

- > RAO Bulletin
- > 15 September 2008
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> MOBILIZED RESERVE 10 SEP 08: The Army, Air Force and Marine Corps announced the current number of reservists on active duty as of 10 SEP 08 in support of the partial mobilization. The net collective result is 7,744 more reservists mobilized than last reported in the Bulletin for 1 SEP 08. At any given time, services may mobilize some units and individuals while demobilizing others, making it possible for these figures to either increase or decrease. The total number currently on active duty in support of the partial mobilization of the Army National Guard and Army Reserve is 87,818; Navy Reserve, 5,619; Air National Guard and Air Force Reserve, 12,466; Marine Corps Reserve, 8,007; and the Coast Guard Reserve, 738. This brings the total National Guard and Reserve personnel who have been mobilized to 114,648 including both units and individual augmentees. A cumulative roster of all National Guard and Reserve personnel, who are currently mobilized, can be found at <http://www.defenselink.mil/news/Sep2008/d20080910ngr.pdf>. [Source: DoD News Release 759-08 10 Sep 08 ++]

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> CREDIT SCORE UPDATE 01: Too many consumers still don't get it when it comes to credit scores. And what you don't know about credit scores can hurt you when it's time to buy a home -- especially in a tight credit market. Only 28% of consumers are aware they need at least a 700 credit score to qualify for a low-rate mortgage. Three of every four consumers incorrectly believe that credit scores are influenced by income. And even more, 79%, erroneously believe that credit scores can be obtained for free once a year. (They're probably thinking about their credit report, instead.) . Those are among the findings of a new report, "Consumer Understanding of Credit Scores Improves but Remains Poor" commissioned by the Consumer Federation of America (CFA) and Washington Mutual Bank (WaMu). First, your credit score is a number assigned to your creditworthiness. Your credit score indicates how well or how poorly you'll repay a debt. The higher the number, the more likely you'll repay on time. Your bill paying information on credit reports provides the basis for your credit score. Consumers who take the time to obtain their credit score, for only about \$15 under most circumstances, are more likely to have a better understanding of the scores. That includes knowledge that mortgage lenders rely heavily upon credit scores to approve or reject home loan applications.

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> Informed consumers also know they can generally raise their credit score by consistently paying bills on time every time; by paying off debt and closing those paid off accounts; by not coming close to maxing out credit cards and by regularly checking their credit reports to make sure they are accurate. Your credit report is free from AnnualCreditReport.com. For more information about your credit score go to MyFICO.com. The study

also found that consumers could save \$28 billion a year in lower finance charges if they improved their credit scores by 30 points. The study's findings include:

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> . When asked to define "credit score," only 31% correctly identified the answer "risk of not repaying the loan" in a multiple choice question that also included "financial resources to pay back loans" (21%), "amount of consumer debt" (16%), "knowledge of consumer credit" (15%), and "attitude toward consumer credit" (9%) as other options.

> . Consumers typically fail to understand that a credit score reflects only how they use credit, not factors such as income and age. Significant percentages incorrectly believe that credit scores are influenced by income (74%); age (40%); marital status (38%); the state in which they live (29%); level of education (29%); and ethnicity (15%).

> . Majorities correctly understand that they can learn their credit scores if they are denied a mortgage loan (72%) or declined for a credit card (65%). But, an even larger group, (79%), incorrectly believes that credit scores can be obtained for free once a year. Only credit reports are free every year.

> [Source: Real Estate Update Broderick Perkins article Aug 08 ++]

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> VA RURAL ACCESS UPDATE 06: The Department of Veterans Affairs (VA) will open 10 new Rural Outreach Clinics by 2009 to increase the convenience of care for thousands of veterans living in rural areas. The clinics will provide primary care services, case management and mental health services. Each outreach clinic will be part of a VA network, maintaining VA's quality standards and access to larger VA facilities for specialized needs. The 10 new clinics include a facility recently put in operation in

> Aroostook County ME. Scheduled to begin operation this October are facilities in Houston County GA, Juneau County AK, and Wasco County OR. Clinics to be operational by AUG 09 are in Winnemucca NV, Yreka CA, Utuado Puerto Rico, Lagrange TX, Montezuma Creek UT; and Manistique MI. The Department's recent outreach to veterans in rural areas includes:

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> . The Creation of a 13-member Veterans Rural Health Advisory Committee to advise Peake on issues affecting veterans in rural areas ([www.va.gov/opa/pressrel/pressrelease.cfm?id=1511](http://www.va.gov/opa/pressrel/pressrelease.cfm?id=1511));

> . Announcement of the roll-out in early 2009 of four new mobile health clinics to serve veterans in 24 predominately rural counties ([www.va.gov/opa/pressrel/pressrelease.cfm?id=1552](http://www.va.gov/opa/pressrel/pressrelease.cfm?id=1552));

> . Announcement of three new Veterans Rural Health Resource Centers -- in White River Junction, VT; Iowa City IA; and Salt Lake City -- to develop practices and products that will improve health care for veterans in rural areas ([www.va.gov/opa/pressrel/pressrelease.cfm?id=1548](http://www.va.gov/opa/pressrel/pressrelease.cfm?id=1548));

> . Nearly tripling the mileage reimbursement -- from 11 cents per mile to

28.5 cents per mile -- paid to veterans who travel significant distances to receive VA health care ([www.va.gov/opa/pressrel/pressrelease.cfm?id=1447](http://www.va.gov/opa/pressrel/pressrelease.cfm?id=1447)) > <<http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1447>> ); and > . Creation of a "Travel Nurse Corps" to augment existing nursing staff in needed areas <<http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1466>> ). > [Source: VA Media Relations 12 Sep 08 ++]

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> VA COLA 2009: The House cleared a cost-of-living bill Wednesday that would provide an increase for veterans with service-connected disabilities, as well as dependency and indemnity compensation (DIC) for families of deceased veterans. The Senate passed the veterans' COLA measure in July. The COLA bill, S 2617, provides for a Dec. 1 increase in disability compensation, dependency and indemnity compensation, and pensions that will match whatever increase is provided in Social Security benefits. The increase, which applies to about 2.8 million veterans and survivors, would first appear in January paychecks. The Social Security increase won't be known until mid-October, but is expected to be a minimum of 6 percent. The Social Security COLA automatically applies to military and federal civilian retired pay, but veterans' disability and survivor benefits and pensions increase only through the enactment of new legislation. The COLA bill now awaits the President's signature. [Source: VFW Washington Weekly 12 Sep 08 ++]

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> FDA DRUG SAFETY ISSUES: The U.S. Food and Drug Administration (FDA) recently posted a list of drugs being evaluated for potential safety issues on their website. This information is being provided under provisions of the Food and Drug Administration Amendments Act, which was signed into law last year. The "Potential Signals of Serious Risks/New Safety Information" list at [www.fda.gov/cder/aers/potential\\_signals/default.htm](http://www.fda.gov/cder/aers/potential_signals/default.htm) identifies drugs based on a review of reports submitted through the FDA's Adverse Event Reporting System (AERS). The first report lists the 20 drugs below and the potential safety issue(s) associated with them. A new report will be generated each quarter listing additional medications and related safety information. Information from previous quarters will remain available on the website. Note; the appearance of a drug on this list does not mean that FDA has concluded that the drug has the listed risk or that FDA has identified a causal relationship between the drug and the listed risk. It is simply on the list because FDA has identified a potential safety issue with the medication and is monitoring it.

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> Arginine Hydrochloride Injection (R-Gen 10) -- Pediatric overdose due to labeling / packaging confusion

> Desflurane (Suprane) -- Cardiac arrest

> Duloxetine (Cymbalta) -- Urinary retention

- > Etravirine (Intelence) - Hemarthrosis
- > Fluorouracil Cream (Carac) and Ketoconazole Cream (Kuric) -- Adverse events due to name confusion
- > Heparin Anaphylactic-type -- reactions
- > Icodextrin (Extraneal) -- Hypoglycemia
- > Insulin U-500 (Humulin R) -- Dosing confusion
- > Ivermectin (Stromectol) and Warfarin Drug -- interaction
- > Lapatinib (Tykerb) -- Hepatotoxicity
- > Lenalidomide (Revlimid) -- Stevens Johnson Syndrome
- > Natalizumab (Tysabri) -- Skin melanomas
- > Nitroglycerin (Nitrostat) -- Overdose due to labeling confusion
- > Octreotide Acetate Depot (Sandostatin LAR) -- Ileus
- > Oxycodone Hydrochloride Controlled-Release (Oxycontin) -- Drug misuse, abuse and overdose
- > Perflutren Lipid Microsphere (Definity) -- Cardiopulmonary reactions
- > Phenytoin Injection (Dilantin) -- Purple Glove Syndrome
- > Quetiapine (Seroquel) -- Overdose due to sample pack labeling confusion
- > Telbivudine (Tyzeka) -- Peripheral neuropathy
- > Tumor Necrosis Factor (TNF) Blockers -- Cancers in children and young adults
- > [Source: NAUS Weekly Update 12 Sep 08 ++]
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- > TRICARE URFS: Since 1 OCT 03, the Defense Enrollment Eligibility Reporting System (DEERS) reflects TRICARE eligibility for URFS (Unremarried Former Spouses) under his/her own name and Social Security Number (SSN), not his/her former sponsor's. The URFS now use their own name and SSN to schedule medical appointments and to file TRICARE claims. As an URFS of a uniformed service member, you may be eligible for continued benefits if you do not remarry, are not covered by an employer-sponsored health plan and meet certain requirements. If a URFS remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce. However, if the URFS remarries a uniformed service active duty or retired member, he or she becomes TRICARE-eligible under his/her new sponsor.
- > There are eligibility requirements that URFS must meet.
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- > 1. Situation 1-20/20/20 Rule: Medical benefits are extended, and continue as long as requirements continue to be met, to an URFS when:
  - > § The parties had been married for at least 20 years
  - > § The member performed at least 20 years of service creditable for retired pay
  - > § There was at least a 20-year overlap of the marriage and service
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- > 2. Situation 2-20/20/15 Rule: Medical benefits are extended to an URFS, if divorce occurred before 1 APR 85, when:
  - > § The parties had been married for at least 20 years

- > § The member performed at least 20 years of service creditable for retired pay
- > § There was at least a 15-year overlap of the marriage and service
- > Note: If the divorce occurred on or after 29 SEP 88, these 20/20/15 former spouses qualify for medical benefits for one year from the date of the divorce decree.
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- > Benefits are:
  - > - TRICARE Prime: This is a managed care option similar to a civilian health maintenance organization and is offered only in certain geographical locations. TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime enrollees receive most of their care from a military treatment facility (MTF), augmented by the TRICARE contractor's provider network. TRICARE Prime enrollees are assigned a primary care manager (PCM). It is important to note that the URFS are no longer covered by the family plan status, since he/she is now a sponsor in his/her own right, under his/her own social security number. Therefore, he/she becomes responsible for his/her enrollment fees at the retirees rate, even though the former spouse may still be on active duty.
  - > - TRICARE Standard: Under this plan, you can see the TRICARE authorized provider of your choice. (People who are happy with coverage from a current civilian provider often opt for this plan.) But having this flexibility means that care generally costs more than Prime (Standard requires a 25% cost share of the TRICARE allowed amount and has a \$150 individual fiscal year deductible). Treatment may also be available at a MTF, if space allows and after TRICARE Prime beneficiaries have been served. Furthermore, TRICARE Standard may be the only coverage available in some areas.
  - > - TRICARE Extra: Under this option, you will choose a doctor, hospital, or other medical provider listed in the TRICARE Prime provider directory. The advantages of TRICARE Extra include the fact that cost-shares are five percent less than TRICARE Standard (Extra requires a 20% cost share of the TRICARE allowed amount and consists of a \$150 individual fiscal year deductible); there is no balance billing or enrollment fee; and there are no claims forms to file. The disadvantages of TRICARE Extra are you have no PCM; your provider choice is limited; you pay the deductible and the cost shares; and the option is not universally available.
  - > - TRICARE for Life (TFL): This is Medicare-wraparound coverage. A single, nationwide contract provides claims processing, customer service and administrative services for individuals who are eligible for both TRICARE and Medicare, regardless of whether they are over or under age 65. Under TFL, TRICARE becomes second payer to Medicare: you must be eligible for Medicare Part A, and enrolled in Part B. For more TFL information refer to <http://www.tricare.osd.mil/tfl/default.cfm>.
  - > - Pharmacy- under this benefit, you are eligible for the basic MTF Pharmacy services, TRICARE Mail Order Pharmacy, TRICARE Retail Pharmacy, and Non-network Pharmacy option. For more information on pharmacy benefits

refer to <http://www.tricare.osd.mil/pharmacy/default.cfm>.

