

STATEMENT of
the MILITARY OFFICERS ASSOCIATION OF AMERICA

on
LEGISLATIVE PRIORITIES for
VETERANS' HEALTH CARE and BENEFITS
1st Session, 109th Congress

before the
SENATE VETERANS' AFFAIRS COMMITTEE
HOUSE VETERANS' AFFAIRS COMMITTEE

April 14, 2005

Presented by

Colonel Robert F. Norton, USA (Ret.)
Deputy Director, Government Relations

Commander John Class, USN (Ret.)
Deputy Director, Government Relations

MSSRS. CHAIRMEN AND DISTINGUISHED MEMBERS OF THE COMMITTEES, on behalf of the 370,000 members of the Military Officers Association of America (MOAA), we are honored to have this opportunity to legislative agenda for veterans health care and benefits programs.

MOAA does not receive any grants or contracts from the federal government.

VETERANS HEALTH CARE

Funding Shortfall

The FY 2006 VA Medical Care Budget includes \$28.1 billion in discretionary appropriations and \$2.6 billion in increased collections for a total of \$30.7 billion for VA medical care. Even if one assumes Congress were to endorse proposed new enrollment fees and collections – an unlikely prospect it would seem -- the VA medical care budget will increase only 2.5% compared to FY 2005. This increase falls far short of even modest estimates of medical inflation and clearly does not begin to address rising demand from returning combat veterans including the 470,000 members of the National Guard and Reserve forces who have been mobilized since September 11, 2001.

The President's Task Force to Improve Health Care Delivery for Our Nations Veterans report recommended in May 2003 that the VA system should be fully funded to meet the needs of all veterans enrolled in priorities 1-7 and to resolve the issue of priority 8 veterans' access to care. Unfortunately, the PTF's strong message seems to have been ignored.

MOAA continues to support legislation to provide full funding to the VA health care system; we urge support for H.R.515.

Access

Year after year, the VA budget request understates the real demand for VA health care services, and this year is no exception. VA has long argued that its quality improvements meet or exceed national standards. By many measures of excellence that is true, unless access is included as a quality metric. On that score, the VA has failed to live up to its commitment to the veterans it has agreed to treat. Demand for VA health care continues to exceed the VA's capacity to provide timely, quality services to enrolled veterans. Until a durable, full-funding mechanism is put in place, the VA system is likely to remain chronically under funded.

Veterans are still experiencing unacceptably long waiting lists ranging from six-months to one-year for initial or specialty appointments. Only by locking out priority 8 applicants – a policy set in motion in January 2003 – has the VA been able to reduce the number of veterans stuck on its waiting lists. Still, in a number of VA facilities, even with a reduced backlog, some veterans are not being seen within 30 days for routine care – the VA's published access standard.

Most Americans with health insurance would not accept waiting 30 days for routine care, yet those who have worn the nation's uniform must abide a lower standard.

Once the VA has agreed to accept a veteran for care there is an absolute obligation to provide high quality care in a timely manner.

Usage Fees and Drug Co-pays

The administration's FY2006 budget request once again proposes a \$250 usage fee for about 2.3 million priority 7 and 8 (P7-8) veterans enrolled in VA care.

The administration is also reviving its proposal to increase pharmacy co-payments from \$7 to \$15 for these veterans. Disabled, indigent, and special needs veterans, (priorities 2-6) would be exempt from increased drug co-payments. Severely disabled veterans (priority 1) are exempt from all drug co-payments.

Plans to reimburse veterans' out-of-pocket expenses for emergency care obtained outside the VA system and to exempt VA hospice care from co-payments are a positive development and we endorse them.

The Administration estimates that the \$250 enrollment fee would drive 213,000 veterans from the system. While that may be true, the proposal fails to consider the lost revenues from P7-8 veterans who have other health insurance (OHI) coverage. The VA is authorized to collect third party insurance held by veterans. Driving P7-8 veterans out of the system could actually result in lost collections that exceed the projected savings.

Further, any comparison of the proposed enrollment fee with TRICARE Prime fees is fallacious. TRICARE Prime is a managed care (HMO) component of the military care delivery system. The fees are optional for those who choose this coverage over TRICARE Standard. Participants pay modest annual fees to secure assured access to TRICARE providers under established access standards under TRICARE contracts. The proposed VA fees do not ensure payers will be assured timely access to VA services. To the contrary, their stated purpose is to drive veterans away.

Finally, it's likely that some returning National Guard and Reserve combat veterans – 470,000 have been activated since 9/11 – would be required to pay these fees if they seek VA health care. Our nation surely can do better than to honor their extraordinary sacrifice by charging such fees.

Fortunately, however, the Senate has rejected the fees in its version of the budget; the House Budget Committee does not address the need for the fees.

MOAA believes that during this long and difficult war on terror, Congress would send the wrong signal to the nation's warriors and future veterans by endorsing enrollment fees for VA health care. We strongly urge the Committees and Congress to reject VA enrollment fees and higher drug copays.

Seamless Transition

Our nation's service men and women deserve first class treatment and services before, during and after separation from military service. DoD and VA have critical, complementary roles in the transition process. Unfortunately, bureaucratic inertia and intramural priorities in DoD and the VA have slowed the pace of collaborative efforts towards the goal of "seamless transition".

Some of these efforts have been going on for decades with little or no substantive progress, in part because those responsible for action have come to have low expectations. Time and again, progress has been stymied by a combination of a lack of leadership priority and oversight, management turnover, bureaucratic inertia, and technological backwardness.

With tens of thousands of veterans separating every year and upwards of ten thousand wounded Iraq and Afghanistan war veterans, improving the transition process must be made a major priority for both departments working together.

The PTF final report on DoD - VA collaboration addressed the need to improve services and support for separating service members to ensure the receipt of timely, quality health care and other benefits. The PTF urged development of an interoperable, bi-directional electronic medical record, an electronic service separation document (DD-214), and enhanced post-deployment health screening among other initiatives. At this time when hundreds of thousands of service members are deployed in combat operations, the stakes are even higher – putting them at greater risk for long-term, service-connected health and disability problems.

