply to inpatient hospitalizations under the emergency benefit. **If there are two or more changes to the same benefit, please show each change clearly.**
- Describe the rationale or reasoning for the proposed benefit change.
- State the actuarial value of the change and if it change represents an increase or decrease in (a) the existing benefit and (b) your overall benefit package. If an increase, describe whether any other benefit offsets your proposal. Include the cost impact of the change as a biweekly amount for the Self Only and Self and Family rates. If there is "no cost impact" or if the proposal involves a "cost trade-off" with another benefit, indicate which result is applicable, i.e. no cost or trade-off.

C. Benefit Clarifications

Clarifications are not benefit changes. Please use Attachment III as the template to submit all clarifications that better explain to members how a benefit is covered.

Information Required for Proposal:

- Show the current and proposed language for each proposed clarification and reference all portions of the brochure it affects. **Prepare a separate worksheet for each proposed clarification.** You may combine more than one clarification for the same benefit, but you must present each one clearly on the worksheet. Remember to use plain language.
- Explain the reason for the proposed clarification.

D. Continued Focus from Previous Years

1. Health & Wellness

We continue to encourage you to offer financial incentives to enrollees who (a) complete a health risk assessment or biometric assessment or (b) participate in wellness activities or treatment plans to improve their health status.

Information Required for Proposal: Attachment XII-Health & Wellness

2. Increase FEHB providers

We continue to encourage you to increase the number of health care providers in FEHB plan networks who are board certified or have training in geriatrics.

Information Required for Proposal: Attachment XIII-Geriatric Providers

3. Affinity Products

We encourage you to add products on the "non-FEHB" page of your plan brochure that may be of interest to members and ineligible family members, especially individual policies for domestic partners as well as for members who may seek additional insurance products, such as short-term disability.

Information Required for Proposal: Attachment XIV-Affinity Products

4. Organ/Tissue Transplants

We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance. When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following table in Attachment XV:

- Table I—OPM's required list of covered organ/tissue transplants. Although we no longer require coverage for autologous transplants for breast cancer, plans may continue to offer it.

Information Required for Proposal: Attachment XV: 2013 Organ/Tissue Transplants and Diagnoses

5. Describing Prescription Drug Co-Pays in the Guide to Federal Benefits

Plans that use levels or tiers to denote different prescription drug co-pays must clearly describe the coverage and difference between each level or tier in the 2013 brochure. The *2013 Guide to Federal Benefits* will illustrate the prescription drug co-pays at the following levels.

- Level I—generally includes generic drugs, but may include some brand formulary or preferred brands. Usually represents the lowest co-pays.
- Level II—generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range co-pays.

- Level III – may include all other covered drugs not on Levels I and II, i.e. non-formulary or non-preferred and some specialty drugs.

If your plan has more than three co-pay levels for prescription drug coverage, please work with your OPM Contract Specialist to ensure that we accurately reflect your coverage in the *2013 Guide to Federal Benefits*.

Attachment E

2006 OPM Ltr to Rep Christopher Smith



OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

JAN 27 2006

The Honorable Christopher Smith
U.S. House of Representatives
Washington, DC 20515

Dear Representative Smith:

Thank you for your recent communication concerning applied behavior analysis (ABA) for autism. You asked that the Office of Personnel Management (OPM) direct the Federal Employees Health Benefits (FEHB) Program carriers to provide information on the extent of their coverage for therapies such as ABA.

OPM has conducted an extensive literature review on ABA and consulted with medical experts in this field. While it appears that ABA is considered a promising behavioral intervention therapy for autism, there is no strong scientific evidence of its benefit. A National Library of Medicine "Medline" search of the scientific literature from 1966 to present revealed no evidenced-based articles on behavioral therapy of autism. The current evidence rests on small numbers of children with autism treated over several years. ABA has not yet been proven in randomized experimental trials and is considered to be experimental or investigational. Therefore, benefits coverage under the FEHB Program is not available.

The American Academy of Pediatrics and the National Research Council indicate that more replicative studies with improved methodology are needed before ABA can be recommended for all autistic children. The National Institute of Mental Health reported in April 2004: "Research is beginning to show that specific medical and behavioral treatments, and combinations of these treatments, are effective in ameliorating various problems that are often associated with autism. Further research is needed to fully evaluate the efficacy and effectiveness of such treatments."¹ In May 2004, the National Institutes of Health's Interagency Autism Coordinating Committee reported that "Randomized controlled trials of behavioral interventions are also needed, as well as outcome measures for behavioral treatment studies."²

Under its mental health coverage, the Federal Employees Health Benefits (FEHB) Program provides benefits for services related to autism as it does for medical conditions. For example, if a specific service (e.g., speech therapy) is covered by a FEHB Plan, the service cannot be excluded if it is prescribed to treat autism. These mental health benefits, along with pre-authorization requirements, limitations, and exclusions of services considered experimental or investigational are described in each carrier's plan brochure available during open season. As with any type of service (medical or mental), regardless of the condition, OPM cannot authorize benefits for services that are considered to be experimental or investigational.

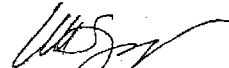
The Honorable Christopher Smith

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It is OPM's most sincere hope that one day randomized trials will demonstrate ABA to be an effective course of treatment for autism and no longer be considered investigational. OPM has great empathy for the families affected by this tragic disorder, and regret our decision could not be more favorable.

I appreciate the opportunity to respond to your interest in this matter.

Sincerely,



Linda M. Springer
Director

¹ Department of Health and Human Service, National Institutes of Health, National Institute of Mental Health, Congressional Appropriations Committee Report on the State of Autism Research, April 2004, Pg. 16.

² Department of Health and Human Services, Interagency Autism Coordinating Committee, Meeting Highlights, May 11, 2004, National Institute of Health, Pg. 3.

Attachment F

2011 Ltr to Assistant Secretary Posny

Dr. Alexa Posny
 Assistant Secretary for Special Education and Rehabilitative Services
 United States Department of Education
 400 Maryland Avenue, S.W.
 Washington, D.C. 20202

Dear Assistant Secretary Posny:

We are active duty members and/or their spouses who have a child with a disability who receives special education services under the Individuals with Disabilities Education Act (IDEA). We request that the Department of Education via your office investigate a number of serious issues related to the ability of military children to receive appropriate services in our nation's public schools.

There are over 150,000 military children impacted by a disability (many more if you count Reserves and Guard families). The root of our problem is that military orders and requirements cause military families to move more often than the general public. We move both due to short term training and deployments (6 months to 1 year) and normal military transfers (every three years on average). It is not uncommon for military families to relocate 15 or more times in a 20 year career, generally across state lines. When we move, our children with disabilities are impacted and they often fall behind at school. Families and children must adjust to new IEPs, new staff and new programs. At a time when they need more services due to the transition, a number of families find that the new school district significantly cuts their child's services or alters them to the child's detriment. Some districts deny the child accommodations they had through their previous school district. Some of these districts seem to be aware that families will move soon again, and have little ability to protect themselves (once a family moves, it may be difficult to bring due process). We wish to recognize that there are school districts that provide excellent services to military children with disabilities and many individual teachers and staff who go above and beyond in providing effective educations to military children. These staff and schools are heroes to the families they serve. But still these problems persist with a number of school districts.

There are five significant issues for your consideration.

First, contrary to IDEA 2004, children who move into new school districts do not necessarily receive services comparable to those in their prior IEP. 20 U.S.C. 1414 (d)(2)(C)(i)(II) of IDEA states "the local educational agency shall provide such child with a free appropriate public education, including services comparable to those described in the previously held IEP." Regulatory Commentary states that "comparable" was intended to mean "similar or equivalent" to the old IEP [71 Fed Reg. 46681 (2006)]. But, it has been our

experience that some school districts ignore the commentary. This is because the commentary is not legally binding, and school districts have told parents this when they cite it. But regulations are binding and making the commentary part of the regulation would be a significant step toward solving the problem. A number of families find that their child's services are cut significantly and accommodations and modifications are not provided. Assistive technology needs may not be recognized across districts, forcing students to learn new programs and computerized devices with each move. As one example, military parents of a child with hydrocephalus and associated issues moved from Texas to Alabama for a required 10 month military training program. The new Alabama district reduced the child's services by half, effectively ignoring the Department of Education's commentary. Since the family was in Alabama for such a short period, they had little recourse. Their story is included from the September 2009 edition of *Exceptional Parent Magazine*. We ask for three things with regard to this section of IDEA 2004.

We ask that the regulatory commentary should be made part of the regulations. There are school districts that ignore the commentary because it is not binding. Regulations are legally binding and everyone must follow them. Most families do not even know about the Commentary or that they need to go find an August 2006 Federal Register notice to access it. Most schools and families simply focus on the regulations. Military families, often with a family member deployed or otherwise serving their country, often find it difficult to take on advocacy for their child on top of everything else. Consequently, we would be grateful for clearer regulations.

Pending this regulatory reform, we would request focused, clear guidance be issued to school districts and State Educational Agencies. It would be most helpful if the new school district fully understood the requirement to provide similar or equivalent services, per the previously agreed to IEP from the losing school district.

Third, we hope that guidance can be developed around evaluation needs related to this part of IDEA. IDEA 2004 appears to suggest that an LEA needs to conduct an evaluation before writing an IEP. 20 U.S.C. §1414 (d)(2)(C)(i)(II). This further delays services, as states go through the evaluation period. Districts get 60 days to write IEPs unless states set their own deadlines, and some deadlines exceed 60 days. After this, there is a delay before the IEP is written, and then a slight delay again for implementation. It seems that districts should be urged to adopt assessments that have already been conducted, which would save LEAs money. It wastes resources to conduct the same assessment twice in a year, merely because a child moves.

Second, military families moving school districts face difficulty with evaluations. As mentioned previously, state evaluation periods can vary from 60 days to much longer. For military children who move in the middle of the evaluation, the delay in services can become appalling. One military family noted that they notified Child Find in late March in one state, only to eventually be provided a IEP and services in another state in late October. We would ask that you clarify in regulations and in guidance that 20 U.S.C. 1414(a)(1)(C) requires the evaluation timeline to begin from when the child is first evaluated in the old district. Some districts take the position that it does not.

Third, the protections in IDEA for moving families are limited to moves during the “school year.” Because military families move during the summer, LEAs refuse to implement their old IEP or provide similar or equivalent services. They simply read IDEA 2004’s protections for families which move as inapplicable, since the family moved in the summer. We urge you to clarify that the intent of IDEA, even with summer moves, is for school districts to implement comparable, meaning similar or equivalent, IEPs.

Fourth, we’d request that coordination be conducted between the Department of Education and the Department of Defense regarding the above investigation. Many times, a military child who needs to access special education will transition from a public school to a DoDEA school or vice versa. Our families need both entities to be on the same page to ensure our children receive an appropriate education.

Fifth, school districts know that military families are a transient population and that the large majority are unable to effectively access IDEA’s procedural safeguards (most notably the due hearing process), due to cost and timeliness issues. This creates incentives for some school districts to deny services and refuse to negotiate. Many times, families who move give up certain due process rights, except those related to compensatory education. Moreover, military families, with one spouse deployed or otherwise serving the country, are already stretched to the breaking point without considering the extensive time and energy required to advocate for our children who access special education. We would request that the Department of Education, in accordance with Presidential Directive No.9 “Strengthening our Military Families”, consider regulations and guidance on ways to help military families impacted by their child’s disability, particularly related to transitions and procedural safeguards. It is directly in line with the Directive’s “Priority #2: Ensure excellence in military children’s education and their development” that clear guidance should be provided on the requirements that schools must implement for military families and their children who access special education.

We would request you consider the following documents as supportive of our comments:

- **GAO Study: Education of Military Dependent Students: Better Information Needed to Assess Student Performance**
(<http://www.gao.gov/products/GAO-11-231>)
- **RAND Study on Effects of Deployments on Military Child's Education**
(<http://www.rand.org/pubs/monographs/MG1095.html>)

An upcoming study provided by the National Council on Disability is expected to also validate our complaints above.

Thank you very much for considering our concerns. We are providing our names and contact information below, if you need further information or to follow up.

Sincerely,

Mike Barrett
US Army
barrettfamily@hotmail.com

Laura Blair
US Navy
laura.blair@navy.mil

Karen Driscoll
USMC Spouse
Karen0622@aol.com

Jeremy Hilton
USAF Spouse
ktp1995@gmail.com

Please note that our signatures in no way imply endorsements by the Department of Defense or our individual branches of services. The views expressed are our own.

Attachment G
USMC Family Programs Briefing



FAMILY CARE BRANCH



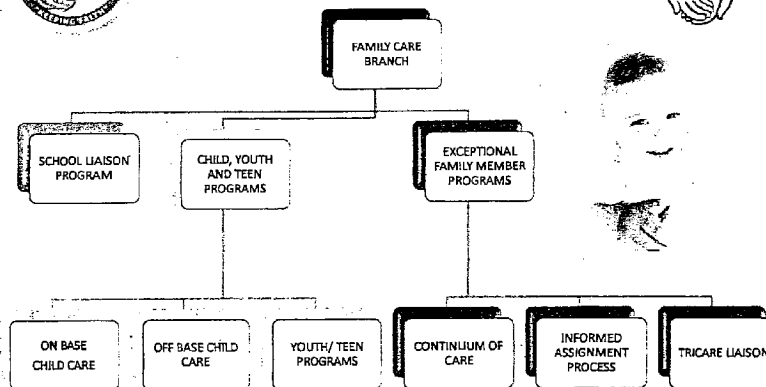
For HQMC Contact Information

https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MF/F_Family%20Care

"Keeping Faith"



FAMILY CARE BRANCH

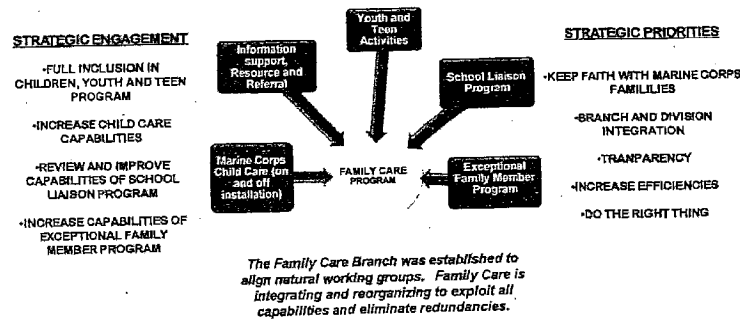


"Keeping Faith"



FAMILY CARE PROGRAMS (MFY) Strategic Concepts

Enhancing Marines and their families' quality of life through programs that provide, support, or facilitate, care and services for children, youth and teens and exceptional family members



"Keeping Faith"



CYTP – Inclusion Services

A Primary Focus for MC CYTP

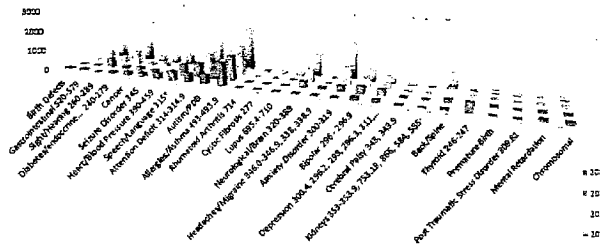
- CDC Nurses hired to serve CYTP at over 70% of MC installations with 100% goal. The Marine Corps CYTP benefitted from training and technical assistance offered through a *Kids Included Together (KIT)* program, contracted by DoD to provide installation staff with professional technical assistance and partnership with the Exceptional Family Member Program and the School Liaison Program to meet the individual needs of children with specific disabilities and challenging behaviors.
- A Diabetes Management Pilot Program was also successfully implemented at three pilot sites to promote and ensure safety and support for children with diabetes in CYTP. CYTP nurses were hired to support the special medical needs of children enrolled in and to provide increased awareness and training for CYTP staff.
- Behavior Specialists. During 2012, the Marine Corps is adding another critical capability to support the inclusion of all children. Behavior Specialists will be added at each installation to support service to children with social, emotional or behavioral concerns.

"Keeping Faith"



EFMP Enrollment

Enrollment. EFMP support to enrolled families is provided by both HQMC and installation EFMP personnel. Since FY08, EFMP has experienced a steady increase in enrollment from 4,500 Marines to 8,404 Marines to over 11,000 EFMs. EFMP enrolled Marines account for 4.1 % of the Marine Corps population. A myriad of diagnoses may lead to EFMP enrollment.

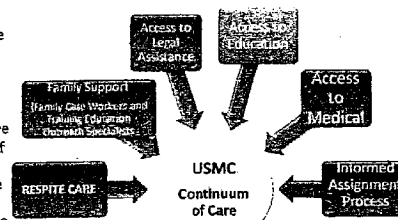


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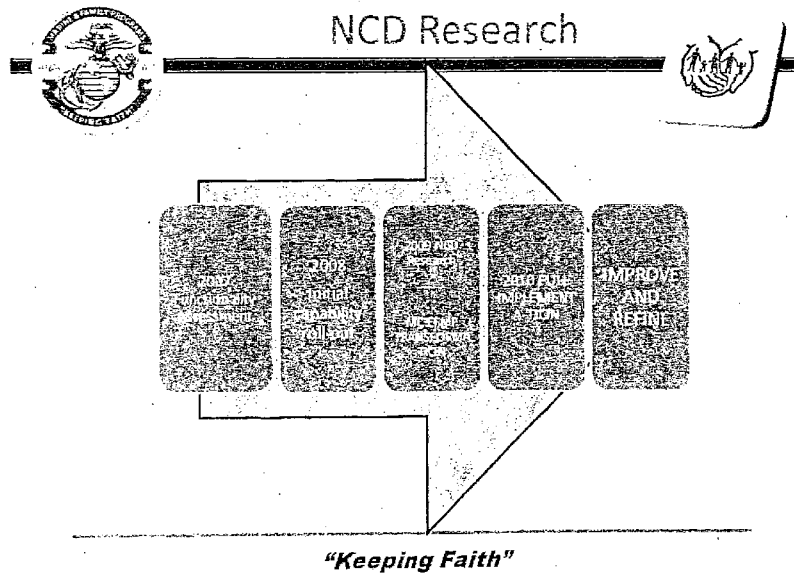


THE USMC EFMP CONTINUUM OF CARE

Assignment Coordination. HQMC EFMP Assignment Coordinators reviewed 3,125 orders to ensure availability, accessibility and reasonable travel time to TRICARE-approved medical providers. Family Case Workers (FCW) at the installation has provided over 80,000 hours of direct and indirect support to enrolled families. An improved assignment process and Investigative protocols, results in HQMC EFMP endorsement of 90% of first identified assignments for enrolled Marines, allowing Marines to remain competitive for promotion while ensuring the continuum of care for EFMs. On-going analyses of declines have resulted in conversations with OSD Office of Special Needs and Navy Medical which could result in gap resolution.



"Keeping Faith"



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- ## NCD Research
- A joint undertaking of the USMC and the National Council on Disability (NCD)
 - NCD is an independent federal agency "...to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, and that empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society." (www.ncd.gov)
 - NCD contracted ICF International, a professional research firm with extensive background in military community research, to conduct the Research.
 - The Research took place fall 2009 through fall 2010.



Research Purpose

How to Improve Access to Healthcare, Special Education, and Long-Term Supports and Services to Family Members with Disabilities

- Document the experiences of USMC families with members with disabilities in accessing appropriate and effective healthcare, special education and related services, and long-term supports and services in the U.S.
- Identify barriers impeding access to appropriate supports and services
- Develop recommendations to improve access to healthcare, special education and related services, and long-term supports and services for Marine Corps family members with disabilities.

"Keeping Faith"



Research Approach

- Data collection period/sites:
 - MCB Quantico (January 2010)
 - Camp Lejeune (February 2010)
 - Camp Pendleton (March 2010)
- Data collection methods: Focus groups and interviews
- Instrumentation: Discussion guides and demographic sheets
- Research participants: EFMs, their caretakers, and service providers
- Research outputs: Aggregated findings, NCD recommendations, final report.



EFMP—Strengths

- USMC relies on EFMP as the primary USMC resource for families with special needs
- Participants almost unanimously recognized that EFMP is a program in transition that has grown significantly in recent years
- Many families and providers affiliated with other base and off-base programs praised EFMP and described a number of EFMP providers as exceptional.

"Keeping Faith"

Findings



EFMP—Areas for Improvement

- Barriers to EFMP program entry:
 - Lack of awareness among potential enrollees about EFMP
 - Misinformation regarding who is eligible to enroll and benefits of enrollment
 - Lingering stigma associated with EFMP and its impact on a Marine's career
 - Inconsistent referral of appropriate candidates by providers (incl. physicians)
- Communications barriers:
 - Inconsistent communication between losing and gaining EFMP offices about PCSing families .

"Keeping Faith"

Findings



EFMP—Areas for Improvement

- Barriers to delivery of quality service:
 - Absence of outreach contact from EFMP (reported by many families)
 - Large caseloads
 - Under-qualified caseworkers
 - Perception of limited services (assignment coordination, information & referral)
- Distrust of assignment process:
 - Skepticism about the capabilities of assignment monitors to make appropriate assignment decisions on behalf of Marines and their EFMs
 - Concern about impact of enrollment on the Marine's assignment options, deployability, and advancement.

"Keeping Faith"

Findings



Key Recommendations—Short-Term

- Conduct accessibility review of human service programs and facilities on USMC bases (incl. base housing). Develop plans for each base to make programs and facilities accessible, as necessary, i.e., ADA compliant. Execute plans. (USMC)
- Increase accuracy and timeliness of information EFMP families receive from Tricare by instructing Tricare case managers to assist families in accessing services, assigning Tricare case managers to a larger proportion of the EFMP population, and establishing multiple communication mechanisms (incl. a 24/7 Tricare telephone hotline for EFMP families, similar to the Medicare hotline. (Tricare)
- Disseminate to Local Education Agencies (LEAs) and EFM families detailed guidance for implementing initiatives included in the Interstate Compact on Educational Opportunity for Military Children. (Interstate Commission, Federal and State DoEs, LEAs, DoDEA)



Key Recommendations—Long-Term

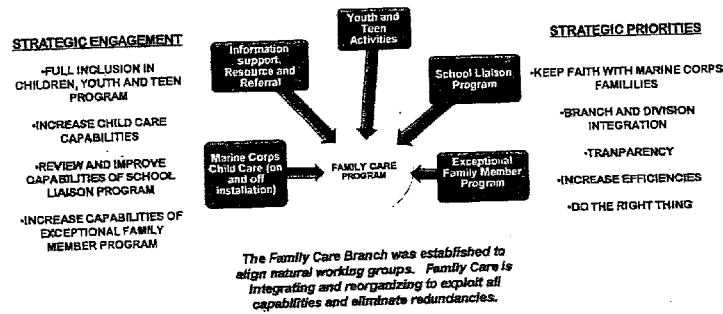
- Implement mechanisms to enable military EFM's to maintain Medicaid waiver services when they move from state to state, rather than requiring them to go to the bottom of the waitlists each time they PCS:
 - Place incoming EFM's on the new state's waitlist based on their position on the previous state's waitlist (i.e., based on "time served"). If individuals have a Medicaid waiver in the previous state, they should automatically receive one in the new state. (Congress and state agencies)
 - For EFM's who lose Medicaid waiver services as a result of a PCS, provide the same benefits the EFM received in the previous state until eligibility can be established in the new state. (Congress and state agencies, DoD, Tricare)
- Increase the flexibility of services covered by ECHO to closely mirror the services available through a Medicaid waiver. (Congress, DoD, Tricare).

"Keeping Faith"



FAMILY CARE PROGRAMS (MFY) Strategic Concepts

Enhancing Marines and their families' quality of life through programs that provide, support, or facilitate, care and services for children, youth and teens and exceptional family members



43% INCREASE IN ENROLLMENT • 48% INCREASE IN CHILD CARE CAPABILITIES • \$10.5M IN K-12 PARTNERSHIP GRANTS

Attachment H
SBP Legal Analysis



The Dilemma for Military Parents of Children with Disabilities

By KELLY A. THOMPSON

Military parents of children with disabilities face a serious dilemma at retirement—whether or not to choose the military Survivor Benefits Plans (SBP) retirement option for their children. Saying “yes” to a monthly income for your child seems the obvious choice, BUT it may well be the wrong one under current law!

Let's explore the differences between military SBP and Medicaid benefits, the usefulness of combining eligibility for both programs, and the unfair dilemma that military families now face when planning for the future of their special children.

SBP BENEFITS & SSI/MEDICAID BENEFITS COMPARED

The SBP will pay up to 55% of the military member's retirement pay to a spouse and/or dependent child when the retiree dies. The member can also select a lesser benefit at a lesser cost. The military member can select coverage for a spouse only, a spouse and children, or children only. The member takes a reduction of about 6.5% in retirement pay for SBP for a spouse and only about \$20/month for dependent children.

In addition to (or in place of) the survivor benefit, a military member can provide an array of benefits for a child with a disability. In most cases, a disabled child over age 18 can be designated as an Incapacitated Dependent (DD Form 137-S) and be permanently eligible for military post privileges as well as TRICARE health benefits. However, these military benefits do not include supportive living programs or vocational opportunities. Unfortunately, the SBP and TRICARE benefits are often not enough to pay privately for all the help that may be needed by an adult child with a disability. So, the military family must often look to other programs to provide for a child's needs.

If the child with a disability who has reached age 18 has assets less than \$2,000 and minimal income, he or she will usually be eligible for Supplemental Security Income

(SSI) and Medicaid. Although SSI pays only \$674 monthly (2011 maximum benefit) and Medicaid may seem to duplicate TRICARE's health benefits, Medicaid “waiver” programs pay for a wide variety of programs and services that TRICARE does not. If the child with a disability is living independently, SSI is intended to pay for the child's food and shelter, while Medicaid may pay for supported living programs, day programs, job coaching and other services. Thus, TRICARE and Medicaid provide a complementary mix of health care benefits and support services needed by many adults with disabilities.

THE DILEMMA

The dilemma is that the SBP income payments after a military parent's death paid to a child with a disability may cause the loss of the child's SSI and essential Medicaid benefits. SSI payments are offset by other income received (including SBP payments) by the recipient. ANY unearned income over \$20 offsets SSI income, dollar-for-dollar. Once SSI income reaches zero, SSI is lost and, in the majority of cases, Medicaid is lost also. If the military member dies having chosen SBP for his or her child with a disability, that child will receive as much as 55% of the retiree's income. If that SBP payment to the child amounts to more than \$674 monthly, the child with a disability will lose SSI and Medicaid health care and community support benefits. In my home state of Virginia and in many states, if the SBP exceeds \$2,022 per month, then all supported living assistance, job coaching, respite care and other services provided under Medicaid “waiver” programs are lost.

A recent example concerns a 52-year-old man with an intellectual disability who had lived in a group home for 18 years and attended a day program for individuals with disabilities. His only income was SSI of \$674 per month. His SSI benefits and Medicaid paid for his programs and services. However, when his father, a retired

House Resolutions 2059 and 3324 were introduced in 2009, allowing assignment of the SBP to a special needs trust that provides for payback to Medicaid at the death of the SBP recipient.



Special needs require special attorneys.

Navy officer, died, his adult son began to receive military SBP in the amount of \$2,030 per month. This SBP payment made him ineligible for Medicaid waiver services. The private pay cost of the programs and services he was receiving prior to his father's death is \$8,600 per month, more than four times his SBP payment. He lost his group home placement, as well as his day program, and was transferred to a state "training center"—a large institutional setting isolated from the community.

PLANNING OPTIONS?

What about just canceling the SBP beneficiary payments? If the military retiree has already made an SBP election that includes a benefit for children, and he or she has a child with a disability, then the retiree can apply to the Board for Correction of Military Records to modify the SBP election. This option must be completed while the retiree is still alive, since SBP beneficiary payments to the disabled child start upon death. The member must complete DD Form 149, justifying why the SBP selection option must not include children (i.e. spouse only). For example, the retiree might tell the Board that he or she did not understand when the retiree originally made the election including children how the SBP benefit would negatively impact the disabled child's other benefits. The individual services have separate Boards for the Correction of Military Records that will consider such requests.

Unfortunately, once the retiree has died and payments begin, there is no way to stop them. Medicaid will not allow the renunciation of the SBP payment and will continue to count it as income even if not collected, and the child with a disability will lose Medicaid. The only true option under current law is NOT to elect the SBP benefit when the military member retires.

PLANNING OPTIONS UNFAIRLY LIMITED FOR MILITARY FAMILIES

Most of my military clients feel that this SBP issue as it affects their children with disabilities is blatantly discriminatory and unfair. Non-military parents can easily assign their pension and life insurance benefits to a special needs trust for their child with a disability. This allows the child to receive SSI and Medicaid and to supplement those benefits with distributions from a special needs trust containing the parents' other assets. The rules for military families are different, however. Defense Finance and Accounting regulations (based on a provision of the United States Code) provide that the SBP

A military family may spend years on a waiting list for Medicaid waiver services in one state and finally receive benefits, only to be transferred to another state and start the waiting list process all over again.

payment may only be paid to a "person." When interpreted literally by the military, this means that SBP payments cannot be assigned to a trust for the benefit of that "person."

Support is growing for a legislative fix to this problem, by allowing the SBP payment for a child with a disability to be assigned to a special needs trust. House Resolutions 2059 and 3324 were introduced in 2009, allowing assignment of the SBP to a special needs trust that provides for payback to Medicaid at the death of the SBP recipient. Identical provisions were introduced by Senator James Webb (D-VA) as amendments to the National Defense Authorization Act. Unfortunately, the 2009-2010 initiatives were unsuccessful and, in the recent political climate, it is difficult to get attention focused on this issue.

YOU CAN HELP

The Military Coalition has placed this SBP issue on its legislative agenda and has actively sought an amendment to the United States

Code to allow assignment of SBP payments to a special needs trust. The American Bar Association and The Arc of the United States have also endorsed such an amendment. As of August 1, 2011, Senator Webb has agreed to introduce the measure again. Meanwhile, the Coalition continues to look for a sponsor on the House side.

Military families who have a member with a disability face numerous challenges not faced by most families. Frequent transfers make meeting the educational needs of their children a moving target. Those same transfers mean that applying for Medicaid and other benefits for their children is repeated often as the families move from state to state. A military family may spend years on a waiting list for Medicaid waiver services in one state and finally receive benefits, only to be transferred to another state and start the waiting list process all over again. The inability to assign SBP payments to a special needs trust is one challenge facing military families that can and should be fixed. Add your voice to this effort. •

Kelly A. Thompson has been a lawyer for 32 years, practicing law in Arlington, Virginia for the last 16 years. Her clients include many military families and her practice focuses on planning for individuals with disabilities and the elderly, special needs trusts, trust administration and estate planning. She has been honored as a Super Lawyer, and is listed as one of America's Best Lawyers and as a Washingtonian Magazine Top Lawyer. Ms. Thompson is a member of the Special Needs Alliance, a national, non-profit organization committed to helping individuals with disabilities, their families, and the professionals who represent them. Contact information for a member in your state can be obtained by calling toll-free 1-877-572-8472, or by visiting: www.specialneedsalliance.org

Attachment I

Stories of Individual Military Families,
Provided by Mr. Jeremy L. Hilton

John P. Wilson
497 Candlebark Drive
Jacksonville, Florida 32225

June 17, 2012

Dear Sir or Ma'am,

I'm writing to you pleading to make the current TRICARE ECHO benefits a permanent benefit for all military service members who are active, retired due to disability, or retired after serving 20 plus years.

