



OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, D.C. 20301-4000



PERSONNEL AND  
READINESS

FEB 20 2004

The Honorable Duncan Hunter  
Chairman  
Committee on Armed Services  
United States House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

The National Defense Authorization Act for Fiscal Year 2002 (Public Law 107-107, sec 546) directed that the Department of Defense conduct a review of the health and disability benefits for pre-accession training and education programs. The enclosed report is provided in response to that request.

The report reviews the health and disability programs available to recruits and officer programs engaged in training, education, and other types of programs while not yet on active duty. Specifically, it emphasizes the health and disability benefit programs available to cadets and midshipmen at the Service Academies.

I trust that the enclosed report is responsive to the request of the House Committee on Armed Services and will prove useful in your consideration of Defense personnel programs. A similar letter has been sent to the Chairman and Ranking Member of the Senate Committee on Armed Services.

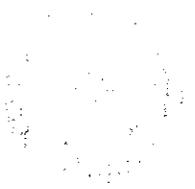
Sincerely,

  
Charles S. Abell  
Principal Deputy

Enclosure:  
As stated

cc:  
The Honorable Ike Skelton  
Ranking Member





HOUSE COMMITTEE ON

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# **FINAL REPORT**

## **DISPARATE TREATMENT OF DISABILITY DURING ACCESSION TRAINING**

**PREPARED FOR**

**DIRECTOR, ACCESSION POLICY**

**OFFICE OF THE UNDER SECRETARY OF DEFENSE  
(PERSONNEL & READINESS)**

**12 DECEMBER 2003**

Prepared By Thomas Cuthbert  
Brigadier General  
U.S. Army (Retired)



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## EXECUTIVE SUMMARY

This report, prepared in response to a Congressional requirement established in the Department of Defense Authorization Act for 2002, addresses the health and disability programs available to recruits and officer candidates engaged in training, education and other types of programs while not yet on active duty. The report also reviews the health and disability programs available to the cadets and midshipmen attending the Service Academies.

With respect to the Service Academies, the report concludes that programs for long term disability, conducted under the aegis of the Department of Veterans Affairs, provide an appropriate level of compensation and benefits. However, with respect to health benefits, cadets and midshipmen who are separated for medical disability, face unnecessary and unfair burdens in maintaining continuity of health care. This denial of health care for service incurred illness, injury and disease comes at a time when these discharged cadets and midshipmen may be facing imminent critical health care needs. The report proposes a legislative solution which would include cadets and midshipmen in the military disability discharge and retirement system. The cadets and midshipmen would receive no additional monetary compensation from this proposal because Department of Veterans Affairs compensation exceeds the level of monetary compensation the cadets and midshipmen could receive from the Department of Defense. Current law, commonly described as "concurrent receipt," limits monetary compensation in a manner that prevents dual benefits. Accordingly, the only real cost of this proposal would be the increased cost of medical care, estimated to be \$4.6 million over a 10 year period.

With respect to participants in the Senior ROTC programs of the Services, the report concludes that the programs for long term disability, conducted by the Department of Veterans Affairs, also provide an appropriate level of

compensation and benefits. With respect to health benefits for Senior ROTC participants who incur illness, disease and injury as a result of their military training, there is a separate and unique deficiency in their compensation. These ROTC participants presently are not being adequately compensated for their medical expenses when training injuries, illness or disease causes them to be temporarily disabled prior to returning to full duty. Congress charged the Department of Labor with the responsibility to pay the expenses for the treatment of these medical problems. However, the program, operating under the Federal Employees Compensation Act, is unresponsive to the requirements of the ROTC community. Medical care providers, many of whom have not been compensated for their prior work, decline to treat ROTC patients unless they use private medical insurance. Cadets and midshipmen are harassed by debt collectors for unpaid medical bills that clearly are the responsibility of the Federal Government. The reputation of the ROTC has been severely damaged on campuses throughout the country. Senior ROTC leaders of the Department of Defense unanimously support a revision of this program that would transfer medical claims responsibility to the Department of Defense. A legislative proposal would authorize the use of supplemental health care program funds to support a program that would be centrally controlled and operated by the TRICARE Management Agency. No additional benefits would be added for the Senior ROTC participants, but the proposal would result in these participants being fairly compensated for illness, injury or disease they incur in the line of duty.

The report also considers the predicament of personnel who are in the Delayed Entry Programs of the Services awaiting orders to active duty. These individuals also incur injuries, illness and disease, but none of these medical maladies is incurred as a result of military training or military duty. Accordingly, personnel in the Delayed Entry Program receive no disability or health benefits. This result leaves Delayed Entry Program personnel in the same position as an active member of the National Guard or the Reserve, but that is little solace to the

Delayed Entry Program participant. The report proposes a comprehensive review of the Delayed Entry Program, as health care is only one of the problems that have surfaced due to the long term expansion of the Delayed Entry Program. The report also suggests inclusion of Delayed Entry Participants among the beneficiaries of any legislation that might expand health care benefits for the members of the National Guard and the Reserve.

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## 1.0 INTRODUCTION

The genesis of this report occurred in the weeks and months prior to September 2001. During that period a few leading Congressional officials had become concerned about a persistent history of seriously disabled cadets and midshipmen at the Service Academies. These cadets and midshipmen were discharged from the Armed Forces without any entitlement to future medical care or disability benefits. In each of these cases the cadets and midshipmen had been injured in the line of duty. In some cases they had graduated and been commissioned as officers, but they were discharged without benefits because an old academy injury had resurfaced and led to a finding of medical unfitness. In a few of the cases the cadets or midshipmen had been subjected to serious financial hardships in addition to the permanent disabilities they received. Their military careers had been ended. Their prospects for civilian careers, education and financial success were greatly diminished. These former cadets and midshipmen uniformly believed that they had been misled, or worse. They were recruited as being among the best and brightest of their generation, and they had signed an unlimited liability contract with their Government. In their view, they were irreparably injured and cast aside.

Within the Reserve Officer Training Corps (ROTC) a related problem had also received some notoriety. Problems concerning permanent disability had been addressed successfully by Congress over the years; the problems perceived as extant at the Service Academies did not exist within ROTC. However, within all the

Services, there were repeated instances of ROTC cadets being required to pay for their own medical care after being injured during military training conducted under the auspices of the ROTC program. It was not clear how this problem had arisen after years of successful care through a combination of military medical care and civilian medical care when authorized by the appropriate military authority. Moreover, there was a program operated by the Office of Workers Compensation within the Department of Labor that was authorized and funded to pay for the civilian medical care for ROTC cadets who were injured as a result of their military training. Why wasn't this program responsive to the needs of the ROTC community?

Several individual legislative proposals surfaced to solve these problems, but there was no consensus within Congress or in the Executive Branch that these individual hardship cases required legislative action. Within the Department of Defense, the Military Departments were not in agreement that these were real problems requiring action. Understandably, key Congressional staff members and their principals were reluctant to support solutions to problems that were neither well defined nor understood. The fact that some exceptional young Americans and their parents were complaining vigorously to their elected officials was clear. Establishing the precise cause for these complaints and an equally precise resolution of them was perceived by all interested parties as essential. However, as the time frame—September 2001—implies, there were events of far more significance to the National Defense that were about to occur. With the tragic events of 11 September 2001,

concerns about a few cases of individual hardship quickly turned to the broad range of issues arising from the terrorist attacks of that date.

Congress, however, did not ignore these cases of individual hardship. But rather than seek an independent and immediate Congressional solution to the problems presented, the legislature required, in Section 546 of the Department of Defense Authorization Act for 2002, the Secretary of Defense to review the health and disability benefit programs available to recruits, officer candidates, and cadets and midshipmen at the service academies. The results of this review were to be reported to Congress the following year.

The reporting requirement included more than just a legal and factual analysis of the problems involved. Interviews with the affected parties intended to receive benefits, and legislative solutions, if appropriate, were also required. In addition, the Congress required the report to include a discussion of the benefits provided by the Department of Labor and the Department of Veterans Affairs in conjunction with benefits provided by the Department of Defense.

What follows, then, is a detailed explanation and a discussion of the problems highlighted above.

The solutions I propose do not require the establishment of novel or experimental programs. Instead, the solutions take advantage of existing programs designed to care for ill or injured members of the Armed Forces. None of these solutions is particularly expensive because the number of individuals affected is small. In some of the cases, better coordination of remedies between Governmental agencies would do much to alleviate the complaints. I will propose that coordination, but neither the concerned reader nor I should be naïve enough to believe that these major Governmental agencies will establish new coordinating apparatus to solve the problems of a small number of cadets and midshipmen. In addition, I propose the restoration of the program used by the Military Departments for many years to pay for medical care for injured ROTC cadets. In my view, there is existing legal authority for this program. Although I am aware that there is not unanimity within the legal community of Department of Defense on this subject, I believe that the basic authority authorizing treatment of these injuries in military medical treatment facilities also permits the expenditure of funds for follow-up care in civilian treatment facilities. Regardless of how this issue of basic authority is resolved, it would be prudent to explain to the Congress precisely what and how much of the medical funds involved were being expended for the care of ROTC cadets injured in the line of duty. Here again, the numbers are small--budget dust--to use the expression that I heard on several occasions as I described these issues to experienced DOD budget professionals.

Before embarking on a detailed discussion of these topics, a few remarks about the historical context of the medical disability program of the Department of Defense are necessary. In the aftermath of World War II, Congress undertook a major revision of military medical disability. The basic disability provisions of the new law, The Career Compensation Act of 1949, are unchanged today. Occasionally forgotten, however, is the political environment surrounding military service in the 1940s. The Nation had just concluded a great war in which nearly all who were capable of serving in the Armed Forces had done so. Universal Military Training was more than just a slogan. All able bodied men had an obligation to serve. Some were fortunate enough to begin that service at a Service Academy or in college ROTC, but all had an obligation to serve. That was a far different time than the environment today when military service is seen as a civic virtue but not a civic obligation. It follows that the rights and benefits established at a time of universal military service may not be the right mix of rights and benefits for the volunteers who serve when all citizens are not required to serve. As the discussion turns to the details below, it is important to keep in mind that solutions to disability problems that were correct for the draft-based Armed Forces of 1949 may not be appropriate for the volunteer Armed Forces of the 21<sup>st</sup> Century.

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## **2.0 SERVICE ACADEMY ISSUES**

### **2.1 History**

When career military professionals, including legal professionals, first confront the issue of cadet disability, they suspect that an arcane legal opinion has distorted the intent of Congress in the application of military disability law. But the law is clear. The exclusion is neither a mistake nor a lawyer's artifice. Section 1217, Title 10, United States Code, unequivocally excludes cadets and midshipmen of the academies from any coverage under the basic military disability law. How could this small, occasionally pampered but never ignored, segment of the Regular Armed Forces be excluded from the provisions of such a fundamental disability and compensation reform law? As is the case in most legal mysteries, the answer lies more in history than in logic.

Until the enactment of the Career Compensation Act of 1949, disability retirement was a perquisite of commissioned officer service. The most significant reform of disability provisions of this legislation was the inclusion of enlisted personnel within the group eligible for benefits. Prior to 1949, cadets and midshipmen, as well as the enlisted personnel force of the Armed Forces, were denied disability benefits. There is no record of cadet disability being seriously considered until the review of pay and benefits that led to the Career Compensation Act of 1949. At that time, however, it is clear that Congress established the policy that exists today. During the hearings

on H. R. 5007, which became the Career Compensation Act of 1949 (63 Stat. 802), the following colloquy occurred before the Senate Armed Services Committee.

"Senator Baldwin. On page 63, in the provisions of the law as written here, with reference to retirement for disability, does service at the Coast Guard Academy, Annapolis, and West Point—is that included in the period of service?

"Admiral Fechteler. Now.....

"The Chairman. Suppose a man is disabled while he is at the Naval Academy or the Coast Guard Academy or at West Point; suppose he breaks his leg in such a fashion that he cannot walk well any more, and you gentlemen decide that he is unfit? What happens to him if he is in one of the three academies?

