

STATEMENT of
the MILITARY OFFICERS ASSOCIATION OF AMERICA

on
LEGISLATIVE PRIORITIES for
VETERANS' HEALTH CARE and BENEFITS
2d Session, 108th Congress

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

March 25, 2004

Presented by
Colonel Robert F. Norton, USA (Ret.)
Deputy Director, Government Relations
Military Officers Association of America

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. 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.

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 United Nations 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.

MSSRS. CHAIRMEN AND DISTINGUISHED MEMBERS OF THE COMMITTEES. On behalf of the 376,000 members of the Military Officers Association of America (MOAA), I am honored to have this opportunity to express our views today concerning issues affecting veterans, service men and women, their families, and survivors.

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

VETERANS HEALTH CARE

Chronic Mismatch Between Demand for Care and Resources. 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 underfunded.

This fact was brought home most recently at the VA Budget Request hearing on 11 February 2004. Responding to questions from members of the House Veterans Affairs Committee, the Secretary of Veterans Affairs, the Hon. Tony Principi, acknowledged that his department had sought an additional \$1.2 billion for the VA health system for FY 2005, but was denied the increase by administration officials.

In 2002, upwards of 315,000 veterans were on 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.

But this issue is not only about managing the numbers. It's about real people, our nation's veterans, who are in many parts of the country still forced to wait long periods for their health care appointments. The demand – resources gap is having an adverse impact on veterans' health simply because many can't get care when they need it.

MOAA believes that the VA should at least be fully funded to meet its own very modest access standards. That means that a veteran should be able to obtain routine care within 30 days. 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.

Consistent with the President's own Task Force on Improving Health Care Delivery for Our Nation's Veterans (PTF Recommendation 5.1), MOAA strongly recommends full funding for all veterans enrolled in priority groups 1-7 to ensure timely, high-quality access to VA health care services. As an important step towards that goal, MOAA endorses the bi-partisan "Views and Estimates" recommendation of the House Committee on Veterans Affairs to the House Budget Committee for a \$2.5 billion increase in discretionary spending above the administration's budget request for FY 2005.

Dual-Eligible Veterans. 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.

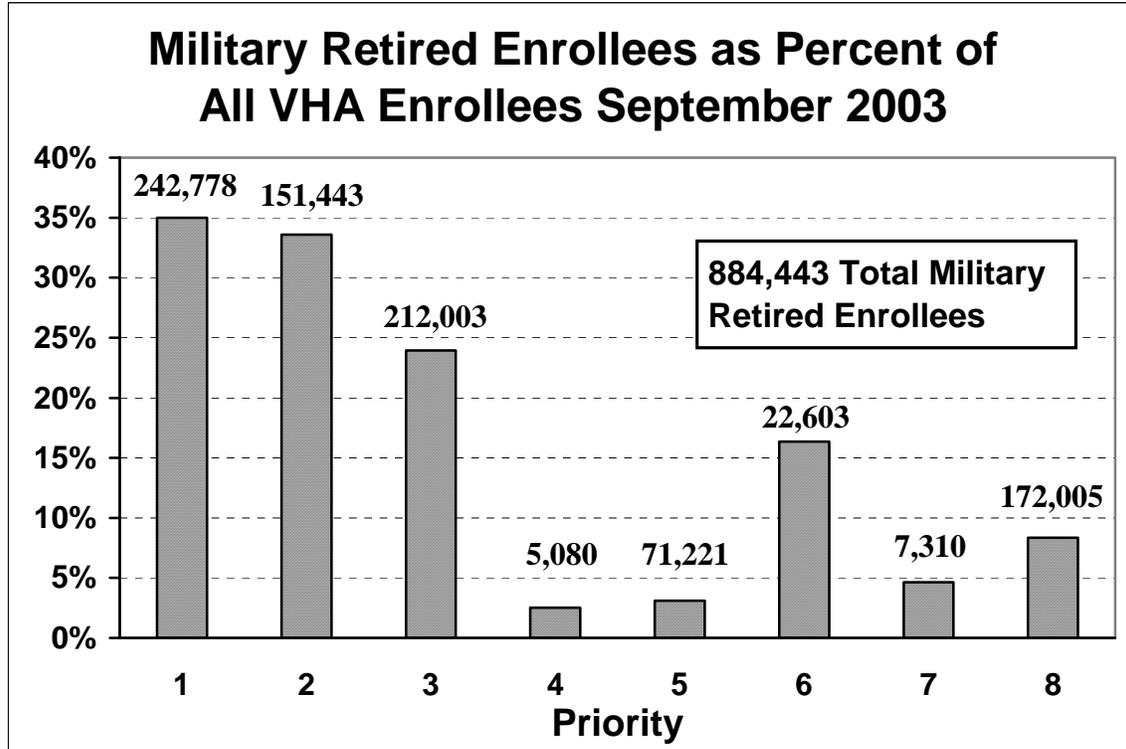
A growing number of dual-eligible veterans use the VA for at least some of their care. Reliance on VA care increases with disability level. VA enrollment and “unique patient” data show that:

- One out of eight enrolled veterans is a dual-eligible veteran.
- One out of eight users (“unique patients”) of VA care is a dual-eligible veteran.
- 30% of all disabled enrollees and disabled patients (PG 1-3, incl. Purple Heart and former POWs) are military retired veterans.
- 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 884,443, as of Sep 2003).

Military Retired VHA Enrollees, September 2003

Priority	1	2	3	4	5	6	7	8	Total
Under 65	155,692	105,779	139,410	1,252	33,616	12,760	2,971	80,491	531,971
65 & up	87,079	45,655	72,571	3,827	37,603	9,842	4,339	91,508	352,424
Unknown	7	9	22	1	2	1	0	6	48
Total	242,778	151,443	212,003	5,080	71,221	22,603	7,310	172,005	884,443

Source: VHA. Dual-eligible enrollment and patient data as of 30 September 2003.



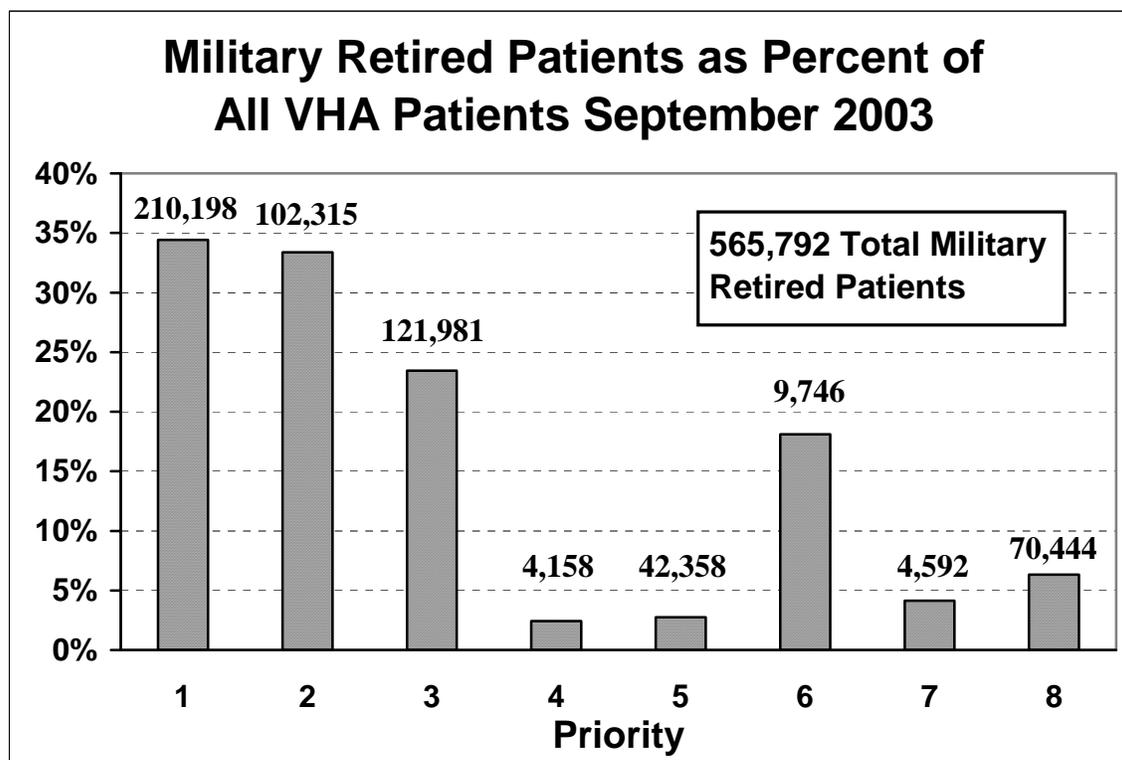
Source: VHA data as of 30 September 2003.

