

RAO BULLETIN

1 April 2010

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GI BILL UPDATE 74: Having missed its original deadline last summer to streamline claims processing for the Post-9/11 G.I. Bill, the Obama administration is trying to make good by launching new software 1 APR. Veterans Affairs Department data shows the still-new college aid program has improved at getting payments to veterans and universities after its rocky introduction last August. But computerizing the benefits is the only permanent solution to tame the complicated system of tuition and housing funds, according to Roger Baker, the VA's assistant secretary for information and technology. Baker said it was crucial that the Obama administration increased the VA's budget from \$98 billion to \$113 billion in fiscal 2010, because that let the department add more programmers. They came not a moment too soon, in light of criticism leveled during a 18 MAR summit that assessed all VA claims processing for 2010, academic and otherwise. Its organizer, House Veterans' Affairs Chairman Bob Filner (D-CA), described the existing system as an "insult to veterans" and said swift, effective computerization is the only solution. "It looks like we are going backwards rather than forward," Filner said to the summit panel. "No matter how much we raise the budget, no matter how many people we hire, the backlog seems to get bigger."

Baker said much of the confusion last fall resulted from underestimating the "amended awards" benefits system, which determines how much money goes to the student through factors such as length of service and class credits being taken. Since the student gets a housing stipend check and the college gets tuition payments, the software is designed to match benefits with different states' college standards and definitions of tuition. "We've been able to reach the bottom of those amended awards, and that's why they're going to be ready for the next version, but we had to take them out for this upcoming version," Baker said about the cautious optimism surrounding the first version of the software. Some veterans groups, like Student Veterans of America, are pleased with the program's comprehensive coverage -- for those students whose benefits have been processed in full. Last year there was

widespread criticism over claims delays; recently, Paul Sullivan, spokesman for Veterans for Common Sense, also criticized the ongoing implementation of benefits because "education experts should have been consulted" in the drafting of the bill to streamline tuition processing.

The G.I. Bill was met with a deluge of claims when it debuted, and a backlog remains for some students and universities, said Sen. Jim Webb (D-VA) who authored the 2008 law. "The backlog for veterans' benefits was 600,000 even before the G.I. Bill," Webb said. "If they could do it for 7.8 million people after World War II before the age of computers, one would expect they could do it for these people." Numbers from the Veterans Affairs Department show some evidence benefits processing has gained steam. In January, approximately \$237 million was paid to veterans for education claims, as opposed to approximately \$58 million in September, during the second month of the program. But while fewer than 12,000 accepted benefits claims for the spring semester have not been processed, approximately 58,000 of the approximately 435,000 applications have been rejected since the bill took effect for unspecified reasons. Acting Under Secretary for Benefits Michael Walcoff, who started in the Veterans Benefits Administration during the Bush administration, said his group is paying close attention to avoid the mistakes of the fall semester. "Whatever the law is I think veterans have a right to expect that we're going to do whatever is necessary for them to get their benefits," Walcoff said. "And the fact that we had a problem in the fall, I'm not going to say it's because the bill is so complex, I can't do that. I'm not going to blame that on anybody but us."

Eric Hilleman, director of Veterans of Foreign Wars' legislative service, credits Veterans Affairs Secretary Eric Shinseki with generating momentum to work through the bill's complications when he came into office. Shinseki distributed \$3,000 emergency loans in October to veterans whose claims had not been processed. "Asking the VA to administer a benefit more complicated than existing processes was a tough challenge," Hilleman said. The Veterans Benefits Administration "has not had a sound track record with software programs." With those advance checks due to begin recouping on 15 APR, the 1 APR deadline is all the more urgent. Although Space and Naval Warfare Systems Command failed to meet its AUG 09 deadline to complete the GI Bill benefits software, Baker was confident that "pre-existing relationship" will help complete the final version of the claims processing software by December as a "long-term solution." The VBA is so focused on meeting that computerizations deadline that its director of education services, Keith Wilson, spoke before the House Veterans' Affairs Committee on 25 FEB, advising against "significant changes to the Post-9/11 GI Bill" before December. To meet these demands for efficiency, Baker said they are taking a more step-by-step approach to release the software by sticking to milestones and prioritizing completion of simpler goals, like processing backlogged claims, before completing new ones to stay productive. "We're going to run real claims through it by real claims examiners and make sure we have what we're looking for," Baker said. [Source: National Journal Tom Risen article 29 Mar 2010 ++]

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MILITARY BENEFIT UPGRADES Update 02: A key lawmaker warned groups pressing for increases in military benefits that tight budgets will force a choice between devoting a little money to several things or a lot of money to one dramatic improvement. The caution from Rep. Susan Davis (D-CA), chairwoman of the House Armed Services Committee's military personnel panel, came 23 MAR after a congressional budget expert outlined the difficulty lawmakers will face in finding money for improvements in benefits. The wish list from the Military Coalition, a group of more than 30 military-related organizations, includes improving National Guard and reserve retirement benefits, allowing concurrent receipt of retired pay and disability compensation to all those eligible for both benefits, and an end to the offset in military survivor benefits for those who also receive dependency and indemnity compensation from the Veterans Affairs Department. Davis said the Armed Services Committee is hunting for a way to raise money for such items but warned it is unlikely there will be enough for all

of them. She asked the groups whether they prefer to see modest gains in several areas or all available funds spent on one issue.

Association representatives at the hearing said they were not ready to make that choice, but were ready to compromise if needed. “I am confident we could get a consensus,” said Steve Strobbridge of the Military Officers Association of America, one of the groups in the coalition. Davis raised the funding issue after Sarah Jennings, an analyst in the nonpartisan Congressional Budget Office, explained that paying for increases in retired pay and survivor benefits is more complicated than just finding room in the budget for additional spending by cutting things like ships or aircraft. Jennings said the committee can try to cut spending on similar programs from within the defense budget, but reducing benefits for some people to pay for benefits for others is not something Davis seemed willing to consider. New benefits could be paid for by raising taxes, but tax hikes fall under the House Ways and Means Committee, which would have to consent to help. Defense-owned assets also could be sold, although Jennings said this often does not raise much money. In 2008, Congress ordered the sale of some of the military’s stockpile of cobalt, but this produced just \$10 million, not enough to cover the \$6 billion needed to eliminate the offset in survivor benefits; the \$4.5 billion to fully fund concurrent receipt for all disabled retirees; or the \$1 billion to make retroactive a 2008 change that gives credit toward earlier retirement checks for reservists mobilized for 90 days or longer since Sept. 11, 2001. [Source: NavyTimes rick Maze article 29 MAR 2010 ++]

TRICARE USER FEE Update 46: Tricare beneficiaries will not be asked to accept fee increases in their military health care benefits unless lawmakers believe the Defense Department has exhausted all other cost-cutting measures, said a key senator whose support the Pentagon will need if increases in fees, co-payments and deductibles are ever to become law. Sen. Lindsey Graham (R-SC), senior Republican on the Senate Armed Services Committee’s military personnel panel, said 24 MAR that he believes Tricare fees — unchanged since 1995 — probably need to increase as part of an effort to control health care costs. “I do not see how we can do this forever,” Graham said of the longstanding freeze on Tricare fees. At the same time, Graham said, increases cannot be made lightly. “I want to be fair to those who served,” Graham said. The 2011 defense budget does not ask for increases in Tricare fees, but Defense Secretary Robert Gates has warned lawmakers that rising costs threaten to squeeze funding for other defense programs such as weapons modernization.

Dr. Charles Rice, the Defense Department’s top medical officer, said military health care officials are trying to cut expenses. “We constantly strive to make the system more efficient,” he said. Rice said the 2011 plan includes some initiatives that try to control costs, such as capping retail pharmaceutical costs, trimming management costs for supplies, increasing efforts to identify fraud and overpayments to civilian medical providers and rolling out a new payment system that reduces reimbursements to private-sector medical facilities for outpatient visits. Even with those changes, the 2011 budget includes a \$1.2 billion increase just for the private-sector aspects of the Tricare system that result from more people being enrolled and using their benefits, Rice said. The overall military medical budget has soared from \$19 billion in 2001 to a proposed \$50.7 billion in the 2011 budget plan, Rice said. The Senate hearing came one day after the Military Coalition, a group of more than 30 military-related organizations, asked for help from Congress not just in capping Tricare enrollment fees, deductibles and co-payments, but also in preventing an increase in the charge for outpatient hospital care. [Source: NavyTimes rick Maze article 24 Mar 2010 ++]

MEDICARE REIMBURSEMENT RATES 2010 Update 08: The House passed legislation (H.R.4851) to delay until 1 MAY the 21% cut in Medicare and TRICARE payments to doctors now

scheduled for 1 APR and forwarded the bill to the Senate. The intent was to allow more time for Congress (which went on a two-week recess 26 Mar) to work out a longer-term fix. But a Senate effort to approve the bill quickly by a "unanimous consent" procedure hit a snag when Sen. Tom Coburn (R-OK) refused to consent. Under Senate rules, any senator can object to bringing a bill to the floor for action. Coburn objected on the grounds that the cost of the bill is not offset by other spending reductions. Senate leaders could not work out an agreement on 26 MAR, the last day before their scheduled two week Easter recess. Thus, the 21% cut will take effect prior to their return on 12 APR. Ironically, the Senate already passed a six month fix two weeks ago (H.R.4213), but the House didn't agree with the funding for the bill and in turn passed only a one-month fix.

Failure to reach an agreement on an extension on the eve of the congressional two-week Easter recess could prove detrimental to TRICARE and Medicare beneficiaries even if Congress applies a retroactive solution when they return in mid-April. Doctors have become weary of the increasing number of short-term patches applied by Congress rather than a long-term solution. Some are already limiting the number of patients who use these programs. For military retirees the end result could be decreased access, reduced quality, or higher costs to them and their families for the benefits earned in career service. Congress has to find a way to end these monthly crises under which tens of millions of Medicare and TRICARE beneficiaries are held hostage to the prospect of devastating payment cuts that will cause their doctors to stop seeing them. [Source: MOAA Leg Up 26 Mar 2010 + +]

Hearing Shut Down

VA HOMELESS VETS Update 15: U.S. Senator Daniel K. Akaka (D-HI), Chairman of the Veterans' Affairs Committee, held a hearing 24 MAR on VA's plan to end veteran homelessness in the next five years. It is estimated that over 100,000 veterans are homeless in the United States on any given night. The hearing ended abruptly at 11 a.m. after opponents of health insurance reform objected to allowing most committee hearings, including the Veterans' Affairs hearing, to continue. Senate rules require unanimous consent on the Senate floor for committees to meet two hours after the Senate convenes. Objections to the routine procedure are extremely rare. "The Senate should be a place for debate, but I cannot imagine how shutting down a hearing on helping homeless veterans has any part of the debate on the health insurance reform. I am deeply disappointed that my colleagues chose to hinder our common work to help end veteran homelessness," said Akaka.

The hearing included witnesses from the Departments of Veterans Affairs, Labor, and Housing and Urban Development, as well as community providers who help homeless veterans, and a veteran in transitional housing. Chairman Akaka was forced to gavel the hearing to an end in the middle of testimony from witness Dr. Sam Tsemberis from Pathways to Housing, a service provider with hands-on experience helping homeless veterans, particularly those with psychiatric disabilities and addiction disorders. "With a growing commitment from Congress, the federal government, and community providers, we are on track to end veteran homelessness in five years. We must stay focused and work together to accomplish this important and ambitious goal," said Akaka. For more information on the hearing, witness testimony and webcast, refer to veterans.senate.gov. [Source: Sen. Akaka Press release 24 Mar 2010 ++]

VA SPINA BIFIDA PROGRAM: The Department of Veterans Affairs (VA) provides monetary allowances, vocational training and rehabilitation and VA-financed health care benefits to certain Korea and Vietnam Veterans' birth children who have been diagnosed with spina bifida. For the purpose of this program, spina bifida is defined as all forms or manifestations of spina bifida (except spina bifida occulta). Effective 10 OCT 08,

there was a change to Public Law 110-387, Section 408, which outlines the benefits available under the Spina Bifida Program. As a result of this change, medical services and supplies for spina bifida beneficiaries are no longer limited to the spina bifida condition. This program now covers comprehensive health care considered medically necessary and appropriate. The VA's Health Administration Center in Denver, Colorado, manages the Spina Bifida Health Care Program, including the authorization of benefits and the subsequent processing and payment of claims. At their Hotline number 1(888) 820-1756 Vietnam veterans can get their questions answered about health care benefits for their children who have spina bifida. Callers can speak to a benefits adviser M-F, 1000 to 1330 and 1430 to 1630 EST.

If you are the birth child of a Vietnam veteran and you have been diagnosed with spina bifida you may already be receiving monetary allowances, vocational training or rehabilitation due to your condition. However, you might also be entitled to VA-financed healthcare benefits. To be qualified you must be diagnosed with spina bifida as the VA defines it, basically, as all forms or manifestations of spina bifida (except spina bifida occulta), including complications or associated medical conditions related to spina bifida. Healthcare benefits you would receive under this program are limited to those necessary for the treatment of your spina bifida and related medical conditions. You should however, be aware that this program is not a comprehensive healthcare plan and does not cover medical services unrelated to spina bifida. In general, the program covers most healthcare services and supplies that are medically or psychologically necessary for the treatment of conditions related to spina bifida. While some services require specific advance approval or preauthorization, the following services are specifically excluded from coverage

- Care unrelated to spina bifida.
- Care as part of a grant study or research program.
- Care considered experimental or investigational.
- Drugs not approved by the U.S. Food and Drug Administration for commercial marketing.
- Services, procedures or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair.
- Services provided outside the scope of the provider's license or certification.
- Services rendered by providers suspended or sanctioned by a federal agency

While administration of the program is centralized to VA's Health Administration Center (HAC) in Denver, Colorado, applications must first be made through the Denver VA regional office. Contact the Denver regional office by calling 1 (888) 820-1756. Once the Denver VA regional office determines eligibility, spina bifida awardees (or guardians) are automatically contacted by the Health Administration Center and registered for healthcare benefits. Beneficiaries receive detailed program material from HAC specifically addressing covered and noncovered services and supplies, preauthorization requirements, and claim filing instructions. Once registered, the HAC assumes responsibility for all aspects of the spina bifida healthcare program, including the authorization of benefits and the subsequent processing and payment of claims. Providers should use a standard billing form (UB-04, CMS 1500) to provide the required information. Beneficiaries who are filing claims for reimbursement of out-of-pocket expenses should use the HAC supplied form, Claim for Miscellaneous Expenses (10-7959e) which can be downloaded at http://www4.va.gov/vaforms/medical/pdf/vha-10-7959e-fill_110308.pdf. Mail claims for payment to: VA Health Administration Center, PO Box 469065, Denver CO 80246-9065. [Source: <http://www4.va.gov/hac/forbeneficiaries/spina/spina.asp> Mar 2010 ++]

VA SPINA BIFADA PROGRAM Update 01: On 26 MAR the Senate unanimously passed S.3162, a bill to clarify that the health care VA provides to children with spina bifida born to veterans of the Vietnam War and to some veterans who served in Korea during specified times, as well as to children of women

Vietnam veterans with certain birth defects, meets the standard of minimum health care coverage required by the Patient Protection and Affordable Care Act. "This legislation will put to rest any question: veterans' dependents receiving VA health care meet the new health insurance reform law's minimum health care coverage standard," said the author of the bill Senate Veterans' Affairs Committee Chairman Daniel K. Akaka (D-HI). This unanimously approved legislation garnered 59 cosponsors during its two days on the floor, before passing the Senate this afternoon. The bill now moves to the House of Representatives. Under the Patient Protection and Affordable Care Act, individuals must hold a minimum level of health care coverage. Senator Akaka's bill would simply clarify that care provided by VA to certain dependents with spina bifida and other birth defects as well as to other dependents under the CHAMPVA program satisfies that requirement. To view the text of the bill and read Senator Akaka's introduction in the Congressional Record, refer to

http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2010_record&page=S2026&position=all. [Source: Sen. Akaka Press release 26 Mar 2010 ++]