"Admiral Fechteler. He is just discharged.

"The Chairman. Does he get any severance pay?

"Admiral Fechteler. No, Sir.

"The Chairman. He is just out of luck?

"Admiral Fechteler. That is right.

"The Chairman. Through no fault of his own, while actively engaged in the curriculum prescribed for these men?

"Admiral Fechteler. He still gets nothing.

"Senator Baldwin. I would hate to see a good back for the Navy going around an Army end for a touchdown, break his leg and come to such an end.

"Senator Chapman. That is the present law?

"Admiral Fechteler. That would continue under this.

"The Chairman. That is an interesting observation, nevertheless.

"Senator Baldwin. What does the committee think about that?

"The Chairman. I would be inclined to think that while we would exclude it, service in these different academies, exclude that service from the right to claim it for

more pay, nevertheless there is a pretty good ground for an exception to that general rule if the man is incapacitated for life. If a mast drops on his leg, hits him on the arm and renders him in some manner incapacitated for life, while he is doing his duty, it seems to me to draw the line a little tight, not to give him some consideration in a case of that kind, particularly when you have a 5-year period when you are going to reexamine him again to see whether, being young, he will grow out of it.

"Senator Baldwin. Suppose a boy is injured in an airplane flight while in the service, while on a training cruise?

"The Chairman. Or in the Chemical Warfare Service before he is graduated, suppose some bombs accidentally explode near where he is standing at Aberdeen Proving Grounds, and they blow up while he is being instructed, and he is seriously injured, it seems to me he ought to have some consideration. "Frankly, I think it would be a very exceptional case but nevertheless we have taken this man down there; he is really on active service, you might say, like a draftee; it is part of his training and he is rendered permanently disabled, we will assume in this hypothetical case, and is told that he cannot serve in the Army or Navy or Air Force but must go out and nothing comes to him.

"Admiral Fechteler. May I suggest that we get together with General Mudge and examine these things?

"The Chairman. I think here is another place where, as Senator Baldwin and Senator Chapman suggest, the matter ought to be pretty carefully worked out to see whether or not we have done an injustice.

"Senator Chapman. And that also to cover the Coast Guard.

"The Chairman. Everybody covered in the bill.

"Senator Baldwin. As a matter of fact, isn't that training at the academies much more rigorous and vigorous than it used to be in the old days, when you have injected into this thing such things as airplanes.....

"The Chairman. And submarine duty.

"Senator Baldwin. Yes; and service with the artillery, in handling munitions and explosives, and all that sort of business? Don't these boys get a better and more active training than in the old days?

"Admiral Fechteler. I believe they do sir. Insofar as airplane flights are concerned, they are covered by free Government insurance which is also applicable to aviation cadets, but that is just in that particular category.

"The Chairman. I think we can leave this with the understanding that you gentlemen and the staff will scan this and give us your best thought on it.

"Admiral Fechteler. All right, sir."

Following the quoted discussion, the Committee moved on to other matters and never returned to the Service Academy disability proposal. The law, as proposed by Admiral Fechteler, was enacted. The relevant provisions have not been revised since 1949.

## **2.2 Recent Cases**

Since enactment of the 1949 law, cases raising its implementation have surfaced infrequently within the legal establishments of the Armed Forces. Individual hardships distributed widely throughout the United States never reached the critical mass necessary to become a major legislative issue. Service Judge Advocate General files contain more than a few challenges to the "no disability coverage rule," but relief was uniformly denied. Challenges in the federal courts met similar result as claims were denied under the Feres doctrine. See, for example, Collins v. United States 642 F. 2d 217 (7<sup>th</sup> Cir. 1981). A significant reason that these denials of benefits did not gain more notoriety was that the benefit system administered by the Department of Veterans Affairs provided support, even though the Department of Defense did not. Even more importantly, the total number of cases each year was

small, and the cadets and midshipmen involved appear to be more interested in focusing on their future prospects than what they perceived as past injustices.

The quiet calm that surrounded this issue disappeared in the years of 2000 and 2001. One case, involving an officer who graduated from West Point in December of 1998, brought the draconian provisions of the law in question to the attention of many. In the course of my research I learned of worse cases, but none were as poignant. A few facts about the case will make the reasons for this notoriety more obvious.

James H enlisted in the Army on his 17<sup>th</sup> birthday. He attended basic training at Fort Leonard Wood, Missouri, and then returned home to finish high school while he served in his local Reserve unit. During that year he was selected competitively to attend the US Military Academy Preparatory School and did so. After graduating from the Prep School he entered West Point as a member of the Class of 1998 and completed his first three years of education and training without incident. During the summer after his junior year he attended a rigorous but routine course of training back at Fort Leonard Wood, Missouri. His own words, in a letter to the President, describe his injury and the following events well. The letter is long, but it is worth reading in its entirety.

*Dear Mr. President:*

*Three years ago during the summer of 1997 I attended the US Army Sapper Leader Course for combat demolition training. It was the summer between my junior and senior years at the US Military Academy. While I was training at Fort Leonard Wood, Missouri I suffered from a condition called hyponatremia (a heat stress injury). I had a seizure and went into a coma. For thirty-six hours I stayed in the coma while my body deteriorated. When I awoke I weighed less than 150 pounds. At 6'4" I was frail and decrepit.*

*After suffering hyponatremia my body released what is called anti-diuretic hormone vasopressin (ADH). This release began to slowly eat away at my muscle tissue, my liver and my kidneys. This explains my rapid weight loss. I spent two weeks in intensive care. During which time I did not have the strength to shower, shave or eat by myself.*

*I was told that I would never return to the academy. After serving six years in the army I would lose my career. I was also told I would never again lead a normal life. I refused to believe it. At the time, I had very little long-term memory and no short-term memory. I slurred my speech and stuttered. I could not walk more than 15 feet outdoors without collapsing. Yet I would not give up.*

*I was sent home on six months convalescent leave. I stayed with my sister and struggled every day to deal with my condition. I suffered extreme depression. I suffered severe weight loss and had very little strength. Initially, I could not lift more than 15 pounds. But I persisted. After six months I had regained my strength and size. Emotionally, I was stronger too, though I still stuttered and slurred with temporary bouts of memory loss.*

*I was ordered to Walter Reed Medical Center where I was evaluated by a team of army doctors, including a neurologist. It was determined that I could return to West Point with no restrictions. I was able to complete my courses and graduated six months after my class had. Again, I was evaluated by a team of army doctors. It was determined that I could enter into active, commissioned service as a combat arms officer with no restrictions.*

*I received my commission in the Field Artillery with orders to the 82<sup>nd</sup> Airborne Division. I was ecstatic. Before I could report there though I had to attend Field Artillery Officer's Basic Course at Fort Sill, Oklahoma. It was there that I began to experience more seizures. While on a strenuous*

*field problem I collapsed from the heat. Over the course of the next six weeks I was sent to the emergency room eight times—each time being returned to service.*

*Finally, after several months of testing I was sent to see a civilian neurologist. Immediately, I was diagnosed with a seizure disorder. What was supposed to have been a one-time incident, an unfortunate accident, had now become a permanent condition.*

*I now take 400mg of Dilantin a day. This is an anti-convulsant reserved for the most persistent cases. The medication takes care of the seizures, yet it has its own side-effects which are themselves incredibly tough to deal with—drowsiness, insomnia, migraine headaches, irritable, etc.*

*On August 24<sup>th</sup>, I was medically discharged from the U.S. Army. After 8 1/2 years of continuous active service I was now a civilian. Yet my problems had only begun.*

*I enlisted on my 17<sup>th</sup> birthday. Since that day I have spent every day of my life in uniform. I was selected to attend West Point in order to receive my commission as an officer. As a Cadet I was considered active duty military. I carried the green, active duty ID card, and was subject to the Uniform Code of Military Justice. If I had committed a crime I would have been punished as a soldier.*

*Yet, now I come to find out that my permanent condition all reflects upon my time as a cadet. There is an army regulation (sic) (Section 1217, Title 10, United States Code) that "excludes of service academies from eligibility for disability." Although I was a commissioned officer when I was discharged, my case refers back to my initial injury. Therefore, I am not eligible for disability. The army can not grant me severance. I was active duty as a cadet yet I am not eligible for disability from an injury I received while training.*

*Still, the wound goes deeper.*

*As I was signing my discharge paper work I was informed by the finance officer that I was now indebted to the United States government. As I was told, "When you agreed to attend the U.S. Military Academy you signed an agreement to serve a five year commitment. Because you did not complete this commitment you now owe the remainder of your debt for the education you received." I am told I now owe upwards of \$200,000 to the government in order to repay my education.*

*In fact, my entire last paycheck was garnished in order to payback that part of the debt. I was not informed that this would occur, and so \$2,000 worth of checks bounced.*

*I joined the U.S. Army because of what it stood for. It preaches the "Seven Army Values" of Loyalty, Duty, Respect, Selfless service, Honor, Integrity and Personal Courage (LDRSHIP). I gave everything to the army—almost including my life. I lived by those standards. Yet now it seems as though the military is turning its back on me. After my discharge, I wrote a letter to my Commanding General. I requested the opportunity to speak with him personally, at his convenience. I did not receive a response. I feel as though I gave what I had to offer and now I am of no more value to the U.S. Army.*

*I was not the first cadet to be seriously and permanently injured. I guarantee I will not be the last. It has been six years since I reported to West Point. As Cadets, we are encouraged, even required to attend many various training schools throughout the summers—schools such as airborne, air assault, Sapper, and combat diver. Yet, no one has ever mentioned to the cadets or the faculty what happens to a cadet who is seriously injured.*

***I am writing this letter in the hopes that you will help me in this matter. I ask to be forgiven of this debt. Yet, more importantly I ask that you help me overturn this regulation. There will be others who become seriously injured. What will become of them? I know that the young men and women who enter in the academies do so because of a strong personal conviction and a willingness to serve. I would hate to see just one more individual treated the way I have been. (Emphasis added)***

*Respectfully,*

*Mr. H*

Things got worse for Mr. H before they got better. Although he applied for benefits from the Department of Veterans Affairs immediately after his discharge, he had to wait twenty months before his application was granted. While he was waiting he was destitute. He was virtually unemployable because of his disability, and he had

no means to obtain medical care. He lived with friends, and supported himself by doing odd jobs and increasing his indebtedness. As an act of desperation, he explained his predicament and advertised his West Point Class Ring for sale on EBAY.

Mr. H received over one thousand responses. Most offered sympathy; many offered assistance; a few offered criticism. His life began to turn around, and, when the Department of Veterans Affairs granted his claim, he was able to get useful employment assistance in addition to the 40% disability grant. At about the same time, the fiscal officers of the Department of Defense admitted their error in collecting for a debt that was not owed. (Persons medically disqualified from further military service are not obligated to reimburse educational costs absent evidence of fraud, concealment, gross negligence, intentional misconduct or misrepresentation.) The garnished pay was returned to Mr. H, although he received no interest or assistance in dealing with creditors.

Mr. H remains concerned about this issue, and it is my estimate that he will continue to approach the Government at every level to change the law. At one point, with a bit of stealth and the magic of electronic communication, he arranged an unauthorized presentation of his story to the entire Corps of Cadets. This effort caused real consternation at the academy, but as he explained the situation to me,

“no one should have to go through what I have been through, particularly someone who made a commitment to a lifetime of service to his country.”

Not all the disabled cadets or midshipmen I interviewed relayed such a positive final result. The complaints tended to focus on the draconian aspects of the law, but several affected individuals raised concerns about the lack of individualized treatment for their predicaments. I will relate several of these cases in the paragraphs that follow, but it is my conclusion that the command, medical and legal structures at the academies generally do as well as could be expected given the constraints of time, money and mission under which they operate. As one officer stated to me, “Our mission is to make soldiers out of civilians. Every time one of these young folks is discharged without graduating, this institution and I have failed.” These same officers are uniform in their dismay over the current state of the law. They do not understand why Congress would choose to treat cadets and midshipmen differently from every other member of the Regular Armed Forces.

