

- > RAO Bulletin Update
- > 15 August 2007
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- > THIS BULLETIN [CONTAINS THE FOLLOWING ARTICLES:
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- > -- Tricare Hospice Care ----- (Coverage)
- > -- Military Spouse Monument ----- (Proposed)
- > -- VA Claims Assistance [03] ----- (Triple Compensation)
- > -- Fisher House Expansion [01] ----- (Tampa Opens)
- > -- Tricare Uniform Formulary [21] ----- (Changes Announced)
- > -- Publix Prescription Offer ----- (No Cost Antibiotics)
- > -- Filipino Vet Inequities [05] ----- (Republicans Protest)
- > -- VDBC [20] ----- (CRDP Recommendation Reversed)
- > -- Minnesota Veterans Homes ----- (Commission Appointed)
- > -- Acid Reflux Disease ----- (Cancer Impact)
- > -- Minnesota LinkVet ----- (First in Nation)
- > -- VA Clinic Openings [06] ----- (Non-hospital Dental Care)
- > -- Tricare Prime Travel Reimbursement ----- (100 miles +)
- > -- Tricare Provider Tax Credit ----- (Oregon)
- > -- Oregon Taxes ----- (Military Retirees)
- > -- Depleted Uranium [04] ----- (Report Due OCT 07)
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- > -- VA Care Vet Backlash ----- (Claim Acceptance)
- > -- Puerto Rico Medical Fraud ----- (AZ-FL-NY-TX-VA Impact)
- > -- Saluting the Flag ----- (Veterans)
- > -- VA Facility Expansion [05] ----- (Ft. Bragg)
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- > -- VA Clinic Openings [05] ----- (Guam Summer 2009)
- > -- SBP Basics [01] ----- (Program Explanation)
- > -- Retiree Annual COLAs [01] ----- (Tracking Inflation)
- > -- VA Fraud [01] ----- (\$120,000 Embezzled)
- > -- Vet Home Tennessee ----- (Fined \$200,000)
- > -- HVAC [02] ----- (Support for 7 Bills)
- > -- Commissary Construction ----- (Program Impacted)
- > -- SBP Paid Up Provision [03] ----- (30 Year Payers)
- > -- Agent Orange Diseases [01] ----- (Associated)
- > -- Agent Orange Diseases [02] ----- (Non-Associated)
- > -- Agent Orange & Hypertension ----- (Possible Association)
- > -- Retirement Tax Considerations ----- (Sales & Income)
- > -- Veteran Legislation Status 13 AUG 07 ---- (Where We Stand)
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- > Editor Note 1: Effective immediately I will cease using the email addree

raoemo@mozcom.com <<mailto:raoemo@mozcom.com>> because Spam messages at this addree have reached 150 daily. My email addree raoemo@sbcglobal.net <<mailto:raoemo@sbcglobal.net>> will be the only addree I will be monitoring after 15 SEP. Also, I will be relocating to the Philippines 21 AUG and will not be able to respond to messages 20 to 24 AUG. [Source: RAO Director]

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> Editor's Note 2: Attached is a listing of veteran legislation with current cosponsor status that has been introduced in the 110th Congress. To see any of these bills passed into law representatives need input from their veteran constituents to instruct them on how to vote.

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> TRICARE HOSPICE CARE: Tricare hospice care is available to beneficiaries who have received a terminal diagnosis. Its function is to provide care for terminally ill patients with a life expectancy of six months or less if the illness runs its normal course. In particular, curative treatments are not covered, while personal care and home health aide services are covered. It may include physician services, nursing care, counseling, medical equipment, supplies, medications, medical social services, physical and occupational services, speech and language pathology, and hospice short term inpatient care to manage acute or chronic symptoms or to control pain. Room and board are not covered under the Tricare hospice benefit; however, inpatient care is covered when needed. You cannot receive other Tricare services or benefits related to curative treatment of the terminal illness, unless the hospice election is formally revoked.

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> The hospice, in conjunction with your regional contractor, is responsible for the arrangement of all care while you are under the hospice election. To formally revoke the hospice election, you must submit a signed and dated statement through the hospice provider. This does not alter your ability to elect and reenter hospice care at a later time. Hospice care can be provided in a Home, Hospice facility or Inpatient acute care facility. Care can shift among these facilities without affecting the hospice benefit. For example, if you are receiving hospice care at home, but the family member caring for you is overwhelmed with caretaking responsibilities, you may choose to receive short term, inpatient respite care at a hospice facility in consultation with your hospice care team. This is an available option under the hospice benefit.

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> Hospice care is managed by the hospice medical director, the hospice care team managing your case, and your primary care manager (PCM) or primary care provider, who are always in consultation with you and your family. Your case manager and PCM or primary care provider will assist in locating appropriate hospice care. A hospice evaluation does not require

authorization. Only Medicare certified hospices are authorized to provide covered services to TRICARE beneficiaries. You can locate a Tricare authorized hospice provider through your regional contractor. There is no deductible for hospice care, and Tricare pays the cost of all covered services, except for small cost share amounts which may be collected by the individual hospice (at their option) for outpatient drugs and inpatient respite care. Check with your regional contractor or hospice provider for specific cost information.

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> Hospice care is provided in three benefit periods, each of which requires prior authorization from your regional contractor. The first two benefit periods are each 90 days long. The first period begins on the day you sign a hospice election statement and both the attending physician and the hospice medical director sign a physician's certificate of terminal illness. Each subsequent period requires recertification of the terminal illness by the hospice medical director or the physician on your hospice care team. The final benefit period is made up of an unlimited number of 60 day periods, each of which requires physician recertification of the terminal illness.

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> You, your PCM or primary care provider, or a family member acting on your behalf can initiate hospice care. However, it is important to understand that the hospice cannot provide services without a referral from your PCM or primary care provider, prior authorization from your regional contractor, and certification of the terminal illness. When considering hospice care, you should discuss the options with family members and your PCM or primary care provider. The hospice benefit also covers a consultation with the medical director of a Medicare certified hospice so you may ask questions and learn more about a specific hospice program. You must complete and sign an "election statement," which the hospice provides, that indicates your full understanding of hospice care. By signing this statement, you waive your right to any Tricare benefits associated with curative treatment of your illness. The election statement is then filed with your regional contractor. [Source: Tricare Hospice Care Brochure 29 Nov 06 ++]

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> **MILITARY SPOUSE MONUMENT:** Due to the efforts of two military spouses, the first steps toward a monument to honor the courage and sacrifice of military spouses have been taken. Representative Thelma Drake (R-VA-02) recently introduced The Military Spouses Memorial Act of 2007 (H.R. 3026) to authorize a monument to be erected in the Washington DC area. The Military Spouses Legacy Association, Inc. was founded in 2007 by Nicole Alcorn, herself a military spouse and the daughter of a military widow, and Karie Darga, who lost her husband in Iraq. The association has received its 501(c)3 non-profit status and is collecting the private donations to fund

the construction and maintenance of the monument. To learn more about the Military Spouses Legacy Association, refer to <http://www.militaryspousemonument.org/home.html>. [Source: NMFA Government & You e-News 14 Aug 07 ++]

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> VA CLAIMS ASSISTANCE UPDATE 03: A recent study by the Institute for Defense Analysis shows that wounded veterans who approach the V.A. without professional assistance receive on average about one-third of the compensation that those who are represented by a lawyer or service organization like the Disabled American Veterans (DAV) get. DAV representative Eric McGinnis said, "That's not surprising at all. If you know the proper vernacular, a few simple phrases, it makes things a lot easier. But you'd be hard-pressed to find a vet who knows exactly the right things to say and do." McGinnis' experience in that arena is both professional and personal. The Army veteran came to work for the DAV after the organization helped him obtain compensation after the VA initially told him he'd get none. "It's a common story," he said. Complicating matters further, is a compensation process that requires veterans to approach the VA, openly advertising their own physical and psychological wounds in order to receive benefits. "These aren't always people who are comfortable advocating for themselves," said McGinnis. Utah State Department of Veterans Affairs Director Terry Schow said it would be nice if the system weren't so adversarial and complex that veterans needed help from outside groups to obtain just compensation for their wounds. "The process is so involved and complicated, that I think it's just wise to do that. And so we encourage everyone to get assistance from a service organization."

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> DAV is an organization of disabled veterans who are focused on building better lives for disabled veterans and their families. They accomplish this by providing assistance to veterans, their families, their widowed spouses and their orphans in obtaining benefits and services earned through their military service. The organization is fully funded through its 1.2 million membership dues and public contributions. It is not a government agency and receives no government funds. However, it is the foremost representative of the interests of disabled veterans and before federal, state, and local governments. In 88 offices, 260 National Service Officers (NSOs) and 26 Transition Service Officers (TSOs) directly represent veterans with claims for benefits from the Department of Veterans Affairs and the Department of Defense. NSO/TSO personnel assist in filing claims for VA disability compensation, rehabilitation and education programs, pensions, death benefits, employment and training programs, and many other programs. This service is available to all veterans at no charge. DAV's Voluntary Service Program consists of a transportation network which provides veterans with rides to and from VA medical facilities for treatment, and a program which facilitates volunteers at VA hospitals, clinics, and nursing homes.

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> NSO representation covers development and prosecution veterans' claims through in-depth reviews of medical histories in conjunction with sound application of current law and regulations. In representing veterans and their families, NSOs assist in the thorough preparation of claims and written briefs, which includes helping to assemble evidence in support of those claims. They also review rating board decisions and inform veterans and their families of the appeals process and their appellate rights. DAV National Appeal Officers represent the largest percentage of claimants in cases decided by the Board of Veterans Appeals (BVA). They also provide representation before the U.S. Court of Appeals for Veterans Claims through which veterans have the right to independent judicial review of appeals denied by the BVA. Veterans seeking assistance can refer to www.dav.org/veterans/service_office.html <http://www.dav.org/veterans/service_office.html> to locate an office accessible to them. [Source: The Salt Lake Tribune Mathew LaPlante article 13 Aug 07 ++]

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> FISHER HOUSE EXPANSION UPDATE 01: The newest Fisher House was dedicated 6 AUG 07 at the James A. Haley Veterans' Hospital in Tampa, Florida. The new Fisher House will provide families free lodging, making it easier to participate in the care and recovery of loved ones. Veterans Affairs Secretary Jim Nicholson participated in a ceremony transferring ownership of the Fisher House to the VA. It will operate and maintain the home at no cost to its residents. This is the 38th Fisher House built by the Fisher House Foundation and the ninth operated by VA. At 16,000 square feet, the Tampa Fisher House is among the largest of these comfort homes, which can accommodate up to 21 families. Some families travel long distances to Tampa's Polytrauma Center - one of four unique VA polytrauma facilities in the United States where the most severely injured and disabled veterans are treated. In addition to polytrauma patients, those receiving care in the hospital's other specialized programs, such as spinal cord injury, post-traumatic stress disorder and traumatic brain injury, will benefit from the Fisher House. [Source: NAUS Weekly Update 10 Aug 07 ++]

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> TRICARE UNIFORM FORMULARY UPDATE 21: The Tricare Management Activity

announced the following changes to the Uniform Formulary:

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> - Nexium, which is used to treat heartburn and gastric disorders, has been reclassified as a first-tier medication. First-tier medications (formulary generics) are available at most military treatment facilities at no charge, or for a \$3 co-pay through the Tricare Retail Pharmacy (30-day supply) or the Tricare Mail Order Pharmacy (90-day supply).