In a recent report, *Vocational Rehabilitation; More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Service Members* (January 2005), the GAO recommends that VA and the DoD reach an agreement for VA to have access to information to promote recovery and return to work for seriously injured service members and to develop policy and procedures for regional offices to maintain contact with seriously injured service members.

Without systematic data from DoD, the VA cannot reliably identify all seriously injured service members or know with certainty when they are medically stabilized, when they are undergoing medical evaluation, or when they are medically discharged from the military. Patient tracking and quality and continuity in medical care then become bigger issues in achieving seamless transition goals.

MOAA is grateful that in the fiscal year 2005 National Defense Authorization Act (P.L. 108-375) Congress required DoD to do a better job of collecting baseline health status data through a formal medical readiness tracking and health surveillance system.

DoD and VA are gradually implementing a single separation exam at Benefits Delivery at Discharge (BDD) sites for active and reserve component members. But service-wide implementation at all 136 BDD sites has not been realized.

MOAA is particularly concerned about the significant gaps in implementing a single separation physical in the Washington, DC area. Key medical treatment facilities (MTFs) like Walter Reed Army Medical Center and National Naval Medical Center do not have a single, systematic process in place. This is particularly alarming considering the DoD and VA are headquartered here. It seems reasonable to expect the Washington, DC MTFs to serve as models for other DoD

and VA medical delivery systems. MOAA recommends the Committees to provide continued oversight to ensure that this important program is implemented promptly and effectively at all sites.

MOAA urges the Committees, working with the Armed Services Committees, to direct and oversee a concerted “Manhattan Project” effort to ensure full and timely implementation of seamless transition activities, a bi-directional electronic medical record (EMR), enhanced post-deployment health assessments, implementation of an electronic DD214, additional family and mental health counseling services, and one-stop physical at time of discharge.

Greater Transparency Needed in the DoD-VA Joint Executive Council

The 2003 National Defense Authorization Act formally established the DoD – VA Joint Executive Council (JEC) structure to oversee benefits and health collaboration between DoD and the VA. The JEC also oversees development and implementation of the Joint Strategic Plan between DoD and VA. The mission of the JEC also includes identifying opportunities such as policy, operations and capital planning, to advance seamless transition initiatives.

Under the JEC, the Health Executive Council (HEC) is responsible for identifying changes in health care related policies, procedures and practices and assessing further opportunities for the coordination and sharing of health related services and resources.

MOAA believes that military and veterans’ groups have valuable insights to offer the JEC and HEC forums since our constituents are users of both the VA and DoD healthcare systems.

MOAA recommends the Committees aggressively oversee the actions of the DoD – VA Joint Executive Council and schedule periodic joint hearings with the Armed Services Committees to assess progress on “seamless transition” initiatives.

Expansion of Mental Health Services

Mental Health Care. Recent studies project that 1 out of 6 servicemembers returning from Iraq and Afghanistan will need care at some point in their lives for PTSD and other mental health conditions. The VA Budget request takes an important first step in addressing the growing need for additional clinical capacity for mental health services. It includes an increase of \$100 million in obligations over 2005, and funds an additional 627 Full-Time Equivalent (FTE) positions to support the VA’s Mental Health Strategic Plan.

Additionally, MOAA urges Congress to push for the availability of robust preventive mental health counseling services for service members, families, and survivors, including training programs that will help individuals know when to seek professional help.

MOAA urges the Committees to support additional resources for the mental health needs of our service members, veterans, and their families.

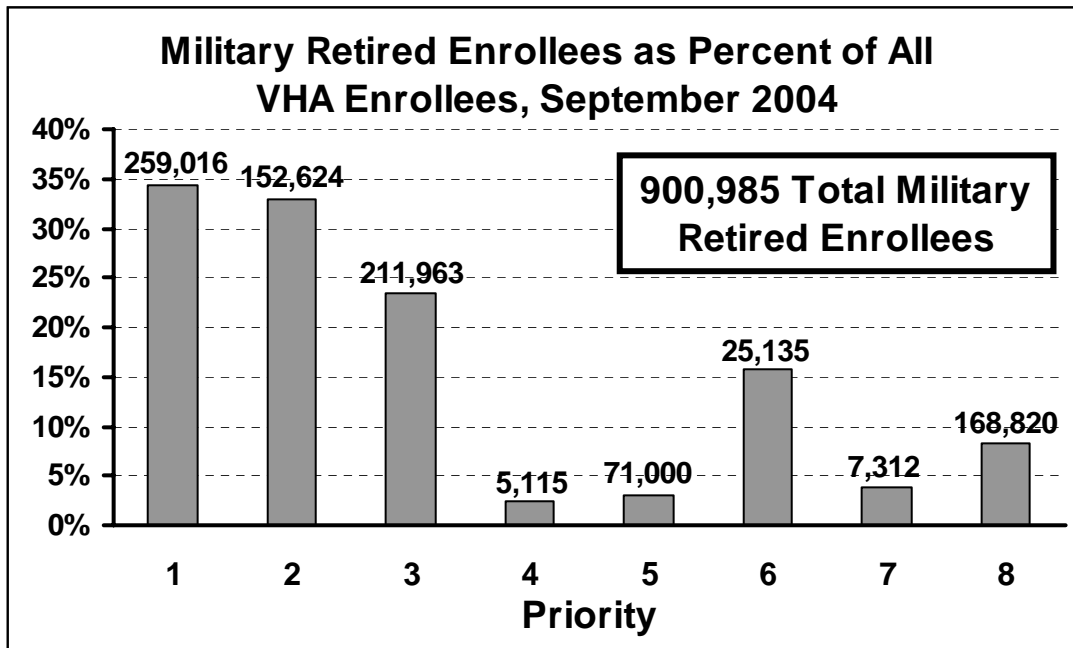
Retired Military Veterans Access To Earned DoD-VA Health Care Benefits