Less well known than Mr. H's case is that of Mr. G who entered a service academy in the summer of 1998. He was raised in a rural mountain state and attended public schools prior to attending the academy. He was an “honors student” who lettered in Basketball, Track and Cross Country and was the Captain of two of those teams. He was also a state scholar-athlete in all three sports. He was a Boy Scout, an avid outdoorsman, the American Legion Boys State Representative from his school, and

a U.S. Marine Corps Distinguished Athlete for his home state. His volunteer activities were too numerous for me to relate in this report. In short, he was precisely the type of young American that the service academies seek to recruit.

Mr. G completed plebe summer without incident and entered the academic year full of enthusiasm. On 1 September 1998, in a mandatory boxing class, he received a concussion that left him hospitalized for a day and a half. The record of what occurred after the hospitalization is not entirely clear. There is no question that what began as a routine plebe year quickly deteriorated into a potentially life threatening series of events. During the next month and a half Mr. G had three seizures that were treated by military medical officials. According to Mr. G's father, Mr. G was not treated properly for these seizures, and his "voluntary resignation" occurred only after Mr. G expressed extreme depression and disorientation from the closed head injury that resulted from the boxing injury. Mr. G's father, a retired Lieutenant Colonel, asked academy officials to ensure the Mr. G was given all the medical and physical treatment necessary to ensure his recovery prior to his release from active duty, but the academy declined to provide additional care and swiftly accepted the "voluntary resignation" tendered by Mr. G.

After extensive private treatment paid for by his parents, Mr. G sought relief from the Department of Veterans Affairs. Fourteen months later, Mr. G received a rating of 50% for service connected "cognitive disorder with depression post concussional

disorder." He is attending a small private college that specializes in individual assistance to students with special needs. He will receive job placement assistance from the Department of Veterans Affairs. In his parents' eyes, he is clearly not the same young man they sent off the Armed Forces nearly five years ago. They are apprehensive about his future. They are also dismayed by the treatment that their son received from Lieutenant Colonel G's Service and their Government.

Ms A, formerly Second Lieutenant A, provides an additional element of insight into the cadet and midshipman disability equation. Ms. A initially reported to West Point in the summer of 1996. She was diagnosed as having a hairline fracture of a bone in her arm at that time and was given a one year delay as the completion of plebe summer with a broken arm was not acceptable to the academy. Upon her return she established an excellent record of physical and academic achievement. She participated on the sky diving team and received high marks for military aptitude. She was graduated and commissioned with the Class of 2001 because the proper medical authorities had concluded that the injuries described below were not permanent and that she could serve her commitment after a short period of rehabilitation.

Regrettably, she was not so fortunate. In a document she prepared for a Physical Evaluation Board at Walter Reed Army Medical Center, she described her injuries as follows.

**My injury originated during Air Assault training at Camp Smith, NY on approximately 18 June 1999. I first felt pain in my left knee, thigh and hip during a road march and was unable to complete the route. After being examined by a medic who assured me it was simply a pulled muscle, I continued and attempted to complete the last week of Air Assault School. However, the rough terrain of the 12 mile road march proved too difficult for my injury and the course instructors ordered me to stop after 8 miles of pounding on my injured leg. If not for the injury, I would have finished the course as the distinguished honor graduate. Instead I watched my classmates receive their wings as I iced my leg under a nearby tree. An orthopedic physician immediately evaluated me later that day, but all MRI and X-Rays proved negative. I was diagnosed with a pulled muscle, and later cleared to return to regular physical activity including returning to my duties on the West Point Parachute Team. However, excruciating pain continued to drive me back to a physician for more answers. A bone scan in the fall of '99 finally showed a stress fracture of the left public ramus.**

As a doctor at West Point explained to me, "With a broken pelvis she had run 8 miles with a full pack and then she went on to jumping out of airplanes. There aren't many officers who are tough enough to do that." And as one combat arms officer on the staff explained to me, "Ms A is so tough I'd be pleased to have my sons serve in combat under her leadership." But toughness was not enough. Serious rehabilitation would evolve into more serious injury, and after the second surgery at the Hospital for Special Surgery in New York City, it was clear that Lieutenant A was not going to be medically fit to continue her military service.

At this point, Ms A entered the military disability separation program. Because she was an officer and not a cadet she was entitled to the full panoply of rights that are provided to all active duty personnel, except cadets, who undergo military disability

separation. Unfortunately for Ms A, however, the counselor assigned to her case did not understand that Ms A was not entitled to benefits for disabilities incurred prior to her commissioning. Ms. A also expressed substantial concern about the lack of precision in disability processing and the general lack of understanding exhibited by personnel in the Physical Disability Agency. She was particularly distressed with the draft decisional document provided to her that indicated that her injuries occurred while she was not on active duty. In her rebuttal to the Agency she explained that she was indeed a member of the Regular Army and that she was on active duty during her service as a cadet. She waived some of her rights in this process because of what she perceived as excessive delays by the bureaucracy, and, as she indicated to me, "even if they don't know what my status is, I now know that I am not entitled to anything from the Army." In a separate communication to me she wrote: "To summarize my experience, I was unable to find an expert on any of the subjects pertaining to my situation. I had to become my own referral service in order to survive the medical hold/board process. For the sake of injured cadets in the future, the process needs to be clarified and personnel need to be more informed."

Ms A's experience was not unique in this regard because few of the cadets or midshipmen who are separated for disability are aware that they will be discharged without benefits if they are permanently disabled. At each academy there are a few key personnel who understand these rules, but the vast majority of the cadets and midshipmen and their parents are unaware of this potential trap until it is too late.

Unless the cadet or the midshipman talks to the experts early in the process, there is a great potential for misunderstanding and regret.

The case of Mr. V displays another pitfall in the process of excluding cadet injuries. Mr. V attended Airborne School while he was a cadet and sprained his knee. This injury recurred infrequently through the remainder of his cadet years. Routinely, he was given Motrin and was excused from heavy physical activity for a brief period. He graduated and was commissioned. Eighteen months later he was deployed to Saudi Arabia for the campaign to liberate Kuwait. The problem flared up again, but neither the Navy nor the Army doctors who treated him could provide relief. Eventually, he was medically evacuated to Landstuhl Medical Center in Germany where the doctors concluded that his knee was fine but he had a severely degenerated hip and rheumatoid arthritis. After several additional attempts at rehabilitation Mr. V was medically discharged from the Army with a 10% disability. The Disability Agency rated his injuries at 30%, enough under normal circumstances for medical disability retirement, but they concluded that 20% of the disability was incurred while he was a cadet, and only 10% related to his service as an officer. Within three months of his discharge from the Army, Mr. V received a 30% disability award from the Department of Veterans Affairs. As Mr. V explains, 30% of a commissioned officer's pay is substantially in excess of the \$310 per month he receives from the Department of Veterans Affairs. In addition, although he does not know what kind of medical care he would get from the Defense Department, he

knows he receives only routine prescription care from the Department of Veterans Affairs.

The problems raised above were reiterated by the more than 100 former cadets and midshipmen that I interviewed. Their principal complaint was that no one told them, prior to their injuries, that they would be separated without benefits. Secondly, they were convinced that the military bureaucracy did not know how the rules were to be applied to servicemembers with cadet or midshipman service. And, finally, they did not understand why they were the only members of the Regular Armed Forces who were excluded from the disability program. To them, the result was not fair.

### **2.3 Service Academy Medical Separation Procedures**

All three academies use a modified version of the Medical Separation Procedure established pursuant to Chapter 61, Title 10, United States Code, for the medical separation of active duty personnel. The full procedures used by the Services are not required since the law excludes cadets and midshipmen from the provisions providing for extensive due process protections. Significantly, I did not hear any substantive complaints about this process, as long as it was used by the academies. I did hear some concerns expressed about cadets or midshipmen being encouraged to submit unqualified resignations rather than go through the medical separation process, but the process itself was well regarded. The only complaints I heard were those relating to lack of speed, as opposed to quality of outcome.

The Air Force provides the most detailed procedures and protections for the medically separated cadet. As with regular physical disability separations, the process starts with a medical evaluation board. This board begins with a summary prepared by the treating physician, but develops into a full review by three medical professionals including a psychiatrist if psychiatric issues are raised. The procedures provide the cadet with an opportunity to obtain an independent second medical opinion and detailed review procedures up through the Air Force Personnel Council and the Secretary of the Air Force in cases where the cadet opposes the medical separation. Given the fact that no property or liberty interests are involved, this is clearly more than adequate "due process."

The Navy has similar procedures although it requires only two physicians to agree on a proposed resolution of a medical separation issue. The Navy requires all medical separations to be approved at the Headquarters of the Navy's Bureau of Medicine. As a long term observer of military separations, I view this independent review as a very valuable protection for the midshipman. It is also a sound means to ensure the long term validity of the academy's medical separation process. The Navy process appears to be designed to work more quickly than the Air Force procedure. There are also less procedural protections for the midshipmen. But as I indicated above, there is not much due process required when no liberty or property interests are involved. The Naval Academy also has an excellent "plain English" handout that it provides to all midshipmen going through this process. In my

opinion, such a document is extremely helpful to the midshipman who only vaguely understands the process. Additionally, the handout would be particularly valuable to a parent or mentor who is attempting to assist the sick or injured midshipman. The Naval Academy has an additional protection for this process that is not found at the other academies. An experienced medical officer, whose duties include medically screening all applicants for the academy, reviews all the medical separations and provides information to separating midshipmen about their rights and benefits. In his assessment, properly screening applicants is a very effective means of avoiding future medical separations. Obviously, this program involves the use of an expensive and scarce resource. In my view this is a solid investment in the health and fitness of the active duty commissioned force.

At the Military Academy the process is even more abbreviated. A single doctor prepares the "board"—actually a paper record, as is the case in the other services. The standards used are those in Army Regulation 40-501, the fitness for duty standards applicable to all Army personnel. The "board" is then reviewed by the hospital commander, the senior medical officer at West Point. If the hospital commander concludes that separation is the appropriate resolution, the cadet is then advised of his or her rights by a counselor at the hospital. This counselor, called a Physical Evaluation Board Liaison Officer, has no formal legal training but has a duty to provide impartial advice. If a cadet asks for legal advice, the Academy routinely provides experienced counsel for advice. But the only right of appeal is a written

appeal to the same hospital commander. As is the case with the other services, there is no right to a formal hearing. If the hospital commander concludes, finally, that separation is appropriate, the file is forwarded to the Superintendent who has discharge authority for freshmen and sophomores. For juniors and seniors all separations are approved at Headquarters, Department of the Army. Notwithstanding this abbreviated process, I did not hear significant complaints about the manner in which it operates. The reasons for this result probably lie in the fundamental fairness of the medical professionals who serve in this system. By training and by inclination their focus is on preserving or restoring the health of the cadets. Where serious health issues are involved the cadets are routinely referred to Walter Reed Army Medical Center or extremely high quality civilian medical care facilities in New York City. Moreover, due process rights attach only when substantial liberty or property interests are involved. Where, as here, the law provides no benefits, minimal due process—notice and an opportunity to respond—meets the requirement of the Constitution and federal law.

It is my assessment that there may some value in the academies working together to make their separation procedures more uniform, but the procedures in place are more than adequate to protect the Government and the cadets. If I had to choose one system as a model, I would choose the approach taken by Annapolis. It focuses on eliminating potential problems prior to admission, and it appears to be user

friendly even though it does not provide all the regulatory protections provided by the Air Force.

## **2.4 Service Academy Benefits Advice**

All three Service Academies do advise incoming cadets, midshipmen and their families in writing about the medical benefits that are available. The advice is included in the brochure that is familiar to all college parents, if not their children. These pamphlets tend to be read carefully as they are chock full of essential information for freshmen and their parents. The Service Academy pamphlets that provide this advice are sent to the entering classes well before they report for duty. In all instances there is language in the pamphlets that discusses medical care and encourages parents to continue covering their cadet or midshipman on their family medical insurance.