> - Dental - URFS are not eligible for TRICARE dental coverage.

> [Source: The URFS Tricare Fact Sheet Sep 08 ++]

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> TRICARE URFS UPDATE 01: The URFS can verify his/her DEERS information by contacting their regional TRICARE contractor, the local TRICARE Service Center, or the nearest uniformed services personnel office (ID card facility). They can also update their addresses and personal information via the online Real-Time Automated Personnel Identification System (RAPIDS). When updating addresses, you should make sure to specify a mailing address and not just a home address. The URFS must visit his/her uniformed services personnel office or nearest RAPID site in person and present the necessary documentation, e.g., a marriage certificate, divorce decree and/or birth certificate, to add or be removed from the database. To update DEERS eligibility information:

> . Visit your local uniformed services personnel office or contact the Defense Manpower Data Center Support Office (DSO) at 1-800-538-9552. You can find the nearest uniformed services personnel office at:

[www.dmdc.osd.mil/rsl/](http://www.dmdc.osd.mil/rsl/).

> . Go online at [www.tricare.osd.mil/DEERSAddress](http://www.tricare.osd.mil/DEERSAddress) to update your information.

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> To update your personal information:

> . Fax address, phone numbers and email changes to DEERS at 1-831-655-8317.

> . Mail the address change to the Defense Manpower Data Center Support Office, ATTN: COA, 400 Gigling Road, Seaside, CA 93955-6771.

> . Go online at [www.tricare.osd.mil/DEERSAddress](http://www.tricare.osd.mil/DEERSAddress) to update your information.

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> The current Uniformed Services Identification and Privilege Card, DD Form 1173, held by the URFS is still valid until it expires. Upon renewal, the URFS will be issued a replacement Department of Defense/Uniformed Services Identification and Privilege Card, DD Form 2765 with their own SSN information. The URFS should always keep his/her DEERS information current and up-to-date. For questions regarding medical records, contact the MTF medical records department where your DoD medical records are stored.

[Source: The URFS Tricare Fact Sheet Sep 08 ++]

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> SBP DIC OFFSET UPDATE 11: The Senate, by a vote of 94-2, added an amendment to the National Defense Authorization Act (S. 3001) that would totally eliminate the SBP/DIC offset that some 57,000 widows now suffer from. Thanks to the efforts of Sen. Bill Nelson (D-FL) and the support of numerous veteran and military associations, this is the fourth year in a row the Senate has taken this action. Unfortunately, every previous year this

legislation has been removed in conference with the House. Last year, in an attempt to give the widows something, a new benefit for those affected by the SBP/DIC offset was passed. This token payment of \$50 per month starts 1 OCT this year and will increase by \$10 yearly increments until it reaches \$100 per month. [Source: NAUS Weekly Update 12 Sep 08 ++]

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> **WORLD WAR I MEMORIAL:** More than nine decades after driving ambulances on the battlefields of Europe, 107-year-old Frank Woodruff Buckles is the nation's last known survivor of World War I. Now he's also become the face of an ambitious campaign to erect a national memorial honoring the 4.6 million Americans who endured "the war to end all wars." Buckles was the celebrity participant at a news conference 9 SEP to unveil plans for a National World War I Memorial on Washington's National Mall. It would be midway between memorials already there to World War II and the Korean War. Planners envision refurbishing and expanding an existing memorial that President Herbert Hoover dedicated in 1931 to honor World War I veterans from the District of Columbia. That circular open-air Doric structure, ravaged by time and neglect, is tucked among trees at the southern edge of the Mall and often is ignored or overlooked by tourists. It was named as one of Washington's most endangered places in 2003 and 2006.

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> Rep. Ted Poe (R-TX) has introduced the Frank Buckles World War I Memorial Act to renovate the memorial and rededicate it as a national shrine in 2018, when America observes the 100th anniversary of the end of the First World War. Buckles said the 21st-century commitment was needed to make the memorial "what it should be" by honoring all who'd gone before him. "I just feel there should be some recognition," he said. Buckles was born in 1901 in Harrison County, Mo. He lied about his age to enlist, telling a skeptical recruiter that Missouri didn't keep birth records when he was born. He was dispatched to England, then France, where he served as an ambulance driver. After the armistice, he delivered German POWs back to their home country. Buckles spent the next 20 years as a merchant seaman before he was entangled in another world war. He was working in the Philippines in 1941 and was captured by the Japanese shortly after the bombing of Pearl Harbor. He spent the next three and a half years in Japanese prison camps. After World War II, he returned to the United States, married and settled down on a 33-acre West Virginia farm, where he still lives. His wife died in 1999.

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> The D.C. Preservation League and a newly formed World War I Memorial Foundation will take the lead in planning, designing and raising money. Refurbishing the monument is expected to cost just under \$1 million but planners said it was too early to project a total cost. The circular memorial, composed of Vermont marble, was intended as a bandstand for memorial concerts to World War I participants. It stands on a 4-foot-high circular marble platform around which are inscribed the names of the 499

Washington residents who died in the war. Planners said they hoped to pay for much of the work through private donations. One priority, they said, will be to preserve and improve the existing monument as a "place of peace and reflection" without trying to rival or surpass the scope of more opulent monuments such as the World War II Memorial. [Source: McClatchy Newspapers Dave Montgomery article 9 Sep 08 ++]

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> VA SUICIDE PREVENTION UPDATE 05: A blue-ribbon panel has praised the Department of Veterans Affairs (VA) for its "comprehensive strategy" in suicide prevention that includes a "number of initiatives and innovations that hold great promise for preventing suicide attempts and completions." Among the initiatives and innovations the group studied were VA's Suicide Prevention Lifeline 1-800-273-TALK. The lifeline is staffed by trained professionals 24 hours a day to deal with any immediate  
> crisis that may be taking place. Nearly 33,000 veterans, family members or friends of veterans have called the lifeline in the year that it has been operating. Of those, there have been more than 1,600 rescues to prevent possible tragedy. Other initiatives noted included the hiring of suicide prevention coordinators at each of VA's 153 medical facilities, the establishment of a Mental Health Center of Excellence in Canandaigua, N.Y., focusing on developing and testing clinical and public health intervention standards for suicide prevention, the creation of an additional research center on suicide prevention in Denver, which focuses on research in the clinical and neurobiological conditions that can lead to increased suicide risk and a plus-up in staff making more than 400 mental health professionals entirely dedicated to suicide prevention.

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> With the praise, the panel also recommended a mixture of more research, greater cooperation among federal agencies, and more education for health care workers and community leaders to further strengthen and share VA's ability to help veterans and their families. Called the "Blue Ribbon Work Group on Suicide Prevention," the five-member group was composed of suicide prevention experts from VA, the Department of Defense, the Centers for Disease Control and Prevention, the National Institute of Health, and the Substance Abuse and Mental Health Services Administration. The group was created by Peake and met 11-13 JUN 08. Among the panel's recommendations to further enhance VA's outstanding

> programs, many of which VA has already begun to implement, are:

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> \* Design a study that will identify suicide risk among veterans of different conflicts, ages, genders, military branches and other factors. VA has committed to work with other federal agencies to design such a study within 30 days.

> \* Improve VA's screening for suicide among veterans with depression or post-traumatic stress disorder (PTSD). VA is in the process of designing a

new screening protocol, with pilot test undertaken during the fiscal year quarter beginning Oct. 1, 2008.

> \* Ensure that evidence-based research is used to determine the appropriateness of medications for depression, PTSD and suicidal behavior.

VA's is providing written warnings to patients about side

> effects, and the Department's suicide prevention coordinators are

contacting health care providers to advise them of the latest evidence-based research on medications.

> \* Devise a policy for protecting the confidential records of VA

patients who may also be treated by the military's health care system. VA is already developing a plan to clarify the privacy rights of patients who come to VA while serving in the military.

> \* Increase research about suicide prevention. VA has announced several funding opportunities this year for research on suicide prevention and is developing priorities for suicide prevention research.

> \* Develop educational materials about suicide prevention for families and community groups. VA is examining the effectiveness of support groups and educational material for the families of suicidal

> veterans, and producing a brochure for the families of veterans with traumatic brain injury about suicide, which will be available within 30 days.

> \* Increase training for VA chaplains about the warning signs of suicide. VA offices responsible for chaplains and mental health professionals are studying ways to implement this recommendation, with a > report due by 1 NOV.

> \* Develop a gun-safety program for veterans with children in the home, both as a child-safety measure and a suicide prevention effort. A VA directive establishing the program is being developed, with full implementation expected during the fiscal year beginning Oct. 1, 2008.

> [Source: VA Media Relations Sep 08 ++]

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> VA VOTER REGISTRATION BAN UPDATE 02: The Department of Veterans Affairs

said 8 SEP that it would no longer ban voter registration drives among veterans living at federally run nursing homes, shelters for the homeless and rehabilitation centers across the country." Back in May, the VA "said such drives would violate the prohibition on political activity by federal employees and would be disruptive. The reversal came after months of pressure from state election officials, voting rights groups and federal lawmakers who said that such drives made it easier for veterans to take part in the political process." In a press release, VA Secretary James Peake commented on the reversal, saying his agency "has always been committed to helping veterans exercise their constitutional right to vote." The Department will welcome state and local election officials and non-partisan groups to its hospitals and outpatient clinics to assist VA officials in registering voters at VA facilities. Such assistance, however, must be

coordinated by those facilities in order to avoid disruptions to patient care. The policy requires that information about the right of VA patients to register and vote, and other patients' rights, be posted in every VA hospital, and that all VA patients be provided a copy of these rights when they are admitted to a VA facility.