Veterans who have completed a full career in the armed forces or the Public Health Service and NOAA Corps have earned lifetime entitlement to health care benefits in the Department of

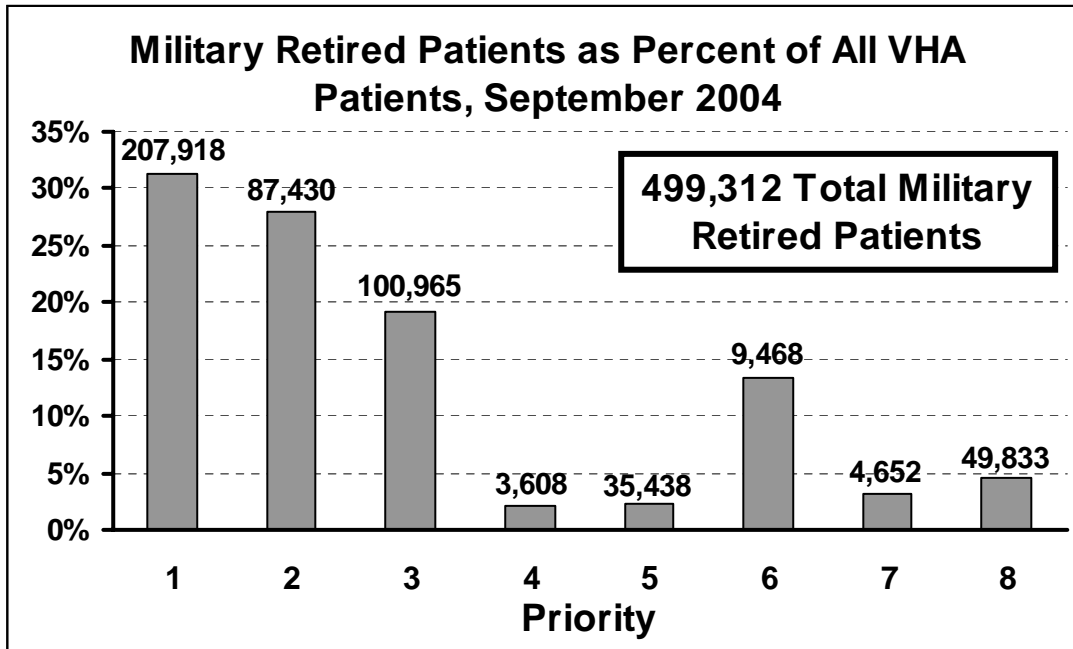
Defense TRICARE system, and eligibility for VA health care services.

A growing number of dual-eligible veterans use the VA for at least some of their care. Reliance on VA healthcare increases with disability level. VA enrollment and “unique patient” data show that:

- One out of eight enrolled veterans is a dual-eligible veteran.
- One out of nine users (“unique patients”) of VA care is a dual-eligible veteran.
- Enrollment of military retired veterans has increased by one-third since June 2000 when VA began tracking the data (600,870 retired veteran enrollees to 900,985 as of Sep 2004).



Source: VHA data as of 30 September 2004.



Source: VHA data as of 30 September 2004.

As one might expect, the higher a disability rating, the more likely it is that a veteran would seek VA care and specialty services.

- 80% of dual-eligibles with disabilities rated at 50% or greater used VA care last year.
- 57% of dual-eligibles with disabilities rated 40-50% used VA care last year.
- 48% of dual-eligibles with disabilities rated 10-30% used VA care last year.
- By contrast, only 29% of PG 8 retired veterans used VA care last year.

Overall, 55% of enrolled retirees used VA health care in some way last year.

Because many enrolled retired veterans have serious disabilities, it is imperative that they have assured access to the VA's spectrum of health care services including its well-regarded specialty care capabilities.

As we have noted in past testimony, military retired veterans often prefer to obtain their routine health care locally from the TRICARE network, but are willing to travel some distance to have access to VA specialty care services. MOAA supports TRICARE and VA developing better coordination-of-care mechanisms provided that retired veterans are not caught in the middle of "dueling bureaucracies."

MOAA is most appreciative of Congress' action to protect dual-eligible veterans' access to all earned health care benefits provided by DoD and VA. The government should not force military retirees to relinquish any earned health care benefit.

We are encouraged that the DoD and VA Health Executive Council has developed reimbursement rates to support better coordination-of-care activities between TRICARE and VA health care. Agency-level coordination mechanisms must be designed in ways that foster budget

coordination and reconciliation without limiting dual-eligibles' access to earned health care benefits for the convenience of the government.

MOAA appreciates Congress' continued support in opposing "forced choice" proposals that would compel dual-eligible veterans to relinquish access to earned DoD or VA health care services.

Capital Assets for Enhanced Services (CARES)

MOAA and others have noted that the CARES planning process does not include planning for mental health services and long-term care. MOAA continues to urge inclusion of those requirements in ongoing facilities decisions resulting from the CARES process.

CARES and DoD Facilities Planning Process. The VA Budget Request includes \$15 million to advance DoD – VA facilities collaboration. It is not clear whether ongoing or planned projects have been integrated in the CARES process or DoD's preparation for the next round of military base realignment and closure -- BRAC. MOAA maintains that these collaborative efforts must include as an outcome measure the enhancement of service to eligible veterans and service members.

MOAA urges the Committee to closely monitor use of funds for VA-DoD facilities collaboration and to judge sharing projects on whether they improve access and quality of care for all eligible beneficiaries.

VETERANS BENEFITS

Overview. The 2006 VA Budget Request includes \$37.4 billion for entitlement costs associated with benefits administered by the Veterans Benefits Administration (VBA). Additional funds are earmarked for improving compensation claims processing and the management of benefits programs including disability compensation; pensions; education; vocational rehabilitation and employment; and life insurance.

Death Benefits Enhancement

Military insurance (Servicemembers Group Life Insurance, SGLI) and death gratuity fall short of what is needed when measured by private sector standards for employees in hazardous occupations.

