

WRITTEN TESTIMONY

**PETER J. DUFFY
DEPUTY DIRECTOR, LEGISLATION
NATIONAL GUARD ASSOCIATION OF THE UNITED STATES**

**BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES MILITARY PERSONNEL
SUBCOMMITTEE OF THE HOUSE ARMED SERVICES COMMITTEE
24 February 2009**

Chairwoman Davis, Ranking Member Wilson, and Members of the Committee:

Thank you for the opportunity to present testimony on behalf of the National Guard Association of the United States to address critical personnel issues facing members of the National Guard and their families. It will provide factual background, analysis and corrective recommendations for the Committee to consider.

The Unique Citizen Service Member

The National Guard is unique among components of the Department of Defense in that it has a dual state and federal mission. While serving in a Title 10 active duty status such as Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF), National Guard units are under the command and control of the President. Upon release from active duty, members of the National Guard return to all parts of their home states under the command and control of their governors where they train, not only for their federal missions, but for their state missions such as fire fighting, flood response and providing assistance to civil authorities in a variety of possible security and disaster scenarios.

While serving in their states, members are scattered geographically with their families as they hold jobs, own businesses, pursue academic programs and participate actively in their civilian communities.

Military service in the National Guard is uniquely "community based". The culture of the National Guard remains little understood outside of its own circles. When the Department of Defense testifies before Congress to present its programmatic needs, it will likely recognize the indispensable role of the National Guard as a vital "Operational Force" in the Global War on Terror (GWOT) but it will say little about the benefit disparities, training challenges and unmet medical readiness issues that exist for National Guard members and their families at home. These conditions exist before, during and after deployment. The National Guard Association of the United States asks this Subcommittee to recognize that the personnel issues of the National Guard are different from those of the active forces, and in some cases radically so. We ask that they be given a fresh look with the best interests of the National Guard members and their families in mind in reviewing the recommendations set forth below.

Support for Individual Medical Readiness Needs

According to *The Task Force on the Future of Military Health Care*, "Today's Operational Tempo raises the importance of all responsible parties doing their part to ensure the Individual Medical Readiness (IMR) requirements are satisfied to facilitate maximum deployability of our forces."

The Department of Defense (DoD) requires all members of the National Guard to be medically ready as a condition for deployment. IMR must address the medical and dental needs of those members deploying for the first time as well as those subject to redeployment whose health care needs arising from prior service in OIF and OEF have become a significant problem. Using the National Guard as an operational force in the Global War on Terror will require more accessible health care for members and their families pre and post deployment in order to maintain the necessary medical readiness required by deployment cycles. It cannot be a simple post deployment send off by the active military of "Good job. See you in three years."

DoD has found dental deficiencies throughout the entire reserve component to be the cause of a significant amount of lost duty time. Seventy percent of dental emergencies in the National Guard were preventable by examination and treatment prior to mobilization. The Department of Defense must expand the pre-deployment period during which it provides active duty-equivalent medical and dental care to our members from 90 days to one year beginning with the alert notice. This would allow needed time for proper screening and treatment of potentially disqualifying dental, physical and behavioral conditions during the compressed alert periods.

In addition to an expanded medical and dental care during the alert period, the Department of Defense must do more to bring the National Guard to a constant state of medical readiness to better support the short notice deployments that occur regularly within the National Guard. For example, the Air National Guard must maintain constant dental and medical readiness because of the short notices they receive for deployments, which sometimes can be as little as 72 hours. Short notice deployments also occur regularly with cross leveled members who, with as little as two or three weeks notice, must fill in for members from other deploying units who for various reasons become disqualified for deployment. Members in the pool of Individual Mobilization Augmentees (IMAs) can also be assigned to fill positions in deploying units on short notice without the benefit of the pre-mobilization medical/dental preparations.

This constant state of medical and dental readiness could be better maintained if mandatory annual screenings were given to all members, including IMA members, followed by government treatment to correct any medical or dental readiness deficiencies discovered at the screenings. This would allow for a more medically and dentally ready deployable force and would help to limit the time diverted for medical and dental treatment during the training-intensive alert periods.

