

**STATEMENT OF  
THE RETIRED OFFICERS ASSOCIATION**

**ON  
VETERANS' HEALTH CARE and BENEFITS  
LEGISLATIVE GOALS**

**before the**

**SENATE VETERANS' AFFAIRS COMMITTEE  
HOUSE VETERANS' AFFAIRS COMMITTEE**

**March 20, 2002**

**Presented by**

**Colonel Robert F. Norton, USA (Ret.)  
Deputy Director of Government Relations  
The Retired Officers Association**

**Biography of Robert F. Norton, COL, USA (Ret.)**

Deputy Director, Government Relations  
The Retired Officers Association (TROA)

Colonel Norton is responsible for TROA's legislative goals for veterans' health care and benefits. A native New Yorker, COL Norton was born in Brooklyn and raised on Long Island. Following graduation from college in 1966, COL Norton 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 to return to 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. He specialized in manpower, personnel, and quality-of-life programs for the Army's reserve forces. 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.

While assigned to the Office of the Secretary of Defense (Reserve Affairs), Colonel Norton was responsible for implementing the Reserve Montgomery GI Bill. He served as the senior military assistant to the Assistant Secretary of Defense for Reserve Affairs from 1989-1994. 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.

Colonel Norton joined Analytic Services, Inc. (ANSER), Arlington, VA in 1995 as a senior operational planner supporting various clients including United Nations humanitarian organizations and the U.S. Air Force's counterproliferation office. He joined TROA'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.

**Executive Summary**  
**Recommendations of TROA**  
**To the**  
**House Committee on Veterans' Affairs**  
**Senate Committee on Veterans' Affairs**

**Veterans' Health Care**

**Matching VA Health Care Budget to Enrollment Growth.** TROA recommends the Committees oppose the \$1500 annual deductible for Priority Group-7 veterans and endorse an increase of at least \$1 billion for these veterans' care in FY2003.

**VA – DoD Health Care Collaboration.**

- *Strategic Planning.* TROA recommends the development of a joint VA – DoD strategic planning document similar to the “National Security Strategy of the United States” that lays out national goals and objectives for DoD – VA collaboration and the ways and means to achieve them.
- *VA's Potential as a TRICARE Partner.* TROA recommends that DoD and VA jointly evaluate the current barriers that inhibit the use of the VA as a TRICARE network provider and recommends increased coordination between the VA and the TRICARE Management Activity.
- *Force Health Protection and Military Medical Surveillance.* TROA recommends greater collaboration between the DoD and VA medical systems in military medical surveillance and force health protection since the outcome of such work is beneficial both to national security (force health protection) and veterans' health care and disability claims.
- *Information Management / Technology and Common Medical Record.* TROA recommends development and deployment of a common DoD – VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections.
- *Market-driven Regional VA/DoD Collaboration.* TROA recommends the Committees examine the potential for using the experience of a TRICARE / VA (VISN 23) / Military Treatment Facility partnership in the Central U.S. region as a potential model for health-care planning between the VA and DoD in other market-specific regions.

**“Forced Choice”: the Wrong Solution.** TROA recommends the Committees continue to uphold the principle that military retired veterans have earned and deserve access to both VA and DoD care systems and they must not be forced to forego either benefit. Budget-driven proposals should be resolved by the DoD and VA and not visited on the backs of those who earned those benefits through service to their country.

**VA Medicare Subvention.** TROA continues to support testing the feasibility of using Medicare funds in VA facilities for the non-service connected care of Medicare-eligible veterans.

**Future of VA / DoD Facilities Partnering.** TROA recommends incorporating an independent strategic assessment of current co-located facilities into VA “CARES” and DoD “BRAC” planning.

### **Veterans’ Benefits Issues**

**Aggressive Pursuit of Disability Claims Backlog.** TROA recommends adequately funding the VBA to meet its resource needs, including manpower, in order to meet performance goals for managing veterans benefit claims.

**Concurrent Receipt of VA Disability Compensation and Military Retired Pay.** TROA requests the members of the Committees to urge leaders and members of the House and Senate to provide funding for substantive concurrent receipt relief in FY 2003.

### **Veterans’ Education Benefits Issues.**

- *Indexing Montgomery GI Bill Benefits.* As a founding member of The Partnership for Veterans’ Education, a group of 52 military, veterans, and higher education associations, TROA continues to endorse the worthy goal of fully restoring the value of the MGIB and sustaining its value over time by indexing benefits to the average cost of a four-year public college or university education.
- *Active Duty Servicemembers with No Education Benefits.* TROA recommends that the Committees sponsor legislation permitting a one-time MGIB enrollment opportunity for servicemembers who declined VEAP or MGIB on service entry. In fairness to other servicemembers and to partially offset the cost to the MGIB educational trust fund, the fee should be similar to the \$2700 premium under the recent VEAP conversion program.
- *National Guard and Reserve Education Benefits Issues.* TROA recommends that the Selected Reserve MGIB authority be transferred to Title 38 so that the Committees can oversee and balance all MGIB program adjustments. TROA also supports extending the Reserve Montgomery GI Bill benefits usage period an additional five years beyond the current ten-year eligibility window for those who successfully complete the requisite six-year service obligation.

**Protections for Activated Guard and Reserve Servicemembers.** TROA urges extension of Soldiers’ and Sailors’ Civil Relief Act (SSCRA) protections to National Guard servicemembers activated at the request of the Commander-in-Chief in state status (Title 32) to support the war on terrorism. TROA also supports assuring reemployment rights are available under the Uniformed Services Employment and

Reemployment Rights Act (USERRA) for Guard servicemembers called-up for state active duty for Homeland Defense missions.

**Dependency and Indemnity Compensation Equity.** TROA supports as a matter of equity a change in law to permit a DIC widow(er) who marries after the age of 55 to retain DIC status and benefits.