> - Prevacid, Zegerid, Protonix and Aciphex, are also used to treat gastric

disorders and will be reclassified as non-formulary medications effective 24 OCT 07.

> - Avodart, a medication used to treat prostate-related problems will move to the third tier on 24 OCT.

> - Hypertension drugs Avapro, Avilide, Benicar, Benicar HCT, Diovan, Diovan HCT, Teveten, and Teveten HCT along with cholesterol-lowering medications Anataara, Tricor, Omacor, and WelChol will be reclassified as non-formulary medications on 21 NOV. The price of non-formulary medications is \$22.

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> Beneficiaries using the above medications may want to consult with their health care providers about other options including generic equivalents or establishing medical necessity for the third-tier medication if appropriate. If medical necessity is established, the co-payment is reduced to \$9.

Third-tier medications are not available at military treatment facility (MTF) pharmacies unless an MTF provider establishes medical necessity and writes the prescription. Medical necessity forms and criteria are available at

> www.tricare.mil/pharmacy/medical-nonformulary.cfm

<<http://www.tricare.mil/pharmacy/medical-nonformulary.cfm>>. For a complete list of medications, their formulary status and where they are available, beneficiaries may refer to

> www.tricareformularysearch.org/dod/medicationcenter/default.aspx

<<http://www.tricareformularysearch.org/dod/medicationcenter/default.aspx>>.

Additional information on the TRICARE Retail Pharmacy and locations, and the

TRICARE Mail Order Pharmacy can be found at www.express-scripts.com/TRICARE

<<http://www.express-scripts.com/TRICARE>>

or by calling 1(866) 363-8779 for the retail pharmacy or 1(866)363-8667 for the mail order pharmacy. [Source: NAUS Weekly Update 10 Aug 07 ++]

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> PUBLIX PRESCRIPTION OFFER: On 6 AUG the Publix Super Market chain said it would make seven common prescription oral antibiotics at no charge to its customers via their 648 pharmacies. With a valid prescription, new or current Publix customers can receive a 14-day supply that will be filled at no charge and can be refilled. The antibiotics include:

> * Amoxicillin

> * Cephalexin

> * Sulfamethoxazole/Trimethoprim (SMZ-TMP)

> * Ciprofloxacin (excluding ciprofloxacin XR)

> * Penicillin VK

> * Ampicillin

> * Erythromycin (excluding Ery-Tab)

> These antibiotics account for almost 50% of the generic, pediatric prescriptions filled at Publix. Publix is not limiting the number of prescriptions customers may fill. The antibiotics will be provided to customers regardless of their prescription insurance provider. Publix

operates stores in Florida, Georgia, South Carolina, Alabama and Tennessee.
[Source: NAUS Weekly Update 10 Aug 07 ++]

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> FILIPINO VET INEQUITIES UPDATE 05: The Filipino Veterans Equity Act of 2007 (H.R.760) passed the House Committee on Veterans Affairs. This is a bill to amend title 38, United States Code, to deem certain service in the organized military forces of the Government of the Commonwealth of the Philippines and the Philippine Scouts to have been active service for purposes of benefits under programs administered by the Secretary of Veterans Affairs. As amended it will eliminate special monthly pensions currently being paid for severely disabled veterans over 65 who are also receiving pensions for wartime service. The legislation would use nearly all of the \$965 million saved by this unprecedented cut in veterans' benefits to provide budgetary offsets to fund oversized pensions for non-citizen, non-resident World War II Filipino veterans. Similar legislation, S.1315, is being considered in the Senate. The American Legion among others does not support this legislation as amended. While the Legion supports improvements to Filipino Veterans Benefits they oppose overturning the Court decision in the Hartness case and eliminating an earned benefit for disabled veterans. The American Legion is asking that their membership contact their members of Congress and express support for securing the earned benefits of severely disabled veterans by protecting the Hartness decision. [Source: AL Weekly Update 10 Aug 07 ++]

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> VDBC UPDATE 20: Veterans won an important victory this week when the Veterans Disability Benefits Commission (VDBC) reversed itself on the issue of giving both VA disability payments and full military retirement pay to Chapter 61 and TERA retirees. At the JUL 07 meeting of the Commission they pointedly voted to not support both benefits for those groups. But discussion among a number of the commissioners after that vote in July made it apparent that many of them did not understand the implications of their votes. In the weeks since that meeting, veterans groups provided information to the commission that led to the change this week. The new language adopted by the Commission in a 12 to 1 vote was as follows: Congress should eliminate the ban on concurrent receipt for all retirees and disability retirees. Future priority should be given to Chapter 61 retirees with less than 20 years and greater than 50% service-connected disabled and all combat disabled Chapter 61's. At last month's meeting the Commission already decided to recommend that both full Military Retired Pay and VA Disability Pay be given immediately to all longevity retirees with VA disabilities ratings (including those with 10%-40% ratings.)

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> The Commission next meets 22-24 AUG in Washington, D.C., at the Hotel Washington, which is located at 15th St. and Pennsylvania Avenue, NW.

Anyone in the area or visiting D.C. is encouraged to attend this very important meeting. The purpose of the Veterans' Disability Benefits Commission is to carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service, and to produce a report on the study. The VDBC is meeting several times a month in order to complete the work of the Commission by its 1 OCT deadline to make their report to Congress and the President. Their conclusions are only recommendations but they will certainly help in veteran groups lobbying efforts. is due sometime around the 1 OCT this year. [Source: TREA News flash 10 Aug 07 ++]

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> MINNESOTA VETERANS HOMES: The Minnesota Veterans Home - Minneapolis, once

called the Old Soldiers Home, was built in the late 1800's for indigent veterans of the Civil War. The Home is located on a 51 acre wooded campus overlooking the Mississippi River near Minnehaha Falls. At the end of the 19th century the intent was to create a beautiful, comfortable, community for veterans in need of care in their later years. Unfortunately, the home has experienced numerous inspection problems in recent months. Gov. Tim Pawlenty appointed a seven-member Veterans Long-Term Care Advisory Commission tasked with recommending ways to end the Minneapolis home's frequent problems and consider whether the five Minnesota homes should serve more people than the 863 people housed in its nursing homes and assisted-living facilities. Since 2005, the Minneapolis Home has been cited by the state for 67 rule violations, the most recent last month, and fined \$42,300 when the problems were not corrected. Separately, the U.S. Department of Veterans Affairs, which pays about 20% of the care costs, found 48 violations since 2005.

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> The Minneapolis facility has asked the federal government to approve a \$44 million "Cadillac plan" to renovate the nursing home. The proposed renovation project, still in the design phase, would reduce the number of beds in the home's main building from 250 to 198. The remodeled home would be divided into 14 to 16 room "neighborhoods," each with its own kitchen. All the beds in the renovated facility would be in single rooms with private baths. The home also has a 91-bed nursing-home dementia unit and a 61-bed assisted-living facility in separate buildings. It had to stop taking new nursing-home residents in December while it fixes the care problems and now has about 350 people on its waiting list. The home's governing board has submitted the plan to federal officials as a project list "place holder." If approved, the VA would pay 65% of the \$44 million cost. The Legislature would have to approve the remaining \$15 million. As the Minneapolis Home plans a major overhaul, a commission is considering an expanded role for the five state-owned residences. The plan would have the board provide an array

of services for the state's 140,000 aging veterans.

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> Admissions criteria for acceptance in a Minnesota home include:

Honorably Discharge, 181 Consecutive Days on Active Duty, Minnesota Resident (or had service credited to Minnesota), Spouses of eligible Veterans over 55 years of age and reside in the state, and applicants ability to demonstrate medical need. The states five homes are located at:

> - 1821 North Park ST., Fergus Falls MN 56537 Tel: (218) 736-0400 or 1(877) 838-4633.

> - 1200 East 18th ST., Hastings, MN 55033 Tel; (651) 438-8504 or 1(877) 838-3803)

> - 1300 North Kniss Ave., P.O. Box 539, Luverne MN 56156 Tel: (507) 283-1100 or 1(877) 588-8387.

> - 5101 Minnehaha Ave. South, Minneapolis MN 55417 Tel: (612) 721-0600 or 1(877) 838-6757.

> - 45 Banks Boulevard, Silver Bay MN 55614 Tel: (218) 226-6300 or 877-729-8387

> [Source: Minneapolis Star Tribune Warren Wolfe article 9 Aug 07 ++]

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> ACID REFLUX DISEASE: Acid Reflux (i.e. heartburn) is caused when acid from the stomach flows upwards into the long feeding tube that connects the stomach and throat (esophagus) causing a burning sensation. Unlike the stomach, which has a lining that protects it from the acid, the esophagus is delicate and easily irritated by acid. Nighttime heartburn is heartburn that occurs at night. Anyone can have occasional heartburn as might occur after a spicy meal. Frequent and recurring heartburn, however, may be a symptom of a more serious condition. Gastroesophageal reflux disease is caused when the opening between the esophagus and the stomach becomes looser or relaxes at the wrong times. Normally, this opening allows food to travel only from your esophagus into your stomach. A muscular valve, called a sphincter, normally keeps stomach contents, including stomach acid, in the stomach. When the sphincter between the stomach and the esophagus becomes loose or relaxes at the wrong time, the stomach contents can flow up from the stomach into the esophagus. This irritates the esophagus, which doesn't have a special lining to protect it from acid like the stomach does. Studies have also shown that if you lie in bed, the protective effect of gravity can become lessened.

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> New research from scientists at UT Southwestern Medical Center and the Dallas Veterans Affairs Medical Center underscores the importance of preventing recurring acid reflux while also uncovering tantalizing clues on how typical acid reflux can turn potentially cancerous. In research published in July and August, scientists discovered that people with acid reflux disease, particularly those with a complication of acid reflux called Barrett's esophagus, have altered cells in their esophagus containing shortened telomeres, the ending sequences in DNA strands. Combined with

related research to be published in AUG, the findings indicate that the shortened sequences might allow other cells more prone to cancer to take over. "The research supports why it is important to prevent reflux, because the more reflux you have and the longer you have it, the more it might predispose you to getting Barrett's esophagus. So you want to suppress that reflux," said Dr. Rhonda Souza, associate professor of internal medicine at UT Southwestern and lead author of the paper which appears in the July issue of the American Journal of Physiology - Gastrointestinal and Liver Physiology.