However, only the current version of the Air Force Academy pamphlet mentions the fact that medical care entitlements end when the cadet or midshipman is separated for any reason including medical disability. The Air Force covers the issue in a separate paragraph that reads:

### **"Continuation of Medical Insurance Coverage**

We highly recommend your parents contact their insurance carrier and inquire as to whether you may legally remain on their health insurance policy while you are a cadet. During your time at the Academy, you do have medical coverage. However, **if you leave the Academy for any reason to include disenrollment for a medical condition**, the Air Force will no longer

be financially responsible for any medical expenses you may incur once your identification card expires. After graduation you will no longer need to have separate medical insurance coverage because you will be on active duty."

Although the existing version of the Naval Academy and Military Academy pamphlets do not contain similar language, the versions that the incoming classes receive in 2003 will contain advice similar to that provided by the Air Force.

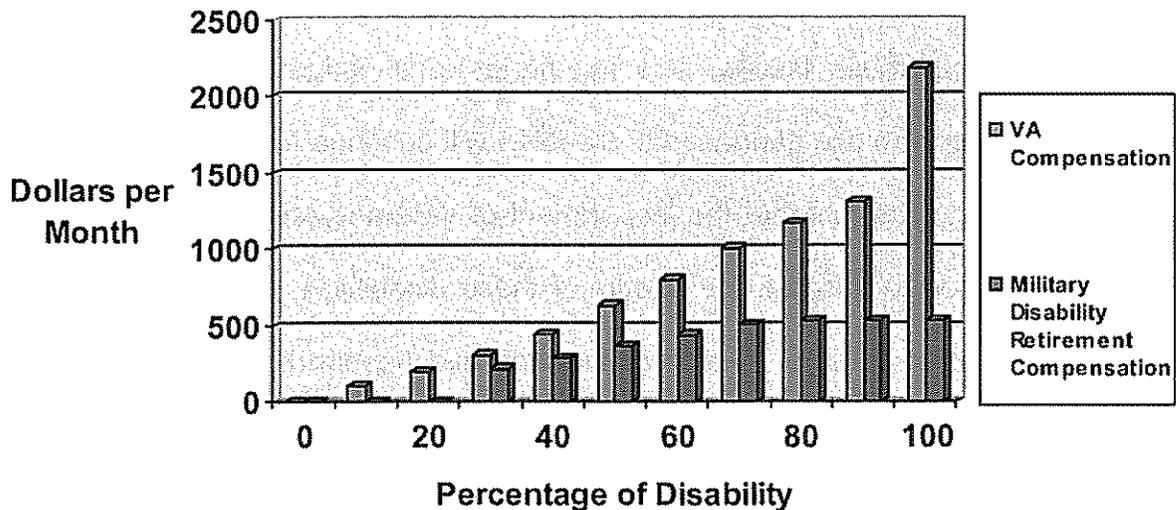
Notwithstanding these current efforts to ensure that cadets and midshipmen are not misled about these issues, it is my professional judgment that the cadets and midshipmen who are permanently disabled will continue to express concerns about their status. The fact that the Department of Veterans Affairs provides benefits will also continue to mitigate the effects of these disabilities, but it will not reduce the expressions of outrage. These cadets and midshipmen know that they have been singled out for adverse treatment, and they don't like it.

## **2.5 Department of Veterans Affairs Assistance**

The Department of Veterans Affairs provides cadets and midshipmen injured in the line of duty with benefits and treatment identical to the benefits and treatment they provide to all other members of the Regular Armed Forces who become ill or injured while they are on active duty. These benefits are separate and distinct from the benefits provided by the Department of Defense, and, in some ways, they are clearly superior to the benefits that would be received from the Department of Defense if

both were available. For example, the chart below displays the disability compensation provided by the two Departments for identical percentages of disability. Since both departments use the rating system established by the Department of Veterans Affairs, it is a nearly one for one comparison.

## VA and DOD Disability Comparison



The reason the military disability rates are so low in comparison is that cadet pay is low in comparison to regular active duty pay. Congress concluded years ago that free education justified modest rates of pay. Military disability pay is derived from applying a percentage of disability against actual pay. Current cadet pay is \$734.10 per month. Accordingly, the maximum military disability pay is \$540 per month or 75% of total cadet pay. Thus, for a medically discharged cadet with 100% disability,

the Department of Veterans Affairs provides \$2193 as opposed to the \$540 that would be provided by the Department of Defense. For a former cadet with 50% disability the difference in pay is not as great, but it is substantial. The Department of Veterans Affairs provides \$633 per month while the Department of Defense would provide \$367 per month. The difference between veterans' compensation and military compensation grows even greater when the veteran has dependents, with increases of veterans' compensation ranging from 10% to 20% varying with the number of dependents.

Moreover, benefits administered by the Department of Veterans Affairs include inpatient and outpatient medical and dental care for service connected disabilities. While access to this care is subject to availability, these are real and substantial benefits. Additionally, the Department of Veterans Affairs administers wide-ranging programs involving aid for the blind, prosthetic devices and domiciliary care that are not available through the Department of Defense. Employment assistance including preferential treatment in Government employment is also a major benefit provided under the auspices of the Department of Veterans Affairs.

Why then, is there such a level of concern over being included within the Department of Defense military disability retirement program? **There is one very good reason, and that is "continuity of care."** The greatest issue faced by the young men and women who are discharged for medical disability is that of obtaining

continuous, high quality medical care. The difficulty with the Department of Veterans Affairs is that the veteran must file his application upon discharge, and then he or she must wait. And wait. And wait. In most instances this process involves months and even years before a final benefits determination is reached. For the military disability retiree this is not an issue because military treatment facilities will provide care during the interim. For the discharged cadet or midshipman the only alternative is their parents' insurance or welfare programs. This issue will be discussed in greater detail in the next section of the paper, but it is important to realize that current Department of Veterans Affairs programs are not responsive to critical medical needs of medically discharged cadets and midshipmen.

## **2.6 Discussion of Possible Solutions**

This portion of the report will discuss the options listed below. Of course, more sweeping changes are possible, but I have attempted to limit the range of options to those that will work within the existing Department of Defense pay and disability framework. Sweeping changes, i.e., creating a unique system for the cadets and midshipmen, may appeal to some, but the beneficiaries would invariably suffer from the same difficulty that causes the current system to flounder. Unique systems for unique parts of the Department of Defense invariably fail to keep current if they are not part of the comprehensive systems that support the department's operations. That is what has happened with cadet and midshipman disability. It was consistent

with attitudes and expectations in the 1940s; in today's environment it is considered archaic.

The options:

- A. No Change
- B. Require DOD and DVA to Coordinate Remedies
- C. Retain Cadets and Midshipmen on Active Duty Until Accepted for Treatment and Compensation by DVA
- D. Eliminate Statutory Prohibitions on Cadet and Midshipman Military Disability

Option A, retaining the current system is not without its attractions. It does not meet the test of being consistent with the basic military disability compensation program, but this option clearly is the least expensive; it is, virtually, a no cost option. This option also requires the least administrative adjustment on the part of the agencies affected by the law. More significantly, this option does have the advantage of treating Academy cadets and midshipmen almost identically to students in the Reserve Officers Training Corps programs of the Armed Forces. The Congress, as will be discussed in the next section of the report, has steadily improved the protections for ROTC cadets in the fifty years since the end of World War II. While the law and tradition have never required identical treatment of officer candidates in

these two programs, recent trends in legislation have tended to equate the two groups.

With no change in the military disability laws, cadets and midshipmen of the Academies would continue to be treated more favorably than ROTC cadets with respect to obtaining medical care. Cadets and midshipmen of the Academies are entitled to free medical care without regard to causation from date of entry until the date of discharge. ROTC cadets have a far more limited entitlement.

What the "No Change" option does not do, however, is that it does not solve the problem. The continuity of care issue is real; it is not imaginary. ROTC cadets are aware that they are in an environment where civilian health care insurance is their primary source of protection. They act accordingly. Cadets and midshipmen of the Academies are in an environment where the Department of Defense is the exclusive health care provider. In addition, the congressionally enacted improvements in protection for ROTC cadets have essentially treated the ROTC cadets like true members of the Reserve components of the Armed Forces. These improvements have reduced the time in which ROTC cadets are treated uniquely as students and increased their consideration as true members of the Reserve. In a similar manner, Service Academy cadets and midshipmen seek to be treated as true members of the Regular components of the Armed Forces. To me, this is a persuasive argument.

Option **B** would require the Department of Defense and the Department of Veterans Affairs to coordinate their remedies so that no cadet or midshipman was abandoned without living expenses or medical care due to a service connected disability. This mandate could be enacted by Congress or made part of an interagency agreement. It is a tidy solution that relies on the fact that beneficiaries of both the military and veterans compensation laws are prohibited from receiving a duplication of compensation. (The commonly used term that describes this legal doctrine is "concurrent receipt." Although Congress frequently considers repeal of this prohibition, prior to this year it has chosen to leave it in place for budgetary reasons.) Why not just direct the two agencies to keep from abandoning the cadet or midshipman from the time the Academy decides discharge is appropriate until the time benefits are received by the disabled former cadet or midshipman? This option is more appealing today than it has been in any time in the past. There is an experimental program in effect under which the Department of Defense and the Department of Veterans Affairs are relying on each other's services for separation physical examinations. Military medical officials see some positive results from the program and senior Department of Veterans Affairs' officials are enthusiastic about the experiment. Given the small numbers involved, the three Academies indicate that their total for medical discharges in the past five years is less than 200, perhaps the Academies could be made part of the experiment.

But I am searching for a practical solution. Experimental programs wax and wane in the Government, and the problems facing cadets and midshipmen are too small in number to affect the outcome of the experiment. Moreover, these two huge bureaucracies, Veterans Affairs and Defense, do not have a great track record of cooperation. Where, as here, the principal parties concerned about cooperation are the same disabled veterans who have been raising this issue for years, it is not cynical to suggest that they won't have any better luck at enforcing cooperation than they have had in getting the Department of Veterans Affairs to act promptly. A better approach would be to establish a program that will be self-enforcing. Such a program need not provide a guarantee of perfect results; it needs only to provide equal treatment before the law. Accordingly, I do not support a mandatory cooperation requirement as the solution to the dilemma faced by disabled midshipmen and cadets.

Some military medical officials suggested to me that Option C, Retaining the Cadets and Midshipmen on Active Duty until they are Approved for Benefits by the Department of Veterans Affairs might be a reasonable alternative. They suggested this approach because a substantial number of cadets and midshipmen presently are "Turned Back" for a year while they recuperate from medical problems. This process involves leaving the Academy, returning to their homes, and reporting to military or civilian medical care facilities when required to complete their recuperation. This "Turn Back" process works well for the cadets and midshipmen as

well as the academies. This option, essentially a variation of Option **B**, suffers from the same weaknesses as Option **B**. It depends on the cooperation of the two agencies. Moreover, it may result in a cadet or midshipmen becoming trapped in a limbo status while the agencies adjudicate his or her case. This solution does have the advantage of ensuring a high standard of medical care for the disabled cadet or midshipman, but my discussions with the potential beneficiaries indicates that they would accept this approach only in the case of extreme disabilities. A midshipman, who left Annapolis near the end of his sophomore year due to a chronic medical problem, spent a year and a half on excess leave awaiting his discharge. He is now finishing an Honors English program at Fordham, and he indicated to me that there were no circumstances under which he would want to remain at the Academy or on active duty elsewhere unless he ultimately would be able to partake of the normal routine and graduate with his peers. Most cadets and midshipmen would share that view. Academy officials with whom I spoke are also unsupportive of this approach. They want to help these young men and women get on with their lives, and they do not perceive that languishing in an administrative hold status would help this process. Accordingly, I believe Option **C** is the least useful of the potential solutions.