**Codification of Rules Governing Burial in Arlington National Cemetery.** TROA continues to recommend codification of all the rules governing interment in the nation's most hallowed final resting place for its military heroes, including H.R.3423, and further recommends that the members of the Committees work out a suitable compromise on a limited exception authority.

### **Other Issues**

- *Presumption of Service Connection for Hepatitis-C Infection.* TROA recommends legislation adding presumption of service connection for Hepatitis-C in servicemembers exposed to this disease prior to development of a definitive screening test in 1992.
- *Medal of Honor (MOH) Recipient Issues.* TROA recommends, as a matter of equity, that MOH special pensions (Title 38, Section 1562) should be authorized for all MOH recipients or their immediate surviving dependents retroactive to the date of the act of valor. It is also recommended that Congress authorize an annual cost-of-living adjustment to the special pension.
- *Accelerated Death Benefit for Holders of Certain Government Insurance Policies.* TROA recommends that Congress enact a change in law to permit holders of National Service Life Insurance (NSLI) and U.S. Government Life Insurance (USGLI) policies to have the same accelerated death benefit option as SGLI / VGLI policy-holders.
- *Flag Anti-Desecration Amendment.* TROA recommends Congressional action to pass the proposed Flag amendment so that the issue may be referred to the fifty states where the people may exercise their will.

## **INTRODUCTION**

The Retired Officers Association (TROA) is very grateful to the Chairmen and distinguished members of the Senate and House Veterans Affairs' Committees for the opportunity to express our views on issues affecting all members of the veterans community including uniformed services retirees. TROA is the largest military officers association in the nation and fourth largest veterans' organization with nearly 390,000 members. Our membership consists of active duty, National Guard / Reserve, retired and former officers of the seven uniformed services and their surviving spouses. TROA was founded in 1929 and is dedicated to "serving those who serve America".

As a founding member of The Military Coalition (TMC), a consortium of prominent veterans and military organizations representing more than 5.5 million current and former members of the seven uniformed services, plus their families and survivors, TROA has a keen interest in veterans' issues and works closely with major veteran organizations to achieve common goals. This Statement, however, represents the views only of TROA.

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

## **VETERANS' HEALTH CARE ISSUES**

1. Matching VA Health Care Budget to Enrollment Growth
2. VA – DoD Health Care Collaboration
3. “Forced Choice”: the Wrong Solution
4. VA Medicare Subvention
5. Future VA / DoD Facilities Partnering

### **Matching VA Health Care Budget to Enrollment Growth**

VA's successes in attracting large numbers of veterans to enroll in and use VA health care is due to commendable improvements in the quality of care, safety, and an ongoing open enrollment policy. The fastest growing enrollment category since open enrollment began in 1999 is Priority Group 7 veterans – those with no disabilities or non-compensable disabilities and incomes above \$24,000.

Total Enrollment is projected to be about 6 million veterans this year and 6.5 million in 2003. To meet this demand, the administration recommends Congress enact a medical care budget (excluding research and collections) of \$22.7 billion for FY2003 and impose an annual \$1500 deductible on PG-7 veterans.

Under the administration-proposed plan, PG-7 veterans would have to pay up to a \$1500 annual deductible at a rate of 45% of VA's reasonable charges for each episode of care. Normal inpatient and outpatient copayments would apply after the deductible was met. Drug copays (\$7 for a 30 day supply) would remain unchanged and would not count against the deductible. The VA would bill any other health insurance held by PG-7 veterans for the deductible.

What's wrong with the \$1500 annual deductible? For more than three years, the VA has aggressively recruited PG-7 veterans into VA health care and they now account for about 22% of total users of the care. The VA justified increasing its healthcare budget, set up hundreds of new community-based outpatient clinics, and retained aging infrastructure in large part by aggressively recruiting PG-7 veterans into the enrollment ranks.

Now a victim of its own success, it is contradictory for the VA to change the rules so abruptly – especially after just recently lowering outpatient copays for this group – and unfair to impose such a high tax on the very group that helped VA win resources to improve health care services for all enrolled veterans.

TROA is greatly concerned about the imposition of a \$1500 deductible and we believe there are other workable alternatives other than taxing veterans who enrolled in good faith and agreed to pay copayments for their care. We appreciate Chairman Smith's strong stance on this issue at the 13 February hearing before his Committee on the VA's Budget request: "Congress should not endorse a policy designed to discourage veterans from obtaining health care from the VA," he said. "This proposal is a non-starter and I will oppose it."

TROA agrees. Instead of imposing annual deductibles, the near-term solution is to increase the VA health care budget by at least \$1 billion for FY2003. Then, Congress should test using Medicare funds in the VA health care system for the non-service connected care of Medicare eligible veterans. (This issue is explored in greater detail in a separate section).

***TROA recommends the Committees oppose the \$1500 annual deductible for Priority Group-7 veterans and endorse an increase of \$1.1 billion for these veterans' care in FY2003.***

## **VA – DoD Health Care Collaboration**

TROA contributed to The Military Coalition's statement on VA – DoD health care collaboration before a joint hearing of the Military Personnel Subcommittee of the House Armed Services Committee and the Subcommittee on Health of the House Veterans' Affairs Committee on 7 March. TROA supports efforts to improve coordination between the two departments, but only if those efforts would enhance or

maintain access to health care, quality, safety, and services offered to beneficiaries of each of the departments. No decision should be made, regardless of how “business-wise” it may seem, unless it is clear that all beneficiary groups will not be negatively impacted. We look to greater collaboration, not substitution or integration, as the solution. We would like to highlight a few recommendations from TMC’s testimony on VA – DoD medical cooperation.

- **Strategic Planning**

TROA supports a strategic analysis of collaboration from the standpoint of how the headquarters levels of both DoD and the VA can empower local leaders to work together, holding them accountable for delivering quality health care for each system’s beneficiaries. By thinking strategically while remaining focused on desired beneficiary outcomes such as health status and patient satisfaction, the departments can significantly increase collaborative efforts to the advantage of not only the beneficiaries but also for the two systems, as well as the American taxpayers.

