STATEMENT

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

LEGISLATIVE PRIORITIES

for

VETERANS' HEALTH CARE and BENEFITS

2nd Session, 114th Congress

before the

SENATE and HOUSE VETERANS' AFFAIRS COMMITTEES

March 16, 2016

Presented by

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EXECUTIVE SUMMARY

VETERANS' HEALTH CARE PRIORITIES

HEALTH SYSTEM ACCESS, REFORM AND ACCOUNTABILITY

- Reform and consolidate Community Care Programs, including a strategy for a new Veterans' Choice Program to streamline, improve access to care, and integrate purchased care into the broader VA health system.
- Sustain congressional attention and oversight over the 32 Department of Veterans Affairs (VA) Health Administration (VHA) operational weaknesses identified in GAO's *2015 High Risk List* to better manage risks and improve VA health care and patient outcomes.
- Establish new standards and simplify eligibility criteria for access and enrollment in the VA health system.
- Provide funding and other resources to support the Secretary of VA's plan to fill critical executive director positions throughout the VHA.
- Fully fund VHA and sustain two-year advance appropriations, including implementing the major recommendations outlined in the 'critical issues' section of The Independent Budget (IB) Veterans Agenda for the 114th Congress.
- Oppose proposals that would privatize veterans' health care or would combine VHA and the Military Health System/TRICARE on the premise of creating efficiencies or potential cost-savings.
- Preserve the integrity and access to VA and Department of Defense (DoD) health systems for dually eligible members.
- Authorize adult children of survivors entitled to Civilian Health and Medical Program of the VA (CHAMPVA) to be carried on their parent's insurance up to age 26.
- Require VA and DoD to achieve full interoperability of electronic medical and personnel records, including interface capability for outside provider.
- Strengthen VA and DoD health system collaboration by implementing recommendations outlined in the 2015 Military Compensation and Retirement Modernization Commission (MCRMC) report.

HEALTH CARE PROGRAMS

MENTAL HEALTH CARE AND SUICIDE PREVENTION

- Amplify initiatives to improve the delivery of mental health services, including staffing and resources for direct referral of high-risk active and Reserve component servicemembers to the VA health system prior to discharge.
- Assure sufficient resources to train and educate VA staff and community mental health providers on the unique cultural needs of military, veterans and their families.
- Strengthen and expand suicide prevention programs for veterans, including members of the Reserve Components.
- Fully implement the Fiscal Year 2016 National Defense Authorization Act provision to establish a joint formulary for pain and psychiatric drugs for transitioning veterans.

MILITARY SEXUAL ASSAULT-TRAUMA — Improve collaboration and resolve discrepancies in VA and DoD reporting of military sexual assaults-trauma cases, including policies and practices for prevention, care and services, and benefits to assure positive outcomes to men and women seeking support.

WOMEN VETERANS — Aggressively implement VA's Women Veterans Strategic Health Care plan to improve access to gender-specific medical and mental health care.

SEAMLESS TRANSITION AND CONTINUITY OF CARE

- Ensure greater emphasis on the standardization, execution, and funding of wounded, ill, and injured and disability programs and policies to achieve seamless transition between the VA and DoD health and benefit systems.
- Ensure catastrophically disabled veterans have access to the same reproductive services as are available in the DoD health system.
- Support additional funding for collaborative, mid-long-term research between VA and DoD with emphasis on psychological and physical health care, including veterans exposed to toxic substances during military service, catastrophic injuries, and long-term disability care and support services.

CAREGIVER SUPPORT PROGRAM — Extend eligibility for the VA Caregiver Support Program to full-time caregivers of catastrophically disabled veterans of conflicts before September 11, 2001.

VETERANS' BENEFITS

APPEALS MODERNIZATION – REFORM OBJECTIVES AND PRINCIPLES

- Overhaul the VA's notice of action and decision to ensure transparency and utility for the veteran.
- Provide for a meaningful hearing before the fact-finder in appeals cases.
- Ensure a *de novo* review of any initial disability claim decision
- Require an 'open record' throughout the appeals process until the claim reaches the U.S. Court for Veterans Appeals.

CAMP LEJEUNE 'BAD WATER' CLAIMS REGULATIONS

- Require Camp Lejeune 'Bad Water' Claims regulations be effective from the date the veteran was first diagnosed with the recognized condition; allow the surviving family to make claims on behalf of the deceased veteran and collect retroactive benefits in his or her stead.

AUTOMATION OF VA PENSION OFFICES

- Require the VA to set as a priority the automation of pension offices and to authorize sufficient resources for that purpose.

COORDINATION BETWEEN THE VA AND THE DEFENSE FINANCE AND ACCOUNTING SERVICE (DFAS) FOR MILITARY RETIREES

- Ensure close oversight of VA plans and procedures to achieve timely processing of disability pay to retired veterans also entitled concurrently to military retired compensation.

'BLUE WATER' NAVY VIETNAM VETERANS

- Authorize service connection for "Blue Water" Navy Vietnam veterans who have one or more diseases on the Agent Orange presumptives list.

VETERAN TRANSITION, READJUSTMENT AND EMPLOYMENT

- Require all service members going through the improved Transition Assistance Program (TAP) "GPS" to take the education track to gain a basic understanding of training and education opportunities available under the Post-9/11 GI Bill.
- Re-authorize certain Vocational Rehabilitation and Employment provisions in the VOW to Hire Heroes Act (P.L. 112-56) to support the drawdown of servicemembers under sequestration.

GI BILL PROGRAMS

Oversight, Outcomes, Transparency

- Expand the VetSuccess On Campus program and make the application and school selection process transparent.
- Mandate the educational counseling provisions under Chapters 36 and 38 U.S. Code via appropriate means, including modern technologies, and permit veterans to opt out. Raise the $6 million cap in the counseling provision to meet the enormous demand of new GI Bill enrollments.
- Require all academic programs receiving funding under the GI Bill be Title IV compliant under Department of Education rules.