After reaching High Year Tenure, I transfer to the Fleet Reserves after 26 years of Honorable service in the Navy on 30 June 2012, and that's the day my benefits expire for my autistic 10 year old son, Adam, who will still be autistic. We were very excited when TRICARE announced ECHO and we were enrolled and receiving benefits two months after it started as well as respite care.

Due to all of his therapies, school, etc., I have to be a stay at home dad once I retire and do side jobs when I can. His mother served 10 years active duty Navy, got out while I was on active duty to raise two boys and is now a RN.

Adam was a non-verbal and totally dependent child before starting ABA therapy and now talks in four to five word sentences, can go to the bathroom, sit in his chair at school, dress himself, starting to socialize with his peers, etc. I contribute all of these milestones to ABA therapy.

Even though Florida has mandated that insurance carriers offer ABA therapy, there are loop holes that I can't seem to get through. The main loop hole is the companies insurance has to be fully funded whereas most are self funded. I have exhausted all avenues in search of insurance to cover his ABA and we have applied to many programs to assist with no avail.

With all of his medical expenses and our limited income we have to reduce his ABA in half (which was half of the recommended treatment to begin with), reduce his speech and OT therapies from four times a week each to one, and are still out \$1884.00 a month with TRICARE Prime for Retirees, who doesn't cover any ABA. We are going to do everything we can to give Adam a chance in life and will do this until our savings is depleted and credit cards are maxed out, after that we are on our own...unless this bill passes.

I have read that treating autism early is much less expensive then dealing with it later in life.

Thank you for your time and consideration, and thank you so much in advance for approving this bill.

Sincerely,
John P. Wilson and Family



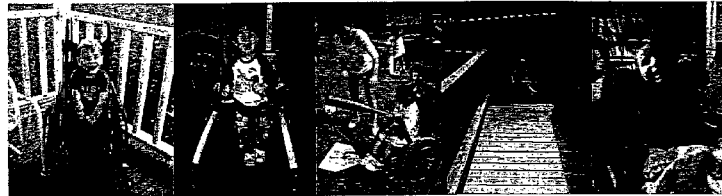
Bo Brown



Military Support System Struggles:

- * The Browns pays \$25,000 per year for ABA therapy not covered by Tricare. This comes as a huge financial burden to the family.
- * Because of the funds being applied to ABA therapy, there is no money left over for normal family experiences like a simple vacation
- * The Brown family has moved seven times in the last fourteen years. They have three more moves coming up in the next four years.

The McClenney Family



Branch: US Navy

Duty Station: VFC-12, Oceana Naval Air Station

Carsun McClenney, son of PO2 Cecil McClenney and Brenna McClenney of VFC-12 Oceana Naval Air Station, was born with Cerebral Palsy (CP). Now almost 5 years old, he is unable to walk independently without medical equipment. Although still very young, Carsun has already endured a bilateral femur osteotomy (surgical reshaping of the femur and pelvis) in hopes that would help make walking easier. Unfortunately the surgery was unsuccessful, and it has actually made walking harder for Carsun. He will be undergoing a second surgery July 19th to remove plates from previous surgery.

While the McClenneys feel they have been more fortunate than most in America to have health insurance, they have still faced many trials at trying to make life better for Carsun. One of the many difficulties the McClenneys have encountered is finding out what kind of medical equipment is best for their son, and then locating companies to purchase the equipment. They do extensive research, only to be faced with a brick wall when it comes to TRICARE. The McClenneys are paying extensive out of pocket expenses for the equipment, while they wait significantly long times to even be seen by specialists at their Military Treatment Facilities. It has created a financial burden on the McClenneys to have to pay for equipment upfront, when it is TRICARE that is holding up the process. For example, the family ordered Carsun a pediatric wheelchair on March 1, 2012, and to date, they are still fighting with TRICARE and the equipment has yet to be ordered.

Petty Officer McClenney decided to move his family back to their hometown so they could have a larger support network. Unfortunately, their new home could not accommodate Carsun, so they requested for a ramp through TRICARE. Unfortunately, neither TRICARE nor ECHO covers any type of ramp, even when it is a necessity. Fortunately, through the love of a close-knit community, the townsfolk built the McClenneys a ramp, at no expense to the family.

Medical and equipment needs will always be a necessity for Carsun. As he gets larger, the McClenneys will need a vehicle lift, which is also NOT covered by insurance. But the McClenneys will continue to fight and advocate for their son's needs, no matter what.

Above are some pictures of Carsun: some of Carsun in his equipment, one of him right after surgery, him in his temporary wheelchair on his new ramp, and also a picture of him participating in the Special Olympics for Young Athletes. This will show you how happy and full of life he is, despite his disabilities.

Thanks,

PO2 Cecil McClenney and Brenna McClenney

The Adams' Family consists of John, Kathy, Brent (14) and Claire (12). John is an active duty Marine stationed at Quantico with 21 years of service. Our daughter Claire was referred to the developmental center at 15 months. She regressed in health and developmentally sometime after turning one.

She began Occupational and Speech therapy at 18 months. At that time there were no providers in the Cherry Point area accepting Tricare, and the family had to commute 45 minutes to Jacksonville, NC for 30 minutes of therapy. Claire's mother noticed that children of the same age and with less noticeable delays with Medicaid insurance were receiving 1 hour of therapy.

At 2, Claire was diagnosed with Cerebral Palsy and Physical therapy was added. At 34 months, Claire was diagnosed with Pervasive Developmental Disorder-Not Otherwise Specified by Dr. Gretchen Meyer at Portsmouth Naval Hospital.

In October 2002, Claire began ABA services after filling out extensive paperwork to get \$1000 covered under the Person's with Disabilities Program under Tricare. \$1000 did not cover the recommended 40 hours of intensive therapy that is recommended and the family decided to pay the overages. The family was able to hire "tutors" to work directly with Claire, while being supervised by a Board Certified Behavior Analyst.

In 2006, Claire's mother began inquiring about respite options for Claire thru the state and insurance. She was told she could only get respite thru insurance if receiving ABA services. After close to a year wait (paperwork misplaced) she started receiving respite thru North Carolina's Intellectual Disability Waiver and was allotted 9 hours a week. In 2010, the respite hours were taken away due to budgetary cuts.

In 2008, Claire's mother pursued respite thru the new Exceptional Family Program. She was told she could get reimbursed up to 10 hours per week at the rate of \$18 an hour, but that she would need to find her own provider. Finding a qualified provider was difficult and they did not receive respite for some time. Then the rates dropped to \$15, to \$10 and after major cuts to \$6.

In 2010, the family decided it was in Claire's best interests to move to Northern Virginia for better services (ABA, schools, respite). In VA, there are more ABA providers but many do not accept the new Autism Demo ECHO guidelines which reimburse up to \$3000 a month; this will typically cover 10- 15 hours a week of supervised ABA programming. She is currently getting tutoring thru Curriculum Autism Services and is making quick progress with the communication program Proloquo to Go with the iPad.

In early 2011, Claire's mother applied for Medicaid as was told the wait in VA was 10-15 years, especially if the child was under 18 and the parents were in good health. She was referred to the ID waiver for respite. In March 2011 she was meeting with the ID respite caseworker, who told her they reimburse at a \$6 an hour rate, when Claire fell out of chair into a grand mal seizure. She was hospitalized for 6 days.

After the seizure, Claire's health status made her eligible for services under the Elderly and Disabled Waiver, reimbursing at \$11.37 per hour. Claire began receiving up to 30 hours per week of respite in the Spring of 2011.

Claire's father is approaching retirement and they are concerned about services for Claire. ABA has been integral for Claire and is opening a world to her, but these services will no longer be covered after retirement and few states provide coverage for older children. Please re-consider extending the services to retirees! Also consider the difficulty military families have obtaining services and have to re-start the wait in each state when they move ... this should not be the case! Furthermore, states receiving Federal bailouts should not have been allowed to make employee cuts (does not help stimulate the economy) which led to respite services being discontinued. It is disconcerting, that Tricare is not universally accepted by civilian providers; our soldiers are putting their "lives on the line" in service and their families deserve the best. Our country is not prepared for the epidemic rates in which the disabled children are approaching adulthood.

John and Kathy Adams 10800 Park Road, Lorton VA 22079 703-339-0729 jkandkb@yahoo.com



To the Senate Armed Services Subcommittee on Personnel:

My name is MSgt Melinda Burts, and I have been an active duty member of the United States Air Force for 15 years. My oldest son, Simon, was diagnosed with autism at 20 months old in 2006. My husband and I were devastated. He was completely non-verbal and behaviorally was nearly impossible to control. I cannot express how thankful my husband and I are that Simon was able to receive ABA Therapy beginning at age 2, and that this therapy was covered under my Tricare insurance. Although the road has been frustrating and challenging at times, Simon's progress has been truly astounding. He has been receiving ABA Therapy now for over 5 years. He just completed first grade in a mainstream classroom. He still has plenty of academic and behavioral issues to work on, but he was able to handle the kindergarten and first grade academic curriculum with some special education support. He was even identified by the Advanced Academics Teacher for being gifted in math, and received weekly group instruction in advanced math concepts. He is a success story (yet still a work in progress) and I truly believe he would not have made these strides without years of intensive ABA Therapy.

My husband and I watched our younger son, Alex, very closely for signs of autism throughout his infant and toddler years. His language, cognitive, and social skills seemed to be on track for a while. But at age 4, we started to notice delays in some of these areas and also a few familiar autism behaviors. Alex was diagnosed with autism in November of 2011 at age 4. His condition is milder than his older brother's, but he has issues that definitely need to be addressed. Again, my husband and I are relieved that we have access to ABA Therapy that is covered by Tricare, and Alex has already made progress in many areas in the few months he has been receiving therapy.

I cannot imagine how my family could have survived financially if I had been paying for this therapy without the help of insurance. The going rate for a BCBA (Board Certified Behavior Analyst) is \$150 per hour, and the going rate for an ABA Tutor is \$50 per hour. If I add up the services that my children currently receive in a typical month, at these rates it comes to \$3800 for Simon and \$2400 for Alex, for a total of \$6200 per month. But because each child with autism is different, the services that each child needs can vary. Also, the services that a child needs can vary at different times in his life. For example, Simon was having some behavioral difficulties at school this year, and our BCBA spent a lot of time at his school working with his teachers to create a behavior plan for him. It was extremely successful and all of his teachers agree that his behaviors improved drastically after the plan was put in place. But this required our BCBA to spend as much as 15 hours a week at his school for several weeks. This comes to an extra \$2250 per week (or an extra \$9000 per month) for a temporary period of time. I am an enlisted member of the U.S. military and my husband is a public school teacher. There is just no way that our family would have been able to afford this level of ABA services without help.

I strongly believe that all medical insurance plans should cover ABA Therapy. I have seen with my own eyes how incredibly beneficial ABA Therapy is for all children with autism, both the mildly impaired children and the severely impaired children, and all of those in between. And as I approach 20 years of service in the military, I must admit that I am nervous about how I will pay for ABA Therapy for 2 children after I retire. I cannot impress enough how important I believe it is for ABA Therapy to be covered for Active Duty Members, Federal Employees, and Retired Military Members alike. Please consider taking the action necessary to make this happen for your service members.

Sincerely,

Melinda M. Burts

Autism Blog: www.placesonthespectrum.wordpress.com

Drake Andrews



Military Support System Struggles:

- * System is hard to navigate, easy to get lost in the shuffle**
- * Lack of coverage of sensory equipment and communication devices like iPads.**
- * Tricare continuing to refer patients to companies that have histories of fraud and neglect.**
- * Financial burden of paying for durable equipment that TRICARE does not cover for disabilities, such as SPIO vests, lycra swings.**

14 June 2012

Senate Armed Services Subcommittee on Personnel
Russell Senate Office Building
Washington, DC 20510

Dear Ladies and Gentlemen,

I am an active-duty Army officer who has served for thirty years and am currently undergoing a Medical Evaluation Board for my injuries and illnesses incurred during that time. I also have a fourteen year-old son with profound autism. He has never said a single word in his life, has to use diapers, has had his own struggle with many medical issues; but I consider him one of the happiest kids that I have ever met. A large part of that happiness can be attributed to the Applied Behavior Analysis (ABA) therapy that he has received through the TRICARE Extended Care Health Option (ECHO) Program. His increasing ability to understand his environment and the verbal commands of others can be directly related to this therapy. In one instance, his ability to understand my verbal command of STOP prevented him from walking in front of a car which he was unaware of. When he stopped, the car was literally inches from his nose and the front of his shoe was actually touching the tire of the car, but he was completely unaware that there was even a car in front of him due to his autism and his fixation on the object that he was running towards. Unfortunately, his ABA therapy is due to end when I retire after thirty years and with my own set of significant medical issues.

The TRICARE ECHO Program and its predecessor programs have provided ABA therapy to a very small percentage of affected dependents of active-duty service members since the late 1990's under a supplemental program to the TRICARE Basic Program for special education purposes. Since that time, ABA therapy has been deemed medically necessary by the Office of Personnel Management for Federal employees and by the legislatures of thirty states. It is time for the Department of Defense to similarly declare this crucial therapy to be medically necessary, so that it is also available to the affected dependents of retirees and applicable Guard and Reserve families that can benefit from this life-saving therapy.

If you would like any further information, please feel free to contact me at (703) 241-2640 or at campbellsservices@gmail.com. Thanks very much for considering this information in your deliberations.

Respectfully,



Scott A. Campbell
Lieutenant Colonel, United States Army
3537 Devon Drive
Falls Church, VA 22042



The Chen Family US Army

In March of 2010, Casey Chen was diagnosed with PDD-NOS, ADHD, and an adjustment disorder with anxiety, while his family was stationed in Germany. At the time, he was significantly behind his peers in all areas, and would not speak above a whisper in the presence of unknown people. He was profoundly afraid of other kids his age, and would avoid interaction.

In December of 2010, the Chen family was granted a compassionate reassignment to JBLM due to lack of services and his inability to access ABA. Within 3 months of arriving, Casey began receiving ABA, in addition to private speech and OT. Within 5 months of beginning ABA, Casey began speaking with his regular volume of speech, starting interacting with his peers, and had almost caught up with his peers in school. His teacher and ABA therapist have worked closely together to help him.

Casey's father is currently deployed. The above picture was their last hug. Under the current regulations, Casey will lose his much needed ABA benefits if his father is injured to the point that he is no longer able to serve or worse. ECHO is only for active duty families. Ling's father will be eligible to retire in 3 years. However, if he chooses to retire, Casey will lose his ABA benefits. If ABA is made a benefit directly under TRICARE, he can continue receiving it.

Casey continues to make huge strides and is now ending the school year on grade level, and is continuing to make friends. We fear that he may not do as well in the future without this much needed therapy. His father is willing to serve as long as he can to enable his son to continue to receive ABA. However, after 20 years of deployments to Iraq and Afghanistan, peace keeping missions in Bosnia, TDYs to Korea, and countless training exercises, Ling would like to retire and physically be able to help his son more. He is currently on a path that will lead to an independent life as an adult. Please allow our son to continue receiving this amazing therapy.

The Cunliffe Family



Aurora - Age 3

Panhypopituitarism
Survivor
Adrenal Insufficiency
Autism Spectrum
Sensory Issues
-Non-Verbal
-High Wandering Risk

Averie - Age 11

Extreme Prematurity
Ulnar Club Hand
Autism Spectrum/
Aspergers
Sensory Issues

Serena- Age 44

Brain Tumor
Neurological Issues
Sensory Issues
PTS, Depression
-Unable to Drive

Struggles with Barriers to Care:

- Varying Educational Support Eligibility across State lines - Autism diagnoses does not guarantee school services
- Denied ECHO coverage for our oldest daughter without an IEP
- Limited coverage for ABA therapy does not meet recommended hours
- Need for specialized equipment covered under same cap
- Access to needed medical specialties not available at MTF and limited locally. Waiting times are up to two years under some circumstances.
- System does not accommodate or assist caregivers/spouses with authentic transportation issues. This results in care being simply inaccessible independent of the service member
- Complementary therapies such as Speech/Language Therapy and Occupational Therapy are not available to take place in the home after the age of three

June 18, 2012

To the Senate Armed Services Subcommittee on Personnel:

I write this letter, hopeful, as Tricare's stance on ABA coverage and the financial aid for military retirees' dependents is being reviewed. On April 11, 2007, my son, at the age of two, was diagnosed with one of medicine's greatest and most frustrating mysteries: Autism. Upon his diagnoses, my heart broke. My every desire became giving my son the best chance for a normal life that I could. At his initial diagnosis and the recommendation of Developmental Pediatrician, Lt. Col. Dr. James P. Vandercar, my husband and I enrolled Zachary in ABA Therapy. It was urged by the doctor that Zachary receive the maximum number of hours (40) of therapy. Unaware of exactly what we were dealing with, as parents new to having a child with disability, we began Zach's therapy one month later in May of 2007. Our son initially received ABA therapy 3 hours/week, progressing to 12 hours/week and now is receiving 24 hours/week. This increase in therapy hours is still far less than what is prescribed for the best outcome of a child on the Autism Spectrum as severe as my son, but it is what our income could afford financially.

Since this process began, five long years ago, I have battled insurance companies, filing claim after claim with Tricare for ABA Therapy to be paid for. Repeatedly, I was denied. Their representatives stated that "military retirees' were exempt from ECHO, and Tricare would not cover ABA therapy." Frustrated, but persevering, I continue this battle.

After months of disheartening attempts, I was blatantly told one day, by a Tricare Representative, that if I did not like the way the law was written I could contact my Congressman, Jeff Miller (FL). Again, I plead my case. Although my Congressman has sympathy, and has tried, the bills enacted to revoke the present statute denying military retirees' dependents ABA coverage, were not passed. What could I do? Here I stood, doing everything in my power to get treatment for my son, and finding myself useless in this battle. It was then, that a fellow autism mom, Karen Driscoll, whose husband serves in the Marine Corps, provided me with a spark of promise. A lawyer in Michigan, Dave Honigman, had joined the fight for families just like mine. His firm had recently won a case against Blue Cross Blue Shield, regarding the coverage of ABA therapy. Somehow renewed and hopeful, in December of 2010, I contacted Mr. Honigman and joined the class action lawsuit to change the present ruling. Regrettably, the case is still waiting to be heard.

As I continue the battle of finding a way to financially give my son the tools he needs, he is fighting his own battle. Zachary is enrolled at the Emerald Coast Autism Center in Niceville, Florida, where he receives 24 hours per week of ABA therapy. In the past quarter, Zach has made the largest gains on the Verbal Behavior MAPP, an assessment used to chart knowledge acquisition, since beginning treatment. I could not be more proud or a stronger believer in ABA. When he first began, his vocabulary consisted of about 20 words. He now has over 200! He is able to functionally communicate with 2-3 word requests, and is able to understand 2 word commands. He has learned self-control and is more personable with therapists and family. While Zachary is still considered an early-learner, with the mental capacity of a 3-year old (he is now 7), I am confident that his gains are a direct result of ABA therapy. Sadly, at a cost of \$53,000 per year, my family is financially tapped and may soon have to dis-enroll my son from the Center. I am beyond words at the thought of stopping treatment and doing this disservice to Zachary. I fear for a loss of what progress he has made and worry that once the ball stops rolling, we may never be able to start it again.

I fervently plead that you assist military retirees in ABA coverage for their dependents. My husband served in the USAF for 22 years, and put his life on the line for our country. He chose to remain in the military not only out of a love for his country, but a love for his family, understanding that medically, his family would be provided for in exchange for his service. It is ludicrous to deny our son the therapy he desperately needs, because my husband is retired. It is a daily challenge for any family to raise a child with Autism Spectrum Disorder, but the trial becomes infinitely larger as the battle with insurance companies to obtain coverage, is constant. I appeal to each of you to help us change this legislation, not only for my family, but for each family that bears this same cross.

Thank you for your time and consideration in this vital matter.

Dawn L. Berge (wife to Ret. MSGT. Kenneth Berge, mom to Carson and Zachary)

My name is Dr. Lois-Lynn S. Deuel and I am a proud military spouse. My husband, LTC George L. Deuel, U.S. Army, is currently stationed at the Pentagon, Headquarters, Department of the Army. We live with our son, Lance, 8, in Arlington, VA. Lance is an EFM. We have been stationed at multiple locations throughout CONUS, Germany and Italy over 20+ years of service. We are honored to serve and are grateful for the comprehensive health care that Tricare provides. With few exceptions, we believe that the military system takes good care of services members and their families. This note is to inform of you of two areas where policy changes, with respect to medical care, can and should be made to improve care for service members in EFMP.

As both a psychologist and parent of a child with special needs, I have always found it curious as to why Tricare ECHO would require a medical doctor to provide a prescription for something that they consider an "educational modality." We don't ask our pediatricians to write prescriptions for Social Studies or Science. Outside of military medicine, other medical, psychological and educational professionals view Applied Behavior Analysis (ABA) as an evidence-based medical therapy (not an educational one) that is considered the standard of care for individuals with autism spectrum disorders. In addition, the arbitrary rationing of ABA through Tricare ECHO falls short of the standard of care (25-40 hours/week), as military families can only receive 3 to 5 hours of ABA therapy per week. Indeed, the effectiveness of delivering ABA in such small, rationed amounts is questionable and there is absolutely no scientific evidence supporting delivery in the manner used by Tricare ECHO. I ask you to: 1) eliminate Tricare ECHO which only serves as a barrier to military families, 2) provide ABA as an ordinary medical therapy through Tricare prime or standard, 3) provide an appropriate number of ABA therapeutic hours that adheres to the standard of care, and 4) ensure that ABA therapy continues for families of all retirees, including wounded warriors who are medically retired.

The military currently has many avenues that accommodate the extra special needs of families that are in the EFMP program. Commanders and career managers routinely consider assignments that ease the burdens for service members and their families. Please commend them for this! We are grateful for the effective supports provided by EFMP and associated efforts. Frequent moves and deployments are the new normal and all military families understand this. However, the structure of Tricare into three regions detrimentally affects the continuity of care for families with special needs. Every PCS between regions results in a complete cessation, often for several months, of all critical medical therapies for special needs families. Until a service member signs into a new unit, and the family is entered into the system for the new Tricare region, families cannot make any medical appointments, cannot get any referrals for speciality care and cannot get on any waiting lists for therapies. For example, your current PCM in California cannot make a single referral for you in your new duty station in Virginia. I ask you to either 1) eliminate Tricare regions or 2) streamline the PCS process and make it seamless so that special needs family members can get medical referrals, make medical appointments and set up therapeutic services at the new duty station BEFORE/DURING their PCS.

Please contact me directly at (703) 340-0585 or lsdeuel@hotmail.com if you have any questions about issues facing military families with special needs. Thank you for your interest and concern.

My husband is an active duty Army officer. He has served 21 years so far. We have a 16 year old, autistic, mentally challenged, daughter named Shaylin. In the sixteen years we have moved 5 times. Each move caused a set back in Shaylin's behavior. We are now dealing with a very aggressive, irritable, 159 lb, 5'11" child.

With each move we have to reestablish Shaylin in a self contained, autism specific, classroom. During our last tour (my husband was at the Pentagon & the Natl. War College) we spent \$15,000 in legal fees. The IEP team wanted to admit Shaylin into Key Center which was not appropriate for Shaylin for several reasons. We ended up with a questionably suitable placement at a district middle school.

In the previous duty station, Hawaii, we had to obtain an attorney to force the local elementary school to establish an autism specific classroom. After it was established we struggled for 4 years to keep the setting and the services related to it. When our daughter was transitioned into middle school the prior elementary school did away with the autism program. And yes, there were still autistic children there in need of such a program.

We now have a very serious problem on our hands. Since my husband is training to deploy for the fourth time, we opted to move me & our three daughters near family for support. Unfortunately, Shaylin's behaviors have escalated to a level that it is not safe at times to have her live in our home. Not safe for us nor Shaylin as she is self injurious & lashes out at us with no regard to her own safety. For almost a year we have attempted to get support services for Shaylin. As I write this note, we still have no services. There is no ABA therapist in our area that works with adolescents. And there are no respite caregivers that provide that service in our area either. Attempts to have Shaylin admitted into psychiatric clinics for evaluations have failed as well as our attempts to have her placed into residential settings designed to treat autistic children.

Our military, normal-functioning, children have issues with the frequent PCS's and deployments much of the time. When you have a special-needs child those issues are compounded tenfold. Autism is a very complex disorder that can be improved. These improvements are only seen with constant training and oversight by individuals highly trained to provide therapy. A care-over support system is imperative for a family dealing with an autistic child in their home. When needed, residential schools designed for autistic children should be a viable option. This is especially true if the active duty service member (or reservist) is on deployment. These schools and services are expensive. They are nowhere near as expensive as government financial support needed to sustain these children once they become adults.

Our military children and their families have to fight for services for their children. This is outrageous when it is those same families that are already sacrificing so much to support our military.

Thank you for listening to a parent of a special child that is very much loved.

Shawn Diaz

240 Tidewater Road

Hattiesburg, MS. 39402

My husband and I both served in the Army when our older two children were born. We began to realize something wasn't quite right with our children. I was medically discharged from the service fairly soon after that and began looking for answers as to what was going on with our children. Eventually the heart stopping answer came, autism. After our initial shock wore off, we began researching treatments. Our children have been very lucky to have all the services they needed paid for through the Tricare system and excellent service providers. These amazing children have gone from the possibility of being declared moderately mentally retarded to children whom most people cannot tell have autism. They no longer need IEP's or behavioral modification plans at school and are academically equal with their peers.

These successes would not have been possible without the support of Tricare. They still see specialists on a weekly basis. I cannot imagine, after serving for so many years and retiring, losing those benefits or having to shoulder the financial burden of paying out of pocket on a reduced retirement budget.

Jeremy, let me know if this is what you were looking for. I'd be happy to make any modifications.

V/R, Maureen



Hello, my name is Sheila I. Almendras-Flaherty and I am an Active Duty Navy Nurse. I have 4 beautiful children Dakota Skye Flaherty age 6, Chase Robert Flaherty age 8, Sheila Renee Velasco age 16 and Desiree Jasmine Velasco age 17. And as the years went by my husband, Robert Joseph Flaherty, and I noticed changes in our children and had them evaluated like any good parents. The providers provided us multiple diagnoses for our children ranging from mild reflux to ADHD and Autism. Needless to say our world was turned upside down and our family went through all the stages of grief. I wish I could tell you more about all the issues we had to go through as a family with each of our children, but that would take up your whole day. Please know that Our Family has and continues to meet all the challenges that come along with having a special needs family, especially one that has 3 out of 4 children with Special Needs. It has not been easy an easy transition for our family but I can tell you that our pain and struggle were made a lot easier by the support and dedication of those in the Exceptional Family Member Program (EFMP) especially in the Marine Corps. We established stability and sense of normalcy through the information and opportunities we were given through EFMP. Even with their guidance, I can tell you from my own experiences as a Medical Professional and a Mother of Special Needs Children that the Military still has much opportunity to grow and improve on regarding the issues that affect their Military Members' Families with disabilities.

I would like to give you a few bullets on the issues Our Family has experienced to give you a better understanding.

- Not having the Specialists needed to provide the care needed either by none in the Network or not available in the area where the family resides even after the Detailer and EFMP cleared family for area according to Category. (i.e. Developmental Pediatricians)
- Traveling 2-4 hours in each direction for One Specialist Appointment. Active Duty Member needed as Medical Escort to provide support to Spouse. (i.e. so child didn't hurt himself or jump out of car/)
- Not having an EFMP Case Manager like the Marines Corps have. EFMP Case Managers knows the family, offers assistance the entire time the family is enrolled and direct them to local community programs and services. Navy only offers EFMP Coordinators who basically assist with the application process that is it and families are left out in the cold wondering "Now What?", "What do I do next?", "So I'm a Category X, what does that mean for the Active Duty Member and the family?"
- Issues with Schools especially when moving since many times the Individual Education Plan (IEP) is from another state. The new receiving school may not offer similar programs or may just refuse since they know the family may not be aware of their rights because state or city laws may be different. Need More Local Military Special Needs Advocates and continuation of School Liaison Officers. Large need for Military Special Needs Lawyers so families don't have to spend their own money fighting the School System each time they move. This is especially important because the schools that educate children from base housing know the families don't have much of a choice and many families choose to stop fighting because of money, time and energy.
- Continue and expand the Navy EFMP Respite Care. It has helped my family plan and deal with all the struggles of having Special Needs Children especially when geographically separated from any type of social support and the Military Member is away 50-80 hours a week or deployed in harms way serving their country.
- Continue the ECHO Services as this has supplemented other needed services and treatments not covered under Tricare-Prime. This service has made a huge positive impact not only to my child but the family because of all the progress made.

I am an Army Veteran, spouse to a retired 1st Sergeant, mom to 3 fabulous children and advocate for my son with autism.

Currently, "TRICARE" military healthcare provides less than half the recommended treatments for autism, and only to children of active duty service members. Service members who retire after more than twenty years and Wounded Warriors forced to medically retire are stripped of what little treatment TRICARE allows via the Extended Care Health Option (ECHO).

Our son was the lucky recipient of such services. He received these services known as ABA, Applied Behavior Analysis. This is a scientifically proven medical treatment for children with autism. Scott received these services for nearly 6 years. During this time of treatment, we have seen marked improvement with his behavior and educational assessments. With the support of ABA, Scott was able to learn how to talk, write and even go potty. This one-on-one therapy played a major part of his development and overall well being. Since his father retired from the Army after serving 25 years, this service was no longer available to Scott.

Congress and the Department of Defense have been denying what our military children need, what my child needs all in the name of saving money and trimming the budget.

Scott stopped receiving ABA therapy 6 months prior to my husband's retirement in April. Those 6 months and the months up to today, without ABA have been met with great challenges for our son. His behavior has dramatically worsened and he no longer participates in school activities. He refuses to complete simple tasks he once mastered such as going potty or brushing his teeth. Everyday we are met with temper tantrums and rage. His behavior has changed so much that he has recently begun treatment through medications. Drugs he never needed prior to the absence of ABA therapy.

In late 2003 my husband purchased a vintage hobby car, a 1969 Mercury Cougar Convertible. He loved that car! It was to be the kind of thing that every father dreams about doing with their only son. Father/son bonding while rebuilding a classic car only to pass it on to his son when he becomes a teenage driver. That was until 6 months later when Scott was diagnosed with autism at the age of 4. That dream of rebuilding the car became a memory as we were thrust into the world of disabilities. Then in 2006 Scott started to receive ABA therapy. Once Scott started to gain skills through the work of his ABA therapists, that dream started to look more like a reality. Scott started to learn. He was beginning to talk and learn how to communicate his needs to his father and me. We were so excited with his development. After 6 years of therapy and progress, Scott was denied access to these remarkable services. All because his father served his country and retired from active duty. Now that car sits collecting dust, never to be worked on by this father/son team.