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

- 87% of dual-eligibles with disabilities rated at 50% or greater used VA care last year.
- 68% of dual-eligibles with disabilities rated 40-50% used VA care last year.
- 57% of dual-eligibles with disabilities rated 10-30% used VA care last year.
- By contrast, only 40% of PG 8 retired veterans used VA care last year.
- Overall, 64% of enrolled retirees used VA health care in some way last year.

Military Retired VHA Patients in FY 2003, September 2003

Priority	1	2	3	4	5	6	7	8	Total
Under 65	131,979	67,809	72,293	1,093	19,712	5,425	2,057	33,053	333,421
65 & up	78,215	34,503	49,686	3,064	22,646	4,321	37,390	37,390	267,215
Unknown	4	3	2	1	0	0	0	1	11
Total	210,198	102,315	121,981	4,158	42,358	9,746	4,592	70,444	565,792



Source: VHA data as of 30 September 2003.

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 urges the Committees support full funding of VA health care needs, including specialty care, adequate medical research funding, and needed facilities upgrades for all enrolled veterans who rely on VA services.

No “Forced Choice”. 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 and VA health care services.

DoD – VA Health Systems’ Collaboration. The *President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans (PTF)* issued a Final Report in May 2003 on its findings and recommendations.

We want to emphasize that the initiatives in this Report ultimately are not merely about bureaucratic efficiencies; rather, the Report contains very important recommendations that affect our service men and women as they transition between military service and the VA during extremely difficult and traumatic moments in their lives, often following physical and psychological injury from military service.

The President charged the PTF with three tasks: (1) identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments; (2) review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and (3) identify opportunities for improved resource utilization through partnership between VA and DOD to maximize the use of resources and infrastructure. Interest in VA-DoD health systems’ collaboration is supported by passage of joint initiatives legislation in the FY2003 National Defense Authorization Act and other legislation.

MOAA continues to support the careful expansion of VHA/DOD sharing agreements. We agree with the PTF Report conclusion that true sharing will not be possible until Congress addresses the underlying mismatch between demand for VA services and available resources.

MOAA does not support the presumption that joint activities demonstrate the need to integrate the management of the two systems, nor that dually-eligible beneficiaries – that is, military retired veterans -- should be forced to relinquish earned access to one system or the other. Complementary business systems can offer benefits to users of both systems, but these benefits do not mean that a total integration of the two systems is practical or in the best interests of all beneficiary groups.

MOAA is pleased to re-state certain PTF Report recommendations that we believe the Committees should aggressively oversee in the best interests of service men and women and veterans.

- ***Leadership and Reporting.*** A re-structured VA-DoD Joint Executive Council was a direct result of the PTF. MOAA believes that the Committees, working with their colleagues in the Armed Services Committees should direct the DoD and VA to report annually on the activities and accomplishments of the VA-DoD Joint Executive Council. As indicated in the PTF Report, the Council should oversee the development of tools to measure the “health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes.” (PTF Recommendations 1.1 and 2.3)

MOAA believes that up until now there has been insufficient transparency in the work of the VA-DoD Executive Council and its subordinate components such as the Health Executive Council and the Benefits Executive Council. Servicemembers and veterans as well as other stakeholders need transparent information on the likely impact of various sharing initiatives.

MOAA recommends the Committees continue to use the PTF Report as a blueprint to monitor DoD – VA partnering work and we urge an annual joint oversight hearing with the Armed Services Committees to measure progress and provide information to stakeholders.

- ***Seamless Transition.*** MOAA notes significant progress in initiatives to support the transition of acutely wounded returning servicemembers between the DoD and VA health care systems.

According to recent reports, 12,000 combat wounded or ill veterans from the Afghanistan – Iraq war have returned so far with more being evacuated every day. They return home for care in military hospitals, rehabilitation, and, in some cases, medical evaluation boards. Their sacrifice speaks to the vital importance of accelerating development of DoD – VA plans to seamlessly transfer medical information and records between the two federal departments.

Current plans call for implementing records transfers “seamlessly” by 2006 or 2007 at the earliest. As pointed out in recent hearings on this subject, the technology already exists to accomplish the goal. At a time when the United States has two robots exploring the surface of Mars, it should not be too much to ask for the government and Congress to provide the funding and oversight to accelerate fielding this initiative. A lifetime service medical record will help servicemembers obtain early, accurate and fair VA disability ratings, facilitate pre- and post-deployment care, and enable research to advance standards of care for servicemembers and veterans. (PTF Recommendations 3.1, 3.2, 3.3, 3.4).