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> Over time, the persistent acid bath from acid reflux can cause normal skin-like cells in the esophagus to change into tougher, more acid-resistant cells of the type found in the stomach and intestine, a condition called Barrett's esophagus, explained Dr. Stuart Spechler, professor of internal medicine and senior author of the paper. "Unfortunately, those acid-resistant cells are also more prone to cancer," Dr. Spechler said. According to the National Cancer Institute Adenocarcinoma of the esophagus, the cancer that is especially associated with Barrett's esophagus, is currently the most rapidly rising cancer in the U.S., with a six fold increase in cases during the past 30 years. Understanding how and why the cells change in some cases and not others has been a major challenge for investigators. The research was funded by the Department of Veteran's Affairs, National Institutes of Health, the Harris Methodist Health Foundation, the Dr. Clark R. Gregg Fund and AstraZeneca. [Source: UT Southwestern Medical Center article 10 Aug 07 ++]

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> MINNESOTA LinkVet: To make it easier to find services and to ensure immediate crisis intervention, Minnesota Gov. Tim Pawlenty announced the launch of LinkVet - the Veterans Linkage Line for Minnesota veterans and their family members. The toll-free customer service line is the first of its kind in the nation and will provide information referrals, immediate crisis intervention and psychological counseling 24 hours a day, seven days a week at (888) LINKVET (546-5838). The new line is up and running. LinkVet will be answered by trained staff at the Minnesota Department of Veterans Affairs (MDVA) and Crisis Connection, a Twin Cities based non-profit mental health telephone counseling service. MDVA staff, who are veterans themselves, will manage the lines M-F from 08-1600. Crisis Connection social workers will field all crisis calls during business hours, and all calls after hours, on weekends and holidays. Veterans who call LinkVet and need to be transferred to someone other than a MDVA staff member will be connected in a three-way call to the necessary resources. MDVA staff will remain on the line with the caller until the veteran's issue has been successfully resolved.

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> LinkVet was developed by the Governor's Yellow Ribbon Task Force

Crisis Line Workgroup. This group met during the spring and included representatives from several state agencies, the National Guard and non-profit veteran services providers. After discovering there were several toll-free lines for crisis intervention and suicide prevention for returning soldiers and veterans, and that United Way's 211 referral line is not cell phone accessible, the workgroup proposed a statewide one-stop call line for veterans similar to the Senior Linkage and Disability Linkage lines. Revation, the company that has supplied the software for Senior Linkage and Disability Linkage lines, has agreed to provide a one-year free trial of the Veterans Linkage Line software. After the first year, there will be no additional hardware required and approximately \$0.04 per minute operating costs. Last year, MDVA launched www.minnesotaveteran.org <<http://www.minnesotaveteran.org>>, a one-stop Web site for information about education, medical, employment, retirement and other benefits. [Source: Independent Review Kristin Holtz article 13 Aug 07 ++]

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> VA CLINIC OPENINGS UPDATE 06: A joint effort of two Department of Veterans' Affairs medical centers has put dental health care closer to the homes of many eastern North Carolina veterans. An open house was held 9 AUG at the VA Outpatient Clinic in Morehead City to celebrate the opening of the first community-based VA dental clinic in the state. Eligible veterans, who would normally travel to either the VA medical centers in Durham or Fayetteville, can now be referred to the Morehead City clinic for general dentistry and dental cleanings. While the Morehead City clinic is affiliated with the medical center in Durham, many area veterans who are patients at the Fayetteville medical center also live close to the Carteret County site. By working together, the two medical centers are making the new dental clinic accessible to all those eligible veterans who live nearby. While VA dental services have traditionally been associated with its hospitals, VA Mid-Atlantic Health Care Network Director Daniel Hoffmann believes the Morehead City clinic will be an example for others to follow.

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> For many of the area's veterans, trips to a VA hospital require several hours. While specialty dental care may still require visits to Durham or Fayetteville, the Morehead City clinic is now equipped with four dental exam rooms and will be staffed by two general dentists, a dental hygienist and dental assistants. The Morehead City outpatient clinic currently provides primary care and mental health care services to about 2,400 veterans. The planned enrollment for the dental clinic is expected to be about 700 patients in the first year. The clinic was originally designed under the premise that it would serve as a joint clinic with the U.S. Navy. When that plan did not work out, the VA decided to proceed with building the larger facility to accommodate future growth. At a community meeting last October, it was announced that VA staff would be taking over operations of

the clinic from the private corporation that had provided care since the clinic's opening. VA officials said at that time that the move would allow for better health care for veterans in the area. An eye clinic is expected to be added to the Morehead City site in October and the possibility of other services is being evaluated. All the unused space will be filled with the additions, but other services such as dermatology or podiatry might be possible through visiting specialists.

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> The dental care at the Morehead City clinic is for dental-eligible veterans only. Congress has established special eligibility rules for dental care for veterans. The majority of patients who are eligible are either 100% disabled due to a service-connected condition, have a service-connected disability for a dental condition or are within 90 days of discharge from active duty. Patients must be referred to the clinic by the VA Medical Center in Durham. Priority will be given to eligible dental patients who are currently treated in Durham or Fayetteville, who live closer to Morehead City and whose providers feel they may transfer their care. Patients in these categories will be called or will receive a letter telling them of their options to transfer their routine dental care to the Morehead City clinic. Current users of VA care who would like to request dental care at the Morehead City clinic may call the Durham VA Medical Center at 1 (888) 878-6890, ext. 6247. New patients to the VA system should complete VA Form 10-10EZ in full, listing "Morehead City CBOC" in section 1B. Packets can be picked up at the clinic, requested from the Durham VA Medical Center or obtained electronically at www.1010ez.med.va.gov <<http://www.1010ez.med.va.gov>>. Include a copy of DD214 if available and mail to: Eligibility Office (136); VA Medical Center; 508 Fulton St.; Durham, N.C. 27705. Patients will be contacted by phone once registration is complete. [Source: Jacksonville NC Daily News Staff Jannette Pippin article 9 Aug 07 ++]

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> TRICARE PRIME TRAVEL REIMBURSEMENT: Tricare Prime beneficiaries referred by their primary care manager for specialty services at a location more than 100 miles from their provider's location may be eligible to have their reasonable travel expenses reimbursed by Tricare. Beneficiaries must have a valid referral and travel orders prior to traveling, and file a travel claim upon their return. This can be requested at the military treatment facility (MTF) or from the Tricare Regional Offices (TRO) if the doctor is a Tricare network provider. Beneficiaries will receive a briefing on the entitlement process, coverage, and their responsibilities at the MTF or from the TRO point of contact. Reasonable travel expenses are the actual costs incurred by the beneficiary when traveling to their specialty provider. Costs include meals, gas, tolls, parking, and tickets for public transportation (i.e., airplane, train, bus, etc.). Beneficiaries must submit receipts for

expenses above \$75. The MTF or TRO will provide the beneficiary with specific instructions on how and where to submit his or her travel entitlement claim. Government rates are used to estimate the reasonable cost. Beneficiaries are expected to use the least costly mode of transportation. Costs of lodging and meals may be reimbursed up to the government per diem rate. This benefit does not apply to travel expense for specialty care experienced by active duty uniformed service members, or active duty family members residing with their sponsors overseas, which are reimbursed by other travel entitlements. For more information on the Tricare Prime Travel Reimbursement, refer to www.tricare.mil/factsheets <<http://www.tricare.mil/factsheets>>.

[Source: Tricare News Release 8 Aug 07++]

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> **TRICARE PROVIDER TAX CREDIT:** The leadership of the state of Oregon took a giant step forward in their unprecedented efforts to help Tricare beneficiaries receive the health care they deserve. A bill-signing ceremony was part of the fanfare surrounding the legislation, which features a tax incentive package that encourages health care providers to support military families by participating in Tricare, the health care plan for the uniformed services, retirees, and their families. The incentives include a one-time tax credit of \$2,500 for new providers in the Tricare system, plus an additional annual credit for treating patients enrolled in Tricare. It also creates a deduction from federal taxable income in the first two years of a provider's participation in the Tricare system. TriWest Healthcare Alliance, the managed care support contractor for the Tricare benefit in Oregon and 20 other western states, applauded the efforts of Oregon Governor Ted Kulongoski and the Oregon legislature.

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> TriWest has been conducting a proactive campaign to enlist state governors in their service area to support active duty, retiree and Guard and Reserve families by encouraging physicians to accept patients with Tricare. With the encouragement and support of state leadership, the Oregon War Veterans Association and the Oregon Medical Association, TriWest Healthcare Alliance has increased the Tricare provider network in Oregon by 35% since the fall of 2004. There are currently more than 9,000 providers serving the 65,000 Tricare beneficiaries in Oregon. Maj. Gen. Elder Granger, Deputy Director, TMA said, "Increased availability of health care providers will become even more important as an improved Tricare Reserve Select (TRS) health care program launches this fall." TRS offers a premium-based health care plan to National Guard and Reserve members. Starting 1 OCT 07, all eligible members of the Selected Reserve will be able to purchase health care coverage under the new TRS and all will pay the same low monthly premium. The current TRS plan, which remains in effect through 30 SEP, has a complex three-tier system requiring activation in support of a contingency operation, among others, to qualify for the lowest monthly premiums. Members

of the Selected Reserve can refer to www.tricare.mil <<http://www.tricare.mil>> for more information on

the improved TRS program. [Source: Tricare News Release 8 Aug 07 ++]

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> OREGON TAXES: The following taxes are applicable to military retirees:

> Sales Taxes - State Sales Tax: None; Gasoline Tax: 24.9 cents/gallon & Diesel Fuel Tax: 24.3 cents/gallon (Local fuel taxes may add 1 to 3 cents/gallon); Cigarette Tax: \$1.18/pack of 20.

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> Personal Income Taxes - Tax Rate Range: Low - 5%; High - 9%. For joint returns, the taxes are twice the tax imposed on half the income.

> - Income Brackets: Lowest - \$2,750; Highest - \$6,851 w/3 brackets.

> - Personal Tax Credits: Single - \$154; Married - \$308; Dependents - \$154; and a credit equal to 40% of federal credit

> - Standard Deduction: Single - \$1,840; Married filing jointly - \$3,685; Single over 65 - \$1,200; Married over 65 filing jointly \$2,000.

> - Medical/Dental Deduction: Full only for age 59 or older, if itemized.

> - Federal Income Tax Deduction: \$5,000 (\$2,500 if married filing separately)

> - Oregon has a statutory provision for automatic adjustment of tax brackets, personal exemption or standard deductions to the rate of inflation.