Integration of Educational Assistance Programs in Unified Program Architecture

- Sunset the Montgomery GI Bill (MGIB) – Active Duty (Chapter 30, 38 USC)
- Consolidate GI Bill programs under a single platform in Title 38 structured under a principle of scaling benefits according to the length and type of service performed:
    - Recruits who initially enter the National Guard and Reserve would receive the lowest benefit level.
    - Reservists called to active duty (Title 10) for aggregates of 90 days or more would receive a portion of the new GI Bill (Chapter 33, 38 USC) as currently authorized.
    - Service members who complete 36 months of qualifying active duty would receive the maximum benefit under Chapter 33.
    - Re-codify the MGIB-Selected Reserve from Chapter 1606, 10 USC as a sub-chapter in Chapter 33, 38 US Code.

GI Bill Transferability Contracts

- Pass legislation to ensure GI Bill transfer policies are being honored when the Service causes the separation through no fault of the member, as required in DoD regulation.

SURVIVORS' AND DEPENDENT BENEFITS

Survivors' Fry Scholarship Usage Period

- Urge final passage of a House-passed provision to extend the Fry Scholarship usage period for surviving spouses who lost their military spouse in the immediate years after September 11, 2001.

Dependency and Indemnity Compensation (DIC) Equity

- Establish the annual DIC rate at 55 percent of the compensation rate for a 100 percent service-connected veteran.

Caregivers of Catastrophically Disabled Veterans

- Increase the income replacement rate for survivors of catastrophically disabled veterans.

Retain DIC on Remarriage at Age 55

- Establish age-55 for retention of DIC upon the remarriage of a surviving spouse, thereby bringing the benefit in line with rules for the military SBP program and all other federal survivor benefit programs.
- Allow survivors qualified for Civilian Health and Medical Program of VA (CHAMPVA) to enroll in a proposed CHAMPVA dental program.

NATIONAL GUARD AND RESERVE VETERAN

Reemployment Rights and the Office of Special Counsel

- Ensure a continuing, robust role for the federal Office of Special Counsel (OSC) in USERRA claims brought by members of the National Guard or Reserve who are federal employees.

Service members Civil Relief Act (SCRA)

- Make mandatory arbitration agreements in certain financial contracts unenforceable under the SCRA.
- Authorize civil fines for violations of the SCRA, criminal penalties in egregious cases of violation of the statute, and recovery of reasonable attorneys' fees by servicemembers from SCRA violators.

Honoring as Veterans for Certain Career National Guard and Reserve Members

- Enact legislation (H.R. 1384) that would honor certain career Reservists as "veterans of the Armed Forces of the United States."

CHAIRMAN ISAKSON, CHAIRMAN MILLER, RANKING MEMBERS BLUMENTHAL AND BROWN, on behalf of the more than 390,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA's major legislative priorities for veterans' health care and benefits this year.

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

VETERANS' HEALTH CARE PRIORITIES

HEALTH SYSTEM ACCESS, REFORM AND ACCOUNTABILITY

MOAA is grateful for the Committees' and Congress' steadfast commitment to keeping our nation's veterans and their families as a top priority. We especially thank you for your public announcement at a recent hearing stating veterans have "the Committees' commitment that there will never be a break in veterans' health care and we will always meet the needs of veterans."

Today's Department of Veterans Affairs Health Administration has evolved into the largest integrated health systems in America.

Yet, through evolution, this system of care has become vastly more complex and access requirements more complicated than ever, even after decades of reform efforts and enhancements like the Choice Program. Veterans must contend with a multiplicity of access points, eligibility criteria and gatekeepers to access health care and services. The experiences of veterans using VHA vary widely across the country. The inconsistencies and complexities across the health system erode the trust and confidence veterans have in their system.

Congress plays a critical role in VA reform by helping resolve health system inconsistencies and gaps. We urge Congress to continue its strong oversight and targeted attention on resolving ongoing systemic weaknesses, especially the 32 VHA issues outlined in GAO's *2015 High Risk List*, including: ambiguous policies and inconsistent processes; inadequate oversight and accountability; information technology challenges; inadequate training for VA staff; and, unclear resource needs and allocation priorities.

We believe the swift passage of two key bills: the Veterans Access, Choice and Accountability Act of 2014[1] and Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015[2], as well as additional funding to address shortfalls in several VHA accounts are the foundational steps in reforming health care and benefits systems across the VA.

Secretary McDonald and his leadership team have committed significant resources and attention to not only fixing current health care system problems, but also are moving aggressively to implement reform through a major effort called MyVA. We commend the Secretary for his vision and tenacious leadership as he leads the organization in a new direction.

Despite frustrations with the implementation of the Veterans Choice Program, most agree there has been significant progress in improving access in a relatively short period of time. Though access to care is improving, VA continues to experience multiple systemic issues across the agency, affecting its current mission as well as its ability to meet the growing demand and changing veteran population.

Although the veteran population is expected to decline over the next decade, a unique mixture of demographic factors is leading to increased demand for VA services and is expected to continue for the foreseeable future.

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[1] P.L. 113-146, or the Choice Act

[2] P.L. 114-41, or the VA Budget and Choice Improvement Act

The VA has certainly embraced the opportunity for reform with the New Veterans Choice Program (VCP) plan to consolidate community care. Implementing Choice has brought to light many of the systemic issues mentioned, and with it, the opportunity to consider a new vision for VA health care that might otherwise have been missed.

MOAA believes the New VCP plan is a step in the right direction to simplify community care and integrate the entire system to enhance the veterans' experience and health outcomes. If collectively we can focus on reforming and consolidating VCP—that is, if we can get this program right – we are confident further VHA system reform will follow and will be more effective.

Regardless of what the system of care will look like in the future, the nation has a shared responsibility to ensure veterans have access to the care, benefits, and services they have earned, deserve, and value. The key elements of a health system veterans and their families and caregivers value most include high quality, accessible, comprehensive, integrated, and veteran-centric care—a system that is simple, easy to understand and navigate, and is seamless whether the care is delivered in-house or in the community.

Multiple ideas and solutions to reform VHA have come forward in recent months, providing a unique opportunity to take a fresh look at health care.