VA CLAIM ERROR RATE Update 03: On 24 MAR the House Veterans' Affairs Committee's Subcommittee on Disability and Memorial Affairs held a hearing on the Veteran Benefits Administration's (VBA) tool for assessing the quality of decisions VA makes in claims for benefits. Quality is determined under a protocol called the Systematic Technical Accuracy Review Program (STAR), used since OCT 98 to measure the accuracy of claims processing. Subcommittee Chairman, John Hall (D-NY) noted that VBA has set a goal of completing all compensation claims without error 90% of the time. VA reports a national error rate in disability claims of 17%. (Individual offices error rates range from 8% in Des Moines to 31% in Baltimore). VA Office of Inspector General and GAO (MAR 09) reports revealed several problems that hinder the efficiency and accuracy of the STAR system. They also found gaps in the STAR program that show VA may be underreporting errors by as much as 10%. VA has slowly made some changes to the STAR program but quality remains poor with little likelihood of improvement in the near future. [Source: VFW Washington Weekly 26 MAR 2010 ++]

HASC Update 05: The House Armed Services Military Personnel Subcommittee held a 24 MAR hearing specifically to get inputs from beneficiary advocates on issues affecting active duty, Guard/Reserve, retired members, families and survivors. At the hearing a panel of Military Coalition (TMC) witnesses was called on to testify and answer their questions. Among many other inputs, the Coalition witnesses particularly urged the Subcommittee to:

- Provide at least a modest increase above the 1.4% pay raise proposed by the Pentagon, in the belief that troops being asked to endure more sacrifice than at any time in the last 50 years shouldn't be provided the lowest pay raise in almost 50 years.
- Authorize Reserve Retirement-age credit for all active service rendered since Sept. 11, 2001. Under current law, only service since Jan. 28, 2008 is allowed, which denies credit for hundreds of thousands of combat tours.
- Approve the Administration's proposal to authorize concurrent receipt for all medically retired servicemembers, with the continuing goal of ending the unfair disability offset for all disabled retirees.
- End deduction of VA survivor benefits from Survivor Benefit Plan (SBP) annuities for survivors of members whose deaths were caused by service

MOAA Director of Government Relations Col Steve Strobridge (USAF-Ret), addressing health care issues, urged statutory protection against an expected \$110-per-day increase in the TRICARE Standard inpatient deductible

due in October and clearer recognition in the law that military people pay large up-front premiums of service and sacrifice over and above the cash fees they pay in retirement. He also expressed concern that seamless transition oversight has been hampered as senior DoD and VA positions have remained vacant for more than a year, that more needs to be done to help caregivers for wounded warriors, and that "many who suffer the after-effects of combat continue being barred from reenlistment or separated for other reasons because service disciplinary and administrative systems are less flexible and resilient than we ask our troops to be."

Two Gold Star Wives representatives, Mrs. Suzanne Stark and Mrs. Margaret McCloud, provided particularly compelling testimony on the SBP-DIC issue. Stark told the committee, "An 85-year-old widow shouldn't have to start dating and remarry to have SBP restored,". McCloud added, "It's discouraging to hear, year after year, 'We support you in principle, but just can't find the money'," A witness from the Congressional Budget Office outlined the limitations the Armed Services Committee has in proposing funding for any retirement or survivor benefit changes, explaining that, under normal congressional rules, the Committee would have to find offsetting reductions in spending on retirement, survivor, or TRICARE For Life. But Rep. Joe Wilson (R-NC) observed, "When House leadership deems it a priority, rules can be set aside." Subcommittee Chair Susan Davis (D-CA) asked how the Coalition witnesses would prioritize needs if the Subcommittee managed to identify some specific amount of qualifying offsets. Strobridge said that the Coalition associations would have to confer, but that when such circumstances have arisen in the past, the Coalition has worked successfully with the Subcommittee to craft an appropriate package of improvements. [Source: MOAA Leg Up 26 Mar 2010 ++]

HYPERTENSION Update 02: High blood pressure, also known as hypertension, is a serious disease that is often neglected by patients and their caregivers, according to a report from the Institute of Medicine (IOM). In a Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension, the IOM reports:

- Many Americans have undiagnosed high blood pressure.
- High blood pressure is the second leading cause of death in the U.S.
- Physicians tend to overlook mild to moderate high blood pressure, and high blood pressure in older adults, and they don't always recommend treatment programs for people with high blood pressure.
- Even though high blood pressure is easy to diagnose and treat, unchecked high blood pressure causes more than one-third of heart attacks and almost half of heart failures in the United States each year.
- People know it's important to have their blood pressure checked, but don't take the necessary steps to control high blood pressure when it's diagnosed.

What's the answer? Learn about high blood pressure, have your blood pressure checked regularly, and follow your doctor's program for reducing high blood pressure. The IOM recommends these lifestyle changes to help reduce high blood pressure: Watch your weight, reduce your salt intake, get more exercise, and eat a healthy, potassium-rich diet. Foods rich in potassium are raisins, prunes, apricots, dates, strawberries, bananas, watermelon, cantaloupe, citrus fruits, beets, greens, spinach, tomatoes, mushrooms, soy products, veggie burgers, peas, beans, turkey, fish, beef, salmon, and cod. Hyperkalemia is a condition where there is too much potassium in the blood. Usually this is due to an underlying medical condition such as a kidney disease or diabetes. Doctors want to keep an eye on elevated potassium levels because very high levels can be damaging to your heart. [Source: About.com: Senior Living Apr 2010 ++]

VETERAN SERVICE ORGANIZATIONS: Veteran service organizations (VSOs) are designed for the benefit of the veteran and community. Most areas of the country have a local American Legion, Disabled American Veterans, or Veterans of Foreign Wars post/chapter. There are many more service organizations, such as the Marine Corps League, Viet Nam Veterans of America, Non-Commissioned Officers Association, Military Order of the Purple Heart, Fleet Reserve Association and others geared to particular groups of veterans. Each organization has its own individual requirements for membership, of which some are more stringent than others. The requirements range from honorable service during any time period to service in a combat zone to requiring a service-connected disability. These VSOs welcome any eligible member, regardless of age, race, religion or gender. Many of these organizations host auxiliaries so that spouses and other family members can also participate. These organizations provide countless hours of local community service. You'll see veterans proudly marching with our nation's flag at the forefront of parades or donating time and money to local causes. The firing squad and the person who presents the flag at a military funeral are members of veteran service organizations. Sometimes it's as simple as going to the VA hospital to play cards or bingo with the patients. Although they are all separate organizations, there is commonality in their goals:

- They are a voice for returning and currently deployed service members and their families;
- They monitor and lobby for legislation that directly impacts our veteran community;
- They help to develop the next generation of patriots through character-enhancing programs. VSOs sponsor Boy Scout troops, Badger Boy's State, Legion Baseball, scholarships and the annual oratorical contests.

Virtually all of our veteran's legislation has been driven by these VSOs or the combined efforts of 36 of them through the military coalition (TMC). The United States wouldn't have the GI Bill if not for them. Each of these groups has service officers who assist and advocate for veterans in filing claims for service-connected disabilities and negotiating the ways of the Veterans Administration. VSOs are responsible for getting post-traumatic stress disorder and the Agent Orange related diseases, among others, recognized by the Veterans Administration. VSOs are at the forefront of public policy related to national defense, services for homeless veterans, adequate funding for the Department of Veterans Affairs, concurrent receipt of retirement pay and disability compensation by disabled military retirees, veterans employment and training, POW/MIA accountability and flag protection. What can you do for them? Simply put, join one and participate. Contribute your time, energy, and assets. Take advantage of the camaraderie unique to military veterans. Help out at a fundraiser. There is strength in numbers. When the National Commanders go to Congress to lobby for veteran-friendly legislation, numbers count. Large organizations have clout. Nationwide, memberships in veteran service organizations are down. In order for these organizations to be around when you need them, they must be self-perpetuating. Joining one is something to consider the next time you are concerned about a veteran related issue. They are a voice for all of us. [Source: Jackson County WI Service Officer Randy Bjerke article 24 Mar 2010 ++]

ILLINOIS VETERANS HOMES Update 02: Gov. Pat Quinn is proposing a plan that would increase the cost of staying in Illinois' four nursing homes for veterans by as much as 45%. Quinn has asked lawmakers to approve a \$400 per month increase in the maintenance fee for veterans' home residents. The plan is designed to bring in about \$3.5 million to help operate the state nursing homes in Anna, LaSalle, Manteno and Quincy. A spokeswoman for the Illinois Department of Veterans' Affairs says the current \$929 per resident monthly maintenance fee hasn't been increased since 1979. Spokeswoman Sabrina Miller says, if approved by lawmakers, the increase would go into effect 1 JUL. Department of Veterans' Affairs Director Dan Grant says the proposed \$1,329 rate will cover less than 17% of the actual cost of caring for the estimated 1,000 veterans who live at the four homes. [Source: Salem IL WJBD.com Radio AP article 24 MAR 2010 ++]

AO CAF GAGETOWN NB USE: The Canadian federal government and two chemical companies went to court 23 SEP 09 in a bid to stop a class-action lawsuit launched by people who claim they developed cancer after being exposed to Agent Orange at Canadian Forces Base Gagetown in New Brunswick. The suit, brought by more than 1,700 people from across the country as well as 35 from the province, was certified in the Supreme Court of Newfoundland and Labrador trial division. Lawyers representing federal Attorney General Rob Nicholson, Minister of National Defence Peter Mackay, the Dow Chemical Company and the Pharmacia Corp. argued in the St. John's courtroom to have the certification order overturned. The plaintiffs say they have been diagnosed with cancers including leukemia, Hodgkin's disease and non-Hodgkin's lymphoma because of their exposure to Agent Orange at Gagetown between 1956 and 2004. "All the time I was at Gagetown was out in the field training — you're sleeping on the ground, you are eating your hard rations ... you're eating with your hands, so basically you're ingesting it," said retired soldier John Mallard, who is convinced his cancer stemmed from exposure to the herbicide at Gagetown. "You're sleeping in it, you're burning bush to keep warm, so you're inhaling it." Retired brigadier-general Ed Ring, a Newfoundlander and another of the plaintiffs, was outraged by the bid to stop the suit.

Ring, of St. John's is a member of a class-action suit claiming exposure to Agent Orange left him with cancer. (CBC) "I am appalled that we have large organizations like the federal government and these chemical companies trying to deny us the opportunity to even have our case heard in court," he said. The federal government and the companies maintain Agent Orange — a herbicide developed in the United States for use in the Vietnam War — was only one of 23 chemicals sprayed on the base, so there is no way to determine who was exposed to which chemical and for how long. They also say there's not enough common ground among the ailments suffered by the plaintiffs to justify a class-action suit. In SEP 07 the federal government announced a \$96-million compensation package for people exposed to the herbicide at Gagetown — a \$20,000 payout to anyone who qualified for it. Members of the class-action suit refused to accept the settlement. [Source: CBC.com News 23 Sep 09 ++]

AO CAF GAGETOWN NB USE Update 01: A Framingham MA service officer for the American Legion veteran says many Massachusetts National Guard soldiers - and others from New England - may have been exposed to dangerous levels of Agent Orange defoliant if they trained at a military base in New Brunswick. Richard Pelletier says the Canadian and American governments are responsible for spraying toxic defoliants Agents Orange, White and Purple over Canadian Forces Base Gagetown, New Brunswick, and possibly exposing guardsmen and Reservists from Massachusetts, Maine, Rhode Island, New Hampshire and Vermont to the toxins. Pelletier is a former Marine and member of the National Guard. He said he caught a Canadian newscast one night in 2005 revealing Canada's use of Agents Orange, White and Purple from 1956 to 1984 over the camp in Gagetown. The newscast revealed the U.S. had also sprayed 439 liters of Agent Orange from airplanes over about 80 acres over a period of seven days sometime in 1966 and 1967. The morning after the newscast, Pelletier notified the American Legion and other veteran service agencies. Then he reached out to U.S. senators Susan Collins and Olympia Snowe, both Maine Republicans, and U.S. Reps. Michael Michaud and Tom Allen, two Maine Democrats.

On 2 MAR 06, Maine National Guard Adjutant Maj. Gen. John W. Libby and Director of Maine's Veteran's Services Peter W. Ogden issued an update on the use of Agent Orange and Purple in Gagetown which said, "In June of 2005, the Canadian Department of National Defense (DND) announced that for three days in June 1966 (14-16) and four days in June 1967 (21-24), testing of various defoliants, including Agent Orange and Agent Purple, took place over a limited portion of the Canadian Force Base (CFB) Gagetown, New Brunswick". The report also said the Maine National Guard began training there in 1971 and invited veterans who were on the base between 1966 and 1967 to register for an Agent Orange examination. A few weeks later, Pelletier was issued an award from Maine state officials recognizing him for bringing the Gagetown issue to their attention. He said claims from Maine

veterans began pouring into the Legion office, which were sent down to the Board of Veterans Appeals in Washington, D.C. Five years later and still without any new developments, Pelletier has only grown agitated. "I've been waiting on the congressional delegation to do their job, but they didn't. They failed. It's time to get the word out there", he said.

Since 2006, he and his supervisor Robert Owen, Department Service Officer for the Legion in Maine, have been working to raise awareness on the issue. "What we're trying to do is get those people who did go to Gagetown to file a claim if they have one of the presumptive disabilities", Owen said. "The sad part is a great many of them have passed on. They may have widows out there, and if we can swing it, they can get compensation." Although Maine officials only invited veterans who served or trained in Gagetown in 1966-67 to register, Pelletier wants anyone who served and might be suffering from the effects of Agent Orange to file a VA claim with the American Legion. Conditions related to Agent Orange include prostate cancer, Hodgkin's disease, respiratory cancers and Parkinson's disease, among others. As a member of the Maine National Guard, Pelletier trained in Gagetown for two weeks in 1981, but says he has not developed any chemical-related illnesses. However, since the Canadian government gave \$20,000 through an ex gratia - a non-obligatory - payment to a number of their exposed military personnel they are admitting that yes, there is a problem, and yes, these chemicals caused disease and sickness. A Canadian Department of Defence document titled "Overview of Herbicide Spray Programme 1956-1984" acquired in 2005 through the Freedom to Information Act shows over one billion grams of the three chemical agents were sprayed over the Gagetown base.

Contacted at the Massachusetts National Guard in Milford, Lt. Col. John McKenna said he didn't know when the state started sending troops to Gagetown, but said, "Elements of the 26th Yankee Division used to train in Gagetown, but the last time we have a record of anyone from Massachusetts training there is in 1988." While Pelletier tries to find out which units trained in Gagetown and when, he is calling on elected officials throughout New England to investigate. Newly elected U.S. Sen. Scott Brown (R-MA) said he's willing to review the matter. Brown, a longtime member of the Mass. National Guard, said he, personally had not trained at the New Brunswick site. "I know that we trained in Gagetown, but I don't have any knowledge of this particular claim," Brown said. "I look forward to getting (the information) and seeing what I can do to answer his questions." Pelletier is asking that any widow or veteran who served in Gagetown and has symptoms of conditions related to Agent Orange contact the American Legion Boston Headquarters at (617) 727-2966 and file a claim. If any sick veteran or widow needs help filing the claim, he can be contacted at mrpelletier@rcn.com for assistance. [Source: The MetroWest Daily News Ashley Studley article 10 Feb 2010 ++]

REIKI: Reiki is a spiritual practice developed in 1922 by Japanese Buddhist Mikao Usui that uses a technique commonly called palm healing as a form of complementary and alternative medicine. Through the use of this technique practitioners believe that they are transferring "healing energy" in the form of qi through the palms. Reiki is being offered by a growing number of nurses, chaplains and other staffers at New York's Crouse, Upstate University and the VA Medical Center in Syracuse. About 15% of hospitals nationwide (including the Cleveland Clinic, Children's Hospital in Boston and Johns Hopkins Hospital in Baltimore) provide Reiki. During a treatment, a practitioner puts his or her hands on, or just above, several parts of a fully-clothed patient's body. "That energy is going through me to the patient," said Joyce Appel, a registered nurse and Reiki practitioner at Crouse. "I know it sounds strange." There's no conclusive scientific evidence Reiki works. But Reiki proponents point to anecdotal evidence that suggests it eases stress, relieves pain, and can improve a person's overall sense of well-being. The National Center for Complementary and Alternative Medicine, a division of the National Institutes of Health, says Reiki appears to be generally safe and no serious side effects have been reported. It also says more than 2.2 million U.S. adults have used it.