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> Retirement Income Taxes: Federal income tax rules generally determine the amount of your pension that is taxed by Oregon. However, you may subtract some pensions on your Oregon return that were taxed on your federal return. Pensions not taxed are Social Security benefits, Veterans Administration benefits and Railroad Board benefits. Oregon allows a subtraction for part or all of the payments you receive from the federal pension system. Generally, retirement income is subject to Oregon tax. A tax credit of up to 9% of taxable pension income is available to recipients of pension income, including most private pension income, whose household income was less than \$22,500 (single) and \$45,000 (joint), and who received less than \$7,500/\$15,000 in Social Security or Railroad Retirement benefits. The credit is the lesser of tax liability or 9% of taxable pension income.

> a. Retired Military Pay: Federal retirees, including military personnel, may be able to subtract some or all of their federal pension income. This includes benefits paid to the retiree or to the surviving spouse. The subtraction amount is based on the number of months of federal service before and after October 1, 1991. Retirees can subtract their entire federal pension if all the months of federal service occurred before October 1, 1991. If there are no months of service before October 1, 1991, retirees cannot subtract any federal pension. If service included months before and after October 1, 1991, retirees can subtract a percentage of their pension income.

> b. Military Disability Retired Pay: Disability Portion - Length of Service Pay; Member on September 24, 1975 - No tax; Not Member on September 24, 1975 - Taxed, unless combat incurred. Retired Pay - Based solely on disability: Member on September 24, 1975 - No tax; Not Member on September 24, 1975 - Taxed, unless all pay based on disability and disability resulted from armed conflict, extra-hazardous service, simulated war, or an instrumentality of war.

> c. VA Disability Dependency and Indemnity Compensation: Not subject to federal or state taxes.

> d. Military SBP/SSBP/RCSBP/RSFPP: Generally subject to state taxes for those states with income tax. Check with state department of revenue office.

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> Property Taxes: Oregon does not grant homeowners a homestead exemption. Tax rates are set by the counties and any special considerations are levied by county officials. Homeowners 62 or older may delay paying property taxes based on certain income criteria. The state offers a Disabled Citizen Property Tax Deferral Program and a Senior Citizen Property Tax Deferral Program. Both deferral programs allow qualified taxpayers to defer payment of their property taxes on their homes. The state pays the taxes to the county, maintains the account, and charges 6% simple interest, which also is deferred. Taxes are owed when the taxpayer receiving the deferral dies, sells the property, ceases to live permanently on the property, or the property changes ownership. To qualify for either program, the taxpayer must live on the property and have a total household income of less than \$36,500 for the year before application. Participants may remain on either program as long as their federal adjusted gross income does not exceed that amount. If a participant's income exceeds the \$36,500 limit, part of the taxes still may be deferred. Participants can come in and out of the programs if their income changes. In addition to meeting the income limitation and property ownership requirement, disabled persons must be receiving or be eligible to receive federal Social Security Disability benefits to qualify. Residents must be 62 years old or older to qualify for the Senior Citizen Property Tax Deferral Program. Call 800-356-4222 or 503-376-4988 for details or refer to <http://www.oregon.gov/DOR/SCD/faq.shtml#Anchor-What-49575> <<http://www.oregon.gov/DOR/SCD/faq.shtml>>.

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> Inheritance and Estate Taxes: An Oregon inheritance tax return is required to be filed whenever a federal estate tax return (Form 706) is required to be filed. For a resident decedent, Oregon taxes real property and tangible personal property located in Oregon and intangible personal property wherever it is located. For a nonresident decedent, Oregon taxes real property, tangible personal property, and intangible personal property located in Oregon. An exemption is allowed for intangible personal property located in Oregon if a like exemption is allowed by the state of residence.

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> For latest information, visit the Oregon Department of Revenue site
<<http://www.oregon.gov/DOR/>> or call (503) 378-4988. [Source:
<<http://www.retirementliving.com/RLstate3.html>> Aug 07 ++]

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> DEPLETED URANIUM UPDATE 04: In the wake of an Iraqi official in blaming America's use of depleted uranium (DU) munitions in its 2003 "Shock and Awe" campaign for a surge in cancer there, the Defense Department is facing an OCT 07 deadline for providing a comprehensive report to Congress on the health effects of such weapons. The report is required by the National Defense Authorization Act for Fiscal Year 2007, which President Bush signed into law last year. The request for the study is an outgrowth of claims by Iraq war veterans that exposure to depleted uranium and other toxic substances there has negatively affected their health and that, therefore, their illnesses should be recognized as war-related and the treatment covered by the Veterans Administration. Currently, the State Department's Web site says fears about adverse health effects of DU, are "unwarranted," and it lists worries about DU under a section called "identifying misinformation." The site says the American military uses the material in ammunition to take advantage of its unsurpassed ability to penetrate armored vehicles, and it cites four separate studies -- by NATO, the Rand Corporation, the European Commission, and the World Health Organization -- that found no evidence of adverse health effects from depleted uranium.

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> Even so, worries persist. According to Rep. Jim McDermott [D-WA 07] who pushed for the report from the Pentagon, "There are countless stories of mysterious illnesses, higher rates of serious illnesses, and even birth defects. We do not know what role, if any, DU plays in the medical tragedies in Iraq, but we must find out." In contrast to soldiers who have lost limbs to explosive devices in Iraq, who qualify for Traumatic Servicemembers Group Life Insurance injury benefits of up to \$100,000, veterans with unexplained cancers don't get benefits because cancer is a disease and not a war wound. On 23 JUL 07, Iraq's environment minister blamed at least 350 sites in Iraq being contaminated during bombing with depleted uranium weapons for about 140,000 cases of cancer there and for between 7,000 and 8,000 new cases each year. A U.N. Environment Program report states that depleted uranium poses little threat if spent munitions are cleared from the ground. However, no major clean-up or public awareness campaigns have been reported in Iraq, the report added. [Source: New York Sun R.B. Stuart article 6 Aug 07 ++]

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> VA NORTH TEXAS SITREP: The Veterans Affairs medical system in North Texas has a new director, Joe Dalpiaz, the third director in less than three years. He faces many challenges one of which is restoring local veteran's faith in the ability of VA to care for their needs. The veterans of Tarrant, Johnson, Parker and Wise counties can hardly be faulted for their concerns.

The VA's clinic on West Rosedale Street has been acutely overcrowded for close to a decade, and officials have talked about needing a larger one for at least six years. The VA system in North Texas is confronting a daunting array of problems -- overwhelming demand for services, long waits for appointments, complaints about rude employees and scathing reports from its own inspector general. Dalpiaz, 49, who took over in May as part of a management overhaul, vows to work on getting it right. The North Texas system (the Dallas hospital, Fort Worth clinic and a hospital and nursing home in Bonham) is the fifth-largest VA system in the nation, drawing from a pool of 481,000 veterans in 40 counties. This year's budget is \$511 million. Even as it has struggled, and sometimes failed, to handle the World War II, Korean War and Vietnam-era veterans, hundreds of veterans from the Iraq and Afghanistan wars have further burdened the system. Thirty percent of the new enrollees are young men and women, many with complex mental health or brain injuries that require considerable time and care.

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> Dalpiaz seemed surprised when he took over to discover there was no strategic plan, no blueprint for where to go or how to get there. He insists that veterans must be treated better by employees. The Fort Worth hospital terminated 150 employees in the last year as a result of stricter performance and customer-service expectations, and the hospital is actively seeking more and better nurses, Dalpiaz said. He would like to improve the morale of nurses and physicians, and he said he is working to improve pay in a brutally competitive medical market in North Texas. He also expects to hire more people to answer the phones and reduce the wait time for a doctor appointment, all of which he believes would improve people's perceptions of their care. Eight months ago, the Fort Worth clinic closed its enrollment to veterans, an extraordinary step. The 45,000-square-foot building, opened in DEC 91, was designed for 45,000 outpatient visits a year. But just a few years after the facility opened, the squeeze started, in part because the Air Force closed the hospital at Carswell AFB. Patient numbers rose after a congressional decision to open VA healthcare to any veteran, the managed-care crunch and ballooning cost of prescription drugs. Last year, the facility recorded 149,429 outpatient visits -- three times more than it was designed to handle. In December, officials at the Fort Worth clinic decided to close enrollment to new veterans when the patient workload per doctor exceeded standards for care. There are only 13 doctors and physician assistants working in the building.

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> Anyone new who joins the system must drive to the Dallas hospital in Oak Cliff. "That's not good," Dalpiaz conceded. That's because the Dallas facility is no less crowded than the Fort Worth clinic. The Dallas facility sees close to 91,000 veterans annually and recorded more than 700,000 outpatient visits last year. Just trying to park at the Dallas facility can take half an hour or more and involve a 10-minute walk.

> The VA's requirement that a veteran get an appointment within 30 days is

being met only half the time. Mike George, the newly named clinic administrator, said there's a ripple effect on the entire facility if a doctor falls behind, a suicidal patient shows up, a doctor calls in sick or a crush of veterans drop in without appointments. Eldon Armstrong of Grand Prairie, adjutant of the state Disabled American Veterans chapter, said more funding is the answer to the VA's problems. Other than an overburdened system, he characterized VA care in North Texas as outstanding. "If the Congress would fund the VA to build additional facilities and fund the cost of staffing those, then that would help a patient like me get a timely appointment," Armstrong said.

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> The VA has closed a real estate deal in south Fort Worth and drawn up conceptual plans, and money has been set aside in the budget. Officials expect to break ground by the summer or fall of 2008. The new clinic will dwarf the existing building -- 193,000 square feet larger, hundreds more parking spaces, a lunch cafe and expansion room just off Interstate 20. The two-story building will have room for 32 doctors, more than a twofold increase. The VA also hopes to start offering cardiology, endoscopy, pulmonary and dermatology services in Fort Worth and would like to open a women's clinic. Plans include moving mental health services back into the facility. "It will be the largest leased clinic in the entire VA system," said Bob Bearden, a facility planner for the system. Like the facility on Rosedale, the VA will lease it from a private developer for 20 years. Officials believed that they could no longer wait for VA construction money to build it. But that means that the estimated \$4.2 million lease will come out of the North Texas system's operating budget -- the same money used to buy drugs and pay nurses. The VA will increase doctors, nurses and support staff in Fort Worth, but whether it can afford to fully staff the clinic remains to be seen. [Source: Fort Worth Star-Telegram Chris Vaughn article 5 Aug 07 ++]

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> VA CARE VET BACKLASH: Angry veterans shouted down U.S. Rep. Ciro Rodriguez [D-TX-23] as he tried to bring order to a forum for veterans held in downtown San Antonio 5 AUG. "We know, we understand, how crucial this issue is," the San Antonio congressman tried to tell an overflow crowd of veterans who had been invited to ask questions and share experiences with U.S. Rep. Bob Filner [D-CA], chairman of the House Committee on Veterans' Affairs, along with Rodriguez and two other Democratic congressmen from Texas. But Rodriguez was drowned out and ultimately gave the floor to Jack E. Long, one of several vets who heckled the moderator as she tried to read e-mail questions that had been sent to the congressmen in advance. "Don't try to talk over me!" Long yelled to Rodriguez as he clutched his wife's hand. "I've had PTSD for years, and I've been turned away from the VA five times! I served my country for 44 years!" Veterans and their families around him cheered and clapped. Then they set about telling the congressmen that a

nation that claims to support its troops hasn't done well by them since they served; many of them said they've had to deal with PTSD, or post-traumatic stress disorder. Hancock Darrell refused to sit until he, too, could tell his story. "I've had PTSD for 24 years," Darrell shouted. "I've been diagnosed five times. But what does the VA say? 'We need more information.' And they turn me down again."