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> Every hospital is now also required to publish a written policy on voter assistance, allowing patients to leave the hospital to register and vote, subject to the opinions of their health care providers. Patients unable to leave the facility must be assisted to register and to vote by absentee ballot. In their written policies, VA hospitals are required to establish the criteria they will use to evaluate requests from outside agencies to register voters, and to determine where, when, and how such registration activities will be conducted. They will also develop procedures to coordinate offers of assistance from state and local governments and from non-partisan organizations, and how to work with VA's Regional Counsel offices to determine whether or not groups offering registration help are non-partisan, as required by law. Voluntary Service Program Managers at each of VA's 153 hospitals will be responsible for implementing the new policy, and for providing timely and accurate voting information to veterans cared for at their facilities. They will also obtain and maintain materials that are needed to assist veterans with voter registration requirements. [Source: VA Media Relations 8 Sep 08 ++]

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> FLU SHOTS UPDATE 01: The nation is set to receive between 143 million and 146 million doses of flu vaccine this fall, a record amount that comes as the government is urging more children than ever to be inoculated. Each year, influenza causes 200,000 hospitalizations and 36,000 deaths, according to the Centers for Disease Control and Prevention. The elderly, young children and people with chronic illnesses are at greatest risk for severe illness, but the CDC recommends that a wide variety of people get vaccinated:

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> . All children between ages 6 months and 18 years, unless they have a serious egg allergy. Until now, flu vaccine was recommended for children under 5 or those with chronic illnesses such as asthma. The expanded recommendation takes into account that healthy school-age children have higher rates of flu than other age groups.

> . Adults 50 and older.

> . People of any age with certain lung, heart or other chronic disorders, or a weakened immune system.

> . Women of any age who will be pregnant during flu season.

> . Residents of nursing homes and other chronic-care facilities.

> . Health care workers.

> . Parents or other caregivers of people with high-risk conditions.

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> Choices include standard flu shots for all ages, and the nasal vaccine FluMist, which can be used in healthy people ages 2 to 49. The CDC says there should be plenty of flu vaccine available despite the extra influx of children. While 140 million doses were manufactured last year, fewer than 113 million were actually distributed. Many pediatricians already had ordered vaccine by the time CDC added school-age children to the list. While acknowledging that they may not be ready to fully vaccinate this group until next year, CDC is urging them to try and encouraging more programs that provide flu vaccine in schools, with parents' permission. Hawaii has announced a "Stop Flu at School" program to offer free flu vaccination at elementary and middle schools statewide. [Source: Washington Post AP article 8 Sep 08 ++]

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> **MEDICAL PRICING:** Healthcare providers and insurers put a dollar value on medical services using policies so inscrutable that they leave patients unable to determine a fair price for any treatment. This is most evident in trying to evaluate the differences between what medical providers bill and what insurers' pay. "It's a Byzantine system," said Jim Lott, executive vice president of the Hospital Assn. of Southern California. "There's no question about that." Peggy Hinz, a spokeswoman for Anthem Blue Cross, said the insurer "relies on the latest medical pricing data and experts in the field" to determine how much it will pay for specific services. "We always strive to reimburse a fair amount based on a provider's cost and based on what is reimbursed to other providers for like services," she said. Most physicians will not discuss how they arrive at their billing amounts and often claim they have nothing to do with setting prices for their practice or negotiating contract terms with insurers.

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> Lott at the hospital association, which represents UCLA and about 170 other medical facilities, said patients are wrong to think that the charge on their bill reflects the actual cost of treatment. Rather, he said, hospitals use a "cost-plus" system by which charges include both the cost of a service and a portion of general overhead, including treatment of uninsured people who can't afford the provider's cost-plus prices. At the same time, insurance companies, along with state and federal authorities representing Medi-Cal and Medicare members, negotiate lower rates in return for delivering thousands of patients to a particular clinic or hospital. The upshot is that providers are overcharging insured patients because they have no other way of meeting total expenses, while insurers are paying significantly less than the billed amount because they know they're being hit up for unrelated costs. Insurers' underpayments, in turn, only force providers to increase bills even more. It's a system that both condones and perpetuates inflation while all but eliminating transparency in the marketplace. It also spells doom for the 45 million Americans lacking health

coverage, who have no choice but to pay the full amount of a hospital's cost-plus charges and thus can be wiped out financially by a major medical problem.

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> "Healthcare is the one sector where market mechanisms work least," said Peter Lindert, an economics professor at UC Davis who specializes in public-health issues. "Prices are whatever you can get away with." As my colleague Jordan Rau reported last week, California state lawmakers managed to pass some bills in the latest session that address healthcare problems but came up well short of their goal of reforming the system to make it friendlier -- and more accessible -- to patients. Among legislation torpedoed by lobbyists for doctors and hospitals was a bill that would have given the state new powers to collect information on prices charged by healthcare providers. Support for the bill dwindled after lobbyists managed to exempt doctors from the reporting requirement and inserted language recognizing the "tremendous burden" that revealing actual costs would be for providers. Score that a win for the status quo and a setback for anyone who thinks healthcare costs are out of control. "We are rapidly approaching a time where important policy discussions are going to have to be had on this issue," said Santiago Munoz, associate vice president of clinical services development in the UC president's office. What's needed is a massive infusion of political courage to tackle genuine healthcare reform. [Source: Los Angeles Times Consumer Confidential David Lazarus article 7 Sep 08 ++]

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> VET JOBS UPDATE 04: The Internal Revenue Service has met its goal of hiring a minimum of 1,000 additional veterans in fiscal 2008. With three weeks to go before the fiscal year ends on 30SEP, IRS officials said they had hired 1,052 veterans. "We are not going to stop there," IRS Commissioner Doug Shulman said in a statement. "We will continue to recruit from this talented pool of people who already have demonstrated their leadership, work ethic and dedication." To hire the veterans, the IRS worked with major advocacy groups like the American Legion, Veterans of Foreign Wars, Blinded Veterans of America and Paralyzed Veterans of America. The IRS also worked with the Pentagon and Veterans Affairs Department, which have veteran's employment programs. The Treasury Department, which oversees the IRS, ranks among the worst federal agencies in terms of veterans in its work force. According to an Office of Personnel Management report on veterans' hiring, only 10% of Treasury Department workers are veterans. Only the Education Department, with veterans making up 8.2% of its workforce, and the Department of Health and Human Services, at 7.8%, did worse. The Defense Department - led by the Air Force, which has veterans in 48.6% of its civilian positions - topped the list. The VA and Transportation Department also ranked high in the OPM study. [Source: Navy Times Rick Maze article Posted 9 Sep 08 ++]

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> **MILITARY STOLEN VALOR UPDATE 10:** Former Army serviceman Randall Moneymaker was sentenced to three years in prison 5 SEP for embellishing a brief military career into that of a decorated combat veteran. Moneymaker is part of the growing problem of "phony war heroes," across the nation, Assistant U.S. Attorney Craig "Jake" Jacobsen said. "As the wars drag on in this country, you have more and more wannabes" who make claims of sacrifices never suffered and medals never earned, Jacobsen said. Unlike other imposters who seek only bragging rights or political gain, Moneymaker was motivated mostly by greed, the government contended -- making his false claims to collect more than \$18,000 in disability and military benefits. Moneymaker was sentenced by Judge James Turk following a March trial in U.S. District Court in Roanoke. After hearing testimony that Moneymaker made up tales of firefights, Ranger missions and hundreds of parachute jumps, a jury convicted him of six charges of fraud and theft. "I'm sorry for what I've done," Moneymaker told the judge, apologizing to his family, his country, his fellow soldiers and "anyone else that I've done wrong."

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> After spending just two years in the Army in the mid-1980s, Moneymaker would later claim to be a decorated Army Ranger with more than 20 years of service that included tours in Iraq, Afghanistan, Bosnia, Panama and Grenada. But during the years when he told of suffering post-traumatic stress disorder from seeing his fellow soldiers killed beside him, Moneymaker was actually attending college and working in the telecommunications field. And the scars on his back that he attributed to shrapnel wounds were actually the result of liposuction, federal prosecutors said. Moneymaker was "someone who obtained respect, sympathy and benefits based on the sacrifices and the blood of other veterans who went through what he claimed he went through but didn't," Jacobsen said. Although Moneymaker wore Ranger badges and a Purple Heart he never earned, the charges he was convicted of were limited to the paperwork he filled out to receive benefits from the U.S. Army and Veterans Affairs. The charges included five counts of making false statements on forms he filed or in claims he made while applying for disability benefits or inquiring about a military pension. He also was charged with theft for receiving \$18,449.32 in disability payments to which he was not entitled.

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> Moneymaker, a 44-year-old who now lives in North Carolina, was ordered to pay the \$18,449.32 back to the government, plus another \$600. Moneymaker spoke only when asked by the judge if he had anything to say just before his punishment was announced. Looking across the courtroom, he apologized to Jacobsen, who as a veteran of the war in Iraq has said he takes the case especially seriously. Defense attorney C.J. Covati questioned Jacobsen's statement that Moneymaker's crimes were among the worst he has seen in his 17 years as a federal prosecutor. "To say that it's one of the worst ever is to let moral indignation get a little bit ahead of the facts

in this case," Covati said. Following the hearing, Moneymaker was allowed to remain free on bond until he is ordered to report to prison, which Covati said will probably be in two or three months. [Source: The Roanoke Times Laurence Hammack article 6 Sep 08 ++]

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> VA TELEHEALTH UPDATE 01: Exploring how best to extend telehealth services to veterans living in rural areas will be one of the key missions of three Veterans Rural Health Resource Centers to be opened by the Veterans Affairs Department on 1 OCT. The centers, to be located at the White River Junction VA Medical Center in Vermont, at the Iowa City VA Medical Center, and at the Salt Lake City VA Medical Center, will serve as satellite offices for VA's Office of Rural Health. Patricia Vandenberg, assistant deputy undersecretary of veterans affairs said in an interview, "The rural resource centers are envisioned not to be providers of services but rather enablers of systematic care for veterans in rural communities. The objective is to conduct policy studies and analyses of data and to develop pilot projects to potentiate and enhance access" to existing telehealth and telemedicine services." The centers are also meant to be "repositories of information and facilitators of information exchange within the Veterans Health Administration nationwide, as well with other government agencies such as the Department of Health and Human Services and the Indian Health Service, and with nongovernmental entities," she added. The VA is planning to capture and disseminate insights from center studies through a Web site. "In that way, we will have real-time communication of information across the three centers and across the system at large," Vandenberg said. "The compilation of information and insights and their rapid dissemination will enhance the quality of service we provide to veterans in rural areas." Vandenberg did not rule out the possibility of investing in other information technologies to capture and analyze data from the centers but added, "It will take at least nine months to gain the intelligence" needed to inform those decisions. Vandenberg expects the centers to spotlight, not only what diverse rural communities have in common, but also how they are distinct, as far as delivering health care services to veterans. [Source: Government Health IT Peter Buxbaum article 29 Aug 08 ++]

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> MEDICARE PART D UPDATE 25: Less than one month from now, private insurance companies will begin marketing their 2009 Medicare health and drug plans, hoping to convince people with Medicare to sign up for coverage for the new year. The open season for seniors to initiate or switch carriers is 15 NOV through 31 DEC. The marketing of Medicare private health plans has been plagued by abuse. Unscrupulous agents who troll senior housing complexes and even nursing homes have misrepresented or outright lied about the plan benefits and coverage, and cajoled or tricked frail older adults into signing enrollment forms in order to gain the commissions, bonuses and

prizes the insurance companies award for these enrollments. The passage this summer of the Medicare Improvement for Patients and Providers Act over President Bush's veto sets some new ground rules for marketing this fall, including a ban on cold-calling and other unsolicited contact (such as accosting patients in hospital parking lots), and federal regulation of agent commissions. How these new rules are implemented and enforced will determine whether the Bush administration seizes, or squanders, its last chance to stop the abuse that has so far characterized the market for Medicare private health plans.