Among Reiki's fans are cardiac surgeon and TV show host Dr. Mehmet Oz, who recently urged viewers to try it. "This alternative medicine treatment can manipulate your energy and cure what ails you," he said on his program. Critics, including the U.S. Conference of Catholic Bishops, say Reiki is bunk. The bishops issued guidelines last year saying Catholic hospitals and other facilities should not offer it. " ... a Catholic who puts his or her trust in Reiki would be operating in the realm of superstition, the no-man's-land that is neither faith nor science," the bishops said in a statement. St. Joseph's Hospital Health Care Center in Syracuse, a Catholic hospital, used to offer Reiki in its palliative care unit for dying patients. It stopped providing it after an employee trained in Reiki left the hospital, according to Denise Robertson, a hospital spokeswoman. The discontinuation of Reiki was unrelated to the bishops' statement, she said. Local hospitals say they don't use Reiki as a substitute for conventional medical treatments, but offer it as a complementary service. Health insurance does not pay for Reiki so Crouse and Upstate offer it free. The VA provides Reiki to some patients in its pain clinic and includes it as part of a regular exam.

Dr. Scott Treatman, Crouse's director of employee health, said Crouse's patient surveys suggest Reiki helps patients. Crouse surveyed 390 patients who received Reiki between JAN 08 and DEC 09. Patients were asked to rank their stress levels before and after treatments on a scale of 0 to 5, with 0 being no stress and 5 being high stress. They also ranked their pain before and after treatments. The average patient's stress score was 2.77 before Reiki and .97 after Reiki. The average patient's pain score was .99 before Reiki and .78 after. "The evidence, although it's not in peer-reviewed journals, speaks for itself," Treatman said. "We're not only in the business of yanking out gallbladders, but also making the patients' experience here more comfortable." Nancy J. Barnum, a nurse practitioner in the VA's pain clinic said learning how to relax is a key strategy for chronic pain patients. Medication, behavioral therapy and other relaxation techniques don't work for some patients. For those people, alternatives like Reiki are sometimes more helpful. "If you can help someone to manage their stress level and induce more of a relaxation response, the pain becomes more bearable," Barnum said. Reiki, long available in the community from private practitioners and through some medical practices, is gaining more traction in hospitals.

A few nurses began offering Reiki at Crouse seven years ago. As patient interest in the alternative therapy increased the hospital formalized the program. "Administration said, 'If patients are benefiting from it, why would we not do it,'" said Bob Allen, a Crouse vice president. Joyce Appel, an experienced Reiki teacher, or Reiki Master, coordinates the Reiki program at Crouse. She and 16 other Crouse employees trained in Reiki offer it on their own time to maternity, cancer and chemical dependency patients. The hospital hopes to expand the program so it can make the therapy available to even more patients. Upstate Medical University has trained about 30 staff members to offer Reiki to patients. There is no formal regulation of training and certification of Reiki practitioners. That has created a credibility problem for Reiki, according to Pamela Miles, a Reiki Master and author from New York City. "Practitioners are all over the board, literally from people clicking on a Web site and considering themselves to be Reiki Masters to people who've gone through many years of training," Miles said. "It's really a buyer beware market." She recommends consumers ask practitioners if they have been trained in person by a Reiki Master. Miles also said consumers should ask practitioners about their clinical experience, their fees and -- most importantly -- whether the provider practices Reiki-self treatment every day. [Source: Syracuse The Post-Standard James T. Mulder article 23 Mar 2010 ++]

MOBILIZED RESERVE 23 MAR 2010: The Department of Defense announced the current number of reservists on active duty as of 23 MAR 2010. The net collective result is 508 fewer reservists mobilized than last reported in the 15 MAR 09 Bulletin. At any given time, services may activate some units and individuals while deactivating others, making it possible for these figures to either increase or decrease. The total number currently on active duty from the Army National Guard and Army Reserve is 108,456; Navy Reserve, 6,153; Air

National Guard and Air Force Reserve, 15,895; Marine Corps Reserve, 6,453; and the Coast Guard Reserve, 752. This brings the total National Guard and Reserve personnel who have been activated to 137,709, including both units and individual augmentees. A cumulative roster of all National Guard and Reserve personnel who are currently activated may be found at <http://www.defense.gov/news/d20100323ngr.pdf>. [Source: DoD News Release No.230-10 dtd 24 Mar 2010 ++]

BRAC Update 22: Some military installations are consolidating and getting new names as joint basing becomes a reality. The 2005 Base Realignment and Closure (BRAC) Commission's directive to consolidate 26 stateside military installations into 12 joint bases has brought names such as Lewis-McChord, Langley-Eustis, and even the trilateral McGuire-Dix-Lakehurst into the lexicon of military installations. Settling on new names was but a fraction of considerations undertaken in the four-year joint-basing process, which produced 12 agreements that range from 600 to 1,000 pages and cover everything from billeting to signage to services, said Air Force Col. Michael "Mickey" Addison, the Defense Department's deputy director of joint basing. While each joint base has its own unique challenges and experiences, Addison said, the process created much-needed uniformity in directing 49 like functions for each base. "The Department of Defense now has common output level standards," he said. The 12 new base names which became effective in the last six months are:

- Fort Lewis and McChord Air Force Base became **Joint Base Lewis-McChord**, led by the Army;
- The Navy's Anacostia Annex and Bolling Air Force Base here became Joint Base Anacostia-Bolling, led by the Navy;
- Naval Station Pearl Harbor and Hickam Air Force Base, Hawaii, became **Joint Base Pearl Harbor-Hickam**, led by the Navy;
- Charleston Air Force Base and Naval Weapons Station Charleston, S.C., became **Joint Base Charleston**, led by the Air Force;
- Elmendorf Air Force Base and Fort Richardson, Alaska, became **Joint Base Elmendorf-Richardson**, led by the Air Force;
- Lackland and Randolph Air Force bases and Fort Sam Houston, Texas, became **Joint Base San Antonio**, led by the Air Force;
- Langley Air Force Base and Fort Eustis in Virginia became **Joint Base Langley-Eustis**, led by the Air Force.
- Naval Amphibious Base Little Creek and Fort Story in Virginia became **Joint Expeditionary Base Little Creek-Fort Story**, led by the Navy;
- Fort Myer and the Marine Corps' Henderson Hall in Virginia became **Joint Base Myer-Henderson Hall**, led by the Army;
- Andrews Air Force Base and Naval Air Facility Washington, in Maryland, became **Joint Base Andrews**, led by the Air Force;
- McGuire Air Force Base, Fort Dix and Naval Air Engineering Station Lakehurst, all in New Jersey, became **Joint Base McGuire-Dix-Lakehurst**, led by the Air Force;
- Navy Base Guam and Andersen Air Force Base in Guam became **Joint Region Marianas**, led by the Navy.

[Source: AFPS Lisa Daniel article 24 Mar 2010 ++]

VA PROSTATE CANCER PROGRAM Update 05: The Nuclear Regulatory Commission on 17 MAR announced its second-largest fine ever against a medical institution (\$227,500) after finding that the veterans hospital in Philadelphia had caused an “unprecedented number” of radiation errors in treating prostate cancer patients. N.R.C. fines for medical errors involving radiation rarely exceed several thousand dollars. But commission officials said the size of the fine was justified by the magnitude of the failure at the hospital. Federal investigators said the hospital made significant errors, misplacing radioactive seeds, in 97 of 116 procedures involving patients with prostate cancer from 2002 to 2008. “The lack of management oversight, the lack of safety culture to ensure patients are treated safely, the potential consequences to the veterans who came to this facility and the sheer number of medical events show the gravity of these violations,” said Mark Satorius, a regional administrator for the commission, which regulates the use of nuclear isotopes in medical treatment. Richard Citron, director of the Philadelphia Veterans Affairs Medical Center, acknowledged that there had been shortcomings in its oversight when the mistakes occurred. But he added, “The fact remains that our V.A. staff self-discovered these potential dosing issues almost two years ago, closed the program, self-reported to the N.R.C., cooperated fully with multiple investigations and have been transparent throughout the entire process.”

The fine was levied against the hospital’s parent agency, the Department of Veterans Affairs. According to the commission, the veterans agency has been reluctant to acknowledge all the errors. While it initially concurred with the commission’s findings, it has since changed its position, disputing both the nuclear agency’s definition of a medical error and the number of mistakes at the Philadelphia hospital, said Viktoria Mitlyng, a spokeswoman for the commission. “They thought they could retract the events,” but they cannot, she said. However, the Department of Veterans Affairs can still challenge the proposed fine. The regulatory commission’s largest fine against a medical provider was 15 years ago and totaled \$280,000. That case also involved radiation errors. The full scope of the problems at the Philadelphia hospital was first reported in June by The New York Times. They found that one radiation oncologist, Dr. Gary D. Kao, had been responsible for the great majority of the mistakes. Dr. Kao no longer works at the hospital. “V.A. officials can’t comment on specific actions taken against specific people,” Katie Roberts, a spokeswoman for the department, said. “However, we can confirm that actions have indeed been taken, while additional actions are still in progress.” [Source: New York Times Walt Bogdanich article 17 Mar 2010 ++]

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HEALTH CARE REFORM Update 25: National health care reform has a key new benefit for families that will not apply to military families enrolled in the Tricare health insurance program. A key expansion of benefits in the Patient Protection and Affordable Care Act, H.. 3590, is a requirement for health insurers to cover unmarried children up to the age of 26 who are carried on the policy of a parent. This change, like the rest of the bill, does not apply to Tricare, according to Defense Department and congressional sources. But congressional aides, speaking on the condition of anonymity, said several lawmakers have begun investigating how to alter Tricare so that it also covers older children who do not have their own coverage. A change is being considered for inclusion in the 2011 defense authorization bill, which the House and Senate armed services committees will begin writing later this year. Currently, Tricare covers unmarried children up to age 23 if they are attending college or up to 21 if they are not. Tricare spokesman Austin Comacho said he could not give a definitive statement about whether Tricare’s age limit for children would be changed. “The only thing we can be sure of is that there will be no adverse impact to our beneficiaries,” he said.

Robert Gates, Secretary of Defense, released a statement on 21 MAR2010 which stated: "Our troops and their families can be re-assured that the health care reform legislation being passed by the Congress will not negatively impact the Tricare medical insurance program. In the interim, Rep. Martin Heinrich (D-NM) introduced a bill on 25 MAR that would extend TRICARE health coverage to dependent children from age 23 to age 26. The Comptroller estimates this additional cost would be in excess of \$600 million per year. The TRICARE Dependent Coverage

Extension Act (H.R.4923), would require Defense to provide a key benefit created by the Patient Protection and Affordable Care Act President Obama signed into law which allows parents to keep dependent children on family health insurance plans up to age 26. TRICARE is governed by Title 10 of the U.S. Code and is not affected by the new health care law. H.R.4923 would amend Title 10 to reflect the new requirement, which would take effect 1 OCT 2010. [Source: NavyTimes Rick Maze & GovExec.com Today articles 22 & 25 Mar 2010 ++]

HEALTH CARE REFORM Update 26: Here are the effective dates of major provisions of the health care overhaul legislation approved 21 MAR:

90 days after enactment:

- Provide immediate access to high-risk pools for people with no insurance for at least six months because of pre-existing conditions.
- Impose a 10% excise tax on indoor tanning for services provided on or after 1 JUL 2010

Six months after enactment:

- Bar insurers from denying people coverage when they get sick.
- Bar insurers from denying coverage to children with pre-existing conditions.
- Bar insurers from imposing lifetime caps on coverage.
- Require insurers to allow people to stay on their parents' policies until they turn 26.

Nine months after enactment – 50% of the donut hole will be covered. Eventually, the health care reform bill will close the donut hole entirely

Within A Year:

- Provide a \$250 rebate this year to Medicare prescription drug beneficiaries whose initial benefits run out when they enter the donut hole.
- Require new insurance policies to cover certain preventive-care measures with no out-of-pocket cost to the consumer.
- Require Insurance companies to stop imposing lifetime coverage limits on your insurance.
- Sharply limit annual caps on your insurance.
- Require Insurers with unusually high administrative costs to offer rebates to their customers, and every insurance company has to reveal how much it spends on overhead.

2011:

- Require individual and small group market plans to spend 80% of premium dollars on medical services. Large group plans would have to spend at least 85%.
- Taxes begin being levied on drug manufacturers.
- Physicians' Medicare fees will be cut more than 25% unless the sustainable growth rate is permanently repealed by Congress; -
- Initiate Medicare bonus of 10% over five years for primary care and general surgery (family medicine, internal medicine, geriatrics and pediatrics)

2012 - Businesses must file Form 1099s for all business-to- business transactions of \$600 or more.

2013 :

- Increase the Medicare payroll tax and expand it to dividend, interest and other unearned income for singles earning more than \$200,000 and joint filers making more than \$250,000.
- Require public reporting of physician performance to begin.
- Begin testing Medicare pilot programs care payments based on "quality over quantity" of services rendered.
- Make fewer medical expenses tax deductible.
- Raise wage taxes from 1.45% to 2.35%; - New tax of 3.8 percent levied on unearned income streams like interest and dividends; - New tax of 2.9 percent on medical device sales.

2014:

- Provide subsidies for families earning up to 400% of poverty level, currently about \$88,000 a year, to purchase health insurance.
- Require most employers to provide coverage or face penalties.
- Require most people to obtain coverage or face penalties for noncompliance.
- Create state insurance exchanges for individuals and small businesses to purchase coverage.
- Prohibit Insurance companies from denying coverage for pre-existing conditions.
- Expand Medicaid to all Americans under age 65 earning up to 133% of the federal poverty level.
- Increase Subsidies for some small business providing coverage to employees.

2015 - Initiate independent Payment Advisory to make recommendations for cutting Medicare costs.

2016:

- Penalties for individuals refusing to purchase insurance rise to 2.5% of taxable income or \$695, whichever is greater.
- Multi-state compacts allowed to sell policies across state lines

2018 - Impose a 40% excise tax on high-end insurance policies.

2019 - Expand health insurance coverage to 32 million people.

[Source: Speaker of the House, Congressional Budget Office, Kaiser Family Foundation via McClatchy Newspapers article 21 Mar 2010 ++]

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HEALTH CARE REFORM Update 27: The Obama Administration's health-care reform, which passed 219-212 in the House of Representatives 21 MAR and has been signed into law by the President, will lead to significant changes in the way millions of people find and buy health insurance. Advocates for consumers and patients hailed the overhaul's passage. "While the new reforms won't solve all the problems in our nation's broken health-care system, they will go a long way toward achieving the goal of affordable, reliable health care for all Americans," Jim Guest, chief executive of Consumers Union, said in a statement after the vote. Immediately following President Barack Obama's signing of the bill 12 states filed a lawsuit challenging several provisions of the new law. The suit alleges, among other things, that unfunded state Medicaid mandates and forcing individuals to purchase health insurance are unconstitutional. The lawsuit was filed by the participating states' attorneys general and names the U.S. Departments of Health and Human Services, Treasury and Labor. States joining in the lawsuit include Alabama, South Carolina, Florida, Louisiana, Nebraska, Texas, Michigan, Utah, Pennsylvania, South Dakota, Washington and Colorado. In the interim here's an outline of what you can expect depending on your employment, income, health and lifestyle factors. The exact timing of several provisions has yet to be determined:

- **If you have employer-sponsored coverage:** Any lifetime caps on how much your health plan will cover, often set between \$1 million and \$5 million, will be eliminated in both group and individual health plans starting later this year. Employers will have to disclose the cost of workers' health coverage on their W-2 tax forms starting in 2011.
- **If you have a small business:** Small firms starting this year may be eligible for new tax credits that would cover up to 35% of health-insurance premiums for businesses that have fewer than 25 employees. Workers at small businesses eventually will be able to buy policies on new health-insurance exchanges, where health benefits will have to meet a new minimum standard.
- **If you're uninsured:** Over the next 10 years, the bill will extend coverage to an estimated 32 million people who would otherwise lack coverage. It does this by expanding the government safety net and providing subsidies for low- and moderate-income people without employer health benefits to buy private plans on health-insurance exchanges, which are due to start in 2014. For the first time, all citizens and legal residents will have to buy health insurance -- with financial aid from the government if they can't afford it, on a sliding scale up to 400% of the poverty line -- or face a penalty starting in 2014, with some exceptions for low-income people. The amounts are set to rise annually, beginning with a fine of \$95 or 1% of income, whichever is greater, and growing to as much as \$695 or 2.5% of taxable income by 2016.
- **If you're low-income:** The law significantly expands Medicaid, the federal-state health program for the poor, making it available to an estimated 16 million more people with incomes up to 133% of the federal poverty level. Adults without dependent children will qualify for the first time. In addition, community health centers, on which many of the working poor rely, will receive enhanced funding.
- **If you're a young adult:** Starting six months after enactment, kids can stay on their parents' policies until age 26. Individuals younger than 30 who don't have insurance also will have the option of buying catastrophic coverage on the exchanges, according to the Kaiser Family Foundation.