MOAA strongly recommends accelerated funding for the development of a “seamless, transferable, lifetime medical record” for service men and women and investment in supporting information management / technology upgrades for DVA and DoD.

- ***Returning Veterans and Military Occupational Exposure Issues.*** Recent VA data reveal that of the 110,323 veterans who have separated from active duty up to February 2004 following service in Iraq and /or Afghanistan, about 13% have sought care in VA facilities for one or more conditions. 58% of Iraqi Freedom veterans who sought VA health care are members of the National Guard and Reserve forces according to the VA.

With the largest troop rotation since World War II now underway, the VA is likely to experience continuing demand for its services from this new generation of veterans. MOAA believes the VA needs to continually assess its capacity to respond to these veterans' needs especially in the area of mental health and family support counseling.

PTF Recommendations 3.5, 3.6, and 3.7 specifically endorse action that will enable VA and DoD to expand their collaborative efforts to identify, collect, and maintain specific data to recognize, treat, and prevent illness and injury resulting from military occupational exposures and hazards occurring in-service.

MOAA commends the VA policy that permits returning Guard and Reserve combat-theatre veterans to have initial access to VA health care without regard to a priority group determination; that is, they are nominally assigned to Priority Group 6 during the first two years of their care in a VA facility pending completion of a VA disability rating.

But, we wish to emphasize that every effort must be made to ensure that Guard and Reserve veterans who use VA health care during the two-year window are then assured continued enrollment and access to the system.

MOAA strongly recommends that the Committees ensure the health care needs of returning veterans be fully funded, including any needed upgrades for specialty care services such as family counseling and clinical services for PTSD.

- ***Joint Venture Sites.*** DoD and VA have identified 60 sharing initiatives at the facility level and DoD has labeled 20 of these as “priority” initiatives. In October 2003, the departments jointly announced a series of eight demonstrations required by the fiscal year 2003 national defense authorization act to test improving business collaboration between VA and DoD health facilities. The two departments plan to use the demonstration projects to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. All well and good, but despite these interactions, there does not appear to be any systems-wide analysis of the impact of these projects in either the VA “CARES” or the next round of DoD base closure and realignment – BRAC -- processes.

‘CARES’ Commission Report. The Capital Asset Realignment for Enhanced Services (CARES) Commission issued its report to the Secretary of Veterans Affairs on February 12, 2004. The Commission’s charter was to provide an objective, external perspective to the VA’s planning process for realigning and allocating capital assets necessary to meet the demand for veterans health care services over the next 20 years. Hearings on the Commission’s work have just begun. In releasing the Report, the Commission noted – and the VA has acknowledged – that the Commission’s work was not able to assess the VA’s facilities needs from a national perspective for long term care, assisted living, and domiciliary care for severe psychiatric patients. The VA has undertaken to develop a strategic plan for these requirements.

MOAA notes that the CARES Commission believes there is “demonstrated value” in VA / DoD sharing initiatives, but that leadership, cultural, and other challenges often hamper collaboration efforts. The Commission recommended that VA / DoD collaboration should be one of the first considerations in addressing health care needs locally, but that senior DoD – VA leadership needs to provide authority, accountability, and incentives to local commanders and managers to encourage and facilitate sharing activities that improve health care delivery.

MOAA recommends the Committees provide continued oversight to the CARES process to ensure that future facilities needs and DoD – VA collaborative efforts are judged primarily by the ‘E’ in CARES, that is, Enhanced services to military and veterans beneficiaries.

VA Medicare Subvention and ‘Medicare + Choice’ Initiative. Among federal agencies, only the Indian Health Service is permitted to use Medicare funding in its facilities. MOAA continues to be very disappointed with the on-again off-again Congressional interest in permitting the VA to at least test the concept of Medicare “subvention” in its facilities. The reality is that more than 40% of enrolled veterans are eligible for Medicare. In effect, rules excluding use of Medicare funds in VA facilities result in the government paying redundant costs for procedures and tests performed by Medicare providers and then, again, in VA facilities. That alone should be reason enough to test using the VA as a Medicare provider.

