Retired Enlisted Association LeRoy Riddell, NCC (SW), USN (Ret.), National President

TESTIMONY OF
LeRoy Riddell, NCC (SW), USN (Ret)
National President
Of
THE RETIRED ENLISTED ASSOCIATION
Before a
JOINT HEARING
Of the
SENATE VETERANS AFFAIRS COMMITTEE
And
HOUSE VETERANS AFFAIRS COMMITTEE
On
April 21, 2005

BIOGRAPHY OF LeRoy Riddell, Navy Counselor Chief (Surface Warfare), USN (Ret)
LeRoy is a Life Member of TREA and founded Chapter 96 in Hibbing, MN. He served as their first President and published their Chapter Newsletter. He has served on the National Board of Directors since 1999. He was first elected as National Director, and then went on to serve as National 1st Vice President before being elected as the National President. He has chaired many committees, including Membership, Build A New Chapter (BANC) and Public Relations.
LeRoy's community activities include Retiree Air Council of the Duluth Air Guard Base, planning Retiree Appreciation Days, Hibbing Memorial Building Veterans House Committee, Hibbing Senior Citizens Board of Directors, Hibbing Memorial Days Program, DAV Forget Me Not Program, and the ?Support Our Troops? program. He also spearheaded the renovation of the Veterans Quarters of the Memorial Building for use by various local veterans groups.
LeRoy enlisted in the U.S. Navy in 1954. Although retired, he is still attached to the NRD Minneapolis as North Eastern Minnesota Recruiting District Assistance Council (RDAC), which assists local Navy recruiters.
LeRoy is also a member of VFW, DAV, American Legion, and the Fleet Reserve.
LeRoy and his wife, Debra, currently reside in Coon Rapids, MN. They have 5 sons and 1 daughter.
DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS
The Retired Enlisted Association does not currently receive, has not received during the current fiscal year or either of the two previous years any federal money for grants or contracts. All the Association's activities and services are accomplished completely free of any federal funding.
Mr. Chairman: It is an honor for The Retired Enlisted Association to testify about our concerns for America's veterans before your two dedicated Committees.

The Retired Enlisted Association is a Veterans Service Organization founded over 40 years ago to represent the needs and points of view of enlisted men and women who have dedicated their careers to serving in all the branches of the United States Armed Services active duty, National Guard and Reserves, as well as the members who are doing so today.

We are here today while hundreds of thousands of enlisted men and women are serving in war zones all across the world. We all share an admiration and loyalty for these dedicated and brave men and women and a duty to protect and serve them. What we all can do is joining together to make sure that when they return to their home, America, they obtain the best health care and other benefits that they have been promised. And for those who we have lost we must provide for the love ones they have left behind.

VA HEALTH CARE

It is of course well known to all of you that VA health care is not adequately funded. According to the Bureau of Labor Statistics, Consumer Price Index (CPI) News Release on March 23, 2005, medical inflation is 4.3 percent as of February 2005. In Secretary Nicholson's testimony before this committee, he stated the FY 2006 VA medical care program would increase by 2.5 percent over the enacted level for 2005. Furthermore this figure includes $2.6 billion that is proposed to come from third party insurance payments and increased co-pays from veterans. The Administration proposes both a $250 yearly enrollment fees for veterans enrolled in Categories 7 and 8 and an increase from $7 to $15 for these same veterans for their prescription co-pays. TREA strongly opposes both proposals. These increases are burdensome and unwise.