My husband served his country, your country for 25 years. He earned most of his stripes and commendations as a Special Forces Soldier. He served in Operation Desert Storm-Iraq, Operation Joint Guardian-Kosovo, Operation Silent Warrior-Turkey and Operation Iraqi Freedom-Iraq. He has missed most of the important milestones each of our 3 children reached during his service. He has watched his children grow up from the battlefield.

My husband has faced many enemies over the years battling for his country and other countries in support of honor and duty. Now he has to stand up and fight against the very same government he fought for, all so his son is able to have the same opportunities as others and to learn and BE a citizen of this country he loves.

Each day, month that passes our son loses a little more of himself. Without the ABA Therapy that was denied him when his father retired, Scott's future no longer looks as bright as it once did. We worry more everyday what his future may include. Unfortunately one of the topics has included the "what iPs" and the possibility of an institution.

It is time to do the right thing here.

It is not too late for Scott. Approve this funding to all military children, active and retired, for a better life of these children and for the brighter future of our community. More funding and therapy NOW will mean less funding and institutionalization when these children become adults

Our brave service members never leave a fallen soldier behind. Can our government say the same?

Thank you.

Retired 1SG Brian & Christine Garton,

Shaylynn, 16

Scott , 12

Laura, 8

Moore County, NC



Hello and thank you for taking time to read our story. We are the Geraghty's, a proud Marine Corps family with two sons, Caden and Cole, and a baby girl on the way. I have the honor of serving as Military Spouse Magazine's 2012 Marine Corps Spouse of the Year and my platform revolves around Stroller Warriors Running Club. This nonprofit organization encourage military wives to live happier healthier lives through running, goal-setting, networking, family-building, and community outreach. These women have been a source of joy, inspiration, and support for me, especially during our son's diagnosis. Cole has a genetic neuromuscular disorder called Spinal Muscular Atrophy (SMA). He may never gain the ability to walk and the nature of the disease is to worsen. There is no cure but growing attention for the disease has supported research.



Our military community and Brian's unit have supported us throughout testing, diagnosis, and treatment. TRICARE, Extended Care Health Option (ECHO), and the Exceptional Family Member Program (EFMP) have also been a huge asset. Without them, we would not have the care and equipment that Cole needs. TRICARE and ECHO have been extremely prompt in authorizing referrals and the coverage far exceeds other insurance companies. However, THESE PROGRAMS MUST RETAIN FUNDING AND NEED EVEN MORE ATTENTION in order to continue accommodating our needs and those of many other military families. Despite the positives, our experience has not been without trials and tribulations and I would like to share with you some areas that need attention and revision, from our perspective as a special needs family.

TRICARE:

- We were unable to pursue testing for Cole before he turned 18 months. Until a child misses a milestone, they are discouraged to pursue testing. The entire process should have been accelerated so Cole could receive the physical therapy he needed earlier. **MILITARY DOCTORS SHOULD NOT BE FORCED TO ADHERE TO STANDARDS WHEN PROFESSIONAL OPINION OVERRULES.**
- Every time I call the TRICARE Benefits Department and ask for clarification on coverage, they supply ambiguous answers or no information at all. I have called numerous times so this is not an isolated occurrence. **THE BENEFITS DEPARTMENT SHOULD BE KNOWLEDGEABLE ABOUT COVERAGE AND WILLING TO HELP CUSTOMERS.**
- TRICARE refuses to cover transportation for necessary durable medical equipment. It can cost up to \$25,000 to modify a vehicle to accommodate a wheelchair and several thousand dollars to purchase a trailer. Cole needs his wheelchair 100% of the time but they deem transportation "not medically necessary." **TRANSPORTATION FOR NECESSARY DURABLE MEDICAL EQUIPMENT MUST BE COVERED TO ACCOMMODATE PATIENTS' NEEDS.**
- Specialists are too far away for remote military locations. We drive 4 hours each way for each of Cole's neurology appointments. They authorize 1 night of hotel stay, even if the appointment is mid-day. That means we leave the house obscenely early or drive into the night. I have paid for rooms out of pocket for our own health and safety. **TRICARE NEEDS TO ACQUIRE MORE SPECIALTY DOCTORS SO PATIENTS DO NOT NEED TO TRAVEL GREAT DISTANCES.**

Extended Care Health Option (ECHO)

- ECHO possesses the same policy as TRICARE and will not cover transportation for necessary durable medical equipment. **TRANSPORTATION FOR NECESSARY DURABLE MEDICAL EQUIPMENT MUST BE COVERED TO ACCOMMODATE PATIENTS' NEEDS.**

Exceptional Family Member Program:

- The staff at our base does not show concern for our family. The case manager and staff contact us only to correct paperwork. During these numerous calls, they never once inquired about Cole's progress, nor offered assistance. **EFMP EXISTS TO HELP FAMILIES AND STAFF SHOULD BE TRAINED TO PAY ATTENTION TO CLIENT NEEDS.**
- The childcare respite program is a wonderful resource but the paperwork is excessive. They change formats frequently and require perfection. I personally know of several families that would use the program but do not because of the time, effort, and turmoil. **EXCESSIVE PAPERWORK SHOULD NOT PREVENT CLIENTS FROM WANTING TO USE THE PROGRAM.**

Once again, we are thankful for the benefits we have and these shortfalls can be remedied with more attention and a retaining budget. Thank again for your time and consideration for our needs. We appreciate your concern and advocacy.

Regards, Stephanie and Brian Geraghty of Camp Lejeune, NC



Gerwig Family

USN – Active Duty stationed at NIOC MD and living on Ft Meade

Our son, four years old, was diagnosed with autism at age 2.5. He receives ABA services through ECHO, attends speech and behavior management therapy through TriCare and ECI services through the county under IDEA. We also anticipate an upcoming appointment with a Developmental Pediatrician will result in our 2.5 year old son also being diagnosed.

We have had a huge problem with the county school on post not complying with federal and state laws in regards to special education children. It is a huge disservice to send military families into a school district that does not comply with existing laws and makes families work to get some semblance of these protections for their children. I recently filed an Official Complaint with the Maryland State Board of Education and their Letter of Findings has been issued. Of the four violations they investigated, the school was found in violation for each item. There is no reason military families should have to invest so much time, energy and sanity exhausting all resources when it comes to special education. No family should have to truthfully, but when you are known to be transient members of a community and dealing with all that comes with military life as well as whatever comes with your special needs family member(s) – there should be some way to ensure Commands are aware of existing issues and willing and able to address the family readiness issue SpEd noncompliance is. Especially when the school is located on post.

We look forward to the EFMP program being run as one rather than by branches. Having things separate can be especially confusing and disjointed at joint commands.

I very much support the efforts Mr Hilton and so many others to have ABA therapy rolled into regular TriCare in recognition of its true function for our ASD children and with full regard given to those retired servicemembers who have a family member on the spectrum.

At the top of my list of things that should exist in the EFMP is a JAG Officer stationed at all major bases/posts whose specialty is SpEd, or who is tasked with becoming meaningfully well versed in the Federal and State laws regarding SpEd. This Officer would hold some form of periodic town halls (virtual or not) or meetings with parents to pin point any possible areas needing their attention. While they would not become a lawyer to be involved in Due Process complaints or anything, they could meet with families and give them educated and on point advice re: their situation. They could also draft letters to the school referencing the specific applicable laws and asking for clarification on specific situations in the expectation that knowing families have a SpEd lawyer available to guide them on their issues many schools will stop looking at our families as ignorant or overcommitted and unlikely to tackle systemic problems in local school systems.

The Gorman Family

Active duty Marine Corps for 12 years

5 year old child Madeline survived leukemia, now suffers from multiple seizures daily with severe delay in all areas



Challenges with Tricare/ECHO/EFMP

Inconsistent policies regarding coverage of medical equipment

In our region, the Tricare Management Authority refuses coverage of certain items like a seizure safety-proofed bed. Other areas of the country allow coverage of these beds. This was an extremely large out of pocket expense for our family and it seems unfair that it is being covered without issue in other places, forcing us to question if we should just wait until we get transferred elsewhere to get it covered.

Inadequate EFMP Respite program

For families like ours with children who cannot do anything independently and who are extreme safety risks, respite care is extremely important to give the parent or caregiver a break. Service members work long hours and deploy often. Forty hours per month is not enough, especially during deployment. Respite hourly pay coverage and time allotted should be on a scale that more accurately reflects the disability and needs of the child.

Medicaid Portability

This affects families both military and civilian with special needs children, but the greater burden is on military families who move every 2-3 years on average. It puts great stress on families at an already stressful time (relocation) not knowing if their child will be able to receive similar services in the next area.

HAWKINS FAMILY STORY



Aly Hawkins was born at 35-weeks' gestation with a rare birth defect called esophageal atresia tracheoesophageal fistula (EA/TEF), which means that her esophagus was not attached to her stomach, while her trachea and esophagus were connected. After a traumatic birth, Aly was transferred to the local Children's Hospital, where she endured painful PICC lines with no sedation and was denied any nutrition for over a week. During the operation, the surgeon damaged nerves and paralyzed her stomach and intestines, as well as caused respiratory problems and heart rate and pulse issues. The physicians released her after two weeks, although her health continued to decline. She began turning blue. She screamed every time I would feed her. We would rush her to the emergency room only to be told there was nothing wrong. The physicians refused to treat my baby.

I immersed myself into research and found a doctor in Boston that specialized in EA/TEF and we hopped on the next flight, carrying an infant who was so dehydrated, she was on the verge of seizing. She spent three months in-patient at Boston Children's Hospital, enduring six surgeries, hundreds of x-rays and studies, and finally found the issues: not only was her esophagus barely opening, but scar tissue had developed. She also had two heart defects and a severe tracheomalacia that caused her airway to collapse almost 100% with every respiratory cycle. She had developed clonus and tremors in her extremities because of the previous surgeon's damage during her first operation. Aly went home three months later with a GJ tube, feeding pump, pulse oximeter, and referrals to every specialist under the sun.

TRICARE and ECHO were great while we were stationed in California. She received 40 hours a week nursing services, a special lift reflux bed, and approved the Synagis vaccine that helps prevent RSV virus, which could have been fatal to our baby girl. All of her therapies and specialists were approved quickly, even though we were TRICARE Standard.

Then we transferred to Virginia, where healthcare for Aly is awful. It is a 6-week or longer wait to see a pediatrician and even longer to see a specialist. We have to see a civilian pediatrician now because we just can't put her care on hold like that. TRICARE has denied the referral for Aly to see a dietician, and as a result, my child, who is 100% G-tube fed has not seen a dietary specialist since we moved here twelve months ago! Therapies are non-existent, as their waiting lists are extensive. We have been fighting tooth and nail to get the Occupational and Speech therapies that she desperately needs, but they are only able to provide for her sporadically through the month. ECHO has been a nightmare, too. They have repeatedly denied nursing care here, stating "We are a different region, and you do not qualify here in Virginia." Why isn't there consistency in services?

We have been on the waiting list for much needed respite care services for two years. We pay out-of-pocket expense of \$852 for the Synagis vaccine, because in Virginia, it's not covered, either. There is no available ADA military housing for us in Virginia, and the local housing office seems to be very corrupt.

Aly has fallen through the cracks in Virginia, and health care here is a joke. Why aren't services through TRICARE and ECHO uniform throughout the regions? I feel hopeless that the services that my daughter desperately needs and deserves are not being taken care of. Please help our family and others like us. Our military children deserve better!

Kris Hawkins, wife of LT Rudolf A. Hawkins, Pilot, US Navy



This is Jesse. He was born happy and healthy at Blanchfield Army Community Hospital at Fort Campbell, Kentucky. Two months after his second birthday, he was diagnosed with autism and I was told that he may never talk or be affectionate. I was promised that early intervention is critical and we were lucky to have him diagnosed so young. Our pediatrician stressed the importance of speech therapy, occupational therapy, and Applied Behavioral Analysis (ABA) therapy if we wanted Jesse to gain crucial skills. With my husband deployed and no family within 2,000 miles – I immersed myself into his world to do everything I could. We enrolled in the Exceptional Family Members Program so that we could then apply for ECHO and be eligible for ABA therapy.

It worked. Jesse will be six this September and will be entering a mainstream kindergarten classroom. Not only does he speak, he never stops speaking! He has stories to tell about dinosaurs to anybody that stands still long enough for him to talk to. He isn't without his struggles, we still utilize ABA therapy and are constantly working on behavior and social issues that pop up.

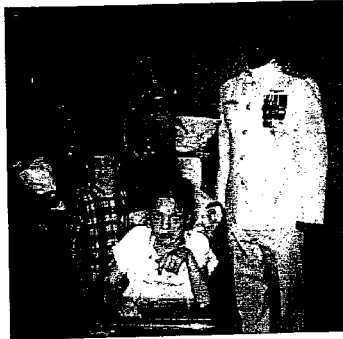
As of December 1, 2012 my husband will retire after 20 years of honorable service and we will lose our coverage for ABA therapy completely. Please don't let this happen. There are children out there that need this – not just to succeed but some need it just to make it through daily tasks that we all take for granted. We don't just want ABA therapy for our son, we need it. He needs it. We need your help.

16 June 2012

1. My son was diagnosed with autism while we were stationed in Germany. He was 15 months old. As overwhelming as the diagnosis was, it was even more overwhelming to get all the necessary care he needed. There was speech, occupational and physical therapy, allergy and immunology, etc.... and there was ABA. Stateside military members had already worked hard to have ABA recognized as a need but only under Tricare ECHO (Extended Health Care Option), which still denied it as MEDICALLY NECESSARY for children with a diagnosis on the autism. There was only one American operated ABA company available in Germany. It was very expensive, and we were constantly struggling with Tricare to receive reimbursement. By time we left Germany, private ABA and his medical necessities, that we refused to wait for months for in the system, had depleted our savings and investment accounts.
2. We fought with the Air Force assignments team, explaining that they needed to send us to a location that had available ABA for our son. With patience and persistence, we arrived at Andrews AFB. Because we had heard about schools that offered self-contained classrooms for children with autism, we decided to live in Virginia. In the meantime, we begin our journey trying to find him ABA services. There were several companies, but they had 8-12 month waiting lists. When we finally did find a company that Tricare would cover, they left billing to us. The company billed us, and we would wait for Tricare to reimburse us. At times, our credits cards were maxed well (upwards of \$20,000) while we waited for reimbursement. And the interest was not low. So we are now, broke.
3. Before my son started receiving up to 12 hours a week of ABA, he did not speak, had tremendous behaviors that included hitting himself, spinning, crying constantly, and lived in constant frustration. After only one month of ABA, he began to sign then steadily began his journey to beginning to communicate. I will save the complicated details, but I will tell you that he legitimately passed the 2nd grade recently. He still however cannot leave a self contained classroom, and we long for him to be mainstreamed. ABA works. It's been proven to work. It is also MEDICALLY NECESSARY.
4. We are frustrated. Upset. Tired. We have the weight of the world on our shoulders. Any parent knows the pain of watching your child go through something that you just can't seem to fix. But how about knowing there is something that will benefit your child is out there, but you only get access to a SMALL portion of it. You don't only give a "little bit of chemo" if you have cancer, or a "little bit of physical therapy" to someone who was in a car accident and broke their legs. You give them what will benefit them completely. I feel like someone has dangled that carrot on a stick we continue to chase. I feel as if someone is saying to us, "There is this scientifically proven, medically necessary therapy that can benefit your child, but we are only going to give you a quarter of it."
4. Currently, my husband is stationed in Dover, Delaware and commutes home on weekends. Because he was force to move, we lost nearly \$1,000 in a month in housing allowance and now have to maintain two households. There are no ABA services in Delaware. And even if there was there would be waiting lists. So, we separate our family so that my son can continue to receive his ABA services. And my husband continues his service faithfully in hopes that the military will do due diligence and take care of his family in his absence.
5. ABA should be given to us as it was found to be the most beneficial, at 40+ hours per week. It should also be made to available to military retirees. Cutting these services at retirement from active duty is a travesty. Our men & women who serve our country deserve peace of mind that their family is taken care of both during and after the completion of their military service. They earned it and our children deserve it.

MELISSA A. HENDRIX,
Military Spouse

The Samuels Family



BRANCH: US Navy

DUTY STATION: NAS Fort Worth JRB

EFMP CATEGORY: 5

Kaitlyn Samuels was born with severe brain abnormalities which resulted in severe global developmental delays, cerebral palsy, scoliosis and a seizure disorder. The family's biggest hurdle in caring for Kaitlyn has been gaining access to the Medicaid Waiver. They are entitled to this, however, Mark's military service has made this impossible at every duty station except for one. Here is their experience:

Due to Mark's career we have moved five times since Kaitlyn's birth in 1996. While we have managed to make every move successful for Kaitlyn in terms of medical care (by being on Tricare Standard rather than the more cost effective Prime) and school (by living within the best available school districts) one area that is frustratingly difficult is access is the Medicaid Waiver program. As you are aware each state handles its own program, therefore military families must start over with each move. Of the six locations we have lived with Kaitlyn, only the state of Maine did not have a waiting list for their Medicaid Waiver (the Katie Beckett Waiver in Maine). Our current waiting time here in Texas is over 4 years for one waiver and over 10 years for another. This is the typical wait time we have encountered in each of the other locations in which we have lived. As you know, military orders are rarely longer than 2-3 years, therefore, in most states military families never make it off the waiting list before being put at the bottom of the list in their new state when relocating. One of the most helpful benefits of the Medicaid waiver is access to respite care. Military families rarely live near extended family and very often the active duty parent is gone. Therefore respite care is an even greater need for military families than most others. My daughter is 15, but requires the care of an infant. I must dress, feed, bathe and diaper her. Having respite care when we lived in Maine gave me a chance to do things with my other two children that are hard to do with Kaitlyn. It gave me time to catch my breath both physically and emotionally. And it gave me an extra set of hands when my husband was gone. There must be some way to address this problem. Possibly some type of waiver program for military families that is not tied to a particular state. I am not seeking help for something special for military families. I am asking for help for what we are already entitled to, but our family member's service denies us.

Jennifer Samuels
Navy wife of 19 years

Sir/Ma'am:

We are an active duty family with an autistic 6 year old daughter and an 8 year old daughter that is recovering from difficult leukemia treatment and currently receiving her treatment at the New Walter Reed hospital in Bethesda, MD. I have over 20 years in the military on active duty and as I am nearing retirement, we are very concerned on how we are going to continue Haynah's Applied Behavior Analysis (ABA) therapy.



My autistic daughter's treatment plan for autism includes a wide variety of treatment aside from the ABA therapy to include but not limited to speech, occupational therapy, hypotherapy, gluten/casein-free diet, LDA shots, and attendance at a Fairfax County Public School autism elementary program. The ABA therapy has and continues to be a critical part of her treatment as we cannot even imagine where my daughter would be without it. The financial burden is already very significant as we pay out-of-pocket expenses not covered by TRICARE. Even though the ABA therapy benefits are a true blessing, my daughter still requires more hours than allocated, therefore, we also pay out-of-pocket for these additional hours. However, with the current ABA policies for retirees, her treatment plan will be seriously affected by our inability to support her financially.

Please consider our huge challenges and that of many other military families that have similar circumstances. Treatment of autism is a huge financial and emotional undertaking for the families and all involved, and your help would be greatly appreciated by all, but mostly by these autistic children.

Sincerely,

Theo Kang and Family
7981 Viola St.
Springfield, VA 22152
Kang.theo@gmail.com

16 June 2012

I am the proud father of twin sons who were both diagnosed with autism while I was on active duty in the Army with more than 28 years of military service. Both sons received Applied Behavior Analysis (ABA) medical care while I was on active duty. But when I reached mandatory retirement at 30 years of military service, DOD TRICARE would no longer pay for any ABA treatment. Does my retirement change anything about my children's condition?

One of my twin sons is non-verbal and requires OT as well as speech therapy in addition to ABA therapy. Military readiness and the fair treatment of all categories of military personnel, active duty as well as retired, are important considerations for DoD health care. I have many out of pocket medical expenses resulting from the autism spectrum disorder diagnosis of my two sons.

I hope this unfair policy, in which retired military family members are excluded from reimbursement of ABA medical treatment by DOD Tricare, is finally corrected.

Kenneth D. Shive

COL (ret) US Army

McIntyre-Brewer Family, US ARMY

Pediatric Needs: Lorelei, 7 years, hypoplastic left heart syndrome (HLHS), PTSD, OCD, Harlequin Syndrome, seizures, tics, extensive pulmonary scarring
 JoJo, 5 years, cerebral palsy, plagiocephaly, residual PDA, BAV, insufficient aorta, tricuspid prolapse, endocarditis, multiple tumors

Primary Issues Relative to Access to Care:

1. Continuity of care from one permanent change of station (PCS) to next was denied despite proof of history with in-network providers through the Children's Hospital of Philadelphia (CHOP) was denied in the referral process by a doctor who wished to retain children within the Military Treatment Facility (MTF) and a written care plan previously established through the Exceptional Family Member Program (EFMP). Recourse protocol was followed and ended with a switch to Tricare Standard despite contacting the central EFMP office at the Pentagon, advocacy from CHOP, and proof that adequate care was not being provided by clinician who tagged referral for Right of First Refusal. Review of files was done in-house, rather than a third party review, and limited patient advocate recourse for proper advocacy.
2. Continued reductions in payout for services to civilian providers have caused various specialists and hospitals to refuse Tricare patients, limiting qualified care. The financial crisis has been cited as reason for limiting distance travel to visit facility used since birth and denying referral despite proven patient history with institution, willingness to forfeit travel reimbursement expenses, and limited availability of specialized services for patient.
3. MTF medical records have been lost multiple times or NOT recorded, including the entire first years of our daughter's life. MTFs also regularly ignore requests from civilian providers for information, despite using correct channels for acquisition of information. Loss of records has led clinicians to request procedures that were unnecessary and redundant, including sedated MRIs, echocardiograms, labs, and other interventions that proved a waste to taxpayer dollars and trauma to pediatric patient.
4. Communication and appointment collaboration for children with complex medical needs is disjointed and very seldom followed through. The disconnect between front desk services and inability to contact clinicians has created various instances of ignored medical requests, situations where hospitalization could have been easily prevented with early intervention, and inability to access care.
5. Right of First Refusal ultimately compromises the health and well-being of chronically and severely disabled children as it retains children who should be routinely monitored by the same team of experts who have the ability to establish adequate protocol, limit the misfiling of information, and ensure longevity of health for patient. While useful in healthy patient circumstances with temporary medical needs, it is inappropriate for life-long medical issues with established care protocol in place already.



My name is Jennifer Lockwood and I'm writing to you today to ask for your support of HR 2288, the Caring for Military Kids with Autism Act.

I've been married to military since before I was married. My father is a veteran who retired with 20+ years in the Navy; my husband is in US Army, with close to 25 years active duty.

In July of 2008, at the age of 4 my son was diagnosed with Autism. My husband and I were highly encouraged by my son's Developmental Pediatrician to enroll in both the Exceptional Family Member Program (EFMP) and the Extended Care Health Option (ECHO) Program, which would enable us to start Applied Behavior Analysis (ABA) immediately.

My husband submitted all the required paperwork for my son's enrollment into EFMP by mid-July and in September I was told that there was no paperwork and my son was not in the system. Essentially we had to start the process over again. My son was not authorized to begin ABA therapy until he was processed through EFMP and enrolled in ECHO. For children with Autism, it is imperative to start early intervention as soon as possible to ensure the most benefit and the greatest positive impact. Because of the lengthy enrollment process and the lost applications, it was January 2009 before my son was fully enrolled and approved. Due to the demand for ABA therapy, my son did not receive his first session until April 2009. Had ABA been an approved medically necessary therapy under Tricare, I suspect we would not have lost close to a year of my son's precious time.

Although the recommended amount of ABA therapy is 30 - 40 hours/week, my son only receives 10 hours/week, not near what is recommended, but absolutely better than nothing. Due in part because of these services, my son has gone from functioning as an 18 month old to functioning of a 6 year old; and this would not have been so had these services not been available through ECHO.

Because of where my husband is currently stationed, I live thousands of miles away from my family and have no family support. When my husband was deployed, there were many days when I was so tired and exhausted from being mother, father, and therapist to my son, that I just needed a few hours to myself. I called to inquire about respite care, which is a benefit that the EFMP and ECHO program provides for their families of deployed soldiers. I was told that any respite care that was provided would be deducted from my son's already minimal ABA therapy hours. Respite for a deployed soldier's family should not be provided at the expense of a child's medically necessary ABA therapy hours. I chose to forego respite; because my son's medically necessary therapy was more important than his mother's well-being.

As I stated earlier, my husband has over 25 year's active duty Army Special Forces. He has deployed multiple times throughout his military career, potentially risking his life each time. He recently returned from a yearlong combat deployment in Afghanistan and is scheduled to deploy again in August, for what will most likely be another year. Although my husband has more than enough years to retire from military service, he cannot for fear of losing all medically necessary autism therapies for our son; retirees are not eligible for ECHO services.

My husband has made many sacrifices for this country, so I ask you to do what is right and offer your support to him by supporting HR2288. The medically necessary therapies that our son requires should not preclude our son from having a father present in his life.

The Maki Family
USAF

Caleb, 5 years old

Diagnoses:

Autism, Celiac disease, Apraxia of Speech, Sensory Integration Disorder



Our current base is 45 minutes from the nearest city that provides the necessary services, such as, Speech, Occupational and Physical therapies. Our in-home ABA therapists travel 45 minutes each way 3-4 days a week to work with him and our BCBA drives over 2 hours each way when she comes up to supervise. Caleb received some additional ABA services through our state programs, but that has now ceased due to a health bill that was passed mandating insurance coverage. The gains made in the last 6 months when he received a total of 25 hours per week in ABA therapy are now threatened without those additional hours and Tricare cannot fill that void leaving us with the cost of maintaining those additional hours that he so desperately needs. In future months we will have to choose between providing that much needed behavioral support and continuing to provide him with the specific nutrition that he needs due to Celiac and various other allergies and sensitivities.

Struggles:

- Remote base location and limited resources available locally
- Limited amount of ABA therapy funds
- High cost of maintaining gluten free diet and nutritional supplements

Hello Committee Members,
Thank you for the opportunity to share the concern that my husband and I have regarding Autism care. We sincerely appreciate this forum to provide our family's story.

We live in Eagle River, Alaska. Dave is an active duty member of the Alaska Air National Guard. His active duty status allows us the benefits of the Tricare insurance coverage. He has met the time requirements for retirement, and one month ago we had to make the difficult decision to submit retirement paperwork. Last year Dave had to have surgery on both feet to repair severe arthritis that has developed, over the course of his military career, due to combat training injuries from when he was in the Army. Because of these surgeries, he is on a waiver for the physical fitness tests. He was told that there was a very strong chance of him being forced to retire due to these medical issues. This is so scary for us because the Tricare benefits for our son will change. He will no longer be eligible for his Applied Behavioral Analysis therapy.

Cole, our six year old son, is an absolutely precious boy who loves Star Wars. He can create the most fascinating things with Legos. He loves to snuggle with us and read stories. If you had an opportunity to meet Cole, his sweet smile would melt your heart.

Cole has high functioning autism, with horrific meltdowns that threatened to tear our family apart. For years these occurred several times a day, and required that my husband or I wrap him up and hold him tight for over 30 minutes to an hour while he screamed and raged and fought us. Our family was held hostage by these behaviors.

Over the course of two years, we sought help from a psychologist, two psychiatrists, and our son's pediatrician. While these professionals were empathetic and supportive, they were unable to help us. We were told by our psychologist that most families would not have been able to maintain as long as we had, and they would have had to place their child in residential treatment.

As horrifying as the thought was to have to put our 4 year old into such a restrictive setting outside of our home, we understood families who had to make that choice. With the exception of strong psychotropic medication, and weekly counseling, there was not the intensive support available that we needed. That is until we found out about Applied Behavioral Analysis (ABA) therapy.

Our family was so fortunate because we found out that we were eligible for this therapy due to Dave's active duty status. This therapy was a God's send to our family. Our son is progressing and learning the necessary skills to interact appropriately without defaulting into explosive rages. His therapists are highly trained, amazing people. They come into our home and work with him for three hours, four days each week.

This last school year, Cole was only able to attend Kindergarten half of the day. He becomes-overwhelmed very quickly, and can only handle a few hours of the incredible sensory stimulation that occurs at school. He struggles during play dates, and usually leaves crying or angry after a short amount of time. He is so very aware of how others perceive him, and desperately wants to fit in and have friends and be "normal" as he says. His ABA therapists are trained to work through several goals at a time, and when he attains each goal, they tackle another area of need. It is a slow process, but IT WORKS! It is amazing to see the difference in our child after the last year and a half of ABA therapy. I would like to make an important point that many people may not understand. ABA is NOT provided in the classroom for most children who have autism in this country. Perhaps severely autistic children who do not speak will be placed in the intensive needs classrooms with special education teachers who may use parts of ABA to get them through the day. However, this is not the case for the high functioning child who has the greatest chance of being able to function independently with this therapy.

As we think of Cole growing older, we have great hope for him. He is an extremely smart boy, and has the potential for a life that includes friends, a college education, and a self-sustaining career. ABA therapy is a critical resource for Cole during this important developmental time in his life.

Once Dave retires, although we will be able to retain our Trivest insurance, the ECHO program under Trivest that provides for the ABA therapy changes. Cole will no longer be eligible for this vital therapy that is helping him become the person he is meant to be. Our family desperately NEEDS this therapy to continue. Thank you for taking the time to review this extremely important matter to thousands of families.

1997年12月, 中国科学院南京地质古生物研究所的科学家们, 在安徽怀远县境内, 发现了一个保存完好的, 距今约2.5亿年的三叶虫化石。这个化石的发现, 不仅填补了我国三叶虫化石的空白, 而且为研究三叶虫的演化提供了重要的实物证据。



The Mendiola Family



Our son, Michael, was diagnosed with autism on his third birthday, November 23, 1994. At the time we were stationed in Yokosuka, Japan, and the doctor informed us that we would need to return to the states ASAP because appropriate therapies were not available in Japan. It took six months for the Navy to finally get us transferred to the states.

At that time, ABA was not covered by CHAMPUS (which has since been replaced by TRICARE), but we tried multiple times to get our son approved for speech therapy. We were finally approved for speech therapy and occupational therapy when he was in third grade, age 8 or 9. By then a great deal of time had been lost that we couldn't recover.

When ABA became a covered therapy under ECHO in 2005, we were preparing to transfer, so we waited until we had moved before we pursued it. After the transfer, it took over 18 months to find an ABA provider with space on her schedule for our son. During that time, we saw much regression, as we had no therapy for our son. Once ABA started, we were very pleased with the progress we saw. Language progressed impressively, independent living skills were becoming a reality, and his interaction with those in the community was becoming more age-appropriate. Through all of this great progress, the dark cloud hanging over our heads was the knowledge that upon retirement from the military, ABA therapy would no longer be covered by our insurance, and we would likely have to discontinue it.

My husband retired from the US Navy with over 30 years of service to our country on August 31, 2011. We could not afford to continue ABA therapy for our son as private-pay clients, so we had to discontinue it. Since that time, our son has visibly regressed. At first we thought it was just our perception, but everyone (bus drivers, school teachers, friends in the community) has noticed and mentioned it to us. It is very difficult to get him to speak with people anymore. His ability to focus and complete a task is almost non-existent. He is retreating into "his own little world", and we are finding this heartbreaking to watch. We do everything we can to encourage progress, using techniques we learned from his therapists over the years, but it just isn't enough.