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> Filner then told the audience that the House had committed "tens of billions" into the 2008 budget for PTSD. He said he was working to change the adversarial relationship the Department of Veterans Affairs has with so many veterans, especially those of the Vietnam era. "I want to run a claim system like the IRS," he said. Such a system would accept a veteran's claim on its face rather than force the veteran "to prove Agent Orange caused this. You shouldn't have to prove anything. You served us; now we should be serving you." U.S. Rep. Charlie Gonzalez [D-TX-20] of San Antonio, who joined Filner, Rep. Henry Cuellar [D-TX-28] of Laredo and Rodriguez on the stage, took the microphone to plead for unity. "We're not fighting smart," he said. "We're fighting ourselves here today. We have to show people that veterans are not part of our past." The key to a healthy volunteer military, he said, is showing young people who might be interested in serving that they will be taken care of after they leave the military. Rodriguez, who sits on the Veterans' Affairs Committee, noted that 80% of veterans get no care from the VA, many because they've become disillusioned with an agency that has a backlog of claims close to 800,000 claims that can take years to resolve.

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> In his opening remarks, Filner said he had come to listen and learn, and he asked the capacity crowd how many had served in Vietnam. The majority in the room raised their hands. "Thank you for your service," he said, "And I am sorry. We did not do the job for you." More than 200,000 homeless Vietnam veterans will sleep on the streets tonight, he told the crowd, and as many Vietnam veterans have now committed suicide as died in the war. "And that is a moral disgrace. We must correct it as best we can and make sure it never happens again." The ratio of injured to killed in today's wars is a staggering 17-to-1, he said. In Vietnam, it was 3-to-1. "We spend \$1 billion every two and a half days" in Iraq and Afghanistan, he said. "Supporting our troops at home needs to be part of that cost." Congress has added \$13 billion to the 2008 budget for veterans' affairs, Filner said, calling it the largest increase ever. "The resources will be there. It's our job to make sure they serve you." Long before the audience was ready, the hour long session came to a close and the congressmen headed to Del Rio for another veterans forum that evening. [Source: San Antonio Express-News Tracy Hamilton article 5 Aug 07 ++]

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> PUERTO RICO MEDICAL FRAUD: Over 80 doctors and licensing board

administrators from Puerto Rico have been indicted by a US federal grand jury for taking part in a large scale fraud that helped unqualified doctors in the self governing US territory obtain medical licenses through alleged bribery and deception. Most of the defendants are Puerto Rican and have been practicing as doctors in Puerto Rico, including in emergency departments, but so far, according to the authorities, none has practiced on mainland USA. A medical license from Puerto Rico is recognized in five US states: Arizona, Florida, New York, Texas, and Virginia. The defendants are said to have obtained false licenses by various means, including bribing officials with up to \$10,000 and substituting exam papers submitted by successful candidates for their own. According to ABC News, a secretary at the licensing board allegedly cut and paste extracts of papers from successful candidates into the papers submitted by some of the defendants so they could be passed off as authentic. Some of the cases are thought to have involved "intermediaries". These are people who approached doctors who failed their exams and suggested to them they could get licenses by other means. The intermediaries liaised between the doctors and the licensing board officials.

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> Some of the defendants had failed their medical exams a dozen times. Most of them did their medical training overseas, for instance in the Dominican Republic, Mexico and Cuba. One of the people arrested is the former executive director of the licensing board in Puerto Rico, Pablo Valentin. Television news showed him being led away by local police and agents from the US Food and Drug Administration (FDA). The current list of charges could be the tip of the iceberg as federal agencies unravel the threads of a fraud that could stretch farther back than 2001, the year the current charges reaches back to. The pattern of the scores on the test papers suggests this could have been going on much earlier, said one attorney. Also, there could be implications in other areas of the law. For instance, if the defendants have prescribed medication while unlicensed, then they could face charges under the Controlled Substances Act. And if they have submitted claims to Medicare or Medicaid while unlicensed, these actions may attract charges of false statements and mail fraud. The defendants, if convicted, could face prison terms of 5 to 20 years. Federal authorities are searching for nine other suspects, 3 believed to be in Puerto Rico and 5 in Philadelphia, Florida and the Dominican Republic. [Source: AP Michael Melia article 3 Aug 07 ++]

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> SALUTING THE FLAG: The Senate has passed legislation to ensure that veterans and service members can salute the flag when not in uniform. The bill S.1877, sponsored by Sen. James Inhofe [R-OK] would address the ambiguity of current law, which states that veterans and service members not in uniform should place their hand over their hearts, without specifying whether they can or should salute the flag. Inhofe said, "The salute is a

form of honor and respect, representing pride in one's military service. Unfortunately, current U.S. law leaves confusion as to whether veterans and service members out of uniform can or should salute the flag." Inhofe said he believes this is "an appropriate way to honor and recognize the 25 million veterans who have served in the military and remain as role models to others citizens. Those who are currently serving or have served in the military have earned this right, and their recognition will be an inspiration to others." The House would have to agree to the legislation before it could become law. The bill does not address the ambiguity of veterans saluting during The Pledge of Allegiance and playing of the National Anthem. Present policy for saluting is:

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> - When the flag passes in a procession, or when it is hoisted or lowered, all should face the flag and salute.

> - To salute, all persons come to attention.

> - Those in uniform give the appropriate formal salute.

> - Citizens not in uniform salute by placing their right hand over the heart and men with head cover should remove it and hold it to left shoulder, hand over the heart.

> - Members of organizations in formation salute upon command of the person in charge.

> - The pledge of allegiance should be rendered by standing at attention, facing the flag, and saluting. When the national anthem is played or sung, citizens should stand at attention and salute at the first note and hold the salute through the last note. The salute is directed to the flag, if displayed, otherwise to the music.

> [Source: ArmyTimes Daily News Roundup 3 Aug 07 ++]

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> VA FACILITY EXPANSION UPDATE 05: VA and Ft. Bragg have opened a newly expanded facility to explain benefits to transitioning service members at the post's Soldier Support Center. Dedication of the facility, called a Benefits Delivery Office, was held 1 AUG at Building 4-2843 on Normandy Drive. In North Carolina, in addition to Fort Bragg, VA operates benefits offices on Camp Lejeune Marine Corps Base and New River Marine Corps Air Station, with services provided at Cherry Point Marine Corps Air Station and Seymour Johnson Air Force Base. The Benefits Delivery Office is open from 08-1600 weekdays. Information on VA benefits can also be obtained by calling 1(800) 827-1000, or by visiting the VA website at www.va.gov <<http://www.va.gov>>. [Source: NAUS

Weekly Update 3Aug 07 ++]

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> VA LOCAL ACCESS: The Department of Veterans Affairs is represented by numerous Regional offices (VARO), state Benefit Offices, Vet Centers, and medical facilities throughout the U.S. and its territories. Locations of

these facilities can be found at:

> - VARO: <<http://www.vba.va.gov/benefits/ROcontacts.htm>>

> - State Benefit Offices: <<http://www.va.gov/statedva.htm>>

> - Vet Centers: <<http://www1.va.gov/directory/guide/vetcenter.asp>>

> - Medical, cemetery, and all the above:

<<http://www1.va.gov/directory/guide/home.asp>>.

> - The yellow pages of your local telephone directory under "Government Offices"

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> For questions or information you get an email response by asking your question at <<https://iris.va.gov/scripts/iris.cfg/php.exe/enduser/home.php>>.

To talk to someone you can go to your local VA office or call the following

> - VA Benefits: 1(800) 827-1000 for Burial; Civilian Health & Medical Program of the Department of Veterans Affairs (CHAMPVA); Death Pension; Dependency Indemnity Compensation; Direct Deposit; Directions to VA Benefits Regional Offices; Disability Compensation; Disability Pension; Education; Home Loan Guaranty; Life Insurance; Medical Care; Vocational Rehabilitation & Employment.

> - Education (GI Bill): 1(888) 442-4551

> - Health Care Benefits: 1(877) 222-8387

> - Income Verification and Means Testing: 1(800) 929-8387

> - Life Insurance: 1(800) 669-8477

> - Mammography Helpline: 1(888) 492-7844

> - Special Issues - Gulf War/Agent Orange/Project Shad/Mustard Agents and Lewisite/Ionizing Radiation: 1(800) 749-8387

> - Status of Headstones and Markers: 1(800) 697-6947

> - Telecommunications Device for the Deaf (TDD): 1(800) 829-4833

> - Suicide Call Center: 1(800) 273-TALK (8255).

> [Source: VA website www.vba.gov <<http://www.vba.gov>> Aug 07 ++]

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> VA CLINIC OPENINGS UPDATE 05: The Department of Veterans Affairs (VA) announced week to construct in Guam a new \$5.4 million outpatient clinic (OPC) on the periphery of the island's naval hospital. The plan approved by VA Secretary Jim Nicholson calls for a 6,000 square-foot outpatient clinic next to the grounds of the naval hospital, with its own parking area. Patients will not have to pass through Navy security to get to the facility. The new OPC is scheduled to open in the summer of 2009. It will replace the existing 2,700 square-foot VA OPC at the naval hospital. VA will still partner with the naval facility for emergency and after-hours health care, acute inpatient care and some specialty services. About 9,000 veterans live on the island. The existing clinic employs a staff of 11, including an internal medicine physician, psychiatrist and nurse practitioner. It provides primary care, mental health care, limited specialty services and physical examinations for VA's compensation and pension benefits. [Source: NAUS Weekly Update 3 Aug 07 ++]

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> SBP BASICS UPDATE 01: When a military retiree dies their retirement pay stops. This means that the surviving spouse will be left without a substantial income source. If you are considering retirement you need to give serious thought to how you can protect your spouse from the hardships caused by the loss your retirement pay. One option available to you is the Survivor Benefit Plan (SBP). This is an insurance plan that will pay your surviving spouse a monthly payment (taxable annuity) to help make up for the loss of your retirement income. The plan is designed to protect your survivors against the risks of your early death; your survivor outliving the benefits; and inflation. At retirement, full basic SBP for spouse and children will take effect automatically if you make no other valid election. You may not reduce or decline spouse coverage without your spouse's written consent. This means you will have to have your spouses input in the decision and his or her signature is required. If you are divorced or not married than any future spouse can be signed up within one year of the marriage.

