Colonel Ana R. Smythe, USMC (Ret.) Deputy Director, Government Relations, MILITARY OFFICERS ASSOCIATION OF AMERICA

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VETERANS' HEALTH CARE and BENEFITS
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SENATE and HOUSE VETERANS' AFFAIRS COMMITTEES

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Presented by

Colonel Ana R. Smythe, USMC (Ret.)
Deputy Director, Government Relations

Mr. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEES, on behalf of the 362,000 members of the Military Officers Association of America (MOAA), I am honored to have this opportunity to present the Association's legislative priorities and recommendations for veterans' health care and benefits for FY 2008.

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

VETERANS HEALTH CARE

VA Health Care Funding.

The VA budget request for FY 2008 contains a more realistic, though still insufficient, projection of the resources needed to match demand on the system. MOAA maintains that the VA's enrollment and usage projection models still do not account for growing demand from a new generation of veterans from the war on terror, including National Guard and Reserve veterans.

Moreover, we believe that the VA should adhere to its own published access standards in building its funding requirements. Instead, in many VA medical facilities, demand is triaged by placing veterans on long waiting lists.

Veterans Health Administration directive 2006-041 requires all new patients desiring routine care to be seen within 30 days. Additionally, routine follow-up and specialty appointments must be

available within 30 days under the VA's own policy. Those standards are not being met in many VA medical facilities.

MOAA applauds the Committees' recommendations in their "Views and Estimates" to the Budget Committees that begin to address these concerns by adding resources for the VA health care system in FY 2008.

MOAA recommends reform of the VA's enrollment projection model and enactment of a requirement for the VA to submit a budget that fully satisfies its own access standards. This recommendation is consistent with the President's Task Force Report (2003) recommendation that the VA system should be fully funded to meet demand by "using a mandatory funding mechanism, or by some other changes in the process to achieve the desired goal."

FY 2008 Veterans Independent Budget (IB) Projections. As a proud endorser of the IB, MOAA would like to emphasize to the joint Committees that last year's (2007) IB, as in previous years, was a better barometer of actual demand on the VA health care system. MOAA recommends that the Committees closely review the FY2008 IB Report.

Usage Fees. Once again the VA and the Administration have proposed the imposition of annual usage fees and higher VA drug co-payments. Apparently, someone is not getting the message. Over multiple sessions of Congress, these fees have been soundly rejected, as well they should be. The latest proposal would have veterans enrolled in the lowest priority groups (PG 7 and PG 8) pay an enrollment fee based on a means-test. Prescription copays would rise from from $8 to $15 for a 30 day supply.

MOAA remains strongly opposed to VA annual usage fees and increased drug copays. We appreciate the Committees' rejection of these views in their respective "Views and Estimates" for the FY 2008 VA budget. During this protracted war on terror, Congress would send the wrong signal to the nation's warriors and future veterans by endorsing usage fees for VA health care.

Seamless Transition

MOAA appreciates the continued interest and support of the Committees to press the VA and DoD in realizing long overdue "seamless transition" policies, procedures, and technologies for our nation's service men and women and their families.

Widely reported breakdowns in the management of care of our severely wounded troops at Walter Reed Army Medical Center reflect the fact that policies and procedures for that care, rehabilitation, outprocessing and transitioning are not working "seamlessly" in their best interest or their families'.
For decades there has been strong congressional interest in improving the DoD and VA relationship to gain greater efficiency in the services provided both the active duty member and the veteran. Today Congress is focusing more attention to this issue and the need to improve the transition process for service members. It is apparent both departments are making serious efforts; progress has been speeding up, but the results still fall far short of the current need and the impending growth rising from Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF). The same concerns MOAA highlighted in previous years' testimony are more urgent than

ever.
Congress and MOAA agree that our nation's servicemen and women have earned first class health care, during and following separation from the military. DoD and VA have critical, complimentary roles in that transition process. The pace of the two departments' collaborative and cooperative efforts has been slowed by bureaucratic and parochial barriers as they struggle to bridge the gap between the departments. Time and again, progress continues to be stymied despite the DoD - VA's Joint Executive Council's (JEC) oversight of collaborative activities.
The keystone in MOAA's view is a coordinated top-down strategy which engages both departments' leadership from a single point of attack. As a committee, the JEC is not empowered to direct such change, only to talk about it and report back to Congress on joint efforts underway. Recent testimony outlined the progress to date well but also clearly demonstrates much remains to be done. In short we are into the fifth year of the war and the hand-off between the departments for those who are in the greatest need is not seamless.
The VA has established an office for seamless transition and it is a catalyst in VA's outreach efforts, focused on providing our servicemembers a smooth transition. However, without DoD as an integral partner in this effort only limited success is possible.
A joint or federal transition agency should be established to provide oversight, direction and implementation of the JEC's overarching guidance as suggested by VA Deputy Secretary Gordon Mansfield in his testimony before the House Veterans' Affairs Committee. (28 September 2006). The agencies responsibilities should address such issues as:

- Joint In-Patient Electronic Health Record Implementation
- A Joint DoD /VA Physical
- Special Needs Health Care
- Traumatic Brain Injury (TBI)
- Timely Access to Care
- Joint Research

MOAA recommends that Congress establish a separate agency responsible to oversee accomplishment of essential seamless transition services. The "Joint Transition Office"(JTO) would have permanently assigned, cross-trained personnel from the DoD and VA with responsibility for this mission. The JTO would provide the top down execution and unity of effort currently missing on seamless transition.