Tax-related changes

- **If you have a flexible-spending account for health expenses:** Nothing changes for three years. A \$2,500 cap on contributions to these accounts, which allow users to sock away money pretax to spend on qualified health expenses, appears likely to go into effect in 2013. The cap will receive annual cost-of-living adjustments.
- **If you have a health savings account (HSA) or Archer medical savings account:** In 2011, the penalty for withdrawing funds for nonqualified medical expenses increases to 20% from 10% for HSAs and from 15% for Archer MSAs.
- **If your earned or investment income exceeds \$200,000:** In about two years, the Medicare payroll tax will rise nearly 1 percentage point to 2.35% on wages of individuals with earnings greater than \$200,000 and married couples earning more than \$250,000. A new 3.8% Medicare tax will be levied on investment income including interest, dividends and capital gains that exceed those thresholds.
- **If you itemize deductions for income tax:** Starting in 2013, medical expenses have to reach 10% of your adjusted gross income to qualify for a tax deduction, as opposed to today's 7.5% standard. But seniors age 65 and older would be able to claim an itemized deduction at 7.5% of income through 2016.
- **If you have high-cost health insurance:** A so-called Cadillac tax of 40% on plan administrators offering the richest job-based health benefits will take effect in the next few years and apply to the amount of annual premiums exceeding \$10,200 for individuals or \$27,500 for families. The thresholds are higher for retirees and workers in certain high-risk jobs.

Medicare, preventive care and tanning

- **If you have Medicare:** This year, beneficiaries with the Part D drug benefit who fall into the coverage gap that for 2010 is between \$2,700 and \$6,154 of spending will receive a \$250 rebate. In 2011, those who hit

the gap will receive a 50% discount on their brand-name drugs. The so-called doughnut hole gradually will close by 2020.

- **If you take advantage of preventive care:** Full coverage for some services is slated to take effect in six months. At that time, all new insurance policies will have to make certain preventive-care visits and screenings exempt from health plans' deductibles and other cost-sharing.
- **If you go to a tanning salon:** A 10% excise tax on indoor tanning may kick as early as this summer for services provided on or after 1 JUL 2010.

[Source: Wall Street Journal MarketWatch Kristen Gerencher article 22 Mar 2010 ++]

PTSD Update 40: The Santa Rosa-based research group The Stress Project "is trying to convince the Department of Veterans Affairs to adopt" alternative medicine emotional freedom techniques, or 'EFT' therapy, "as a standard treatment for veterans with PTSD." Tapping, known formally as EFT, is a therapy in which patients, guided by someone trained in the procedure, tap on acupuncture points by the eye, over the lip, on the chest and under an arm. At the same time, the patient describes past traumas, ranks the intensity of the memory and repeats statements meant to affirm self-acceptance in the face of the experience. Once trained, they can use the technique on themselves as needed. Private therapists have used EFT with veterans over the past 15 years. Although some clinical psychologists working with VA may use the technique, the VA itself has not recognized it, and EFT is not used at the VA's National Center for PTSD in Menlo Park, and no doctors knew enough about it to comment, a VA spokeswoman said. In Massachusetts, clinical social worker Marilyn Garland is preparing a workshop to introduce EFT to VA staffers hailing from around the country.

VA therapists and military psychologists who have used EFT said it is highly effective. "It shows massive drops in PTSD, pain, depression, all kinds of things," said Dawson Church, an author on alternative medicines and the Stress Project's executive director. According to a clinical study conducted at the Marshall University Medical School in Huntington, W.Va., and published in the International Journal of Health and Caring, veterans' anxiety was reduced by 46%, depression by 49% and PTSD levels by 50%. The VA "is pretty careful about not wanting to use treatments too soon before they've been thoroughly tested," said Patrick Reilly, director of mental health services at the Santa Rosa veterans clinic. Reilly said pilot studies done to date may have been too small to produce enough data for the VA to consider. The Stress Project is now winding up a larger study in which about 60 veterans nationwide have undergone six therapy sessions and six months of follow-up study. Adherents hope the results will help persuade the VA to take a more thorough look at EFT, Church said. A 2009 Stanford University study concluded that the PTSD rate among Iraq War veterans will be about 35%. The San Bernardino County Sun reported on 15 MAR that 49,637 patients diagnosed with PTSD were treated last year at the Jerry L. Pettis Memorial Veterans Medical Center in Loma Linda CA. This is a 114% increase from 2005. As of 2007, 1.5 million service members had served in Iraq or Afghanistan, according to the Office of the Surgeon General. [Source: The Press Democrat Jeremy Hay article 13 Mar 2010 ++]

PTSD Update 41: Thousands of miles and a lack of facilities have kept the Army from providing treatment to soldiers with post-traumatic stress disorder. But the Defense Department plans to deploy a solution soon that relies on a transportable telehealth system that will virtually bring doctors to patients. The portion of Iraq war soldiers suffering from PTSD is estimated to be as high as 35%. As a result, Lt. Gen. Eric Schoomaker, the Army surgeon general, has pushed the service to consider using technology to provide much-needed treatment. The National Center for Telehealth and Technology, which is part of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, took delivery last week of its first transportable unit, said Matt

Mishkind, acting chief of the center's clinical telehealth division. It marks a first step in meeting Schoomaker's challenge to use technology to replace face-to-face sessions between clinicians and soldiers. The telehealth unit is actually a standard 8-by-20 foot shipping container that houses most of what can be found in a brick-and-mortar clinic, including three treatment rooms. The difference, however, is there is no doctor on staff. Patients see physicians via the unit's computer network, which is equipped with video conferencing (VTC) systems supplied by Tandberg.

VTCs allow a clinician to view a remote patient, an essential part of treating PTSD and traumatic brain injury, said Gregory Gahm, director of the National Center for Telehealth and Technology and a retired Army psychologist with 20 years of active-duty service. When treating brain injuries, a remote clinician will use the VTC to evaluate a soldier's gait, for example, which is a good way to evaluate brain damage typically caused by an explosion, he said. The first transportable unit, manufactured in Hawaii, arrived at the center's headquarters at Joint Base Lewis-McChord in Tacoma, Wash. It is outfitted with room partitions and wiring. Officials planned to install the VTC equipment at the headquarters, test the systems and start treating remote patients in American Samoa in the South Pacific later this year, Mishkind said. The unit also will treat members of an Army Reserve unit deployed in Iraq, linking them to clinicians at the Veterans Affairs hospital in Honolulu. The unit will be installed at a VA clinic in American Samoa, allowing the Telehealth and Technology Center to piggyback on a dedicated VA T-1 line (1.544 megabytes per second) between the two islands. The center also is developing other programs to treat the invisible wounds of war, including one that will use virtual reality to treat PTSD, a Web site to help troops and their families deal with issues that arise after they return from combat, and an iPhone application for clinicians to use when treating PTSD patients. [Source: Next.gov Bob Brewin article 22 Mar 2010 ++]

LIFE EXPECTANCY Update 01: When people think about aging, they often look to their immediate family for clues about their own longevity. But while genes certainly play a role in how we age, they may not be as important as people once thought. For most people, only about 30% of aging is based on genetics, according to scientists who study the aging process, which means that most of the factors that affect how quickly you age and how long you may live are under your control. These variable factors range from regular exercise, good nutrition and watching your weight to getting enough sleep and maintaining strong friendships and a positive attitude. Another piece of good news is that taking charge of these lifestyle factors can help people of any age to improve health and fitness, sharpen mental acuity, slow the aging process and enrich their lives. Recent studies have shown that seniors between the ages of 65 and 75, who exercise with resistance weights, can improve their memory and decision-making skills. Researchers in Germany found that staying physically active helps people over age 55 lower their risk of developing cognitive impairments. Other studies have shown that maintaining a network of close friendships and having a positive outlook can improve health, reduce frailty and help people live longer. So if you want to live longer and live better, start today. It's never too late to live a healthier and happier life. [Source: About.com Senior Living Sharon O'Brien article 23 Mar 2010 ++]

OHIO VET BONUS: Ohio State officials are moving forward with plans to distribute voter-approved bonus payments to veterans of recent and ongoing military conflicts in the Middle East. Families of veterans who were killed or missing in action could begin receiving checks in September, with others starting in NOV 2010. In NOV 09, voters passed a constitutional amendment allowing the state to pay cash bonuses of \$100 a month up to \$1,000 to Ohio military men and women who served in the Persian Gulf, Afghanistan and Iraq -- those serving in current conflicts in the area, plus those involved in Operation Desert Storm in the early 1990s. Veterans who served outside war zones during those conflicts will get \$50 a month up to \$500. Family members may also apply for a

death benefit of \$5,000, which will be based on an application process. For more information, refer to the Ohio Department of Veterans Services at <http://dvs.ohio.gov> or call the Department at 1(888) 387-6446. [Source: Ohio.com 3 Nov 09 & Military.com Veterans Report 22 Mar 2010 ++]

COLA 2011 Update 01: The 2010 cost-of-living adjustment for retirees could test the idea of whether something really is better than nothing. After getting no COLA in military and federal civilian retired pay, veterans' disability compensation and Social Security last December because of the weak national economy, congressional economists are estimating the 1 DEC 2010 pay adjustment is going to be just 0.1%. That COLA forecast was issued 12 MAR by the Congressional Budget Office in relation to a bill that would increase veterans' disability and survivor benefits. While Social Security and military and civilian retired pay are automatically adjusted each 1 DEC based on the change in the Consumer Price Index measure of the cost of goods and services, increases in veterans' benefits require a change in law. Pending legislation would give veterans the same increase that goes to Social Security recipients. [Source: Federal times News Digest 21 Mar 2010 ++]

US NAVY VETERANS ASSOCIATION: The St. Petersburg Times has run the first of a two-part series detailing its findings from a six-month investigation into US Navy Veterans Association, which it says is "steeped in secrecy" and whose management, money and records are "all but invisible." The group's website shows its CEO since its founding in 2002, as Jack L. Nimitz, but notes that the reporters "searched for Nimitz for six months but could not find him or 83 other executives and state officers whose names appear on tax forms filed with the IRS. The newspaper searched directories and online public records databases, including property records, court records and voter registration records," as well as LexisNexis, which has never profiled or quoted Nimitz. The paper also discloses that the national headquarters in Washington, DC listed by the organization, which claims 66,000 members in 41 chapters and reported over \$22 million in income last year, turns out to be a rented mailbox at a UPS shipping store. The article said that addresses listed for state chapters also turned out to be rented mailboxes, and the only locatable contact for its Florida chapter was "one man, the association's director of development, Bobby Thompson, and one place, his \$1,200-a-month rented duplex across from the Cuesta-Rey cigar factory in Ybor City." Thompson has claimed to be retired Navy lieutenant commander, but the paper said it could find no service record for him. The organization's website www.navyvets.org claims it is a nationally recognized U.S. Department of Veterans Affairs Veterans Service Organization and is an Internal Revenue Code Section 501(c)(19) war membership organization, fully tax-exempt with contributions fully tax-deductible. [Source: The St. Petersburg Times Martin Testerman article 21 Mar 2010 ++]

VA VALET PARKING SERVICES: Soon veterans headed to the Veterans Affairs Department hospital in Loma Linda, California, will be served with the same kind of highfalutin parking service experienced by the pampered set at upscale restaurants. Hospital officials say they plan to issue a request for proposals in late MAR for valet parking services they need to alleviate its parking problems. The contract will go to a 100% service-disabled veteran-owned small business, officials said. The VA hospital in La Jolla CA has had a Valet Parking Services system in place for a number of years which has proven to be very effective and much appreciated by veterans using that facility. At La Jolla parking attendants, who are not allowed to accept gratuities, are surprisingly courteous and efficient in their duties. [Source: Next.gov Bob Brewin blog 19 Mar 2010 ++]

BURN PIT TOXIC EMISSIONS Update 13: When falling debris from the World Trade Center attacks crushed former soldier John Feal's foot as he helped clean up the wreckage, he figured medical benefits would be available. But as he and 70% of the others in the cleanup effort developed respiratory problems and had to fight for benefits for even obvious injuries, Feal realized he would have to lead the charge to get the workers the health care they needed. Rep. Tim Bishop (D-NY-01) helped fight for those benefits. That experience made him especially alert when he began hearing similar tales from troops years later: The symptoms of those who said they were exposed to burn pits in Iraq and Afghanistan were eerily similar. "For me, what this was very reminiscent of, unfortunately, was the ailments that came after 9/11 in my district," Bishop said. "We had perfectly healthy people who, six months later, couldn't get up the stairs." That made sense to Bishop. Both groups were exposed to burning debris. Both were exposed to similar chemicals and particulate matter. And both groups were exposed all at once to a multitude of things that, combined in ways that had not been studied before, could add to the list of symptoms. And both groups had to fight to prove their illnesses were connected to their exposures.

"We're vindicated now," Feal said. "We weren't crying wolf." Since Feal developed his own respiratory problems in addition to having part of his foot amputated, he has made a 45-minute documentary in 2008 detailing the ailments of four first responders. Then, he said, he hand-carried a copy to every member of Congress. Since then, scientists and doctors have come forward saying there is a connection. New York City created a registry of all first responders and writes an annual report every year. "Eight hundred people have died, according to the state," Feal said. "Cancers have gone up over the past two years — blood cancers that don't show up immediately." According to a report from the Mount Sinai School of Medicine, 8% of first responders are experiencing asthma. Mount Sinai researchers also discovered that 50% of 1,236 first responders they examined had a heart ailment that causes shortness of breath and can lead to heart failure. Mount Sinai researchers have also found that 24% of first responders have lung-function issues.

Rep. Carolyn Maloney (D-NY-14) first became interested after workers couldn't shake the "World Trade Center cough," a spokeswoman said. Over time, the illnesses became more severe. The spokeswoman said it has taken seven to eight years of "sustained effort" to get a bill before Congress, even with the entire New York congressional delegation behind it. The first responders are hoping to see passage of H.R.847, a bill that would provide medical monitoring, evaluation, education and compensation for first responders sickened by the aftermath of the World Trade Center attacks. A settlement was reached 11 MAR in a lawsuit against the city of New York for \$657.5 million in compensation for 10,000 first responders. The plaintiffs have 90 days to decide whether they will accept the settlement. Meanwhile, those who were exposed to burn pits in the war zones are hoping for an amendment to the 2011 defense authorization bill that would provide monitoring and medical care, and would ban the burn pits. Bishop, who is working on that legislation, said both groups are worthy of compensation. "It's heart-wrenching," Bishop said. "These are both examples where the government is responsible."?