We oppose the enrollment fees for two reasons. First, there is no guarantee of health care for those in Categories 7 and 8. To charge veterans an enrollment fee but with no guarantee that they will receive health care is simply wrong. Veterans deserve better treatment than that. It amounts to nothing more than trying to balance the VA budget on the backs of those who have served their country in uniform. Also, the Department of Veterans' Affairs website states those in need of care for a service-connected disability or are 50 percent service-connected or higher and need care for any condition, the VA will schedule you for a primary care evaluation within 30 days of desired date. If your outpatient appointment cannot be scheduled within this timeframe, VA will arrange to have you seen within 30 days at another VA health care facility or obtain the services on fee basis, under a sharing agreement or contract at VA expense. ALL OTHER VETERANS WILL BE SCHEDULED FOR A PRIMARY CARE APPOINTMENT AS SOON AS ONE BECOMES AVAILABLE. Also, what about specialty care?? According to information from The American Legion's Veterans Affairs and Rehabilitation Division, waiting times received directly from VA facilities indicates the following:

Neurology: 6 months or longer
Audiology: 5 months or longer
Neurosurgery: 6 months
Orthopedics: 84 days
GI: 118 days
Podiatry: 112 days

These wait times are for specialty clinics. They are not averages but randomly selected from different VAMCs. Clearly there is problem here.

Second, it is our strong belief that veterans who already pay premiums or enrollment fees for a health care plan should not be charged a fee to enroll in VA health care. By definition, veterans in Categories 7 and 8 have their own health insurance, for which they pay a monthly premium, already enrolled in TRICARE, or they pay the Medicare Part B premium. Either way, they have

already paid for health care. The Department of Veterans Affairs currently collects from third party insurance as payment for the services they provided to veterans with private health insurance. It is our position that VA should also have the right to collect from Medicare as the third party insurer for those veterans who are enrolled in Medicare. Further, section 1645 of Title 25 allows Indian Health Care to directly bill Medicare, Medicaid and other third party payors.

Representative Lane Evans of Illinois introduced H.R. 2318, ?Assured Funding for Veterans Health Care Act of 2003 in the 108th Congress with 188 co-sponsors. CBO scored this bill on August 26, 2003 indicating that about half of all enrolled veterans are also eligible for Medicare benefits. CBO estimates under H.R. 2318 Medicare spending would decline by about $1.3 billion in 2006 and $20 billion over the 2006-2013 period. Put another way, the VA currently absorbs this cost due to being unable to collect from Medicare. We recognize this subcommittee does not have primary jurisdiction over this issue, but nonetheless, we strongly advocate for Medicare reimbursement to the Department of Veterans Affairs.

With regard to the increase in prescription drug co-pays, while an increase of $8 a prescription may seem small at first glance but most of these beneficiaries do not take a single pill a day -- they take 5 or 10. This increase alone can mean an increase of $80 to $100 a month for a veteran. We know that the cost of drugs is worrisome issue for retirees and seniors throughout our nation. We should not fail to mention how pleased we are that the President's proposal includes allowing the VA to pay for emergency and urgent care for enrolled veterans in non VA facilities.

Additional money is also needed to provide the promised 2 year VA medical care to all veterans returning from Iraq and Afghanistan. We don't know what that benefit will end up costing (because we don't know how it will work and how many returning Vets will take advantage of it). But we do know that it is crucial at this time in our Nation's history that we both keep all the promises that we make to veterans and that we are seen keeping the promises.

Effective and sufficient VA Health care is crucial to all Veterans including Military Retirees. In Categories 1-3 (service disability qualification) 30% of all enrollees are Military Retirees (as of September 30, 2003: 606,234 out of 2,030,111). In total 890,072 of the approximately 7,000,000 present VA enrollees are Military Retirees. It is a very important benefit for our members. Retirees especially need to take advantage of the areas of expertise that the VA has developed. Approximately 2/3 of the Retiree enrollees are service connected disabled.

The Retired Enlisted Association believes that all military retirees without service-connected disabilities, as well as those disability classifications lower than Category 3, should be put in Category 3 with other special veterans, such as Purple Heart recipients and ex-POWs. Along with veterans with service-connected disabilities and indigent veterans, military retirees were promised a health care benefit for the rest of their lives. If a military retiree lives in an area where there is no access to the DoD health care system, that retiree should have access to VA health care that is guaranteed. Such is not the case for those now enrolled in Categories 7 or 8. In addition, we advocate that those veterans who have a service-connected disability rating of 0 percent also be put in Category 3. Currently, those veterans cannot enroll in the VA health care system if they are not already enrolled. However, those with a rating of 0 percent are classified as disabled veterans. Under the proposed legislation, those not currently enrolled would be forced to pay an enrollment fee for something to which they are entitled.