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> Only aggressive oversight and enforcement-levying hefty fines and freezing enrollment-by the Centers for Medicare and Medicaid Services (CMS) will discourage plans from employing agents who flout the rules. (A little due diligence and oversight by the plans will uncover who most of these agents are.) CMS can send a signal of a new, no-nonsense approach with the marketing rules it sets for the new season. Here are three examples:

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> . No cold-calling prospective clients. Period. No exceptions, including cold calls that follow up mailings.

> . No outrageous commissions, bonuses or promises of trips to Vegas that encourage agents to sell unsuitable plans to boost their sales volume. Reports of agents engaging in fraudulent and abusive marketing invariably lead back to plans that pay the highest commissions, or give volume-based bonuses. CMS needs to ensure high commissions are not used to push low-value plans.

> . Clear explanation of plan benefits and coverage restrictions on all marketing material. In particular, the Summary of Benefits and the CMS plan finder must clearly list what, if any, services, are excluded from the financial protection provided by an annual limit on enrollee out-of-pocket spending.

> [Source: Medicare Consumer Advocacy Update 4 Sep 08 ++]

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> **MILITARY HISTORY ANNIVERSARIES:** Following are some September significant events that occurred in military history:

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> . 1783 - The Peace Treaty of Versailles was signed between the USA, Britain, France, and Spain, ending the American Revolution.

> . 1787 - United States Constitution Approved.

> . 1814 - US Naval Captain Oliver Hazard Perry defeated a British flotilla in the Battle of Lake Erie (War of 1812).

> . 1814 - During a British naval attack on the City of Baltimore, Francis Scott Key composed a poem entitled "The Star Spangled Banner."

> . 1847 - American forces captured Mexico City, effectively ending the Mexican War.

> . 1864 - Confederate troops abandoned Atlanta in the face of continuing

attacks by federals under General W.S. Sherman (Civil War).

> . 1899 - Founding of the Veterans of Foreign Wars of the United States.

> . 1908 - LT Thomas E. Selfridge was killed at Ft. Myer, VA, in a plane flown by Orville Wright. Selfridge was the first man to die in an airplane accident.

> . 1939 - German troops invaded Poland, beginning World War II.

> . 1939 - Britain and France declared war on Germany (World War II).

> . 1941 - British Naval forces sank the German battleship Bismarck off the French coast (World War II).

> . 1943 - The allied invasion of Italy began (World War II).

> . 1945 - V-J Day, Japan signed formal surrender (World War II).

> . 1951 - Battle of Heart Break Ridge began (Korean War).

> . 1962 - United States Naval Sea Cadet Corps Incorporated.

> . 1967 - Siege of Con Thien Began (Vietnam War).

> . 1969 - President Richard Nixon ordered resumption of heavy bombing of North Vietnamese targets (Vietnam War).

> . 1994 - Operation Uphold Democracy began (Haiti).

> [Source: VetJobs Veteran Eagle Newsletter 1 Sep 08 ++]

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> TRDP UPDATE 06: An upcoming change to Tricare soon could give military retirees living overseas reason to smile. Beginning 1 OCT, those retirees will have access to the Tricare Retiree Dental Program (TRDP) insurance benefits that have been previously unavailable outside the United States, Tricare officials said in an e-mail to Stars and Stripes on 5 SEP. Jeff Album, spokesman for Delta Dental, the California-based contractor that handles Tricare's dental coverage, said the company expects about 14,000 of the 35,000 eligible retirees to take advantage of the optional program in its first year. While the change is good news for many, it might not be cost-effective for every retiree living overseas, said Ed Chan, the Tricare Pacific director. For instance, out-of-pocket expenses for dental care in the Philippines are generally much less than monthly insurance premiums, he said. "In some cases, they may not get back what they paid into it," he said. In South Korea and Japan, he said, retirees might have national insurance if they're married to citizens of those countries, which includes some dental coverage. In some places in Japan and Okinawa, officials say, retirees can receive free space-available care on base. Retirees in South Korea have very limited on-post care. They are authorized emergency care and can get cleanings during special events such as retiree appreciation days and noncombatant evacuation exercises, said Chris Vaia, chairman of the retiree counsel at Yongsan Garrison in Seoul.

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> Under the new Tricare contract, beneficiaries will be able to use off-post dentists on Tricare's approved list of providers, which can be found at [www.tricaredentalprogram.com](http://www.tricaredentalprogram.com). For orthodontic care or implants, however, special approval must be granted in advance of the work. Providers

will work with local patient care representatives to obtain approval. Patients must pay their co-pay at the time of care, and Tricare will settle the rest of the bill. To enroll you will need to make a prepayment of two month's premiums to ensure that you will be able to participate as soon as your coverage is effective. Once a payment process is established for you, either through mandated automatic deduction from your retired pay or other applicable billing method, the unused portion of the premium will be refunded. Premium rates vary by region. For example monthly premiums for retirees living in the Philippines (Region D) are \$41.73 for single, \$81.01 for two people, and \$135.40 for a family of 3 or more. These rates for the Enhanced TRICARE Retiree Dental Program are effective 1 OCT 08 through 30 SEP 09. Monthly premiums are scheduled to change each year, on 1OCT. Department of Defense directed implementation of further program enhancements could result in the contractual establishment of monthly premium rate changes. If you move or change your enrollment option, your monthly premium rate may also change. Album said retirees living overseas can enroll in the Tricare dental program at [www.trdp.org](http://www.trdp.org) or by calling 1-866-721-8737. [Source: Stars and Stripes Pacific edition Jimmy Norris & Vince Little article 6 Sep 08 ++]

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> VA RETRO PAY PROJECT UPDATE 13: In SEP 06 the Department of Veteran's Affairs (DVA) identified more than 133,000 recipients of Combat Related Special Compensation (CRSC) or Concurrent Retired Disability Payment (CRDP) potentially eligible for additional retroactive compensation. Since then the Defense Finance and Accounting Service (DFAS) in coordination with the DVA have processed all of the original cases as of 8 JUN 08. Throughout the project DVA identified additional retirees that were prospectively eligible for retroactive payments. The agency also resubmitted accounts, from the original 133,000, for potential supplementary entitlements. Those accounts, classified as "new and returning," were processed as of 29 JUN 08. Those people identified with potential eligibility for retroactive payment after JAN 08, were placed in a category referred to as "On-Going." The On-Going category documents the most recently received new and returning VA Retro cases. Those accounts as of 20 JUL 08, have been processed. To date a total of more than 230,000 accounts have been processed. Going forward, plans are to process all incoming claims within 30 days. While certain accounts may have received payment from DFAS, you may also be eligible for payment from the Department of Veteran's Affairs (DVA). Once your account has been processed at DFAS, the information is forwarded to the DVA for additional validation and possible payment. There may often be a lapse of time between the payments from the two different agencies. Questions concerning the VA can be addressed by calling 1-800-827-1000. [Source: DFAS <http://www.dfas.mil/retiredpay/retroactivepayment.html> 5 Sep 08 ++]

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> VA RETRO PAY PROJECT UPDATE 14: The Heroes Earnings Assistance and Relief Tax Act of 2008, signed into law on 17 JUN 08, changed the federal income tax filing deadlines and the length of the look-back period for amended tax returns when retirees are affected by a retroactive VA disability compensation determination. Amended tax returns usually are required when you have paid income taxes on past retirement income that later becomes tax-free income as a result of the award of retro-VA compensation. For retro-VA compensation determinations as of 18 JUN 08 or later, retirees have up to one year to file their amended return from the date of the VA determination. The retiree now can amend tax returns going back five years. It used to be a three-year look-back. There also is a transition period allowed in the tax code change. For retro-VA compensation determinations from 1 JAN 01 through 17 JUN 08, retirees have until 17 JUN 09 to file amended returns for tax refunds for tax years 2001 to the present. Consult your tax specialist for more detailed information about how these changes affect you. Refer to H.R. 6081, Section 106, which amends the IRS Tax Code Section 6511(d) by adding a new paragraph (8). For a technical explanation of H.R. 6081 on the House of Representative's Web site refer to [www.house.gov/jct/x-44-08.pdf](http://www.house.gov/jct/x-44-08.pdf). additional reference can be located at [www.govtrack.us/congress/billtext.xpd?bill=h110-6081](http://www.govtrack.us/congress/billtext.xpd?bill=h110-6081) and

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frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110\_cong\_bills&docid=f:h6081enr.txt.pdf . [Source: MOAA News Exchange 10 Sep 08 ++]

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> MEDICARE PART B NON-ENROLLMENT: Tricare beneficiaries who qualify for Medicare Part A will automatically be enrolled in Medicare Part B at an increased marginal cost unless declined by the beneficiary. However, subject to the exceptions noted below, the consequences for declining Medicare B can be potentially disastrous, as Tricare can pay nothing for care while a beneficiary is eligible for Medicare Part A unless the beneficiary also has Medicare Part B coverage. Tricare will also recoup any benefit payments made to physicians for a disqualified beneficiary for the period that the beneficiary was eligible for Medicare Part A but declined Medicare Part B. The same consequence would apply to Tricare beneficiaries who are awarded two years or more of retroactive Medicare Part A coverage because of a Social Security disability award but decline the option to take Medicare Part B for the period of retroactive Medicare Part A coverage. Any payments made to physicians during a period of retroactive Medicare Part A coverage for which Medicare Part B is declined will be recouped by Tricare.

> The mandatory Medicare Part B enrolment rule does not apply if the beneficiary has an active duty sponsor, is enrolled in the US Family Health Plan, or is covered under Tricare Reserve Select. Tricare beneficiaries who are changing Tricare coverage, such as those switching to Tricare for Life and those Tricare beneficiaries with potentially successful Social Security claims should particularly take heed of the Medicare Part B requirement if

they want to continue Tricare coverage. The clear message from Tricare Management Activity to Tricare beneficiaries covered by Medicare Part A is that if they decline Medicare Part B coverage, they do so at their peril as this could terminate Tricare payments of claims. It is possible to later enroll in Medicare Part B for those who decline the initial coverage but substantial penalties could apply. Questions on this requirement should be directed to your Tricare contractor. You can also visit the Tricare website for your region or program as follows.