Recommendation:

The National Guard Association of the United States recommends that the National Guard Bureau, the Department of Defense, and the Congress of the United States support authorization and appropriations for programs that will:

- Amend 10 USC 1074(d)(B) to provide all members of the National Guard one year prior to deployment with coverage under TRICARE Prime that will include all medical and dental procedures necessary to bring the member into compliance for deployment
- Provide all members with an Annual Dental Examination (ADE) and medical screenings at no cost to the member and amend 10 USC 1074 a(f)(1) to mandate the Department of Defense to provide treatment needed to correct any deficiencies discovered in the screenings.

Post Deployment Health Assessments and Mandatory Medical Screenings at the Home Station

It is imperative post-deployment, that our members while still on active duty deployment orders, be examined confidentially at the home station by qualified health care providers in order to address the under reporting of physical and mental health conditions that occurs on the self administered Post Deployment Health Assessment(PDHA). The PDHA is currently being completed by a homeward-bound member at a demobilization site often several states away from home.

When the PDHA is completed, it is accompanied by the “instruction” that the self assessing member may be “medically held” on active duty at the demobilization site if he or she reports a medical condition requiring that action. To avoid the risk of being held at the demobilization site after a long deployment, members are simply not fully reporting their physical and behavioral injuries. This under-reporting not only delays treatment but can prejudice later claims with the VA for service connected disabilities arising from conditions not previously reported on the PDHA.

What is needed forthwith is a free and confidential reporting of physical and mental health conditions at the home station by all members, stigma free, to a health care provider trained to elicit that information and to screen for those conditions without the fear of being medically held far from home. If medically holding the member is advisable, it should be done as close to home as possible.

The irony in the current PDHA under-reporting phenomenon is that a medical hold is usually in the best interest of the member and his or her family as it allows pay and benefits to continue during treatment for a condition that may well render the member unemployable once discharged. The medical hold should not cynically be administered as a threat to discourage reporting of injuries when, if properly administered in a friendly environment, it offers substantial benefits to the members and his or her family.

Insurance companies, in performing their due diligence before the issuance of an insurance policy do not allow an applicant's self assessment of health to be the only determinant. Neither should the military. If geographical separation from families is causing under reporting and non-reporting of physical and psychological combat injuries on the PDHA, then moving this process to the home station would likely produce a better yield at a critical time when this information needs to be captured in order for prompt and effective treatment to be administered. If necessary and appropriate, the examining health care provider in coordination with the National Guard J-1 and State's Surgeon General can cause the member to be retained on active duty locally for further treatment and evaluation.

This is especially critical in screening for behavioral conditions. It is absolutely imperative that members returning from deployment be screened with full confidentiality at the home station while still on active duty by trained and qualified mental health care providers from VA staff and/or qualified health care providers from the civilian community that could include primary care physicians, physician assistants and nurse practitioners who have training in assessing psychological health presentations. Prompt diagnosis and treatment will help to mitigate the lasting effects of mental illness.

Please see the copy of a November 5, 2008 electronic message to NGAUS from Dr. Dana Headapohl (a practicing occupational physician in Missoula, MT) set forth in the Appendix which strongly recommends a surveillance program for our members before they are released from active duty. Dr. Headapohl opines the obvious in stating that **"...inadequate medical screening of our members before they are released from active duty is "unacceptable to a group that has been asked to sacrifice for our country." (emphasis added)**

Recommendation:

The National Guard Association of the United States recommends that Congress support authorization and appropriations for programs that will:

- Require the Post Deployment Health Assessment for National guard members to be administered at the home station before releasing members from active duty
- Mandate medical and behavioral screening of all National Guard members returning from deployment by health care professionals at the home station before releasing the members from active duty.

Community Based Mental Health Care for Members and Their Families

Our Nation faces a serious challenge as our troops return from deployment and war. These soldiers and airmen often return to strained relationships, broken homes, depression, and even Post-Traumatic Stress Disorder (PTSD). The response these individuals and their families receive should ensure that they have the support they need to live productive and successful lives as well as prepare for future deployments.