In practical terms, a strategic approach to collaboration means defining “joint” requirements that are derived from each agency’s unique missions. For example, DoD and VA’s missions intersect in the areas of medical research, graduate medical education, mass casualty management, military medical surveillance, and now homeland defense collaboration. Yet, there is no national level policy document (such as “The National Security Strategy of the United States”) that adequately spells out how these common mission areas are to be translated into specific requirements along with the capabilities and resources to carry them out in the nation’s best interest. Many studies have “come and gone” on the need for improving the planning process between DoD and the VA, but until collaboration is directed at the highest levels of government, all of the historic and cultural reasons for not working together will prevail.

***TROA recommends the development of a joint VA – DoD strategic planning document similar to the “National Security Strategy of the United States” that lays out national goals and objectives for DoD – VA collaboration and the ways and means to achieve them.***

- **VA’s Potential as a Tricare Provider**

The VA’s role as a TRICARE network provider is a potential source for increased access to quality health care for all DoD beneficiaries. If VA’s capacity allows, and its core mission is not compromised, then the VA should play a vital role in offering primary and specialized care to TRICARE beneficiaries as a network provider.

In a June 1995 Memorandum of Understanding, TRICARE contractors were authorized to include VA medical centers (VAMCs) in provider networks and,

therefore, TRICARE contractors were encouraged to use VA facilities. Due to persistent billing and reimbursement problems, VA's potential as a network provider has not been fully realized. Despite 80% of VAMCs currently being considered TRICARE network providers, three-quarters of the activity occurs in only 26 facilities and the total level-of-effort was miniscule according to the GAO (May 2000).

Current TRICARE contracts will begin to expire over the next few years, and TROA is pleased that the VA is represented in the new contract development. TRICARE Management Activity (TMA) has acknowledged the importance of considering the VA in the next generation of contracts. In light of the growth of VA's Community Based Outpatient Clinics (CBOCs), the VA could be a service delivery alternative for TRICARE beneficiaries where capacity exists.

Expanding the use of VA providers as TRICARE-authorized providers to care for all TRICARE beneficiaries would provide greater access to care in areas where TRICARE Prime is not available.

***TROA recommends that DoD and VA jointly evaluate the current barriers that inhibit the use of the VA as a TRICARE network provider and recommends increased coordination between the VA and the TRICARE Management Activity.***

- **Force Health Protection and Military Medical Surveillance System.**

This work is valuable to DoD's readiness mission since a critical aspect of medical readiness is to develop "force health protection" strategies that preserve the fighting force and effectively use the right medical capabilities to support deployed troops. VA's stake in this work is to improve health care delivery for service-connected veterans who have been deployed to various operational environments during their service and to facilitate the adjudication of claims for service connected disabilities.

In a recent report (October 16, 2001), the GAO reported that a "medical surveillance system involves the ongoing collection and analysis of uniform information on deployments, environmental health threats, disease monitoring, medical assessments, and medical encounters." The report states that some progress has been made in developing such a system but points out that there remain significant gaps. The report notes that the Gulf War "exposed many deficiencies in the ability to collect, maintain, and transfer accurate data describing the movement of troops, potential exposures to health risks, and medical incidents in theatre." Without reliable deployment and health care information, it was "difficult to ensure that veterans' service-related benefits claims were adjudicated appropriately."

***TROA recommends greater collaboration between the DoD and VA medical systems in military medical surveillance and force health protection since the outcome of***

*such work is beneficial both to national security (force health protection) and veterans' health care and disability claims.*

- **Information Management / Technology and a Common Medical Record**

The FY 2002 National Defense Authorization Act includes a provision (Section 734) that encourages an ongoing pilot program in which the VA conducts separation physicals for the DoD. A software program developed to support the pilot project creates data needed by DoD for the separating servicemember and concurrently provides the VA with the information needed to make a disability determination. The project eliminates the need for a second physical exam performed by the VA after separation and standardizes a “one exam” process.

Earlier efforts have not been as encouraging. In 1997, the administration directed development of a “comprehensive, life-long medical record for each service member.” In January 1998, the VA, DoD, and IHS initiated the Government Computer-Based Patient Record (GCPR) project. Later that year, the two agencies were directed to develop a “computer-based patient record system that will accurately and efficiently exchange information.” Initial plans for the project called for its deployment by October 1, 2000, but intermediate target dates were not met. The project now has no defined implementation date.

The initial challenges inherent in the project should not deter the VA and DoD from creating a common DoD – VA medical record. The GCPR has the potential to improve the efficiency and effectiveness of both the VA health care and claims systems, lower DoD and VA medical expenditures, facilitate data exchange for research and other purposes, and help servicemembers and veterans get better health care and prompt, accurate disability decisions.

*TROA recommends development and deployment of a common DoD – VA medical record as quickly as possible, along with the capability to exchange data seamlessly between the two systems using appropriate privacy protections.*

- **Market driven strategic VA/DOD collaboration**

A promising regional collaboration offers insight into how the VA and DoD health care planners can take advantage of market-driven opportunities. VA and DoD / TRICARE officials recently created the Central Region Federal Health Care Alliance (CRFHCA), a collaboration between the Department of Defense, the Department of Veterans Affairs and the TRICARE Central Region managed care support contractor (TriWest Healthcare Alliance). This group has come together to maximize the use of federal resources in meeting the health care needs of all stakeholders. TROA believes that the CRFHCA model has great potential for immediate application in other regions.