> . North Region: [www.healthnetfederalservices.com](http://www.healthnetfederalservices.com)

> . West Region: [www.triwest.com](http://www.triwest.com)

> . South Region: [www.humana-military.com](http://www.humana-military.com)

> . Tricare for Life: [www.tricare-4u.com](http://www.tricare-4u.com)

> [Source: NGAUS Leg Up 5 Sep 08 ++]

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> NATIONAL GUARD BENEFITS: Currently, enlistees may be eligible for up to a \$20,000 cash signing bonus for select careers and up to \$32,000 for your college education through the Montgomery G.I. Bill and other incentive programs. The Guard offers many federal benefits/entitlements to their unit members and their families such as the Base Exchange, Commissary, use of Morale Welfare And Recreation facilities, and up to \$400,000 life insurance at reduced rates. Members can also take advantage of Tricare Reserve Select Health Insurance and Tricare Dental. Both of these Health Insurance programs offer low cost premiums that round out the benefits necessary for families to maintain good health. Federal education benefits through the Montgomery G.I. Bill are available to most unit members provided they enlist for 6 years. These benefits are available to members after completion of basic training and technical school. This program is a non-contributory benefit, meaning no payment or reduction in pay is required to receive these benefits. Federal benefits received: Montgomery GI Bill chapter 1606; up to \$317 per month to offset college cost of attending college fulltime. Other Education Benefits for members enlisting for six years in a critical skills job are: Montgomery GI Bill kicker up to \$350 per month for full-time college enrollment, Student loan repayment program; up to \$20,000 paid throughout enlistment. If you have prior military service and elected the active duty MGIB, you may still take advantage of this benefit up to a maximum of 48 months of combined benefits at the full-time rate. In addition to the federal benefits listed above, each state may offer additional benefits for their members such as: up to 100% tuition assistance, state tax deferment, and reduced auto license fees. Some of these benefits extend to member's families. To search for benefits by state refer to [www.goang.com/benefits/](http://www.goang.com/benefits/). For more information refer to:

> . Army Guard: [www.1-800-GO-GUARD.com](http://www.1-800-GO-GUARD.com)

> . Air Guard: site is [www.GOANG.com](http://www.GOANG.com)

> . Coast Guard Reserve: <http://www.gocoastguard.com>

> . Marine Corps Reserve: <http://www.marforres.usmc.mil/join/Bonus.asp>

> . Navy Reserve:

[http://www.navyreserve.com/?campaign=Reprise\\_YahooPI\\_Homepage\\_Homepage\\_Text](http://www.navyreserve.com/?campaign=Reprise_YahooPI_Homepage_Homepage_Text)

> [Source: NGAUS Leg Up 5 Sep 08 ++]

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> NDAA 2009 UPDATE 05: The Senate returned to work and took up consideration of the cloture motion to proceed to S.3001, the DoD Authorization bill on 8 SEP. Two hours later they proceeded to a roll call vote on the Motion to invoke Cloture which was approved 83-0 allowing the Senate to move to debate on this bill. Cloture is a procedural vote to limit debate and force a vote on a particular issue. It prevents excessive discussion of an issue (called filibustering or talk-a-thon). Three-fifths of all senators (sixty if there are no vacancies) must vote for the motion for cloture for it to be invoked. Once cloture is invoked, the Senate must take final action on the issue by the end of the thirty hours of consideration and may consider no other business until it takes that action. Each senator may speak for a total of no more than one hour. Senators may yield all or part of their hour to one of the floor managers or floor leaders that may in turn yield that time to other senators, but each manager and leader may be yielded no more than two hours. No delaying amendments or motions are allowed, and all debate and amendments must be relative to the debate. Only amendments filed before the cloture vote may be considered; no new amendments may be offered. No senator may call up more than two amendments until every other senator has had an opportunity to do so.

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> Certain senators want cloture to be invoked, so that the bill will move faster through the Senate, into conference committee, and to the President's desk for signature into law. They may want to protect language they have already inserted, or limit discussion on amendments they wish to offer. With adjournment slated for September 26th, time is of the essence. Others senators do not want cloture to be invoked, for a variety of reasons. They may feel pressured into certain limitations on amendments they want to offer to the bill. They may desire to insert an earmark for their state or for a particular project. They may want to debate a provision of the bill for which they disagree. If the cloture vote fails, debate may continue without limit. Usually the bill is set aside rather than having unlimited debate. Setting aside the NDAA would not have been in the best interests of anyone. [Source: NGAUS Leg Up 5 Sep 08 ++]

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> NDAA 2009 UPDATE 06: Some of the most important legislation for the military community on Congress' agenda from now until it finally adjourns are the FY2009 Defense Authorization Act, the FY2009 Defense Appropriations Act and the FY 2009 Military Construction and Veterans Affairs Appropriations Act. There was a flurry of activity in the Senate on both defense bills this week, but only time will tell whether or not they will

actually pass the bills and then go to conference committees with the House of Representatives. On 10SEP, the Senate Appropriations Defense Subcommittee approved a \$487.7 billion spending bill, which is \$4 billion less than the President requested but 6.2% above the FY2008 spending level. In July the House Appropriations Defense Subcommittee approved a similar measure with the same total amount of discretionary funding but the full House Appropriations Committee will not vote on the final bill until the week of 15 SEP. That means the appropriations bill still has to go through both the Senate and House Appropriations committees and then go to each floor for a final vote. Whatever differences there are between the two bills will then have to go to a conference committee, and once agreement is reached there on one final bill, it must go back to the full House and Senate for a final vote before it can be sent to the President for his signature.

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> While the leaders of both the House and the Senate have said they want to finish the bill in SEP, the amount of time left, together with the workload still facing Congress, and the need they feel to adjourn so they can campaign, leaves many observers wondering if the bill will actually ever pass - at least prior to the November election. The full Senate was busy this week debating the annual defense authorization bill for FY2009. The House passed its version of the bill back in May. On 8 SEP there were reported to be at least 177 amendments to the Senate bill, but by 12 SEP that number had risen to 220. One of those amendments was by Senator Bill Nelson of Florida, which would repeal a requirement that the survivors of military personnel killed in action have to offset the amount of benefits they receive from the Defense Department by the amount they net from the Department of Veterans Affairs. The amendment passed by a vote of 94 to 2 and is something Senator Nelson and others have sought for eight years to repeal. Although the Senate leadership had originally stated their goal was to finish the bill 12 SEP they have now scheduled the vote on the legislation for 16 SEP. A dispute over earmarks that are part of the bill has become the major obstacle to passage, and that debate is tied directly to the elections, with many Republicans campaigning against earmarks in general. Beyond that, President Bush has threatened to veto both the House and Senate versions of the bills because of provisions targeting the use of contractors in combat zones. [Spource: TREA Washington Update 12 Sep 08 ++]

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> **MILITARY COMPENSATION REVIEW UPDATE 04:** The new report of the Quadrennial

Review of Military Compensation (QRMC) proposes a number of changes in military pay and benefits. Under the law, the Defense Department must conduct a QRMC every four years. MOAA previously addressed concerns about the QRMC's proposed changes in the military retirement system (refer to "Purposes and Pitfalls of Retirement Reform" at [www.moaa.org/lac/lac\\_asiseeit/lac\\_asiseeit\\_2008/lac\\_asiseeit\\_080813.htm](http://www.moaa.org/lac/lac_asiseeit/lac_asiseeit_2008/lac_asiseeit_080813.htm)).

Now they have provided an assessment of the QRMC health care recommendations. The Military Officers Association of America (MOAA) is in agreement with proposals to stress preventive care by removing copays and deductibles for procedures and medications that are intended to guard against health problems, including colonoscopies, mammograms, and medications intended to control chronic conditions such as diabetes. Similarly, they think the QRMC is on the right track in outlining a variety of initiatives to improve recruiting and retention of the full spectrum of military medical professions and expand contract, reimbursement, and other options to attract the needed level of civilian providers to meet the military community's needs. But they have a pretty big hiccup on QRMC proposals to:

- > . Increase and means-test Tricare fees for retirees under 65
- > . Double retail pharmacy copays
- > . Establish an annual enrollment fee for Tricare Standard
- > . Establish an accrual accounting system to pay for health care for retirees under 65
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- > The QRMC would establish an annual enrollment fee for Tricare Standard and set the fee at 15% of the Medicare Part B premium for single members. The enrollment fee for single retirees in Tricare Prime would be set at 40% of the Part B premium. The premium would be doubled for retirees with spouses or families. While those amounts would start out at lower levels than the Pentagon and others have proposed, it would represent a fundamental change in the philosophy of military benefits.
- > . First - Part B premiums by law represent at least 25% of the cost of delivering care to the elderly and disabled. MOAA doesn't believe that standard is a proper one for establishing fees for people between ages 38 and 64.
- > . Second - Part B premiums can rise dramatically based on the family's adjusted gross income as reported to the IRS. MOAA has a problem with that kind of means-testing of federal benefits in any event, but at least there's some case to be made for it in social insurance programs like Medicare that apply to all Americans, regardless of their contributions to the country. But they draw the line at means-testing military compensation and benefit programs that are earned by a career of service and are supposed to be provided by the Defense Department as part of the employer's compensation package.
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- > Less than 1% of the health coverage plans offered by any other American employers vary with income. The U.S. president pays the same for his health care as the lowest-grade federal civilian. It makes no sense to MOAA to say that some military retirees who complete 20 to 30 years of arduous service somehow deserve a cut in their military health benefits if they inherit some money from a parent or if their spouse lands an outstanding job. Further, MOAA doesn't support an enrollment fee of any kind for Tricare Standard or

Tricare for Life (TFL). Tricare Prime has an enrollment fee because it guarantees access to care for those who enroll. There's no such guarantee for Tricare Standard or TFL, and many military beneficiaries encounter difficulties finding providers who will accept Tricare - which doctors see as the lowest-paying insurance program in America.

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> Finally, hard experience has shown that establishing a health care accrual accounting system for retirees under 65 may be an accountant's dream, but it's a beneficiary's nightmare. The accrual funding system established in 2001 for beneficiaries over 65 has proven to be a significant hindrance in making needed adjustments because of strict congressional budget rules for any benefit program governed by accrual accounting. That means benefit adjustments can be made relatively easily for retirees under 65, but making improvements for those over 65 is nearly impossible. That's also the reason that it's like pulling teeth to make even minor adjustments on concurrent receipt or the Survivor Benefit Plan, both of which are covered by accrual accounting systems. The last thing we need, given the many problems that we know exist in the Tricare system, is another budgetary roadblock in getting them fixed. [Source: MOAA Leg Up 5 Sep 08 ++]

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> **MILITARY COMPENSATION REVIEW UPDATE 05:** Every four years, DoD is required

by law to conduct a review of military compensation. As previously reported in the AUG Volume II of the 10th Quadrennial Review of Military Compensation (QRMC), testing a complex four-part retirement plan for the military on several thousand volunteers is recommended. But the final QRMC report makes other eyebrow-raising suggestions. Other than the Tricare recommendation addressed in Update 4 these suggestions include:

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> . Paying federal impact aid money - now earmarked for local public schools near military bases - directly to military families as cash vouchers to attend alternative schools, including private or parochial schools;

> . Prioritizing access to military child-care centers based on service needs instead of traditional waiting lists; (Children of servicemembers who are deployed or have critical skills would be given preference.); and

> . Encouraging national and regional supermarket chains to offer discounts to servicemembers, particularly those who live far from a base commissary.