The problem of inadequate funding is a structural problem that must be corrected in a systematic way. This problem of insufficient funding is not going to go away in a year. This Committee can

move forward to systematically correct this problem by making the funding for VA Health Care guaranteed. For the last several years the problem has been the same. It is not any individual year's budget that is the problem; it is method of funding itself. What is really necessary is guaranteed funding. That is something that only Congress can do. The non-partisan Congressional Budget Office (CBO) published a paper in March 2005 titled ?The Potential Cost of Meeting Demand for Veterans' Health Care?. The summary states ?Health care costs have risen faster than overall price inflation in the past few decades. In projecting the cost of meeting the demand for VA medical services from 2005 through 2025, CBO assumed VA would face the same rate of growth in health care costs as the rest of the economy. Specifically, CBO assumed that per capita health care costs would grow 6.1 percent in 2006 in nominal terms, falling to 4.2 percent by 2025?. Also, on page 8 of this paper, CBO states that in 2003, 88 percent of those in categories 7 and 8 have medical insurance, including 60 percent having Medicare Part B, 45 percent with Medigap and 5 percent with Medicaid.

In Chairman Buyer's Views and Estimates dated February 23, 2005 he states ?The VA has $3 billion in uncollected debts. Therefore, it is time for Congress to focus its commitment to veterans based on the clear priorities and ageless military values that should define the VA health care system?. The Government Accountability Office (GAO) has produced numerous reports on how the VA can improve its operation and collect more. The latest report ?Guidance Needed for Determining the Cost to Collect from Veterans and Private Health Insurers?, dated July 2004 indicates on page 12 ?To accurately determine and report the cost to collect first and third party payments, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to provide guidance for standardizing and consistently applying across VA the accounting of costs associated with collecting payments from veterans and private health insurers?. Mr. Chairman, how many more reports from GAO do we need before action is taken?

TREA urges Congress to reject the proposed increases in drug co-pays and the proposed $250 yearly user fee for Categories 7 and 8 enrollees. TREA also urges Congress to adopt guaranteed funding for all enrolled VA beneficiaries.

TREA urges the committee to review the wait time issue for specialty clinics.

TREA urges the committee to support legislation to allow the VA to become a Medicare provider.

VA CLAIMS BACKLOG

For years the delays in adjudication of VA claims have been crippling. Often claimants had to wait for years to get an initial decision and then there are further long delays if an appeal is appropriate. Secretary pledged to work on reducing this backlog and indeed the VA has made substantial progress. In 2002 the waiting list went from 600,000 to 463,000 cases. Last year the case load dropped further and is now approximately 348,000 pending cases. That is a dramatic improvement and movement toward Secretary Principi's stated goal of 250,000 pending claims. We should take notice when things are getting better. And this is much better. However, the job is still not done. The VA needs to continue to hire the most talented professionals that are available and to provide them with sophisticated continuing professional training.

TREA hopes that Congress will continue to monitor the improvement in Claims adjudication.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

When there is a massive plan to close or realign numerous hospitals and facilities that are depended upon by our members we would always be very concerned. TREA is well aware that the goal of the CARES Program is to make the VA more efficient and modern- an unassailable stated goal. However, even in the best of any circumstances such a plan would cause great

dislocations and difficulties. Today CARES implementation will cause huge difficulties. In the present proposal TREA is particularly concerned that the CARES Commission did not analysis the VA'S future needs in light of its Mental Health and long term health care requirements. The VA is required to provide long term health care (nursing home care) for Veterans with a 70% and over disability or for a veteran whose VA disability is the reason he or she requires nursing home care. With the demographics of today it is clear that this will be a growing focus and job for the VA. They will need the plants and equipment for this new mission. They also need adequate plant, properly placed around the country to deal with residential mental health treatment capabilities. This is again a crucial area that the CARES Commission did not take into account when making its plans. Residential mental health treatment is a critically necessary service for some of our veterans. It is both expensive and difficult to find in the civilian system. The VA can additionally bring the expertise necessary to treat problems for military veterans that most psychiatric hospitals and practitioners do not have. It is a service that should not be shortchanged. By moving ahead with the CARES Commission's recommendations before considering these two areas would be foolhardy. It should be done right the first time.