The CRFHCA's first initiative is being undertaken in the Veterans' Integrated Service Network (VISN) 23, which includes North and South Dakota, Minnesota, Nebraska and Iowa. The TRICARE Lead Agent, the VISN Director, and the Military Treatment Facility (MTF) commanders from Ellsworth AFB, Grand Forks AFB and Minot AFB, as well as TriWest Healthcare Alliance meet to discuss areas for coordination to include sharing resources and services: catastrophic case management, telemedicine, radiology, mental health, data and information systems, prime vendor contracting, joint provider contracting, joint administrative processes and services, education and training. The next step is to expand to Colorado Springs later this year.

***TROA recommends the Committees examine the potential for using the experience of the CRFHCA as a potential model for health-care planning between the VA and DoD in other market-specific regions.***

### **“Forced Choice”: the Wrong Solution**

Last year, Congress included a provision in the VA-HUD Appropriations Act for FY2002 that denied the use of VA funds this fiscal year to compel military retirees to relinquish either their DoD (TRICARE) or VA health care benefits.

The Armed Services Committees also took strong action on this issue by permanently prohibiting DoD from requiring retirees to obtain their government-sponsored health care solely from the Defense Department. (Section 731 of the FY2002 National Defense Authorization Act).

These strong actions are most appreciated and we are grateful to the members of the Committees and the entire Congress for them. Still, the administration has not given up on its “forced choice” idea.

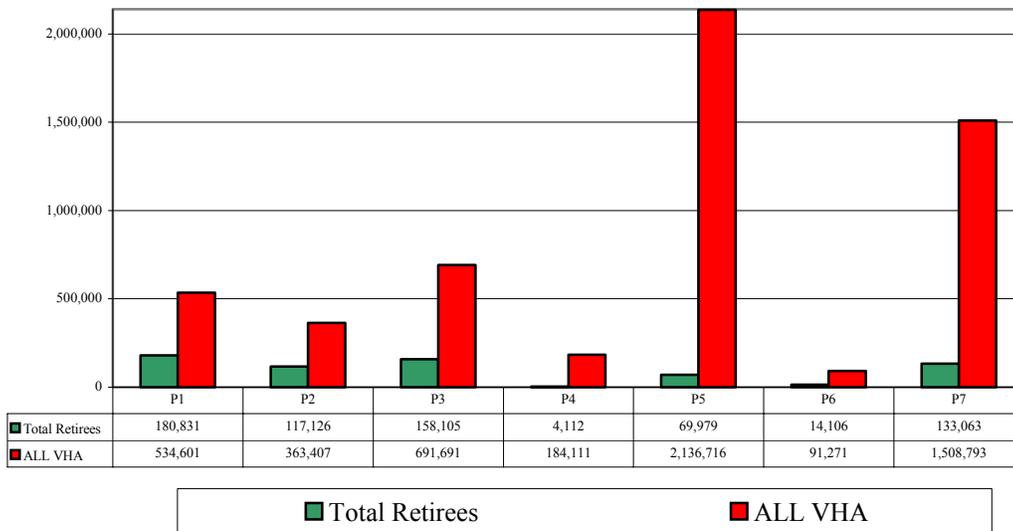
The press release accompanying the VA-HUD Appropriations Act for FY 2002 (P.L. 107-73) stated: “The VA/DoD Medical Care Choice initiative would ensure that all military retirees annually choose either the Department of Defense or the Department of Veterans Affairs as their health care provider. This would enhance quality and continuity of care and prevent duplication of services and costs.” More recently, the Office of Management and Budget testified on March 7 before the HVAC Subcommittee on Health and the Subcommittee on Military Personnel of the House Committee on Armed Services that requiring military retired veterans to choose either the DoD or VA as their primary source of care was a good idea. It is not.

Some officials apparently fail to grasp two key facts on this issue: first, military retirees are veterans and have earned access to DoD (TRICARE) health care and VA health care through their long careers of service to their country. Second, the vast

majority of retired veterans already enrolled in VA care have need for the specialized services the VA uniquely provides. Retiree enrollment data show that:

- Of the 677,000 retirees enrolled in VA health care, 81% qualify for mandatory care in the VA health care system
- 67% of enrolled retirees have service-connected disabilities, were recipients of the Purple Heart or former POWs.
- 27% of enrolled retirees have severe disabilities rated at 50% or greater.

**Military Retiree Distribution in VA Enrollment Priorities Compared to All Enrollees**



(Source: Veterans Health Administration. Data as of 30 Sep 2001)

DoD and VA care are significantly different, in terms of their services and the population served. Many retirees are willing to drive long distances to obtain specialized VA care for spinal injuries, prosthetics, etc., but prefer to obtain their routine care through local doctors under the TRICARE system.

TROA believes that the proper and fair solution is to preserve retirees’ access to all earned benefits and improve the coordination of care mechanisms between the two health care systems. Key is establishing adequate reimbursement protocols for cross-over care. Tricare for Life (TFL) may indeed encourage some Medicare-eligible retirees enrolled in PG-7 to seek all their care exclusively through TFL providers. But, as discussed earlier, expanding the VA’s role as a TRICARE provider is an alternative that could benefit beneficiary as well as government stakeholders.

***TROA recommends the Committees continue to uphold the principle that military retired veterans have earned and deserve access to both VA and DoD care systems***

*and they must not be forced to forego either benefit. Budget-driven proposals should be resolved by the DoD and VA and not visited on the backs of those who earned those benefits through service to their country.*

## **VA Medicare Subvention**

In recent years, the House and Senate have passed VA subvention in separate sessions, but have not been able reach agreement on a design to test the use of Medicare funds in VA facilities. Medicare Subvention could prove beneficial to beneficiary and government stakeholders alike.

For veterans, VA Subvention would mean improved access to care, as about 58% of enrolled veterans are Medicare eligible. These beneficiaries have paid into Medicare throughout their working lives. One important question that needs to be answered is whether the VA can deliver Medicare-sponsored services more efficiently than Medicare in the private sector.