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> Retired Air Force Brig. Gen. Jan "Denny" Eakle (director of the 10th QRMC) said in an interview, "We were allowed very broad latitude to think about anything that would enable us to better expend the valuable dollars we invest today in our compensation system. We really wanted to see what we could do, both for military members and taxpayers, if unconstrained by thoughts like 'What's the political climate on this?' As a result, she said, some recommendations are very controversial and we know it. We knew it when

we put it on paper. But we thought we had an obligation to give the department our best insight into what we thought might have promise. They've got to go study it now and figure out, in the political climate, if it is doable." Elaborating on the other QRMC recommendations she noted:

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> . Dispersing impact aid money directly to families is important for allowing "them to choose where their children go to school." Poorly performing school districts near some military bases, she explained, "make it very difficult for us to encourage people with school-age children to accept assignments to those places." What are the political consequences of sending federal dollars, now earmarked for public schools, to military parents so children can attend parochial or private schools? "Remember this is the QRMC's recommendation to the department." What defense policy makers do with it, she suggested, is their concern, not hers.

> . Giving children of deployed servicemembers and those with high-demand skills first crack at on-base child care also is sure to be controversial with families used to a first-come, first-served arrangement. But she suggested it is time child-care dollars are used to enhance service priorities. Besides, she said, another QRMC recommendation is to begin a child-care voucher system - taking money now earmarked for military child development centers and giving families cash to help them afford other child-care arrangements, perhaps nearer to their homes.

> . Eakle didn't dispute the notion that encouraging commercial grocers to offer military discounts could be seen as a first step toward eliminating the prized commissary system. Her intent, however, only is to ensure that active duty servicemembers and reservists living far from commissaries can enjoy grocery shopping discounts, too. "I'm a military retiree who has access to a commissary. But I will tell you, the concept of having discounts in lieu of driving to the commissary will have a lot of appeal to retirees and to military members who are not near a commissary. Think about reservists. So we're not suggesting that we close the commissaries; we're suggesting that this be an alternative that perhaps we pursue."

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> The freedom she was afforded to propose any ideas that would enhance the value of military compensation, both to servicemembers and taxpayers, is "one reason why this report will ultimately be viewed as rather different from previous reports," Eakle said. The 10th QRMC report can be viewed online at [www.defenselink.mil/news/qrmcreport.pdf](http://www.defenselink.mil/news/qrmcreport.pdf) . [Source: MOAA News Exchange Tom Philpott article 10 Sep 08 ++]

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> **GREYHOUND MILITARY DISCOUNT:** Greyhound Bus Company is offering a fare discount to active duty and retired military personnel and their family members. The offer is a 10% discount off the Greyhound walk-up (unrestricted) fare and a maximum fare of \$198 round trip anywhere in the continental U.S. The following terms apply:

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> 1. Fares are valid on Greyhound schedules and those of participating interline carriers. Not available on Greyhound Canada routes.

> 2. This fare applies only to active and retired members of the United States Armed Forces, which includes the U.S. Air Force, Army, Coast Guard, Marines, and Navy; members of the National Guard, reservists and bonafide identifiable spouses and dependents of the above. A valid military picture identification card must be presented upon request.

> 3. A 40-percent discount for children of military personnel is available. This discount not available with \$198 maximum military fare. No other discounts apply.

> 4. Only totally unused tickets may be refunded to the location of the original purchase. A 15% penalty fee applies upon refund. No refund will be allowed if any portion of the ticket has been used.

> 5. Departure date and time may be changed for a charge of \$10 per ticket provided that the advance purchase requirement is not violated.

> 6. Advance purchase tickets purchased over the phone require a minimum of ten days for delivery by mail and for online orders.

> 7. Casino, commuter, Discovery Pass, student or other special military fares do not qualify for the military discount.

> 8. Fares are subject to change until purchase and may be higher during peak holiday travel periods.

> 9. Ten-percent discount may not be used in conjunction with the \$198 maximum fare.

> [Source: NAUS website <http://naus.org/benefits/travel.html> 5 Sep 08 ++]

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> CRDP UPDATE 42: As previously reported, last year's National Defense Authorization Act authorized full, immediate concurrent receipt for disabled retirees rated as "Individually Unemployable" (IU) by the VA. The provision takes effect 1 OCT 08 with payment retroactive to 1 JAN 05. It is estimated that 50,000 are eligible to receive these increased payment amounts.

According to Defense Finance and Accounting Service (DFAS), the increase in IU payment will come in the November check. DFAS says, "Retirees will not need to take any action in order to receive this increased benefit amount.

The Defense Finance and Accounting Service receives this information from the DVA [Department of Veterans' Affairs] on a regular basis." In recent contact with DFAS, we are told that the retroactive payment is being worked out. While there is no clear timeline for these back-payments, DFAS informs us that a lump sum payment will be made once the calculation of individual payments is final.

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> To qualify for the CRDP entitlement, the retiree must have 20 years of service or retired under Temporary Early Retirement Authority (TERA), must be in receipt of retired pay, in receipt of DVA compensation, rated 50 percent or higher by the DVA. Those rated by the DVA as IU, are compensated

at the 100 percent rate in accordance with the DVA disability compensation basic rates. Payment is not a separate payment but reduces the dollar for dollar offset that retirees give up for every dollar they receive from the DVA. This will eliminate the offset and give retirees in this category all of their retired pay, and they will continue to receive the DVA compensation as they have been all along. In addition, to receive the additional compensation amount, the retiree must be receiving compensation at a disability rating not less than 60 percent and be rated IU. Additional information can be found at the DFAS site: DFAS-IU Information. [Source: NAUS Weekly Update 5 Sep 08 ++]

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> MEDICARE FRAUD UPDATE 09: Three years into the Medicare Part D prescription drug benefit, the Government Accountability Office (GAO) has found that the Centers for Medicare and Medicaid Services (CMS) has not exercised the oversight necessary to ensure Part D plans are safe from fraud, waste and abuse. To conduct the analysis, the GAO examined five Part D prescription drug plans offering nationwide coverage and representing about 35% of all Part D enrollments. Although all plans had the required policies and procedures on paper, they varied widely in their implementation of fraud and abuse controls. For example, only one of the five plans examined had conducted effective training and education of these guidelines for their personnel. In addition to examining these Part D plans, the GAO looked at CMS oversight of the fraud and abuse prevention program. The findings show that neither of the two offices within CMS responsible for overseeing the implementation of these programs had conducted an audit of the Part D plans' fraud and abuse programs. CMS countered that it required Part D plans to conduct self-assessment surveys of their fraud and abuse programs. The purpose of these fraud and abuse programs is to protect people with Medicare, taxpayers, as well as the prescription drug plans from waste and abuse. CMS is responsible for ensuring both the proper implementation of the program and compliance with the requirements by all Part D plans. To help protect the Part D program, the GAO recommended that CMS conduct timely audits of the Part D fraud and abuse programs. CMS disagreed that its oversight had been limited, although they agreed with the GAO's findings that plans had failed to properly implement programs to control fraud and abuse. [Source: Medicare Watch 2 Sep 08 ++]

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> MEDICARE PART D UPDATE 25: For the first time since the inception of the Medicare Part D program, there is a comprehensive analysis of how many people fall into the coverage gap, or "doughnut hole," and what they do when they must begin paying full cost for their prescription drugs. The Kaiser Family Foundation analysis estimates that 3.4 million individuals fall into the gap, or "doughnut hole" in the Part D drug benefit and respond by stopping medication use, skipping or splitting pills, or switching to less

expensive drugs when they must pay full price for their prescription drugs. The "doughnut hole" refers to a distinctive aspect of the Medicare Part D Drug benefit, a period when there is a gap in coverage, and the enrollee must pay the full cost of drugs. After total drug expenses reach \$4,050 in 2008, they are out of the gap and eligible for catastrophic coverage, where they are responsible for 5% of the total drug costs.

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> 2007 is the first full year in which people with Medicare were enrolled in a Part D plan, and this is the first report that examined the experiences of people with a Medicare prescription drug plan over an entire year. This report did not examine individuals with coverage under the low-income subsidy, as they do not face a gap in coverage. Among people with a Medicare Part D plan that filled a prescription in 2007, over one quarter entered the doughnut hole during 2007, half of whom entered the gap by the end of August. Of these individuals, only 15% had out-of-pocket spending high enough to receive catastrophic coverage at some point during the remainder of their year. When considering the entire population of individuals who enrolled in a Medicare prescription drug plan, the report found that 14%, or 3.4 million enrollees, had entered the coverage gap during 2007. In 2007, an enrollee was responsible for \$3,051 worth of out-of-pocket drug expenses during the doughnut hole, before entering catastrophic coverage. This amount has increased to \$3,216 this year; it rises to \$3,454 in 2009. Individuals' monthly out-of-pocket spending during the coverage gap was more than twice as much as before the gap.

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> For many people, these costs can affect their ability to buy their medications. The report examined enrollees' changes in behaviors across 8 drug classes and found that, of those who reached the gap, 15% stopped taking their medication, 1% reduced their use of medication and 5% switched to a lower-cost generic. For people with chronic illnesses, changes in medication use can cause serious consequences. For some individuals, such as those with diabetes, problems from improper medication use can result almost immediately, while others, such as those with high cholesterol for example, may feel the effects later. [Source: Medicare Watch 2 Sep 08 ++]

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> DIET AND EXERCISE MYTHS: Every year, millions of Americans resolve to lose weight, whether on New Year's Day, their birthdays, or just some morning when their mirror or the bathroom scale seems particularly unkind. And every year, many get frustrated and give up before they reach their goals. Contributing to this problem is a host of bad information about diet and exercise that circulates through gyms, workplaces, and over the Internet. To help more people achieve and maintain a healthy weight, Julie Bender, a dietitian with Baylor University Medical Center at Dallas, and Phil Tyne, director of the Baylor Tom Landry Health and Wellness Center agreed to "weigh in" on many of the most common diet and exercise myths.

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> . #1: Crunches will get rid of your belly fat. False. "You can't pick and choose areas where you'd like to burn fat," Tyne says. "In order to burn fat, you should create a workout that includes both cardiovascular and strength training elements. This will decrease your overall body fat content."

> . #2. Stretching before exercise is crucial. False. Some studies have suggested that stretching actually makes muscles more susceptible to injury. They claim that by stretching, muscle fibers are lengthened and destabilized, making them less prepared for the strain of exercise. "You might want to warm-up and stretch before a run, but if you are lifting weights wait until after the workout to stretch your muscles," Tyne suggests.

> . #3. You should never eat before a workout. False. "Fuel" from food and fluids is required to provide the energy for your muscles to work efficiently, even if you are doing an early morning workout. "Consider eating a small meal or snack one to three hours prior to exercise," Bender says. "Load up your tank with premium 'fuel' and choose some fruit, yogurt, or whole wheat toast."