One idea MOAA believes should be seriously considered is the Veterans' Independent Budget's (IB) veterans service organization (VSO) concept, a *Framework for Veterans Health Care Reform*.

The approach builds upon VA's progress in transforming VHA, but goes beyond the legislative, regulatory and bureaucratic constraints hampering the system today.

MOAA believes the IB concept provides an excellent framework for development of an overall strategy for what a veterans' health care system should look like. This is an important distinction for the VA Commission on Care to consider when making its recommendations to Congress.

MOAA endorses the IB recommends moving away from arbitrary federal access standards to a clinically-based decision made between a veteran (to include family and caregivers) and a physician or health care professional, offering the potential for simplifying eligibility requirements and expanding access across the system.

We urge the Committees to fully fund VHA and sustain two-year advanced appropriations to help implement the major recommendations outlined in the "Critical Issues" section of the IB Veterans Agenda for the 114th Congress. Doing so will help address VHA funding shortfalls, ensure budgets and resources are allocated to address modernization efforts, and meet the evolving demand for medical services.

To drive change and address systemic issues, the VA must also address the growing number of leadership and employee vacancies in its health system.

According to Secretary McDonald, 10 of his 16 executives are new to their positions since he was confirmed. Today, 21 percent of Veterans Integrated Service Networks (VISN) director positions are vacant. These vacancies take an average of four to eight months to recruit and fill. Also concerning, according to VA officials, is the number of applications for medical positions is down by 78 percent. The VA recognizes there is great uncertainty and lack of stability and tenure in the workforce, and the system does not do a good job with succession planning or leadership development.

Recently we received a letter from a MOAA couple, both physicians, sharing a recent experience with VA's hiring process and cultural challenges at one VA medical center:

"…during the past year, my wife, (who has a very creditable psychiatric CV and who last served as the MS State Mental Health Officer) made a conscious decision to "switch" to the VA to see if she could assist with the MH services there. The effort was onerous beginning with the application process which took "forever". Then, after working about six months in the VA hospital in Columbia, SC, she resigned due to the unresponsiveness of the system and an overwhelmingly burdensome bureaucracy, which ranked patient care very near the bottom of their everyday concerns, despite the fact that the division was hugely overstaffed when compared to civilian models.

Since her departure, she has been astounded to realize how many physicians and other health care professionals have previously worked with the VA and have left to take other mental health positions which paid far less and offered far fewer perks and time off…"

More must be done to modernize the VA human resources system by requiring the VA to implement a workforce management and succession planning strategy for attracting, training, retaining, and sustaining high quality health care personnel and executive-level leaders.

MOAA urges the Committees' to direct funding and resources to provide the necessary tools and incentives needed for the Secretary to fill critical executive director positions throughout the VHA for assuring stability, cultural change and long-term transformation efforts.

We remain concerned about the multiple budget crises this last year and the outlook for future funding of the VHA health system. Some may see an opportunity to consolidate or dismantle the VA health system or transfer more of the costs of health care to our veterans. MOAA strongly supports the preservation of the VA health system. VHA is a system with a unique and comprehensive mission of meeting the needs of those who have borne the battle—a mission unlike that of any other health system in America today.

The Patient Protection and Affordable Care Act[3] allows adult children to be carried on their parent's insurance up to age 26 under specific circumstances. All other health plans now authorize such coverage, including TRICARE and the Federal Employee Health Benefit Plan. For young adults up to age 26 who could be carried on their CHAMPVA-eligible surviving parents' coverage, a technical correction to Title 38 is needed. MOAA thanks Senator Tester (D-Minn.), Ranking Member Brown (D-Fla.), and Rep. Fortenberry (R-Neb.) for their support of this issue and we urge the Committees to favorably report out S. 170, H.R. 218 and H.R. 220.

MOAA believes efforts to reform health systems present an ideal opportunity for the VA and DoD to develop even stronger partnerships. The January 2015 MCRMC report highlighted the deficiency in departmental coordination and recommended "improved collaboration between DoD and VA by enforcing coordination on electronic medical records, a uniform formulary for transitioning service members, common services, and reimbursements (Pages 127-140)."

The VA and DoD have yet to implement a truly interoperable integrated electronic health record (iEHR), with no viable plan to meet congressional and presidential mandates on the horizon. The Departments' essentially abandoned a single system, choosing instead to maintain and invest in individual technology systems. Such a path will continue to disadvantage veterans.

MOAA feels strongly that an iEHR should remain a top priority and urge Congress to require VA and DoD to achieve interoperability. We believe the iEHR is central to achieving a seamless transition and is crucial to VHA transformation.

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[3] P.L. 111-148, or the ACA

MOAA recommends the Committees:

- ***Reform and consolidate Community Care Programs, including a strategy for a new Veterans' Choice Program to streamline, improve access to care, and integrate purchased care into the broader VA health system.***
- ***Sustain congressional attention and oversight over the 32 Department of Veterans Affairs Health Administration operational weaknesses identified in GAO's 2015 High Risk List to better manage risks and improve VA health care and patient outcomes.***
- ***Establish new standards and simplify eligibility criteria for access and enrollment in the VA health system.***
- ***Provide funding and other resources to support the Secretary of VA's plan to fill critical executive director positions throughout the VHA.***
- ***Fully fund VHA and sustain two-year advance appropriations, including implementing the major recommendations outlined in the 'critical issues' section of The Independent Budget (IB) Veterans Agenda for the 114th Congress.***
- ***Oppose proposals that would privatize veterans' health care or would combine VHA and the Military Health System/TRICARE on the premise of creating efficiencies or potential cost-savings.***
- ***Preserve the integrity and access to VA and Department of Defense (DoD) health systems for dually eligible members.***
- ***Authorize adult children of survivors entitled to Civilian Health and Medical Program of the VA (CHAMPVA) to be carried on their parent's insurance up to age 26.***
- ***Require VA and DoD to achieve full interoperability of electronic medical and personnel records, including interface capability for outside provider.***
- ***Strengthen VA and DoD health system collaboration by implementing recommendations outlined in the 2015 Military Compensation and Retirement Modernization Commission (MCRMC) report.***

HEALTH CARE PROGRAMS

Mental Health Care and Suicide Prevention

MOAA is extremely grateful to the Committees and the VA for the relentless determination to improve the physical and mental wellness of our veterans, devoting significant time, funding, and resources to provide timely access to care and services.