In the military, according to morbidity reports, annual cases of chronic obstructive pulmonary disease have gone up by about 10,000, and "respiratory signs and symptoms" have increased by 10,000 cases since the wars in Iraq and Afghanistan began. And 500 people who believe they are sick because of exposure to the burn pits have been added to a Disabled American Veterans database. Doctors have found connections between inhalational exposure to something - possibly burn pits, possibly particulate matter, possibly both - and bronchiolitis. The Defense and Veterans Affairs departments recently have begun studying the effects of burn-pit smoke and particulate matter, though an official database does not yet exist. [Source: NavyTimes Kelly Kennedy article 20 Mar 2010 ++]

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TRICARE GRAY AREA RETIREES Update 04: Tricare Standard coverage for so-called “gray area retirees” became law last fall, and the Pentagon was directed to set up the program. Six months later, those retirees (reservists who qualify for military retirement but cannot begin receiving the benefits until they are 60 years old) are still waiting, and wondering what they’ll end up paying. The new provision, part of the 2010 Defense Authorization Act and tentatively called Tricare Retired Reserve, was to start “on or after” Oct. 1, 2009. Family members will also be eligible. Until the law passed, reserve retirees had no Tricare options until they turned 60. And until the Pentagon decides how to implement the program, they still don’t. “Next thing we knew, there was an announcement from DoD Health Affairs that it would take between 11 and 18 months to implement this program,” said Marshall Hanson, legislative director of the Reserve Officer Association (ROA).

When it formally announced the program in early DEC, Tricare said that qualified retired reservists would be able to buy coverage by late summer or early fall. That’s still expected to be the case, Tricare spokesman Austin Camacho said 18 MAR. “Which kind of almost is, rough ly, a little improvement over the 11-month estimate,” Hanson said. Also to be determined: the cost to qualified veterans. Under Tricare Standard, the rough equivalent of the new program now available only to reserve retirees age 60 and older, those in the program pay only 28% of the government’s calculation of the overall premium cost, divided by the total number of eligible veterans. But the law requires that premium rates in the new program must equal the full cost of the coverage “that the secretary of defense determines on an appropriate actuarial basis.” That language concerns Hanson. He figures that if it were simply a matter of adjusting the premium from 28% to 100%, it would have been done by now. At the 100% level, the government would not subsidize any of the cost, Camacho said.

Hanson’s additional concerns are that the change will affect relatively few people, and he says the Pentagon views the potential recipients, 40 to 60year-olds, as a higher-risk health group. Taken together, he said, that means premiums are likely to be higher than 100% of the government’s calculation of the overall premium cost, “even though they have no idea how much this program will actually cost.” To add to the uncertainty, the law calls for separate premiums to be established for eligible retirees with dependents and without. As of this writing Tricare could not answer questions about whether it is considering premium costs higher than 100%, or how many retirees it estimates will be eligible for the program. Hanson said he recently got a phone call from an ROA member asking what was happening. “A lot of these people are going without health care that would love to get into this system,” Hanson said. “There’s a general frustration among the community that things probably could have been done a little faster.” [Source: NavyTimes William H. McMichael article 29 Mar 2010 ++]

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VFW UNMET NEEDS PROGRAM: The Veteran of Foreign Wars “Unmet Needs Program”, funded by public donations, provides assistance to veterans who have served on active duty in the last three years and are experiencing financial hardships primarily due to deployment or military service. Funds awarded by the program are offered in the form of grants--not loans--so recipients don’t need to repay them. Expenses eligible for consideration for payment under the program are:

- Household expenses: mortgage, rent, repairs, insurance.
- Vehicle expenses: payments, insurance, repairs. Major repairs for vehicles over ten years old will not be considered).
- Utilities, Food and Clothing.
- Children’s clothing, diapers, formula, school or childcare expenses.
- Medical bills, prescriptions & eyeglasses: The patient’s portion for necessary or emergency medical care only.

Expenses Ineligible for consideration for payment are:

- Credit cards, Military charge/debit cards, retail store credit cards.
- Personal, student or payday loans.
- Cable and internet and secondary phone.
- Cosmetic or investigational medical procedures and expenses.
- Taxes –property or otherwise.
- College Expenses.
- Furniture rentals.
- Expenses related to civil, personal, legal and domestic situations.
- Any other expense not determined to be a basic life need.

The eligible and ineligible expense lists are not all inclusive and each expense will be considered on a case-by-case basis. Payment will be made at the discretion of the approval committee. Payments are made directly to creditors. Applicants must be the service member listed or eligible to be listed as a dependent of the service member under DEERS. Other persons eligible to apply on behalf of the military family in need are VFW Personnel; Military Unit Point of Contact -Family Assistance Center Coordinator, Commanding Officer, Medical Hold Case Worker; and VA Representative or VFW Service Officer assisting with a VA claim.

Applications can be downloaded at www.unmetneeds.com/assets/Unmetneedapp9-15-2008.pdf . In order for the Unmet Needs Program to verify your bills, you must contact your creditors and allow the Unmet Needs access to your account information. If your application is received without all of the required supporting documentation, it will be closed after (20) business days. Supporting documentation may be mailed, faxed, or emailed to Veterans of Foreign Wars, Attn. Unmet Needs Program, 406 West 34th Street, Kansas City, MO, 64111 Fax: (816) 968-2779; E-mail: unmetneeds@vfw.org; Website: www.vfw.org/military. Upon receipt of a completed application a representative may contact you to discuss the specifics of the case and/or to request additional information. The approval process normally takes twenty (20) business days and you will be contacted you as soon as a final determination has been made in your case. Status checks by applicants will not be responded to while the file is being processed. Documents required to be enclosed with an application are:

- DD-214 or Military Members most recent orders.
- A written statement from the Military Unit point of contact (member of Chain of Command, Family Assistance Center Representative, VA Rep or VFW Rep) that verifies the member’s military status and financial hardship. This statement must be signed and dated by the Military Unit point of contact, and on letterhead if possible.
- Copy of the bills for which you are requesting assistance. This must include the account holder’s name and the account number, as well as the creditor’s name and phone number with area code. For assistance with repairs or other services, two different written estimates on company letterhead are required. (For example, if requesting assistance with rent, a copy of your lease agreement is required.)
- Copy of Terms & Conditions to creditors (keep copy for self).

[Source: www.unmetneeds.com/default.aspx Mar 2010 ++]

GULF WAR PRESUMPTIVE DISEASES: VA Secretary Eric Shinseki announced 18 MAR he is taking steps to make it easier for veterans to obtain disability compensation for certain diseases associated with service during the first Gulf War, as well as those who served in Iraq and Afghanistan on or after Sept. 19, 2001. VA will publish a proposed regulation in the Federal Register to establish new service-connection presumptions for nine specific infectious diseases. Specifically:

- Brucellosis

- Campylobacter jejuni
- Coxiella burnetii (Q fever)
- Malaria,
- Mycobacterium tuberculosis
- Nontyphoid Salmonella
- Shigella
- Visceral leishmaniasis
- West Nile virus.

Without a rule change for presumptive conditions, veterans are required to provide medical evidence to establish an actual connection between a specific disease and military service in Southwest Asia or Afghanistan. With the proposed rule, a veteran would only have to show service in Southwest Asia or Afghanistan, and a current diagnosis of one of the nine diseases. A final regulation will be published after a 60-day public comment period. For more information about disability compensation or health problems associated with military service during the first Gulf War and OEF/OIF, go to www.publichealth.va.gov/exposures/gulfwar/ or www.va.gov. [Source: Washington Weekly 19 Mar 2010 ++]

SGLI/VGLI PAYMENT RESTRICTIONS: There are several myths, rumors and misconceptions about SGLI and VGLI insurance. Below, are listed some of the most commonly held misconceptions.

- **Payment of TSGLI reduces the amount of SGLI payable at the time of the service member's death.** False: Payment of TSGLI has no impact on the amount of SGLI payable. For example, if a service member is insured for \$400,000 of SGLI coverage and receives a TSGLI payment of \$50,000 for a traumatic injury, that member is still insured for the full \$400,000 of SGLI coverage, which will be paid upon the service member's death.
- **SGLI won't pay if you die while wearing privately purchased body armor or a privately purchased helmet.** False: SGLI claims are paid regardless of body armor or helmet type. Wearing body armor or a helmet is not a requirement for a SGLI claim to be paid.
- **SGLI or VGLI won't pay if you die in a motor vehicle accident or airplane accident and wasn't wearing a seat belt.** False: SGLI or VGLI claims are paid regardless of whether the member was or was not wearing a seatbelt.
- **SGLI or VGLI won't pay if you die in a motorcycle accident and I was not wearing a helmet.** False: Your SGLI or VGLI proceeds will be paid to your beneficiary or beneficiaries, regardless of whether you were or were not wearing a helmet.
- **Reservist/National Guard member SGLI coverage is only good while at drill.** False: If you are a Reservist or a National Guard member and have been assigned to a unit in which you are scheduled to perform at least 12 periods of inactive duty that is creditable for retirement purposes, full-time SGLI coverage is in effect 365 days of the year. You are also covered for 120 days following separation or release from duty.
- **SGLI or VGLI won't pay if you die as the result of a terrorist attack.** False: Your SGLI or VGLI proceeds will be paid to your beneficiary or beneficiaries if you die in a terrorist attack.
- **Some bill was passed that allows you to apply for the SGLI insurance dividend based on military service.** False: Rumors that Congress approved a "Special Dividend" for veterans who do or do not have Government life insurance have been spread for over 30 years. More recently, it has been adapted to state

that a dividend is being paid on Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI) coverage. VA and OSGLI have done everything possible to stamp out the rumor but it still persists.

- **SGLI Coverage cannot be forfeited.** False: The coverage provided by the SGLI program will be forfeited only when an insured member is found guilty of mutiny, treason, spying, or desertion, or refuses, because of conscientious objections, to perform service in the Armed Forces of the United States, or refuses to wear the uniform of such force. No insurance shall be payable for death inflicted as a lawful punishment for crime or for military or naval offense except when inflicted by an enemy of the United States.

[Source: www.insurance.va.gov/sgliSite/SGLI/mythsRumors.htm Mar 10 ++]

NDAA 2010 Update 06: House Armed Services Committee Chairman Ike Skelton (D-MO) introduced H.R.4887 to use as a provision in the FY2011 Defense Authorization Bill to amend national health care reform legislation to explicitly state that Tricare "meets all requirements for individual health insurance." Committee staff members indicate this is a technical correction to make doubly sure Tricare beneficiaries don't suffer any inadvertent penalties under the language of national health care reform legislation currently pending in the House. According to staff, the new House language cites Medicare, Tricare for Life, and VA care as meeting the requirements, but didn't explicitly include Tricare. Skelton tried to amend the bill to include Tricare, but House rules governing reconciliation bills like the national health reform bill bar amendments that don't involve funding. But the lack of funding issue means Skelton will be able to make the fix in the defense bill instead. While it would be incongruous in the extreme to consider Tricare as failing to meet any reasonable requirements for health insurance, the technical fix will make doubly sure Tricare beneficiaries won't be subject to financial penalties applicable to people who don't obtain qualifying insurance. It would also require that Tricare make a change to allow continued coverage of non-dependent children until age 28 if they don't have qualifying employer-sponsored coverage. Details on how to accomplish that would have to be worked out in the defense bill if the national health reform legislation passes.

On 20 MAR H.R.4887 was approved on the house floor by a vote of 403 to 0. The bill now passes to the Senate. Veterans concerned over this issue should contact their senators and urge them to vote in favor of this bill. This can easily be done by going to [http://capwiz.com/usdr/issues/alert/?alertid=14839981&queueid=\[capwiz:queue_id\]](http://capwiz.com/usdr/issues/alert/?alertid=14839981&queueid=[capwiz:queue_id]) and forwarding the preformatted message to your Senator. If it can pass the Senate Tricare and the Non-Appropriated Fund health plans, will meet the minimum requirements for individual health insurance coverage, and no Tricare or NAF health plan beneficiary will be required to purchase additional coverage beyond what they already have. [Source: MOAA Leg Up 19 Mar 2010 ++]

VA CLAIMS BACKLOG Update 37: The Veterans Affairs Department's chief technology officer said 18 MAR at a roundtable discussion about ways to cut the growing backlog of claims and improve accuracy that bailing wire and bandages can't save the veterans disability claims process. In my judgment, it cannot be fixed," said Peter Levin. "We need to build a new system, and that is exactly what we are going to do." Levin's comments came at a meeting organized by the House Veterans' Affairs Committee to toss around ideas for repairing a system that has a backlog of about 1.1 million claims awaiting decisions and an error rate of 17% to 25%, depending on who is counting. Rep. Bob Filner (D-VA), the committee chairman, described the system as an "insult to veterans" who wait an average of six months for a initial decision on benefits and can wait for years if the decision is appealed. "It looks like we are going backwards rather than forward," Filner said. "No matter how much we raise the budget, no matter how many people we hire, the backlog seems to get bigger. People die before their claim is adjudicated. They lose their home. They lose their car."

Overhauling the disability claims process is the top priority of veterans groups and the Obama administration, but there is no agreement on exactly what to do. The short-term solution proposed by the administration is what VA Secretary Eric Shinseki has called the “brute force” option: hiring more people to process claims. But because fully training new workers takes two years or longer, and the total number of claims received by VA is increasing, hiring more people is not expected to improve the process for three to five years, said Dan Bertoni, director of disability issues for the Government Accountability Office. VA is working on a number of pilot projects that might lead to a new way to process claims, by reducing steps and moving to a fully electronic record system. But the system remains so complex that an easy fix is elusive — which is why Levin talked about starting over. Veterans group, however, are not ready to blow up the system and start over. In a joint letter dated 17 MAR to veterans’ committee members, major veterans groups say they are unaware of any “magic bullet” solution or alternative system to the current problems, but they support changes to the current system. They are pushing the idea of providing quick disability benefits — in 60 days or less — to veterans with disabilities that can be “easily or quickly resolved,” which would include those scientifically linked to military service, orthopedic conditions and hearing loss. [Source: ArmyTimes Rick Maze 18 Mar 2010 ++]

TRICARE & VA USE OPTIONS: Service members who became ill or injured while serving on active duty and are then medically retired have health benefits available to them through both the Department of Defense and Department of Veterans Affairs. Like all retirees, medically-retired veterans can choose Tricare Prime where it’s available, or Tricare Standard and Extra if they are not eligible for Medicare. Their family members have the same Tricare choices. Veterans who are eligible for Medicare because of disability must maintain Medicare Parts A and B to keep their Tricare coverage. Retirees with a service-connected disability rated at 50% or higher; are unemployable due to the service-connected disability; or are seeking care for the service-connected disability are automatically eligible but must request care from Department of Veterans Affairs (VA). Retirees eligible for VA health benefits along with their Tricare retiree health care benefits can receive care from the VA or Tricare. These retirees must apply for health benefits from the VA. Though there is an initial choice each time they seek care for a non-service related condition—VA or Tricare—once treatment has begun, it must be completed using the same benefit. However, when seeking care for a service-related condition, they must use VA benefits.

Almost all VA health care facilities are part of the Tricare network, however treatment of Tricare beneficiaries is provided on a space and resource available basis only. When choosing to use their Tricare benefit, retirees may be authorized to receive non-service related care at participating VA medical centers, a military treatment facility (MTF) or a Tricare network provider. Representatives are available at VA facilities to assist veterans who are eligible for Tricare and VA health care, and VA liaisons and benefit counselors are available at many MTFs to assist veterans transferring from Defense Department to VA care. Veterans can learn about the different financial responsibilities for Tricare-covered services and VA benefits by contacting their Tricare regional contractor, or VA Health Benefits Service Center at (877) 222-VETS. Regional contractor contact information can be found at www.tricare.mil/contactus. There are many programs available through Tricare, VA, the armed services and Tricare’s regional contractors supporting veterans who became ill or were injured serving on active duty. Visit www.warriorcare.mil for more information about these resources. [Source: Tricare news release No. 10-27 dtd 17 Mar 2010 ++]

MILITARY STOLEN VALOR Update 16: A Palm Springs man was sentenced to a year of probation 15 MAR and ordered to undergo mental health counseling for impersonating a Marine and wearing

medals he never earned. Steven Douglas Burton violated a federal statute that prohibits the unauthorized display of military medals. The 39-year-old defendant pleaded guilty to the federal misdemeanor charge 14 DEC as part of a plea deal with the U.S. Attorney's Office. U.S. District Judge Virginia Phillips also ordered Burton to pay a \$250 fine and barred him from owning any military uniforms, insignia or award. Burton told Phillips when he entered his plea that he was seeing a doctor and receiving treatment, though he did not specify for what. He also said he was taking antidepressants. According to the U.S. Attorney's Office, Burton showed up for his 20-year class reunion at Alhambra High School in Martinez, Calif., in OCT 08 wearing a Marine Corps dress uniform studded with medals, including the Navy Cross, the second-highest combat commendation behind the Medal of Honor. Burton wore a lieutenant colonel's insignia and told people he had spent a career in the service, according to the FBI.