> . #4. Lifting weights will make women bulky. False. "Most women's bodies do not produce nearly enough testosterone to become 'bulky' like those body builders on TV," Tyne says. If you do find yourself getting bigger than you would like, simply use less weight and more repetitions.

> . #5. Fat is bad for you, no matter what kind. False. Contrary to popular belief, there are plenty of "good fats" out there that are essential for good health and aid in disease prevention. "They are the ones that occur naturally in foods like avocados, nuts, and fish, as opposed to those that are manufactured," Bender says. "Including small amounts of these foods at meal times can help you to feel full longer and therefore eat less."

> . #6. Restricting calories is the best way to lose weight. False. Both cutting back on calories and moving more will help you lose weight and maintain the lean muscle mass needed to boost metabolism. People often believe the diet and exercise myth that they must take drastic measures to lose weight, such as eating less than 1200 calories per day, but such diets usually do not provide adequate fuel for the body and may slow metabolism. "Drastic measures rarely equal lasting results, so start small and eliminate 100-300 calories consistently from your daily diet, and you will reap the reward," Bender says.

> . #7. As long as you eat healthy foods, you can eat as much as you want. False. A calorie is a calorie. Although oatmeal is healthy, if you eat four cups of oatmeal, the calories add up. "Healthy or otherwise, you still must be aware of portion sizes," Bender says. "You must limit your caloric intake in order to lose weight, however, understanding how to 'balance' calorie intake throughout your day can help you avoid feelings of deprivation, hunger and despair."

> . Myth #8. Exercise turns fat into muscle. False. Fat and muscle tissue

are composed of two entirely different types of cells. "While you can lose one and replace it with another, the two never "convert" into different forms," Tyne says. "So fat will never turn into muscle."

> . #9. Eating late at night will make you gain weight. False. "There are no 'magic' hours," Bender says. "We associate late-night eating with weight gain because we usually consume more calories at night. We do this because we usually deprive our bodies of adequate calories the first half of the day. Start the day out with breakfast and eat every 3-4 hours. Keep lunch the same size as dinner, and you will be less likely to over-indulge at night, yet you can enjoy a small late-night snack without the fear of it sticking to your middle."

> . #10. You have to sweat to have a good workout. False. "Sweating is not necessarily an indicator of exertion-sweating is your body's way of cooling itself," Tyne says. It is possible to burn a significant number of calories without breaking a sweat: try taking a walk, or doing some light weight training, or working out in a swimming pool.

> [Source: About Senior Living Sharon O'Brien article Sep 08 ++]

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> EARWAX REMOVAL: The American Academy of Otolaryngology - Head and Neck Surgery Foundation (AAO-HNSF) will issue the first comprehensive clinical guidelines to help health care practitioners identify patients with cerumen (commonly referred to as earwax) impaction. The guidelines emphasize evidence-based management of cerumen impaction by clinicians, and inform patients of the purpose of ear wax in hearing health. "Approximately 12 million people a year in the U.S. seek medical care for impacted or excessive cerumen," said Richard Rosenfeld, MD, MPH, Chair of the AAO-HNSF Guideline Development Task Force. "This leads to nearly 8 million cerumen removal procedures by health care professionals. Developing practical clinical guidelines for physicians to understand the harm vs. benefit profile of the intervention was essential."

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> Cerumen, commonly called "earwax," is not really a "wax" but a water-soluble mixture of secretions (produced in the outer third of the ear canal), plus hair and dead skin, that serves a protective function for the ear. Cerumen is a natural product that should not be routinely removed unless impacted. Impaction occurs when enough earwax accumulates to cause symptoms (pain, fullness, itching, odor, tinnitus, discharge, cough, or hearing loss), or to prevent needed assessment of the ear. The problem affects 1 in 10 children, 1 in 20 adults, and greater than one-third of the elderly and cognitively impaired. "Unfortunately, many people feel the need to manually 'remove' cerumen from the ears," said Peter Roland, MD, Chair of the Cerumen Impaction Guideline Panel. "This can result in further impaction and other complications to the ear canal." Any excessive cerumen normally migrates out of the ear canal automatically, assisted by motion of the jaw (e.g., chewing), and carries with it dirt, dust, and other small particles

in the ear canal. Recognizing that patients may seek care from many different types of health care providers, the guidelines are intended for all clinicians who are likely to diagnose and manage patients with cerumen impaction. Key features of the new guidelines include:

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> . Cerumen is a beneficial, self-cleaning agent, with protective, lubricating (emollient), and antibacterial properties.

> . Clinicians should examine patients with hearing aids for cerumen impaction because it may cause feedback, reduce sound intensity, or damage the hearing aid.

> . Cerumen may cause reversible hearing loss when it blocks 80% or more of the ear canal diameter.

> . Appropriate options for cerumen impaction are (1) cerumenolytic (wax-dissolving) agents, which include water, saline, and other agents of comparable efficacy, (2) irrigation or ear syringing, which is most effective when a cerumenolytic is instilled 15-30 minutes prior, and (3) manual removal with special instruments or a suction device, which is preferred for patients with narrow ear canals, eardrum perforation or tube, or immune deficiency.

> . Inappropriate or harmful interventions are cotton-tipped swabs, oral jet irrigators, and ear candling.

> . Clinicians should assess patients at the conclusion of in-office treatment for cerumen impaction and document resolution of the impaction.

> . There are no proven ways to prevent cerumen impaction, but not inserting cotton-tipped swabs or other objects in the ear canal is strongly advised; individuals at high risk (e.g., hearing aid users) should consider seeing a clinician every 6-12 months for routine cleaning.

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> "The complications from cerumen impaction can be painful and ongoing, including infections and hearing loss," says Dr. Roland. "It is hoped that these guidelines will give clinicians the tools they need to spot an issue early and avoid serious outcomes." The guidelines were created by a multidisciplinary panel of clinicians representing the fields of otolaryngology, audiology, family medicine, geriatrics, internal medicine, nursing, and pediatrics. [Source: EurekAlert Press Release 29 Aug 08 ++]

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> **DOD VET BETRAYAL CLAIM:** In a letter sent to members of Congress in early SEP, the directors of two major veterans' groups say the Pentagon's personnel chief has intentionally withheld benefits from wounded service members. "We need your immediate assistance to help end the Defense Department's deliberate, systemic betrayal of every brave American who [dons] the uniform and stands in harm's way," states the letter, signed by David Gorman, executive director of Disabled American Veterans (DAV), and Paul Rieckhoff, executive director of Iraq and Afghanistan Veterans of America (IAVA). "Sadly, the 2007 Walter Reed scandal, which resulted mostly

from poor oversight and inadequate leadership, pales in comparison to what we view as the deliberate manipulation of the law" by David S.C. Chu, undersecretary of defense for personnel and readiness, and his deputies, the letter states.

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> Kerry Baker, legislative director for DAV, said Chu sent out a memorandum in March redefining which injuries qualify as "combat-related." The definition is important because Section 1646 of the 2008 Defense Authorization Act said service members with combat-related disabilities no longer must pay back any disability retirement severance they receive from DoD before they become eligible for disability compensation from the Department of Veterans Affairs, as has been the case under longstanding policy. The policy affects service members who receive a disability rating of 20% or less from the Defense Department, and thus receive a severance payment rather than lifetime disability retirement pay. Baker said he has seen cases in which, for example, a veteran receives a \$30,000 severance payment from the Pentagon, uses it for medical care or education, and then, even if subsequently awarded a full 100% disability rating by VA, must pay the \$30,000 back first before he can draw any VA compensation. Baker said this leaves many veterans who may not be able to work in a quagmire of debt. DAV and IAVA think no veteran should have to pay back money he or she earned before becoming eligible for VA benefits, but they still see the new law extending such waivers to veterans with combat-related disabilities as a step forward.

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> Under a separate program called Combat Related Special Compensation (CRSC), which eliminates the offset in retired pay required of some retirees who also receive VA disability compensation, "combat related" is defined as any injury or illness incurred in a combat zone or performing tasks related to combat, such as training for deployment or hazardous assignments like jumping out of airplanes. But according to Chu's memo, the definition of "combat related" for the purposes of the new severance pay waiver is limited only to those injured in a combat zone in the line of duty or as a direct result of armed conflict. In June, DoD spokeswoman Eileen Lainez told Military Times that Chu did not remake the definition to save money, as Baker has charged. She also noted that the law on repaying severance money left it to the secretary of defense to define "combat related." But three lawmakers have told Military Times that their interpretation puts Baker in the right and Chu in the wrong - that they expected the Defense Department to adopt the existing definition used for the CRSC program. "The Department of Defense appears to be interpreting this law in the most narrow and tightfisted way possible," said Rep. Timothy Walz (D-MN) a House Veterans Affairs Committee member. "I am disappointed that [the department] is implementing this policy in a way that makes as few veterans as possible eligible for the benefit."

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> After Walz weighed in, DAV sent a letter to Chu asking for an explanation. William Carr, one of Chu's senior deputies, responded in a letter dated 14 AUG by saying the intent "was to direct the enhanced benefit to those hurt in combat. Such an approach is consistent with our strong belief that there must be a special distinction for those who incur disabilities while participating in the risk of combat, in contrast with those injured otherwise," Carr wrote. But Baker, and the authors of the new letter, continue to insist that congressional intent was not to make a special distinction that leaves out service members hurt in activities defined as "combat related" under other programs. "The law defines such disabilities as those caused by armed conflict, instrumentalities of war, hazardous service and conditions simulating war," Gorman and Rieckhoff wrote. "The [Defense Authorization Act] did not change these definitions; in fact, it reinforced them, and it added disabilities incurred in the line of duty in a combat zone. The letter states that Chu "lacks the authority to change the will of Congress." In an interview with Military Times, Baker laid out cases of veterans already affected by the new memo:

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> . A female soldier in her 30s, who asked that her name not be used, dove for cover into a pile of rocks in Iraq during a mortar attack wearing full battle rattle - Kevlar and body armor that can weigh 20 pounds. Afterwards, she suffered a fused spine and had to have her hips replaced, all of which her doctors said was directly attributable to her dive to safety. "The rating was good, but they said it was not combat-related," Baker said. "You can see Chu's memo confusing the issue. This is a disease process that began in Iraq in the line of duty."

> . In a second case, Marine Cpl. James Dixon incurred a traumatic brain injury from a roadside bomb on his third tour in Iraq. He has headaches, insomnia, short-term memory loss, hearing loss and post-traumatic stress disorder. According to the Pentagon, "the disability did not result from a combat-related injury," Baker said. Dixon's ruling was changed on appeal, but Baker said there should have been no question to begin with about whether his injuries were combat-related.

> . Army Sgt. Richard Manoukian served two combat tours, but when he was diagnosed with PTSD and bipolar disorder after he tried to commit suicide - as well as suffering a spine disability after a hard helicopter landing in Kuwait - the Defense Department called his injuries "not combat related," Baker said.