TREA urges that no additional steps in the CARES process occurs until a full study on the future needs of the VA for long term health care and mental health facilities are studies and incorporated into any future plans.

MILITARY RETIREES AND VA CATAGORIES

As referred to earlier, numerous Military Retirees are daily patients in the VA Health Care system. They have served their nation for at least 20 years. They have developed illnesses and conditions while serving their Country. They deserve to be seen as a special category of patients. To place retirees in Category 3 would acknowledge the lifetime of service they have provided to the military.

TREA urges Congress to place military retirees into Category 3 of the VA Health Care System.

DOD-VA COLLABORATION

It has been a long term goal of TREA'S to have real and seamless medical transition from DOD to the VA. The need of this has become painfully apparent in the last year when combat injured service members are coming home and being transferred from DOD to VA facilities all across the country without adequate preparation and follow up services. DOD and all the services are working to try and improve the handoff to the VA. The continued work on IT integration is part of the answer. Collaboration among DOD, the VA and VSO's is also crucial. Everyone accepts more work is needed. The situation will become even more complicated if the CARES realignments and closings move forward.

TREA hopes your Committees will continue to monitor the progress in this crucial area.

SURVIVORS BENEFITS

TREA knows that the United States as a nation has thousands of new survivors. It is important that we keep our promise to their lost loved one. One thing we can easily do is to attach Survivors' Education Benefits to Title 10 active duty MGIB payments. The widows or widowers and the children of those who have died on our battlefields should have the opportunity to get a four year bachelor degree. If Title 38 benefits were linked to Title 10 benefits this goal could be reached in the future.

TREA is very grateful to the Committees and most especially to Representative Bilirakis for the passage of HR 2297 (108th Congress) including the ?Give Romance a Chance? provisions. Now a DIC recipient can remarry after reaching the age of 57 without losing his or her DIC payments. This is a huge step forward. But we hope in the near future that Congress will be able to move

that provision back to age 55 so it can match CHAMPVA and other federal survivor programs. Representative Bilirakis has introduced HR 1462 in the 109th Congress to lower the age to 55. TREA urges these Committees to make Title 38 education benefits for survivors' equivalent to Title 10 MGIB benefits and that DIC retention after remarriage will be moved back to age 55.

KEEPING TRACK OF OUR NATION'S VETERANS

One lesson that has been learned through our experiences with Gulf War Illness and the recent returnees from Iraq and Afghanistan is the ability to track down veterans after they separate from the military. As we enter a new century this nation still does not have an accurate database of all its veterans. The VA does not necessarily have a copy of the discharge papers (DD-214) for veterans who separated before 1974. That means there are, potentially, millions of veterans from World War I, World War II, Korea and Vietnam who are not recorded in the VA's database. Further, once a veteran moves after they separate, their address is no longer accurate. The 21st Century is the present. It is time we use the technology we have developed in order to track our veterans throughout their lives. By doing so, the VA will better understand there needs and have the ability to inform veterans of their entitlements in a timely and efficient manner.

CONCLUSION

TREA is very grateful for this opportunity to tell you of our members concerns for the future. We are also very aware of the time, energy and dedication all of you expend on Veterans healthcare, education and other benefits. We know that you do not forget those who served. You always remember their sacrifices and needs and those of their families and survivors. And more importantly you act on them. We know what real allies and patriots you are. The members of The Retired Enlisted Association are very grateful.