The only change in services he has had in the past year is the loss of ABA therapy; we therefore believe that this has to be the reason for his regression. At this age (20 years old) his options are very few. He will age out of public school in 18 months and will then have no services whatsoever, as the waiting list in our state for medwaiver services is decades-long. ABA therapy is the only proven method to treat autism. Our son needs this therapy to make progress and become a happy, productive, independent adult. Please make the changes necessary to include ABA therapy under regular TRICARE coverage so that families of retirees are able to provide this therapy for their children on the autism spectrum. This is the right thing to do for these families who have sacrificed so much to serve our nation.

The Mills Family

- Dad was wounded severely in Fallujah Iraq by an RPG and forced to retire because of the severity of his injuries
- As a retired Marine and disabled veteran, the family relies on TRICARE for coverage of medical services
- Son Shane has autism
- Because Dad is retiree, Shane's ABA care is not covered by TRICARE
- Family faces out of pocket costs of nearly \$5,000/month
- Family has sold their home to pay for the medically recommended ABA treatments for Shane





From the Mosser Family; Jim (dad), Trish (mom), Jesse James (age 7) and Wyatt (age 5)

Hi and thank you for taking the time to read my letter about our family.

I am a Military spouse, my husband Jim is in the Army and has served Our Country for almost 29 years. He has been deployed twice and received two Bronze Stars, one for Desert Storm and one for Afghanistan. He has had various other tours stateside and has served over seven years overseas with about 15 moves in total.

In February of 2009, Jesse James was diagnosed with Autism. To add, a Genetics Test revealed he has a 10p15 Chromosome Deletion. Also, he has asthma and a seizure disorder. Wyatt was diagnosed with Autism in July of 2009. To add, he has asthma and sensory processing disorder and multiple allergies to antibiotics which, if taken, can cause febrile seizures.

Jesse and Wyatt have been in early intervention with Occupational Therapy (OT) and Speech Therapy since they were 18 months old. Jesse and Wyatt started Applied Behavioral Therapy (ABA) in February of 2010 and we have seen a tremendous change for the positive for both our boys in spite of their health issues, including three more moves in total. Actually, the learning curve they have achieved has far surpassed our expectations and has made our life so much more fulfilling. We can now do things as a family!!! Had we relied on ONLY Speech and OT we know our boys' progress would have been much slower and their lives much more challenging.

My husband is eligible to retire and it scares the LIVING DAYLIGHTS out of both of us. Even having faith, we are still very concerned about retirement because we know the boys will no longer receive ABA therapy. To financially afford ABA therapy is completely out of our realm to achieve which no parent should have to bear that burden knowing we are unable to pay for a life changing and lifesaving therapy we know will save our children's lives and give them a better future. A future we dream of for them. My husband is also a wounded warrior and we are fortunate he is still able to remain in the Military yet I see that he struggles to do the things he used to do and I know why he puts those boots on everyday and his uniform because he knows that Jesse and Wyatt count on him to have the best possible medical care and he is proud to Serve His Country. We appreciate your time and we have faith that you will give our kids a hopeful and bright future by passing this bill.

17 June 2012

Dear Senate Armed Services Subcommittee on Personnel,

My husband was a dedicated soldier, who dreamed of a lifelong career in the Army. He devoted his time to serving his country well. Unfortunately, he was injured in a training accident, which has permanently deteriorated his knees. Things might have been different had his unit at the time allowed him to seek proper medical attention immediately, but he was told to work through the pain. He did and working through that pain cost him his career. He was medically retired in July of 2007.



We have a five year old daughter, Samara, who we tried so long to get. We went through a lot of heartache before we were blessed with our miracle little girl. Although things on the civilian side of life were more challenging than we had hoped we were and are thankful for our Tricare Standard. When our daughter was diagnosed with Autism we were confident that because we had such amazing insurance we would be fine. Much to my dismay it has been a repeated no. It was even suggested that my child be adopted by someone on active duty so that she could have the therapy she needs.

We are grateful for the Occupational and Speech therapies she receives as a beneficiary, but everyone knows she will flourish with also having ABA therapy. It is dumbfounding that through our medical insurance our country has

turned their backs on our child, and countless others like her with autism. Her father fought and served honorably, for our country. Being retirees with a child with Autism is like a slap in the face. You cannot provide the therapy they need, and no one seems to think your sacrifice to your beloved country matters anymore.

We are respectfully asking that you make ABA therapy available to all Tricare recipients, and to make it affordable. We need to give kids with autism the best life possible, without ABA it isn't the best possible. Her father gave his best; show some appreciation and allow his daughter to possibly achieve her best too.

- Samara is a five year old with Autism, whose father is a disabled Army Veteran.
- She needs 20-40 hours of ABA therapy a week to help her achieve the best life possible.
- If ABA becomes a benefit for all Tricare recipients. Please somehow make it affordable for us. Currently our Tricare has 80/20 coverage. However, even with a 20% co-pay it may place it out of our and many others financial reach due to the sheer amount of therapy involved. Please keep this in mind, and make the out of pocket costs zero to minimal for all recipients.
- Her disability is preventing her from joining her peers in Kindergarten in the fall, with ABA therapy we are hoping she will "catch up" to her peers academically, and socially.
- We have a 9 month old son, Sebastian, who is already showing developmental delays, and has started early intervention therapies. If we receive the diagnosis of Autism we would need him to receive ABA therapy as well.

Respectfully,

Travis, Tami, Samara & Sebastian (Booth) Ort, US Army Retired family



16 Jun 2012

I have served 14 years as an Air Force Dental Corps officer. I am the mother of three children. My second child, Peter, is 9 years old and is autistic. He does not speak or read, has minimal imitation skills, does not understand many social concepts, and lacks many life skills. We have been fortunate to be able to utilize Tricare Extended Care Health Option (ECHO) for services when needed at various bases. However, I believe that these benefits have concerning limits. The present \$36,000 per year allotted by Tricare ECHO may cover 9 hours a week of Applied Behavior Analysis (ABA) therapy—far short of recommended intensive therapy.

Presently, Peter, his siblings, their father, and my mother-in-law live near Joint Base McGuire-Dix-Lakehurst, NJ where I was assigned. Peter is receiving year-round schooling at an ABA-based school paid by the Pemberton, NJ Public School District. Since May, I am living in San Antonio stationed at Joint Base San Antonio where I'm now assigned. I am anticipating my family will remain in NJ for the two years that I will be here. The public school systems in San Antonio do not use ABA therapy, has higher student to teacher ratios, and will not provide summer school for Peter. If we move Peter, his ABA therapy will be reduced from 25 hours per week in school to 10 hours a week using Tricare ECHO funds in a center-based or home-based program. He has lost skills with inadequately trained DODEA teachers when we were overseas and when he was living in San Antonio using the public school system. If we move him back to San Antonio, he would most likely not continue with the same progression of learning.

Our family separation is our solution for now, but we are concerned what will happen to Peter when I retire and when he is no longer eligible to use the public school system. Peter makes consistent but very slow progress learning important life skills. In order to become as independent as reasonably possible and less of a burden on society, Peter will need continued teaching beyond my permitted active duty time. These skills are being taught through his ABA education and not through medical therapies. We are fortunate for now. But other families with special needs family members are not as fortunate due to military status and cannot use services funded through Tricare ECHO. Shouldn't these vital benefits be considered basic medical needs for all—active duty, retirees, guard, and reservists? Shouldn't these special needs dependents be given the opportunity to learn in a way effective to them?

If you have any questions, please contact me via phone (609) 845-7689 or e-mail cc_garin@hotmail.com.

Very respectfully,

Cecilia I. Garin

My name is Linda Reilly and my husband, Shane, is a Major in the US Army. We have 2 kids: Charlotte, who is 7 and Alexander, 5. He is on the Autism Spectrum and has been diagnosed since he was 2. Shane was on Active duty when Alexander was diagnosed so we were enrolled in EFMP and Alexander received ABA therapy through the ECHO benefit. This has helped him tremendously where he went from not even looking at us to speaking in full sentences. We are enrolling him in regular Kindergarten this year because of the progress he has made.

My main concern is continuing benefits once my husband's duty status changes. He has actually taken an assignment overseas to Kuwait to stay in Active duty so we can keep Alexander's benefits. With the upcoming transition to school, it would be devastating to lose these benefits. The company we work with only deals with military benefits and our therapists and ABA has been vital to his growth.

So we are sacrificing our kids' time with their Father for the benefit of Alexander. Why can't ECHO coverage be extended to Guard and Reserve families? It is not fair to just cut off these life-changing therapies.

I hope the current legislation will extend these benefits to ALL military families regardless of status. We need to honor the sacrifice our troops have made for their families and help our kids succeed.

Thank you!



The Reyna Family

Our daughter Karsyn was diagnosed on the Autism Spectrum with PDD-NOS. My husband is currently on Active Duty and we are enrolled in the ECHO program in order to receive ABA benefits. My daughter has made tremendous improvements with that I'm not sure she would have otherwise made without this therapy. Unfortunately, due to the dollar amount \$36,000, Karsyn only receives 6 hours per week. Furthermore, this coverage is only available while my husband is on Active Duty. If he were to get injured in combat, die on active duty, or just retire not only would my daughter face significant difficulties coping with the loss of her father or permanent disability (excluding retirement) but she would also lose the therapy that has will most help her become an independent functioning member of society. Please consider making ABA coverage available for all military, active duty, retired, and medically retired/discharged. It will make a significant difference in many lives of the military members that have sacrificed so much for the United States.





My name is Susan Reynolds and I am married to AF TSgt Jeremy Reynolds. We have a son named Ian who is 22 months. My family is currently assigned to Fort Bragg, NC which is home to the 82nd Airborne Division, and the 18th Airborne Corp. My husband is a Combat Weatherman also known as a Battlefield Weather Airman. Jeremy has deployed twice both to Iraq and Afghanistan and we are now preparing for him to deploy again sometime next year.

Ian, our son was born at 36 weeks and 6 days weighing only 5lbs and 10oz and was only 19 ¾ inches long. Within a few weeks of having Ian home we noticed a flat spot on the back of his head. With our upcoming move, I didn't push the flat spot issue until we settled into our new clinic at Fort Bragg. On April 16th, our rental home was hit by the tornadoes that came through NC. My husband also left for Afghanistan and my son and I moved into my parents' home over an hour away from post.

Ian started having ear infections around that time, and I was pushing more and more about the flat spot and getting a referral. I was told by his pediatrician that Tricare policy stated that Ian had to be a year old and have head x-rays completed before a consult for a pediatric neurologist could be given. I have now discovered that that Tricare policy is not true nor does it exist. I got Ian's x-rays and kept pushing for a consult. Finally in August for Ian's 12 month check up, I was given a consult.

Helmets are most effective for children under the age of 12 months. By the time Ian was in his helmet, he was 14 months old. I was informed that Tricare does not provide coverage for helmets and he recommended another company in Cary that would provide a 50% discount to active duty military families. Ian went to Level 4 Orthotics in Cary (<http://www.levelfour.us.com/>). I chose to pay for my son's helmet because the potential long-term negative effects were unacceptable.

The lack of education on plagiocephaly is ridiculous and the made up policies from my base clinic made the situation worse.

My group is called: Cranial Helmets: Re-Shaping Our Children's Future By Using Our Heads. My son is my inspiration and when I see that he wasn't able to get the best possible care afforded to him, I became upset. Instead of complaining though, I decided to be a part of a solution. That solution is to change the policy and ensure that our military children are receiving the best possible care.

My husband has served his country and been deployed twice. He will be gone again next year. I hear a lot of talk about the sacrifices of military families. When my husband comes home from a deployment or training my son experiences horrifying nightmares because Ian is unable to understand that his father is home. Our lives are dictated to us and our military serves this great nation without question. The least that we can do as a nation is to have the best medical care for the family member.

Congress, help us!
Our son's ABA coverage stops in one week!

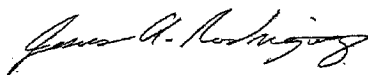
My name is Jesus Rodriguez, and I have recently retired from the U.S. Navy after faithfully serving 20 years of active duty. My wife and I have a 9-year-old boy with Autism. Alex is a remarkable success story of the effectiveness of early intervention, specifically applied behavior analysis (ABA). He has been receiving ABA therapy for the past 5 years, and it has made a significant impact in his communication and self-care skills.

Unfortunately, my TRICARE ECHO benefits are due to expire on 28 June 2012 and cannot be renewed because I am no longer active duty. Our son will cease to have any insurance coverage for this crucial therapy that has made a difference in our family's life. Although Alex has made great strides, Autism is a life-long disorder that did not go away upon my retirement. We are very worried that we will not be able to afford the amount of ABA therapy hours that my son currently receives and will no doubt need in the future. This type of therapy is most effective when consistently applied in childhood, but it is ineffective when it is not provided or is severely limited in hours provided.

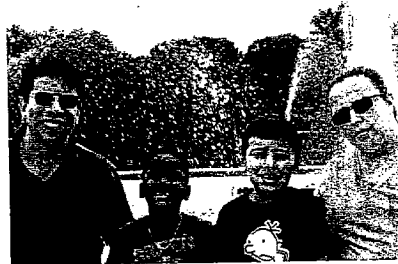
I have never asked Congress to take specific action on an issue as important as this. Similar to many in my situation, it is absolutely personal. Just put yourself in our shoes. We retirees have served our country to the best of our abilities, enduring military life in peacetime and during war. Our spouses have supported us and made numerous sacrifices. Don't we deserve some help when we need it?

All I am asking for is to give my child the support he needs to learn and grow. He may one day thank you himself. I implore Congress to help our children immediately.

Sincerely,



Jesus A. Rodriguez
United States Navy (retired)



The ROUTHIER Family



- On November 3, 2009 our oldest son, William, was diagnosed with PDD-NOS, an autism spectrum disorder.
- 7 days later, David deployed for Afghanistan leaving Michelle with 2 year old, William and 7 month old, Benjamin, who was diagnosed with GERD and failure to thrive. David spent his last days before deployment NOT spending time with his sons and wife, but on base, trying to get William enrolled in EFMP and gather the steps for Michelle to complete the process for ECHO.
- With no help from anyone of base and conflicting answers, it was January 2010 before Michelle managed to find out that Liam had been successfully enrolled in EFMP and then several weeks to complete the ECHO process.
- In terms of therapy, that meant William lost 2 months of potential therapy.
- Since starting ABA therapy under the ECHO program, William has shown significant improvement: gone from not communicating and 35% delayed in social skills to near age level in both language and social skills.
- The Routhier family is about to make their second PCS since David's return home in June 2010, which means more months of waiting list and lost therapy.

The Schuchs-Gopaul Family



BRANCH: US Air Force

DUTY STATION: Davis-Monthan AFB, Arizona (355th Fighter Wing)

The Schuchs-Gopaul family is a dual-military family with two children. In 2008, while stationed at Maxwell AFB, Alabama, they began to suspect that their 16-month old son, Evan, was different. He did not speak at all. This is their story:

In 2006, after 3½ years of being stationed apart, my husband and I were both assigned to Maxwell AFB, Alabama. It was a wonderful assignment that reunited our family, but introduced us to challenges we never could have imagined. Our son, Evan, was born in May 2007 while his father was deployed to Afghanistan. Evan was a happy, healthy and quiet child. He never talked. While other children in his pre-school class were singing songs at circle time, Evan was mute and becoming hard to control. By 16 months, we decided that something was wrong. We found ourselves with few places to turn for help. As EFMP assistance for Air Force families was in its infancy, we were referred by the Air Force to the State of Alabama (Department for Retarded Citizens) as Evan was viewed as having an "educational problem." The State of Alabama tested him, determined that he was delayed, and then provided speech therapy for him once a week.

In 2009, we were assigned to the Pentagon. The State of Virginia accepted Evan's IFSP, provided him even more therapy, and then provided us the bill. While services for an IFSP in Alabama had been paid for by the state, Virginia required parents to cost-share. While we absorbed this increasing and unexpected cost, we were finally given a referral to a developmental pediatrician at Walter Reed Hospital. Evan was diagnosed with autism spectrum disorder (PDD/NOS) and we were told that he needed 20+ hours a week of ABA therapy to progress. Facing thousands of dollars in therapy costs, we finally discovered TRICARE/ECHO. While it would not fully cover the 20+ hours of ABA therapy prescribed by the military doctor, it would help us provide 15 hours a week. At 30 months old, and after only a few months of ABA, Evan said his first word.

Evan is now five years old. Our move to Arizona was challenging. With a different view of PDD/Autism than we found in Virginia, the first thing the school system did was slash Evan's speech therapy services (IEP) by over 50%. With ECHO-provided ABA therapy helping to fill the gap, Evan still progressed. In May, he graduated from an inclusive preschool program and he will start kindergarten with his peers next fall. Evan talks, sings, and loves to pretend he is a pirate; each new step representing a tremendous victory.

We are, and continue to be, grateful for the TRICARE/ECHO program. While every state we move to redefines "free appropriate public education" for Evan, the ECHO-provided ABA services have given this military child a chance to progress -- no matter where we live. We will lose this benefit upon retirement from the military. As parents, we worry if our nomadic lifestyle has affected Evan's ability to succeed -- a worry that will not end upon retirement from active duty. We ask that ECHO benefits continue to be available to our military child who has served along with us -- even after we retire from active duty.

The Stones

- Branch: Air Force
- Status: Both Active Duty (Join Spouse)
- Awesome Warrior Kiddos:
 - Anna, 2 ½
 - Katie, 3 months
- Anna's Diagnosis: Angelman Syndrome
 - Severe neuro-genetic condition
 - Lack of speech
 - Significant developmental delays
 - Feeding difficulty (feeding tube)
 - Life threatening seizures
 - Lifelong care required
- Our experience thus far
 - Air Force works hard to accommodate our complex situation
- Our concerns
 - ECHO benefits after retirement (including ABA for non-Autism diagnosis)
 - Childcare that can handle significant special needs
 - Post 9/11 GI bill transferability for special needs dependents
 - IEP transfer across states



The Tarwater Family



Bob, Adreanna, Nathan (12), Addison (6), and Caden (2)
Currently stationed at Lackland Air Force Base, Texas

Nathan was born with a rare chromosome disorder that has made him dependent on us for all of his care. He is medically fragile, nonverbal, uses a g-tube and is not able to walk or sit on his own. Addison and Caden were both born with cleft lip and palates. Both of them face a lifetime of surgeries and speech therapy.

Concerns:

- **Continuity of health care services for our children.**
 - Nathan is followed by 17 specialists and every time we move we have to start over with his health care. The nature of his medical needs makes it very difficult for a new physician to understand his needs quickly. We have moved three times since Nathan was born and each time, his health declined because of lack of continuity of services.
- **Nursing services.**
 - Through TRICARE, we receive 12 hours, nightly. However the remaining 40 hours are provided by the Texas Medicaid Waiver program. Nathan will continue to have the extra nursing support as long as we remain in Texas. Once we move we will be placed on the bottom of a waiting list for a waiver program and potentially not receive services during a tour. It would be very detrimental for our family, as Nathan's care is so intensive that we really couldn't keep him at home with us without the support. Our other children's lives would be impacted greater since our ability to leave the house or do anything as a family would be compromised.
- **Ease of finding new resources in a new community.**
 - Most EFMP workers do not have the knowledge of physicians, hospitals, nursing services, Medicaid waivers, schools, organizations, etc. Each time we have moved, most information we have obtained has come from other parents, and Adreanna has done the majority of the legwork in getting services set up.
- **Respite Care**
 - Finding a caregiver who can provide respite for all three of our children's special needs has been extremely difficult.
- **Diapers**
 - Thankfully the Texas Medicaid waiver covers our diapers but, if we move from Texas, again, we are at the bottom of a waiting list. TRICARE should be covering them.

The Babiarz Family

Diagnoses:

Our 9 year old son has Autism and our other son has Processing Deficits and Inattentive ADHD.

Military Support System Struggles:

ABA therapy is only covered under the ECHO program while service member is Active Duty.

We are eligible to retire, but must stay active duty as long as possible to receive the needed ABA therapy for our Autistic child. This therapy has allowed our son to engage others in conversation and attempt to relate to the world. This therapy has lowered the frequency of violent outbursts, setting fires, and running away. We cannot do without it.

Limited local service providers result in long waiting lists for Occupational Therapy, Speech Therapy, Pediatric Psychiatrists, and ABA Therapy. Appointments are often located at least one hour away from our home. This means it is nearly impossible for the active duty spouse to be employed and maintain the medical appointment schedule.





The Batchelor Family

Branch: US Air Force
 Duty Station: Nellis AFB, Las Vegas, NV
 EFMP Category: Q coded Assignment
 Deferment
 Children on EFMP program: Age 12, bipolar and ADHD; Age 10, Severe autism, Mental Retardation, Silent Seizures, and No communication disorder; Age 4, reactive airway disease, currently being tested for Behavioral Issues; Age 2, Pervasive developmental disorder-

NOS, traumatic birth injury among multiple health conditions.

Nearly five years ago I joined the Air Force after a lengthy wait on the surgeon general to clear me for active duty because I had open heart surgery at three years old. After going through basic training and technical school, it was time to go to our first duty station. The day before it was time to leave we were told that we could not go to our projected assignment at Moody AFB because they did not have the capability to care for our children. It took two months and countless times of telling me I may have to retrain or possibly be administratively discharged to find a base for us. This was our first and sour taste of the EFMP program.

Eventually we were assigned to Nellis AFB, NV and shortly after visited the EFMP office. This visit also left a sour taste in our mouth as we asked for local resources and were told, "Google is your best friend." The EFMP program has improved very little over the past four years of us being here but still does not provide resources, only a basic package with general information is available, and very little "Family Support is" offered here at Nellis.

Tricare ECHO does provide applied behavioral analysis therapy for our 10 year old who is severely autistic and our 2 year old recently diagnosed with pervasive developmental disorder-NOS. However, they will not pay for a wheel chair or car seat for our 10 year old who has silent seizures that send him into fits of rage and he experiences loss of control of his bodily movements(in short he sometimes falls to the floor like dead weight hitting whatever limb is headed down first.) Also in crowded environments he becomes over stimulated and lashes out at anyone around him, restraints are needed in both of these scenarios and we had to buy one, paying out of pocket. We also tried to use ECHO funds or regular tricare to buy a car seat for our son which was also denied due to being considered a form of restraint. Well our son got out of the back seat walked up to the front of our van and grabbed my wife by her hair while she was driving and she almost wrecked with ALL of our children in tow. We had to get one on our own as well. I also get aggravated that children the Autism Demonstration Program is not case by case. My son who is VERY severe gets the same as our 2 yr old who is NOT as bad. Why can't this be fixed and it be case by case to determine how many units/funding a child can get? Also why can't it be a service covered under Tricare instead of ECHO? Why can't ABA be extended (case by case) to ALL special needs children if determined it's needed?

We have been able to get respite care for twelve weeks through the Airman and Family Readiness Center (because if we use the ECHO for respite then it takes a huge chunk of ABA funds away), after the 10 year old was no longer allowed to go to give parents a break because he is not completely toilet trained "which is silly after they made a class just for him and a couple of other special needs kids." The problem is after the twelve weeks is over, we have to provide financial hardship in order to receive this service any longer. Another losing battle for us, and it seems like we are being punished because we have special needs children. Please take into consideration these issues not just for our family but all our past, present, and future members of the Armed Forces.

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The Beattie Family



Military Support System Struggles:

* After 28 years combined service in the Navy, the Beatties no longer look forward to retirement. They know are left worrying about how their sons will lose services when they need them most, when they become school age.

The Browns



Branch of Service: US Army

Child: Ricky II

Age: 5

Diagnosis: Autism Spectrum Disorder (ASD)

Duty Station at Time of Diagnosis: Monterey, CA

Origin of Diagnosis: Lucile Packard Children's Hospital at Stanford University

Current Duty Station: Fort Belvoir

- Mother noticed delays at 18 months
- Concerns were brought to family's civilian pediatrician
- Son referred to Speech and Language Services
- Son placed on IEP for Speech and Language at 2 1/2
- Mother was concerned it was more than Speech and Language
- Reached out to Stanford University when son was 3 1/2
- Received referral to Lucile Packard Children's Hospital at Stanford University by civilian pediatrician
- Diagnosed with ASD at age 4
- Started TriCare funded Floor Time therapy sessions with civilian Licensed Clinical Social Worker
- IEP updated
- Currently a happy, thriving, well adjusted Kindergartener fully mainstreamed

The Bryan Family

Colorado Springs, Colorado

Jeff Retired Air Force
Lisa Stay At Home Mom
Sara 5 year old with Autism

Our hearts sank when Sara was diagnosed with Autism January 2011.

For our little girl to reach her potential, the Developmental Specialist recommended 25 hours of therapy per week.

We were shocked when we found out Tricare *does not* cover ABA Therapy for Sara because we are a Retired Military Family.



- Our greatest wish is for Sara to be a happy and productive member of society some day.
- The OPM recently confirmed what our medical team has told us all along. ABA is a proven medical therapy for Autism.
- Our daughter deserves to have access to prescribed therapies for her Autism including Applied Behavior Analysis

Please help us give Sara and all military children with Autism every opportunity to "be all they can be" by saying yes to Senator Gillebrand's Amendment.

The Cartwright Family

BRANCH: US Army (retired)



In 2006, Julia, age 2, was diagnosed with autism. She was completely non verbal and had virtually no cognitive abilities. The diagnosing doctor, who was from the National Naval Medical Center, prescribed intense therapy targeting communication and social skills development of 15 hours per week of ABA therapy.

This is their story.

We requested authorization from TRICARE to cover the expense of the ABA therapy the diagnosing doctor had ordered for our daughter. That's when we discovered that ABA therapy was not

available through the basic TRICARE prime program we had. ABA therapy was available to active duty military through the TRICARE ECHO program but I, as a military retiree, was not eligible for ECHO and thus coverage for my daughter for ABA therapy was denied by TRICARE.

We had to foot the entire ABA therapy program. For the last six years, we have paid from \$35,000 to \$50,000 per year out of our pocket for Julia's ABA therapy. This huge outlay for our daughter's therapy has forced our family into a financial crisis and curtailment of all of our family plans – at the same time we have had to deal with the trauma of having a child who suffers from the devastating effects of autism. As devastating as the financial effect of paying for ABA therapy is, there are other effects of having an autistic child in the family which are indescribable to any family who has not experienced it personally. *Autism is worry. Autism is despair. Autism is fear for the future of your child.*

Julia has or had a number of symptoms of autism in addition to not being able to talk. Julia engages in frequent tantrums. Often the tantrums are minutes, or seconds apart and can last 20 minutes or longer. Julia's tantrums are characterized by crying and shouting at the top of her lungs, accompanied by hitting, kicking and spitting.

We have to watch Julia constantly because she picks at wounds on herself – and on other people. If Julia sees or feels a wound of any kind on herself – or on anyone else, she will quickly lance and dig at the wound. We have had put socks on her hands at bed time to prevent her from doing damage to herself.

In the past, Julia frequently ran away from us. In spite of our best efforts to watch her every second; there have been times when we turned our heads for a moment. On one occasion, at a mall, Julia was completely out of the sight of her desperate mother for 20 minutes. Her mother finally found the Julia ¼ of a mile from where she first ran away, and she was still running. *Real fear is losing sight of your beloved child who has no means to protect herself.*

The results of ABA therapy which we paid for out of pocket are nothing short of dramatic. Since kindergarten, she has been in typical classes and just passed second grade. She scores at or in advance of her grade level in all subjects and reads at an advanced level. She still has communication, social and cognitive problems associated with her autism for which she continues to receive ABA therapy but now, at age eight, Julia functions near that of a neurologically typical child.

Julia's progress would not have happened without ABA. We are members of several autism organizations and have regular contact with many other families which have autistic children. The children we know who have autism and have had no ABA have made little or no progress in being able to communicate, relate to their family or peers and have few if any life skills or cognitive abilities. On the other hand, if they had ABA therapy at an early age, they, like our daughter have demonstrated remarkable progress.

It my fervent hope you will recognize the medical necessity of ABA which is supported by the Surgeon General, NIH, OPM and professional associations such as the American Academy of Child and Adolescent Psychiatry.

the Chafoses and our Zachary:

We are a military family living on Fort Meade in Maryland. We are blessed with three beautiful boys: Andrew, age 12, Zachary, age 10, and Anthony, age 2. My husband, Colonel Timothy Chafos, is an active duty Army officer who graduated from the Army War College last weekend and is deploying in two weeks to Afghanistan for one year. We enjoy serving our nation as a military family and we feel fortunate to give our children the fantastic opportunities we have experienced with the Army.



Our middle son, Zachary, was diagnosed with autism at the age of two in 2004. We struggled to understand what he needed when we began our journey. Shortly after Zachary started Early Childhood Intervention services, my husband deployed to Iraq for one year. I had to navigate the complicated world of autism alone. Through lots of research and phone calls, I started Zachary on an intense schedule of speech therapy, occupational therapy, and behavior therapy in addition to educational services. Over the years, my husband has been able to manage his career so we have been able to stay in the D.C. area to keep our family stable. Zachary has flourished and thrived and we are happy with his progress. I believe a lot of his progress is from Applied Behavior Analysis (ABA) therapy. Although we have had to navigate a very complicated TRICARE system and have had numerous therapists over the years, Zachary has done very well with intensive ABA therapy after school each day.

Achieving the proper educational services for Zachary is one of the most significant struggles we have faced. Our local schools have failed to provide appropriate modifications and services required under Zachary's Individual Educational Plan. We had so much trouble in our school on Fort Meade that we hired an advocate to attend all of our meetings and fight for our son. This past school year, after Zachary was forced out of our local school we had the good fortune to place him in a fantastic non-public setting where the teachers are specifically trained for autism and he is doing very well. Zachary attends the Kennedy Krieger School in Baltimore. We know of many military families around the country with autistic children who have faced similar challenges. The military provides little help in navigating the complex world of autism, education, and therapy.

When my husband returns next summer from Afghanistan, we will be moving to San Antonio, Texas so he can command a brigade there for two years. While we are excited for this great career opportunity, I am very nervous about moving our son. We have significant concerns about achieving appropriate school placement and support, as well as delivering the therapies Zachary needs.

We clearly see the benefits of ABA therapy and pray it remains covered under TRICARE. My husband's time left in the military is limited; our son will almost certainly require continued ABA therapy after his retirement. I request that you make ABA therapy available to active and retired families so we can provide our son with continued care after my husband finishes his military career. I am not sure what we can do about the struggles we face with our children and their educational needs, but there is definitely a lot of room for improvement in educational policies, approaches, and resourcing for children with autism. Our schools are failing our children miserably, the scale of the problem is growing. Military families face particular challenges, as continuity of services is extremely difficult to maintain and detailed knowledge of local school services and systems is difficult to attain.

Thank you for your time. Cheryl Chafos, Army Wife

I am Rebeka Edge the mother of 4 and a Board Certified Behavior Analyst. My Husband is an Lt Col and a Pilot in the USAF and we are the proud parents of 4 beautiful children, all with developmental disabilities. Our oldest, Corbin is diagnosed with High functioning autism. Magnola has a learning disorder, dyslexia. Lily-Anne had a significant language delay and our youngest son, Jett, is severely dyslexic and was recently diagnosed with PDD-NOS, a pervasive developmental delay, which is on the autism spectrum.