Today, many Medicare-eligible veterans use VA health care for some services and Medicare HMOs or fee-for-service for the rest of their care. The result is inefficiency, duplication of effort, inconsistency, and patient safety concerns. A recent unpublished VA study revealed that the number of veterans who receive care from the VA and care from a Medicare HMO is "increasing rapidly". The study showed that:

- VA patients covered by Medicare HMOs already receive substantial amounts of VA care.
- Estimated Medicare payments to Medicare HMOs on behalf of veterans who seek care from both government providers were \$305 million in one year (FY 1996).
- For veterans covered by Medicare HMOs for a one-year period (FY 1996), VA spending on Medicare services to those same veterans totaled \$146 million.

VA data show that enrollment of veterans in Medicare HMOs is increasing in areas of the country where VA resource allocations are decreasing. In the study, the proportion of Medicare-eligible VA patients enrolled in Medicare HMOs in the Northeast was up significantly. But in the corresponding VA networks, VA funding was on the decline. The study showed that Massachusetts Medicare enrollment increased from 3.0% to 12.2%; New York from 4.1% to 4.9%; New Jersey, 0.6% to 8.3%; and Pennsylvania, 2.3% to 13.2%.

VA Funding in the corresponding VA Networks from FY 1996 – 1999 was down:

- Boston (VISN 1) – 8.0%;
- Albany (VISN 2) – 5.8%;
- Bronx (VISN 3) – 6.9%;
- Pittsburgh (VISN 4) – 2.0%;

-- Baltimore (VISN 5) – 11.0%.

This may mean that overall government spending for Medicare-eligible veterans is simply being shifted away from the VA to Medicare in certain regions, with no gain in productivity.

In the context of rising Medicare enrollment and regional decreases in VA funding, a Subvention test would determine if veterans would choose VA health care as their primary source of care and if overall government spending for Medicare-eligible veterans' care could be reduced.

A VA Subvention test also would evaluate the economic dynamics in networks where there is rapid enrollment and funding growth. A test would gauge whether government resources can be used more efficiently in regions with growing veteran populations. The VA study showed that the proportion of Medicare eligible VA patients who are also enrolled in Medicare HMOs is significant in those areas where VA funding allocations are increasing.

The following table illustrates this:

**Percent of Medicare-Eligible Veteran Patients Also Enrolled in Medicare HMO**

<b>STATE</b>	<b>% VA Patients Also Enrolled in Medicare HMOs</b>	<b>VISN LOCATION</b>	<b>VA Health Funding INCREASES FY 96-99</b>
Arizona	30.5	Phoenix	+16.8%
California	34.7	San Francisco Long Beach	+ 8.8% + 4.0%
Nevada	24.8	(3 VISNs overlap)	
Florida	20.7	Bay Pines	+ 16.1

(Note: VISN areas of responsibility do not correspond with State boundaries). Texas, Washington, Colorado, and Louisiana also have experienced significant growth in the number of VA patients enrolled in Medicare HMOs and VA funding increases in the corresponding networks.

The table suggests that in areas with rapid growth in the veteran population, the government may be paying twice for the same health care services to veterans. That's because veterans who are treated by Medicare providers must have the same or similar evaluations and diagnostics completed in the VA to obtain prescriptions or other services in VA facilities.

***TROA continues to support testing the feasibility of using Medicare funds in VA facilities for the non-service connected care of Medicare-eligible veterans.***

## **The Future of VA / DoD Facilities Partnering**

TROA supports improving the capabilities of both the VA and DoD health care systems at the corporate level in ways that will enhance efficient and effective service delivery locally. As challenging and frustrating as agency-level coordination has been in the past, we believe real collaboration at the facilities level can only occur when corporate business processes are enabled, including billing procedures, reimbursement, accounting, information management / technology, medical data exchange, and so forth.

Future expansion of jointly managed VA and DoD facilities should be based on an impartial, external evaluation of existing programs. Because there has been no outside, independent evaluation of current joint facilities activities, TROA suggests that the current co-located facilities should be examined to gauge the impact on beneficiaries and program effectiveness, including the following aspects:

- Access standards for affected beneficiary sub-groups;
- Analysis of the collaborative planning process within each joint facility;
- Command and control;
- Determination and allocation of staff;
- Enrollment and referral systems within each joint facility;
- Capital equipment investment and access rules;
- Formulary, pharmacy access, and pharmaceutical purchasing policies;
- Interoperable business systems: appointment, referral, billing, budgeting, cost accounting, medical records and information technology;
- Survey of healthcare outcomes for beneficiary sub-groups (disabled veterans, retirees, active duty servicemembers, PG-7 veterans, dependents) based on quality measures and patient satisfaction.

The VA plans to complete its Capital Asset Realignment for Enhanced Services (CARES) project over the next few years. During the same period, DoD will likely continue planning for the next round of Base Realignment and Closure (BRAC) process authorized by the FY 2002 National Defense Authorization Act.

***TROA recommends incorporating an independent strategic assessment of current co-located facilities into CARES and BRAC planning.***

**H.R. 2667, The Dept. of Defense – Dept. of Veterans’ Affairs Health Resources Access Improvement Act of 2001.**

H.R. 2667 would authorize DoD and VA to test the integration of up to five co-located DoD and VA health care facilities. TROA supports the concept of more co-

located DoD – VA facilities, but opposes test programs whose ultimate objective may be to integrate or merge the two health care systems.

With dramatic changes in beneficiary demographics over the next ten years, there may indeed be opportunities for more jointly managed facilities. On the other hand, the development of new technologies, non-invasive procedures, new drugs, and genetically based treatments may in fact reduce the need for substantial investment in “brick and mortar” health care facilities.

TRICARE and VA health care systems have evolved to the point where medical outcomes indicate the quality of care, safety, and efficient service delivery in today’s health care environment. Legislation to advance DoD-VA facilities’ collaboration should identify the intended beneficiary outcomes as a measure of merit for joint facilities.