Most large employers provide lump-sum death benefits, cost-free to the employee, of two times salary, capped at some limit between \$100,000 and \$250,000. Police and firefighters killed in the line of duty receive a federal, cost-free Public Safety Officers Death Benefit of \$267,000 in addition to a typical five-figure death gratuity.

In today's commercial life insurance markets, insurance coverage for many mid-career workers typically exceeds \$500,000.

Spousal Notification vs. Consent. MOAA is grateful for recent action taken in the Senate and House signaling the likelihood of raising SGLI coverage limits and the death gratuity this year. Earlier, we indicated interest in the concept of "spousal consent" with regards to a decision to

decline SGLI coverage. However, in consultation with our Military Coalition partners, government officials, and professional staff of the Veterans Committees, we now believe a spousal consent clause would greatly complicate or preclude the SGLI decision process:

- ❑ A servicemember with minor children from a prior marriage would be prohibited from naming them as beneficiaries on his life insurance policy unless a current spouse consents.
- ❑ The spouse of a servicemember who has been estranged from a spouse for years, or is in the middle of a divorce proceeding, would be given authority to dictate the policy terms and beneficiaries.
- ❑ No protection or notice would be afforded to the spouse of a servicemember who was single at the time of election, later marries and neglects to change a beneficiary.
- ❑ The provision makes SGLI involuntary for married servicemembers, but voluntary for single members.
- ❑ Spousal consent fails to recognize that not all marriages are healthy and intact at the time a servicemember becomes eligible for SGLI
- ❑ A life insurance contract requiring a second party (a spouse) to dictate the terms of an elective benefit of the first party military sponsor may not be enforceable in law

MOAA strongly recommends the Committees endorse raising SGLI to \$400,000, with \$100,000 provided at no cost to servicemembers who elect \$300,000 coverage, and to increase the military death gratuity to \$100,000 for all deaths, with the coverage increases retroactive to cover all deaths since Oct. 7, 2001 that were deemed “in the line of duty.” MOAA further recommends that a spousal notification requirement be established for the SGLI.

Disability Claims: Quality and Process Improvements Needed

The VA reports that in 2004 initial VA claims averaged 120 days to process. But, 21% of all claims averaged over 6 months to complete. Achieving a consistent output of quality claims – reducing errors and making sound initial judgments -- has eluded the claims system. The Administration’s budget request supports an increase of 113 positions – Full Time Equivalents or FTE - in the claims business. This may not be enough, however, to improve the quality of initial decisions and reduce the backlog. Because of rising workload and other factors, the VA projects that the average time to process an initial claim will increase to 145 days next year, losing an average of almost a month compared to 2004. This trend is going in the wrong direction and must be reversed to be fair to returning disabled veterans. Clearly, the VA needs to model the processes used by successful “tiger teams” and replicate them throughout the system. Additional investment in training, FTE, and technology also will be needed to reach sustainable quality and timeliness goals.

MOAA continues to urge additional claims-workers, technology upgrades, and training to reach and sustain its original strategic performance goal of 100 days on average per VA claim.

A GI Bill for the 21st Century Force

A total force on the battlefield – Active Duty, Guard, and Reserve – should be supported by a total force approach to the Montgomery GI Bill educational benefits programs.

MOAA is very grateful to the Committees and Congress for recent upgrades in educational benefits under the Montgomery GI Bill (MGIB) for active duty, reserve component members, and veterans. Some recent changes enacted in public law include:

- ❑ Three-phase increase to active duty MGIB benefits (Chapter 30, 38 USC) between 2001 and 2004. The rate for full-time study or training is now \$1004 per month
- ❑ Authorization for lump-sum payments for certain technical training and certification exams
- ❑ Proportional access to active duty MGIB benefits for activated Guard and Reserve members who serve from 90 days to 24 months active duty in a contingency operation.

These encouraging developments, however, mask underlying structural problems between the active duty and reserve forces MGIB programs.

The reality is that while our total armed forces are operationally integrated in the field, MGIB programs are not synchronized to accomplish their statutory objectives.

Congress intended the all-volunteer force to be supported by a MGIB that would:

- ❑ aid in the recruitment and retention of high-quality individuals for service in the active and reserve forces;
- ❑ assist in the readjustment of service men and women to civilian life after completion of their service;
- ❑ extend the benefits of higher education (and training) to service men and women who might not otherwise be able to afford such an education;
- ❑ enhance the nation's competitiveness through a more highly educated and productive workforce.

It's clear that separate authorities for the MGIB are limiting its effectiveness in carrying out the purposes Congress intended. Active duty MGIB programs are established under Title 38, Veterans Benefits, whereas Selected Reserve programs (Chapters 1606 and the new Chapter 1607) are established under Title 10, the Armed Forces Code. This may have made some sense during the Cold War, since at that time few people envisioned a need for a readjustment component to Guard and Reserve MGIB benefits. That's hardly true today.

Because MGIB programs are authorized under different titles of the U.S. Code, an adjustment or improvement sponsored by the Veterans Committees often is not matched with an appropriate adjustment for reserve MGIB programs under the jurisdiction of the Armed Services Committees.

MOAA strongly supports the integration of active and reserve force MGIB programs under Title 38 so that these programs can be aligned to better achieve their statutory purposes of recruiting, retention, and readjustment outcomes. Benefits should be tiered to the nature of the contract – active or reserve service -- and the length of the service commitment.

Active Duty MGIB (Chapter 30, Title 38 USC)

On 1 October 2004, MGIB-Active Duty (MGIB-AD) rates increased to \$1004 per month for 36 months of full-time study under a three-year or longer enlistment. But Department of Education data show the current monthly rate only covers 63% of the cost of expenses at the average four-year public college or university education, assuming full-time use of benefits.

Active duty troops may use their MGIB benefits while serving on active duty as well as after separation. VA data show that 8% of currently serving men and women use the MGIB. This low figure is understandable in light of the enormous operational stresses imposed on the force today. When the pace of current operations subsides at some point, off-duty use of MGIB benefit may increase. Service men and women who use their benefits on active duty should get the same reimbursement rate as they would following separation or retirement. MOAA has been an early and aggressive proponent of benchmarking benefit levels to keep pace with the cost of education.