The theory of Medicare Subvention is quite simple: if the VA can deliver a Medicare-sponsored benefit (for non-service connected care) more efficiently than Medicare providers, while eliminating duplicative medical procedures, all stakeholders and especially veterans are likely to benefit. We note that the House and Senate on separate occasions have passed legislation to test subvention in designated facilities, so it’s clear that many in Congress agree that the idea could deliver cost-savings and enhanced services at the same time. MOAA continues to support the concept that Medicare-eligible veterans should be able to obtain their earned Medicare-sponsored services for non-service-connected care in VA health care facilities.

More than a year ago, the VA announced a promising plan to establish a Medicare + Choice program by late 2003. Now projected to begin some time this year, a small number of Medicare-eligible Priority 8 veterans now excluded from enrollment in VA health care would be offered the option of receiving their Medicare benefits from VA facilities designated as Medicare providers.

MOAA continues to support fielding a VA Medicare + Choice plan and we continue to support Medicare reimbursement – VA Subvention -- for non-service connected care of enrolled Medicare-eligible veterans.

VETERANS BENEFITS

Disability Claims Backlog and Process Improvement. MOAA commends the Dept. of Veterans Affairs for making significant progress in reducing the unacceptably high number of backlogged disability claims. The Veterans Benefits Administration announced recently that it has reached a sustainable level of 250,000 claims in progress. There have also been some improvements in the average time to process initial claims. That being said, MOAA believes that much more can and must be done to continue the progress made to date and to improve the quality of initial claims processing. MOAA believes that there should be no cuts in the VBA workforce and sustained investment in training and technology to build upon progress already made.

MOAA opposes administration proposed cuts in the Veterans Benefits Administration (VBA) workforce and we strongly recommend full funding of VBA’s manpower, training, and IM / IT requirements in order to sustain encouraging improvements in claims service delivery.

MGIB Enrollment Window for VEAP-decliners. Active duty career servicemembers who entered service during the Veterans Education Assistance Program (VEAP) era (1 January 1977 - 30 June 1985) but who declined the benefit are the only group of currently serving members – other than

service academy graduates and certain ROTC scholarship recipients -- who have not been offered an opportunity to enroll in the Montgomery GI Bill (MGIB).

Today, there are only 73,844 career servicemembers still on active duty with no education benefits and the numbers decline daily. Many were told by service officials to turn down VEAP enrollment when they entered service because the “new GI Bill is coming”.

These dedicated military leaders are the senior NCOs and officers now leading our younger troops in battle in Afghanistan and Iraq, taking the fight to those who would threaten our nation’s homeland. Yet they soon will exit the service with no education benefits to re-focus their skills for the civilian marketplace and continue as productive citizens, an opportunity denied only to these future veterans.

The last VEAP “conversion” program for those with a VEAP account yielded a modest 11% “take” rate with far lower costs for future MGIB usage than government projections. Because VEAP “decliners” should expect to pay at least a \$2700 MGIB enrollment premium, we estimate that about 10% or less would take advantage of it. Earlier VA estimates (2001) of projected costs for 110,000 VEAP “decliners” unrealistically assumed a 33% take rate, an unprecedented usage rate of 90% of benefits, and failed to offset the estimated ten year cost (\$439 million) by the \$2700 per person enrollment premium.

We estimate the FY2005 cost to be about \$350,000 – \$400,000 with a ten-year cost of \$135 million to \$145 million.

MOAA strongly recommends the Committees authorize a MGIB sign-up window for career servicemembers who declined VEAP when they entered service.

Restoring Reserve GI Bill Benefits. As the largest mobilization of National Guard and Reserve troops since World War II continues, Congress has become increasingly sensitive to the needs of these servicemembers and their families. But one benefit that’s been left behind is the Reserve Montgomery GI Bill.

Last year, Congress enacted a pilot program extending pre- and post-mobilization TRICARE coverage periods; authorized cost-share access to TRICARE for uninsured reservist; approved unlimited commissary visits; upgraded legal and economic protections under the Servicemembers’ Civil Relief Act; and increased pay and survivor benefits.

But education benefit shortfalls for reservists have not drawn the attention they should. When the modern Montgomery GI Bill was established in 1985, National Guard and Reserve GI Bill benefits were set at 47% of active duty benefits. For every \$100 dollars that an active duty servicemember or veteran received in GI Bill benefits a reservist would get \$47. This ratio continued until the late 1990s, when Congress legislated substantial increases to the active duty GI Bill -- but neglected to do so for the Reserve program.