### **Concern over “Unified Medical Systems”**

TROA remains concerned over the concept of “unified medical systems” in H.R. 2667. Section 3(c)(2) of the bill would allow local VA executives and DoD commanders to execute a “unified staffing and assignment system for the personnel employed at or assigned to those facilities”.

This proposal could disrupt medical manpower planning in both the DoD and VA systems. Simply put, the proposal presumes that local arrangements should bypass regional and national DoD – VA mission-based planning for their medical manpower needs.

DoD and VA patient populations have distinctively different characteristics and needs and the two systems have fundamentally different missions. DoD is primarily a primary-care, family focused “HMO” wellness model delivery system ranging from neonates to seniors. The VA, on the other hand, focuses primarily on geriatric, and other specialty care and research. We suggest the two should try to capitalize on the unique capabilities and advantages of each system in a partnership, while keeping in mind that the two are neither equivalent nor substitutable.

### **Coordination of care: Unknown under H.R. 2667**

Section 3(g) of the bill proposes equalization of beneficiary payments between participating facilities, but does not address the need to develop access standards for beneficiaries.

***TROA recommends amending H.R.2667 to specify coordination of care standards for beneficiary groups and assurance that benefits for all stakeholders are not diminished.***

## VETERANS' BENEFITS ISSUES

1. Aggressive Pursuit of Disability Claims Backlog
2. Concurrent Receipt of VA Disability Compensation and Military Retired Pay
3. Veterans' Education Benefits Issues
4. Protections for Activated Guard and Reserve Servicemembers
5. Dependency and Indemnity Compensation Equity
6. Codification of Rules Governing Burial in Arlington National Cemetery
7. Other Issues

### **Aggressive Pursuit of Disability Claims Backlog**

TROA is pleased to note that the Secretary of Veterans Affairs has made reducing the backlog of veterans' claims a priority and has taken important action to back up his commitment to solving this problem. We note, for example, that the VA has implementing many of the recommendations of the VA Claims Processing Task Force (TF) (October 2001) under the direction of VADM Daniel Cooper, USN-Ret.

One recommendation of the TF that is already producing results is the creation of tiger teams to work down aging claims, especially for older, mostly WWII veterans.

Still, as the TF report noted, average processing time for all claims is 184 days and appealed or remanded claims take upwards of two years to resolve. The total backlog of claims in the Veterans' Benefits Administration (VBA) was 668,000 in August 2001.

TROA believes that the long term key to success in reducing the backlog and reaching sustainable goals is investment in people and technical training with supporting information management / technology and communications systems.

***TROA recommends adequately funding the VBA to meet its resource needs, including manpower, in order to meet performance goals for managing veterans benefit claims.***

### **Concurrent Receipt of VA Disability Compensation and Military Retired Pay**

In approving a special compensation for severely disabled retired veterans—and subsequently expanding it to include chapter 61 (military disability) retirees with 20 or more years of service—Congress took two key steps in acknowledging the significant inequity the current law imposes on disabled military retirees. In effect, the current offset law compels disabled retired veterans to fund their own disability compensation by requiring forfeiture of \$1 of their earned retired pay for each \$1 received in disability compensation from the Department of Veterans Affairs.

TROA has long held that military retired pay and veterans disability compensation are paid for different purposes, and one should not offset the other. Specifically, retired pay is earned compensation for completing a career of arduous uniformed service, while veterans disability compensation is paid for pain and suffering and loss of future earnings' potential caused by a service-connected disability. TROA believes the time has come to recognize this essential distinction by authorizing the concurrent receipt of military retired pay and disability compensation paid by the VA.

Legislation introduced by Rep. Michael Bilirakis (H.R. 303) and Sen. Harry Reid (S.170) would correct the unfair and outdated retired pay/disability compensation offset, and this legislation enjoys significant support within both the House and Senate. Currently, 86% of House members and 78% of the Senate have cosponsored corrective legislation that would eliminate the unfair disability offset. This substantial cosponsorship support led to the FY 2002 National Defense Authorization Act provision authorizing concurrent receipt of retired pay and VA disability compensation, *but only if* the President submitted the required funding and legislation—which did not happen. The immediate goal now is to gain congressional funding clearance in the FY 2003 Budget Resolution.

**TROA requests the members of the Committees to urge leaders and members of the House and Senate leaders to enact funding for substantive concurrent receipt relief in FY 2003.**

## **VETERANS' EDUCATION BENEFITS ISSUES**

- **Appreciation for Increases in Montgomery GI Bill Benefits**

TROA would like to express its deep appreciation and gratitude to Chairman Christopher Smith (R-NJ), Chairman John D. Rockefeller IV (D-WV), Ranking Member Lane Evans (D-IL), Ranking Member Arlen Specter (R-PA) and the members of both the House and Senate Veterans Affairs Committees for their leadership in approving significant increases to MGIB benefits last year.

The “Veterans Education and Benefits Expansion Act of 2001” (P.L. 107-103) helps to honor a promise long sought by our nation's veterans, giving them the opportunity to pursue their educational, in-service, and post-service career goals. The new Act authorized an increase to \$800 for full-time study and attaining a maximum of \$985 per month in 2003 for full-time study. This figure represents an increase of \$313 per month over the previous monthly benefit of \$672, a 46% increase.

Without such a strong commitment to veterans, these remarkable increases simply would not have occurred, and TROA is very grateful. But as Chairman Smith has said the work of restoring the value of the MGIB must continue. The horrific events of

September 11 tell us that freedom is not free and that the security of our great nation depends on the service and sacrifice of today's servicemembers, tomorrow's veterans.