Specific Recommendations for the Active Duty MGIB:

- 1. Benchmark MGIB-AD rates to the average cost of a four-year public college or university education.** Despite significant increases in MGIB benefits in recent years, benefits support only 63% of the actual costs of an education at the average four-year college or university. Benchmarking MGIB benefit levels to the cost of education would serve as a powerful recruitment tool for the college “stop-out” market.
- 2. Eliminate the MGIB-AD enrollment fee.** College students receive generous federal loans for their education from their government with no obligation of service to the nation and no upfront payments. Conversely, young Americans who volunteer to serve in the Armed Forces are automatically docked a substantial portion of their first year’s pay in order to enroll in the MGIB-AD. If they decide to leave the service but do not use remaining MGIB-SR entitlement, there is no authority to recover the \$1200 fee. *MOAA supports enactment of S.43 as a first step in eliminating the MGIB enrollment pay-cut of \$1200 for all service entrants.*
- 3. Enrollment Option for Career Servicemembers who Declined “VEAP”.** 63,000 career servicemembers on active duty today declined to enroll in “VEAP” – the Post-Vietnam Era Veterans Education Assistance Program (Chapter 32, 38 USC) – on the advice of military recruiters. In many cases, they were told that they would do better to invest the VEAP enrollment fee of \$2700 and wait to enroll in the coming Montgomery GI Bill. They deserve one opportunity to enroll in the MGIB prior to retirement. *MOAA supports enactment of H.R.269.*
- 4. Equalize reimbursement rates for Active Duty servicemembers with the reimbursement rates for veterans.** Section 3032 of Chapter 30 lowers reimbursement rates for the MGIB for servicemembers who use their benefits on active duty under certain circumstances. At one time, this provision may have served a useful purpose, but today the authority results in inequitable benefit reimbursement if a servicemember takes courses or training on active duty to advance in the military profession or attain personal educational goals.
- 5. Transferability of Benefits.** About two-thirds of today’s force is married. Many reenlistment decisions are based on family needs. To support career force retention programs, MOAA supports enactment of legislation to permit a servicemember to transfer up to one-half of remaining MGIB-AD entitlement to immediate family members

in exchange for a career commitment (e.g., those who commit to serve at least 14 years normally will later complete 20 or more years service).

Selected Reserve MGIB (MGIB-SR) (Chapter 1606, Title 10 USC).

MGIB-SR rates originally were set at 47% of MGIB-AD rates when the program began on 1 July 1985. That ratio was maintained for 15 years until 2000, when Congress enacted a series of rate increases for the MGIB-AD alone. Consequently, MGIB-SR rates dropped sharply in proportion to the MGIB-AD program and today the present ratio is 28.7% -- \$288 per month for full-time use of the benefit. By historic standards, the current rate should be in the range of \$472 to \$502 per month for full-time study.

Benefit coordination challenges. The FY2005 National Defense Authorization contains new authority for mobilized Selected Reserve members to participate in the MGIB-AD proportional to the length of their active duty service. Reservists who serve 90 days to one-year active duty in a contingency operation qualify for 40% of Chapter 30 MGIB benefit rates, up to 80% for 24 months active service in a contingency operation.

While helpful, the new benefit authorized under Chapter 1607 of Title 10 illustrates that MGIB benefit programs are not synchronized with Chapter 1606, 10 USC or Chapter 30, 38 USC to achieve maximum benefit for recruiting, reenlistment and readjustment purposes.

A Guard or Reserve member who completes two years continuous active duty in a contingency operation may simultaneously be eligible for Chapter 30 benefits (if the servicemember agrees to pay the \$1200 enrollment fee); Chapter 1606 (Title 10) benefits based on a previous initial entry in the Guard or Reserve; and, the new Chapter 1607 authority, which entitles the service member to 80% of Chapter 30 benefit levels with no \$1200 enrollment fee. The servicemember has to sort out potentially confusing benefit options since overlapping usage is not authorized. On top of this, a 48 month limitation is imposed on benefit eligibility under multiple programs.

Specific MGIB –SR Recommendations:

- 1. Restore proportional parity between the MGIB-SR (Chapter 1606, 10 USC) and the MGIB-AD (Chapter 30, 38 USC).** To support Guard and Reserve recruitment, MGIB-SR rates should be restored to about 50% of MGIB-AD rates and adjusted automatically with any future changes in the Chapter 30 program.
- 2. Establish a reenlistment or transition benefit for the MGIB-SR.** The MGIB-SR has no value as a veteran's benefit since participants must remain in the Selected Reserve to retain eligibility. Recently, Congress extended the in-service usage period from 10 years to 14 years. However, due to the radically changed nature of reserve service, the MGIB-SR should be structurally aligned with the MGIB-AD. Servicemembers who complete their service agreement should be able either to use remaining entitlement after separation; alternatively, benefit rates should be raised for those who agree to reenlist or extend their service.
- 3. Permit Aggregate Active Duty Service in a contingency operation to qualify for MGIB-AD benefits.** As indicated earlier, P.L. 108-767 established a new program for reservists who serve on active duty since 9/11 to qualify for pro-rated MGIB-AD

benefits. Under Chapter 1607, 10 USC, reservists who serve in a contingency operation may qualify for enhanced MGIB benefits:

- a. 90 days to 12 months = 40% MGIB-AD;
- b. at least one year but less than two years = 60% MGIB-AD;
- c. two years = 80% MGIB-AD.

Due to erratic and inconsistent call-up practices since 9/11 and in fairness to frequently activated members of the Guard and Reserve, MOAA urges a change in law to permit Guard and Reserve troops who aggregate up to two years active duty since 9/11 to be permitted a full MGIB-AD enrollment opportunity. *MOAA urges enactment of H.R. 772.*

In addition, the Chapter 1607 Title 10 requirements should be better synchronized with MGIB-SR rules under Chapter 1606 and MGIB-AD rules under Chapter 30.