One of Burton's classmates, a Navy commander, was suspicious and snapped a photograph of Burton, which shows him wearing 14 medals, including a Navy Cross, Bronze Star, Purple Heart, Legion of Merit badge and Combat Action ribbon. The commander made an official inquiry regarding Burton's service and discovered he had never been in the Corps or any other branch of the Armed Forces, according to the FBI. In the ensuing investigation, federal agents learned the defendant had an Internet blog on which he "bragged" about overseas tours of duty that involved combat in Afghanistan and Iraq. The first documented case of Burton wearing a military uniform with decorations was during a 2007 Halloween party in Cathedral City, according to the U.S. Attorney's Office. A few months later, he posted a photo of himself online showing him standing on a beach on Coronado Island wearing a Marine Corps uniform, complete with medals and stripes indicating the rank of master gunnery sergeant. "The defendant chose the rank of ... gunnery sergeant because it is a well-respected rank within the USMC," court documents state. The documents indicate Burton purchased most of his decorations on eBay and at military surplus stores, including one outside the Marine Corps Air Ground Combat Center at Twentynine Palms, Calif. [Source: MarineCorpsTimes The Desert Sun article 16 Mar 2010 ++]

BURN PIT TOXIC EMISSIONS Update 12: The US military's largest contractor, KBR, has testified in court that it burned hazardous materials (including asbestos) in so-called "burn pits" in Iraq and Afghanistan at the behest of military officials. The company is hoping to avoid being held accountable for the burn pits, which may have exposed US military personnel overseas to toxic materials that could ultimately cause cancer later in life. For example, asbestos burned in the pits could have become airborne. If inhaled or ingested, these airborne asbestos particles can lead to the development of mesothelioma, a rare cancer of the lungs and other major organs and tissues. A class action suit was filed in October of last year against KBR and other companies. Combining 22 lawsuits from 43 states, the class action case was filed in US District Court in Maryland against KBR, Halliburton, and other military contractors. The plaintiffs are seeking damages after developing health issues that were allegedly caused by being in close proximity to these burn pits overseas, which were used for trash disposal. KBR is not denying that the burn pits they operated did contain hazardous materials such as batteries, petroleum, asbestos, and medical waste. Instead the company hopes to challenge the idea that they should be held accountable for the items burned in the pits, as KBR was allegedly just following orders from high-ranking military officials. According to one military reporter: "Though military officials say there are no known long-term effects from exposure to burn pits in Iraq and Afghanistan, more than 100 service members have come forward to Military Times [a newspaper] and Disabled American Veterans with strikingly similar symptoms: chronic bronchitis, asthma, sleep apnea, chronic coughs and allergy-like symptoms. Several also have cited heart problems, lymphoma and leukemia." KBR is also being sued by a group of veterans who were exposed to hexavalent chromium while protecting KBR employees at the Qarmat Ali water treatment plant. The men have since suffered from a variety of symptoms, including difficulty breathing. For more information on hexavalent chromium exposure impact on vets refer to www.mesothelioma.com/veterans_blog/like_asbestos_hexavalent_chromium_a_ticking_time_bomb_for_vets.htm [Source: Mesothelioma News 6 Mar 2010 ++]

VA CLAIM DENIAL Update 06: A leading Republican senator on 16 MAR asked Veterans Affairs Secretary Eric Shinseki to explain why so many veterans' benefit claims are wrongly denied, resulting in a high rate of reversal on appeal. Charles E. Grassley of Iowa, top Republican on the Senate Finance Committee, said that figures cited in a case argued before the Supreme Court last month showed that between 50% and 70% of veterans' benefits claims had been unjustifiably denied. In a letter to Shinseki, Grassley asked what the Department of Veterans Affairs is doing to improve the quality of VA claims decisions and reduce unnecessary appeals. "The fact that the VA's decisions are not only overturned on appeal frequently, but that a majority of claims were so wrongly decided in the first place shows me that there are serious, systemic problems with the process for approving veterans' claims," Grassley said. "After providing substantial increases in taxpayer dollars to the VA to address the claims backlog, it's clear that devoting more money alone is not the answer. The VA needs to tackle this problem head on, because without substantial reform, thousands of veterans will continue to face needless delays and red tape." Veterans who are wrongly denied benefits often suffer significant harm, Grassley said, even if they eventually prevail. So does the taxpayer, he added, because when the government loses on appeal, it must not only pay the benefits in question, it also must cover the veteran's attorneys fees when the court finds the government's position to be unjustified. [Source: CQ Politics News 16 Mar 2010 ++]

CONGRESSIONAL TERMINOLOGY Update 03: A Discharge Petition is a means of bringing a bill out of committee and to the floor for consideration without a report from a Committee and usually without cooperation of the leadership. They are used when the chair of a committee refuses to place a bill or resolution on the Committee's agenda. By never reporting a bill, the matter will never leave the committee and the full House will not be able to consider it. A successful petition "discharges" the committee from further consideration of a bill or resolution and brings it directly to the floor. A successful petition requires the signatures of 218 members, which is a majority of the House. [Source: NMFA eNewsletter 16 Mar 2010 ++]

SBP DIC OFFSET Update 23: Representative Walter B. Jones, Jr. (R-MC-03) has dropped a Discharge Petition for H.R.775, which calls for the elimination of the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP) annuity. H.R. 775, originally introduced by Representative Solomon P. Ortiz (D-TX-27) in JAN 09 has 324 sponsors. The elimination of the DIC dollar for dollar offset to the SBP annuity for eligible survivors has been a top issue for all members of 'The Military Coalition'. Ending this offset would correct an inequity that has existed for many years. Each payment serves a different purpose. The DIC is a special indemnity (compensation or insurance) payment paid by the Department of Veterans Affairs to the survivor when the service member's service causes his or her death. The SBP annuity, paid by the Department of Defense, reflects the longevity of the service of the military member. It is ordinarily calculated at 55% of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure that their family has a guaranteed income should the retiree die. If that retiree dies due to a service-connected disability, their survivor becomes eligible for DIC.

Surviving active duty spouses can make several choices, dependent upon their circumstances and the ages of their children. Because SBP is offset by the DIC payment, the spouse may choose to waive this benefit and select the "child only" option. In this scenario, the spouse would receive the DIC payment and the children would receive the full SBP amount until each child turns 18 (23 if in college), as well as the individual child DIC until each child turns 18 (23 if in college). Once the children have left the house, this choice currently leaves the spouse with an

annual income of \$13,848 (\$1154 x 12), a significant drop in income from what the family had been earning while the service member was alive and on active duty. The percentage of loss is even greater for survivors whose service members served longer. Those who give their lives for their country deserve more equitable compensation for their surviving spouses. Surviving retiree spouses who died of service-connected causes regardless of their percentage rating, will qualify for DIC paid by the VA. This tax-free benefit reduces, dollar-for-dollar, the basic SBP benefits for a spouse. When all or part of an SBP annuity is offset by this DIC compensation, premiums for the offset portion are refunded. For example:

- 1.) If the monthly amount of SBP entitlement (taxable) upon death of the retiree was \$1500 and the amount of DIC (non-taxable) was at the 2009 rate of \$1154, the widow/er would receive \$346 SBP plus \$1154 DIC payments monthly. A onetime check for all premiums paid into SBP by the retiree which equate to the \$1000 DIC offset would be issued to the spouse. The spouse does not have the option to decline the DIC offset in anticipation of Congress passing into law the authorization to receive both SBP and DIC. DIC is compulsory for anyone who is qualified.
- 2.) If the monthly amount of SBP entitlement (taxable) upon death of the retiree was \$700 and the amount of DIC (non-taxable) was at the 2009 rate of \$1154, the widow/er would receive \$1154 DIC monthly payments plus a onetime check for all premiums paid into SBP by the retiree.

The surviving spouse should be advised that the refunded amount of SBP premiums is considered taxable income in the year the check is issued by DFAS. If the SBP refund check is issued in the same year as the death of the retiree the widow/er is allowed to file with the IRS as married and take the standard deduction and exemptions for husband and wife to reduce the taxable amount of income. Social Security benefits for your spouse are not affected by your coverage under SBP or her receipt of DIC.

You would think that getting at least 218 of the 320 plus current cosponsors to sign the petition would be no problem. But it hasn't proved that easy in the past. That's because a discharge petition is an embarrassing move for congressional leaders who are responsible for finding funds to pay for it. In this case, the SBP-DIC fix requires \$7B in mandatory spending that Armed Services Committee leaders don't have offsets for. Normal House rules require that the responsible committee must identify offsets within its jurisdiction. For the Armed Services Committee, that would require cutting military retirement, Tricare for Life or some other SBP area, which isn't going to happen. Committee leaders want to repeal SBP-DIC, but doing that requires House leadership's help to identify other offsets. And that's a problem too, when national health reform and other major initiatives are consuming most of the available offsets. Interested parties, especially those with SBP coverage, are urged to contact their own members of Congress who are co-sponsors of H.R. 775 bill and request that they sign the Discharge Petition when it comes to the floor of the House. A simple way to do this is to access the preformatted message provided by USDR at [http://capwiz.com/usdr/issues/alert/?alertid=14825891&queueid=\[capwiz:queue_id\]](http://capwiz.com/usdr/issues/alert/?alertid=14825891&queueid=[capwiz:queue_id]) and forward it to your legislators. As of 26 MAR only 4 co-sponsors have signed the discharge petition (Reps. Walter Jones, Joe Wilson, Adam Putnam, Henry Brown). To determine if you representative is a cosponsor go to <http://thomas.loc.gov>, select "bill number" and enter HR775, click "search" to open bill summary, and click on "Cosponsors". [Source: NMFA eNewsletter 16 Mar 2010 ++]

AMERICAN LEGION TFA: In the 1920s, The American Legion established a national program of Temporary Financial Assistance (TFA) to keep children of deceased or disabled veterans at home rather than in institutions. This cash aid is still available for cases not covered by subsequent state and federal programs for the needy. In 2008, the program provided nearly \$706,000 to 640 families, benefiting 1,462 children. Through TFA, a local post can request cash assistance to help maintain the basic needs of veterans' children. The fund helps families

meet the costs of shelter, food, utilities and health expenses when parents are unable, thereby keeping the child or children in a more stable home environment. Eligibility is limited to minor children of veterans. The parent must have served at least one day of active duty in the Armed Forces of the United States during one the following periods:

- Dec. 7, 1941-Dec. 31, 1946
- June 25, 1950-Jan. 31, 1955
- Feb. 28, 1961-May 7, 1975
- August 24, 1982-July 31, 1984
- Dec. 20, 1989-Jan. 31, 1990
- Aug. 2, 1990-Cessation of hostilities as determined by the U.S. Government.

Membership in The American Legion is not required. Minor children include any unmarried child, stepchild and adopted child 17 years or younger. Children 18-20 years old will be considered if a current disability requires special schooling or indefinite in-home care, or they are enrolled in an approved high school. No child is considered eligible for TFA until a complete investigation is conducted, a legitimate family need is determined, and all other available resources have been utilized or exhausted. TFA applications must originate and be investigated at the local level. When all other possible resources have been exhausted, contact your local American Legion post, department headquarters, and/or department Children & Youth chairman, or call To obtain assistance for you or someone you know contact your local American Legion Post or call (317) 630-1323. To locate your nearest American Legion Post refer to www.legion.org/posts. [Source: www.legion.org/financialassistance Mar 2010 ++]

UTAH VETERANS HOMES Update 02: The Cedar City Council has committed an 8-acre plot for the construction of a Veterans' Affairs nursing home. The council agreed 10 MAR to dispose of city property three blocks north of the old hospital for the project. City Councilman Steve Wood said the process to approve the land for the project would take between 60 to 120 days. Cedar City is competing with St. George as the site for the proposed nursing home. The \$17 million project would be a 110-bed nursing home on a six- to eight-acre lot. The U.S. Department of Veterans Affairs will provide 35% of the cost for the VA nursing home in the southern Utah area with the remainder of the cost coming from the state. [Source: Deseret News Candice Sandness article 13 Mar 2010 ++]

VA PROSTATE CANCER PROGRAM Update 04: The most commonly used prostate cancer screening procedure, PSA, is at the center of a growing debate after its discoverer said it had become a "hugely expensive public health disaster." In a commentary in The New York Times, Richard Ablin of the University of Arizona said the screening tool he discovered four decades ago now costs too much and is ineffective. The American Cancer Society, which does not recommend the prostate specific antigen (PSA) test, a standard screening for men since the 1990s, has urged doctors to speak to their patients about its risks and its limits. The new recommendations were based on preliminary results from two major studies -- one led in Europe and the other in the United States -- published last year in the New England Journal of Medicine journal. The clinical trials found that the blood test could not be proved to save lives. PSA does not allow to distinguish between aggressive cancers that require intervention and slow-developing tumors that, depending on the patient's age, likely will not be a primary cause of death, according to the American Cancer Society. Furthermore, the test can also provide erroneous results. Prostate cancer, the second most common cancer in men worldwide after lung cancer, kills an estimated 254,000 men each year.

As soon as they turn 50 years old, healthy men who bear no symptoms of cancer and are expected to live at least 10 more years should be informed by their doctors of the pros and cons of a PSA screening before deciding to undergo the test, the cancer society recommends. "For them, the risks likely outweigh the benefits," it said in a statement. According to Ablin, American men have a 16% chance of being diagnosed with prostate cancer but only a three percent chance of dying from it because most cancers develop slowly over time. He deplored PSA screenings' annual cost of at least three billion dollars, much of that paid for by Medicare, the insurance program for the elderly, and the Veterans Administration. "The test's popularity has led to a hugely expensive public health disaster," he wrote in his column. "As I've been trying to make clear for many years now, PSA testing can't detect prostate cancer and, more important, it can't distinguish between the two types of prostate cancer -- the one that will kill you and the one that won't. "Instead, the test simply reveals how much of the prostate antigen a man has in his blood," he added. Levels of PSA, a protein produced only prostate cells, can jump when a prostate tumor grows in size. But they can also increase as the prostate enlarges naturally with a patient's age. [Source: AFP News Jean-Louis Santini article 13 Mar 2010 ++]

CALVET REINTEGRATION ACTION PLAN: The California Action Plan for Reintegration (CAPR), sponsored by the California Department of Veterans Affairs (CDVA), is geared to help returning service members, many who have been unwilling to seek help and support through official channels. CAPR was developed as a plan of action for service members returning home and entering back into civilian life. CAPR is an opportunity to inform Veterans and their dependents about Veterans benefits and how to obtain these benefits through the process of application and representation of claims. By completing the CAPR online form at www.calvet.ca.gov/VetService/reintegration.aspx, you will receive requested information instantly via e-mail. In addition, you may be contacted directly by an appropriate service provider to assist you with your specific request. You will also be automatically subscribed to their e-mail list to receive notifications of new legislation for veterans, news letters, and/or other information about your benefits. [Source: CDVA Veteran News 11 Mar 2010 ++]

ENLISTMENT Update 12: In order to qualify for enlistment in the U.S. Military, you must first travel to a Military Entrance Processing Station (MEPS), and pass a medical physical. The physical actually starts at the recruiter's office, where you will complete a medical pre-screening form. The recruiter sends this to MEPS, where it is reviewed by a MEPS medical doctor. MEPS uses this form to determine if they need you to obtain any civilian medical records to bring with you to the physical, and/or sometimes to determine whether or not to let you take the physical at all. If you have a medical condition or a history of a medical condition which is obviously disqualifying, and the MEPS doctor thinks the condition is such that there is no chance of a waiver, MEPS doesn't have to spend the time and money to process you for a physical. The medical folks at MEPS don't work for any individual service. Instead, they are a joint command (managed primarily by the Army), who work directly for the Department of Defense. Their job is to use published Department of Defense medical standards to determine whether or not you are medically qualified for military service. MEPS will classify you as follows:

- **Medically Qualified.** This means you don't have any disqualifying medical conditions, and can be further processed for enlistment.
- **Temporarily Disqualified.** This means you have a medical condition which is disqualifying right now, but won't be, once it is resolved. An example would be recent broken arm.