Option **D**, Eliminating the Statutory Prohibitions on Cadet and Midshipman Military Disability, is the option of choice for the affected cadets and midshipmen. It is also the option of choice for the Academy officials with whom I spoke.

Before proceeding with the discussion of this option it would be useful to portray the population of the group affected by any potential change, and also to discuss preliminary cost estimates for providing benefits to cadets and midshipmen. The Tables below displays a five year total number of cadets and midshipmen who were discharged from the Academies for medical reasons, and a preliminary cost estimate for providing medical retirement benefits to them. Additionally, 98 cadets and midshipmen were graduated but not commissioned during this same period. Some of these 98 had medical conditions, for example, flat feet, which would serve as a bar to commissioning, but would not amount to a disability.

**CLASSES OF 1997-2001 CADET AND MIDSHIPMAN MEDICAL SEPARATIONS**

<b>ARMY</b>	<b>58</b>
<b>NAVY</b>	<b>34</b>
<b>AIR FORCE</b>	<b><u>77</u></b>
	<b>169</b>

When the Congressional Budget Office considered comparable numbers in 2001 they concluded that the direct spending costs of making this change were as follows:

<b>2002-2006</b>	<b>\$1.1 MIL</b>
<b>2002-2012</b>	<b>\$4.6 MIL</b>

The staff member who prepared these estimates included the cost of Coast Guard Academy cadets in her estimate. Although they are not part of the Department of Defense, these cadets are affected by the same statutory prohibition. Coast Guard figures indicate that they medically discharged 20 cadets during a comparable five year period.

The cost estimates are small in terms of the Department of Defense budget, but in these times it is fair to ask what value is added by the expenditures? The principal value added is that this option assures an entitlement to competent medical care for those who have been injured in the line of duty. These cadets and midshipmen have incurred debilitating injuries or diseases as a result of their voluntary service. Their right to care for these injuries should not end at discharge from active duty. If the injuries occurred as a result of intentional misconduct or while a cadet or midshipman was absent without proper authority, the basic disability law denies relief. But no one that I spoke with during the course of my inquiry, even those who thought the present system was just fine, thought it was fair or reasonable to deny medical care to the cadets and midshipmen who became disabled during the course of their duties.

Those in favor of the status quo, and there weren't many, invariably believed that the cadets could receive a retired pay windfall. Their position was: Look, they are getting a free education. Why should that include a disability benefit? Most of

these skeptics did not understand that ROTC cadets get a very similar disability benefit from the Department of Veterans Affairs. These skeptics also did not understand that inclusion in the military disability retirement program clearly is not the panacea that some perceive. As the discussion of Department of Veterans Affairs' compensation benefits indicates, the "retired cadet" would receive absolutely no permanent compensation benefits as a result of this approach. Because of "concurrent receipt" rules, every dollar that is received in military retirement benefits for a period covered by veterans' compensation is recouped by the Government. Under the law as it exists today, there would be no duplication of benefits. Retirement would carry the standard commissary, exchange, and other related retirement privileges, but these are not matters of major significance to the age group that is the subject of this discussion.

There is no question that there is a positive morale effect that arises from retirement rather than discharge. For the older, committed members of our Armed Forces this has always been the case. Those who are retired are still part of the force; those who are discharged are, by definition, finally separated from their service. I was surprised to hear those same sentiments of commitment being presented to me by the young officers and former cadets and midshipmen with whom I spoke. As an officer who had spent the formative stages of my career in the draft era, I had forgotten just how committed the youngest generation of our Armed Forces can be. They truly are "regulars," and they expect to be treated in that fashion.

If cadets or midshipmen are killed in the line of duty, they are entitled to burial in a national cemetery, and they are entitled the same death gratuity that is extended to every other member of the Regular Armed Forces. Unless they have opted out of Serviceman's Group Life Insurance, their beneficiaries are also entitled to the \$250,000 benefit currently payable under that program. They are omitted from the disability coverage only because of the historical anomaly that is described in detail in Section 2.1 of this report.

It is my assessment that it is time to end that anomaly. I believe that the Chairman of the Senate Armed Services Committee had it right when he said in 1949: "I would be inclined to think that while we would exclude it, service in these different academies, exclude that service from the right to claim more pay, nevertheless there is a pretty good ground for an exception to that rule if the man is incapacitated for life." The proposal that follows in the next section is limited to the issue of disability. It has no effect on the exclusion of service at the academies for the purposes of pay or length of service retirement.

## **2.7 Recommended Legislative Proposal**

This proposal would repeal section 1217, title 10, United States Code, and modify title 37, United States Code, section 203 in order to provide military disability benefits to cadets and midshipmen of the Service Academies.

More specifically, the existing <sup>1</sup> Section 203(c) of Title 37 should be repealed and replaced with a new Section 203(c) that reads as follows:

(c) The basic pay of a cadet at the United States Military Academy, the United States Air Force Academy or the United States Coast Guard Academy, or a midshipman at the United States Naval Academy is established at a monthly rate equal to 35 percent of the basic pay of a commissioned officer in the pay grade O-1 with less than two years of service.

Section 1217, of Title 10 should be repealed <sup>2</sup> and not be replaced.

These cadets and midshipmen are members of the regular armed forces who have been appointed to the United States Military Academy, the United States Naval Academy, the United States Air Force Academy and the United States Coast Guard Academy (the Service Academies.) Current law, established in the Career Compensation Act of 1949, denies to cadets and midshipmen the disability benefits provided to all other members of the regular armed forces. The current law was seriously questioned by the leaders of the Senate Armed Services Committee prior to enactment. While the current law may have served the national interest in 1949, removal of this bar to coverage is overdue. Increasingly rigorous, combat-oriented training and full-contact, required athletic activities produce casualties. Most

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<sup>1</sup> Presently this provision reads: "(c). A cadet at the United States Military Academy, the United States Air Force Academy, or the Coast Guard Academy, or a midshipman at the United States Naval Academy, is entitled to monthly cadet pay, or midshipman pay, at the monthly rate equal to 35 percent of the basic pay of a commissioned officer in the pay grade O-1 with less than two years of service."

<sup>2</sup> Presently this provision reads: "Sec. 1217. - Cadets, midshipmen, and aviation cadets: This chapter does not apply to cadets at the United States Military Academy, the United States Air Force Academy, or the Coast Guard Academy, or to midshipmen of the Navy."

casualties are treated and returned to duty. A few, however, become permanently disabled and require active medical management. Presently, cadets and midshipmen discharged for medical reasons face major delays and expenses as they seek medical care for service-incurred disabilities. These delays adversely affect their standard of medical care. While the Department of Veterans Affairs ultimately accepts responsibility for these service incurred disabilities, the time lost in transferring responsibility from the military medical establishment to the civilian agency results in major medical and financial hardship for the few affected cadets and midshipmen. Continuity of care is the principal issue. Most of the cadets and midshipmen do not have medical insurance. The services, at present do not explain adequately this lack of protection to the cadets, midshipmen and their parents. The impact is particularly disparate on those cadets and midshipmen who have an underlying enlisted status that would provide coverage except for this legal prohibition. The impact also becomes disparate when an academy graduate is re-injured during the first eight years of commissioned service and benefits are denied because of the initial cadet injury. In today's environment of high-risk, high-stress training, and high-cost medical rehabilitation, it is unacceptable to expect the few unavoidable permanent casualties of the disability process to bear personally the burden that should be shared by all.

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### **3.0 RESERVE OFFICER TRAINING CORPS ISSUES**

#### **3.1 History**

When Congress established the Reserve Officers Training Corps (ROTC) in 1916, the enabling legislation made no provision for disability or for medical care for ROTC members who were injured in the course of their training. Given the fact that ROTC members were in a special category and were not members of the organized Reserve of the Armed Forces at that time, this was a logical result. The history that follows, however, discloses that members of Senior ROTC have received expanded disability and medical benefits that followed what is arguably a recognizable trend toward the eventual integration of Senior ROTC into the organized Reserve. These benefits were not expanded as a matter of largesse or as a recruiting incentive. The expansion of disability and medical benefits was a clear case of the Government accepting fiscal responsibility for the injuries directly resulting from rigorous military training that was being imposed upon the Senior ROTC program.

In 1936 ROTC cadets and midshipmen who became victims of disease or injury during ROTC summer camp were authorized medical care in military medical facilities. This was the first medical care coverage for ROTC participants. Twenty years later, in 1956, ROTC cadets and midshipmen were authorized to participate in flight training, and at that time Congress extended medical coverage under the

Federal Employees Compensation Act (FECA) to ROTC cadets and midshipmen injured in flight training as well as to those injured during summer camp.

FECA was originally enacted to provide worker's compensation coverage for federal civilian employees through the Department of Labor. The provisions of FECA are now codified in Sections 8101 through 8193 of Title 5, United States Code. FECA is the exclusive remedy against the United States for any federal employee whose injuries or death fall within the scope of the statute, and it precludes recovery in any other direct judicial proceeding or under the federal tort liability statute. In 1956 FECA was amended to ensure that medical care and disability benefits were authorized for cadets injured in summer training camp and in flight training. However, at this time Congress intentionally withheld such coverage from college training involving drill, ground instruction, rifle practice and similar activities. Congress also declined to extend coverage from the Department of Veterans Affairs at this time. Both results were consistent with benefit coverage provided to active members of the Reserve during that draft-based era.

In 1964 FECA was amended to authorize the Service Secretaries to provide medical attendance and supplies to Senior ROTC cadets who were injured while attending mandatory field training and practice cruises. Specific language was added to Title 10 to authorize similar care in military hospitals for the same limited category of

mandatory field training and practice cruises. Coverage was also extended to cadets injured in flight as well as the preexisting coverage for flight training.

In 1982, with the "volunteer force" well established, Congress extended benefits administered by the Department of Veterans Affairs to ROTC cadets and midshipmen for the first time. The amendments to Title 38 of the United States Code provided basic veterans benefits to ROTC cadets and midshipmen who suffered from permanent disability or death during a period of active duty for training (essentially during ROTC summer camp or summer cruise). These benefits would displace any benefits received from FECA for disease or injury. It is noteworthy that this is the first "volunteer force" extension of benefits to be enacted for ROTC cadets.

In response to a series of training accidents involving ROTC cadets, Congress, in 1988 amended several statutes governing Department of Defense, FECA and Department of Veterans Affairs' benefits. The purpose of these amendments was to ensure comprehensive medical care and compensation for permanent disability or death for all Senior ROTC cadets and midshipmen who are injured, disabled or killed during participation in their training activities. First, the provisions of Section 2109 of Title 10 that previously required "mandatory training" prior to receiving medical care were deleted. The Service Secretaries were authorized to conduct various types of training, both mandatory and elective.

Second, the provisions of FECA, Section 8140, were amended by inserting "training" in lieu of "field training or practice cruise" to indicate that medical care under FECA can be provided to persons injured during all Senior ROTC training. Further amendments ensured that medical care could be provided even though injuries did not result in disability or death. Applicants for enrollment in Senior ROTC were also authorized FECA coverage when injured in ROTC training activities.

Finally, as part of this reform package, Section 101(23), Title 38 was amended to include Senior ROTC training within the definition of "inactive duty for training." This reform made benefits administered by the Department of Veterans Affairs available to Senior ROTC cadets. In addition, other provision of Title 38 were revised to ensure that all Senior ROTC participants who were killed or permanently disabled due to training injuries were covered by the full panoply of veterans' benefits. The extent of these benefits is displayed in the chart that is the Appendix to this report.

### **3.2 Recent Issues**

If, as subsequent sections will explain, the Department of Veterans Affairs is responsible for compensation for permanent injuries and death and the Department of Labor is responsible for the medical treatment of temporary injuries, what is left that requires coverage? My inquiries here in Washington at Service Headquarters and in the field with ROTC units make it clear that the only unresolved problem is that of temporary injuries occurring as a result of training. These injuries occur

throughout the ROTC training spectrum. The problems relate as much to summer camp injuries as they do to voluntary and involuntary training at or near college campuses. These injuries occur to all categories of participants in Senior ROTC: applicants; contract cadets; and participants in MS I, MS II, MS III and MS IV levels of the program. These problems occur throughout all three Services, and they relate directly to the ineffectiveness of the FECA claims process. The report explains this conclusion in Section 3.4, which follows.