In many states, Veterans Administration (VA) facilities are available to readily support the Active component population concentrated within relatively small geographic areas. However, many National Guard OIF and OEF veterans in rural areas do not have ready access to VA facilities and assistance. Obtaining continuing treatment at a VA facility for these veterans means traveling significant distances. This travel may require the veteran, and possibly an accompanying family member, to take time off from work further straining employer/employee relationships already stressed by previous deployments. All service members require and deserve ready access to mental health care providers to address the psychological effects of combat such as PTSD, suicidal thoughts, and other inappropriate behavior regardless of their physical location, home of record or service component.

For those members subject to redeployment who require behavioral readjustment or treatment for post traumatic stress disorder and are willing to seek the same, eliminating time and distance factors will only expedite and ease the transition from non recognition to treatment. Physicians say that the sooner these behavioral conditions can be recognized and treated, the more successful and mitigating the treatment will be. Whether through purchased care by DoD or the Department of Veterans' Affairs (VA), the National Guard and their families need to have access to all available behavioral health care resources in communities throughout the country in order to meet the surge in mental health care needs of care our National Guard members and their families.

Consistent with the Rand Corporation recommendation in its study, *The Invisible Wounds of War*, a network of local, state and federal resources, centered at the community level, must be available to proactively engage veterans and their family members in caring for mental health needs in a confidential and convenient manner that does not require long distance travel or delayed appointments.

The need for adequate community based behavioral health care for our members and their families is urgent. The Journal of American Medical Association (JAMA) reported on November 15, 2007 that Post Deployment Health Reassessment (PDHRA) screenings performed through May 2007 indicated that 42.4 % of all Reserve Component veterans of OIF required mental health treatment, nearly double the mental health needs of active component veterans of OIF. Because many of our National Guard veterans remain in the National Guard subject to future deployment, treating them and their families is essential in sustaining IMR for future deployments. However, treatment for the mental health needs of our National Guard members and their families seems to have fallen through a huge crack in the defense health programs.

Although the VA is expanding mental health care programs, accessibility gaps still exist in providing effective community mental health treatment for our National Guard member/veterans who are subject to re-deployment. This remains a medical readiness issue for those subject to redeployment which DoD needs to address. **According to the National Guard Bureau, this past year, DoD Health Affairs did not spend any of the \$600 million dollars, appropriated for mental health care funds, on National Guard members once they were released from active duty.** This must change.

The National Guard has recently established in each state a Director of Psychological Health to coordinate the delivery of needed behavioral health for our members and their families. The Department of Defense needs to fill this gap by funding treatment for our members and their families with qualified community of mental health care providers in coordination with the National Guard Director of Psychological Health. This will enhance the delivery of behavioral health care to our members in the communities where they live. Medical readiness demands nothing less.

Recommendation:

The National Guard Association of the United States recommends that Congress support authorization and appropriations for programs that will require the Department of Defense to coordinate with the National Guard Director of Psychological Health to provide treatment for National Guard members and their families post-deployment with qualified community based health care providers.

Extend TAMP Coverage with TRICARE Prime Remote

Post deployment care for members under the Transitional Assistance Management Program (TAMP) and their families must be for a period equal to the period of deployment but not less than six months. The TAMP program allows members to obtain at government expense up to six months of TRICARE coverage that is similar, but not identical, to the TRICARE Prime coverage they had been receiving on active duty.

Effective TAMP coverage is a medical readiness issue for the overwhelming majority of our returning members who are subject to redeployment and must maintain their medical and dental readiness. Unfortunately, many are slipping through the cracks post deployment with undiagnosed medical conditions, particularly behavioral conditions, which may not be reported by the returning members when they self assess their medical condition on the Post Deployment Health Assessment (PDHA) administered at the demobilization site. Unreported conditions cannot be treated. As these conditions become known over time, a reasonable period is needed for proper treatment. The current six month TAMP period is proving to be inadequate either because of other demands on the returning members' time or the late disclosure of a service connected injury or condition.