According to GAO[4], veterans receiving mental health care increased by 63 percent during the period 2005-2013 and in 2014, VHA provided mental health outpatient specialty care to more than 1.5 million veterans at over $3.9 billion.

While so much has been done, there is still much more to do. In a new report, *"Balancing Demand and Supply for Veterans' Health Care,[5]"* RAND predicts between the years 2014-2024, "the VA patient population will become less healthy. The aging veteran population and increased numbers of Iraq and Afghanistan veterans will make up a larger share of the patient population—a population with a higher degree of chronic conditions, including mental health conditions such as depression and posttraumatic stress disorder (PTSD)."

The VA continues to make progress in hiring additional providers across all health care fields, particularly in programs targeting high-risk veterans, targeting the debilitating issues associated with homelessness, chronic medical conditions, drug and alcohol abuse, brain or traumatic injuries, and suicidal ideation.

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[4] VA Mental Health, Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO-16-24, October 2015

[5] A Summary of Three RAND Assessments Conducted under the Veterans Choice Act

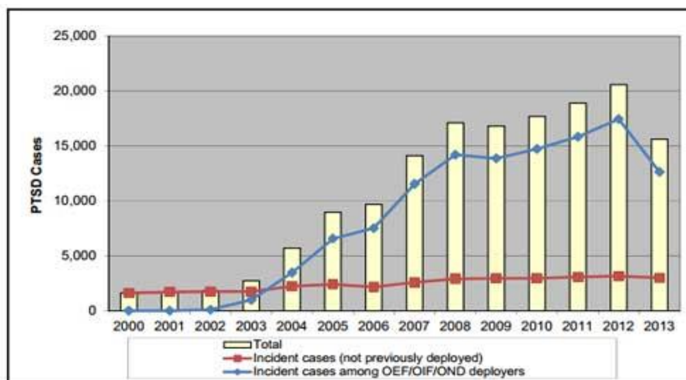
According to the National Alliance on Mental Illness, one in five Americans suffers from a mental health condition, and only about 41 percent of these adults received treatment last year. The entire country is struggling with the lack of available care and providers—the very same challenges facing the VA today.

The VA competes for the same limited quantity and quality of providers and resources as health systems across the country at a time when demand is outpacing supply. Accordingly, the VA must aggressively improve the delivery of mental health services through public-private partnerships, increase care to rural veterans, and expand telehealth opportunities. Special attention should be focused on seamless referral of high-risk active and Reserve component servicemembers to the VA health system prior to discharge.

We must assure sufficient resources are available to train and educate VA staff and community providers on the unique cultural needs and expectations of military, veterans and their families, for both their physical and mental well-being.

In addition to increasing the number of VA physicians, MOAA supports RAND's report[6] recommendations for the VA to grant independent practice authority for all advanced-practice nurses (i.e., nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives) and expand clinical video telehealth.

The rates of PTSD cases in the military continue to trend upward. The Army alone has seen well over 15,000 cases between the years 2008-2013 (see chart below). Military and veterans suicide rates are even more disturbing, needing immediate attention. MOAA believes suicide prevention requires a national strategy coordinated between VA, DoD, other federal, state, and local agencies and communities. The strategy must include a proactive approach to outreach, screening and prevention programs if we are to address the rising demand for mental health services expected in the coming years as a result of 14 years of sustained military operations in Iraq and Afghanistan.



Source: CRS communication with Dr. Michael Carino, Army Office of the Surgeon General, January 10, 2014. Data source is the Defense Medical Surveillance System (DMSS).

The Committees have gone to great lengths to address the issues of mental health care and press for greater transparency in both VA and DoD health systems. MOAA is especially grateful for Congress passing a provision in the FY 2016 NDAA requiring the establishment of a joint formulary for pain and psychiatric drugs to ensure continuity of care for transitioning veterans from DoD to VHA, including Guard and Reserve members.

Military Sexual Assault-Trauma

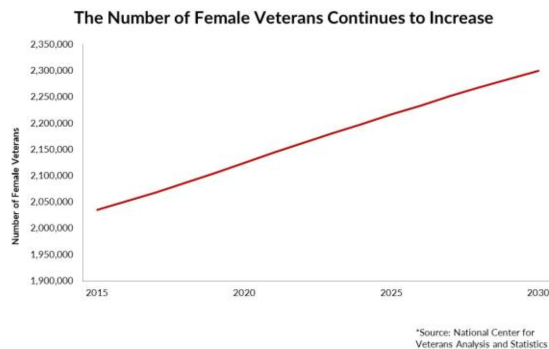
[6] Balancing Demand and Supply for Veterans' Health Care: A Summary of Three RAND Assessments Conducted Under the Choice Act, February 2016

Much emphasis has been placed on eradicating sexual assault in the military. While many congressional hearings, reports, and much media coverage have helped in keeping the spotlight on this important issue, the long-term effects of military sexual trauma (MST) cannot be underestimated. Stronger collaboration between the VA and DoD in reporting MST cases, including policies for prevention, care, services, and benefits will result in better treatment and support for survivors and improve system accountability. While VA provides excellent medical care, integration of care in the community and disability compensation and benefits between VHA and the Veterans Benefits Administration (VBA) are needed for vulnerable victims.

Women Veterans

The proportion of women serving in the military and in the veterans' community is the highest in history. These populations are expected to continue to climb, especially in light of the Secretary of Defense's announcement to open all military occupational specialties to women starting this year.

According to the Department of Labor, in 2013, 2.2 million of the over 22 million veterans in the U.S. are women. More than half of these women served in either Gulf Wars I or II; 66 percent of women veterans were ages 35-64; most were between the ages of 45-54; and, 17 percent of all female veterans were 25-34.



Over 450,000 users of VA health services are women, doubling over the last decade. As this population continues to grow, the VA is working to change the culture of the VA to be more inclusive of women veterans.