Indirectly, these problems also relate to the fact that the Department of Defense has changed the way in which claims for medical care are resolved by the Services. In the not too distant past, the Services paid claims for the medical treatment of injuries incurred by Senior ROTC cadets through similar but slightly different means. Previously, in the Army, commanders of the separate Medical Treatment Facilities would pay these expenses out of funds called supplemental health care program funds. These supplemental health care program funds were appropriated for the treatment of active duty personnel in civilian facilities. In the Navy and the Air Force a similar process was used but the supplemental health care program funds were controlled centrally. For example, current Navy Regulations still prescribe the following process for obtaining civilian care for injured Naval ROTC midshipmen.

“NON-NAVAL HEALTH CARE (BUMEDINST 6230.72). In cases where a Scholarship or College Program (advanced standing) midshipman is injured while in an official status (on active duty for training, en route to or from special additional duties authorized by the Professor of Naval Science, or duties performed on a voluntary basis in connection with prescribed training or maintenance activities of units

to which midshipmen are assigned) non naval health care may be used. Where immediate (emergency) care is required, transport the midshipman to the closest hospital. As soon as possible, contact the Military Medical Support Office (MMSO), Great Lakes at the following numbers. 1-800-876-1131, ext. 680 or 636. Prepare a letter of eligibility signed by the Professor of Naval Science and fax it to the MMSO as well as a copy of the orders (if one was issued). The case-worker assigned will assist in presenting the bills to Tri-Care for payment.

This process is also used for midshipmen who are injured while on active duty for training and returned to the unit, but require additional care.”

This process called for the Professor of Naval Science to treat a claim for medical benefits just like a TRICARE authorization claim he or she would make if the injury occurred to active duty military personnel within the ROTC unit. To the midshipman and the Professor of Naval Science the process was transparent. The injury was treated, the doctor was paid, and the cadet or midshipman returned to duty with his or her unit. The Air Force used an essentially identical process.

However, the legal opinions of the TRICARE Management Activity essentially terminated this effective and efficient process. These legal opinions clearly indicate the funds used to support this program of civilian care of active duty military personnel may not be used for Senior ROTC cadets or midshipmen, even those cadets or midshipmen with an underlying Reserve status such as the contract cadets or the cadets who are in a Military Science III and IV status. These opinions also indicate that the exclusive remedy or source of funds for this type of medical care is a FECA Claim to the Department of Labor. Regrettably, as will be explained

in greater detail in Section 3.4, the FECA Claims process is not responsive to the ROTC units in the field or their cadets and midshipmen.

### **3.3 Department of Veterans Affairs Assistance**

As the discussion in Section 3.1 reflects, the assistance available to Senior ROTC participants from the Department of Veterans Affairs began in 1982. Since that time the benefits package available to Senior ROTC cadets and midshipmen has exhibited steady growth to the point where it essentially matches the benefits available to members of the active Reserve components of the Armed Forces. This system of benefits provides the Senior ROTC participant with virtually the same package of benefits that is available to Service Academy cadets and midshipmen. The latter result is an historical accident. The true parallel is the parallel with the active Reservist.

It is also noteworthy that this benefits package is available only to those participants in Senior ROTC who have been discharged or otherwise separated from the ROTC. This is not a "fix and return to duty" system. This is a system designed solely to aid the transition from military duty to civilian life. Accordingly, other health care and benefit systems must respond to the injuries or illnesses that result in temporary disabilities.

The Department of Veterans Affairs will pay disability compensation to all veterans whose disability resulted from personal injury suffered or disease contracted in line of duty by individuals in the active military service. The term "veterans" is defined as a person who served in active military service. The term "active military service" includes active duty for training while in the line of duty and inactive duty for training while in the line of duty. Senior ROTC cadets and midshipmen who are ordered to training for a period not less than four weeks under the provisions of Title 10 and who are required to complete such training prior to receiving a commission are on "active duty for training" for the purposes of Department of Veterans Affairs benefits. Cadets, midshipmen or applicants for membership in the Senior ROTC, who are engaged in other training prescribed in Title 10, are performing "inactive duty for training" for the purposes of Department of Veterans Affairs benefits. All current Senior ROTC activities are conducted within the rubric of these two categories. An injury or disease will be considered to have been incurred in line of duty if the person was in active military service, whether on active duty or authorized leave, unless such injury or disease was a result of the person's willful misconduct or abuse of alcohol or drugs.

My inquiries in Washington and in the field with ROTC units revealed that this basic authority works well for the ROTC. Claims with the Department of Veterans Affairs must be made by the cadet or midshipman, but the ROTC leadership is required to support this process and apparently does so effectively. Invariably when I sought

out problems concerning this process, I was greeted with a response similar to the one I received from a senior member of a Congressional Veterans Affairs Committee Staff: "Let me know if you find anything, but I believe we solved all those problems in the last century." It is my assessment that she was correct.

This is not to suggest that I received no complaints about the Department of Veterans Affairs' claims process. The usual complaints about excessive time to make the initial benefits decision were present. But I received almost no complaints about the quality of the decision, and the level of concern about excessive time seemed substantially lower than the level expressed by Service Academy claimants. I also received some comments about the Veterans Administration Schedule of Disability Rating. Several disability specialists were concerned about the Department of Veterans Affairs' inability to keep this schedule, used by both the Department of Defense and the Department of Veterans Affairs, up to date. In a more generic sense, these specialist were also concerned that the Schedule of Disability Rating related more to a Twentieth Century agricultural economy than to a Twenty-first Century high tech economy. But these issues relate to broader concerns than the treatment of Senior ROTC cadets and midshipmen. It appears to me that the Senior ROTC cadets and midshipmen are being afforded equal treatment under the law. Most importantly for the purposes of this study, it is my conclusion that the laws relating to the Department of Veterans Affairs have kept

abreast of the changing roles and requirements of the Senior ROTC program of the Department of Defense.

### **3.4 Department of Labor Assistance**

The Department of Labor (DOL) administers the Federal Employees Compensation Act (FECA), which establishes the worker's compensation program for almost all federal employees who are injured in the course of their employment. This is comprehensive worker's compensation legislation that focuses primarily on wage replacement and disability, but it also serves to pay the medical expenses for federal employees who are injured on-the-job. Over time this authority has served as the catch-all for a variety of other public service programs that are not quite full-time Government employment. Accordingly, FECA provides benefits to members of the Civil Air Patrol, Peace Corps volunteers, Job Corps enrollees, Volunteers in Service to America, and to members of the National Teachers Corps as well as to Senior ROTC participants.

As indicated earlier, FECA's only current role with respect to Senior ROTC is to pay the medical bills for Senior ROTC participants who contract disease or become injured in the line of duty. Last year, for example, there were no FECA disability benefits paid to ROTC participants. Even the medical care portion of the ROTC FECA program is not a high volume or a high dollar system. During the period from July 1, 2001 through June 30, 2002, 572 FECA claims were paid. The total value of

claims paid approximated \$500,000. For a comparable period ending in 2001, the total value of claims paid was \$492, 180. However, it is fair to say that neither the adjudicators nor the beneficiaries of this claims system are satisfied with the manner in which it operates.

The FECA system for adjudicating and paying medical treatment claims is not particularly complicated. The injured or diseased ROTC participant must, within thirty days of incurring the disease or injury, fill out two forms with the assistance of a local ROTC official and send the forms to a centralized Department of Labor office in Washington, DC. A Department of Labor official adjudicates the claim and authorizes treatment by sending a third form to the claimant. The claimant provides the third form to the treating physician or medical care provider who must complete and return the form to the Department of Labor for payment. The system presently is based on paper forms, but it is in the process of converting to electronic forms. In theory, the process should work quickly and the care providers should receive adequate compensation. From the users' perspective, and that includes the medical care provider, the ROTC participant, and the ROTC leader, however, the theory is not matched by reality.

Service ROTC leaders, in particular, express grave concern over the operations of this system. Their principal concern is that the system leads to a situation where ROTC participants are routinely advised to use their own medical insurance, if they

have it, to pay for injuries incurred in the line of duty. The FECA system is used only as a last resort if neither private nor college-provided insurance are available to cover the costs attendant to the injuries. This system is not just unfair to the ROTC participants. The system causes real morale problems within ROTC units, and it damages the reputation of the ROTC program on college and university campuses across the nation. The situation is critical enough that the Commander of the US Army Cadet Command, the Vice Chief, Naval Education and Training, and the Commander, Air Force Officer Accession and Training Schools, at their annual Tri-Service Conference in 2002, persuaded the Deputy Assistant Secretary of Defense for Military Personnel Policy to make a written commitment to seek legislation that would end Department of Labor involvement in the provision of medical care to injured ROTC participants.

As I pursued this issue within the ROTC community, I was immediately confronted with large numbers of current complaints that were generated from ROTC units throughout the country. When I asked ROTC officials to document their complaints, my computer was flooded with complaints and most were well documented. A typical example, documented better than most, arose from a summer camp training injury. Cadet L received dental injuries during US Army training at the Fort Lewis advanced camp. He received emergency treatment at Fort Lewis, but required follow-up treatment while he was attending college at Central Washington University in Ellensburg, Washington. Dr. S, the only dentist in Ellensburg who was willing to

treat ROTC patients using DOL procedures, tried for a year to obtain more than the \$13.00 tendered for treatment that he billed at \$1,199.00. Dr. S then sought the assistance of LTC L who was the Professor of Military Science at Central Washington University. The Professor of Military Science (PMS) called the contact numbers provided by the Department of Labor but received no answer. On the following day he called again and spoke to a Customer Service Representative, Ms J, who stated to him that the wrong procedure codes were used. When Ms J tried to transfer the call to Ms E, the official who could provide the correct codes, the PMS was advised that Ms E's mailbox was full and that she was not available. After four more calls that day to three full mail boxes and one "very rude woman," the PMS eventually spoke to Ms E who indicated that she would personally take care of the matter that day and that Dr. S would be paid within three weeks. Approximately three weeks later, Dr. S's assistant called the PMS to inform him that Dr. S's claim had been denied again. At this point the PMS began to call the DOL on a daily basis to inquire about the claim. After three weeks of daily calling without speaking to anyone other than an answering machine, the PMS wrote to the Army's Cadet Command headquarters seeking assistance. The PMS had documented the times and dates of his requests for assistance as well as the names of the DOL personnel with whom he spoke. He also included the names of the personnel attached to the answering machines on which he attempted to leave messages. The claim was never settled to the satisfaction of the medical care provider or the Professor of Military Science.

Military personnel familiar with the FECA claims process indicate that the process has degenerated over time, and they insist that the fault lies with the Department of Labor. Department of Labor officials provide a different perspective. They indicate that at one time, when the FECA claims from the Services came from centralized offices, that the process worked well. But now, in the eyes of the DOL officials, the ROTC officials do not know how to submit proper claims and indicate that it is not DOL's responsibility to educate hundreds of military ROTC departments scattered around the country. In the view of the Department of Labor, the only way the system would work efficiently would be if each of the Services had a centralized office that processed the claim prior to forwarding it to the Department of Labor. As I queried military officials about this proposal, I concluded that there was a degree of validity in the position taken by the Department of Labor. At some time in the past, prior to the time when the Department of Veterans Affairs handled the permanent disability cases and before the time when ROTC programs were reduced to their current size, there probably was enough volume of these cases to justify centralized handling by the Military Departments. In today's environment, each separate college ROTC detachment must deal with the two or three cases they have each year and they don't develop sufficient expertise to provide quality claims to the Department of Labor. Adding another military office to screen the claims might assist the Department of Labor, but it would not do much for the cadet or midshipman or their doctors.