I am the owner of Behavior Matters, a company that provides Behavior Analytic Services. We work to improve the lives of children and young adults using this behavioral science. Between my 12 therapists, and myself we are privileged to serve 28 families in the state of Alaska. We work with individuals up to 12 hours 1:1 weekly to teach functional skills that reduce aversive behaviors including injurious ones to themselves and others while teaching life improving skills such as functional communication, daily living skills and social skills. Another facet of this program is to collaborate with the parents so that programs and interventions continue after therapy.

Every week I receive calls from veteran families inquiring about Applied Behavior Analysis ABA and funding options. I have talked with families as to how these services can be extended to children. At this time there are no funding options for families that are not active duty military dependents.

By providing training and consultation to families, we will improve the quality of life for the individual, the families and ultimately the community. The training will also significantly reduce the risk of moving to a more restrictive and more costly environment.

These children and adults, including my own, are counting-on- you to provide our children with ABA services after we retire. Our country needs a program that provides individual-specific training and ongoing consultation. It will enrich the country and provide for our veterans, in that it will return dignity to individual, provide hope for the family, and help to build a work force that will have specialized training in developing and implementing programs to effectively deal with challenging behaviors.

Sincerely, Lt. Col. Jarrett and Rebeka Edge





THE FISHE' FAMILY

Good afternoon. My name is Katja Kox-Fishe' and I've been an Army wife for 15 years. When our son Quinn was 3, he was not really speaking yet and had many meltdowns. At the time we were stationed in Germany, my husband Charles was in Iraq and I was pregnant with our daughter Kinzey. I can tell you that this was a very trying time for our family. It took me about a year to get Quinn an autism diagnosis, enroll in the Exceptional Family Member Program and the military insurance Tricare Echo which pays for our son's ABA therapy. ABA therapy, also known as Applied Behavioral Analysis, is the only scientifically researched and proven therapy for children with autism and is recommended by the American Association of Pediatrics.

Quinn is now 7. He is able to have a conversation, has no meltdowns and is on grade level with some special education support in a 1st grade inclusion classroom. We still have a way to go to overcome his language and social delays but he has also come such a long way which I can only credit to ABA.

In a year my husband will have 20 years of service. Being faced with the fact that once we retire we will lose Tricare Echo, retiring is not an option for us. We are proud to be an Army family and feel very taken care of by the Army. It is a life unlike any and we accept the challenges, the separation, the uncertainty, the deployments. But when our children are affected that is not a sacrifice we should be expected to have to make.

Unlike civilian special needs families, military families are at a disadvantage with a lack of continuity for their special needs children faced with waitlists for specialists and therapists, varying levels of support from different school districts, years long waitlists for Medicaid waiver services for ABA. Military special needs children have to start all over again with every move with new therapists, new schools, new teachers and hopefully new friends. If teachers were trained in ABA then we could rely on schools to provide this service but until a law is passed to train each teacher in autism best teaching practices we are thankful to have Tricare Echo to provide ABA. So I ask to please close this loophole for our military special needs kids and extend ABA coverage to our Wounded Warriors and other military retired and Guard/Reserves families. Thank you for your attention to this important issue.

Katja Kox-Fishe'

katjaworld@hotmail.com757-6036903

My Autistic daughter Morgan is high functioning, and like other kids on the spectrum she has several other diagnosis' in addition to Autism. She is learning disabled, dyslexic, has an expressive language delay, suffers from anxiety and severe ADHD. Life with Morgan is filled with challenges that add to the already unique lifestyle of a Navy family.

Morgan was always different. She didn't have the "normal" Autistic symptoms. We went thru several physicians in Central California trying to discover what was going on with our little girl. At age 6, Captain Carol Forsell, a Developmental & Behavioral Pediatrician from Portsmouth Virginia, was temporarily assigned to Naval Hospital Lemoore. We were luck enough to get a highly coveted appointment. After listening to our concerns, reading the reports from school testing, and examining Morgan, she changed our lives forever with the diagnosis of Autism.

I expected Autism to change our lives. What I didn't expect was the many hats I'd have to wear to ensure Morgan's equal treatment and appropriate education. I have had to become a lawyer, a teacher, a therapist, an advocate.

In 2009, I had to leave my job after Morgan was diagnosed as the CDC and Youth Center at NAS Lemoore do not have staff specifically qualified or trained to care for special needs children. We travel 80 to 800 miles round trip for medical care. Sometimes several times a week. There are no Behavioral Pediatricians at the Naval Hospital. The nearest one is in San Diego. Our Occupational and Speech Therapy providers are located in Fresno, 47 miles away. Our Applied Behavior therapist travels from over 30 miles away. Our pediatrician has recommended we leave California's Central Valley as they are considered to BR 10-15 years behind other areas in providing services for Autism.

The schools here on station, while state distinguished schools, lack the funding and knowledge needed to teach Morgan. Her dyslexia is ignored and last year she was struck in the head by a substitute teacher, in an attempt to redirect her attention. I have been asked to provide solutions for problem behaviors rather than the trained district Psychologist and I must keep abreast of new legislation and law, to ensure the school provides Morgan's accommodations.

I've had to do all of this in addition to caring for my other daughter and my disabled spouse, who is currently recovering from back fusion surgery, a result of injuries he sustained as a F/A-18 mechanic, and has suffered from for almost 10 years. This year we are faced with the possibility that his career may be over. What is most frightening is not an end to his military career, but the fact that if he is medically retired from the military, our daughter will lose our ABA therapy. This therapy has changed our lives for the better and the chance of losing this life altering therapy keeps me awake at night.

Ladies and Gentlemen-I urge you to make the necessary changes for our Military families. Our men and women in uniform put their lives on the line to defend this great nation. Knowing that their family members at home are receiving the needed care and support, allows them to fully focus on the mission. Most importantly, the diagnosis of Autism does not disappear when the military member leaves service. Ending ABA is a crushing blow to these families. I implore you to continue to improve the quality of life for military families with special needs and to extend ABA coverage to all military families and retirees, not just Active Duty.

Health & Happiness,

~Sara Gain~

6-17-2012

Information for the Senate Armed Services Subcommittee on Personnel:

We discovered ABA therapy for our autistic son, Andrew in 2000. By the time we were approved for services, it was 2010. This benefit provided some amazing therapy for our son, even at the age of 18! We observed encouraging progress. Sadly, that summer my husband retired from active duty and we lost the ABA benefit. We were so discouraged to learn that being retired meant the end of ABA therapy for our son. Families should not have to face that reality. A child receiving a proven and effective therapy, should be able to receive that therapy regardless of location or his parents' military status.

We ask that you approve ABA therapy as a medically necessary therapy for all service members, whether active duty or retired. Our children deserve the best the medical profession has to offer.

Sincerely,

Mary Beth Geringer

June 17, 2012

To Whom It May Concern:

We are a military family living near Eglin AFB. My husband is an active duty soldier in the Army and prior to having children I worked as an ABA tutor for individuals with disabilities, primarily Autism; however I gave up that roll to become a full time mom. Marissa is our 3 year old daughter and happens to have Down Syndrome. In addition to Marissa we have twin boys (Ben and Brayden) that are 19 months old, one of which has a speech delay. We had no idea that Marissa was going to be born with something extra special, but we have been blessed beyond measure having her in our lives. Due to her being born with a heart condition we were re-routed to Fort Bragg North Carolina, which was a location better equipped with a variety of service providers to help care for Marissa.

We immediately enrolled Marissa in North Carolina's early intervention program, which included a developmental therapist, speech, occupational, and physical therapy. Not all the services begin upon our arrival, each happened in their own time. Given my background with ABA, I wanted to get her connected with an ABA tutor and I was elated to learn that Tricare offered a supplemental insurance for individuals with special needs that approved ABA services. I had no previous experience with Tricare Echo, but found that Marissa's enrollment into the program was fairly easy once all the necessary paperwork was gathered and submitted. The case managers took their time to explain the program and ensure I felt comfortable with the information.

Roughly, by the time Marissa was 20 months old, she was receiving ABA therapy through and incredible provider, Creative Consultants, whom we were referred to through Tricare Echo. Our provider took great care in developing and implementing a plan using an approach to increase verbal and communication skills. Sign language, PECS, and verbal skills were taught to increase my daughter's ability to communicate with her family and people within the community. Although we have been reassigned to Eglin AFB, we continue to receive ABA services through another provider, which continues to work on improving Marissa's verbal skills.

Marissa is an amazing little girl. She has a spirited personality and a smile that can light up any room. Although each targeted therapy has played a role in her continued success, I strongly believe that much of the credit is due to our ABA providers and their constant diligence in updating her goals and plans to ensure continued growth and success for her long term future. There is not a doubt in my mind, as a parent and a professional, that Marissa would not be as far along as she is without the services that have been available to us through Tricare Echo and the offering of ABA services. I can only hope these services continue to be offered.

Very sincerely,
Patricia Heath



The Love Family

U.S. Army Special Forces



- Have 2 Children with Autism
 - ☐ Patrick age 10
 - ☐ Conner age 3
- North Carolina Does Not Recognize Educational or Medical ABA Therapies
 - ☐ Patrick regressed in the public school environment
 - ☐ ABA is the ONLY treatment that both Love boys respond to
- Significant Debt Incurred to Cover ABA Therapies Not Covered by TRICARE
 - ☐ Patrick medically prescribed 30-40 hours per week
 - ☐ Parents mortgaged home to save Patrick from being institutionalized
- After 9 Years at Ft Bragg, the Loves are currently in the process of a PCS to Camp Blanding, FL
 - ☐ Medicaid Waiver is NOT portable across state lines
 - ☐ Patrick will lose a crucial component that he has had for almost 6 years
 - ☐ Parents told that Florida's Medicaid Waiver waitlist is approximately 10 years

The McCall Family



Branch: U.S. Army

Stationed: Ft. Leavenworth, KS

- Eldest son, Kyle (6), diagnosed with PDD-NOS and ADHD.
- ABA provider is headquartered in Missouri and has difficulty fulfilling our recommended weekly therapy hours.
- Respite care has become impossible to coordinate since December 31, 2011 with new stringent requirements and reduced wages for our previous respite care providers. Under the current circumstances, they are no longer willing to work. As a result, we have not had respite care since the New Year. During this time, my husband had extended TDY for 6+ weeks.
- Social skills groups are non-existent in our area yet these skills are critical building blocks that my son needs to practice frequently and master in order to be successful and accepted in society.

The Mellott Family



CDR Frank Mellott, USN Ret., Sheri Dyas Mellott and children Alex, Nathaniel and Francesca

During our last 24 months at Naval Air Station Lemoore (CA)... my husband's last 24 months on active duty... all three of our children were diagnosed with special needs. It was a blow to the family like we have never experienced nor ever could have imagined. Our dreams for the future began unraveling faster than we could anticipate.

- July 2007 - Alex (age 10) diagnosed with Asperger Syndrome and with severe OCD 12 months later, now also suffers from PTSD due to 6 years of bullying in public schools, no early intervention and no behavioral therapies like ABA

- February 2009 - Nathaniel (age 10) diagnosed as going blind in one eye, due to amblyopia. Eye doctors missed the diagnosis at age 3, 4 and 5 when surgery would have been recommended

- June 2009 - Francesca (age 5) diagnosed with Autism after many other diagnoses to include phonological disorder and severe verbal apraxia. A year later, OCD diagnosis was added.

Between March 2008 and September 2008, we spent more than \$80,000 of our 20+ years of retirement savings in a Due Process fight to acquire special education services for Alex in the public school system.

My husband retired in June 2009, one week after Francesca's diagnosis, and after 23 years in the Navy, so that our family could find appropriate educational and medical services for all three of our children.

The Nielsen Family

Diagnosis: Robyn has Sheldon Hall Syndrome – a variant of Arthrogryposis

Difficulties within the Military Treatment System:

- Therapies and equipment approved in one Tricare region then denied in a different Tricare region.
- Equipment that is necessary for Robyn to be mobile took 8 months to be delivered. Parts of that equipment necessary for function (wheels) were denied and a work around had to be found.

Positives with Military Treatment System:

- Our Pediatric Orthopedist, Major Jefferson Jex has fought for us every step of the way for everything Robyn needs to be successful in her treatment, including getting her to see the premier Dr in the Country for consultation on her treatment.





The Nielsen Family

Branch: US Navy

Duty Station: Branch Health Clinic Washington Navy Yard

EFMP Category: 5

Our story: Robyn was born at Tripler Medical Center, Honolulu, HI. She was immediately diagnosed with Arthrogryposis. We met with Major Jefferson Jex to determine a treatment plan. He has been with us ever step of the way. When he needed a second opinion about our treatment plan he fought to have us sent from Hawaii to Shriner's Hospital Philadelphia to see the expert in Arthrogryposis, over all of the hurdles the Military put in front of us.

When he was transferred here to Walter Reed National Medical Center, he made sure we were able to transfer with him to continue her care as Arthrogryposis is a very rare disorder effecting 1 in 10,000 children. Here in the Capitol Region we have started having trouble getting the braces and equipment we need to continue her care. These braces and equipment we know would have been approved had we stayed in Tricare West.

There is a large difference between Regions within the Tricare system for what is approved from Region to Region. What we would like to see if the same set of rules across all Regions so when a family PCS's we know the care our family members are receiving will be available.

Jeremy and Scott: My wife Julie forwarded me your email - you'll see below that I'm writing this from Afghanistan. Here's my input - hope you use it. I've also cc'd Ms Jean Winegardner, Washington Times writer and advocate for military families rights; CSM(USA ret) Jim Hussey and Nancy Bobbitt, military assistants to US Senators Chambliss and Isackson. I'll keep the prayers going. Lastly, Scott, I hope that your treatments go well and you're given a clean bill of health. r/ DJ Reyes

TO THE SENATE ARMED SERVICES COMMITTEE FOR PERSONNEL:

I am honored to endorse your passage of this most important piece of legislation that ultimately and positively impacts the morale and health of our military force and their families.

For context, I am currently on a one year deployment to Kabul Afghanistan and will complete my tour next month. Prior to deployment, I commanded the National Security Agency - Georgia (NSAG) which continues to provide critical intelligence support to the Global Fight against Terrorism. I've briefed Senators Saxby Chambliss and Johnny Isackson several times on the great accomplishments of this 3.5K military, civilian, DoD contractor, and allied (UK, AUS, NZ, CAN) force.

I attached a picture of my family the day after I relinquished brigade command in Georgia. My wife Julie and I were blessed with triplets - they were born in Cambridge, UK, while I was commanding the US European Command Joint Analysis Center, circa 2005-2007. Immediately upon relinquishing command, I redeployed to Iraq for another 1 year combat tour.

I share these facts with you because in addition to the "normal" stress of constant deployments while managing multiples, my wife notified me that our son Christian was diagnosed with autism while I was deployed in Iraq in 2007. Long story short, through persistent education, networking, advocacy, and Faith, my wife has been thus far able to 'cobble together' a program of therapeutic support for my son. It has not been easy - at times it has been downright difficult and emotionally turbulent - but like any military family, we persevere, we adapt, we overcome.

I won't lie to you. Statistically, autism appears to be more than just a nuance issue. There's something terribly wrong and it's permeating through our military families. It's putting a tremendous stress on our troops, both deployed and at home station. It's affecting morale. I saw it as a former brigade commander running the Unit Exceptional Family Member Program, and as an active member of the local Autism Now Chapters in Georgia. And more importantly, as a parent of an autistic child.

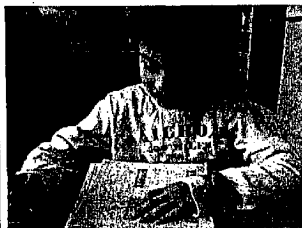
The next issue you're confronting is that of military servicemembers who are retiring or are retired with children who desperately require continuing autism therapeutic support programs. I strongly support your approval of support that continues through active duty service in into retirement. In addition to the obvious financial aspects of support, I believe that it sends the right strategic message to our troops - we never leave a fallen comrade on the battlefield, and we will never leave a fallen comrade's family in their time of need.

Respectfully, DJ Reyes



The Serna Family – A retired military family

Nicholas Anthony Serna retired after 20 years of service in the U.S. Army in 2007. Our son **Bryson** was born in 2003 and **diagnosed with autism** when he was 6 years of age in 2009. Bryson lost all his speech between 18-24 months of age and was non-verbal until he was nearly 6 years old. Life as an active duty family can be challenging with deployments, international moves and stress, but nothing prepared us for the stress and hardship our family faces daily. **Our family receives NO support** because we are a retired military family. We need our son Bryson to be eligible to receive ABA therapy, a medical necessity, through Tricare. Don't let Bryson's smiling face in the pictures below paint the wrong picture. Beneath the smile is a lot of hurt and sadness because he can't communicate very well, because he doesn't have the abilities to make and maintain friendships, and because he has to spend countless hours working hard to achieve things that come very easy to others. **Bryson needs ABA therapy** to improve his speech / communication skills, his social skills, his self-help skills and his academic abilities. Bryson needs ABA therapy in order to be able to live independently one day. Retired CW4 Nicholas A. Serna served his country for 20 years; now his family needs help and support. Please support our retired military family and please support Bryson and all the other military children affected by Autism who will need support past the active duty days.



Sincerely,
Retired CW4 Serna, Fabienne Serna, Bryson Serna and Sarah Serna

The Stockwell Family



We are an active duty Air Force Family living in Colorado Springs, CO.

- Our son Tom was diagnosed with moderate-severe autism in 2009, one month before a PCS.
- Almost had last competitive in-residence school opportunity cancelled because of lack of services at Air University location.
- PCS'd to CO in 2010. PCS initially medically declined because of 'lack of services' (one month prior to PCS), but information held by SGH was incorrect. Denied because of lack of '25 hours of ABA per week' medically recommended for our son. Tricare covers approximately 12 hrs per week. Using this rationale, we could not have PCS'd anywhere. Eventually got decision overturned and PCS'd.
- Services don't share information – Colorado Springs is a Compassionate Reassignment location for Army. AF were denying clearance.
- Our family did EFMP/SGH work for them – they had incorrect information and were unhelpful, as we were preparing to PCS from IDE at Maxwell to a competitive leadership assignment – VERY STRESSFUL.
- Our son is now thriving. With ABA therapy and great schools in Colorado he is preparing to transition to kindergarten and will be mainstreamed.
- ABA therapy has been a huge part of his improvement, giving us hope for his future and independence.

The Wales

- Branch: Air Force
- Status: Husband, retired (22 years) , wife forced to get out of USAF after 14 years to care for son
- Awesome Warrior Kiddos:
 - Zachary, 15
 - Alexander, 12
- Alex/Zach's Diagnosis: X-linked Adrenoleukodystrophy
 - Rare brain disease, destroys myelin sheath in the brain
 - No cure—after 6 years of age, bone marrow transplant will slow the progression
 - High doses of Chemo pre-transplant
 - Disease speeds up until transplant takes hold
 - Eyesight, speech, mobility affected
 - Alex received transplant in July 2009—lost the above attributes and is now quadriplegic
 - Requires nurses in home to monitor at night
 - Lifelong care required
- Our experience thus far
 - Dept of the Air Force works hard to accommodate our complex situation
- Our concerns
 - Tricare Prime Benefits at risk—medicaid benefits at risk
 - Schooling that can handle special needs, specialized clinical services not available in most military areas
 - Post 9/11 GI bill transferability for special needs dependents
 - IEP transfer across states—need for Tricare to provide better long-term benefits for chronic patients and their families



The Walker Family

Branch: US Army

Duty Station: The Pentagon



Eighteen years of active duty service, eight duty stations; six with our 13 year old daughter, Madeline and five with our 11 year old son, Ethan. Both children are enrolled in the Exceptional Family Member Program (EFMP). Madeline was diagnosed at the age of four with severe ADHD, GAD, Allergic Rhinitis; and at the age of nine Eosinophilic Esophagitis. Ethan was diagnosed at the age of 20 months with severe Autism, Sensory Integration Dysfunction Disorder, Auditory Processing Disorder, severe Allergic Rhinitis and Environmental Allergies.

Our daughter is doing well and our primary focus is our son and his services. Ethan is mostly non-verbal and requires 24 hour supervision. Ethan requires a specialized diet (gluten, casein and soy free), HFCS free, peanut free and no artificial colors, flavors or preservatives. He requires specialized classrooms to include ABA, OT and Speech. Ethan currently has a military PCM, an autism clinic and a pediatric allergist and immunology specialist that is non-network (not covered by Tri-Care). Ethan is treated with allergen extracts for his environmental allergies which subdues inflammation and greatly improves his behavior. Inflammation is a direct cause that leads to violent outbursts and self-injurious actions in Ethan. Ethan has been receiving home ABA since 2008. We cannot express enough the positive impact the home ABA services have had on Ethan's quality of life.

Our Concerns:

- Our greatest concern is the loss of ABA services after retiring from the military
- Better coverage from Tri-Care for non-traditional treatments that have proven effective
- MEDICAID services that transfer from State to State for active duty family members
- Enrollment in EFMP programs such as Respite Care that transfers from duty station to duty station without requiring reapplying and being put on a "wait-list"

The Samuels Family



BRANCH: US Navy
DUTY STATION: NAS Fort Worth JRB
EFMP CATEGORY: 5

Kaitlyn Samuels was born with severe brain abnormalities which resulted in severe global developmental delays, cerebral palsy, scoliosis and a seizure disorder. The family has recently experienced a long and costly battle with Tricare regarding physical therapy coverage for their daughter. Kaitlyn is now 15 years old. Here is their experience:

Kaitlyn has received physical therapy utilizing a horse as a therapy tool since 2005. These services were covered by Tricare until 2009. All physical therapy notes documented the use of the horse. These notes were requested and received by Tricare prior to claim approval. In 2010 Humana Military determined Kaitlyn was receiving "hippotherapy" and not physical therapy. It is important to note Tricare does not exclude hippotherapy, in fact, the term is nowhere in the Tricare manual or website. Given this fact, plus the previous payment of services, we had no reason to question coverage. In 20010 Humana Military began denying claims and subsequently recouped all funds they had previously paid. We returned the funds to Humana Military, paid the therapy center for all outstanding therapy sessions and appealed the decision of Humana and later TMA. After losing those appeals we hired an attorney and were granted a hearing on February 10, 2012. Kaitlyn's physical therapist and neurologist both testified on our behalf. Our attorney was told by the judge, Claude Heiny, that he had turned his decision over to TMA on March 30th. Today is June 14, 2012 and we still do not know the outcome. According to Judge Heiny, DOD policy is for his decision to be released with TMA's final decision. There is no regulation requiring TMA to release its decision within a certain time frame. TMA is accountable to no one. TMA makes the rules and TMA enforces the rules. This is a disturbing situation. We followed the proper procedure required of us as beneficiaries, but there are no procedures to ensure TMA meets its responsibilities. Unlike Tricare, private insurance companies are regulated. The situation we experienced would not have been possible with a private insurance company due to those regulations. This situation has cost us a great deal of stress and money and a loss of services for our daughter. At the very least we deserve to know the judge's findings. The fact that TMA is taking such a great deal of time to come to a final decision suggests that the judge may have likely found in our favor. If not, their delay is only exacerbating a very stressful situation for our family.

Jennifer Samuels
Wife of 18 years

The Vetter Family

ut Ryan:
gnosed at 26 months
PDD-NOS

ifferent Addresses with
different schools in 8
rs- 3 of those schools all
in the last 3 years

month regression with
a move



Ryan (8, Autism), Jodi (36, Aspergers/Disabled Veteran),
Sophie (6, gifted), Shane (Active Duty)

Struggles:

-Constant moving has
disrupted development,
and caused significant
regressions

-Husband's career has
been affected by limited
bases we can go to.

-Continuing legal battles
with various school
districts to get my son
appropriate support in
school.



The Vitaliano Family

Branch: US Air Force (Active Duty)

Duty Assignment: Joint Base McGuire-Dix-Lakehurst

Advocacy Initiative:

1. Common bench-marked EFMP support services across all services of the DOD. A family should not have to consider leaving their chosen service to get better service in another branch of the military for their EFMP dependant.
2. Benchmark of successful EFMP programs. Why re-invent the wheel when we have programs out there that work? Lets capture those successful methods/programs and replace failing programs with them across the DOD.
3. Modification of TRICARE ECHO to continue supporting into retirement. Our children never asked for their disabilities but they are demanding the best care possible especially considering the sacrifices their military sponsor's have made over a 20+ year military career.

Our son Spence was born prematurely at 26 weeks gestation while stationed at Kadena AB, Japan on 22 December 2006. The cause of his prematurity was a genetic defect (chromosomal deletion) which went undetected during his prenatal care. Following his birth he was admitted to the NICU at Lester Naval Hospital in Okinawa, Japan where he experienced a severe hemorrhage to his brain on his 3rd day of life. The bleed damaged his pituitary, hypothalamus, and optical nerve resulting in a diagnosis of Cerebral Palsy, Central Diabetes Insipidus, and Cortical Visual Blindness to name a few. During his stay at Lester I worked diligently with the Kadena EFMP staff to get a reassignment for Spence's long term care. Prior to his birth we had an assignment in-hand to Hurlburt Field, FL however, they were unable to support his needs. We submitted EFMP Facility Determinations to Kirtland AFB and Little Rock AFB both of which were denied.

After being stabilized at Okinawa for approximately a month he was transported by an NICU transport team via C-17 to Tripler Army Medical Center in Hawaii where he received laser eye surgery for his Retinopathy of Prematurity and continued care. During his stay at Tripler I continued to work with the AF EFMP Division at AFPC (Randolph AFB, TX) through my close friend and AF Functional Manager (SMSgt (ret) Ian Wightman). Since I was presently assigned to AF Special Operations Command they worked feverishly to keep me within the command due to my special qualifications & experience level however, it was to no avail. It was later determined after direct consultation with Little Rock AFB that they could in fact accommodate Spence's medical needs through the Arkansas Children's Hospital in Little Rock. At this point I received formal EFMP orders to the 314 AW at Little Rock AFB.

Two months into his stay at the Tripler NICU, Spence experienced a severe medication overdose at the hands of one of his NICU nurses. I petitioned the chief physician to transport my son to our follow-on assignment in Arkansas, where he could get civilian care and we could prepare a home for his eventual discharge. With his approval, they coordinated another NICU team to transport Spence via C-5 through Travis AFB and then transferred him on to a civilian Gulfstream aircraft where a civilian team completed his transport to The Arkansas Children's Hospital (ACH). Upon arrival his quality of care improved by 3-fold. The staff was immediately able to diagnosis him with Diabetes Insipidus (this had eluded all of his previous neonatologists), established a nutrition plan, and

necessary to control his worsening hydrocephalus. After the shunt placement, his condition improved substantially and he was discharged 2 months after arrival and approximately 5 months after his traumatic birth in Okinawa, Japan.

During Spence's course of treatment in all of the various hospital, I have consistently received amazing support from my commanders, supervisors and coworkers at each location. I was afforded a great deal of leeway with duty status and permitted to remain with my son daily in lieu of reporting for duty. I without a doubt, am deeply grateful to the commanders and supervisors who allowed me to be a part of my sons ongoing care. It's because of my ability to provide continuity of care, remain actively involved, and advocate daily for my son that he continues to receive some of the best care in the world.

Unfortunately our story is not without its share of problems mostly due to the shortcoming of the Air Force EFMP Program and my sons overall condition. Many months after our arrival to Arkansas, we determined that the EFMP paperwork completed by the neonatologist in Okinawa was inaccurate and failed to identify the complete medical needs of our son. As a result we were assigned to a location that did not have the ability to provide the full range of services required for a medically complex child such as Spence. It's unfortunate that when I reflect back on all the rushed coordination I did before leaving Kadena to get the EFMP process started, I recall being very alone and without any guidance. I recall the Kadena EFMP office telling me they're EFMP Coordinator has PCS'd and that the new guy wasn't trained. I also recall repeatedly being advised of how difficult the process would be and how I couldn't get the package completed in less than two weeks (it was done in 6 days). While we were in Hawaii, I called back to the Kadena EFMP office for support and they refused to assist me stating, I was no longer within their area (how horrible of a person can you be to leave a family such as ours stranded in the system, without any support or semblance of guidance). Unfortunately this continues to be a constant experience in the AF EFMP program even to this day. I continue to advocate for change in our current AF EFMP policy and program overall.

The single most beneficial source for my family's journey has been the parents, Specialized Training of Military Parents (STOMP) staff, JBMDL Military 360 Project and other professionals communicating through the STOMP Listserv. It was through these refreshing resources that I was able to educate myself on policies, processes, and methods to get the best care possible for my special boy. As a result I submitted a 335 page request to AFPC for EFMP reassignment due to lack of medical services with enough justification to make your eyes water. I prioritized McGuire AFB, NJ as our #1 location of choice due to its proximity to the Children's Hospital of Philadelphia (CHOP) and the abundance of medical support in the community. I opted to completely erase any thoughts of Spence receiving care or support from the military medical community and focused on finding the best civilian care in the country. We were of course denied; denied because the inexperienced/newly assigned Chief of Medical Staff (SGH) at McGuire felt the drive time to CHOP was excessive and his pediatricians were unable to get specialty appointments in a timely manner.

I was floored by his response, but I refused to give up, I'm accustomed to dealing with government bureaucracy and receiving the easy answer of no when the hard but correct response often times is yes. So I contacted a very kind and sincere doctor at the Little Rock MDG who coordinated a teleconference between us and the McGuire SGH on Spence's behalf. During the course of the conversation we came to the realization that this was a battle of might - the McGuire SGH was flexing his muscles without concern for the truth. In the end we closed the discussion with a challenge on my part. I informed him I could prove his reasons for denial regarding timeliness of acquiring appointment could be overcome and would prove it in writing; he chuckled and said if I gave him something proving my side he would approve the request (he had no doubts I would be unable to prove this). So I coordinated with the CHOP Complex Scheduling Department and within a week was able to acquire a list of appointments for Spence showing all of them scheduled within a 3 month period following his expect arrival as well as a back-up plan should he need to get in sooner. The doctor was of course floored and then requested I sign a statement that my son would not receive any medical care in the McGuire MDG - I signed and we had orders 3 days later. It just amazes me that this doctor who runs an entire medical staff couldn't understand the impact of triage on appointment scheduling; anyone with any semblance of medical experience knows that those who are more severe get seen faster (it's just a fact of life).

We arrived at McGuire about two weeks after receiving orders and immediately things began to improve. Spence now receives home nursing 16 hours/day to include on the bus and during school. He also received therapy services (OT, PT, Speech, vision, etc) at his school and are working on getting him additional therapies after school in an outpatient environment. Overall the relocation to McGuire AFB has been the best choice for Spence & our family. We've had some hard times since we moved here and the AF EFMP program has been of no help to us however, STOMP & the JBMDL Military 360 Project continues to be our sounding board and the bedrock of our success. I remain deeply grateful to those families/professionals that have and continue to support my family in our journey with Spence.

Hi there!