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> If you do not decline SBP you will be required to pay a monthly premium. If a marriage ends, the SBP premium payments are stopped when the retiree notifies DFAS. Premiums and benefits are based on the base amount or benefit level that you elect. Your base amount can be any amount from full coverage down to as little as \$300 a month. Full coverage is based on your full retired pay meaning your spouse will receive 55% of your retirement pay . If you select lesser coverage then your spouse will receive 55% of your elected base amount. A surviving spouse's SBP annuity is reduced when they reach age 62 and become eligible for Social Security. This is called the Social Security offset. In the past the offset reduced the SBP annuity to 35% of the base amount. Fortunately the NDAA of 2005 established a phase out of the offset. This will increase the SBP offset percentage from the present 50 to 55% effective 1 APR 08. Categories of coverage are:

> - Spouse Only: Eligibility for this requires that a surviving spouse be a widow or widower who was married to a retiree at the time of his or her enrollment; or, if not married at the time of enrollment, was married to the deceased retiree for at least one year prior to the retiree's death; or, if not married at time of enrollment and was not married to the deceased retiree for at least one year prior to death, was the parent of issue by that marriage. Spouse coverage applies not only to the spouse a member has at time of enrollment, but also automatically to any subsequent spouse the member might acquire, unless the member elects to decline coverage for a subsequent spouse within one year of the date of marriage (concurrence of the subsequent spouse is not required, but that spouse will be notified of the member's declination).

> - Spouse (or Former Spouse) and Child: SBP protection is expanded to cover an eligible child or children if there is no surviving spouse, or if a surviving spouse subsequently dies or becomes ineligible to receive benefits

due to remarriage before the age of 55. Thus, if there is a divorce or if the spouse dies before the retiree, the full annuity will be paid to the eligible surviving child or children in the same manner as if the member had elected Child Only coverage.

> - Child Only: This option provides an annuity only for dependent children regardless of whether a member is married or not at time of enrollment (although a married member's spouse must concur with a child only election). Children remain beneficiaries until age 18 or age 22 if a full-time, unmarried student. Children mentally or physically incapable of self-support remain eligible, while unmarried, for as long as the incapacitation exists. A member with no dependent children at time of eligibility to elect coverage may elect coverage for a child subsequently acquired, but the child must be added within one year of being acquired (born, adopted, etc.).

> - Former Spouse: A member who has a former spouse upon becoming eligible to elect a survivor annuity may elect coverage for a former spouse. If the member has more than one former spouse, the member must specify which former spouse is being covered. An election for a former spouse prevents payment of an annuity to a current spouse. A former spouse who was not a member's former spouse on the date a member became eligible to participate in SBP must have been married to the member for at least one year in order to be named as a former spouse beneficiary.

> - Insurable Interest: A member who does not have a spouse or dependent child when eligible to make a program election may elect to provide coverage for a person with an insurable interest in the member (such as, a business partner or parent). DoD defines an insurable interest as a natural person who has a reasonable and lawful expectation of financial benefit from the continued life of the participating member, or any individual having a reasonable and lawful basis, founded upon the relation of parties to each other, either financial or of blood or affinity, to expect some benefit or advantage from the continuance of the life of the retired member. If the election is for a person who is more nearly related than a cousin, no proof of financial expectation is required. An election for insurable interest coverage, for other than a dependent made by a member retiring on or after 24 NOV 03 under a military disability provision, who dies within one year after being retired due to a cause related to the disability for which retired, shall be voided and any premiums paid for that coverage will be paid to the person to whom the annuity would have been paid.

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> Like your retirement pay the SBP annuity is protected from inflation. Each year when retired pay gets a COLA, so does the base amount, and as a result, so do premiums and annuity payments. Meaning that your premiums and annuity payments will increase with the COLA. These increases are determined by the previous year's Consumer Price Index and averages approximately 2.5%. For specific costs on your election refer to

<http://www.military.com/benefits/survivor-benefits/coverage-cost-and-benefits>.

NOTE: Survivors should report retiree deaths to the DFAS casualty office at

1(800) 269-5170. Faxes can be sent to the office at 1(800) 469-6559.

[Source: NCPOA Don Harribine 2 Aug 07 ++]

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> RETIREE ANNUAL COLAS UPDATE 01: Military retired pay rises each year to ensure that inflation does not erode the purchasing power of retirees. These cost-of-living adjustments, known as COLAs, match the annual increase in Social Security benefits. They become effective each 1 DEC and first show up in January paychecks. The foundation for the COLA adjustment is the Labor Department's Consumer Price Index, a measure of the cost of certain categories of goods and services that is updated monthly. There is one overall CPI, as well as a variety of more specific indexes. The index upon which the retired pay COLA is based is called the CPI for Urban Wage Earners and Clerical Workers, or CPI-W. The rate of inflation may rise and fall throughout the year, but the exact increase in retired pay is based only on the average inflation rate over the last quarter of the fiscal year that runs from Oct. 1 to Sept 30. The size of the increase is equal to the difference between the average inflation rate in that quarter and the average inflation rate in the same quarter of the previous fiscal year. For the purposes of military retired pay, this means the only months in which inflation matters are July, August and September. So far this fiscal year inflation rates have been OCT 06 (-1.1), NOV 06 (-1.2), DEC 06 (-1.0), JAN 07 (-0.8), FEB 07 (-0.3), MAR 07 (0.8), APR 07 (1.5), MAY 07 (2.3), & JUN 07 (2.4). Thus, if the last the month's CPI-W rates were to be used to compute the 2008 COLA we would be looking at an increase of $1.5 + 2.3 + 2.4$ divided by 3 which equates to 2.1%. Service members who retire in a given fiscal year receive a partial COLA for that year only, based on the date of their retirement. They receive the full COLA in subsequent years. The retired pay COLA technically is not automatic; Congress must formally approve it each year. To track CPI-W yourself go to www.armytimes.com <<http://www.armytimes.com>> and click on

"Retirement Tracking your COLA". [Source: Army Times Aug 07 ++]

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> VA FRAUD UPDATE 01: The U.S. attorney's office announced 1 AUG that a grand jury has indicted a 63-year-old San Diego woman on charges alleging that she embezzled more than \$120,000 in military veteran's survivor benefits over a 10-year period. Linda Bent Lampert is scheduled to be arraigned on the 36-count indictment 6 AUG, federal prosecutors said in a news release. Lampert is alleged to have received benefits through the Dependency Indemnity Compensation (DIC) program, which provides money to the unmarried, surviving spouses of military veterans who have died. Lampert's mother was eligible to receive the benefits from DEC 75 until her death in AUG 96, but Lampert continued to receive the payments after her mother died, according to federal prosecutors. Lampert is alleged to have forged her mother's signature in AUG 03 on a document submitted to the Department of

Veterans Affairs, which administers the program, according to federal prosecutors. [Source: San Diego North County Times Scott Marshal article 1 Aug 07 ++]

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> VET HOME TENNESSEE: On 1 AUG state officials said the state veterans' home in Murfreesboro TN has been fined nearly \$200,000 for violations thus far this year. The home was being fined \$6,000 a day by the Centers for Medicare and Medicaid Services, but that fine has since been knocked down to \$800 a day because of improvements in care. State Finance Commissioner Dave Goetz told a joint legislative committee that the state can't simply pay the \$198,900 fine because the veterans' homes were set up by the Legislature to be managed by an independent board. Goetz recommended that lawmakers consider changing the management structure for the veterans' homes in Murfreesboro, Humboldt and Knoxville. Gov. Phil Bredesen in JUN 07 put a freeze on new admissions to the homes after an investigation into the Murfreesboro facility found the staff failed to manage residents who showed aggressive behavior, protect residents from harm, report unusual incidents and investigate injuries. The nursing home was also fined by state and federal officials last year after a report by the state Health Department found workers failed to treat bedsores and follow doctors' orders, putting residents' lives in danger. Bredesen lifted the admissions ban for the Knoxville and Humboldt homes last month.

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> When the state's first veterans home opened in Murfreesboro, the plan was for it and any other homes to finance themselves through federal Veterans Affairs money, from Medicare and Medicaid payments and from private pay. But the homes have not become self-sufficient. They have also become riddled with accounting problems that have led to incomplete financial records, according to a state audit. Goetz said the state has put on hold a plan to open a new veterans home in Clarksville. "Given all the things we've had going on, I didn't think we'd get a very positive reception if we pressed at this moment," he said. "I think we're going to have to kind of get things straightened out before we consider proceeding ahead with Clarksville."

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> The first Tennessee veterans' home located on a seven acre lot, deeded to the Board by the U.S. Department of Veterans Affairs, adjacent to the Alvin C. York VA. Medical Center opened in Murfreesboro 10 JUN 91. It is a 140 bed facility offering intermediate and skilled levels of nursing care in a one-story building encompassing 69,278 square feet. Legislation passed by the state's General Assembly in 1993 provided for construction of a second facility in Humboldt Tennessee. Also, a 140 bed facility offering intermediate and skilled levels of nursing care. This one-story building encompassing some 74,870 square feet opened 7 FEB 96. The third home in Knox County opened in DEC 06. This 140 bed facility, offered intermediate and

skilled levels of nursing care in a spacious 73,065 square foot, one-story building and is currently accepting residents. In each of the three facilities, 20 of the beds are located in a secure, special needs unit. Eligible applicants for admission are veterans who are entitled to medical treatment and/or other benefits from the USDVA, and who also meet at least one of the below additional requirements:

- > - Resident of Tennessee at time of admission.
- > - Born in Tennessee.
- > - Entered the U.S. Armed Forces in Tennessee.
- > - Tennessee address is official Home of Record on Veteran's Military Record.
- > - Has an immediate family member (Parent, Spouse, Sibling, or Child) or Legal Guardian who would serve as primary caregiver, who is a resident of Tennessee.