4. **Tuition Assistance and ‘Top Up’ for the MGIB-SR.** The MGIB-SR authorities (Chapter 1606 and 1607) do not permit the Services or their reserve components to pay for authorized educational courses nor permit MGIB-SR users to apply part of their benefit to pay any difference in coursework (“Top Up”). *MOAA recommends authorization of proportional Tuition Assistance and “Top Up” with Chapter 1606 and Chapter 1607 programs as an enlistment or reenlistment incentive.*
5. **Licensure / certification tests and high technology courses for MGIB-SR participants.** Today’s educational system provides students with the opportunity to enroll in a variety of nontraditional, accelerated courses offered through multiple venues. Legislation is needed to permit MGIB-SR participants the flexibility of accelerated, lump sum payments for high-tech courses and for licensure and certification exams. *Both options are currently offered to the MGIB-AD participants, but not MGIB-SR participants.*

MOAA recommends amending the Reserve Montgomery GI Bill rules to allow accelerated lump sum payments of 60% of tuition and fees for short-term, high tech courses. In addition, participants should be able to use up to \$1000.00 entitlement for tests to obtain a license or certification.

MOAA strongly recommends the Committees collaborate with the Armed Services Committees to re-structure the Montgomery GI Bill for the 21st century force.

SCRA and USERRA Protections

MOAA appreciates the Committees’ championing improvements to the laws that provide financial, legal, reemployment, and employment rights protections for our service men and women and their families.

Reemployment rights for National Guard and Reserve servicemembers who perform military duty are governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under Chapter 43, Title 38 USC. Last year, Congress passed legislation that requires employers to post USERRA rights and responsibilities in the workplace. This action

will help to educate employers and their reservist-employees on their mutual rights and responsibilities under the law.

MOAA is also very grateful for action last year amending the USERRA to extend employment-based health plan coverage from 18 to 24 months. Mobilized reservists with employment-based coverage may elect to retain such coverage for up to two years on active duty.

MOAA has long recommended that USERRA rules be published in the Code of Federal Regulations and we are pleased to see that at long last the Dept. of Labor (DoL) promulgated proposed rules for the USERRA last year. The rules are written in a direct, clear, non-bureaucratic style and should be helpful to all stakeholders. We continue to recommend that an accompanying manual of case studies be published by DoL to illustrate the practical application of USERRA in particular situations and to show how cases can usually be resolved through effective communication and understanding of the law.

MOAA recommends the Committees enact a change to USERRA directing the Department of Labor to develop and publish a handbook illustrating best practices in the resolution of reemployment rights cases for returning veterans of the war on terror.

MOAA is also appreciative of the Committees' leadership in endorsing recent upgrades to the financial and legal protections available to service men and women and their families under the Servicemembers' Civil Relief Act (SCRA) as codified in P.L. 108-189.

That good news is tempered unfortunately by recent reports (NY Times, 28 March 2005, pg. 1: "Bills in the Knapsack: A Law Gets Lost; Creditors Press Troops Despite Relief Act") documenting willful disregard or ignorance of the protections afforded by the SCRA.

This problem mirrors occasional violations of reemployment rights of returning Guard and Reserve veterans under the USERRA. Congress addressed that situation by requiring USERRA rights and responsibilities to be posted in the workplace. Similarly, broad dissemination of the SCRA to creditors, banks, and other financial institutions may help educate the credit and financial industry and military men and women about the SCRA.

MOAA has also heard from active duty service members concerning tax problems that arise from changing duty stations. The following is an extract of a recent communication to MOAA from an active duty couple:

"We have been married for almost 11 years and have lived in North Dakota, Oklahoma, Montana, Florida, California, Alabama, and soon Virginia. I have retained my Missouri residency (where I was a resident prior to active duty) and my wife has retained her North Dakota residency. Our cars are jointly owned, titled and registered in North Dakota (changed from Missouri because I would always have to pursue them to re-register and pay personal property tax). I always file a Missouri income tax return, and when my wife works she files both a North Dakota return (as a resident) and whatever other state [return] we are living in – this included Florida where we paid North Dakota income tax despite no income tax in Florida.

"Our next move is to Virginia. As I get familiar with requirements there I read that if our cars are titled and registered in my wife's name as well as mine, the state of Virginia (via the local county) will require us to pay personal property tax. If the vehicle is in my name only there is no tax. Additionally, if my

wife gets a job in the state of Virginia the state requires her to get a Virginia drivers license (this was also true of Montana and California).

“Strangely enough, for us to be a normal married couple that live together, she has to move as often as I do. It is bad enough that getting her bachelors degree has been dragged out by years because of having to change schools, and that her career will be routinely interrupted so I can serve our nation, but to have each state impose rules on her but not me is frustrating, time consuming and costly.

“Additionally, it seems strange that if I change title/registration of my cars back to Missouri, but keep my wife as a co-owner, I will end up paying full personal property taxes to both St. Louis County (MO) and Stafford County (VA). At least with income taxes the states give you credit for tax paid to another state.”

MOAA recommends the Committees conduct a hearing to examine the need for additional family member protections under the SCRA and to examine the cause of recent abuses of the statute by the credit and finance industry with the objective of ensuring widespread understanding and compliance with the law.

Concurrent Receipt of Military Retired Pay and VA Disability Compensation

MOAA applauds Congress for the landmark provisions in the FY 2004 National Defense Authorization Act that expanded combat-related special compensation (CRSC) to all retirees with combat-related disabilities and authorized—for the first time ever—concurrent receipt of retired pay and veterans’ disability compensation for retirees with disabilities of at least 50 percent. The FY 2005 National Defense Authorization Act (NDAA) provided additional relief to those with 100 percent disabilities by authorizing these retirees full concurrent receipt, effective January 2005. Disabled retirees everywhere are extremely grateful for Congress’ action to reverse an unfair practice that has disadvantaged disabled retirees for over a century.