*As a founding member of The Partnership for Veterans' Education, a group of 52 military, veterans, and higher education associations, TROA continues to endorse the worthy goal of fully restoring the value of the MGIB and sustaining its value over time by indexing benefits to the average cost of a four-year public college or university education.*

- **Active Duty Servicemembers with No Education Benefits**

TROA notes that there are more than 116,000 active duty servicemembers who entered service during the Veterans Educational Assistance Program (VEAP) era but declined to enroll in that program. TROA feels it is unfair to deny them the chance to enroll in the Montgomery GI Bill on the basis of a youthful, but irrevocable decision to reject VEAP, a program that all acknowledge was woefully inadequate.

There are also about 151,000 servicemembers who turned down MGIB benefits upon entry. Some simply could not afford the \$1200 enrollment premium taken out during the first year of their service. Both groups now face the prospect of having no educational benefits at separation, or to use on active duty. Allowing these cohorts a one-time enrollment opportunity in the MGIB would help their transition to civilian life and enhance their wage-earning potential for themselves, their families and the economy.

*TROA recommends that the Committees sponsor legislation permitting a one-time MGIB enrollment opportunity for servicemembers who declined VEAP or MGIB on service entry. In fairness to other servicemembers and to partially offset the cost to the MGIB educational trust fund, the fee should be similar to the \$2700 premium under the recent VEAP conversion program.*

- **National Guard and Reserve Education Benefits Issues**

TROA believes there is a need to make proportional increases in education benefits under the Selected Reserve Montgomery GI Bill (MGIB-SR) program authorized under Title 10. Individuals who first become members of the National Guard or Reserve are eligible for these benefits under Chapter 1606 of Title 10 of the U.S. Code. Though technically not within the Committees formal jurisdiction, the SR-MGIB program should be of concern to the members of the Committees. Basic benefits under the active duty MGIB program are established under Title 38. There are two concerns with this arrangement.

First, when increases to basic benefits are made to the MGIB (Title 38), proportional adjustments are often overlooked in the Title 10 MGIB-SR program. For example,

last year Congress authorized a very significant and much appreciated 46% increase to the MGIB, as discussed earlier. However, no corresponding, proportional adjustment was made to the MGIB-SR.

The second concern is that the MGIB-SR benefits are drawn from Reserve and National Guard military pay appropriation accounts. Thus, the Guard and Reserve Chiefs must absorb any MGIB-SR increases from these accounts. In other words, there is no separate line-item in the Reserve budgets for these benefits. TROA believes that total force equity indicates a need for in-kind proportional adjustments to the MGIB-SR. One way to facilitate this objective is to transfer the MGIB-SR program to Title 38.

A third concern is the MGIB-SR usage period. In today's environment, Guard and Reserve servicemembers are under tremendous pressure to juggle employment, military, and family commitments along with their educational goals. Consequently, part-time student-Guard or Reserve servicemembers often require more time to complete their educational programs. To achieve their goals and to have the opportunity to use up all earned educational benefits, reservists should be permitted up to five years beyond the normal ten-year MGIB-SR eligibility period. Successful completion of a six-year service obligation could be set as a prerequisite to the extended usage period. TROA believes that unified oversight of the MGIB-SR under Title 38 would foster a balanced and equitable approach to managing education benefits for these servicemembers.

***TROA recommends that the Selected Reserve MGIB authority be transferred to Title 38 so that the Committees can oversee and balance all MGIB program adjustments. TROA also supports extending the Reserve Montgomery GI Bill benefits usage period an additional five years beyond the current ten-year eligibility window for those who successfully complete the requisite six-year service obligation.***

### **Economic and Employment Protections for Activated National Guard and Reserve Servicemembers**

As Reserve members and units shoulder more responsibility for day-to-day operational workloads alongside active duty forces, they face particular challenges associated with their multiple military, civilian employment, and family commitments.

Employer support was always strong when Reserve members were a force "in reserve" that would be mobilized only in the event of a major national emergency. That support has become less and less certain as Reservists have taken longer and more frequent leaves of absence from their civilian jobs.

Since September 11, more than 76,000 National Guard and Reserve servicemembers have been called up to support the war on terrorism at home and abroad. Some 7000 of those mobilized are National Guard members called up by their governors at the request of the Commander-in-Chief to perform Homeland Defense missions in state active duty status (Title 32). Their duties include guarding our nation's airports, nuclear facilities, and other key infrastructure.

Because of their unique activation status under Title 32, they do not enjoy the same protections and reemployment rights of activated Guard and Reserve servicemembers under Title 10 – federal active duty. For example, although Guard and Reserve servicemembers called up under Title 10 have mortgage relief, protection from eviction, creditor and debt protection under the Soldiers' and Sailors' Civil Relief Act (SSCRA), Guard servicemembers activated under Title 32 for Homeland Defense do not. Also, Title 32 Guard servicemembers may not have adequate guarantees of reemployment in their civilian positions under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

***TROA urges extension of Soldiers' and Sailors' Civil Relief Act (SSCRA) protections to National Guard servicemembers activated at the request of the Commander-in-Chief in state status (Title 32) to support the war on terrorism. TROA also supports assuring reemployment rights are available under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for Guard servicemembers called-up for state active duty for Homeland Defense missions.***

### **Dependency and Indemnity Compensation (DIC) for beneficiaries remarried after age 55**

With a single exception, all U.S. government survivor benefits are retained if a beneficiary remarries after a certain age. The only exception is the military DIC widow or widower. In effect, the current law encourages cohabitation over remarriage, posing a constant conflict among DIC survivors between their hearts, their finances, and their personal values. TROA believes strongly that this is wrong, and that the proper model should be the military survivor benefit program (SBP) which continues SBP benefits for survivors who remarry after age 55.

***TROA supports as a matter of equity a change in law to permit a DIC widow(er) who marries after the age of 55 to retain DIC status and benefits.***

### **Arlington National Cemetery Interment Rules**

TROA appreciates the leadership shown by Chairman Smith and the members of the House Committee on Veterans Affairs for sponsoring legislation (H.R.3423) that would eliminate the age requirement for retired reservists who would otherwise be

eligible for in-ground burial at Arlington National Cemetery. In addition, the legislation would allow in-ground burial of reservists who die in the line of duty while on training duty.