Women veterans look to Congress to press VA to achieve its strategic goals for reducing barriers to women's health care. Such barriers[7] include:

- Understanding of eligibility and scope of services
- Outreach and information on women's health services
- Driving distance to access care
- Location of medical facilities and hours of operation
- Access to childcare
- Acceptability of integrated care (gender integrated comprehensive primary care vs. comprehensive care provided in clinics only for women; female provider preference/availability)
- Gender sensitivity
- Mental health stigma
- Safety and comfort

[7] Study of Barriers to Care for Women Veterans to Health Care Report, April 2015

More than 60 percent of females enrolled in VHA are Post-9/11 veterans. The system must be prepared to address not only the most frequent medical conditions women face, but also the unique and evolving issues associated with women in combat.

Through ongoing collaboration with Congress, VSOs and MSOs, and most important, listening to women veterans, we can expect progress to continue. Though women veterans represent a small population within the larger health system, they are changing how the VA delivers health care to all veterans. What we learn in caring for this population helps improve the entire health system so the VA can deliver the best health care services to all generations and all veterans.

Seamless Transition and Continuity of Care

In our view, VA and DoD collaboration is paramount to achieving seamless transition, an institutional state the Committees have worked vigorously to achieve for well over a decade. A seamless transition between the two health systems not only improves health outcomes for all veterans, but is also critical to the long-term sustainability of the all-volunteer force.

VA and DoD must more aggressively build upon their successes and commit fully to institutionalizing seamless care and benefits programs for transitioning veterans. Improving collaboration will require dedicated investments in leadership, resources, and funding, as well as continuous oversight to keep the two health and benefit systems on the right path.

The problems with standardizing medical and disability programs and policies are well documented. Variances in programs such as aid and attendance, caregiver, care coordination, and accessing reproductive services confuse and frustrate veterans and their families and result in unintended consequences.

For instance, some members are eligible for reproductive services in the DoD health system, but these services are not provided in VA. Catastrophically wounded, injured or ill veterans may not be physically, mentally, or financially prepared to access these services before separation, and are often devastated to learn that when they are ready to consider a family, these services are not available to them in the VA.

MOAA, like many other veteran and military organizations, urges Congress to enact pending legislation that will allow veterans of all eras to be eligible for VA's Comprehensive Caregiver Support Program. We thank members of both Committees for being stalwart champions for caregivers, recognizing the significant role and burdens they shoulder for their loved ones and for their contributions to VHA in reducing or avoiding systems costs. Immediate passage of this legislation will send a message to all veterans and their caregivers that their service is valued.

MOAA recommends the Committees:

MENTAL HEALTH CARE AND SUICIDE PREVENTION

- ***Amplify initiatives to improve the delivery of mental health services, including staffing and resources for direct referral of high-risk active and Reserve component servicemembers to the VA health system prior to discharge.***
- ***Assure sufficient resources to train and educate VA staff and community mental health providers on the unique cultural needs of military, veterans and their families.***
- ***Strengthen and expand suicide prevention programs for veterans, including members of the Reserve Components.***
- ***Fully implement the Fiscal Year 2016 National Defense Authorization Act provision to establish a joint formulary for pain and psychiatric drugs for transitioning veterans.***

***Military Sexual Assault-Trauma* — Improve collaboration and resolve discrepancies in VA and DoD reporting of military sexual assaults-trauma cases, including policies for prevention, care, services, and benefits for those seeking support.**

***Women Veterans* — Aggressively implement VA's Women Veterans Strategic Health Care plan to improve access to gender-specific medical and mental health care.**

Seamless Transition and Continuity of Care

- ***Ensure greater emphasis on the standardization, execution, and funding of wounded, ill, and injured medical and disability programs to achieve seamless transition between the VA and DoD health and benefit systems.***
- ***Ensure catastrophically disabled veterans have access to the same reproductive services as are available in the DoD health system.***
- ***Support additional funding for collaborative research between the VA and DoD, with an emphasis on psychological and physical health care, including veterans exposed to toxic substances during military service, catastrophic injuries, and for long-term disability care and support services.***

***Caregiver Support Program* — Extend eligibility for the VA Caregiver Support Program to full-time caregivers of catastrophically disabled veterans of conflicts before September 11, 2001.**

VETERANS BENEFIT PRIORITIES

VA Advance Appropriations

MOAA is very grateful to the committees and Congress for extending advance appropriations authority to veterans benefits programs in the FY 2015 Appropriations Act. The change in law will ensure that beginning in FY 2017, veterans and military families have certainty in the benefits they've earned and deserve, regardless of government shutdowns or gridlock in Congress.

Disability Claims and Appeals Modernization

MOAA continues to support a comprehensive, integrated strategy for improving the claims-management system with primary emphasis on quality decisions at the initial stage of the process.

MOAA commends the VA for significant improvements in reducing the initial claims backlog despite an enormous increase in the number of claims filed by veterans and more "issues" identified within each claim.

VA defines the backlog as initial claims awaiting decision for more than 125 days. Commendably, the backlog has dropped from 611,073 in March 2013 to 81,451 (as of February 27, 2016), an 86.6 percent reduction. Claim-based accuracy has improved slightly over the past year from 89 percent to 90 percent.

While progress has been achieved in reducing the initial claims backlog, appealed claims have skyrocketed over the past few years. To many veterans, it's a game of 'whack-a-mole,' a hit or miss process with little to no transparency.

Appeals Modernization

It is quite clear that veterans are waiting far too long for VA to adjudicate their appeals – in some cases waiting 10 years to get a final resolution to their claim. Additionally, veterans are confused by the

correspondence that they receive from VA and have serious problems getting straight answers from VA about the decisions made on their claims.

Department rating decisions are often too vague to actually be meaningful to the veteran, making it unclear why VA is denying the claim or not providing the desired disability rating. The end result is the veteran does not know what to submit to VA to obtain benefits and prolonged appeals ensue.
There are improvements that can be made in the VA process of handling these appeals that will result in faster, yet still fair, decisions for these veterans. MOAA is working with other VSOs to contribute a solution for veterans to obtain fair results in a reasonable amount of time and to support efforts to determine the resources required to satisfy its obligations to veterans.