My name is Abby and I am ten years old. I have an extremely rare genetic condition called Alcardi Goutieres Syndrome, or AGS-1. I can't talk, walk or hold my head up, but I can smile real big! There are only about 300 kids worldwide with AGS and less than 30 that are



just like me! My daddy, David, is a police officer with the United States Air Force, and he has served our country for 19 years on active duty. My mommy, Stephanie, is a kindergarten teacher at a church in St. Mary's County. My big sister, Riley, is in seventh grade and is the best sister ever!

Because of my condition, I am wheelchair bound and 100% dependent on my family for my care 24 hours a day. My daddy has to go away a lot for his job and that leaves Mommy and Riley to take care of me. Because my family moves so much with the military, we get no state or federal help to get me a van and the modifications I need.

Tricare does cover monthly feeding supplies, an wheelchair for Abby. With Papa retiring in a few months, all of Abby's benefits will increase our out of pocket expenses. This will include monthly feeding supplies, incontinence supplies, specialty care appointments, and therapy treatments.



June 12, 2012

Dear Members of Congress,

I am writing to you on behalf of military dependents with autism, and specifically, my two daughters Caragh and Camille.

At five and six years old, Caragh and Camille are two AMAZING little girls who would light up any room you enter. They laugh, they play, they dress like princesses, and they have autism spectrum disorder. Both were diagnosed very young, which has changed their lives. However, there is a long road and life ahead of them and our family.

Our girls started intensive ABA therapy when they were two and three years old. It has changed their lives. Because of caps in coverage through the EFMP program we have had to work to juggle hours, take fewer hours than prescribed, and cancel sessions at the end of the fiscal year-aka beginning of school year. This is hard on the girls and certainly hard on our family.

The reality now is that I will retire. Autism for my two girls will never retire. They will need ABA for years to come; and we can only ask for it to become part of Tricare coverage so we can continue to give our children the services they need to function as adults.

Autism is hard. Helping families living with autism is not hard. Just help us help our children.

Again, thank you for all you do,

The Zeigler Family

Branch: US Navy NAS Jacksonville, FL

EFMP Cat: Caragh 5 Camille 4



Margaret Stubbs
6631 Hazel Lane
McLean VA 22101

June 18, 2012

Dear Sir or Ma'am,

My husband is an active-duty Naval Officer, and we have a nine year old son named Wilton who is diagnosed with autism. Over the years, Wilton has greatly benefited from Applied Behavior Analysis (ABA) after school. ABA helps him to mitigate his aggressive behaviors (like biting, spitting, hitting, and kicking) and his anti-social behaviors (like screaming and removing his clothes public). In addition, his ABA therapists have been able to teach him self-help skills such as dressing himself, brushing his teeth, and using utensils when eating. If it were not for ABA, Wilton would be guaranteed to have absolutely no ability to care for himself as an adult. However, because of the skills he has learned from ABA, Wilton may be able to live in a group home as an adult with minimal to moderate assistance and supervision. It is also possible that he may be able to have a low-skill job, making him less of a burden to the tax payers in the long run.

We are concerned because my husband has served for 27 years in the military, and is now at the end of his career. When he retires, Tricare will no longer cover the cost of ABA. This is a problem because we will not be able to pay out of pocket as it costs \$3000 a month for the 15 hours a week he receives outside of school. If Wilton no longer does ABA, I fear that he will never have the skills to live outside of a heavily staffed medical facility once his father and I pass away.

In my view ABA is a good investment. Although it is a weighty initial expense, it will benefit society in the long run. If my son can live a semi-independent life, he is far less likely to end up in jail, prison, or a mental hospital.

Thank you for your attention to my concerns.

Sincerely, Margaret Stubbs



The Rupe Family

Home of Record: Pearland, Texas
Current Duty Station: Norfolk, Virginia



Kyle, 11 years old, EFMP category 4, Autism
Michael, 7 years old, EFMP category 2, congenital limb defect (no special services)

- **EXPERIENCED EDUCATION ADVOCATES:** Kyle has attended 8 schools in 4 public school districts. Advocating for appropriate services for a military child can often be difficult because the school often assumes he will not be attending long enough to fight the system. Experienced advocates in highly populated EFMP areas like Virginia Beach and San Diego would be beneficial to many families.
- **MEDICAID WAIVERS:** Kyle received a Medicaid waiver slot for ABA therapy in one state. He made considerable progress with 25 hours of Applied Behavior Analysis (ABA) therapy a week, which is the minimum recommended by the American Academy of Pediatrics. Now he will be at the bottom of another Medicaid Waiver waiting list and will likely never see the top. Allowing military families to move with their waivers would help so many children—even keeping their spot on a waiting list would help.
- **ECHO - LIMITED ABA:** The TRICARE ECHO program pays for ONLY 6 hours of ABA per week on the Demo program. This is less than 25% of the recommended minimum hours. Moving the ABA benefit to TRICARE Basic would remove the limit and make it available to retirees who still have children with autism when they retire.
- **CONTINUITY OF CARE:** Finding qualified private therapists even in a large city is difficult. Waiting lists are often months long, if you can even get on a list. Contracting with more therapists may help.
- **NO RESPITE:** Our area of the country has a Navy Respite program, but the waiting list is almost ONE YEAR long! ECHO has a respite program, but if you use your ECHO dollars on ABA you don't have any left for respite. It is necessary to fund existing programs and provide respite for all EFMP families.
- **LIMITED MEDICAL KNOWLEDGE OF AUTISM:** Autism is being treated medically with great results all over the world, yet military doctors remain untrained and pass this sense of hopelessness on to the parents of children with autism. Children with autism are entitled to proper non-discriminatory medical care.



The Jamesons

Navy SEAL Reservist activated - March 2012; Mobilized and deployed - May 2012

Our son Ronan has several diagnoses – mitochondrial diseases, autism, non-verbal, developmental delays; his siblings are being screened for mito disease as well

Local schools wouldn't provide ABA and civilian doctors gave us little hope.

We found a private ABA school-based program; he thrived, gained skills and transitioned to a public school special needs classroom upon a move to a new community

With the private school and private therapies we paid for out-of-pocket, we were knee-deep in medical, educational, therapeutic and emotional debt.

Becoming a Reservist presented itself; the benefit of a sign-on bonus as well as a second income was welcomed to offset debt incurred to care for our son

We are now an active-duty family and Ronan qualify for Exceptional Family Member Program (category 5). Through the Autism Demo Program we are awaiting approval for Applied Behavior Analysis (ABA), the same therapy that made an consistent difference for Ronan

But, as with all things government-military related, it has been an exhausting, paperwork-ridden maze trying to figure out how to correctly apply, who to go to to get questions answered, and then knowing when that entire the process is complete.

What we had hoped would be a simple process has become labored. 4.5 months later, we are still jumping through hoops to secure ABA therapy. Now we hear that these benefits might be in jeopardy even before Ronan has the chance to use them!

Funding for Ronan's ABA will end when my husband returns to reservist status in 2013. Ronan has yet to start specific therapy for his needs. Ronan might not lose his autism diagnosis when my husband returns home from deployment, but sadly the ABA benefits will.

Senator WEBB. Thank you very much, Mr. Hilton.
Dr. Dawson, welcome.

STATEMENT OF DR. GERALDINE DAWSON, CHIEF SCIENCE OFFICER, AUTISM SPEAKS, AND PROFESSOR OF PSYCHIATRY, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Dr. DAWSON. Good afternoon, Chairman Webb, and members of the subcommittee. I am Dr. Geraldine Dawson. I am the Chief Science Officer at Autism Speaks, and I serve as Professor of Psychiatry at the University of North Carolina at Chapel Hill. Prior to joining Autism Speaks, I directed the University of Washington Autism Treatment and Research Center for close to two decades.

Autism Speaks is the world's leading autism science and advocacy organization. We are dedicated to funding research into the causes, prevention, treatments, and cure of autism, and to increasing awareness and advocating for individuals with autism and their families.

I am honored to appear before the Senate Armed Services Subcommittee on Personnel, and to participate in this hearing on issues facing military families who have dependents with special needs.

Like their counterparts in civilian life, many military families face challenges in providing proper treatment for their child with autism. I am here today to talk about those challenges and how the military healthcare system can lessen their effect on families.

But first some information about autism. Autism is a developmental disorder that affects a person's ability to form social relationships and communicate with others. People with autism also exhibit repetitive behaviors, some of which can interfere with their ability to learn and function. Autism is caused by a combination of genetic and environmental risk factors.

But autism is no longer considered a rare condition. It affects 1 in 88 children in the United States, 1 in 54 boys. This year, more children will be diagnosed with an ASD than AIDS, diabetes, and cancer combined. The prevalence of autism has risen dramatically over the last several decades. In fact, statistics show a tenfold increase in the past 40 years. Many in the autism community use the word "epidemic" when describing autism.

Fortunately, there are effective treatments for autism that can change a person's course and outcome. Numerous controlled clinical trials have shown that early intensive behavioral treatment significantly increases IQ, language abilities, daily living skills, while reducing the symptoms of autism.

In fact, a 2010 randomized control trial, funded by the National Institutes of Health and published in the prestigious *Journal of Pediatrics*, found that 50 percent of children with autism who received early intensive behavioral treatment for 2 years had a 15-point increase in IQ. One-third of the children showed an increase in IQ of greater than 30 points. This means that early treatment changed these children's life trajectories, setting them on a course that increases their chance of living productive and satisfying lives.

These children will likely attend a regular classroom, develop spoken language, and make friendships. This is not only good for these individuals, it results in significant cost-savings, as fewer

services will be needed in the long-run, and these individuals now can become more productive members of our society.

Behavioral health treatments that are based on ABA have become widely accepted among healthcare professionals as an effective treatment for autism. These treatments are provided by highly-trained licensed and certified professionals. Early-in-life treatment involves working one-on-one with a child typically for 25 to 40 hours per week.

Thirty States now require coverage of ABA treatment as part of medical care. Employers, such as Microsoft and Home Depot, universities, such as Ohio State, Harvard, and Princeton, and healthcare facilities, such as the Mayo Clinic, do so as well.

Earlier this year, OPM concluded that there is enough evidence to classify ABA as a medical therapy. In contrast to the benefits covering ABA treatment that now will be made available to the Federal civilian workforce, the healthcare program for uniform servicemembers and their families, TRICARE, provides only limited coverage for ABA treatment.

TRICARE classifies ABA treatment as an educational intervention, and makes it available only through ECHO, and caps coverage at \$36,000 a year.

Furthermore, ABA treatment is restricted to dependents of Active Duty servicemembers. Dependents of retirees, including dependents of wounded warriors who were retired due to their injuries sustained in combat, are unable to access ABA treatment for their child with autism. Guard and Reserve families receive intermittent care as they move between Active and Reserve status.

\$36,000 a year pays for about 11 hours of ABA treatment per week. Many children with autism, particularly early in life, and some who face severe challenges, need more treatment hours in order to fully benefit from the treatment.

Given all that our military families have shouldered for the past decade, they deserve better. On behalf of thousands of military families affected by autism, I strongly urge Congress to require TRICARE to provide behavior health treatment, including ABA, to military families regardless of duty status, and at the level of care prescribed.

Thank you, Chairman Webb and members of the subcommittee, for this opportunity to speak about this important issue affecting military families. I look forward to your questions.

[The prepared statement of Dr. Dawson follows:]

PREPARED STATEMENT BY DR. GERALDINE DAWSON, PH.D.

Good afternoon, Chairman Webb, Ranking Member Graham, and members of the subcommittee. I am Dr. Geraldine Dawson, Chief Science Officer of Autism Speaks. I also serve as Professor of Psychiatry at the University of North Carolina at Chapel Hill.

Autism Speaks was founded in February 2005 by Bob and Suzanne Wright, grandparents of a child with autism. Since then, Autism Speaks has grown into the world's largest autism science and advocacy organization, dedicated to funding research into the causes, prevention, treatments and cures for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families. We are proud of what we've been able to accomplish and look forward to continued success in the years ahead.

I am honored to appear before the Senate Armed Services Subcommittee on Personnel at this hearing on issues facing military families with dependents who have special needs. Like their counterparts in civilian life, many military families face the

challenge of providing proper treatment for a child on the autism spectrum. I am here to talk about those challenges and how the military health care system can lessen their effect on families.

THE CHALLENGES OF AUTISM

I will begin by providing an overview of autism. Autism is a developmental disorder that affects a person's ability to form social relationships and communicate with others. People with autism also exhibit repetitive behaviors, some of which can interfere with their ability to learn and function. Most scientists agree that autism is caused by a combination of genetic susceptibilities that interact with environmental risk factors.

Autism is no longer considered a rare condition. It affects about 1 in 88 children, including 1 in 54 boys. Let's compare autism's prevalence to that of some other conditions:

- Pediatric AIDS – 1 in 300;
- Type 1 diabetes – 1 in 400; and
- Childhood cancer – 1 in 2,000

This year, more children will be diagnosed with an autism spectrum disorder than AIDS, diabetes, and cancer combined. The prevalence of autism has risen dramatically over the past several decades; in fact, statistics show a ten-fold increase in 40 years. Although broadening of the diagnostic criteria for autism and increased awareness account for some of this increase, experts estimate that approximately 50 percent of the increase remains unexplained. Many in the autism community use the word "epidemic" when describing autism.

Based on metrics used by the World Health Organization, autism represents a significant public health challenge. It is a highly prevalent and chronic condition with an early onset and is associated with significant functional impairments and costs. Its burden is higher than childhood leukemia, cystic fibrosis, and type 1 diabetes—an estimated \$137 billion per year.

Of course, the impact of autism cannot be measured in dollars alone. Autism takes a significant toll on families. Compared to the families of children with special health care needs other than autism, the families of children with autism are more likely to:

- cut back or stop working;
- spend 11 or more hours per week providing care;
- pay more than \$1,000 annually in out-of-pocket medical expenses;
- experience financial problems; and
- avoid changing jobs in order to maintain health insurance.

According to a national survey, only one in five children with autism has adequate health insurance coverage, receives coordinated, ongoing, comprehensive care within a medical home, and had at least one preventive medical visit in the past 12 months.

Military families with a child on the autism spectrum face the added burdens of stress associated with their service. Relocating to a new duty station can cause gaps in care with lifelong consequences. When one parent is deployed, the other may bear the full responsibilities of child care. When a parent returns from deployment, the family may have the additional challenge of combat-related mental or physical health problems.

SCREENING, DIAGNOSIS, AND TREATMENT

The care of a child with autism often begins with a sense by a family member or health care professional that the child's development is not typical. It is now possible to screen for autism at 12 months of age, and autism can be reliably diagnosed by 18 to 24 months of age. In 2007, the American Academy of Pediatrics recommended that all children be screened for autism at 18 and 24 months of age and that appropriate referrals be made if autism is suspected. Yet, the average age of diagnosis in the United States remains close to 5 years. Children from ethnic minority backgrounds are at a particular disadvantage. Research shows that these families have to go to the doctor many more times before receiving a diagnosis, and the age of diagnosis is much older.

Fortunately, there are effective treatments for autism that can change a person's course and outcome. Controlled clinical trials have shown that early intensive behavioral treatment significantly increases IQ, language abilities and daily living skills, while reducing the symptoms of autism. In fact, a 2010 randomized controlled trial funded by the NIH and published in *Pediatrics* reported that 50 percent of children with autism who received early treatment for 2 years had a 15 point increase

in IQ (1 standard deviation). One third of the children showed an increase in IQ of greater than 30 points (2 standard deviations). This means that treatment changed these children's life trajectories, setting them on a course that increased their chances of living productive and satisfying lives. This is not only good for the individual; it results in significant cost-savings for society as children and adults need fewer services and can become productive members of society.

Among the many treatment methods available, behavioral treatments that use the methods of applied behavior analysis (ABA) have become widely accepted among health care professionals as an effective treatment for autism. Mental Health: A Report of the Surgeon General states, "Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior." Study after study has provided evidence for the efficacy of early intensive behavioral treatment based for improving outcomes of children with autism.

Let me say a little more about ABA. Treatments based on behavior analysis use a scientifically validated approach to understanding behavior and how it is affected by the environment. Through decades of research, the field of behavior analysis has developed many techniques for increasing useful behaviors and reducing those that may cause harm or interfere with learning. These techniques bring about meaningful and positive changes in behavior. Success in an ABA program is measured by direct observation and data collection and analysis. Early behavioral treatment based on ABA is provided by highly trained licensed/certified professionals with expertise in ABA and involves one-on-one treatment with the child typically for 25–40 hours per week for at least 2 years. This early intensive investment in treatment results in significant cost savings in the long run, as many children with autism who receive such treatments can now carry on a normal conversation, enter a regular classroom, and form friendships with their peers.

THE GROWING TREND TOWARDS COMPREHENSIVE AUTISM COVERAGE

Autism Speaks is committed to passing insurance legislation that provides access to behavioral health treatments for people with autism. Back in 2001, only the State of Indiana required insurance coverage of effective therapies like ABA. Now 30 States (representing over 70 percent of the country's population) require coverage of ABA treatment as a medical care.

Large employers like Microsoft and Home Depot provide coverage for autism therapies, as do universities such as Ohio State, Harvard, and Princeton and health care facilities like the Mayo Clinic.

After conducting an internal review earlier this year, the U.S Office of Personnel Management (OPM) concluded there is enough evidence for OPM to classify ABA as a medical therapy. This means that Federal Employees Health Benefits Program (FEHBP) carriers may propose 2013 benefit packages that offer behavioral treatments based on ABA. In communicating this decision to Autism Speaks, OPM stated, "This decision reflects our perspective that families covered under the FEHBP should have access to medical treatment that is safe, effective for their individual diagnosis, supported by sound medical evidence, and delivered by appropriate providers."

In contrast to the benefits that will be made available to the Federal civilian workforce, TRICARE—the health care program for uniformed servicemembers and their families—currently provides only limited coverage for ABA treatment. TRICARE classifies ABA as an educational intervention and makes it available only through the Extended Care Health Option (ECHO), a supplement to the basic TRICARE program. ECHO benefits are cumulatively capped at \$36,000 per year which may not adequately cover the early years when intensive treatment is needed. ECHO is restricted to dependents of active-duty servicemembers. Dependents of retirees—including dependents of wounded warriors retired due to injuries sustained in combat—are unable to access ABA treatment under TRICARE. Guard/Reserve families receive intermittent care as they move between active and non-active duty status.

Families report that the ECHO \$36,000 limit on care does not address the need for intensive ABA services. Using TRICARE billing rates, \$36,000 pays for an average of 11 hours of ABA therapy per week, whereas the recommended number of hours is between 25 and 40. Many children with autism, especially those who are newly diagnosed or who face severe challenges, need this level of initial treatment. The out-of-pocket costs associated with this additional medical care are unaffordable to the military family. Even the limited available benefit is difficult to access for some eligible families, who report significant enrollment delays and a lack of TRICARE authorized providers.

Without access to needed services, many military families depend on State Medicaid waiver programs. A change in duty station, however, may move a family to the bottom of a long waiting list and force a stark choice: incur significant debt or do without treatment for their child.

Given all our military families have shouldered for the last decade, they deserve better. The warfighter in Afghanistan should not have health care inferior to that of the civilian employee working within the Pentagon. We owe more than this to the families who are making tremendous sacrifices for our country.

This is not a matter for further study. Action is needed to provide the quality of care our military families deserve and have earned. On behalf of the thousands of military families affected by autism, we ask that Congress require TRICARE to provide behavioral health treatment, including ABA, to military families regardless of duty status and without a dollar cap.

Thank you, Chairman Webb, Ranking Member Graham, and members of the subcommittee, for your time, for your commitment, and for your leadership.

Senator WEBB. Thank you very much, Dr. Dawson.

Mr. O'Brien, welcome.

**STATEMENT OF MR. JOHN O'BRIEN, DIRECTOR OF
HEALTHCARE AND INSURANCE, U.S. OFFICE OF PERSONNEL
MANAGEMENT**

Mr. O'BRIEN. Chairman Webb, members of the subcommittee, thank you very much. Thank you for the opportunity to make a statement on behalf of the FEHB program administered by OPM. We appreciate the subcommittee's interest in our program and its support of families whose children have special needs, specifically those with ASD.

We understand that the subcommittee seeks information on our recent reclassification of ABA as a medical therapy. In contrast to the single provider model of TRICARE, the FEHB program contracts with 91 separate insurance carriers to offer health plans to over 8 million Federal employees, annuitants, and families. All plans are required to provide basic services, and may propose and negotiate to offer a range of additional benefits. All FEHB plans are required to provide children with autism access to pediatric care, physical therapy, occupational therapy, speech therapy, mental health treatment, and medications.

However, during the current 2012 contract year, the FEHB benefit—ABA is not an FEHB benefit because it is classified for the FEHB as an investigational or educational intervention, and, therefore, is subject to a blanket exclusion. That means that children of a Federal employee cannot access ABA services through their health insurance regardless of whether the plan they have selected would have normally considered such a treatment as medically necessary and provide it to its non-Federal subscribers.

Beginning in 2010, Members of Congress, families, and other stakeholders asked OPM to reexamine this blanket exclusion. The OPM Benefit Review Panel evaluated the status of ABA for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB program. The Benefit Review Panel concluded that there is now sufficient evidence to categorize ABA as a medical therapy. Accordingly, plans may propose a benefit package that include ABA.

The insurance marketplace in which the FEHB operates is changing rapidly with regard to ABA therapy. At present, 30 States require some health insurance coverage of ABA. In a week, that number will be 31. Had I been before this subcommittee in

June 2010, the number of States requiring ABA would have been 14. In June 2008, just 4 years ago, the number would have been two.

OPM has made the decision to reclassify ABA as a medical therapy rather than as an educational service based on the evolving body of clinical research and the maturing provider infrastructure to deliver this modality under a medical model. This reclassification does not presume medical necessity, and does not specifically require FEHB plans to add ABA service to their basic benefits package. Rather, it allows plans to propose ABA as an additional benefit under conditions where medical necessity is satisfied and appropriate and qualified providers are available.

Medical necessity criteria are evaluated by each health plan in FEHB, not by OPM. Plans assess whether a proposed treatment is safe, supported by sound medical evidence, effective for an individual, more effective than alternative treatments, and conforms to relevant standards of medical practice. Our decision only applies to the FEHB and not to TRICARE programs, and accordingly, was published as technical guidance to our carriers.

The evidence is not yet sufficient to support an official OPM position requiring coverage by all FEHB carriers. In the interval, our administrative change will allow FEHB plans that choose to make ABA services available as the research and provider base matures. OPM will periodically re-review ABA as the research develops.

We are grateful for the subcommittee's support of Federal employees and their families. Thank you for this opportunity. I am happy to answer any questions you may have.

[The prepared statement of Mr. O'Brien follows:]

PREPARED STATEMENT BY MR. JOHN O'BRIEN

Chairman Webb, Ranking Member Graham, and members of the subcommittee, thank you for the opportunity to make a statement on behalf of the Federal Employees Health Benefit (FEHB) Program, administered by the U.S. Office of Personnel Management (OPM). We appreciate the subcommittee's interest in our program and its support of families whose children have special needs, specifically those with Autism Spectrum Disorders.

We understand the subcommittee seeks information about our recent classification of Applied Behavior Analysis (ABA) as medical therapy. In contrast to the single provider model of TRICARE, the FEHB program contracts with 91 insurance carriers to offer health plans to over 8 million Federal employees, annuitants, and families. All plans are required to provide basic services, and may negotiate to offer a range of additional benefits. All FEHB plans are required to provide children with autism access to pediatric care, physical therapy, occupational therapy, speech therapy, mental health treatment, and medications. However, in 2012, ABA is not an FEHB benefit because it is classified as an investigational or educational intervention. This means that the child of a Federal employee cannot access ABA through their health insurance regardless of whether the plan would normally consider such treatment medically necessary and provide it to its non-Federal subscribers.

Beginning in 2010, Members of Congress, families, and other stakeholders asked OPM to re-examine this blanket exclusion. The OPM Benefit Review Panel evaluated the status of ABA for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Benefit Review Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy. Accordingly, plans may propose benefit packages which include ABA.

Over the last 2 years, the infrastructure to support the delivery of ABA has matured rapidly. Today 30 States require at least some health insurance coverage of ABA, and 14 have licensure procedures for ABA providers. ABA providers most frequently have a graduate degree in Psychology with additional training in ABA, leading to formal Board Certification in Behavior Analysis. States often exercise their

supervision of certified or licensed providers through the same pathway which oversees other health care practitioners, such as a Board of Medicine or Psychological Examiners. It is also common practice to require a physician's or Psychologist's prescription before a health plan will approve ABA for a specific child.

OPM made a decision to reclassify ABA as a medical therapy rather than an educational service based on the evolving body of clinical research and the maturing provider infrastructure to deliver this modality under a medical model. This reclassification does not presume medical necessity and does not specifically require FEHB plans to add ABA services to their basic benefits package. Rather, it allows families of Federal employees to receive the same treatment as families of non-Federal employees by allowing plans to propose ABA as an additional benefit, under conditions where medical necessity is satisfied and appropriate, qualified providers are available. Medical necessity criteria are evaluated by each health plan in FEHB, not by OPM. Plans assess whether a proposed treatment is safe, supported by sound medical evidence, effective for an individual, more effective than alternative treatments, and conforms to relevant standards of medical practice. Our decision applies only to FEHB, and not to TRICARE programs, and accordingly, was published as technical guidance to our carriers.

The evidence is not yet sufficient to support an official OPM position requiring coverage by all FEHB carriers. In the interval, our administrative change will allow FEHB plans that chose to do so to make ABA services available as the research and provider base mature. OPM will periodically re-review ABA as the research develops. We are grateful for the subcommittee's support of Federal employees and their families.

Thank you for this opportunity, I am happy to address any questions that you may have.

Senator WEBB. Thank you very much, Mr. O'Brien. Let me begin by thanking all of you for your extraordinary breadth of experience that has been reflected in your testimony today, both written and oral.

Just as an immediate reaction, before we get into some of these more complex issues that are being addressed with respect to ABA therapy, I think that, Mr. Hilton and some of the others, you raised some very valid points about inconsistencies in the ability to get treatment, and the eligibility requirements when people move. I think that is something I am going to right now encourage staff to pursue further. These are things that could be handled administratively perhaps working with DOD on these sorts of issues.

I remember what it was like to move around when I was a kid. I remember at one point I went to nine different schools in 5 years between the 5th and the 10th grade. We were in England, Missouri, Texas, Alabama, California, and Nebraska. I remember what it was like to be at the bottom of the pile in these types of things. We did not have Medicaid waiver programs when I was a kid. I do not think we had Medicaid when I was a kid. I do not remember any of it.

But certainly there are issues that have been raised that could be dealt with in a more immediate sense just by working with DOD to see if we cannot iron out some of those matters that have been raised.

As I mentioned in my opening statement, let me begin with this. There is a lot of debate with respect to the OPM determination that you, Mr. O'Brien, discussed. I would like to start by getting a better understanding of the factual nature, the specific nature of the treatments. Maybe the best place to start would be with Dr. Tait and Dr. Dawson. If you could help us understand the difference in current practices that are regarded as medical therapy in these cases as opposed to what have been educational interven-

tions. Just in basic terms, what are the differences? Dr. Tait, maybe we will start with you.

Dr. TAIT. Thank you. When I am thinking about and when we are talking in terms of whether this is medical versus educational, unfortunately, when we are looking at any therapy, whether it is occupational therapy, physical therapy, speech, ABA, it has both educational and medical effects. I think maybe the best way that if I could give some examples of that.

If you are looking at ABA, as I mentioned in the testimony, it certainly affects cognition or thinking. It affects language. It affects academics. That is the school piece of it. But if you look at children who have ASD, many of them have specific medical issues that have to be dealt with through a behavioral approach. Examples of that would be self-injury. Many of the children actually are involved in self-injurious behaviors.

Another example would be eating. One of the things that we look at, some children at the extreme of ASD really have such very specific eating habits that unless you look at it behaviorally, they can be malnourished. That is the medical piece of it. They can have what we call Pica disorder, which is eating other objects that you should not be eating, and then you go to the doctors for that.

Another piece of that is, behavior can be such a part of what we are talking about that they cannot get the basic needs they need, like going to a dentist, or getting the medical needs that they have addressed unless they are sedated.

All of those are behavioral in one sense, Senator, but they are also educational. When I am thinking in terms of ABA, I think that it certainly is medically-based. It is also educationally-based.

Senator WEBB. Just for clarification here, in terms of programmatically what is now funded and what is considered educational intervention, what type of program is now funded that does not reach the ABA area? Programmatically, when we say there are certain practices that are acceptable, and at the same time we are saying that the ABA is educational intervention and, as a result, not funded, what are we treating and what are we not?

Dr. TAIT. The way that I look at this is if you look at therapies that are funded—maybe that is the best way to approach it. The therapies that we know that are funded are things like occupational therapy, physical therapy, speech language pathology. If you look at those therapies, they are very specific and individualized with respect to the children that need them.

Those therapies are not as behaviorally-based where you set up a specific behavior program that has to be carried through at home, at school, by the family. You are looking at different, what we call, trials, where you look at behavior changes and trials. I think that is why when we are looking at this, you are saying it is educational because it is looking at the cognition, language, academic performance, and adaptive behavior. But all of that rolls into the medical piece of it too.

Not all children need 40 hours of ABA per week that have autism, and that is why we were saying it has to be individualized. You look at the therapy that is appropriate.

Senator WEBB. Dr. Dawson?

Dr. DAWSON. One way to look at it has to do with who delivers the treatment and the scope of the treatment. When we think about an educational service, it is typically provided in an educational context by educators. When we think about ABA treatment, early intensive behavioral intervention, first of all, it is often prescribed by a physician. Second, it is delivered by either a licensed clinical psychologist or a board certified behavior analyst, not necessarily a special educator. Then, third, it requires many hours of intensive intervention that is not accommodated within an educational program. Educational programs simply do not offer either the level of expertise in this area or the number of hours and intensity. It really goes beyond the scope of a typical educational program that we might offer. Even a child with special needs would not be offered these kinds of services typically in an educational program. So it really goes beyond the scope of what we think of as education.

The other thing to point out is that it has an impact on brain development. In fact, there is study in press right now that shows that it not only impacts things like IQ and language ability, but can change the pattern of brain activity in these children to normalize them over time. It is much more of a whole medical intervention than we think of as restricted specifically to an educational activity.

Senator WEBB. I want to finish this thought with Mr. Hilton. In your own experience with the program, what does it cover, and what does it need to be covered? How does the \$36,000 annual cap fit into that?

Mr. HILTON. Sir, I am just going to back up for a second and piggyback on something that the lady said and give you an example. A lot of these children, for whatever reason, are runners, meaning they run and run. Another thing, they like water for a reason I do not understand.

We lost a little girl, a little Army girl, 7 years old in May, who had autism. She ran and they ended up finding her in a pond not far from the family. This is documented in a variety of different circumstances. So from our perspective, for a lot of our families, this is life or death. I do not think that qualifies educational. That qualifies as medical.

To answer your specific question, what my friends and what I have seen is that particularly when you are talking about younger children, 2- to 5-year range, or the children who need much more intensive therapy, that \$36,000 simply is not enough to cover their costs. I have a friend who is a Navy commander. I served with him a long time ago. He has a child with autism, and this is an O5 that you would think might be able to cover this therapy. He has had to take out a second mortgage on his house. That just gives you an example of what an O5 has to deal with. Imagine an E3 or E4. They are simply just going without the therapy.