- **Permanently Disqualified.** This means you have a medical condition or a history of a medical condition which is disqualifying. To enlist, the service you are trying to join would have to process a medical waiver through their individual medical chain of command.

[Source: About.com: U.S. Military Rod Powers article 19 Sep 09 ++]

INJURY from FALLING: Falling down is the leading cause of injury death for Americans age 65 and older? According to the Centers for Disease Control and Prevention (CDC), each year 35 to 40% of older adult Americans fall at least once. Falling down is not just the result of getting older. Falling can be caused by a variety of circumstances, and many falling mishaps can be prevented. Here are 4 simple steps you can take to significantly reduce your risk of injury by falling down:

Improve Your Body Balance with Exercise to Prevent Falling: If you don't have a regular exercise program, start one. Lack of exercise leads to weakness, and that increases your chances of falling. Exercise can improve your body balance and flexibility at any age, and increasing body balance and flexibility is especially important for people over 50. Having a regular exercise program is also one of the most important ways that people over 50 can reduce their risk of falling. It also makes you stronger and helps you feel better. Try exercises that improve balance and coordination, like Yoga and Tai Chi. Because you work at your own level, these exercises are often suitable for people of any age. If you are over 50 and haven't exercised regularly, check with your health care provider about the best type of exercise program for you.

Increase Your Home's Accessibility and Safety to Reduce Falling Risks: About half of all falls happen at home. To increase accessibility and make your home safer:

- Remove items you might trip over (such as papers, books, clothes, and shoes) from stairs and places where you walk.
- Remove small throw rugs or use double-sided tape to keep the rugs from slipping.
- Keep items you use often within easy reach, so you can avoid using a ladder or step stool.
- Have grab bars installed next to your toilet, and install grab bars in your tub or shower.
- Use non-slip mats in the bathtub and on shower floors.
- Improve the lighting in your home. As you get older, you'll need brighter lights to see well. Use lamp shades or frosted bulbs to reduce glare.
- Make sure all stairways have handrails and sufficient lighting.
- If you are a senior or have a disability, it's best to wear shoes that give good support and have thin non-slip soles.

You might also consider avoiding lightweight slippers (especially backless styles) or athletic shoes with deep treads, which can reduce your feeling of control.

Watch Out for Medication Side Effects: Age can affect the way some medications work in your body, so if you have been taking any over-the-counter medications for awhile, it's important to tell your health care provider. He or she will be able to tell you if the over-the-counter medications are still safe for you to take. Look out for drugs--or combinations of drugs--that have side effects including drowsiness or disorientation. These side effects can increase your risk of falling. This is especially important with over-the-counter cold and flu medications, which can often increase drowsiness. And don't forget herbal remedies. Some remedies increase sleepiness and many react with other types of medication, which could increase your risk of falling down. Be sure to check with your health care provider before trying new medication, especially if you are already taking prescription drugs. And ask your doctor or pharmacist for a complete list of side effects you might expect when taking them.

Have Your Vision Checked Regularly: Vision problems can increase your chances of falling. You may be wearing the wrong glasses, or have a condition such as glaucoma or cataracts that causes vision problems or limits your vision. To reduce your risk of falling, have your vision checked by an eye doctor every year for early detection and correction of vision problems. If you can't see something, it's harder to avoid it, and this increases your risk of falling. [Source: About.com: Senior Living Sharon O'Brien article 9 Mar 2010 ++]

TRICARE HELP: Have a question on how Tricare applies to your personal situation? Write to Tricare Help, Times News Service, 6883 Commercial Drive, Springfield, VA 22159; or tricarehelp@militarytimes.com. In e-mail, include the word "Tricare" in the subject line and do not attach files. You can also get Tricare advice online anytime at www.militarytimes.com/tricarehelp. For basic information refer to the latest Tricare Handbook at www.tricare.mil/mybenefit/Download/Forms/Standard_Handbook_LoRes.pdf or call your regional contractor. Following are some of the issues addressed in recent weeks by these sources:

(Q) Do I have to sign up for Medicare Part B to get TFL if I am still working with job related health insurance? I got Tricare when I turned 60, and now I'm signing up for Medicare and Tricare for Life. Medicare told me that because I'm still working and have health insurance from my job, I don't have to sign up for Part B until I retire. Then, the Navy told me that is true, but that I cannot get Tricare for Life until I sign up for Part B. The only coverage I will have will be my employer's plan and Medicare Part A. I'm confused by the mixed messages. Who is right, Medicare or the Navy?

(A) Both are right. You're dealing with two different laws concerning Part B enrollment — and you must choose between them. The Medicare law says that if beneficiaries have a creditable health insurance policy through employment, they can delay enrolling in Part B without penalty for as long as they work for the employer who sponsors the insurance. A creditable health insurance policy is one whose benefits Medicare agrees are at least as good as what Medicare provides. Some people choose that way if they feel their employer's plan meets their needs, because they can avoid having to pay Part B's monthly premium. But they must understand that when a retiree, or a retiree family member, gets Medicare, Tricare law requires immediate Part B enrollment in order to retain Tricare eligibility. Without Tricare eligibility, they can't have Tricare for Life. They have only Part A and their employer's insurance plan, as you were told. To be eligible for Tricare for Life, Medicare beneficiaries must be enrolled in Medicare Part B. That way, they will have their employer's plan as their primary coverage, Medicare Parts A and B as secondary and Tricare, which is always last, as required by law. Only you can decide what is best for you. If you're married, your loss of Tricare eligibility (if you decide not to enroll in Part B yet) will not affect your spouse's Tricare eligibility in any way.

(Q) How does coordination of benefits work for medical care and prescriptions if my spouse has her own civilian health insurance? I'm a retired reservist with Tricare For Life. My wife has her own civilian health insurance, as well as Tricare Standard, since I am her sponsor. Her drug plan has higher copay for some drugs than Tricare has. Can she use Tricare to get the lower co-pay, or does she pay the higher co-pay and file a claim with Tricare to get the difference? And can my wife and I use the Tricare mail order drug plan?

(A) As required by federal law, Tricare is always last payer to all other health insurance, medical plans such as an HMO, or medical payments such as one might receive for medical bills resulting from an auto accident, slip-and-fall injury, or the like. The beneficiary must file first with all other plans. When the other health insurance (OHI) has paid its maximum and issued the beneficiary an Explanation of Benefits, a Tricare claim may be filed. The only exceptions to the rule making Tricare last payer are if the OHI is a bona fide, specially written Tricare supplement, or if the OHI is a welfare-related plan such as Medicaid (not Medicare), Indian Health Service, and the like. Your

wife must use her OHI first for all medical and pharmacy services. For medical care, to file with Tricare as second payer, she must do the following:

- Complete an official [Tricare Claim Form DD2642](#).
- Attach copies of exactly the same bills (the same sheets of paper) that were sent to the OHI.
- Attach a copy of the OHI's Explanation of Benefits that reports details of its processing of each of those charges.
- Make copies of all the documents for your records.
- Send Tricare's copy of the package to the proper Tricare claims processing contractor for your [Tricare Region](#).

Your wife must use her commercial plan's pharmacy benefit first. To be reimbursed a portion of the OHI's pharmacy deductibles and copayments, contact Express Scripts at 1-877-363-1303 for instructions. Note that because of the way federal law requires pharmacy benefits to be coordinated, Tricare beneficiaries who have OHI are not eligible to use the Tricare Mail Order Pharmacy Plan.

(Q) Social Security says if you were born from 1943 through 1955, you must be 66 to receive monthly Social Security payments. Tricare says we have to join Tricare for Life and have Medicare Parts A and B at age 65. How can you get around that one-year gap in coverage?

(A) Congress changed only part of the Social Security law. Only the age required to receive Social Security payments was changed. The age for Medicare entitlement was not affected — that still begins at age 65. People who apply in a timely manner will become entitled to Medicare on the first day of the month of their 65th birthday. If they were born on the first day of that month, their Medicare entitlement will begin on the first day of the previous month. That is true regardless of when they become entitled to Social Security payments. If Tricare beneficiaries are properly enrolled in Medicare Part A and Part B, and if their Defense Enrollment Eligibility Reporting System registration is properly updated, DEERS will report their eligibility for Tricare for Life effective on the same date their Medicare entitlement is effective. Medicare will bill beneficiaries every 90 days for their Part B monthly premiums. When the Social Security beneficiaries become old enough to receive monthly benefit payments, the Part B premium will be deducted monthly as an allotment.

[Source: NavyTimes James E. Hamby Jr. column 1 Apr 2010 ++]

MEDICARE FRAUD Update 35:

- **Virginia Beach VA** - A local cancer doctor who practiced for 35 years was sentenced 15 MAR for bilking government-run health insurance programs out of \$1.3 million. Dr. Ronald Poulin refused to take responsibility for the crimes a jury convicted him of last fall, appearing to lay the blame on his employees. The 63-month prison term is at the bottom of federally recommended sentencing guidelines. A federal court jury in NOV 09 found Poulin guilty of 28 counts of health care fraud, ruling that the hematology and oncology specialist bilked Medicare and Tricare. Prosecutors documented hundreds of occasions where Poulin billed for greater quantities of chemotherapy drugs than were actually administered to patients, charging for patient office visits that never occurred, and splitting vials of the anemia drug Procrit between two patients and then billing the insurance as if each patient had received a full vial. He also billed for vials of Procrit when patients brought in their own medicine. When federal agents came to investigate, Poulin directed staff to alter records to hide the illegal activity, evidence showed. He was convicted of one count of health care fraud, 26 counts of filing false health care statements and one count of altering records to obstruct the investigation.

- **Palmetto FL** - Jeffrey Friedlander, 50, pleaded guilty 18 MAR to conspiring to distribute and dispense numerous controlled substances and also to conspiring to defraud Medicare. He faces a maximum penalty of 20 years in federal prison for the drug conspiracy and 10 years for the fraud conspiracy. Friedlander was licensed to practice internal medicine, neurology, pain management, and vascular and interventional radiology. While operating Neurology and Pain Center, Friedlander allowed unauthorized and non-medical employees to prescribe controlled substances to patients by using blank prescription forms that he pre-signed. Between 2005 and MAR 09, Friedlander submitted false claims to Medicare for performing paravertebral facet joint block injections, when such injections had not been performed or had been performed improperly, and when some of the injections had been performed by unlicensed nonmedical persons outside Friedlander's supervision.
- **West Hollywood CA** - On 18 MAR owners of a medical clinic were charged for billing public insurance health programs for as much as \$50 million in falsified invoices, in some case billing for services purportedly rendered in 2001 to dead patients. Alla Chernov, 48, and Boris Sokol, 50, each stand accused of one count of conspiracy to commit a crime. They made off with in excess of \$3.2 million in fraudulent Medicare and Medi-Cal billings. The complaint charges the pair with conspiring to involve medical doctors and bribing Medicare workers in order to obtain multiple provider numbers for doctors. They remain in custody; a judge set bail at \$15 million each. If convicted as charged, each faces seven years in prison.
- **Rochester NY** - Podiatrist Dr. Michael Akyuz, a licensed podiatrist, pled guilty on 23 MAR to healthcare and mail fraud. He stole more than \$750,000 by filing false claims and told the judge that it was easy. The government believes he fraudulently billed taxpayers, through Medicare. He also billed Excellus and the Veterans Administration. Over the course of five years, he falsified information on health insurance claims forms for services he never provided. His billing practices came to light after an audit by the justice department. Akyuz spent most of his time tending to elderly patients in nursing homes and retirement communities. Investigators interviewed many of those patients who said the doctor often did little more than trim their nails. In essence, he would go visit a patient, clip their toenails and then bill Medicare for a very complex, more advanced, more complicated medical procedure, which would be reimbursed at a higher level. Akyuz will have to make restitution for what he stole. He's also facing a possible prison sentence of up to 51 months when he is sentenced in July.
- **Joplin MO** - Dentist Samuel A. Miller, age 45, received suspended four-year prison terms and probation 22 MAR on convictions for defrauding the state's Medicaid program of \$550,000. He in plead guilty in SEP 09 to 13 counts of Medicaid fraud in a plea agreement with the Missouri attorney general's office. Each count of making a false statement to receive a health care payment carries up to four years in prison and a \$5,000 fine under state law. About 100 people showed up at the Jasper County Courts Building to show their support for Miller. Many were forced to remain outside the small courtroom in a hallway during the course of the hearing because no seating was left. Miller's lawyer presented the court with a \$300,000 check from his client as initial payment to the state on full restitution required by the settlement of a parallel civil court action the attorney general's office brought against Miller in Cole County Circuit Court.
- **Los Angeles CA** - Leonard Nwafor, 44, was sentenced on 25 MAR to nine years of imprisonment and three years of supervised release for a \$1 million power wheelchair fraud scheme. He will also have to pay \$526,243 in restitution, to forfeit \$526,000 and to pay a fine of \$25,000. He is the owner and operator of a Los Angeles-area durable medical equipment (DME) company. Nwafor was convicted in SEP 08 of conspiracy to commit health care fraud and health care fraud. After conviction, he fled and is considered a fugitive. Pacific City group Inc., Nwafor's business, submitted over a million dollars in fraudulent claims to Medicare. As a result he received \$526,243 from Medicare. The claims submitted to Medicare were for expensive, high-end power wheelchairs and wheelchair accessories that were not needed by the beneficiaries. Nwafor recruited beneficiaries that didn't need a wheelchair. He also used names of L.A. physicians on prescriptions he used to support his claims to Medicare.

- **Aulander NC** - Faith Elaine Sumner, 43, entered a guilty plea in federal court in DEC 09 for health care fraud and was sentenced to a prison term of 3 years and 10 months. As part of a plea arrangement, she was also ordered to repay \$677,272 in Medicare and Medicaid claims that she admitted to falsely reporting to the government and will be under three years of supervised probation following her release from prison. While employed as the office manager for Preferred Medical Transport of Aulander, she unlawfully billed the government in excess of \$650,000 by submitting false claims for reimbursement for ambulatory transports of clients going to and from dialysis treatments. However, transports of dialysis patients are normally of a non-emergency nature and usually performed by a wheelchair accessible van. During the investigation it was found that Sumner falsified trip records and related documents to show that the patient was transported by ambulance for “medical necessity.”
- **Nashville TN** - In a whistleblower lawsuit U.S. District Judge William J. Haynes on 23 MAR handed down a \$19.4 million judgment against Renal Care Group Inc., the once-publicly traded Nashville company that German competitor Fresenius Medical Care AG acquired in 2005. The verdict in an opinion concluded that RCGI had violated the federal False Claims Act by operating through a subsidiary, RCG Supply Company, to offer home dialysis to Medicare patients from 1999 until 2005. The Medicare program paid for home dialysis at a higher rate than it paid for in-hospital treatment. Concluding that "RCGSC was not a legitimate supplier of home dialysis supplies," Haynes found that RCGI had "exhibited reckless disregard" for the laws and rules governing the government's health care program for older people. The one whistleblower named in the case, who stands to receive a percentage of the judgment under federal law, is Julie Williams, a former employee who initially sued the company in St. Louis. It is possible that other complainants will also be entitled to share in the award. Out of the almost \$108 million in total Medicare revenue RCGI took in over those six years, \$19.4 million represented overpayments caused by the company's practices. In addition to refunding that money, he ordered that the company pay an as yet undetermined amount in pre-judgment interest.
- **Sterling Heights MI** - Physical therapist Solomon Nathaniel was sentenced 26 MAR to 62 months in prison, ordered to pay \$2,875,000 in restitution, and to serve a three-year term of supervised release following his incarceration for his role in a wide-ranging conspiracy to defraud the Medicare program. Nathaniel admitted that he and others created fictitious therapy files appearing to document physical and occupational therapy services provided to Medicare beneficiaries, when in fact no such services had been provided. The fictitious services reflected in the files were billed to Medicare through sham Medicare providers controlled by co-conspirators. He admitted that during the course of the scheme he signed approximately 1,250 fictitious physical therapy files, indicating that he had provided physical therapy services to Medicare beneficiaries, when in fact he had not and that he was paid between \$90 and \$110 for each file he falsified. He also admitted that between approximately DEC 03 and JUL 06, he falsified physical therapy files that supported claims to the Medicare program totaling approximately \$6,250,000. Medicare paid approximately \$2,875,000 on those claims.