To be sure, fast does not equal right, so if the government wants both fast and right, the government must be willing to devote the resources that will require.
There are certain legal rights and obligations that must be preserved to both protect the integrity and constitutionality of the process. As a bare minimum, any reform of the VA appeals process must adhere to the following:

- Notice of VA's action and decision in a manner that is transparent and useful to the veteran.
- An opportunity to have a meaningful hearing before the fact-finder.
- A de novo review of any initial decision.
- An open record throughout the process until the claim reaches the U.S. Court of Appeals for Veterans Claims.

Maintaining these bare minimum legal rights and obligations ensures VA appeals procedures are aligned with those rights and obligations contained in other administrative realms under U.S. law. Under no circumstances should a veteran be provided less legal protections than are provided to the average citizen.

Further, VA should strive to reach the goal of being a veteran-friendly agency, even while performing timely claims adjudication. This includes not only satisfying all of the traditional duties to assist a veteran such as gathering necessary evidence, but also being available to answer veterans' questions about their claims.

For example, a MOAA member recently called VA after receiving a letter stating that VA had overpaid her. After one hour on the phone, 90 percent of which was spent on hold, the VA employee was unable to explain when the overpayment had occurred and told the veteran to just file an appeal. This lack of assistance results in unnecessary appeals and veteran dissatisfaction. In short, merely making the VA appeals process more efficient is not enough by itself – it must be accompanied by providing the veteran enough information, assistance and patience along the way to minimize the number of appeals in the first place.

CAMP LEJEUNE 'BAD WATER' PRESUMPTIVES REGULATIONS

Last year, Secretary McDonald announced VA would recognize eight conditions as being presumptively caused by water contamination while servicemembers were stationed or in training at Camp Lejeune, NC between 1953 and 1987.

Unfortunately, the VA has not instituted the regulations required for these veterans to begin receiving their benefits. The conditions caused by toxic contamination include kidney cancer, liver cancer, leukemia, and Parkinson's disease, to name a few.

Every month these veterans wait to receive their VA benefits is another month that they are suffering extremely severe and disabling medical conditions without the deserving assistance this nation owes them.

Although impossible to predict exactly how many, it appears very likely that some of these veterans will die waiting for their benefits.

In order to ensure that the families of those veterans are not penalized for VA's delay in implementing the established presumptions, ***MOAA strongly recommends Congress make the benefits effective from the date the veteran was first diagnosed with the recognized condition and allowing the surviving family to make claims on behalf of the deceased veteran and collect retroactive benefits in his or her stead.***

AUTOMATE VA PENSION OFFICES

Surviving spouses are unable to file or check the status of DIC claims through eBenefits because the VA pension office has not digitized its operations. This has caused an unnecessarily lengthy process of surviving spouses who are sometimes in desperate need of financial assistance during a time of great distress.

MOAA recommends the Committees direct the VA to set as a priority the automation of the pension offices and to authorize sufficient resources for that purpose.

COORDINATION BETWEEN THE VA AND THE DEFENSE FINANCE AND ACCOUNTING SERVICE (DFAS) FOR MILITARY RETIREES

Military retirees entitled to concurrent receipt of retired and disability pay are forced to wait approximately nine months for VA to de-conflict with DFAS regarding the concurrent receipt of these payments. During these delays the veteran's disabled pay is withheld by VA. This process can and should happen faster.

MOAA's inquiries to VA indicate that the issue resides in VA's processing of payments and not in DFAS's communication with VA.

MOAA recommends close oversight of VA plans and procedures to ensure timely processing of disability pay to retired veterans also entitled concurrently to military retired compensation.

MOAA also recommends the Committees:

- ***Authorize service connection for "Blue Water" Navy Vietnam veterans who contract a VA-listed disease presumed caused by exposure to Agent Orange. Favorably report out H.R. 969 (Rep. Gibson, R-NY) and S. 681 (Sen. Gillibrand, D-NY).***
- ***Provide greater focus on non-ratable claims such as dependency claims.***
- ***Improve access to National Guard and Reserves medical records; consider declaring Guard medical records as federal records after a period of federal active duty.***
- ***Authorize additional methods for certain World War II Coastwise Merchant Marines to be recognized veterans under P.L. 95-2002 by passing S. 1775 (Sen. Murphy, D-CT) and H.R. 1288 (Rep. Butterfield, R-N).***

GI BILL PROGRAMS

MOAA is very grateful to Chairman Miller for his leadership in championing legislation to establish in-state tuition rates for non-resident student veterans enrolled in public colleges and universities. His bipartisan bill was included as a provision in the Veterans Access, Choice and Accountability Act[8] signed into law on August 7, 2014.

MOAA also was pleased to see that the VA, in collaboration with other federal agencies, created GI Bill comparison and complaint tools to aid veterans in making informed decisions before using their benefits and, if necessary, reporting any problems experienced with their education or training program or the administration of their benefit.

MOAA recommends the Committees:

- ***Expand the VetSuccess on Campus program and make the application and selection process transparent. In 2013, VetSuccess expanded to 94 campuses from 32 the previous year. The program should be ramped up as rapidly as possible so that more veterans can get academic and career counseling support.***
- ***Amend the educational counseling provisions in Chapter 36, 38 U.S. Code to mandate such counseling via appropriate means, including modern technologies, and permit veterans to opt out. Raise the $6 million cap in the counseling provision to meet the enormous demand of new GI Bill enrollments.***
- ***Require all academic programs receiving funding under the GI Bill be Title IV compliant under the Department of Education rules. The FY 2014 National Defense Authorization Act (P.L. 113-66) includes provisions mandating Title IV compliance for DoD educational assistance programs for service members and their spouses.***

Towards A 21st Century GI Bill Architecture

The 2015 MCRMC report proposed recommendations to streamline GI Bill programs (Page 164).

The commission found that "Education benefits are strong recruiting and retention tools. The 2014 Blue Star Families Military Family Lifestyle Survey determined that approximately 74 percent of Service member respondents indicated they joined the military to receive educational benefits."