While the concurrent receipt provisions enacted by Congress benefit tens of thousands of disabled retirees, an equal number are still excluded from the same principle that eliminates the disability offset for those with 50 percent or higher disabilities. The fiscal challenge notwithstanding, the principle behind eliminating the disability offset for those with disabilities of 50 percent is just as valid for those with 40 percent and below.

MOAA asks the individual members of the Committees to consider those who had their careers cut short because they became disabled by combat, or combat-related events, and were medically retired before they could complete their careers. For these retirees, the disability offset still exists and it is difficult to explain to a lengthy career servicemember, disabled in combat, why his or her service (perhaps as much as 19 years, 11 months) seems to have had no value when a member with 20 years of service and a 10% disability receives full payment for service and disability.

MOAA urges expansion of CRSC to members who were medically compelled to retire before short of 20 years of service solely because of their combat-incurred disabilities, as envisioned in H.R. 1366. This legislation would protect service-based retired pay (2.5% of high-three years’ average basic pay times years of service) from being affected by the disability offset. It would avoid the “all or nothing” inequity of the current 20-year threshold, while recognizing that retired pay for those with few years of service is almost all for disability rather than for service and therefore still subject to the VA offset.

MOAA also urges resolution of inequities associated with the implementation of concurrent receipt legislation enacted in the FY 2005 NDAA. The NDAA authorized the immediate restoration of retired pay for 100 percent rated disabled retirees; however, the Administration has yet to extend full payment to those disabled retirees who—because their serious disabilities prevent them from working—are paid at the 100-percent rate because the VA has certified them as “unemployable”. The exclusion of these “unemployable” disabled retirees has created two classes of 100 percent disabled retirees—a differentiation that is not made in any other circumstance, either by the Department of Veterans Affairs or in the administration of the CRSC program by DoD. Accordingly, MOAA recommends unemployable retirees have their full retired pay restored.

We understand that a significant concern among some critics that still prevents broader concurrent receipt action is the need for a review of the VA and DoD disability systems. MOAA believes much of the concern is misplaced, and that both systems can withstand reasonable scrutiny.

Most importantly, MOAA urges the Committees to ensure that the Commission remains focused on the fundamental principles that have served as the foundation for both the DoD disability retirement and VA disability compensation processes—principles of fairness, due process, and the unique aspect that military duty is 24/7. We look forward to completion of the review and revalidation of policies and procedures that will lead to elimination of remaining concurrent receipt inequities.

MOAA urges Members of the Committees to endorse expansion of combat-related special compensation to disabled retirees who were not allowed to serve 20 years solely because of combat-related disabilities.

MOAA also urges resolution of inequities that prevent those disabled retirees rated 100 percent because of “unemployability” ratings from receiving their full restoration of retired pay. Finally, MOAA strongly urges the Committees to carefully oversee the work of the Veterans’ Disability Benefits Commission and protect the underlying principles guiding the VA disability compensation system.

Arlington National Cemetery Interment Rules

MOAA continues to support the codification of all the rules governing in ground burials in Arlington National Cemetery. On multiple occasions since 1998 the House of Representatives by unanimous or near-unanimous vote has favorably reported legislation that would codify the rules governing interment in our nation’s most hallowed resting place for its military heroes.

We note, too, that the House Committee on Veterans Affairs endorsed legislation that would eliminate the age requirement for retired reservists who would otherwise be eligible for in-ground burial at Arlington National Cemetery (ANC). The legislation also would have authorized an in-ground burial to reservists who die in the line of duty while on inactive duty.

The most recent House-passed legislation would authorize an in-ground burial to:

- members of the Armed Forces who die on active duty;

- retired members of the Armed Forces, including Reservists who served on active duty;
- former members of the Armed Forces who have been awarded the Medal of Honor, Distinguished Service Cross, Air Force Cross, or Navy Cross, Distinguished Service Medal, Silver Star, or Purple Heart;
- former prisoners of war;
- members of the National Guard / Reserve who served on active duty and are eligible for retirement, but who have not yet retired;
- members of the National Guard / Reserve who die in the performance of inactive duty training;
- the President or any former President;
- the spouse, surviving spouse, minor child and at the discretion of the Superintendent of Arlington, unmarried adult children of the above categories.

MOAA understands that many members of the Senate support codification of these rules, but also want to maintain longstanding tradition and practice of considering certain exceptions in the case of individuals who have made extraordinary contributions to the nation.

MOAA continues to recommend codification of the rules governing interment in the nation's most hallowed final resting place for its military heroes, and further recommends that the members of the Committees work out a suitable compromise to preserve the tradition of very limited exceptions in the case of individuals who have made extraordinary contributions to the nation.

Presumption of Service Connection for Hepatitis-C Infection

Medical research has established that there is a significantly higher rate of Hepatitis-C (HCV) infection among veterans than in the general population. Responding to this major health care challenge, the Veterans Health Administration has implemented aggressive screening, treatment and research to combat this healthcare crisis among veterans. MOAA is grateful for this commitment. There is a need now to follow up authorizing presumptive service-connection from HCV under certain conditions.

Before development of a reliable HCV screening test in the early 1990's, many thousands of servicemembers were exposed in service to HCV through air-gun inoculations, surgery, other medical procedures, and battlefield exposure. Accordingly, it is reasonable to presume service-connection for servicemembers exposed to the HCV virus prior to development of definitive screening tools.

MOAA recommends legislation adding presumption of service connection for Hepatitis-C in servicemembers determined to have been exposed to this disease in service prior to development of definitive screening protocols in 1992.

Retention of Dependency and Indemnity Compensation (DIC) for Remarried Spouses

MOAA commends this Committees and Congress for enacting legislation to allow retention of DIC for eligible surviving spouses who remarry after age 57.

MOAA supports lowering the DIC Remarriage Age to 55 to align the benefit with all other Federal survivor remarriage programs.