The coverage available under TAMP does not include access to the provider network under TRICARE Prime Remote, the rural active duty coverage available to family beneficiaries while the military sponsor is deployed. This breaks provider continuity for rural beneficiaries switching to TAMP post deployment who had been treating under the TRICARE Prime Remote program while the military sponsor was deployed. This requires many of our rural families who had been using TRICARE Prime Remote during the deployment to search for a new provider and hopefully find one. The TAMP program should be adjusted to expand its provider network and to specifically allow rural beneficiaries to have access to the same TRICARE Prime Remote providers they had been using.

Recommendation:

It is the recommendation of the National Guard Association of the United States that the Congress of the United States support funding and authority for:

- Extending post deployment TAMP coverage for a period equal to the period of deployment but not less than six months.
- To include access to the TRICARE Prime Remote provider network as part of the TAMP coverage benefit.
- To expand the TRICARE provider network.

Equitably Reduce the Age for Members of the Reserve Components to Collect Retirement Pay

Having transitioned to an operational force, the National Guard of the United States is experiencing a critical loss of senior leadership who are increasingly retiring after 20 years of good service.

More than sixty years ago, the Congress of the United States established the age limit for receipt of retired pay by Reserve component members. That law, with the exceptions provided by the mobilization based credits in the recent amendment in the 2008 National Defense Authorization Act, states that a retired Reserve component member can begin to draw military retired pay upon reaching 60 years of age regardless of number of years served. A National Guard member who enlists after high school at age 18 and retires after 30 years of service at age 48 must wait twelve years before drawing a retirement check.

In contrast, an active component member who enlists at the same age and serves 20 years on active duty can receive retirement pay immediately upon retirement at age 38. Reducing the eligibility age for Reserve component members to draw retirement benefits based upon extended service would not only be a big step in mitigating this disparity but it would serve to stanch the outflow of senior leadership that many units post deployment are experiencing. Retaining the seasoned leadership of officer and enlisted members provides cost offsets by lowering reliance on the “replacement” person.

An amendment to the current law that would both address the inequity of the present system and encourage longer service would be a formula to base eligibility for receipt of retired pay on years of service with the age to draw retirement pay reduced one year for every two years of service beyond twenty years. If an individual were to serve for 22 years, that individual would be eligible for retirement benefits at age 59, and so on.

Recommendation:

The National Guard Association of the United States recommends that the Congress of the United States support legislation to reduce the age at which a retired member of the Reserve component can receive military retirement pay by one year for every two years served after twenty good years of service.

Raise the Ceiling for National Guard Non Dual Status Technicians in the National Guard Full-Time Force

Today's National Guard is changing in response to our nation's call as it engages in military operations around the world. As our country calls on the Guard to serve alongside its active duty counterparts, it must retool the existing technician and full-time manning program to sustain a high level of readiness. Operational tempo has placed considerable strain on Guard resources. The National Guard's long-term ability to effectively support the overseas troop requirements for the Global War on Terror is at risk unless its troops are given the necessary full-time tools to effectively execute all National Guard missions.

The full time manning programs is staffed primarily by dual status technicians who maintain the dual status of being civilian federal employees and military members of the National Guard. Dual technicians staff critical positions in Finance and Personnel usually in state headquarters for support of deployments throughout the state. When they themselves are deployed, it creates gaps which leave other deploying units without their full time support in these critical areas.

Backing up the technician component to maintain a continuity of support services with a cadre of personnel who cannot be deployed are the "non dual status" technicians who have no military membership, hence the term "non dual status". Non dual status personnel currently comprise 1.5 % of the full time manning force. They bring to the table the necessary skills to staff critical support areas uninterrupted by the possibility of deployments. Non dual status positions are often filled by retired or separated dual status technicians with a lifetime of invaluable experience.

In an August 2,199 report entitled "A Plan for Full Utilization of Military Technicians (Dual Status)", DoD acknowledged the bona fide need for non dual status technicians because of the possibility that potential mobilization of the dual status technicians could prevent state headquarters from performing their mission. That distant possibility anticipated by DoD in 1999 is now a real possibility today with the frequent deployment of dual status technicians. If our states are to maintain unit readiness in the current operational tempo environment, the National Guard needs to expand the number of non dual status technicians as soon as possible. This increase will enhance unit readiness and facilitate better pre-mobilization training.