Senator WEBB. Mr. O'Brien, we have been told that DOD has asked OPM to see the studies and the basis for OPM's decision. Is OPM going to share that study with DOD?

Mr. O'BRIEN. Yes.

Senator WEBB. Good. Senator Begich.

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

First, Mr. Hilton, congratulations again on your award as Military Spouse of the Year. I know you corresponded off and on with my wife by e-mail. I thank you. We really appreciate your effort and your lead and your leadership today in representing families in a very succinct way. I will have some questions for you in a second, but I just wanted to acknowledge that I really appreciate your being here today.

I am actually going to take the question that the chairman just asked. If the answer is yes, the question is obviously how long will it take you to review it? When will you do it? That, to me, is very simple.

Dr. GUICE. When we get the information, we will put it in our normal review process and evaluate it according to our requirements by statute and by regulation as to whether or not it serves as medical care according to our criteria.

It may take us very little time, 6 months. It just depends on all the information that we get. We invite others to submit information as well if they have credible evidence, peer review publication of studies, that would help us, inform us about a better or a different coverage decision, we would be delighted to receive those as well, sir.

Senator BEGICH. Can you do that administratively? In other words, once you review and if you determine you can move it to medical therapy, can you then do it?

Dr. GUICE. Yes, sir. If it is deemed to be appropriate according to our criteria, and statute and regulations that we evaluate evidence by, then it can be made a coverage decision.

Senator BEGICH. Okay. Here is the question I have. I guess if I am able to do it right, because I am under one of your policies somewhere in the mix because I pay a bunch of money. I know that despite what people think, we actually have lots of premiums as senators. I think I had my co-payment premiums at \$6,000 last year. So if I wanted to buy additional coverage for one of my policyholders or one of the folks I have under Federal insurance, that is covered as additional, I can get it, correct?

Mr. O'BRIEN. Assuming the plan offers service.

Senator BEGICH. Right.

Mr. O'BRIEN. But it is not a required part of our basic benefit plan. We are offering plans the opportunity to propose this benefit. So this does not guarantee anyone would get this benefit.

Senator BEGICH. I understand that. I understand, but it is now offered where several years ago we had a couple only that offered it, correct?

Mr. O'BRIEN. Right. As of today for the 2012 contract year, there is no child in the FEHB program who is receiving ABA. It is under a blanket exclusion as we have identified it as an educational service. We have removed that blanket exclusion.

Senator BEGICH. Because the evidence is telling you something, and it is worthwhile to ask the question for policyholders to consider, correct?

Mr. O'BRIEN. In our benefit review panel, we went back there. We considered the evidence, and the evidence has said this is a promising therapy. There is also a wiggle around it. Additionally,

we looked at the costs and we looked at what the evolution of the provider infrastructure and the insurance market.

Senator BEGICH. Let me ask you. What have you done there, do you do that frequently?

Mr. O'BRIEN. We have other services we are going to be doing in the future. This is a relatively new process we are doing.

Senator BEGICH. That helps me because you have a standard. You are not just doing it for anything. You are reviewing it, and then you are moving it to the next stage. Then it could move to the next stage. Is that fair to say?

Mr. O'BRIEN. Yes, that is fair to say.

Senator BEGICH. Okay. Your process, once this information and other information may come in, you may have 6 months or so to review. Then at that point, you will determine if it fits your criteria. If not, you will identify what those gaps are. Is that fair to say?

Dr. GUICE. Yes, sir.

Senator BEGICH. Okay. You will keep, I am assuming, the chairman, the subcommittee informed on that process?

Dr. GUICE. We will be happy to.

Senator BEGICH. Great. Mr. Hilton, you brought up a lot of good questions. I am going to take one which the chairman mentioned that I want to follow up on, and that is the Medicaid waiver.

It is interesting. We do not know what the Supreme Court is going to do in the next 4 or 5 days, but under that new program, we pay—when I say “we,” I mean the Federal Government—when it is all done and said, all new entrees into Medicaid at a certain level, we pay 90 percent to any State. So it seems logical to me that there should be probably a veteran or an Active Duty military Medicaid program because we are going to pay 90 percent of it anyway, that is portable.

So you serve in one community, because the way it is going to work—I think this is the way it is going to work. Let us say you are in Alaska. You serve a year or 2. You get transferred. You go to another State. You are going to be a new member on their Medicaid roll. You are going to be a new entry. So, therefore, we are going to pick you up at 90 percent. So, do we not just figure this out now because within a 2- or 3-year period, every military person who needs a service and a Medicaid waiver will be actually a new entry onto States' rolls, which we pay 90 percent of. So why not just cut through it all and create a Medicaid waiver program for military that will actually go into play anyway? Your thoughts on that?

Mr. HILTON. Sir, I think I would be obviously supportive of that.

Senator BEGICH. Yes, I thought that would be the case.

Mr. HILTON. In my written testimony, I list the Medicaid waiver website. There are 423 different Medicaid waiver programs in the Federal Government at the various States. So you can see why we sometimes get confused as we move from State to State. However, as I note in my testimony, there has to be a way to figure out how to serve our military families.

Senator BEGICH. Just sitting here listening to you and thinking about the law by the example I just gave, every military person who needs the Medicaid waiver will automatically become a Med-

icaid new entry in the State they go to. Those are people we are going to be covering 90 percent of under the new law. So why not just do it? That is just a thought that I wanted to share.

I am giving it through the chairman and the staff, and maybe some thought there because I think you bring up, if I can in my last minute here, Mr. Hilton, what other things do you think we in the Federal Government can do? You mentioned a couple in your testimony, and I appreciate that—that we can do to better really serve families that have children with disabilities and special needs?

Mr. HILTON. Sure. If I had to prioritize the variety of things I put in my written testimony—it was pretty lengthy—I would obviously put high on the top of the list the ABA issue. We have been admiring this problem—

Senator BEGICH. To get it classified as a medical—

Mr. HILTON. Yes, sir, as medically necessary. I will be honest with you. I hear medical therapy, but not medically necessary. I hear educational. I hear sea lawyer combined with insurance adjuster, to be honest. That is what our families hear, and that would be at the top of the priority list for me.

Obviously, getting in place appropriate policy to standardize the EFMP process such that, exactly as the chairman said, as we move from base to base, it is consistent. From my perspective, disabilities do not care what uniform you wear, and it is one of those things where we all scratch our head and wonder why are we receiving different services.

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

Senator WEBB. Thank you, Senator Begich. Before I call on Senator Gillibrand, let me just say to her that I was talking well about her before she got here. She was really one of the principal motivating forces behind having this hearing. So we welcome her, and she is now recognized.

Senator GILLIBRAND. Thank you, Mr. Chairman, and thank you so much for holding this hearing. Thank you to each of the witnesses. This is so helpful because this is not an issue that I think gets enough sunlight, enough discussion, and one that so urgently does for families that have children that are suffering. That is what I am really worried about.

I am worried that this would take 6 months; 6 months is a long time. That could be a whole half year for a 1-year-old or a 2-year-old where those therapies are the difference between whether they will ever reach their God-given potential. I think that is too long.

I am very concerned because the prevalence is so high. One in 54 boys today are being diagnosed with autism. The fact that these therapies actually work is the greatest hope that we have. We should not be denying them to any child, certainly not children of military families, certainly not children of wounded warriors or veterans. We have to do better, in my view.

Now, I was very interested in both of the doctors' testimonies because what you described to me sounded very much like psychological therapies that are similar to what we do for post traumatic stress disorder (PTSD). So I want to go to our first witness, Dr.

Guice. Could you tell us, when we look at PTSD, are those therapies covered as medically necessary?

Dr. GUICE. Those are covered as medically necessary, yes.

Senator GILLIBRAND. What is the difference between the types of therapies, because as Dr. Dawson described, she described them being administered by psychologists, by people who have specific training for these needs, very similar to PTSD.

Dr. GUICE. The difference is when we looked at providing ABA back in 2010, the evidence at that point in time convinced us it was still considered a behavioral intervention, and as such could not be covered under our statutory and regulatory requirements for determining medical care that is medically and psychologically necessary to treat a disease or an illness.

Senator GILLIBRAND. So, even as you just described it, that perfectly describes PTSD therapy, something that is behaviorally necessary that actually is an intervention that actually does help these men and women in life and death situations.

Dr. GUICE. The treatment actually treats the underlying condition of PTSD. It is designed to treat PTSD.

Senator GILLIBRAND. Exactly. That sounds exactly what behavioral therapies for ABA are. So I feel that if you did reexamine it, where the literature is today, and since studies are being published every month that show that it is scientifically and medically necessary, that it actually affects the brain and the development of the brain, I think every criteria that you have been using for all these other diseases and disorders and treatments, it will match up perfectly just from the testimony I have heard today.

My question is, how can we do this more quickly? Is there a way for us as the Senate Armed Services Committee, as we do this authorization legislation, to write something that allows you to do this immediately, and to have the resources put in place to understand the literature immediately, to be able to say this is a psychologist offering medical treatment so children can develop their brains, their behavior, their abilities properly?

Dr. GUICE. We have it separate. We have a very defined process through which we look at these potential coverage decisions, and we use that routinely and standardly. It is about getting information and assessing it according to our criteria. We will do it as expeditiously as we possibly can.

Senator GILLIBRAND. I would like to turn my attention now to Mr. Hilton. I want to thank you, sir, for your service. The men and women who serve and their families are the greatest Americans we have. They are some of our best and brightest, and certainly sacrifice more than anyone else. So I want to thank you for coming to this panel to tell us about what the lives of these families are actually like.

Can you describe to me, to the extent you know, and if Dr. Dawson or Dr. Tait can amplify this, I would be grateful. Explain what happens when a child is newly diagnosed? How do they navigate the current system? Please tell me how they navigate whether you are Active Duty or whether you are recently separated or whether you are injured and in wounded warrior status. What are the differences for each of those types of members of our military families, and what needs to be addressed for each person?

Mr. HILTON. That is a pretty big question.

Senator GILLIBRAND. Take your time.

Mr. HILTON. I will just tell you part of our experience from our daughter being in born in 2002. In 2004 to 2008, we moved five times. That was due to deployments, regular PCS. My wife was in training. During that period of time, every time you move, I would start preparing for the next move 6 months prior to. I can consider myself a pretty decent advocate for my daughter, and we only had one daughter at the time. As you are going through the normal PCS process and you are dealing with the deployment, it takes probably 6 months from getting to the next duty station for you to get all the pieces of the puzzle back in play.

Reading through some of the testimony or some of the notes from the parents, and you are talking about the retirees or the veterans or the wounded warriors particularly, I cannot even imagine frankly dealing with those situations and having a child with autism or another developmental disorder.

Senator GILLIBRAND. Because they are not eligible at all?

Mr. HILTON. Correct. If you think about that, going from something to nothing is like hitting a brick wall for these families. For that child, and again, I would really encourage everyone to read their stories. You read again and again how devastating that is for the family and the child.

Senator GILLIBRAND. Dr. Dawson, could you speak a little bit to what is the difference for a child that you are treating that they have now 11 hours covered a week. Imagine it is a child that you have actually prescribed 40 hours a week. What is the difference for that child's future to the extent you can describe it?

Dr. DAWSON. First of all, it is important to keep in mind that the National Academy of Sciences did convene a group. It has been a while now, but they convened a group to look at how many hours should be standard of care. At that point, and this was actually a number of years ago, 2001, it could have even changed now. But standard of care was a minimum of 25 hours a week for a child during the pre-school period.

Senator GILLIBRAND. That was a decade ago.

Dr. DAWSON. That was a decade ago, and the difference is really in IQ points, language ability, and adaptive behavior. So even in the last few years, there have been studies that have examined the difference in IQ, language, and adapted behavior of a child who gets fewer hours versus more, and it does make a difference.

If we want children to have the best possible outcome, then they need to have access to the number of prescribed hours. It is important to keep in mind that that can vary, and it should be looked at by each physician working with a family, as Dr. Tait has said. For some children, it is going to be 40 hours, particularly early on. Other children may only need 10 hours, and that needs to be an individual decision so that that child has the best outcome.

Senator GILLIBRAND. Thank you, Mr. Chairman.

May I submit a statement for the record that Senator Lieberman asked me to submit?

Senator WEBB. That will be entered into the record at this point. [The prepared statement of Senator Lieberman follows:]

PREPARED STATEMENT BY SENATOR JOSEPH I. LIEBERMAN

I would like to lend my strong support for expanded coverage for military families affected by autism. I am struck by the figures provided by our witnesses that show how autism has reached near-epidemic levels in our country: one out of every 88 children, including one out of every 54 boys, is affected, far beyond the rates of childhood AIDS, diabetes, and cancer combined. The Department of Defense estimates that 23,000 military dependents have an autism diagnosis, and I have heard the deeply moving personal stories of but a few of them. It is clear that this is a growing problem that we as a country have yet to address.

Studies have shown that early diagnosis and intensive therapy are the keys to effectively mitigating the effects of autism in children. Therapies informed by applied behavior analysis (ABA) can significantly help the development of life skills for those affected. The efficacy of these methods has been recognized by the U.S. Surgeon General, and 30 States recognize ABA as a medical treatment that should be covered by private insurance. Most notably, the Office of Personnel Management has concluded that ABA is a medical therapy that can be covered in Federal Employees Health Benefits programs.

Unfortunately, TRICARE is behind the curve in this critical area. Unlike the rest of the Federal workforce and a growing majority of the private sector, servicemembers, veterans, and their families continue to face restrictions on these effective autism treatments under TRICARE's Extended Health Care Option (ECHO) program, which I believe place an undue burden on our military families with autistic dependents and thereby affect overall readiness. TRICARE classifies ABA as a nonmedical educational service. Under TRICARE's current allowances for nonmedical services, members can receive limited financial help that is capped annually at \$36,000, sharply limiting the allotment of behavioral analysis hours to less than half what it recommended to make a real difference in the life of an autistic child. Furthermore, the classification of ABA as a nonmedical service limits provision of even this limited support to Active Duty members, leaving retirees and even those who have been separated due to combat wounds.

I believe that our military families should be provided with the best available care, and it is clear to me that behavioral analysis-based therapies constitute the best available means to address autism. The time to address this critical gap in TRICARE is now. I look forward to supporting legislation to address this issue when the Senate takes up the National Defense Authorization Act for Fiscal Year 2013.

Senator GILLIBRAND. Thank you, Mr. Chairman. Thank you, witnesses.

Senator WEBB. Thank you, Senator Gillibrand.

Let me make one point, if I may, just as a follow-on to Senator Gillibrand's comments about PTSD. I was committee counsel on the House Veterans Committee many years ago when we did the initial studies on PTSD. If I were to see a parallel here—first of all, let me be careful. I know there are a lot of frustrated people out here, but I do not think this is a sea lawyer syndrome. I do not think that is fair to the people who have the burden of having to make these determinations.

I think it is more that the process of trying to figure out how to take care of people is an evolutionary process. We went through this back in the late 1970s and early 1980s with respect to PTSD. I think the question is a legitimate one in terms of evaluating the methodology in order to determine whether a particular therapy is medically effective. That is what our challenge is here. I think Senator Gillibrand has given our subcommittee a great shot in the arm in terms of putting this issue in front of the subcommittee.

With that, Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you for having this hearing, and to all our witnesses for being here, and all who have been such effective advocates for families in this situation.

Dr. Dawson, I have read a lot of materials and witness testimony regarding ABA. My impression is that ABA is a widely accepted, successful set of tools that can be used in assisting people who are facing the challenges of being diagnosed with autism and other developmental disorders. You have immensely impressive background experience, as do all of our witnesses here today. I would like to ask you to describe how ABA is being used to assist in the treatment and the effectiveness of this treatment in relation to autism. If you could highlight the differences between the TRICARE coverage of ABA and the coverage in the civilian sector.

Dr. DAWSON. Let us first look at the evidence in terms of what is the impact of ABA on children's outcomes. There have been numerous clinical trials that have been conducted and published. There was a study that was funded by the National Institutes of Health. It was published in the *Journal of Pediatrics*. This is the flagship journal of the American Academy of Pediatrics, and it was published in 2010, that showed that the impact of the early intervention for 50 percent of the children, they had a 15-point IQ gain, and for 30 percent of the children, they had a 30-point IQ gain. That is to standard deviation.

So the majority of children who received this treatment actually moved from a status of intellectual disability into the normal range of cognitive functioning. We know that in terms of predicting long-term outcome, that IQ is the strongest predictor.

Also, let us think about the cost to society. The current estimates, based on an analysis that was conducted this year, are that the costs are \$137 billion annually to care for people with autism in the United States. Most of that cost is based on adult care. The average cost per individual is reduced by about half if they do not have intellectual disability.

Imagine now that we provide this early intervention. You change the life course. This individual has either less severe intellectual disability or none at all, and they have a chance now to go to a regular classroom, form friendships, have language, go on to have a job, and be productive members of society. From a cost benefit analysis, it saves taxpayers a tremendous amount of money.

In terms of TRICARE, the issues are several. One is the fact that they limit the amount of coverage to cover about 11 hours of ABA. For some children, particularly in that early period, they need more than that in order to get the kind of gains that I am talking about. The parents are not getting adequate medically prescribed treatment, what the physician would recommend.

The second has to do with the status, and this has to do with when you retire, you no longer have access to treatment. Or if you are in the National Guard, you are going to have intermittent access to treatment. So if you can imagine your child is doing well and they are in intervention, and then you change your status, and suddenly the treatment program is gone. What happens is that families will do anything. They will mortgage their home. They will give up their other children's college savings in order to get treatment because they know that these are effective. They are aware of the literature. The idea of a parent, after learning about a diagnosis and then rising to the challenge, and then finding that the treatments that we know are effective and that can make a dif-

ference for their child are not available to them, it is just not something that we should be doing. We really need to do better by these families.

Senator BLUMENTHAL. It strikes me as I listen to you Dr. Dawson, and I want to thank you for your service, this hearing room is a very colorless, antiseptic, majestic, but still very abstract setting to talk about what a parent faces in this situation. Since many of us—I have four children—are parents, if we were called in the middle of a family emergency out of the most important hearing in this room or the most important vote ever, we would all be gone in a flash.

The instinctive reaction that you have described to disregard cost and to sacrifice almost anything to mortgage homes, to, in effect, put a family's future under a severe financial cloud, is one that I think we need to understand. We as a Nation, we as a Congress, need to understand.

The hopes offered by ABA, I think, are very impressive. Maybe I can ask others who are on this panel whether they have any comments on what we have just heard.

Dr. TAIT. If I may comment for just a moment, thank you so much. I was just keying off of some of the things that have been said thus far, and I think whether you are looking at PTSD or whatever we are talking about here. We spend a lot of time not separating our head from our body. So when we are talking about health of children, that includes the behavioral health. That includes the physical health.

For a child to be healthy and learn and grow, we have to look at all of those issues, and that is exactly what parents want. They just want their kids to have the services that they need to be able to have them fulfill their potential. I know that is what you all want too.

I just wanted to comment on the navigation of families within systems. I can remember when I have talked to families, and one mother said to me, I want you to know that I spend all my day trying to navigate the payment system and nine care coordinators. I coordinate the care coordinators. They do that willingly, and day-in and day-out so that their children can receive the services that they need.

From the perspective of this hearing, what we want is to make that as successful and easy to the families as we can make it. If they have to worry about what is getting paid or what is not getting paid and not concentrate on the children and the families, then that just puts extra stress on a family that is already stressed for a number of reasons. Thank you.

Mr. HILTON. Sir, if I could offer one other thought. Looking through these 80-plus testimonies of individual military families, I realize it is not a scientific study, so you cannot rely on it exactly. But there is no one in here in this enormous population that says, "oh, we tried ABA and it did not work out." Literally in every story, they say ABA—and it has been beneficial through the ECHO program, and we are thankful, I will admit. It is an amazing program, and it has been helpful to a lot of families.

Every one of them then says, "what we are worried about is retirement," and retirement is one of the stories. It is literally a week

away for this family, and they are looking forward to retirement after multiple deployments, after many, many years. I know families that have put off retirement for a variety of reasons when they would like to, and they simply cannot.

Senator BLUMENTHAL. Thank you. Again, thank you, Mr. Chairman. My time has expired, but I am going to continue my interest. I would like to, again, thank the chairman for being very much attuned to this issue, and my colleagues, especially Senator Gillibrand, for being so active and attentive to it. Thank you.

Senator WEBB. Thank you, Senator Blumenthal. Again, let me emphasize that I do not think there is any disagreement in this room about wanting to help the people who are in need, and particularly for us at this moment, family members and people who are serving and who have served.

Our question, our burden, is evaluating the methodology in order to determine whether this therapy is medically effective. If it is, in those cases where it should be applied, there should not be any question about what we do. But that is the question that is before us.

I understand there are people who would like a second round. Senator Begich?

Senator BEGICH. No, I am good.

Senator WEBB. Okay. Senator Gillibrand, I know you want to ask questions or have other comments.

Senator GILLIBRAND. I would like to go back to the conversation about specifically what we can do to hasten the re-review process. I would like guidance to this subcommittee about how we can help you legislatively.

Dr. GUICE. I do not believe at this point that we would require additional legislation to do it. I think it is just getting the evidence and having the time to sift through it.

I would like to add, though, I think one of the witnesses said that TRICARE limits the ECHO or the payment available for ABA therapy to the \$36,000 per year. That limit is set by Congress.

Senator GILLIBRAND. We could change that. What would the limit have to be to cover the prescribed ABA therapies, Dr. Dawson or Dr. Tait?

Dr. TAIT. We have looked at some of those costs, and they run anywhere from \$30,000 to \$50,000 depending on where you are and whether you need the 40 hours versus the 20 hours. I believe that it is in that range, and that is generally what we are asking at the State level per child, of course.

Dr. DAWSON. I think that is the way to look at it. Think about it from the point of view of a physician making a prescription, and I do not think many children would go above 40 hours. One would look at the range that would cap at 40 hours a week and what that would cost, particularly during that early intensive period. Obviously, when children are entered into school and they are spending the majority of their time in school, they are not going to require 40 hours. So it would over time, that amount would be lessened. But to have that option during the early period is what is critical.

Senator GILLIBRAND. Is there a way to facilitate, both Dr. Dawson and Dr. Tait, getting the studies that you mentioned today to DOD so that you can have immediate answers on trying to prove

the case to DOD so when they do their re-review, they have those studies on hand and those peer review studies?

Dr. DAWSON. Absolutely. In fact, just to point out, since the evaluation was done, which I think was based on 2010, there have been well over a dozen studies that have been published since then. I can certainly provide that literature. Even the Agency for Healthcare Research and Quality (AHRQ) report, which I think was referred to in the testimony, is historically already out of date, and also very limited in its scope. It only looked at 10 years worth of literature, and the literature now that actually began in 1987 was the first clinical trial that was published. None of those studies were included in that particular report.

I think we really need to include the breadth of knowledge in the review that is available today.

Senator WEBB. If I may, as chairman, if there are studies that have not been provided to our staff along those lines, I think we would appreciate being able to look at them as well.

Senator GILLIBRAND. I have at least an informal commitment of this group of people to be a working group to coordinate data, coordinate studies, get it done. To the extent this subcommittee asks for a recommendation in the near future from DOD, that might be a way to formally, at least, request that this process continue as quickly as possible. We could either do that by letter or put something as an amendment into the authorization bill. I would like to work with you on how that should be requested in the way most effective to help your team apply the proper resources to do it now.

Dr. GUICE. We would appreciate that. Thank you.

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

Senator WEBB. Thank you, Senator Gillibrand. Again, I appreciate all of the testimony from a very wide breadth of knowledge and experience, and it has been extremely useful to us.

Your written testimony will be reviewed in very thorough detail as well. Thank you, Senator Gillibrand, for being the motivating factor in having this hearing. I think it has been very useful for us.

This hearing is now adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR SCOTT P. BROWN

APPLIED BEHAVIOR ANALYSIS

1. Senator BROWN. Dr. Guice and Dr. Posante, recently the Office of Personnel Management (OPM) stated there is enough evidence to classify Applied Behavior Analysis (ABA) as a medical therapy rather than an educational service. Can you please explain how the TRICARE Management Activity continues to rely upon information regarding ABA that it gathered in 2010?

Dr. GUICE and Dr. POSANTE. The TRICARE program medical benefit coverage determinations are governed by separate statutory and regulatory mandates not applicable to the insurance plans that participate in the Federal Employees Health Benefits (FEHB) Plan. Currently, the TRICARE program has no authority to provide coverage of educational services, behavior modification modalities, or other nonmedical services under the Basic Medical Program. The authority and scope of the TRICARE program to cover medical treatments under the Basic Medical Program are defined by statute.

In addition, any proposed TRICARE Basic Medical Program benefit characterized as a drug, device, medical treatment, diagnostic, or therapeutic procedure must be determined to be safe and effective in accordance with the longstanding, reliable evi-

dence criteria set forth at Title 32, Code of Federal Regulations Part 199.4(g)(15). The Department of Defense (DOD) has used this published “reliable evidence” standard for the TRICARE Basic Medical Program benefit coverage determinations since 1997 (see 62 Federal Register 625, 629, January 6, 1997). The requirement to use peer-reviewed evidence of safety and efficacy allows DOD to ensure the benefits our beneficiaries receive are tested and proven safe and effective in either the diagnosis or treatment of an injury, illness, or disease.

It should be noted that apart from the medical benefits provided under the TRICARE Basic Medical Program, DOD is authorized to provide additional non-medical services to dependents of Active Duty servicemembers eligible for and enrolled in the Extended Care Health Option¹ (ECHO) to reduce the disabling effects of a qualifying condition. This program was created to support the readiness of Active Duty members who might have a dependent with special needs not otherwise covered under the health plan ECHO supplements other public resources for Active Duty dependents that are subject to geographic relocations based on their sponsor’s duty assignment.

2. Senator BROWN. Dr. Guice and Dr. Posante, how is TRICARE Management Activity able to rely upon dated information regarding ABA?

Dr. GUICE and Dr. POSANTE. The TRICARE program medical benefit coverage determinations are governed by separate statutory and regulatory mandates not applicable to the insurance plans that participate in the FEHB Plan. Currently, the TRICARE program has no authority to provide coverage of educational services, behavior modification modalities, or other non-medical services under the Basic Medical Program. The authority and scope of the TRICARE program to cover medical treatments under the Basic Medical Program are defined by statute.

In addition, any proposed TRICARE Basic Medical Program benefit characterized as a drug, device, medical treatment, diagnostic, or therapeutic procedure must be determined to be safe and effective in accordance with the longstanding, reliable evidence criteria set forth at Title 32, Code of Federal Regulations Part 199.4(g)(15). DOD has used this published “reliable evidence” standard for the TRICARE Basic Medical Program benefit coverage determinations since 1997 (see 62 Federal Register 625, 629, January 6, 1997). The requirement to use peer-reviewed evidence of safety and efficacy allows DOD to ensure the benefits our beneficiaries receive are tested and proven safe and effective in either the diagnosis or treatment of an injury, illness, or disease.

It should be noted that apart from the medical benefits provided under the TRICARE Basic Medical Program, DOD is authorized to provide additional non-medical services to dependents of Active Duty servicemembers eligible for and enrolled in ECHO to reduce the disabling effects of a qualifying condition. This program was created to support the readiness of Active Duty members who might have a dependent with special needs not otherwise covered under the health plan ECHO supplements other public resources for Active Duty dependents that are subject to geographic relocations based on their sponsor’s duty assignment.

3. Senator BROWN. Dr. Guice and Dr. Posante, can you please explain the reasons behind why children of DOD civilians have greater access to ABA rather than children of the men and women we send off to war?

Dr. GUICE and Dr. POSANTE. For DOD civilians, OPM’s reclassification of ABA as a medical therapy rather than an educational service is an administrative decision and does not require FEHB plans to add ABA services to their basic benefits package. Rather, it allows plans to propose ABA as an additional benefit, under conditions where medical necessity is satisfied and appropriate, qualified providers are available. Those plans that include ABA may adjust their premiums accordingly.

The ECHO program for Active Duty servicemembers that allows DOD to help our beneficiaries minimize the disabling effects of Autism Spectrum Disorder (ASD). Importantly, the ECHO program exists to supplement other public resources for Active Duty dependents who are subject to geographic relocations based on their sponsor’s duty assignment. Beneficiaries are required by law to first seek services from the State in which they reside, but DOD realizes the requirements of military service are demanding and may, at times, place a family in a State with more limited State

¹ ECHO is a supplemental program to the basic TRICARE program. ECHO provides financial assistance for an integrated set of services and supplies to eligible Active Duty family members (including family members of activated National Guard or Reserve members). There is no enrollment fee for ECHO; however, family members must have an ECHO-qualifying condition, enroll in the Exceptional Family Member Program (EFMP) as provided by the sponsor’s branch of Service, and register in ECHO through ECHO case managers in each TRICARE region.

benefits. The ECHO program allows us to augment public services to assist special needs dependents of our Active Duty servicemembers.

To increase access to ABA services, DOD implemented, within ECHO, the Enhanced Access to Autism Services Demonstration in March 2008. The demonstration expands the opportunity for access to ABA through a variety of provider types, including tutors. TRICARE extended the demonstration to March 2014, pending inclusion of the demonstration model as a permanent benefit within ECHO.

- As of May 31, 2012, there were 3,793 beneficiaries enrolled in the demonstration, 1,881 ABA supervisors, and 9,201 ABA tutors across all three TRICARE regions.
- DOD's evaluation of the results of the demonstration concluded that it increased the number of and access to the services of authorized ABA providers, as evidenced by the sustained 3 to 5 percent monthly growth in the number of demonstration enrollees since implementation in 2008.
- Parents of dependent children with autism who responded to a DOD survey reported that improved access to ABA contributed to improved military family readiness and retention.
- A proposed rule to establish TRICARE coverage under ECHO of ABA for the Assistant Secretary of Defense was published in the Federal Register, Vol. 76, No. 250 on December 29, 2011. Upon final implementation of this rule, DOD intends to categorize ABA as an "Other Service" and adopt a tiered ABA services delivery and reimbursement methodology.

4. Senator BROWN. Dr. Guice and Dr. Posante, with the eventuality that ABA is considered a medical therapy, I realize there may be some challenges that will need to be worked through to make this change a reality. One is the possible shortage of qualified professionals available to provide. How do you suggest this issue be addressed?

Dr. GUICE and Dr. POSANTE. The National Defense Authorization Act for Fiscal Year 2007 directed the Secretary of Defense to develop a plan within the authority of the ECHO program to provide services to military dependent children with autism. The legislation mandated that DOD develop: (1) requirements for the education, training, and supervision of autism service providers; (2) the ability to identify the availability and distribution of those providers; and (3) procedures to ensure that such services provided by DOD supplement those available through other public sources. In response to Section 717, DOD submitted the required plan (DOD 2007) to Congress in July 2007. In addition to meeting the requirements of Section 717, the report outlined a proposed demonstration that would test the feasibility of expanding the types of providers authorized to deliver autism treatment services to include those not meeting the strict requirements of the then-current departmental regulations. However, the requirements for establishing TRICARE-authorized providers coupled with the relative newness of the Behavior Analyst Certification Board (BACB) and the ABA profession resulted in a shortage of qualified providers available to TRICARE beneficiaries with autism. To mitigate this shortfall, TRICARE has used its authority in ECHO to use non-professional "tutors" to provide ABA through the Enhanced Access to Autism Services Demonstration. The demonstration has been extended to March 14, 2014. The demonstration expands the provider model by including tutors under the supervision of a TRICARE-authorized ABA provider to deliver the hands-on therapy. The supervisor retains all of his/her other responsibilities.