TROA testified in favor of H.R. 3423 in a hearing last December before the HVAC. The bill was subsequently endorsed by the Committee and the full House. It awaits Senate action.

TROA continues to support the codification of all the rules governing access to ANC.

In 1998, the House passed by unanimous vote legislation to codify all the rules governing burial in ANC; again in 1999, the House passed by near-unanimous vote similar legislation.

As passed by the House in the 106<sup>th</sup> Congress (1999), H.R. 70 would have established in law authorization for burial in ANC 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* (emphasis added);
- 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.

H.R. 3423 would add to this framework eligibility of National Guard and Reserve servicemembers who die while in the performance of inactive duty.

TROA understands that Senate Veterans' Affairs Committee (SVAC) members are in general agreement over codifying the rules, but desire additional flexibility to accommodate worthy exceptions.

As we understand it, the Senate may have endorsed such legislation if an amendment were inserted authorizing specific means of approving exceptions. One would permit the Secretary of Defense to approve the burial of any veteran in ANC after consultation with the Chairmen of the House and Senate Veterans Affairs Committees; the other would authorize the President to approve the burial of any citizen who has made a distinguished contribution to the United States.

Unfortunately, when House and Senate Veterans Affairs Committees' conferees met to resolve their differences over codification of the rules over Arlington interment and other veterans' legislation, they were unable to reach a compromise on this issue.

*TROA continues to recommend codification of all the rules governing interment in the nation's most hallowed final resting place for its military heroes including final enactment of H.R.3432, and further recommends that the members of the Committees work out a suitable compromise on a limited exception authority.*

## **OTHER ISSUES**

### **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. TROA is grateful for this commitment. There is a need now to follow up on the benefits side of the VA's house.

Clearly, before development of a reliable HCV screening test in the early 1990's, scores of thousands of servicemembers were exposed in service to HCV through surgery, other medical procedures or on the battlefield. Therefore, a presumption of service-connection for servicemembers exposed to the HCV virus prior to development of definitive screening tools is warranted.

*TROA recommends legislation adding presumption of service connection for Hepatitis-C in servicemembers exposed to this disease prior to development of a definitive screening test in 1992.*

### **Medal of Honor (MOH) Recipient Issues**

In recent years Congress has authorized special MOH pensions in selective cases to certain MOH recipients, retroactive to the date of the extraordinary act of valor "above and beyond the call of duty." Last year, Congress authorized a single retroactive MOH pension and in 1997 seven World War II MOH recipients received the special pension retroactive to the date of the action. But no other MOH recipients have been authorized a special pension retroactive to the date of the action. This appears to be inconsistent with Congressional intent or a simple oversight. The one-time cost for this change would be approximately \$825,000 dollars.

In a related matter, TROA believes that would be appropriate to adjust the special pension to the cost-of-living in the same manner as COLA increases to veterans' disability compensation.

***TROA recommends, as a matter of equity, that MOH special pensions (Title 38, Section 1562) should be authorized for all MOH recipients or their immediate surviving dependents retroactive to the date of the act of valor. It is also recommended that Congress authorize an annual cost-of-living adjustment to the special pension.***

### **Accelerated Death Benefit for Holders of Certain Government Insurance Policies**

The Veterans Benefits Improvement Act of 1998 (P.L. 105-368) includes a provision that permits holders of Servicemen's Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI) policies who have been diagnosed as terminally ill to receive up to half the face value of their SGLI / VGLI policy. To qualify for the accelerated benefit, the policy-holder must be diagnosed as having a life expectancy of less than 12 months. Subsequent premiums are reduced to reflect the remaining face value of the policy. The election may not be made more than once and is irrevocable.

***TROA recommends that Congress enact a change in law to permit holders of National Service Life Insurance (NSLI) and U.S. Government Life Insurance (USGLI) policies to have the same accelerated death benefit option as SGLI / VGLI policy-holders.***

### **Flag Anti-Desecration Amendment**

The Supreme Court has ruled that the Constitution does not give Congress authority to ban the desecration of the Flag, and that this activity is considered "free speech" under the First Amendment. An amendment to the Constitution would be required to change this decision.

By an overwhelming majority, TROA members have endorsed a resolution on this issue that reads: "Resolved, that TROA supports Congressional action to pass the proposed [Flag] amendment so that the issue may be referred to the fifty states where the people may exercise their will."

The wording of the resolution is significant. This is a decision which should be left to the people of the United States, and the only way to accomplish that is for both the House and Senate to pass an enabling amendment. Then, the individual states and their voters will have their say. Even if three-fourths of the states approve the amendment, this would not change the Constitution to prohibit Flag desecration, but would only give Congress the authority to pass laws prohibiting such desecration.

Several years ago, a different proposed amendment would have allowed either Congress or the individual states to enact anti-flag desecration laws — a provision that left open the possibility of having 50 different laws in the 50 states. By limiting such authority only to Congress, this amendment would avoid such potential confusion. In the 106th Congress, the House approved the amendment overwhelmingly, but the Senate failed to attain the necessary two-thirds majority by 4 votes, (63 for and 37 against).

***TROA recommends Congressional action to pass the proposed [Flag] amendment so that the issue may be referred to the fifty states where the people may exercise their will.***

## **CONCLUSION**

TROA appreciates the dedication and commitment of the members of the Committees in protecting, defending and restoring the benefits earned by those who have served our nation in peace and war. Your actions on behalf of today's veteran send a very powerful signal to those future veterans fighting around the world who are protecting our nation and its people from the scourge of global terrorism. Thank you for the opportunity to submit testimony on behalf of the members of TROA and the uniformed services community – tomorrow's veterans.