Recommendation:

The National Guard Association of the United States recommends that Congress raise the statutory ceiling of National Guard non dual status support technicians to 5% of the total full-time force.

Gray Area TRICARE Coverage

Gray Area Retirees are those retired members of the reserve components under the age of 60 who retired with 20 good years of military service who qualify for retirement pay and full TRICARE coverage at 60 but who remain in a "gray area" without these benefits until then.

H.R. 270 sponsored by Congressman Robert E. Latta (R-OH) would authorize our Gray Area retirees to purchase TRICARE Standard at DoD's cost for providing that coverage. It would operate with a de minimus effect on the budget. Under this bill, the monthly cost for individual and family plans would be \$169.68 and \$903.57 respectively which reflects a straight pass through of the full cost that DoD would be paying for the coverage.

Authorizing Gray Area retirees to purchase this coverage would allow those about to retire to maintain continuity of coverage in a cost affordable way. It would also provide an affordable alternative to health insurance in a tough economy for a deserving population of military retirees and their families.

Recommendation:

The National Guard Association of the United States recommends that the Congress of the United States pass H.R. 270 that would authorize Gray Area reserve component retirees to purchase TRICARE Standard at government cost.

In conclusion, we at NGAUS hope that we have both reinforced and amplified this Subcommittee's understanding of the unique personnel needs of the National Guard. Thank you again for the opportunity to address this Committee and for all that you do for our nation's service members.

APPENDIX

Colonel Duffy - I am sending links to articles about the importance of providing medical surveillance examinations for workers in jobs with specific hazardous exposures. I believe this approach could be modified to evaluate National Guard members returning from Iraq and Afghanistan for PTSD, TBIs and depression.

The OSHA medical surveillance model includes the following basic elements:

1. Identification of potential hazardous exposures (chemical, physical, biologic).
2. Screening workers for appropriateness of placement into a specific work environment with such exposures. For example, individuals with compromised liver functions should not be placed in environments with unprotected exposures to hepatotoxins.
3. Monitoring workers after unprotected exposure incidents. Examples- monitoring pulmonary function in a worker exposed to a chlorine gas spill, or following hepatitis and HIV markers in a nurse after a needle stick injury.
4. Conducting exit examinations at the end of an assignment with hazardous exposures, to ensure that workers have not suffered adverse health effects from those exposures. (including concussive explosions or other traumatic events).

Surveillance exams of all types (OSHA mandated surveillance programs, population health screening for chronic disease risk factors) have been a part of my practice of Occupational and Preventive Medicine in Montana for the past 22 years. Early diagnosis and treatment is especially essential for potential medical problems facing military members serving in Iraq and Afghanistan - post traumatic stress disorder (PTSD), traumatic brain injury (TBI) and depression. Timely diagnosis and aggressive treatment is essential especially for these problems, to maximize treatment success and functioning and to mitigate suffering.

There are a number of organizations that design and implement medical surveillance programs. There is no reason the same approach could not be applied to the specific exposures and potential medical problems facing National Guard troops in Iraq and Afghanistan. With proper program design and local provider training, this program would not need to be costly. In my clinical experience, male patients especially are more likely to report symptoms of PTSD, TBI, or depression in the context of an examination rather than questionnaire. Findings can present subtly, but if untreated can have devastating effects on the individual, family and work place.

In my practice, I have seen a number of Vietnam veterans, and more recently National Guard members who have returned from deployment in Iraq or Afghanistan, who have been inadequately screened and/or are suffering unnecessarily because of geographical barriers to adequate treatment. This is unacceptable treatment of group that has been asked to sacrifice for our country. They deserve better.

I applaud your organization's efforts to lobby for better post deployment screening and treatment of the National Guard members returning from Iraq and Afghanistan.

Dana Headapohl MD

<http://www.aafp.org/afp/20000501/2785.html>

https://www.desc.dia.mil/DCM/Files/OSRHealth%20Medical%20Exam_1.pdf This is about military surveillance exams.

<http://www.lohp.org/graphics/pdf/hw24cn06.pdf>

<http://www.cdc.gov/niosh/sbw/management/wald.html>

http://www.ushealthworks.com/Page.aspx?Name=Services_MedSur