Moreover, I perceived substantial validity in the factual assertions made by the ROTC officials concerning the absence of customer assistance by the Department of Labor. During my visit at the Department of Labor I perceived that the factors essential to an effective claims program were absent. I asked for indices of accountability, e.g., average claim processing time, date of oldest claim, average claim payment, total claims payment for a year. In a military base legal office, any young judge advocate claims officer would have similar data immediately available. These data were not forthcoming from the Department of Labor even though I was willing to wait weeks.

As an additional matter, it was apparent from my visit that some institutional and cultural differences between the Department of Labor and the Department of Defense interfered with prompt payment of legitimate ROTC claims. I was asked by an adjudicator how the military could possibly consider it proper to pay a worker's compensation claim for medical payments when the cadet was injured "while playing Frisbee?" As I inquired further, it appeared that the ROTC unit was engaged in physical fitness training that included "Ultimate Frisbee." When I explained that organized physical fitness training can include many forms of physical activity from calisthenics to football, including Frisbee, the adjudicator seemed satisfied with the explanation, but he clearly was not accustomed to dealing with a work setting that included what he perceived to be frivolous activity. Differences in institutional attitudes are not limited to the question of whether military activities are "work

related" in the traditional civilian sense. Travel to and from the job site has a different meaning in the workers compensation setting than it has in the military environment, and in some cases this has led to major disputes between DOL and DOD concerning an ROTC participant's qualification for benefits. The sum and substance of these disputes reveals that these two institutions do not communicate well with each other. The cadets, midshipmen and medical providers pay a substantial price for this lack of communication. This is a cost that these users should not have to bear. Potential solutions to this dilemma will be discussed in Section 3.5 of this report, which follows.

### **3.5 Discussion of Possible Solutions**

This section of the report will consider solutions to the dilemma discussed above. While the possibilities are myriad, three distinct options are, in my assessment, worthy of examination. First, a revitalization of the FECA process will be discussed. Second, contracting for the medical care provided through a system such as the contracts used to support the Department of Defense Medical Examination Review Board (DODMERB) will be explored. Third, the reestablishment of the program that the Services used to provide medical care to injured ROTC participants prior to its cancellation by the TRICARE Management Activity will be examined. (The TRICARE Management Activity had concluded that there was no legal authority to continue the program.) These options will be discussed in the order that I presented them.

Revitalization of the FECA process has some demonstrable advantages. Principal among these advantages to the Department of Defense is that the entire FECA operation, including the dollars paid to the claimants, is not part of the Department of Defense budget. Keeping these items off-budget would be a plus. In addition, the FECA system has been used by the Department of Defense for nearly fifty years, and at one time it was viewed as a panacea to the medical care problems faced by the ROTC community. Moreover, the Department of Labor possesses real expertise in the realm of workers compensation as that body of law and regulations applies to the civilian community. Because the Department of Labor office that supports the ROTC is already centralized and is relatively small, an effort to remove the bars to cooperation that was fully supported by the highest levels of the Department of Defense and the Department of Labor could be helpful. But my intuition and experience lead me in the opposite direction. It is clear to me that District 25, the office within the Office of Workers' Compensation Programs of the Department of Labor, is on the periphery of the agency's structure, and has been unable to communicate its problems outside the Department of Labor. Even within the Department of Labor, there is no recognition of the ROTC problem at the policy level of the Department. More importantly, District 25 appears to be focused exclusively on the issues of the Department of Labor bureaucracy at the expense and to the detriment of the ROTC customers. Reliance on the issue of "workers compensation expertise" could also be misleading in an effort to assess the potential for invigorating the FECA process. First, and most important, is that the expertise

possessed by the Department of Labor demonstrably does not include expertise relating to military and naval working conditions. After fifty years, one would expect claims examiners and adjudicators to possess a more complete understanding of the nature of military life than that which I observed. Second, this civilian expertise actually contributes to the difficulties in communications between the claimants, their advisors and the Department of Labor. Given the small amount of money that is involved, \$500,000 per year, capturing this claims process and operating it efficiently would be substantially more effective for the Department of Defense than any cooperative effort with the Department of Labor.

Since the completion of the initial draft of this report, the Department of Labor has moved the responsibility for ROTC Workers Compensation Claims from District 25 in Washington, DC to District 29 in Cleveland, OH. This change does present an opportunity for a new cooperative effort between the Department of Defense and the Department of Labor. Senior officials in both departments could make the system work for the cadets and their health care providers. If this approach were to be taken, it is clear that a single element of the DOD – probably the TRICARE Management Activity – should be assigned the responsibility of centrally managing this program. However, it is my assessment that this program is too small and the results from poor administration are too attenuated to ever gain the visibility essential to successful reform. These Departments have been aware of these

issues for more than ten years, and the problem has become worse over time. A new approach is required.

The use of a DODMERB analog also has some clear attractions. Contracting for physical examinations has proven to be very successful both for the Department of Defense as an institution and for the applicants who use the contractors for their physicals. The DODMERB program is widely used by the ROTC and is fully supported by these users. The funding and contracting processes are in place. This is a simple, reliable program that has resolved a myriad of problems for the users, most of whom are located at substantial distances from military medical treatment facilities. Could this program be modified slightly to provide the medical care that is required for the ROTC participants? Regrettably, the answer appears to be no. As an experienced health care professional administrator explained to me:

“Physical examinations are like widgets. You can buy widgets with a very simple contract. Health care, on the other hand, is a far more complex product. Providing health care involves fiduciary relationships as well as medical ethical obligations. Widgets and physical examinations do not. Doctors understand this; examinees and patients intuitively understand this. That is why the TRICARE contracts are so much more complicated than DODMERB contracts.”

The quoted view of the health care professional appears to be controlling to me. Certainly it makes no sense to establish a new TRICARE system under the rubric of a DODMERB contract.

This leads to the third option, reestablishing the program the Services used for years prior to 1999 to pay for medical treatment provided by civilian providers with the use of supplemental health care program funds. These funds are now managed by the TRICARE Management Activity, but ROTC leaders see this as a superb solution if it is a lawful solution. They reason that the program worked well before the TRICARE Management Agency concluded it was unlawful. Now, with the TRICARE Remote Program using an almost identical authorization process, a reestablished ROTC injury care program would be a practical adjunct to TRICARE Remote. Because the ROTC detachments use TRICARE Remote for health care for the families of their own active duty military personnel, they will be familiar with the process before they must deal with ROTC participant health care issues. Are there any disadvantages to such an approach? Senior TRICARE officials are aware that TRICARE Remote is not without its own administrative difficulties, but they suggest that this option, if properly authorized, is administratively feasible. Additional cost may be a disadvantage of this approach. It is my belief that an effective medical care program for ROTC participants who contract disease or become injured in the line of duty will cost substantially more than the \$500,000 per year that is the present cost of the FECA alternative. We know that much of the expense for the treatment of line of

duty injuries is presently being paid for by the ROTC participants. If DOD establishes an effective program for paying the cost of training injuries, the subsidy the ROTC participants presently provide will diminish substantially. But this is not a valid argument for rejecting this approach. Is there any legitimate question about whether the Government should bear the costs of disease or injuries sustained in the line of duty? All other participants in the active Reserve and every member on active duty with the Regular Armed Forces have this protection, and there is no substantive reason to deny it to Senior ROTC participants. The unfairness of this result became even more poignant with the enactment of recent legislation. Section 708 of the 2004 DOD Authorization Act extends full military medical benefits to newly commissioned reserve officers who have graduated and been approved for active duty. These benefits were extended to the fledgling officers even though their illnesses or injuries were completely unrelated to the performance of military duties. No other Reservist and certainly no ROTC cadet receives this type of protection. Accordingly, I recommend that the Department of Defense seek Congressional authorization and funding for a program to provide medical care to Senior ROTC participants who incur disease or injury in the line of duty. A legislative proposal to accomplish this end follows in Paragraph 3.6.

### **3.6 Recommended Legislative Proposal**

This proposal would add a new Section 1074I to Title 10, United States Code in order to provide authorization for a program to provide medical care to Senior ROTC

participants who incur disease or injury in the line of duty. The proposal is modeled after Section 1074a of Title 10, United States Code, which provides authorization for medical care for members of the uniformed services who are on active duty for less than 30 days.

**Section 1074I. Medical and dental care: members of, and designated applicants for membership in, Senior ROTC, Chapter 103, Title 10 who are performing duties pursuant to Section 2109, Title 10**

- (a) Under joint regulations prescribed by the administering Secretaries, the following persons are entitled to the benefits described in subsection (b):
  - 1) Each member of, and each designated applicant for membership in, Senior ROTC who incurs or aggravates an injury, illness or disease in the line of duty while performing duties pursuant to section 2109 of this title.
  - 2) Each member of, and each designated applicant for membership in, Senior ROTC who incurs or aggravates an injury, illness or disease while traveling directly to or from the place at which that member is to perform or has performed duties pursuant to section 2109 of this title.
  - 3) Each member of, and each designated applicant for membership in, Senior ROTC who incurs or aggravates an injury, illness or disease in the line of duty while remaining overnight immediately before the commencement of duties performed pursuant to section 2109 of this title or, while remaining overnight, between successive periods of performing duties pursuant to section 2109 of this title, at or in the vicinity of the site of the duties performed pursuant to section 2109 of this title, if the site is outside the reasonable commuting distance from the residence of the member or the designated applicant.
- (b) A person described in subsection (a) is entitled to—
  - 1) The medical and dental care appropriate for the treatment of the injury, illness or disease of that person until the resulting disability cannot be materially improved by further hospitalization or treatment; and

2) Subsistence during hospitalization.

- (c) A member of, and each designated applicant for membership in, Senior ROTC is not entitled to benefits under subsection (b) if the injury, illness, or disease or aggravation an injury, illness or disease of that person described in subsection (a)(2) is the result of the gross negligence or the misconduct of the member or applicant for membership in Senior ROTC.

The Government program, established by Congress in 1956 and expanded twice in the 1980s, to provide FECA coverage to pay the medical care costs of ROTC participants who incur illness or disease or are injured as a result of their military training of duty has an established record of ineffectiveness. The deficiencies in the current FECA program have resulted in individual ROTC participants being required to pay the real costs of the medical care necessary to return them to duty. It is the assessment of the senior commissioned leadership of the ROTC programs of the Armed Forces, and the former Deputy Assistant Secretary of Defense for Military Personnel Policy, Lieutenant General Van Alstyne, that reinvigorating the FECA program will not solve the problem for the ROTC participants and the health care providers who serve them. My independent review supports that conclusion. Neither Service Academy Cadets nor active members of the Reserve bear this financial burden. The deficiencies in the FECA program are harmful to morale in Senior ROTC units and there is corresponding damage to the reputation of the Armed Forces in college and university communities throughout the United States. The Congress, decades ago, established the concept that the Government was legally responsible for the costs of medical care for ROTC participants who incur illness, disease or injury in the line of duty. Now is a propitious time to give real

meaning to that proposition. Granting benefits similar to those available to Reservists injured in training is the proper model to follow, and this approach can be accommodated by the existing health care management systems of the Department of Defense. This proposal will establish clear authority to provide medical care to the intended beneficiaries to civilian as well as military medical care providers and to provide authority to fund this program with supplemental health care funds.

#### **4.0 DELAYED ENTRY PROGRAM ISSUES AND PROPOSED RESOLUTION**

As the discussion above reflects, the problems related to providing medical care for Service Academy cadets and midshipmen can be resolved by ensuring that they are treated as member of the Regular Armed Forces of the United States. Similarly, the problems relating to providing medical care for Senior ROTC cadets, midshipmen and applicants for those programs can be resolved if they are treated as if they are members of the active Reserve components of the Armed Forces. With the delayed entry program, neither the problems nor the solutions are as simple.