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> Spouse, Widow/Widower or Gold Star Parent may also be eligible for admission on a space available basis. Upon meeting the eligibility requirements, an applicant's name will be placed on a Potential Admissions Wait List. Applications are available for download at <http://www.tsvh.org> as well pricing and availability information. Also, a video/DVD on Tennessee's homes can be ordered at no charge. Assistance on completing the application can be obtained by calling call the Admissions office in Murfreesboro at (615) 225-1852, in Humboldt at (731) 824-5776, or in Knoxville at (865) 862-8152. [Source: AP Erik Schelzig article Aug 07 ++]

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> HVAC UPDATE 02: In a Subcommittee on Disability Assistance and Memorial Affairs legislative hearing 1 AUG on H.R. 674, H.R. 1273, H.R. 1900, H.R. 1901, H.R. 2346, H.R. 2696, and H.R. 2697, members expressed general bipartisan support for these bills. One area of concern among subcommittee Republicans is the lack of cost information now available, especially as much of the legislation considered involves the need for PAYGO mandatory funding offsets. H.R. 2696, H.R. 2697, and H.R. 2346 each directly address how Congress determines the location of national cemeteries in a timely manner. Following are the bills that are under consideration:

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> - H.R. 2696, the Veterans Dignified Burial Assistance Act of 2007 introduced by subcommittee ranking member Doug Lamborn (R-CO) contains provisions which would improve the VA burial benefit and state veteran's cemeteries. This bill would increase the burial and plot allowance for a veteran's burial in a private cemetery from \$300 to \$400. The bill would also repeal the current time limitation for state reimbursement of interment costs by VA. Occasionally, a state locates the remains of veterans who were not buried. When states bury these veterans, VA may not be able to reimburse them because of a time limit on reimbursement. Additionally, the bill would authorize the VA secretary to make additional grants to states

for improving and expanding state veteran cemeteries. States would have to submit an application to the secretary, and could receive up to \$5 million.

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> - H.R. 2697, also introduced by Lamborn, would extend eligibility for Veterans Mortgage Life Insurance (VMLI) to members of the armed forces. VMLI is a special type of life insurance that is only available to veterans who qualify for specially adapted housing grants. Many of our nation's injured active duty servicemembers may eventually qualify for VMLI, and would benefit by having this eligibility.

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> - H.R. 2346, introduced by Vito Fossella (R-NY), would direct VA to establish a process to determine whether a geographic area is sufficiently served by existing veterans' cemeteries. The process will take into account the following variables for each geographic area: (1) total number of veterans; (2) average distance a resident must travel to reach the nearest national cemetery; (3) population density; (4) average amount of time it takes a resident to travel to the nearest national cemetery; (5) availability of public transportation for purposes of traveling to national cemeteries; and (6) average amount of fees charged to an individual traveling on the major roads leading to the national cemeteries. This process will be a departure from the current 175,000 population and 75-mile thresholds that the VA uses for determining the need of a national cemetery.

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> - H.R. 674, introduced by Luis Gutierrez (D-IL) would repeal the 2008 sunset provision on VA's Advisory Committee on Minority Veterans. The committee comprises representatives from minority groups, veterans' service organizations, and representatives from many federal, state, and local government agencies. The major functions include: (1) advising the VA secretary and Congress on VA's administration of benefits and provisions of health care, benefits, and services to minority veterans; (2) providing an annual report to Congress outlining recommendations, concerns and observations on VA's delivery of services to minority veterans; (3) meeting with VA officials, veteran service organizations, and other stakeholders to assess the department's efforts in providing benefits and outreach to minority veterans; and (4) making periodic site visits and holding town hall meetings with veterans to address their concerns.

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> - H.R. 1273, introduced by Shelley Berkley (D-NV) extends eligibility for a \$300 plot allowance for burial in a private cemetery who is eligible for burial in a national cemetery and who: (1) was discharged from active service for a disability incurred or aggravated in the line of duty; or (2) is a veteran of any war. Currently, a veteran is only eligible for this plot allowance if they were receiving VA compensation, pension benefits, or died of service-connected injuries. The bill also authorizes the VA secretary to reimburse a veteran's family for the cost of buying a non-governmental headstone. While this authorization would be of great help

to families of deceased veterans, significant mandatory funding offsets would be required needed for its passage.

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> - H.R. 1900, introduced by Nick Rahall (D-WV), would extend eligibility for pension benefits under laws administered by the VA secretary to veterans who received an Armed Forces Expeditionary Medal. The VA has designated "periods of war" to identify veterans who qualify for certain veterans' pension benefits. However, these periods of war may differ from dates given in declarations of war, termination of hostility dates, proclamations, laws, or treaties; thus many veterans who served in hostile areas are not eligible for veterans' pension benefits.

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> - H.R. 1901, also introduced by Rahall, is similar to H.R. 1900, but would only extend the pension benefit to veterans who served during the following time periods: (1) the period beginning on 1 FEB 55, and ending on 4 AUG 64, in the case of active military, naval, or air service performed in the Republic of Korea; (2) the period beginning on 8 MAY 75, and ending on 1 AUG 90, in the case of active military, naval, or air service performed in the Republic of Korea; (3) the period beginning on 24 AUG 82, and ending on 31 JUL 84, in the case of active military, naval, or air service performed in Lebanon or Granada; and (4) the period beginning on 20 DEC 89, and ending on 31 JAN 90, in the case of active military, naval, or air service performed in Panama.

> [Source: HVAC Republican Press Release 1 Aug 07 ++]

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> **COMMISSARY CONSTRUCTION FUNDING:** The chairman of the Senate defense appropriations subcommittee Sen. Daniel Inouye (D-HI) has asked Defense Secretary Robert Gates to help the Defense Commissary Agency (DeCA) with a looming cash squeeze for store construction. Movement of force structure due to base closings and realignment, the planned restationing of forces from forward areas in Europe, and the ongoing expansion of the Army and Marine Corps is forcing the DeCA to divert resources from its ongoing modernization program, "indefinitely delaying many needed projects," Inouye wrote in a 23 JUL letter to Gates. "I have learned that nearly the entire fiscal year 2008 and 2009 construction program has been revamped to accommodate the restationing program . I strongly urge you to allow commissaries to receive military construction or base closure and realignment funding to meet the restationing requirement and will work with you in this regard. It is the right thing to do." wrote Inouye. Michael Dominguez, principal deputy undersecretary of defense for personnel and readiness, told lawmakers at a 13 MAR House hearing that his office unsuccessfully sought \$3.1 billion for construction costs for commissaries and exchanges as part of the Pentagon's fiscal 2008 budget plan. Patrick Nixon, DeCA director, testified in the earlier hearing that the strain on the surcharge account, derived from the standard 5% markup on commissary items that traditionally supports store

construction and renovation, represents the commissary system's biggest challenge. At the 16 military communities that will see significant personnel increases in the next few years, "our existing facilities will not be able to accommodate the increased patron demand," he said. BRAC actions will close six installations with commissaries, while overseas rebasing will affect 28 other stores in various ways. But the concern is those 16 installations (10 stateside and six overseas) which are expected to gain a significant number of people as a result of the ongoing moves, will require increased near-term store construction and expansion. To address that, defense officials have two choices: raise the current 5% surcharge that customers pay on all commissary items, or supplement the surcharge fund by pumping in additional taxpayer dollars. "Besides penalizing servicemen and women at the bases that will have their projects delayed, it is unfair to ask our military people to pay again for construction of stores after they have already paid once for stores at existing bases that are now being closed or down sized," Inouye said in his letter. [Source: Army News Karen Jowers article 2 Aug 07 ++]

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> SBP PAID UP PROVISION UPDATE 03: Effective 1 OCT 08 Uniformed Services Survivor Benefit Plan (SBP) participants who reach 70 years of age and have made 360 payments (30 years), will no longer have to pay premiums for continued SBP coverage and will be placed in "Paid-up SBP" status. Paid-up SBP provisions were mandated by the National Defense Authorization Act for fiscal 1999. The law also established a paid-up status, also beginning on 1 OCT 08 for participants in the Retired Serviceman's Family Protection Plan once they reach 70 years of age. No action is required of SBP participants to be placed in Paid-up SBP status. Once the eligibility criteria has been met, the Defense Finance and Accounting Service (DFAS) will automatically stop deducting premiums from qualifying military retired pay accounts. The law establishing Paid-up SBP does not allow for refunds of premiums paid before October 1, 2008, even though a retiree may have reached age 70 and made 360 or more premium payments.

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> DFAS is currently developing changes to the military retiree pay systems that will monitor the number of SBP premiums paid and the age of the participant. The system updates are targeted for a May 2008 completion date. At that time, SBP participants who will be eligible for Paid-up SBP status on October 1, 2008, or will meet eligibility within a short time of the implementation date, will be notified by mail of their impending paid-up status. Those military retirees who become eligible for Paid-up SBP status after the initial group will be notified of their SBP status on their DEC 08 annual Retiree Account Statements (RAS) that will note the number of premiums paid to date. Each RAS issued after DEC 08, whether annually or as a result of a pay change, will include the Paid-up SBP premium "counter," based on DFAS records, to help retirees monitor their eligibility status.

More information on Paid-up SBP, including frequently asked questions and news updates, should be available at the DFAS Web site at www.dfas.mil/ [<http://www.dfas.mil/>](http://www.dfas.mil/) retiredpay. html within the next several months. [Source: DFAS Notice Aug 07 ++]

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> AGENT ORANGE DISEASES UPDATE 01: The VA has determined that a presumption of service connection will apply to certain claims based on exposure to herbicides that were used during the Vietnam war era. This determination is based primarily but not solely on the Institute of Medicine's [IOM] ability to determine association exists. The following categories of Association are applicable to presumptive conditions:

> - Sufficient - Evidence is sufficient to conclude that there is a positive association. That is, a positive association has been observed between exposure to herbicides and the outcome in studies in which chance, bias, and confounding could be ruled out with reasonable confidence. For example, if several small studies that are free from bias and confounding show an association that is consistent in magnitude and direction, there could be sufficient evidence of an association.

> - Limited or Suggestive - Evidence suggests an association between exposure to herbicides and the outcome, but a firm conclusion is limited because chance, bias, and confounding could not be ruled out with confidence. For example, a well-conducted study with strong findings in accord with less compelling results from studies of populations with similar exposures could constitute such evidence.

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> The National Academy of Sciences "The Veterans and Agent Orange: Update 2006" IOM report has assigned association categories on the following medical conditions:

> 1. Sufficient Evidence of Association:

> - Chloracne

> - Cancers:

> a. Chronic lymphocytic leukemia (CLL).

> b. Non-Hodgkin's lymphoma.

> c. Hodgkin's disease

> d. Soft-tissue sarcoma

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> 2. Limited or Suggestive Evidence of Association:

> - Early-onset transient peripheral neuropathy.

> - AL amyloidosis.

> - Hypertension.

> - Porphyria cutanea tarda.