The MCRMC report also determined that "Duplicative education assistance programs should be sunset to reduce administrative costs and to simplify the education benefit system. Both MGIB and REAP provide similar benefits to the Post-9/11 GI Bill. Yet Service members are enrolling and paying $1,200 for the MGIB, while the Post-9/11 GI Bill is a more valuable benefit for most Service members because there is no enrollment or fees. Reserve Educational Assistance Program (REAP) and the Post-9/11 GI Bill both provide education benefits to activated RC members. . . <u>In the past, when GI Bills were created, they replaced existing benefits. Such replacement did not take place when the Post-9/11 GI Bill was enacted</u>."

MOAA is pleased Congress acted on the MCRMC recommendation to sunset REAP under the FY 2016 National Defense Authorization Act.

However, we are disappointed Congress has not taken up the MCRMC recommendation to sunset the MGIB-Active Duty (AD).

[8] P.L. 113-146

Nor has Congress taken up a longstanding MOAA recommendation to integrate the MGIB – Selected Reserve (SR) into a single GI Bill platform under Title 38.

The plain fact is that the MGIB – SR (Chapter 1606, 10 USC) is not optimized to support Reserve component recruitment and retention programs under an 'earn as you serve principle.'

Since 1999, MGIB-SR benefits have plummeted from nearly 50 cents to the dollar compared to MGIB-AD rates to less than 22 cents to the dollar.

We question the recruitment value of a benefit that continues to offer less and less incentive to join the National Guard or Reserves.

MOAA continues to recommend the new GI Bill be structured under a principle of scaling benefits according to the length and type of service performed:

- ***Recruits who initially enter the National Guard and Reserve would receive the lowest benefit level.***
- ***Reservists called to active duty (Title 10) for aggregates of 90 days or more would receive a portion of the new GI Bill, as is currently authorized.***
- ***Servicemembers who complete 36 months of qualifying active duty would receive the maximum benefit.***
- ***To complete the integration of GI Bill benefit programs, the MGIB-AD should be sunset as recommended by the MCRMC and the MGIB-SR re-codified from Chapter 1606, Title 10 to Chapter 33, 38 U.S. Code.***

GI Bill Transferability

MOAA has received inquiries from service members whose transfer of GI Bill benefits (Transfer of Education Benefits [TEB]) contracts were suddenly and unfairly terminated contrary to DoD and service policy.

Under a TEB contract a servicemember agrees to extend a service commitment for four years having completed at least six years' service in exchange for the right to transfer Post-9/11 GI Bill benefits to eligible dependents.

DoD and service regulations require TEB contracts to be honored in cases where the servicemember is forced to retire or separate through no personal fault as a result of service policy such as an involuntary separation[9].

In at least one case, however, the VA recently sent an overpayment notice to the servicemembers' children for approximately $50,000 claiming the military member failed to serve the four year extension notwithstanding an explicit regulation allowing retention of the benefit when the separation was directed by the service.

MOAA recommends the Committees working with the Armed Services Committees pass legislation to ensure GI Bill transfer policies are honored when the service causes the separation through no fault of the member.

SURVIVORS' AND DEPENDENTS' BENEFITS

Survivors' Educational Benefits

[9] DoDI 1341.13

MOAA is very grateful to the Committees and Congress for enactment of Fry Scholarships for surviving spouses of those who died in the line of duty after September 10, 2001.

This long-sought MOAA legislative priority was included as a provision in the Veterans Access, Choice and Accountability Act[10] and signed into law on August 7, 2014.

MOAA is pleased the House Committee on Veterans Affairs approved an extension of the Gunny Fry usage period for surviving spouses who lost their military spouse between September 11, 2001 and December 31, 2005; and, to open Yellow Ribbon matching for Fry Scholarship recipients who attend private colleges. ***MOAA urges the Senate Committee to pass companion legislation.***

Dependency and Indemnity Compensation (DIC) Equity

DIC is set at a flat rate for all eligible beneficiaries. MOAA believes the DIC rate should be pegged at the same percentage as survivors of disabled federal civil service employees whose compensation is set at 55 percent. The GAO report on Military & Veterans' Benefits (GAO 10-62) found that "*DIC payments are almost always less than workers' compensation payments for survivors of federal employees who die as a result of job-related injuries."* ***MOAA supports establishing the annual DIC rate at 55 percent of the compensation rate for a 100 percent service-connected veteran.***

Caregivers of Catastrophically Disabled Veterans

Catastrophically disabled veterans, whose spouses serve as primary caregivers receive additional allowances due to the severity of their service-connected multiple disabilities. These full-time caregivers, however, are precluded from earning a retirement or Social Security benefits in their own right. When the veteran dies, the survivor's income is reduced to the same DIC rate that other surviving spouses of veterans receive even though the veteran's death was service connected. The percentage of replacement income can be as little as 15 percent. The income replacement of other federal survivor benefit plans is close to 50 percent of the benefit upon which they are based. ***MOAA recommends the committees increase the income replacement rate for survivors of catastrophically disabled veterans.***

Retain DIC on Remarriage at Age 55

Legislation enacted in 2003 allows eligible military survivors to retain DIC upon remarriage after age 57. Congressional staff advised MOAA at the time that the only reason age 57 was chosen was due to insufficient funds, not for any policy purpose. ***MOAA recommends legislation to authorize retention of DIC upon remarriage at age 55. That would align the benefit with all other federal survivor benefit programs.***

CHAMPVA Dental

MOAA supports permitting survivors qualified for CHAMPVA health care to enroll in a CHAMPVA dental program. If modeled on the TRICARE Retiree Dental Plan, this proposal would have no PAYGO requirement since it would be fully funded by enrollees' premiums.

NATIONAL GUARD AND RESERVE VETERANS

National Guard and Reserve members straddle the demands of military service and civilian commitments. These veterans toggle between more frequent activations, civilian employment, career management

[10] P.L. 113-146

challenges, and increased military training requirements. All the while, they strive to maintain a quality family life.