As a result, Reserve MGIB benefits have slipped to 29% of active duty GI Bill benefits. A reservist who initially signs up for a six-year hitch in the Reserves will see only \$282 in monthly GI Bill benefits for full-time study compared to \$985 per month in basic MGIB benefits for active duty service. Restoring reserve MGIB rates to the 47% benchmark would require raising Reserve benefits to \$463 and sustaining the ratio over time to active duty GI Bill benefits.

MOAA strongly recommends restoring the Reserve MGIB (Chap. 1606, Title 10 USC), to 47% parity with basic MGIB benefits. For the longer term, MOAA continues to endorse transferring the Reserve MGIB authority, other than the Reserve college fund “kickers” authority, to Title 38.

Chapter 30 MGIB Benefits for Non-consecutive Active Duty Call-ups. A second issue of concern is opening basic MGIB benefits (Chapter 30, 38 USC) to reservists who serve on active duty for a cumulative period of two years or longer. Currently, individuals who serve at least two years of *continuous* active duty are eligible for Chapter 30 MGIB benefits. MOAA believes that reservists serving at least two years of cumulative active duty within a five-year period after September 11, 2001 should be eligible for the active duty MGIB.

MOAA supports legislation to change the requirement for MGIB eligibility under Chapter 30, Title 38 for Guard and Reserve servicemembers to a cumulative period of two years active duty served within five years from September 11, 2001.

Benchmarking MGIB Benefits. Basic MGIB benefits for full-time study authorized under Chapter 30, 38 USC will account for only about 63% of the average cost of a four-year public college or university for this academic year (2003-2004).

In the 2004-2005 academic year, a veteran can expect to pay on average about \$1690 per month for full-time study at a four-year public college or university (according to Dept. of Education data) but receive just \$985 in MGIB benefits. Since about 60% of veterans are married when they separate, it becomes increasingly difficult for them to achieve their post-service education and training goals unless their educational benefits keep pace with educational inflation.

As a founding member of The Partnership for Veterans Education, MOAA continue to support the goal of tying future MGIB benefit increases to a recognized government index of the average cost of a four-year public college or university education.

Retention of Dependency and Indemnity Compensation (DIC) for Remarried Spouses. MOAA commends this Committee and Congress for legislation last year to allow retention of DIC for eligible surviving spouses who remarry after age 57. MOAA strongly endorses the view that Congress intended for remarried spouses with military Survivor Benefit Plan (SBP) annuities to be allowed concurrently to receive their earned SBP benefits and the DIC payments related to their sponsor’s service-connected death.

MOAA appreciates enactment of the Age-57 DIC remarriage provision and strongly recommends that it be reduced to age-55, in line with all other Federal survivor benefit programs.

Concurrent Receipt (CR) and Combat Related Special Compensation (CRSC). MOAA applauds Congress for the landmark provisions in the FY 2004 National Defense Authorization Act that expand CRSC to all retirees with combat-related disabilities and authorizes -- for the first time ever -- the unconditional concurrent receipt of retired pay and veterans' disability compensation for retirees with disabilities of at least 50 percent. Severely disabled retirees everywhere are extremely grateful for this legislation that reverses an unfair practice that has disadvantaged them for over a century.

MOAA has long held that retired pay is earned compensation for completing a career of arduous uniformed service while disability compensation from the Department of Veterans Affairs is paid for loss of function and future earning potential caused by a service-connected disability.

However, MOAA is concerned that thousands of applicants for CRSC must wait five or six months or more for adjudication of their claims. The services report that a large share of this waiting time is caused by delays in receiving necessary documentation from the VA. This problem is only expected to worsen when the Defense Department implements new eligibility criteria authorize CRSC payments to members with combat-related disabilities rated 40% disabling or less.

MOAA recommends the Committees provide the Department of Veterans Affairs with the resources needed to assist the Defense Department in ensuring timely and reasonable processing of combat-disabled retired veterans' meritorious claims.

Veterans Disability Benefits Commission. While last year's concurrent receipt provisions will benefit tens of thousands of severely disabled retirees, an equal number were left behind. 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 disabilities of 40 percent and below and MOAA urges the Committee to do what it can to extend this principle to the thousands of disabled retirees who were left out of last year's legislation.

We understand that a significant concern among some lawmakers that prevented broader concurrent receipt action was the need for a review of the VA disability system. MOAA believes much of the concern is misplaced, and we are confident that the VA disability rating system will be judged fair and equitable.