Conclusion

The Military Officers Association of America greatly appreciates the opportunity to present the

Association's legislative priorities on veterans health care and benefits issues for the first session of the 109th Congress to this joint hearing of the Senate and House Veterans Affairs Committees. MOAA is very appreciative of the support provided to servicemembers and veterans in the past and we look forward to working with the leadership and distinguished members of the Committees to ensure full funding for veterans health care and benefits programs.

Biography of Robert F. Norton, COL, USA (Ret.)
Deputy Director, Government Relations, MOAA
Co-Chair, Veterans' Committee, The Military Coalition

A native New Yorker, Bob Norton was born in Brooklyn and raised on Long Island. Following graduation from college in 1966, he enlisted in the U.S. Army as a private, completed officer candidate school, and was commissioned a second lieutenant of infantry in August 1967. He served a tour in South Vietnam (1968-1969) as a civil affairs platoon leader supporting the 196th Infantry Brigade in I Corps. He transferred to the U.S. Army Reserve in 1969 and pursued a teaching career at the secondary school level. He joined the 356th Civil Affairs Brigade (USAR), Bronx, NY and served in various staff positions from 1972-1978.

Colonel Norton volunteered for active duty in 1978 and was among the first group of USAR officers to affiliate with the "active Guard and Reserve" (AGR) program on full-time active duty. Assignments included the Office of the Deputy Chief of Staff for Personnel, Army Staff; advisor to the Asst. Secretary of the Army (Manpower & Reserve Affairs); and personnel policy and plans officer for the Chief, Army Reserve.

Colonel Norton served two tours in the Office of the Secretary of Defense (OSD). He was responsible for implementing the Reserve Montgomery GI Bill as a staff officer in Reserve Affairs, OSD. From 1989 –1994, he was the senior military assistant to the Assistant Secretary of Defense for Reserve Affairs, where he was responsible for advising the Asst. Secretary and coordinating a staff of over 90 military and civilian personnel. During this tour, Reserve Affairs oversaw the call-up of more than 250,000 National Guard and Reserve component troops for the Persian Gulf War. Colonel Norton completed his career as special assistant to the Principal Deputy Asst. Secretary of Defense, Special Operations / Low Intensity Conflict and retired in 1995.

In 1995, Colonel Norton joined Analytic Services, Inc. (ANSER), Arlington, VA as a senior operational planner supporting various clients including UN humanitarian organizations and the U.S. Air Force's counterproliferation office. He joined MOAA's national headquarters as Deputy Director of Government Relations in March 1997.

Colonel Norton holds a B.A. in philosophy from Niagara University (1966) and a Master of Science (Education) from Canisius College, Buffalo (1971). He is a graduate of the U.S. Army Command and General Staff College, the U.S. Army War College, and Harvard University's Senior Officials in National Security course at the Kennedy School of Government.

Colonel Norton's military awards include the Legion of Merit, Defense Superior Service Medal, Bronze Star, Vietnam Service Medal, Armed Forces Reserve Medal, Army Staff Identification Badge and Office of the Secretary of Defense Identification Badge.

Colonel Norton is married to the former Colleen Krebs. The Nortons have two grown children and reside in Derwood, Maryland.

**Biography of John S Class, CHE
Deputy Director, Government Relations for Health Affairs
The Military Officers Association of America**

John S. Class is a native of Southern California. The son of a retired Navy Officer John spent his teenage years in Northern Illinois. He is a 1980 graduate of the University of Illinois where he earned his Bachelor of Science in Health Systems Administration. John earned his Master of Arts Degree in Health Services Management and Business Administration from Webster University in 1981 while working at Condell Memorial Hospital in Libertyville Illinois.

He entered the Navy in January 1982 and served at the Naval Hospital Jacksonville Florida as an Administrative Officer primarily overseeing all manpower issues and disaster preparedness operations. Leaving the warm weather behind he trekked back to Northern Illinois and served as the Chief Resources Management at the Naval Hospital Corps School. After a few years and a spring thaw in 1987 he was assigned as the Medical Administrative Officer onboard the USS KITTY HAWK (CV-63) and was responsible for the daily operations of a complete inpatient and outpatient medical facility serving over 5000 active duty service members. Most of his tour of duty was spent at the Naval Shipyard in Philadelphia, where the ship underwent a major overhaul. To see more of the world was not in the cards and in 1990 he was sent back to the Northern Illinois area and assigned as Officer in Charge of the Branch Medical Clinic, Glenview Naval Air Station. The clinic provided outpatient services to over 5000 active duty service members and their families, in addition to 3500 naval reserve members. After completing a three-year tour he was assigned as the Director for Administration at the Naval Dental Center, Great Lakes, Illinois. John was responsible for all administrative functions required supporting a very active dental facility providing dental treatment to over 60,000 navy recruits each year. After serving two years he was selected for the position of Director for Administration at the Naval Medical Research Institute in Bethesda, Maryland. In 1998 he was transferred to the Bureau of Medicine and Surgery where he assisted beneficiaries and answered congressional requests concerning the Navy Direct Care System. In early 1999 John became the Executive Assistant in the Healthcare Operations Directorate. The lure of going back to a hospital was too great to overcome and he was transferred to the National Naval Medical Center, Bethesda where he served as Associate Director for Administration and subsequently Associate Director to the Deputy Commander. He retired from the Navy in February 2002. After a short stint as a healthcare analyst at the Naval Medical Information Management Center he joined Axiom Resource Management, Inc. and served as a Senior Healthcare Analyst at the TRICARE Management Activity. He provided consultative services for the delivery of healthcare to Department of Defense beneficiaries overseas. In November 2004 he began his current position as a Deputy Director, Government Relations for Health Affairs at the Military Officers Association of America where he follows health care reform legislation and its potential impact on the military health services system. Currently he serves as a member of the Base Realignment and Closure Working Group on Military Health Care and is a member of various committees of the Military Coalition, an influential consortium of 35 military and veterans associations.

John is a Certified Healthcare Executive through the American College of Healthcare Executives.