A total of 921,676 Guard and Reserve members have served on operational active duty since September 10, 2001, and roughly 350,000 have served multiple tours[11]. Reliance on citizen-warriors for more than 14 years has no precedent in American history. Use of operational reserve forces is likely to continue indefinitely.

With the drawdown of the active force, the Guard-Reserves constitute more than 50 percent of the nation's military capability. Moreover, the DoD plans to use a new call-up authority in the FY 2012 National Defense Authorization Act[12] permitting as many as 60,000 reservists to be on active duty for up to one year to perform pre-planned, budgeted missions without a national emergency declaration.

For example, the Army's budget request for FY 2017 would nearly double the "man-year" funding for National Guard and Reserve troops to serve on active duty because there are insufficient regular Army forces to handle missions in combat commands throughout the world.

Ever greater reliance on the Reserves means it will be critical for Congress to ensure reservists' re-employment rights are robust, transparent, and vigorously enforced. Similarly, personal financial protections need to be tightened to reflect the sea change in the operational use of our nation's Guard and Reserve forces.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Legislation in the last session of Congress provides a framework for the Committees' consideration of upgrades to the USERRA.

These changes would:

- Allow the United States to serve as a named plaintiff in all suits filed by the Attorney General, while preserving the right of the aggrieved person to intervene in such suits, or to bring their own suits where the Attorney General has declined to file suit. It would also allow the Attorney General to investigate and file suit to challenge a pattern or practice in violation of the USERRA.
- Allow for the suspension and debarment of federal contractors that repeatedly violate the rights of members of the uniformed services provided for under USERRA.
- Provide the Special Counsel with authority to subpoena attendance, testimony, and documents from federal employees and federal executive agencies in order to carry out investigations related to USERRA.
- Authorize the Attorney General to issue civil investigative demands in investigations under USERRA. It would not include the authority to compel oral testimony or sworn answers to interrogatories.

MOAA urges consideration of the USERRA upgrades identified above and strongly endorses a robust role for the Federal Office of Special Counsel (OSC) on USERRA claims brought by members of the National Guard or Reserve who are federal employees.

SERVICEMEMBERS CIVIL RELIEF ACT (SCRA)

Forced Arbitration Clauses

[11] DoD data as of March 1, 2016
[12] P.L. 112-81

MOAA is grateful for the leadership of Senators Graham (R-S.C.) and Reed (D-R.I.) and Rep. Jones, (R-N.C.) for re-introducing their bipartisan companion bills on forced arbitration.

S. 2331 and H.R. 416, the SCRA Rights Protection Act of 2015 would guarantee that our military servicemembers can enforce the rights already granted to them under the SCRA.

On this issue the DoD has concluded: "Service members should maintain full legal recourse against unscrupulous lenders. Loan contracts to Service members should not include mandatory arbitration clauses or onerous notice provisions, and should not require the Service member to waive his or her right of recourse, such as the right to participate in a plaintiff class. Waiver isn't a matter of 'choice' in take-it-or-leave-it contracts of adhesion."[13]

Congress has previously enacted legislation to ban forced arbitration for disputes brought by auto dealers. Certainly, our nation's service members should be afforded the same protections on other types of contracts.

MOAA supports passage of the SCRA Rights Protection Act of 2015 to render arbitration agreements in certain financial contracts unenforceable under the SCRA. *Although under the technical jurisdiction of the Veterans Affairs Committees, we recommend consultation with the Armed Services Committees to protect the financial and economic interests of our nation's uniformed women and men and their families. We agree with DoD that this issue impacts military personnel readiness.*

MOAA also recommends the Committees endorse legislation that would impose civil fines for violations of the SCRA; criminal penalties in egregious cases of violation of the statute; and, recovery of reasonable attorneys' fees by service members from SCRA violators.

HONORING AS VETERANS CERTAIN CAREER NATIONAL GUARD AND RESERVE MEMBERS

National Guard and Reserve members who complete a full Guard or Reserve career and are receiving or entitled to a military pension, government health care and certain earned veterans' benefits under Title 38 are not "veterans of the Armed Forces of the United States," in the absence of a qualifying period of active duty.

Due to military accounting and funding protocols, many reservists actually have performed operational missions during their careers but orders often were issued under other than a Title 10 active duty authority.

Similar versions of enabling legislation have cleared the House — H.R. 1384, Rep. Walz, (D-Minn.) and Section 703 of S. 1203 as amended.

MOAA strongly prefers final enactment of H.R. 1384, which includes language expressly prohibiting award of veterans' benefits under the bill.

CONCLUSION

MOAA is grateful to the Members of the Committees for your leadership and conviction to the issues at hand. We look forward to working with you to improve VA health and benefits systems so we are able to provide the very best support possible to our veterans and their families and caregivers.

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[13] Department of Defense, Report On Predatory Lending Practices Directed at Members of the Armed Forces and Their Dependents, Aug. 9, 2006

Biography of René Campos, CDR, USN (Ret.)
Deputy Director, Government Relations

Commander René Campos rejoined the MOAA staff in February 2015 as the Deputy Director, Government Relations, managing matters related to military and veterans' health care, wounded, ill and injured, and caregivers. She previously helped establish a military family program at MOAA, working on defense and military quality of life programs and policy issues. In September 2007, she joined the MOAA health care team, specializing in Departments of Defense and Veterans Affairs health care systems, as well as advocating for seamless transition programs and women in the military issues.

She began her 30-year career as a photographer's mate, enlisting in 1973 and was later commissioned a naval officer in 1982. Her last assignment was at the Pentagon as the Associate Director, Office of Family Policy in the Office of the Deputy Under Secretary of Defense for Military Personnel and Family Policy.

Commander Campos serves as a member of The Military Coalition (TMC) — a consortium of nationally prominent uniformed services and veterans' organizations, representing approximately 5.5 million current and former members of the seven uniformed services, including their families and survivors, serving on the Health Care; Morale, Welfare & Recreation and Military Construction, and Base Realignment & Closure; Veterans; Guard and Reserve, and Personnel, Compensation and Commissary Committees.