> - Type 2 diabetes (mellitus)

> - Cancers:

> a. Larynx

- > b. Lung, bronchus, or trachea
- > c. Multiple myeloma
- > d. Prostate
- > - In offspring of exposed individuals - Spina bifida
- > [Source: Various Aug 07 ++]
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- > AGENT ORANGE DISEASES UPDATE 02: The VA has determined that a non-presumption of service connection will apply to certain claims based on exposure to herbicides that were used during the Vietnam war era. This determination is based primarily but not solely on the Institute of Medicine's [IOM] ability to determine if association exists. The following categories of association are applicable to non-presumptive conditions:
 - > - Inadequate or Insufficient - The available studies are of insufficient quality, consistency, or statistical power to permit a conclusion regarding the presence or absence of an association. For example, studies fail to control for confounding, have inadequate exposure assessment, or fail to address latency.
 - > - Limited or Suggestive Evidence of No Association - Several adequate studies, which cover the full range of human exposure, are consistent in not showing a positive association between any magnitude of exposure to the herbicides of interest and the outcome. A conclusion of "no association" is inevitably limited to the conditions, exposure, and length of observation covered by the available studies. In addition, the possibility of a very small increase in risk at the exposure studied can never be excluded.
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- > The National Academy of Sciences "The Veterans and Agent Orange: Update 2006" IOM report has assigned association categories on the following medical conditions:
 - > 1. Inadequate or Insufficient Evidence to Determine Association
 - > - Neurobehavioral disorders (cognitive and neuropsychiatric)
 - > - Movement disorders, including Parkinson's disease and amyotrophic lateral sclerosis
 - > - Chronic peripheral nervous system disorders
 - > - Respiratory disorders
 - > - Gastrointestinal, metabolic, and digestive disorders (changes in liver enzymes, lipid abnormalities, ulcers)
 - > - Immune system disorders (immune suppression, autoimmunity)
 - > - Ischemic heart disease *
 - > - Circulatory disorders (other than hypertension)
 - > - Endometriosis
 - > - Effects on thyroid homeostasis
 - > - Cancers:
 - > a. Oral cavity (including tongue), pharynx (including tonsils), or nasal cavity (including ears and sinuses).
 - > b. Pleura, mediastinum, and other unspecified sites within the respiratory

system and intrathoracic organs.

- > c. Esophagus.
- > d. Stomach.
- > e. Colorectal cancer (including small intestine and anus).
- > f. Hepatobiliary cancers (liver, gallbladder, and bile ducts).
- > g. Pancreas.
- > h. Bone and joint.
- > i. Melanoma *
- > j. Non-melanoma skin cancer (basal cell and squamous cell).
- > k. Breast *
- > l. Reproductive organs (cervix, uterus, ovary, testes, and penis; excluding prostate).
- > m. Urinary bladder.
- > n. Kidney.
- > o. Brain and nervous system (including eye) .
- > p. Endocrine cancers (thyroid, thymus, and other endocrine).
- > q. Leukemia (other than CLL).
- > r. Other and unspecified sites.
- > - Abnormal sperm characteristics and infertility.
- > - Spontaneous abortion (other than for paternal exposure to TCDD).
- > - In offspring of exposed individuals:
 - > a. Neonatal or infant death and stillbirth.
 - > b. Low birth weight.
 - > c. Birth defects (other than spina bifida).
 - > d. Childhood cancer (including acute myelogenous leukemia)
- > * Indicates the committee could not reach consensus as to whether the evidence for these health outcomes related to exposure to the chemicals of concern was "limited, suggestive" or "inadequate," so they were retained in the inadequate category.

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> 2. Limited or Suggestive Evidence of No Association - Spontaneous abortion following paternal exposure to TCDD

> [Source: Various Aug 07 ++]

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> AGENT ORANGE & HYPERTENSION: A new report from the Institute of Medicine (IOM) finds suggestive but limited evidence that exposure to Agent Orange and other herbicides used during the Vietnam War is associated with an increased chance of developing high blood pressure in some veterans. The report is the latest update in a congressionally mandated series by the IOM that reviews every two years the evidence about the health effects of these herbicides and the type of dioxin - TCDD - that contaminated some of them. The committee that wrote the report also concluded that there is suggestive but limited evidence that AL amyloidosis is associated with herbicide exposure. Characterized by the accumulation of protein deposits in and around organs, this rare condition affects one in 100,000 people annually in

the United States. The committee based its conclusion on the fact that AL amyloidosis shares many biological and pathological similarities with multiple myeloma and certain B-cell lymphomas, which have been found to be associated with exposure to herbicides.

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> A finding of "limited or suggestive evidence of an association" means that scientific studies of adequate quality have yielded information pointing to a possible statistical link or plausible biological means by which exposure to the chemicals of concern could result in a particular health effect, but that contradictory results from other studies, biases, or other confounding factors limit the certainty of the evidence. Two recently published studies of Vietnam veterans who handled Agent Orange and other defoliants provide evidence that these veterans have higher rates of hypertension. Defined as blood pressure exceeding 140/90, hypertension affects more than 70 million American adults and is a major risk factor for heart attack, stroke, and other cardiovascular ailments. It is often associated with age, race, being overweight, or having diabetes. The two new studies were able to adjust for the impact of common risk factors for hypertension on the results. The results also were consistent with findings from several other studies that looked at the health effects of herbicides and their contaminants on Vietnam veterans but were not adjusted for known risk factors and had poorer measures of exposure. At the same time, a new environmental study and an earlier study of workers in an herbicide manufacturing plant did not find evidence of an association between herbicide or dioxin exposure and increased incidence of high blood pressure. Given the studies' limitations and inconsistent results, the committee found the cumulative body of evidence suggestive of, but insufficient to conclude with certainty, an association between high blood pressure and herbicide exposure.

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> The committee also reviewed studies that provide intriguing findings on rates of ischemic heart disease and exposure to defoliants or dioxin. However, many of the studies did not have information necessary to adjust for the impact of weight, smoking, and other known risk factors on the results, and their measures of heart disease were somewhat imprecise. The committee members could not agree on whether these factors distort the studies' results. The report presents scientific data only and does not imply or suggest policy decisions that the U.S. Department of Veterans Affairs might make. Also, the findings relate to exposures and outcomes in populations. Researchers' abilities to pinpoint the health risks faced by individual veterans are hampered by inadequate information about veterans' exposure levels during their service in Vietnam. The report series is sponsored by the U.S. Department of Veterans Affairs and can be read at <http://national-academies.org>. Established in 1970 under the charter of the National Academy of Sciences, the IOM provides independent, objective, evidence-based advice to policymakers, health professionals, the private

sector, and the public. Pre-publication copy of Veterans and Agent Orange: Update 2006 can be read on the Internet at <http://books.nap.edu/openbook.php?isbn=0309107083>. [Source: NAS New/Report 27 Jul 07 ++]

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> RETIREMENT TAX CONSIDERATIONS: If you plan to move to another state when you retire, examine the tax burden you'll face when you arrive. State taxes are increasingly important to everyone, but retirees have extra cause for concern since their income may be fixed. Many people planning to retire use the presence or absence of a state income tax as a litmus test for a retirement destination. This is a serious miscalculation since higher sales and property taxes can more than offset the lack of a state income tax. The lack of a state income tax doesn't necessarily ensure a low total tax burden. States raise revenue in many ways including sales taxes, excise taxes, license taxes, income taxes, intangible taxes, property taxes, estate taxes and inheritance taxes. Depending on where you live, you may end up paying all of them or just a few. At

<http://www.retirementliving.com/RLtaxes.html> you can obtain information by state on state income taxes, sales and fuel taxes, taxes on retirement income, property taxes and inheritance and estate taxes. It is intended to give you some insight into which states may offer a lower cost of living. Since everything is subject to changes recommend you check with the state tax office you decide to retire in to obtain the latest tax information.

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> All states except Alaska, Delaware, Montana, New Hampshire and Oregon, collect sales taxes. Some have a single rate throughout the state though most permit local additions to the base tax rate. Those states with a single rate include Connecticut, Hawaii, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Jersey, Rhode Island, Vermont, Virginia, and West Virginia. States with the highest sales tax are: California (7.25%), Mississippi (7.0%), New Jersey (7.0%), Tennessee (7.0%), Rhode Island (7.0%), Minnesota (6.5%), Nevada (6.5%), and Washington (6.5%). Many cities and counties have the option of imposing an additional local option sales tax. For instance, in Tennessee some cities add as much as 2.75%. Nevada's sales tax varies by county and can be as high as 7.75%. Most states exempt prescription drugs from sales taxes. Some also exempt food and clothing purchases and a few also exempt non-prescription drugs.

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> A total of 41 states impose income taxes. New Hampshire and Tennessee apply it only to income from interest and dividends. Seven states (Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming) do not tax personal income. Of the 41 with a broad-based income tax, 35 base the taxes on federal returns, typically taking a portion of what you pay the IRS or using your federal adjusted gross income or taxable income as the starting point. Most states specify amounts for taxpayers and each of their

dependents that can be used as an offset in determining taxable income. Most also specify the amounts that persons 65 or older can deduct. Most states treat health care expenses as having already been deducted from federal returns. Two states (North Dakota and Oregon) allow full deductions while Indiana does not permit itemized deductions on state taxes. Only 12 of the 41 states with broad-based income taxes permit taxpayers to deduct federal income taxes. This is an advantage if you are deciding between two states with similar rate structures but only one allows you to deduct. The latter would give you a lower effective tax rate. [Source:

www.retirementliving.com/RLtaxes.html

<<http://www.retirementliving.com/RLtaxes.html>> Jul 07 ++]

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> VETERAN LEGISLATION STATUS 13 AUG 07: The House and Senate have both adjourned for the August recess. Congress will return on 4 SEP. For a listing of Congressional bills of interest to the veteran community that have been introduced in the 110th Congress refer to the Bulletin attachment.

By clicking on the bill number indicated you can access the actual legislative language of the bill and see if your representative has signed on as a cosponsor. Support of these bills through cosponsorship by other legislators is critical if they are ever going to move through the legislative process for a floor vote to become law. A good indication on that likelihood is the number of cosponsors who have signed onto the bill. A cosponsor is a member of Congress who has joined one or more other members in his/her chamber (i.e. House or Senate) to sponsor a bill or amendment. The member who introduces the bill is considered the sponsor. Members subsequently signing on are called cosponsors. Any number of members may cosponsor a bill in the House or Senate. At <<http://thomas.loc.gov>> you can also review a copy of each bill, determine its current status, the committee it has been assigned to, and if your legislator is a sponsor or cosponsor of it. To determine what bills, amendments your representative has sponsored, cosponsored, or dropped sponsorship on refer to

<<http://thomas.loc.gov/bss/d110/sponlst.html>>. The key to increasing cosponsorship on veteran related bills is letting our representatives know of veteran's feelings on issues. At the end of some listed bills is a web link that can be used to do that. Otherwise, you can locate on

<<http://thomas.loc.gov>> who your representative is and his/her phone number, mailing address, or email/website to communicate with a message or letter of your own making. [Source: RAO Bulletin Attachment 30 Jun 07 ++]

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> Lt. James "EMO" Tichacek, USN (Ret)

> Director, Retiree Assistance Office, U.S. Embassy Warden & IRS VITA Baguio City RP

> PSC 517 Box RCB, FPO AP 96517

> Tel: (760) 839-9003 when in U.S. & Cell: 0915-361-3503 when in

Philippines.

> Email: raoemo@sbcglobal.net <<mailto:raoemo@sbcglobal.net>> Web:
<http://post_119_gulfport_ms.tripod.com/rao1.html>

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