Joint In-Patient Electronic Health Record.
MOAA appreciates the recent VA and DoD announcement of a commitment to create an interoperable electronic health record by 2012. But, why so long, especially since there have been other promises going back decades? A reality by 2012 is unacceptable. Congress must press VA and DoD to speed delivery of an interoperable, bi-directional and standards-based electronic medical record. We must see concrete timelines and milestones for action. A joint medical record is a key goal to ensure we meet seamless transition requirements for wounded men and women moving from DoD care into VA care.
MOAA continues to strongly urge as a top priority the immediate development of a bi-directional interoperable standards-based electronic medical record between DoD and the VA.
Joint DoD/VA Physical
A "one stop" separation physical supported by an electronic separation document (DD214) is a cost-saving initiative that once again feeds into the seamless transition model. Although prototypes exist in some facilities, one has yet to be accepted as a standard throughout the two

departments. It must become the "gold standard" of effective and efficient transitions.
MOAA continues to support the immediate development of a single separation physical for DoD and the VA.

Polytrauma Centers and Traumatic Brain Injury

Advances in medical treatment and casualty management during the "golden hour" have raised the survival rates for our wounded warriors to unprecedented levels. But, unfortunately, the injuries often are much more severe and may involve multiple systems intervention and rehabilitation in highly advanced polytrauma centers.

The four VA Polytrauma Rehabilitation Centers were established to meet the specialized clinical care needs of these polytrauma patients. They provide comprehensive inpatient rehabilitation services for individuals with complex cognitive, physical and mental health problems of severe disabling trauma. These centers require special attention in order to ensure the needed resources are available to include specialized staff, technical equipment and adequate bed space in order to ensure the continued health care for the severely injured service members and veterans.

TBI is the signature injury of OIF/OEF -- its impact on combat-zone veterans ranges from severe to mild. Recognizing TBI and developing best practices for its treatment is necessary, including research on the long-term consequences of mild TBI. The goal of achieving optimal function of each individual TBI patient requires improved interagency coordination between VA and DoD. Service members and veterans should be afforded the best rehabilitation services available and the opportunity to achieve maximum functioning so they can reenter society or at minimum achieve stability of function in an appropriate setting.

MOAA strongly urges the Committees to ensure full funding is provided for needed upgrades to VA polytrauma centers. In addition, MOAA strongly endorses further integration of TBI care and research, supported by additional resources, into VA polytrauma centers.

Medical Research - Joint and VA

Combined Research Initiatives would further enhance the partnership between VA and DoD. Since many of the concerns are shared research crosses agency lines and once again collaboration of effort should enable research dollars to go much further.

In addition, the VA indicates that OIF/OEF research is a high priority and special research is being done concerning PTSD, TBI, prostheses and other trauma associated with blast injuries.

Service members have seen a dramatic increase in their survivability rate during the current conflict due to improved field medical procedures and efficient transportation activities. This has caused an increase in medical conditions that past service members did not experience. Research will be essential to future care, rehabilitation, and the quality of life that injured service members must now live with. The Administration, however, has shown a propensity to rely more heavily on non-direct funding from other private and public medical research as a way to enhance VA medical research activities. Although that trend is changing and specific funds are being earmarked for research it is important to ensure those dollars are specifically spent as intended.

MOAA strongly urges Congress to ensure an adequate funding level for medical research -- including traumatic brain injury, spinal cord injury, prosthetic devices, burn therapies and PTSD.

Expansion of Mental Health Services.

Recent studies project that 1 out of 6 service members returning from Iraq and Afghanistan will need care for PTSD and other mental health conditions. Some independent studies suggest even

higher PTSD rates. We are pleased that the VHA Mental Health Strategic Plan Workgroup is developing a 5-year strategic plan to eliminate deficiencies and gaps in the availability and adequacy of mental health services. We are equally concerned that the Administration should request appropriate levels of funding for treatment of these debilitating disorders.

Our deepest concerns remain prevention, identification and treatment of war-generated PTSD. We are impressed and gratified by the scope of efforts both large and small to deal with it. But the results of good intentions and great efforts can be undermined if they are not governed by a systemic, coordinated approach.