MOAA looks forward to the opportunity to work with the Veterans Disability Benefits Commission established in last year's defense authorization. Congress established the Commission to carry out a study of the benefits under law that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. MOAA stands ready to assist the Commission and participate in the debate with relevant information and data affecting the full spectrum of disabled veterans and their families and survivors.

MOAA urges the Committees to ensure that the Veterans' Disability Benefits Commission focuses on the fundamental principles that have served as the foundation for both the DoD disability retirement system and VA disability compensation processes -- principles of fairness, due process, and the unique aspect that military service is "24/7." We look forward to completion of the review and revalidation of the process as important steps toward resolving the remaining concurrent receipt inequity.

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.

Multiple Usage of VA Home Loan Authority. The administration's VA budget request for FY 2005 includes a proposal to restrict eligibility for the VA home loan program to one-time use for veterans (active duty servicemembers would be exempt from the limitation). The VA home loan program is one of the most popular benefits used by veterans. A 2001 VA survey showed that 60% of 20,000 veterans surveyed reported they had used VA's home loan program to purchase, improve or refinance their home. Multiple users of the benefit have shown sound credit worthiness, yet they would be the ones targeted under the proposal. The modest projected savings clearly don't add up in this case.

MOAA is opposed to limiting the VA home loan authority to a one-time use of the benefit.

Arlington National Cemetery Interment Rules

MOAA appreciates the leadership shown by the House Committee on Veterans Affairs for endorsing legislation in the last session of Congress (107th) that would eliminate the age requirement for retired reservists who would otherwise be eligible for in-ground burial at Arlington National Cemetery (ANC). In addition, the legislation would have authorized an in-ground burial to reservists who die in the line of duty while on inactive duty.

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

Since 1998 the House Committee on Veterans Affairs and the full House have by unanimous or near-unanimous vote favorably reported legislation that would codify the rules governing interment in our nation's most hallowed resting place for its military heroes.

The most recent House-passed legislation from the 107th Congress 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 are in general agreement with codifying the rules, but would prefer to include provisions that would ensure some flexibility for individuals considered to have made extraordinary contributions to the United States. One way to accommodate this interest would be to include a provision authorizing the President to approve the burial of any citizen who has made a distinguished contribution to the United States.

MOAA continues to recommend codification of all 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 on a limited exception authority.

Strengthening the Uniformed Services Employment and Reemployment Rights Act (USERRA).

The USERRA (Chapter 43, Title 38 USC) is intended to protect the employment and reemployment rights of individuals who enter active military service.

MOAA is grateful to the House Subcommittee on Veterans Benefits for holding a hearing last July 24, 2003 on the USERRA. The Military Coalition, which includes MOAA, presented testimony at that hearing on its recommendations to strengthen the protections the USERRA provides.

With more than 350,000 National Guard and Reserve servicemembers mobilized since September 11, 2001, it is difficult to underestimate the importance of the USERRA to reserve servicemembers, their families and employers. Strong reemployment rights laws are an essential aspect of maintaining an all-volunteer Guard and Reserve force and these laws have an undeniable impact on military readiness.

In the 1990s, Congress enacted a number of technical changes in the USERRA, but further improvements are needed to ensure reemployment rights are kept current and that mobilized National Guard and Reserve servicemembers have the support of their government in cases where the law is not being followed.

MOAA is particularly concerned about strengthening reemployment rights of mobilized state workers; clarifying rules regarding restoration of salary and benefits under the "escalator" clause in cases where compensation is determined by merit or annual reviews instead of a "pay table"; promulgating federal regulations that implement the USERRA; clarifying and strengthening the roles of the Department of Justice and the Office of Special Counsel with regard to contested cases involving mobilized workers; directing the Department of Labor to publish a comprehensive handbook on illustrative reemployment rights cases; including the National Oceanic and Atmospheric Administration Corps of Commissioned Officers (NOAA Corps) under USERRA coverage since it is one of the uniformed services as defined in law.

MOAA recommends the Committees accelerate efforts to modernize reemployment rights under the Uniformed Services Employment and Reemployment Rights Act.

Conclusion

The Military Officers Association of America appreciates the dedication and commitment of the members of the Committees to protect, defend, restore, and improve the benefits earned by those who have served our nation in peace and war. Your actions on behalf of today's servicemembers send a very powerful signal to future veterans serving at home and abroad that their service is recognized and honored. Thank you for the opportunity to submit testimony on behalf of the members of MOAA.