Delayed entry programs for officer acquisition have existed throughout the latter half of the twentieth century. Delayed entry for enlisted personnel became popular only after the era of draft-based enlistments concluded. With the end of the draft, the basic training establishment of all the Armed Forces was reduced substantially. Manpower officials sought ways to maintain a steady flow of trainees through the initial training programs operated by a training base infrastructure that was substantially reduced in size. This training base reduction created problems for recruiters who needed to recruit all year long, not just when the training base could accept applicants. The same manpower officials sought high quality applicants. With the best quality applicants graduating from college and high school at approximately the same time in the spring of the year, a dilemma confronted the Services. The training "pipeline" could get choked if nothing was done to smooth the flow of high quality initial trainees. The Delay Entry Program (DEP) was one simple

means of controlling the flow in the pipeline. The problem of flow in the officer pipeline had been less critical but it was exacerbated as the reduction in the size of the Armed Forces reduced the requirement for initial officer orientation courses.

Unfortunately, as is the case with many good ideas in the personnel field, the DEP program has grown beyond its initial boundaries without a corresponding review of its effects. Under today's DEP programs, the delays between graduation and order to active duty can be extensive. Moreover, as the matrix at the Appendix reflects, DEP members receive no medical benefits until they depart from their home to travel to their first duty station. College graduates who complete their education and receive Reserve commissions in May or June may not be ordered to active duty until March or April of the following year. Health care coverage is only one of their problems. Their most pressing problem is that these DEP participants are virtually unemployable in career enhancing fields because of their active duty commitments. Similar problems occur in the enlisted force because employers who offer high quality employment want a commitment of years before they commit to recruiting and training a new employee. In both cases, menial or temporary work may be the only solution for the DEP participant. In menial or temporary employment, health care benefits are seldom included.

As the discussion in Paragraph 3.5 reflects, medical coverage for newly commissioned ROTC graduates has largely been resolved in their favor. Enlisted

personnel, however, have no similar protection. Their exposure to illness or injury is identical to that facing the newly commissioned officer. Nevertheless, their incipient military status frequently leads to an absence of medical insurance coverage.

As the discussion above reflects, the medical problems of personnel in the DEP are not related to their military status. Illness, disease or injury do not, however, wait until the prospective active duty servicemember begins his or her travel to their first duty station. Typically, these young men and women have lost the insurance coverage that their parents provided while they were in school. They are emancipated, but they tend not to be financially independent and only those with great foresight have bought gap medical insurance coverage.

The principal advantage of the DEP to the Government is that it is inexpensive. The personnel in the DEP receive no pay or benefits. They have agreed either by contract or by appointment or enlistment in the Reserve to serve on active duty, but they receive little in return other than a delay in their reporting date. In most cases this delay is not a result sought by the member of the DEP. As a group, DEP participants would prefer to report for duty at the conclusion of their current civilian educational or training program. Thus, what began as a one-sided bargain affecting small numbers of personnel is now a staple of the initial entry process. It is my assessment that the DEP needs a comprehensive review, and health care related issues should be addressed as part of that comprehensive review.

There is, however, an intriguing legislative initiative that may permit the health care portion of the DEP problems to be solved in a manner that is independent of the larger issues in the DEP. A version of Senate Bill 852, entitled the National Guard and Reserve Comprehensive Benefits Act, recently was enacted as part of the Iraq Emergency Funding Bill. This bill extends, on a trial basis, the TRICARE program to all National Guard and Reserve members who are in a drilling status and are unable to obtain employer sponsored health insurance. This initiative would extend comprehensive health care benefits to nearly one million National Guard and Reserve families. If this program becomes permanent, it would be a simple enough matter to extend, by corresponding legislation, this TRICARE program to members of the DEP. DEP members, just as would be the case with active Guardsmen and Reservists, could rely on this health insurance program for all their medical problems. The problem, of course, is cost. According to the proponents of S.852, single members would pay only \$420 per year in premiums. This payment would cover only 28% of the cost, the same percentage paid by Federal employees for their health care insurance. The government subsidy would be \$1500 per year for a single member of the DEP. With dependents, the subsidy would be over \$5000 per year. While such a program would provide a powerful incentive to join the Armed Forces, the cost of providing such a program is entirely inconsistent with the general tenor of the DEP. Clearly such a benefit is not likely to be provided to the DEP independently because DEP members are not an effective political constituency. But as a part of a powerful National Guard and Reserve initiative, such a program

## 5.0 CONCLUSION

This report reviews the health and disability benefit programs available to recruits and officer candidates engaged in training, education and other types of programs while not yet on active duty. The report also reviews the health and disability benefit programs available to cadets and midshipmen at the Service Academies. My general conclusion, derived from numerous interviews with the personnel affected as well as system proponents, is that the permanent disability programs for all these categories, with the exception of participants in the Delayed Entry Program, provide a meaningful and logical system of benefits. With respect to the Delayed Entry Program the system is logical, but it is not very meaningful. For long term disability, benefits received by Service Academy cadets and midshipmen are equivalent to benefits provided to all other active duty personnel. For long term disability, benefits provided to members of the Senior ROTC are equivalent to the benefits provided to National Guardsmen and active Reservists who are injured in the line of duty. Delayed Entry Program participants receive no long term disability benefits unless they are injured during their travel to their first duty station. This may seem harsh, but it is exactly the same treatment they would receive if they were active members of the National Guard or the Reserve. Benefits are generated only if the Reserve component victim is actively involved in the military training process.

With respect to medical care the report identifies two serious deficiencies and proposes appropriate remedies. Medical care for cadets and midshipmen at the

Service Academies works well until these personnel are too ill or too injured to be retained on active duty. When they are discharged, there is a serious gap in their medical care coverage that may last more than a year. Some of these personnel need immediate and continuous care, and yet they must be discharged from active duty. The only real solution to this problem is to medically retire these cadets and midshipmen. These medically retired cadets and midshipmen will receive no additional monetary benefits from this action because the benefits from the Department of Veterans Affairs exceed the benefits from the Department of Defense and the law presently precludes collecting both benefits at the same time. The only significant benefit to be derived from the medical retirement process is high quality, continuous medical care, and that is exactly what these former cadets and midshipmen require.

The other serious deficiency in medical care relates to those participants in Senior ROTC who sustain illness, disease or injury during their training and are able to return to duty. Although the Department of Labor, through the Federal Employees Compensation Act (FECA), is charged with the responsibility of paying for medical bills resulting from ROTC training, the current medical claims process has become completely unresponsive to the requirements of the ROTC. Cadets have been forced to personally pay service-connected medical bills in order to avoid debt collection agencies. Doctors are declining to provide care to injured cadets because bills are not paid. The reputation of the ROTC on campuses nationwide has been

seriously damaged by this failure of the FECA process to pay claims properly. The best solution to this dilemma is to establish clear authority and responsibility for the Department of Defense to pay these claims with supplemental health care program funds. The amounts are not large. FECA paid slightly less than the \$500,000 for a total of 572 claims last year. The total will climb when the bills are properly paid, but it is clearly not appropriate to expect ROTC cadets and midshipmen to pay the cost of injuries, illness or disease incurred in the line of duty.

Except for the newly commissioned Reserve officers discussed in Paragraph 3.5, Delayed Entry Program personnel received no Government provided medical care until they have departed from their homes on their way to their first duty station. This policy provides the same level of benefits that an active member of the Reserve components would receive because the DEP participant has no training obligation. Such limited coverage clearly does not provide a very robust system of benefits. The report suggests that any expansion of medical benefits for the Reserve components should include a similar level of benefits for participants in the Delayed Entry Program. More significantly, the report recommends a comprehensive review of the Delayed Entry Program in order to ensure that its participants receive fair consideration for the time they are waiting to report to active duty. Additional legislation prior to a comprehensive review would likely lead to a series of piecemeal reforms that would not be productive.

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**APPENDIX – Service Academy ROTC Benefits Matrix**

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## SERVICE ACADEMY/ROTC CADET COMPARISON BENEFITS MATRIX

DUTY DESCRIPTION		BENEFITS UPON INJURY, ILLNESS, AND DEATH									
ACTIVITY	CADET CATEGORY	MILITARY MEDICAL CARE	MILITARY MEDICAL RETIREMENT	FECA MEDICAL & DISABILITY	FECA MEDICAL	VA MEDICAL & DISABILITY	VA DIC	VA BURIAL BENEFIT	SGLI BENEFITS	SOCIAL SECURITY BENEFITS	
Private Activities On or Off Campus w/No Military Connection	All Service Academy Cadets	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	
Private Activities On or Off Campus w/No Military Connection	All ROTC Cadet Categories	No	No	No	No	No	No	No	No	No	
Attending Classroom Instruction	All Service Academy Cadets	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	
Attending Civilian Classroom Instruction	All ROTC Cadet Categories	No	No	No	Yes	No	No	No	No	No	
Military Activity On or Off Post	All Service Academy Cadets	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	





## DETAILED ROTC CADET BENEFITS MATRIX

DUTY DESCRIPTION		BENEFITS UPON INJURY, ILLNESS, AND DEATH									
ACTIVITY	CADET CATEGORY	MILITARY MEDICAL CARE	MILITARY MEDICAL RETIREMENT	FECA MEDICAL & DISABILITY	FECA MEDICAL	VA MEDICAL & DISABILITY	VA DIC	VA BURIAL BENEFIT	SGLI BENEFITS	SOCIAL SECURITY BENEFITS	
Voluntary Off-Campus Local FTX (other than Flight or Flight Training) Authorized by PMS	Non Scholarship MS I & MS II (No USAR Status)	No - But Emergency Treatment Available	No	No	Yes	No	No	No	No	No	
	Non Scholarship MS III & MS IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	No	No	
	Scholarship MS I, II, III, & IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	No	No	
Engaging in ROTC Sponsored Flight or Flight Training	Non Scholarship MS I & MS II (No USAR Status)	No - But Emergency Treatment	No	Yes	Yes	No	No	No	No	No	
	Non Scholarship MS III & MS IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	No	No	
	Scholarship MS I, II, III, & IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	No	No	

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## DETAILED ROTC CADET BENEFITS MATRIX

DUTY DESCRIPTION		BENEFITS UPON INJURY, ILLNESS, AND DEATH									
		CADET CATEGORY	MILITARY MEDICAL CARE	MILITARY MEDICAL RETIREMENT	FECA MEDICAL & DISABILITY	FECA MEDICAL	VA MEDICAL & DISABILITY	VA DC	VA BURIAL BENEFIT	SGLI BENEFITS	SOCIAL SECURITY BENEFITS
Authorized Voluntary Training (Airborne, Air Assault Ranger)	Non Scholarship MS I & MS II (No USAR Status)	Yes	No	No	Yes	No	No	No	No	No	
	Non Scholarship MS III & MS IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	No	No	
	Scholarship MS I, II, III, & IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	No	No	
Attending or Traveling To or From Advanced Camp or Ranger Training	Scholarship MS III & IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	
	Non Scholarship MS III & MS IV (USAR Status)	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	
Attending or Traveling To or From Basic Camp	Applicable Only to ROTC Applicants (No USAR Status)	Yes	No	Yes	Yes	No	No	No	No	No	





## SERVICE ACADEMY/ROTC CADET BENEFITS MATRIX

DUTY DESCRIPTION		BENEFITS UPON INJURY, ILLNESS, AND DEATH									
ACTIVITY	CADET CATEGORY	MILITARY MEDICAL CARE	MILITARY MEDICAL RETIREMENT	FECA MEDICAL & DISABILITY	FECA MEDICAL	VA MEDICAL & DISABILITY	VA DIC	VA BURIAL BENEFIT	SGLI BENEFITS	SOCIAL SECURITY BENEFITS	
Attending Service Academy Prep School	(Prior Enlisted Status)	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	
	(No Prior Enlisted Status)	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	
Delayed Entry Program Recruits	Awaiting Initial Entry Training - Engaged in Civilian Activities	No	No	No	No	No	No	No	No	No	
	Traveling to Initial Entry Training	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	

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