To be eligible for the demonstration, the Active Duty family member must be registered in ECHO. Eligible beneficiaries can receive ABA services under ECHO but that program recognizes only ABA providers who are State-licensed or certified or are certified by the BACB. Under ECHO, those providers are responsible for developing a behavior plan, providing periodic beneficiary assessments, and delivering ABA therapy.

TRICARE continues to increase access to ABA services and is leading the Nation in fielding an effective ABA provision model that overcomes the national shortfall in available BACB credentialed providers. Regular reports to Congress demonstrate increasing participation by ABA supervisors, tutors, and TRICARE beneficiaries. Based on positive results from the demonstration (as noted in the response to Question #3), a proposed rule to establish TRICARE coverage under ECHO of ABA for Assistant Secretary of Defense was published in the Federal Register, Vol. 76, No. 250 on December 29, 2011. Upon final implementation of this rule, DOD intends to categorize ABA as an "Other Service" and adopt a tiered ABA services delivery and reimbursement methodology. However, reducing or eliminating the national shortfall of board-certified providers of ABA will require a concerted national effort

that falls outside of DOD's mission area and might best be led by other departments.

Appendix A

[The prepared statement of the National Military Family Association follows:]



Statement for the Record

of the

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

**Subcommittee on
Personnel**

of the

**UNITED STATES SENATE
ARMED SERVICES COMMITTEE**

JUNE 20, 2012

**Not for Publication
Until Released by
The Committee**

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

Association Volunteers in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteers are our "eyes and ears," bringing shared local concerns to national attention.

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

Our website is: www.MilitaryFamily.org.

Chairman Webb, Ranking Member Graham, and Distinguished Members of the Subcommittee, the National Military Family Association thanks you for the opportunity to present testimony for the record concerning the quality of life of military special needs families. After 11 years of war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate your recognition of the service and sacrifice of these families, as well as the unique challenges facing families who have a child or other family member with special needs. Your response through legislation to the increased and ever-changing need for support has resulted in programs and policies that have helped sustain these families through difficult times.

Support for Special Needs Families

Military families tell our Association the issues they face in caring for a special needs family member while simultaneously supporting the service of the military member are complex. Most often, meeting these needs requires the coordination of many distinct military and community entities, with the responsibility for that coordination too often falling to the already-burdened family. Military families caring for a special needs family member need not just medical and educational support. They also need assistance from state and local agencies, relocation help, respite, and family support, especially if they are also dealing with the deployment of their service members.

True support for these families must be designed and delivered holistically, but with the understanding that diagnoses and the severity of conditions vary from one special needs family member to another. No "one-size-fits-all" solution exists to solve the problems these families face. The military support systems guided through Department of Defense (DoD) offices, such as Health Affairs and Military Community and Family Policy, and the programs implemented by the individual Services and installations must be coordinated and flexible enough to meet the variety of needs in the military community. The military must lead an outreach to schools; other federal, state, and local government agencies; and charitable service-delivery organizations to ensure families know about and have access to the full range of support for which they are eligible.

To engage in this outreach and to support these families, and thus the service member, DoD must have the resources. We encourage you, in this time of scarce resources, to direct the Services to maintain robust Exceptional Family Member Programs and to provide enough School Liaison Officers to assist ALL families with issues they experience transitioning from school to school. While installation School Liaison Officers are available to assist all transitioning military families, special needs families especially benefit from their assistance as part of the installation support team in ensuring proper, timely placement, and delivery of educational services. Respite and family support programs provided by the Services for special needs families pay off in greater family capacity to meet the challenges of military life and deployment. Unfortunately, funding and availability for these programs has varied among the Services and among installations. We believe the support for the family and assistance with their special needs family member make these programs crucial in enabling the service member to focus on the mission.

While many issues remain for families caring for their special needs member, we are encouraged by the progress made at the installation, Service, and Department levels when adequate resources and the proper focus are provided. Your creation of the Office of Community Support for Military Families with Special Needs (OSN) in the National Defense Authorization Act for Fiscal Year 2010 (NDAA FY10) is one sign of progress. OSN's mission is to enhance and improve DoD support around the world for military families with special needs, whether medical, educational, relocation, or family support. Last year when discussing the OSN in testimony, our Association expressed concern about a lack of coordination on these issues between the various DoD program and agency stovepipes. Our Association is pleased OSN now regularly meets with the Department of Defense Office of Health Affairs to address the medical resources our special needs families require. We are also pleased the OSN has twice convened the Advisory Panel on Community Support for Military Families with Special Needs created in the NDAA FY 11 to get input from families on medical, educational, relocation, and family support resources our special needs families require.

Despite the progress, a holistic approach to supporting these families still remains the goal and not the reality for many. Case management for military beneficiaries with special needs is not consistent across the Services or the TRICARE Regions because the coordination of care for the military family is being done by a health care system whose individual elements do not always work in synergy. Beneficiaries try to obtain an appointment and then find themselves getting partial health care within the Military Treatment Facility (MTF), while other health care is referred out into the purchased care network. Thus, military families end up managing their own care. Incongruence in the case management process becomes more apparent when military family members move, not just from one TRICARE Region to another, but often even when transferring within the same TRICARE Region. This incongruence is further exacerbated when a special needs family member requires not only medical intervention, but non-medical care as well. Each TRICARE Managed Care Support Contractor (MCSC) has created different case management processes.

Families need a seamless transition and a warm hand-off between and within TRICARE Regions and a universal case management process across the Military Health System. We believe TRICARE leaders must be more engaged with their family support counterparts both through the Office of Community Support for Military Families with Special Needs and at the local level to develop a coordinated case management system that takes into account other military and community resources, as well as health care. We recommend a Government Accountability Office (GAO) report to examine the case management process for special needs families.

ECHO

The Extended Health Care Option (ECHO) program, the primary benefit enhancement for special needs military families, has been the topic of a great deal of debate among military families and by Congress. Congress created the ECHO program to allow active duty families with special needs to receive additional services to offset their lack of eligibility for state or federally provided services due to frequent moves. We assert that this focus on supporting currently-serving families is appropriate and should remain the priority for DoD. We suggest that, before making any more

adjustments to the ECHO program or to other benefits, Congress should request a GAO report to determine if the ECHO program has been effective in addressing the needs of the population it was intended to serve in the way it was intended. The report should also address ECHO coordination with other benefits, both the regular TRICARE benefit and state and local resources.

Special needs families come in all demographics and diagnoses. It is important to note that the TRICARE ECHO program provides services for all types of diagnoses. A military spouse eligible for ECHO can be diagnosed with multiple sclerosis, an adolescent with psychosis, or a child with Down's Syndrome. Recent focus on TRICARE ECHO has been on supporting military children diagnosed with autism spectrum disorder. However, family members with other diagnoses are also enrolled in the ECHO program and benefit from its services. As the conversation on changing ECHO or TRICARE benefits continues, we ask Congress to recognize that special needs family members enrolled in ECHO with diagnoses other than autism spectrum are also benefiting from Applied Behavior Analysis (ABA) therapy. These diagnoses include, but are not limited to, Down's Syndrome, Mental Retardation, Angelman Syndrome, Cerebral Palsy, developmental delays, and Fragile X.

Under the ECHO benefit, the TRICARE Management Activity established an Autism Demonstration, known to beneficiaries as the "Demo." The Demo provides beneficiaries with an autism spectrum diagnosis the ability to purchase more ABA therapy through the use of tutors. ECHO-enrollees who cannot qualify for the demo based on diagnosis, but who would benefit from ABA, cannot use the tutors and thus their benefit would not cover as many hours. Our Association recommends any changes made to the TRICARE ECHO benefit or related demonstration programs need to incorporate the needs of ALL diagnoses among program-eligible family members.

We also hear from our ECHO-eligible families that they could benefit from additional programs and health care services to address their special needs. We request a DoD pilot study to identify what additional services, if any, our special needs families need to improve their quality of life, such as cooling vests, cranial helmets, diapers, or nutritional supplements. We recommend families in the pilot have access to \$3,000 annually above what is provided by ECHO to purchase self-selected items, programs, and/or services not already covered by ECHO. DoD would be required to authorize each type of purchase to verify the requested item, program, or service is appropriate. This pilot study could identify gaps in coverage and provide DoD and Congress with a list of possible extra ECHO benefits for special needs families.

The Reserve Component (RC) has unique challenges with their special needs family members. They only qualify for ECHO when they are on active duty status. The population is relatively small, but our Association is concerned with the coordination of care and seamless transition of services as the special needs family member becomes eligible to receive ECHO benefits and then loses them when the member is deactivated. We request that Congress direct GAO to examine ECHO benefits during the activation and deactivation cycle, and the impact on the RC family and the special needs family member.

Transitions

We applaud the attention Congress and DoD have given to our special needs family members in recent years and the desire to create robust health care, educational, and family support services for special needs family members. However, these robust services do not follow the family members when the service member retires from the military. When ECHO was created as an active duty support program, its creators believed families in retirement would be able to access similar services through other federal, state, or community programs.

We know the transition to retirement can be difficult for many families, however, because of the immediate loss of ECHO benefits upon retirement. Both TRICARE and civilian insurers face growing pressure to incorporate coverage of services currently available for military families only through ECHO into their basic benefit package, even though only certain special needs family members may benefit. As you review possible TRICARE changes, we ask you to ensure that benefits changes balance the needs of all members of our community

We remain concerned about the transition of wounded, injured, or ill service members and their families from active duty status to that of medically-retired, especially when the family includes a special needs family member. We support DoD's proposal to exempt medically-retired service members, survivors of active duty service members, and their families from the TRICARE Prime enrollment fee increases. However, we believe wounded, ill, or injured service members need even more assistance in their transition. We continue to recommend that a legislative change be made to create a three-year transition period in which medically-retired service members and their families would be treated as active duty family members in terms of TRICARE fees, benefits, and MTF access. This transition period would mirror that currently offered to surviving spouses and would allow the medically-retired time to adjust to their new status without having to adjust to a different level of TRICARE support, increased costs, and the immediate loss of ECHO benefits for their special needs family member.

Our Association has always recommended that special needs families be allowed to pick their last duty station, preferably in the state where they will reside after they retire from the military. This additional time would give them a head start on establishing themselves in their communities, enrolling in state Medicaid Waiver programs, and receiving local services. As our military downsizes, the preparation for transition and establishing eligibility for needed services before entering civilian status could become more difficult. We recommend the Services allow special needs families enrolled in EFMP the opportunity to choose their final duty station before retirement. Because such a move is not always possible, we recommend legislation be passed to extend ECHO eligibility for one year after retirement for enrolled family members to provide more time for families to transition to state and local services or employer-sponsored insurance.

We also encourage you to use your Congressional bully pulpit to stimulate more awareness in the states about the needs of military families. We believe one of the most critical issues at the state level for our special needs families is the availability of and military family eligibility for Medicaid waivers. The Office of Community Support is studying Medicaid availability for special needs military family members. Our Association is anxiously awaiting this study's findings. We will

be especially interested in the types of value-added services individual State Medicaid waivers offer their enrollees and whether state budget difficulties are making it harder for military families to qualify for and participate in waiver programs. This information will provide yet another avenue to identify additional services ECHO may include in order to help address our families' frequent moves and their corresponding inability to qualify for these additional value-added benefits in a timely manner.

We have also asked the DoD State Liaison Office to consider exploring ways to stimulate state discussions on how to provide portability for military family members' enrollment in Medicaid waivers. Too often, military families arrive in at a new duty station, put their special needs family member on a waiting list for a waiver, and finally start receiving services under the waiver not long before it is time for another military move to a different state, where they must start the process to obtain a waiver all over again. We know achieving portability may be difficult because each waiver program has its own set of eligibility requirements, services determined, and funding provided by the states, but believe it is important to raise awareness about the issue and stimulate discussions at the state level.

Recommendations

To meet the needs of all our special needs military families, we need a coordinated approach to both service-delivery and information gathering. We encourage Congress and DoD to seek more information from a variety of sources:

- military families representing the full range of diagnoses and conditions
- DoD service providers in the Service and Installation Exceptional Family Member Programs
- civilian and military health care providers and case managers, including those working for the TRICARE contractors
- educators in DoD and civilian school districts
- state and local agencies, such as Medicaid
- representatives of the national disability organizations

Only with the right information can DoD apply correct solutions to meet the needs of these families. Our Association believes the Medicaid waiver report, a GAO report on the ECHO program, along with our recommended pilot study will provide DoD and Congress with necessary information to determine if the ECHO program needs to be modified in order to provide the right level of extra coverage for our special needs families. We also recommend a report examining the impact of wartime deployments on special needs military families.

In conclusion, we ask Congress to:

- *Ensure any changes made to the ECHO benefit incorporate the needs of families with ALL diagnoses.*
- *Direct DoD to expand the Autism Demo 's coverage of Applied Behavioral Analysis therapy to all eligible ECHO-enrolled beneficiaries when therapy is deemed necessary by their physicians.*

- *Create a DoD pilot study to identify what additional service(s) special needs families need to improve their quality of life.*
- *Allow medically-retired service members and their families to maintain the active duty family TRICARE benefit for a transition period of three years following the date of medical retirement, comparable to the benefit for surviving spouses.*
- *Allow already-enrolled family members in ECHO to remain eligible for one year following the service member's retirement from the military.*
- *Require GAO reports*
 - *to evaluate DoD's existing case management programs and program coordination for special needs family members*
 - *to evaluate how well ECHO coordinates with other benefits: with the regular TRICARE benefit and those offered by other federal, state, and local government agencies and community resources.*
 - *to examine the impact of almost 11 years of war on our special needs families.*
 - *to examine the impact of ECHO benefits during the activation and deactivation cycle on the RC family and the special needs family member and if the program has been effective in addressing the needs of this population.*
- *Direct the Services to maintain robust Exceptional Family Member Programs*

Military Families – Our Nation's Families

Bringing the troops home does not end our military's mission or the necessity to support military families, especially their children, dealing with the long-term effects of more than a decade at war. Downsizing and budget cuts will present new challenges. The government should ensure military families have the tools to remain ready. Effective support for military families with special needs must involve a broad network of government agencies, community groups, businesses, and concerned citizens. Our Nation must continue to fund what works to support military families, protect the most vulnerable, and, above all, value their service.

Appendix B

[The prepared statement of the National Council on Disability follows:]



National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their Families.

Statement for the Record For the

Senate Armed Services Committee, Subcommittee on Personnel June 20, 2012 Hearing on Department of Defense Programs and Policies to Support Military Families with Special Needs

In 2009, the U.S. Marine Corps (USMC) requested that the National Council on Disability (NCD) conduct a study to systematically examine the challenges experienced by Marine Corps Families with disabilities and to identify steps toward ameliorating these challenges. The objectives for the study included: 1) documenting the experiences of USMC Families that have dependents with disabilities in accessing appropriate and effective services in health care, special education and related services, and long-term supports and services; 2) identifying barriers impeding access to appropriate resources and services; and 3) developing recommendations to improve access. While some of the recommendations that were made are directed specifically to the Marine Corps, many more recommendations would require action by other entities such as Congress, Department of Defense (DoD), Tricare, the Department of Education, and individual states, but in the end would benefit military Families in all branches of the military. The complete report is available online at <http://www.ncd.gov/publications/2011/Nov282011>.

The USMC's chief instrument for addressing the needs of USMC Family members with disabilities is the USMC Exceptional Family Member Program (EFMP). EFMP was established by the Marine Corps in 1990. The EFMP provides assignment coordination and Family support.

Focus groups, as well as interviews of caretakers, Family members with disabilities, and service providers were conducted between January 2010 and March 2010 at Marine Corps Base Quantico, Camp Lejeune, and Camp Pendleton—three large USMC bases to which many EFMP Families are assigned.

Findings

EFMs and their Families described a number of barriers that span the domains of healthcare, education, and long-term supports and services. Caretakers stated that navigating the service systems and obtaining and maintaining disability-related services require relentless hard work. For some—particularly young

parents, Families with more than one EFM, parents who are themselves EFMs, and Families with a deployed sponsor—it is an overwhelming prospect. Despite having health insurance, some Families experience substantial unreimbursed costs if not financial hardship, and the demands of caring for the Family member with a disability can make it impossible for the caretaker to work outside the home. EFMP Families who live off base, which describes the majority, are apt to be less Familiar with base services, and to be ineligible to use them.

Access to Health Care

Many Families who were more successful than others at navigating the complex health care service and reimbursement systems attributed their success, in large part, to the assistance of case managers through EFMP, Tricare, and ECHO. Most Families, however, reported not having been assigned a case manager, not being able to access their case manager, or not knowing whether they were eligible for case manager services. Certain individual healthcare providers were described as exemplary in assisting Families to navigate the health care system.

Participants consistently said there is a dearth of nearby specialists (especially in behavioral health), requiring them to routinely travel long distances to obtain specialty care. Some Families also described cumbersome Tricare processes and a protracted system for obtaining healthcare referrals, which are particularly burdensome for those that rely heavily on the healthcare system. Many lamented the limitations of Tricare coverage—particularly Tricare coverage of Applied Behavior Analysis (ABA) therapy, offered under the Tricare Extended Care Health Option (ECHO), which falls well short of the recommended standard of care.

Access to Special Education

USMC students frequently attend public schools, because bases with Department of Defense Education Activity (DoDEA) schools are the exception rather than the rule. Parents described DoDEA schools as well-resourced and praised DoDEA's inclusive model for students with disabilities. Similarly positive remarks were made about EDIS (Early Development Intervention Services), a base program that feeds into the DoDEA system. Participants also mentioned valuable national-level civilian resources for advocacy and advocacy training within the educational environment—most notably Specialized Training of Military Parents (STOMP) and Task.Mil. Despite these resources, EFMP Families encounter a number of obstacles to special education-related services. With great regularity, parents described feeling that they must fight schools to secure disability-related resources for their children – a lengthy process that may not be resolved before a Family has another permanent change of station (PCS). Several parents and providers observed that schools and other educational facilities (including on- and off-base) are not fully accessible to students with disabilities.

Access to Long-Term Supports and Services

Relatively few of the focus group participants had experience in this arena. For the most part, unlike healthcare and education, the military is not involved in the delivery of long-term supports and services, and USMC EFMs who need such resources must look to the civilian sector. The greatest barrier to long-term services raised by the study participants is the absence of Medicaid portability when USMC Families PCS from state to state. It was also noted that adult EFMs currently lack access to services such as transportation for medical appointments and personal care attendants. Many Families do not live on the same base long enough to qualify for Medicaid waivers, which provide these services for families that meet state residency and other requirements.

Permanent Change of Station and Access to Disability-Related Services

The requirement to move, or PCS, regularly, often to destinations not of one's choosing, is a constant in military life that entails logistical, emotional, and financial stressors. The focus group results reinforce that PCS challenges can be significantly more arduous for Families with EFMs, especially if the Families are young and/or the EFM's disability is severe. Every time a Family PCSes, they must re-educate themselves about the resources available to them and the process for accessing them. They must also reassemble their EFM's continuum of care—i.e., request, coordinate, and potentially fight for the services their EFM needs. Families often PCS without knowing exactly where they will be living (e.g., on-base/off-base, school district) which significantly hinders their ability to plan in advance and can result in substantial delays in services. On arrival, there may be a wait for housing (on-base or off-base), necessitating a difficult if not costly stay in temporary lodging. A number of resources can potentially facilitate the PCS move. The EFMP assignment policy, for example, is intended to ensure that Families are assigned to locations where their EFMs' needs can be met. However, in practice, this often is not the case. Priority on-base housing is a significant resource for PCSing EFMP Families. Some Families were concerned that the current elimination of the EFMP category system, which grades level of need based on disability severity, may jeopardize continued access to priority housing. Families and providers also described EFMP caseworkers as PCS resources, at least for Families who are familiar with EFMP services and have an EFMP caseworker. Caretakers mentioned additional resources for all PCSing Families, e.g., Family Readiness Officers (FROs), Military OneSource, the PCS planning tool on the Military Homefront website, and the Interstate Compact on Educational Opportunity for Military Children.

Permanent Change of Station and Access to Healthcare

The cycle of interrupting and re-establishing healthcare is part and parcel of the PCS experience. The more severe and involved the Family member's condition,

the more challenging the process of re-establishing the continuum of care. Many Families noted that the process of finding new providers is time-consuming and prolongs the lag in healthcare services. The new location may fall under a different Tricare region, necessitating burdensome re-enrollment. EFMs lose momentum and ground in progress toward their treatment goals. There can be problems accessing healthcare, including prescriptions, while in transit and before meeting with the new Primary Care Manager (PCM). Although the obstacles to healthcare during PCS are substantial, there are resources to help Families deal with them. Notwithstanding limitations in community awareness, EFMP is available to help coordinate the healthcare transition. Various medical and non-medical case managers, including EFMP caseworkers, can help Families with the healthcare transition, although it is not clear which, if any, is specifically assigned this responsibility. Some individual physicians go out of their way to suggest or talk with specialists at the new location, although a “warm handoff” from doctor to doctor is not the norm. Military OneSource and Tricare websites offer listings of healthcare providers by geographic area, although it was noted that the Tricare lists are not always accurate or easy to navigate.

Permanent Change of Station and Access to Special Education

Many PCSing Families are dealing with the public schools, rather than DoDEA schools, on one or both ends of the PCS. The primary difficulty that parents encounter is inconsistency across states and installations in education policies and resources, which often leads to a lack of continuity and gaps in the special education services offered to their child. The perception of degradation in services, real or otherwise, causes parents great frustration, which both educators and parents said contributes to an adversarial dynamic between parents and the schools. Participants noted that a number of base resources are in place to facilitate EFMs’ educational transition. EFMP and the School Liaison (SL) office are two prime examples; however, many suggested that both are under-utilized by PCSing EFMP Families due to a lack of awareness of the PCS-related services these programs offer. It also should be noted that EFMP and SL staff couldn’t provide Families specific school support until the Families can tell them where they will be living—information that frequently is unavailable before the Family’s departure. Educational and Developmental Intervention Services (EDIS) was touted as another reliable base resource for facilitating the educational transition of early-intervention clients. Although the participants acknowledged that the public schools, and public school/DoDEA Directors of Special Education, have the potential to play meaningful roles in the educational transition of military students with disabilities, it does not appear that there are systems in place to support this.

Permanent Change of Station and Access to Long-Term Supports and Services

EFMs must start anew each time they move, learning the services and policies of the new jurisdiction and complying with often complex application procedures. State to state differences in services and eligibility criteria create the risk of privation for PCSing EFMs—i.e., gaps in services—and potentially expose the Family to financial hardship. The lack of Medicaid waiver portability, specifically, is a significant obstacle to obtaining and keeping long-term supports and services for PCSing EFMs, because there are long waiting lists for the waivers and the EFM's name starts at the bottom of the wait-list each time the Family moves to a new state. Study participants identified no resources that facilitate access to long-term supports and services during PCS; they did, however, call out the absence of a mechanism to help individuals retain Medicaid benefits. Additionally, although the current study did not target EFMs of retirees, it was evident that some currently serving EFMP Families are concerned about continuity of care for their EFM upon retirement, e.g., how access to services will be affected by the loss of ECHO.

EFMP and Other Base Programs

The USMC relies on the EFMP as the primary USMC resource for Families with special needs. Participants almost unanimously recognized that EFMP is a program in transition that has grown significantly in the past few years and is continuing to increase its capacity to serve EFMs and their Families. Many Families and providers affiliated with other base and off-base programs praised the work EFMP is doing, and described a number of EFMP providers as exceptional. EFMs, caretakers, and providers also identified areas for improvement within EFMP.

EFMP Program Entry

Several factors potentially interfere with entry of eligible Families into the program. There continues to be a lack of awareness among potential enrollees about EFMP, as mentioned earlier, as well as misinformation regarding who is eligible to enroll and what the benefits of enrollment are. A lingering stigma associated with EFMP, and its impact on a Marine's career, may affect a Family's willingness to enroll. Finally, providers—including physicians—do not consistently refer appropriate candidates to EFMP, which needlessly delays some Families' enrollment and timely receipt of invaluable services (e.g., respite care, services covered by ECHO).

EFMP Communications

Communication among base-level EFMP proponents about PCSing Families apparently is inconsistent, and sometimes EFMP offices are unaware of incoming Families. Shortfalls in communication between local programs and enrollees also were identified, with many Families saying they do not receive the information from the local EFMP office that they should. Many Families voiced

frustration that the EFMP office frequently sends communications only to the Marine, rather than directly to the spouse, who typically is the primary caretaker of the EFM or the EFM herself (or himself).

EFMP Service Delivery

Providers and enrollees identified opportunities for improvement related to quality of service delivery. A large number of enrollees said they were not receiving outreach contact from EFMP. Many participants, including providers, indicated there are too few caseworkers to meet enrollees' needs; some suggested that there are existing EFMP caseworkers who lack the requisite knowledge and background. Additionally, some enrollees characterized EFMP as an assignment program and an information and referral operation, and suggested that EFMP should offer a broader scope of services.

EFMP Assignment Process

Families expressed skepticism about the capability of assignment monitors to make appropriate assignment decisions on behalf of Marines and their EFMs. There also was considerable discussion about how enrollment impacts assignment options, deployability, and advancement. As noted previously, there seems to be lingering concern within the USMC community regarding a potential adverse impact of EFMP enrollment on the Marine's career advancement.

Other Base Resources

A number of base entities other than EFMP play an important role in supporting the needs of EFMP Families. Providers and enrollees frequently lauded the EFMP respite care program, often describing it as the greatest benefit of EFMP enrollment. Caretakers and providers also mentioned EDIS and the New Parent Support program as other good sources of base-level support for EFMP Families. Caretakers expressed concern about the disability-accessibility of base housing, describing it as "adaptable" rather than "accessible"; many indicated the quarters to which their Family was assigned did not adequately accommodate their EFM's disability. In several instances, participants also identified accessibility problems with public spaces on base. Lastly, a number of participants suggested that Families are not sufficiently aware of the base resources available to them.

It should be noted that significant improvements were made to the EFM program during the time this study was being conducted. However, the need for EFMP services still far exceeds program capacity, and many Families remain unaware of program improvements.

NATIONAL COUNCIL ON DISABILITY STUDY RECOMMENDATIONS

Based on the study findings, and drawing upon decades worth of experience working with people with disabilities, NCD formulated recommendations for improving USMC EFM access to disability-related services. Many of these recommendations echo or build upon suggestions made by the study participants. Chapter IV of the report contains a comprehensive list of recommendations, followed by the entity or entities to which each recommendation is targeted (e.g., Congress, DoD, Department of Navy, USMC, Tricare, EFMP). The complete list of recommendations is presented in Appendix H according to which entity or entities each recommendation is directed.

For purposes of this summary statement, ten recommendations, five short-term and five long-term, are being called out for immediate attention, as having the potential to have the greatest impact on Families with members with disabilities.

Short-Term Recommendations

1. Conduct an accessibility review of human service programs and facilities, including base housing, on USMC bases. Develop plans for each base to make programs and facilities accessible, i.e., ADA compliant, if they are not already. Execute plans as appropriate. (USMC)
2. Increase the accuracy and timeliness of information EFMP Families receive from Tricare by assigning Tricare case managers to a larger proportion of the EFMP population and/or establishing a dedicated Tricare telephone hotline (staffed 24/7) for EFMP Families, similar to the Medicare hotline. (Tricare)
3. Disseminate to Local Education Agencies (LEAs) detailed guidance for implementing initiatives included in the Interstate Compact on Educational Opportunity for Military Children. (Interstate Commission, Federal and State DoEs, LEAs, DoDEA)
4. Educate the military and civilian community about EFMP (i.e., base and unit leadership, military and civilian healthcare providers, relevant base and community agencies/providers, including LEAs, and members of the USMC community at large) by designing and implementing a robust, ongoing, multi-faceted public relations (PR) campaign to educate stakeholders and the USMC community as a whole to:
 - a. Raise their awareness of today's EFMP and sensitivity to EFM issues
 - b. Publicize the specific benefits of enrollment
 - c. Mitigate myths, concerns about stigma, and resulting resistance to enrollment
 - d. Increase the capacity of the entire community (i.e., military leaders, military and civilian healthcare providers, base and community agencies, LEAs, USMC community members) to inform USMC Families about EFMP and to be a supportive presence in the lives of USMC Families with members with disabilities.

- e. Promote the Medical Home concept, particularly within the military and civilian healthcare communities.
(EFMP, USMC, Department of Navy, Tricare)
- 5. Ensure EFMP offices systematically gather, maintain, and update contact information from caretaker/EFM spouses and consistently direct all communications—whether by email, telephone, or US mail—to them.
(EFMP)

Long Term Recommendations

- 1. Address the implications of retirement for continued access to disability-related services, including considering the extension of ECHO coverage.
(DoD, Tricare)
- 2. For EFMs who are prescribed ABA therapy, continue to work toward full coverage, consistent with the recommended standard of care and healthcare reform. (Congress, Department of Defense, Tricare). (Tricare)
- 3. Minimize the gaps in healthcare services related to PCS:
 - a. Adjust Tricare procedures to provide EFMs referrals for routine specialty care without needing to be seen by their new Primary Care Manager. (Tricare)
 - b. Facilitate transfer of medical records between bases and between off-base and on-base providers by digitizing EFM medical records.
(EFMP)
 - c. With the help of a Medical Home, establish a mechanism to ensure EFM Families have sufficient prescription medications while in transit between installations. (Tricare, EFMP)
 - d. For recipients of ABA therapy, provide linkage to ABA therapist trainees in the vicinity of the gaining installation (who must complete volunteer hours for their ABA certification) until a longer-term solution can be implemented. (EFMP, Tricare, local health care providers, certifying authorities such as colleges and universities)
- 4. Implement mechanisms to enable military EFMs to maintain Medicaid waiver services when they move from state to state, rather than requiring them to go to the bottom of the waitlists each time they PCS:
 - a. Place incoming EFMs on the new state's waitlist based on their position on the previous state's waitlist (i.e., based on "time served"). If individuals have a Medicaid waiver in the previous state, they should automatically receive one in the new state. (Congress and state agencies)
 - b. For EFMs who lose Medicaid waiver services as a result of a PCS, provide the same benefits the EFM received in the previous state until eligibility can be established in the new state. (Congress and state agencies, DoD, Tricare)
- 5. Increase the flexibility of services covered by ECHO to closely mirror the services available through a Medicaid waiver. (Congress, DoD, Tricare)

NCD appreciates the opportunity to provide this Statement for the Record, and would welcome the opportunity to work collaboratively with others to facilitate implementation of the report recommendations and improve supports and services for military Families with disabilities.

[Whereupon, at 3:55 p.m., the subcommittee adjourned.]