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> "The list of cases like this is reprehensible and growing every day," Gorman and Rieckhoff wrote in their letter. "Moreover, if cases like these are ruled not combat-related, then one can only imagine how many other less obvious cases are suffering the same fate." They asked Congress to look into how many cases have been ruled not combat-related under Chu's memo and have them reviewed by a group independent of the Pentagon. "Congress should then take immediate action to ensure DoD upholds the plain and unambiguous

language of the law," they wrote. "Most of these service members have no representation in the military disability evaluation system and are therefore unaware of the benefits stolen from them - they are depending on you. [Source: AirForceTimes Kelly Kennedy article Posted 29Aug 08 ++]

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> SSA MILITARY WAGE CREDITS UPDATE 02: In JAN 02, Public Law 107-117, the Defense Appropriations Act, stopped the special extra earnings that have been credited to military service personnel. If you earned military pay while on active duty since 1957 (including active duty time for training), Social Security taxes were paid on those earnings. And since 1988, inactive duty service in the reserves (such as weekend drills) has also been covered by Social Security. Under certain circumstances, special extra earnings for your military service from 1957 through 2001 can be credited to your record for Social Security purposes. These extra earnings credits may help you qualify for Social Security or increase the amount of your Social Security benefit. Special extra earnings credits are granted for periods of active duty or active duty for training, but not for inactive (reserve) duty training. If you served on active duty:

> . From 1957 through 1967, the Social Security Administration will add the extra credits to your record when you apply for Social Security benefits.

> . From 1968 through 2001, you do not need to do anything to receive these extra credits. The credits were automatically added to your record.

> . After 2001, there are no special extra earnings credits for military service.

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> Here's how the special extra earnings are credited on the record of those who received active duty military service earnings from 1957 through 2001:

> 1. Service from 1957 through 1977: You are credited with \$300 in additional earnings for each calendar quarter in which you received active duty basic pay.

> 2. Service from 1978 through 2001: For every \$300 in active duty basic pay, you are credited with an additional \$100 in earnings up to a maximum of \$1,200 a year. If you enlisted after 7 SEP 80 and didn't complete at least 24 months of active duty or your full tour, you may not be able to receive the additional earnings. Check with your local Social Security office for details or refer to the Social Security Administration's website <http://www.ssa.gov/retire2/military.htm>.

> [Source: TogetherWeServed US Navy Newsletter Aug 08 ++]

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> TRRx UPDATE 03: The government's cost of providing brand-name drugs to military beneficiaries through Tricare's vast retail pharmacy network (TRRx) is falling by 25% as new law forces drug manufacturers to expand price discounts. The change won't affect co-payments charged military family members and retirees who have 60 million prescriptions a year filled in

retail drug outlets. But Department of Defense pharmacy costs will be cut by more than \$700 million next year and by higher amounts in following years. The cost savings flow from a provision in the fiscal 2008 defense authorization act that requires drug makers to extend federal pricing discounts to brand-name medicines dispensed to military beneficiaries through drug stores, supermarkets and other commercial outlets.

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> For years, pharmaceutical companies have been required to grant federal discounts only for drugs dispensed on base, or through Tricare's mail order option or through Department of Veterans Affairs' pharmacies. Defense officials tried administratively to get the same discounts for the retail pharmacy network but that effort was blocked in 2006 through a successful industry lawsuit. A short time later, when Tricare officials sought a legislation solution, White House politicians quietly sided with the Pharmaceutical Research and Manufacturers Association in opposing imposition of discounts on prescriptions through retail outlets. Meanwhile, the administration has pressed Congress over the last three years to raise beneficiary co-payments at retail pharmacies to entice greater use of mail order and base pharmacies where federal prices do apply. In passing the 2008 defense bill, the Democratically-led Congress left beneficiary co-payments unchanged, and directed that federal price discounts be expanded to brand name drugs filled in the Tricare retail network. The projected pharmacy savings for fiscal 2009, which total \$719 million, exceeds the savings estimate used by Bush administration to argue for higher drug co-payments in the retail network. Only time will tell whether expansion of manufacturer discounts relieves budgetary pressure for raising retail pharmacy co-pays for beneficiaries.

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> Under the new law, drug companies that refused to extend discounts to Tricare retail outlets risk seeing their drugs removed from the DoD uniform formulary. Drugs left off the formulary for "not honoring federal ceiling price," said Rear Adm. Thomas McGinnis, chief of Tricare pharmaceutical operations, won't be dispensed without preauthorization which means a phone call to confirm the specific drug is medically necessary. Then the co-payment will be \$22 per prescription rather than \$9. "No firm is going to want that for their product," McGinnis said. A "plain reading" of the new law shows Congress wanted the discounts to be effective at retail outlets 28 JAN 08, the day President Bush signed the bill, McGinnis said. But drug makers have filed a lawsuit in U.S. District Court challenging that contention, and arguing that the discounts don't apply until DoD publishes a final rule for implementing the law. A proposed rule was published in the Federal Register 25 JUL. Industry comments are due back by 23 SEP. If the court finds that a final rule must be in place before lower prices apply to retail outlets, drug makers will avoid as much as \$700 million in refunds to DoD for retail drugs dispensed since 28 JAN. "Because there's so much money involved here," McGinnis predicted, "we will see some creative arguments

from the industry."

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> DoD drug spending more than tripled from fiscal 2000 through 2006, rising to \$6.2 billion from \$1.6 billion. Most of the increase was in the convenient retail network where annual costs jumped nine-fold, from \$455 million to \$3.9 billion. McGinnis estimates that the cost of drugs dispensed through retail outlets will reach close to \$4.5 billion in the current fiscal year. One reason DoD eased up on its push for federal price discounts in the retail network was the level of savings being realized through voluntary agreements with drug manufacturers for base pharmacies and the mail order program. In establishing a DoD uniform formulary, or approved list of drugs, DoD began studying whole classes of drugs to determine what medicines are both clinically effective and cost effective. Through last October, 322 drugs had been reviewed and 249 were kept on the formulary. The rest were bumped, many of them for being too costly with no evidence that they were more effective. McGinnis said during this review process the cost of some drugs fell sharply because manufacturers wanted to ensure that their drugs were on the formulary.

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> "The industry has been bidding prices below the federal ceiling price, both at the military treatment facility and at the mail order pharmacy," McGinnis explained. "It will take a while until we see whether they bid some of these retail pharmacy prices below federal ceiling prices." If that occurs, he said, forcibly extending federal discounts to Tricare retail outlets could lead to savings greater than the current 25%. For now, McGinnis said he will continue to urge beneficiaries to save themselves and the government money by using base pharmacies and mail order to fill their prescriptions. With mail order, beneficiaries get a three-month supply for the same co-pay as a one-month supply through retail. Drugs dispensed on base or through mail order also will continue to cost DoD less. Federal pricing in retail outlets, McGinnis said, merely has narrowed the savings disparity. Using mail order or base pharmacies had saved the government 49% on each prescription. Now it will save about 24%, he said. [Source: Stars and Stripes Tom Philpott article 30Aug 08 ++]

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> MEDICARE Part D UPDATE 24: Medicare regulations establish an appeals process that, in theory, can be navigated by any person with Medicare who has been denied coverage for a prescription by his or her Part D plan. But problems frequently arise because Medicare Part D plans refuse to abide by the rules and prevent people from getting medically necessary medicines. These are the most common obstacles patients face:

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> 1. Plans ignore appeals submitted by members and their physicians. Part D plans routinely fail to respond to requests for drug coverage. Time and again patients or their physicians submit requests for coverage and weeks,

if not months, pass before their plan reached a decision-if one was provided at all.

> 2. Consumer representatives cannot provide information to members about the status of their appeals. When Part D enrollees do not receive a response to their appeal, it is virtually impossible to get any information about the status of a pending appeal from Plan customer service representatives. When advocates call customer service lines to inquire on behalf of clients, they are told that consumer representatives have no access to the appeals database. Advocates are then referred to another hotline, and forced to leave messages. Guess what? Often, these messages are never returned.

> 3. Plans do not take into account submitted medical support, but rather "rubber stamp" denials, and customer service representatives cannot advise members what (additional) medical documentation is needed. Part D plans notoriously fail to read physicians' supporting statements indicating that alternative medications have been harmful or ineffective. Plans deny medications for failure to meet step therapy or prior authorization requirements even when physicians explicitly indicate that such requirements have been met. Furthermore, when frustrated members call their plan for advice, customer service representatives routinely tell them they must meet plan requirements. They rarely, if ever, provide substantive advice about the appeals process or what additional medical information may be necessary to win an appeal.

> 4. Customer service representatives often misinform members about their appeals rights. Medicare private plans must abide by strict timelines in issuing decisions. Plans must return decisions on standard (not expedited) exception requests for coverage within 72 clock hours and appeals decisions within seven calendar days. Clients who call their Part D plans to find out the status of their appeals are repeatedly been told by representatives that these timelines count only business hours, not clock hours. Plan representatives claim that the plans have 30 days to make decisions. This is only true for grievances, not for requests for coverage.

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> By making the appeals process as frustrating and protracted as possible, Part D plans are driving many of their enrollees to simply give up and either stop taking needed medications or pay out of their own pockets. The Medicare rights Center (MRC) has created an advocate's manual for navigating the Medicare private drug plan appeals process . This easy-to-understand Part D appeals manual has consumer-friendly language for advocates who help people with Medicare get the drugs they need. This 25-page manual offers a complete overview of the entire appeals process, real-life case examples from their Client Services department, a glossary of important Part D appeals terms, a sample appeals protocol for advocates, and links to important resources and documents. The manual can be accessed and downloaded at [http://www.medicarerights.org/partd\\_appeals\\_manual.pdf](http://www.medicarerights.org/partd_appeals_manual.pdf). [Source: Asclepios/MRC Advocacy 14 Aug 08 ++]

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> **HAVE YOU HEARD:** Harold was an old Retired Navy Chief Engineman. He was sick and was in the VA hospital. Anyway, there was this one young nurse that just drove him crazy. Every time she came in, she would talk to him like he was a little child. She would say in a patronizing tone of voice, "And how are we doing this morning, or are we ready for our bath, or are we hungry?"

> Harold had had enough of this particular nurse. One day, Harold had received breakfast, and pulled the apple juice off his breakfast tray, and put it on his bed side stand. He had just been given a urine

> bottle to fill for testing. So.....you know where the juice went.

> Well, the nurse came in a little later and picked up the urine bottle. She looks at it. "My, but it seems we are a little cloudy today....." At this, the Chief snatched the bottle out of her hand, pops off the top, and drinks it down, saying, "Well, I'll run it through again, and maybe I can filter it better this time."

> The nurse fainted..... Harold just smiled.....Typical Chief!

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> **VETERAN LEGISLATION STATUS 13 SEP 08:** Refer to the Bulletin's House & Senate attachments for or a listing of Congressional bills of interest to the veteran community that have been introduced in the 110th Congress. 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's content, 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 and subsequent passage into law 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. You can also reach his/her Washington via the Capital Operator direct at (866) 272-6622, (800) 828-0498, or (866) 340-9281 to express your views. 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. Refer to [http://www.thecapitol.net/FAQ/cong\\_schedule.html](http://www.thecapitol.net/FAQ/cong_schedule.html) for future times that you can access your representatives on their home turf. [Source: RAO Bulletin

Attachment 13 Sep 08 ++]

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