Source: Fraud News Daily reports 15-31 Mar 2010 ++]

MEDICAD FRAUD Update 11:

- **Fall River MA** - Michael Clair, 51, has been indicted on charges of assault and battery, larceny over \$250, Medicaid False Claims, and illegally prescribing a Class B Substance and a Class C Substance. He had previously been excluded as a provider from the Medicaid program for allegedly inserting pieces of paper clips into patients' mouths as a post in root canals instead of utilizing standard posts made of stainless steel, and billing Medicaid for the costs using other dentists' provider numbers. Clair allegedly hired several dentists at Harbour Dental, his Fall River dental practice, that were eligible MassHealth providers and would file claims with MassHealth using their provider numbers for dental services he performed. Clair

fraudulently billed approximately \$130,000 to Medicaid for those services for a period between AUG 03 and JUN 05. Investigators also found that Clair unlawfully prescribed Hydrocondone, Combunox and Percocet to staff members, who then gave all or a portion of the prescribed medication back to Clair. An arraignment has been scheduled for April 8.

- **LANSING MI** - A Florida woman who authorities say fraudulently filed more than \$3.3 million in Medicaid claims in Michigan from 2007 to 2009 has been arrested and charged with fraud and racketeering. Michigan Attorney General Mike Cox says 56-year-old Deborah D'Anna was arrested 16 MAR at her home in Ocala. She was being held pending extradition and faces 25 Medicaid fraud counts and one racketeering charge. Authorities say D'Anna was the owner and office manager of Palmer Park Medical Center, which had clinics in Detroit and Romulus until 2005. D'Anna billed using identification numbers of former Palmer Park doctors. The doctors weren't implicated. D'Anna spent \$88,000 alone buying from TV shopping channel QVC.
- **Albertson NY** - Dr. Muhammad Ejaz Ahmad, age 52, was sentenced 23 MAR to 21 months in prison and ordered to make restitution of \$1.7 million for Medicaid kickbacks. Ahmad specialized in infectious diseases, including the treatment of AIDS/HIV patients. He paid an illegal kickback of \$40 to patients at office visits and then referred these patients to one of three pharmacies he owned, billing Medicaid for medications that were never dispensed. New York state's commissioner of health, said Monday he used his emergency powers to summarily suspend the license of Ahmad. A summary suspension precludes Ahmad from caring for any patients pending the outcome of a disciplinary hearing and is based on the commissioner's determination that the continued practice of medicine by the physician constitutes an imminent danger to the health of the people of New York. In addition, he summarily suspended licenses of:
 - Dr. Gope Chelaram Hotchandani, who has an office is in Wisconsin and was convicted of insurance fraud.
 - Dr. Alexander Israeli of New York, who was found guilty of two counts of insurance fraud.
 - Dr. Alexander Rozenberg of New York City, who was found guilty of falsifying business records and insurance fraud

[Source: Fraud News Daily reports 15-31 Mar 2010 ++]

MILITARY HISTORY:

In early 1966 events in Vietnam escalated signaling that Hanoi was desperately in search of a victory. The Communists' increased willingness to stand and fight whatever the cost, plus evidences of a mounting buildup of forces then coming directly across the demilitarized zone separating North and South Viet Nam could only lead to increased conflict. On 16 MAR 66 in enemy-held Vietnam's Zone D only 35 miles northeast of Saigon, a 10,000-man allied sweep of the dense jungle area called Operation Silver City erupted in a major clash with the NVA. This became known as the battle of Landing Zone Zulu Zulu. The dug in 2d Bn 503d Parachute Infantry, 173d Abn Bde (Sep) had cleared an area for helicopter resupply. Short of water for days, they thirstily watched the first water-laden chopper drop down from the sky. Suddenly an enemy automatic weapon chattered, knocking the chopper in flames to the earth. On the signal, the jungle around the paratroopers erupted in gunfire. The landing zone, called Zulu Zulu, was completely encircled by the 400 Communist troops-90% of them North Vietnamese regulars-of the Viet Cong's 271st main-force regiment. Thus began a seven-hour battle won by the Airborne with fewer casualties and more enemy dead than any major engagement of the Viet Nam war. Time and again the outmanned and outgunned Viet Cong charged. Coolly and methodically, the well dug-in paratroopers cut them down. Australian artillery laid a lethal ring of steel around Zulu Zulu; dive-bombers plastered the attackers on an average of every six minutes for five hours running; "Mad Bomber" Huey helicopters rigged with plywood tubes pointing downward dropped 81-mm. mortar shells right on the heads of the enemy. The enemy troops finally gave up. Operation Silver City resulted in 400+ NVA KIA, 19 U.S. KIA, and 200+ U.S. WIA. In AUG 67, President Lyndon Johnson awarded the 2d Battalion, 503rd Infantry, and attached units the Presidential Unit Citation for

extraordinary heroism at LZ Zulu-Zulu. This citation is the highest unit award made to any army organization. For a detailed description by those who participated in the battle and an After Action Report refer to www.ibiblio.org/173abn/2bat/Issue5.pdf . [Source: Time Magazine article 25 Mar 1966 & 2/503d Newsletter Sep 09 ++]

MILITARY HISTORY ANNIVERSARIES:

- Apr 01 1865 - Civil War: Battle of Five Forks - In Siege of Petersburg, Confederate General Robert E. Lee begins his final offensive.
- Apr 01 1945 - WWII: Operation Iceberg - United States troops land on Okinawa in the last campaign of the war.
- Apr 01 1948 - Cold War: Berlin Airlift - Military forces, under direction of the Soviet-controlled government in East Germany, set-up a land blockade of West Berlin.
- Apr 01 1954 - President Dwight D. Eisenhower authorizes the creation of the United States Air Force Academy in Colorado.
- Apr 02 1865 - Civil War: The Siege of Petersburg is broken - Union troops capture the trenches around Petersburg, Virginia, forcing Confederate General Robert E. Lee to retreat.
- Apr 02 1917 - WW I: U.S. President Woodrow Wilson asks the U.S. Congress for a declaration of war on Germany.
- Apr 02 1972 - Vietnam: The Easter Offensive begins - North Vietnamese soldiers of the 304th Division take the northern half of Quang Tri Province.
- Apr 03 1865 - Civil War: Union forces occupy the Confederate capital of Richmond, Virginia.
- Apr 03 1942 - WWII: The Japanese begin their all-out assault on the U.S. and Filipino troops at Bataan.
- Apr 03 1945 - WWII: US 1st army conquers Hofgeismar, Germany
- Apr 04 1917 - WWI: The U.S. Senate votes 90-6 to enter World War I on Allied side.
- Apr 04 1918 - WWI: The Battle of the Somme ends.
- Apr 05 1968 - Vietnam: Operation Pegasus was launched by the 1st Air Cavalry Division to relieve the marines at Khe Sanh.
- Apr 06 1862 - Civil War: The Battle of Shiloh begins - in Tennessee, forces under Union General Ulysses S. Grant meet Confederate troops led by General Albert Sidney Johnston.
- Apr 06 1865 - Civil War: The Battle of Sayler's Creek - Confederate General Robert E. Lee's Army of Northern Virginia fights its last major battle while in retreat from Richmond, Virginia.
- Apr 06 1917 - WWI: The United States declares war on Germany (see President Woodrow Wilson's address to Congress).
- Apr 06 1972 - Vietnam: Easter Offensive - American forces begin sustained air strikes and naval bombardments.
- Apr 07 1862 - Civil War: Battle of Shiloh ends - the Union Army under General Ulysses S. Grant defeats the Confederates near Shiloh, Tennessee.
- Apr 07 1943 - Holocaust: In Terebovlia, Ukraine, Germans order 1,100 Jews to undress to their underwear and march through the city of Terebovlia to the nearby village of Plebanivka. There they are shot dead
- Apr 07 1945 - WWII: The Japanese battleship Yamato, the largest battleship ever constructed, is sunk 200 miles north of Okinawa while en-route to a suicide mission in Operation Ten-Go.
- Apr 07 2003 - Gulf War: U.S. troops capture Baghdad; Saddam Hussein's regime falls two days later.
- Apr 09 1865 - Civil War: Robert E. Lee surrenders the Army of Northern Virginia (26,765 troops) to Ulysses S. Grant at Appomattox Courthouse, Virginia, effectively ending the war.
- Apr 09 1916 - WWI: The Battle of Verdun - German forces launch their third offensive of the battle.

- Apr 09 1917 - WW I: The Battle of Arras - the battle begins with Canadian forces executing a massive assault on Vimy Ridge.
- Apr 09 1942 - WWII: The Battle of Bataan/Bataan Death March - United States forces surrender on the Bataan Peninsula
- Apr 09 2003 - Invasion of Iraq: Baghdad falls to American forces.
- Apr 10 1972 - Vietnam: For the first time since NOV 67, American B-52 bombers reportedly begin bombing North Vietnam.
- Apr 11 1951 - Korea: President Truman fires General Douglas MacArthur as head of United Nations forces in Korea.
- Apr 12 1966 - Vietnam: 1st B-52 bombing on North Vietnam
- Apr 13 1861 - Civil War: Fort Sumter surrenders to Confederate forces.
- Apr 14 1918 - WWI: Douglas Campbell is 1st US ace pilot (shooting down 5th German plane)
- Apr 14 1945 - WWII: US 7th Army & allies forces captured Nuremberg & Stuttgart in Germany

[Source: Various Mar 2010 ++]

TAX BURDEN FOR MISSISSIPPI RETIREES: Many people planning to retire use the presence or absence of a state income tax as a litmus test for a retirement destination. This is a serious miscalculation since higher sales and property taxes can more than offset the lack of a state income tax. The lack of a state income tax doesn't necessarily ensure a low total tax burden. Following are the taxes you can expect to pay if you retire in Mississippi:

State Sales Tax: 7% (prescription drugs, residential utilities, motor fuel, newspapers, healthcare services, and payments made by Medicare and Medicaid are exempt); County and city taxes may add an additional 3% to the state rate.

Gasoline Tax: 27.2 cents/gallon

Diesel Fuel Tax: 27.2 cents/gallon

Cigarette Tax: \$.56 cents/pack of 20

Personal Income Taxes

Tax Rate Range: Low - 3%; High - 5%.

Income Brackets: 3 (Lowest - \$5,000; Highest - \$10,000). The tax brackets reported are for single taxpayers. For married taxpayers filing jointly, the same rates apply to income brackets ranging from \$31,860 to \$126,580 (2008).

Personal Exemptions: Single - Single - \$6,000; Married - \$12,000; Dependents - \$1,500. For details refer to www.mstc.state.ms.us/taxareas/individ/whoshouldfile.htm.

Additional Exemption: 65 or older - \$1,500

Standard Deduction: Single - \$2,300; Married filing jointly - \$4,600

Medical/Dental Deduction: Partial

Federal Income Tax Deduction: None.

Retirement Income Taxes: Qualified retirement income is exempt from state income tax. Social Security is not taxed, regardless of total income. Retirement income from IRAs, 401s/403s, Keoghs and qualified public and private pension plans is not taxable. Interest income from federal securities and obligations of Mississippi and its political subdivisions are all exempt.

Retired Military Pay: Retired pay is exempt after January 1, 1994. The exemption is also available to the spouse or other beneficiary upon the death of the primary retiree. Widows' pensions received from the VA are not taxable.

Military Disability Retired Pay: Retirees who entered the military before Sept. 24, 1975, and members receiving disability retirements based on combat injuries or who could receive disability payments from the VA are covered by laws giving disability broad exemption from federal income tax. Most military retired pay based on service-

related disabilities also is free from federal income tax, but there is no guarantee of total protection.

VA Disability Dependency and Indemnity Compensation: VA benefits are not taxable because they generally are for disabilities and are not subject to federal or state taxes.

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

Property Taxes

Property and automobiles are both subject to ad valorem taxes - meaning that the tax is assessed in relationship to the value of the property. Single family residential property is taxed at 10% of its assessed value. All other personal property is assessed at 15% of its value. Motor vehicles are taxed at 30% of their value. The state offers a homestead exemption to all eligible taxpayers. Eligible homeowners should make application with the Tax Assessor in the county where the home is located. This application must be filed between January 1 and April 1. The maximum exemption for regular homeowners is \$300. For homeowners 65 years of age or totally disabled, there is an exemption on the first \$75,000 true value. You do not have to apply for homestead exemption each year. You should reapply if there were changes in your homestead status (marital, property, ownership, etc.). For additional information, call 601-923-7631 or refer to www.mstc.state.ms.us/taxareas/property/advvalor.html.

Inheritance and Estate Taxes - There is no inheritance tax. An estate tax is imposed on the value of a decedent's estate when the total gross estate exceeds the federal exemption of \$1,000,000. The exemption amount will follow the federal exclusion under 26 USC 2010.

For further information, visit the Mississippi State Tax Commission site www.mstc.state.ms.us or call 601-923-7000 [Source: www.retirementliving.com Mar 2010 ++]

VETERAN LEGISLATION STATUS 29 MAR 2010: Congress is on spring recess and will be home in their district offices for the next two weeks. They return to Washington 12 APR and reconvene. Now is the best time to visit them and discuss the health care reform law as well as all of our legislative priority goals - let them know that you expect them to do the right thing by our veterans and service men and women. For or a listing of Congressional bills of interest to the veteran community that have been introduced in the 111th Congress refer to the Bulletin's Veteran Legislation attachment. 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. Any number of members may cosponsor a bill in the House or Senate. At <http://thomas.loc.gov> you can 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/d111/sponlst.html>.

Grassroots lobbying is perhaps the most effective way to let your Representative and Senators know your opinion. Whether you are calling into a local or Washington, D.C. office; sending a letter or e-mail; signing a petition; or making a personal visit, Members of Congress are the most receptive and open to suggestions from their constituents. The key to increasing cosponsorship on veteran related bills and subsequent passage into law is letting legislators know of veteran's feelings on issues. You can reach their Washington office 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> your legislator's 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 for dates that you can access your legislators on their home turf. [Source: RAO Bulletin Attachment 29 Mar 2010 ++]

HAVE YOU HEARD? Why Men Can't Win

If you work too hard, there is never any time for her.
If you don't work enough, you're a good-for-nothing bum.

If she has a boring repetitive job with low pay, it's exploitation.
If you have a boring repetitive job with low pay, you should get off your butt and find something better.

If you get a promotion ahead of her, it's favoritism.
If she gets a job ahead of you, it's equal opportunity.

If you mention how nice she looks, it's sexual harassment.
If you keep quiet, it's male indifference.

If you cry, you're a wimp.
If you don't, you're insensitive.

If you make a decision without consulting her, you're a chauvinist.
If she makes a decision without consulting you, she's a liberated woman.

If you ask her to do something she doesn't enjoy, that's domination.
If she asks you, it's a favor.

If you try to keep yourself in shape, you're vain.
If you don't, you're a slob.

If you buy her flowers, you're after something.
If you don't, you're not thoughtful.

If you're proud of your achievements, you're an egotist.
If you're not, you're not ambitious.

If she has a headache, she's tired.
If you have a headache, you don't love her anymore

[“I know not with what weapons World War III will be fought, but World War IV will be fought with sticks and stones.”](#)

Albert Einstein

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