We also believe that the magnitude of the problem may well be greater than current statistics indicate. The military culture tends to foster reluctance to report symptoms and seek help because doing so is perceived to be a weakness in terms of the warrior ethic, even after they leave the service. This unfortunate and counterproductive view is most prevalent in those who carried the brunt of the fight and lived in "Harm's Way".

It is imperative that the military, VA and civilian communities work collaboratively to remove the sense of stigma, to recognize symptoms and to encourage those who need treatment before it becomes disabling.

The trauma servicemembers experience in war will be with them as long as they live. PTSD is real and directly impacts military members' ability to work, cope, and succeed in all aspects of their lives, as well as those of their families.

We must train and sustain more trained mental health professionals with the special skills needed to work through the range of mild-to-severe PTSD based on exposure to traumatic events such as combat, killed or wounded comrades and civilians, and attacks on women and children. Each of these experiences is a searing wound to the psyche. It cannot be left untended.

We must recognize that many cases will require longer-term treatment and services.

MOAA strongly urges Congress to enact legislation that will require the VA and DoD to work in concert to ensure the implementation of a unifying strategy for mental health treatment, providing consistent guidance, coordination of effort and cross-feed of results of segmented studies, task forces and programs that are currently underway between the two departments.

Retired Military Veterans Access To Earned DoD-VA Health Care Benefits

Veterans who complete a full career in the armed forces earn lifetime entitlement to health care benefits in the Department of Defense TRICARE system, and eligibility for VA health care services. Enrollment of military retired veterans has increased significantly since June 2000 when VA began tracking the data.

Today, approximately one million military retired veterans are enrolled in VA care and, based on past usage data, about 50% of these enrollees seek VA care each year. Not surprisingly, many retired veterans have serious disabilities and VA data show that use of VA health care rises with the level of the service-connected disability. The more severe a disability, the more likely it is

that a veteran would seek VA care. For routine care, however, many enrolled retirees prefer to use their TRICARE or TRICARE for Life benefits closer to their homes. From MOAA's perspective, the root issue is improving the coordination of care and reimbursement procedures between the VA and TRICARE systems, not imposing arbitrary and unfair rules that would lock out retirees from either system.

MOAA appreciates Congress' continued support in opposing "forced choice" proposals that would compel dual-eligible veterans to relinquish access to earned DoD or VA health care services.

VETERANS BENEFITS

Disability Claims: Timeliness, Quality and Process Improvements Needed

The workload and complexity of VA disability claims continues to increase. As of mid-February, there was a backlog of 626,429 claims. VA projects that by year's end there will be at least 800,000 claims in the system. Moreover, disability claims processing time rose to nearly six months (177 days) on pending claims in 2006 against a stated performance goal of 100 days.

We believe that VA's workload estimates do not fully account for the expected increase in the number of new claims from Operations Iraqi Freedom (OIF) Enduring Freedom (OEF) veterans, nor do they address the likely increases among mobilized National Guard and Reserve veterans. It takes about two years for a new claims worker to become proficient, if not expert, in adjudicating a VA disability claim. Additional investment is needed now to begin to address the backlog and to develop a competent claims workforce going forward.

MOAA notes with appreciation that the Committees' "Views and Estimates" to the Budget Committees on the FY 2008 VA budget recommends additional resources and full-time equivalent positions for the compensation and pension service.

MOAA strongly supports adding about 1000 claims-worker positions above the Administration's budget request for FY 2007 as well as additional resources for training, technology upgrades and integration in support of claims processing.

Seamless Transition. Earlier in this statement, we stressed the importance of accelerating efforts to realize a seamless transition for service men and women between the DoD and VA health care systems. Seamless transition also should be a priority on the benefits side of the equation.

The Veterans Disability Benefits Commission (VDBC) established by Congress has been examining a range of issues associated with the laws, policies and procedures for making disability determinations. An area we believe needs closer scrutiny is the interface between the military services disability rating / medical retirement system and the VA disability system.

While recognizing that the military services rate disabilities on fitness for duty, they are required by law to use the VA's Schedule for Rating Disabilities (VASRD). It has long been observed that there are inexplicably wide variations among the Services in rating very similar disabling conditions and even more puzzling gaps between the Services and the VA using the same

VASRD standards. At the end of the day, these disjointed procedures result in unfair and inadequate benefits for medically separated or medically retired veterans. On March 20, 2007, the House Armed Services Committee unanimously voted in favor of legislation to address many of these issues.

MOAA urges speedy enactment of H.R. 1538, a bill that would improve the management of medical care, personnel actions, and quality of life issues for members of the Armed Forces who are receiving medical care in an outpatient status, and for other purposes.

Transition Assistance Program (TAP) for National Guard and Reserve Veterans. TAP resources are inadequate to meet the needs of service men and women separating from active military service, including de-mobilizing members of the reserve forces. The GAO concluded in a 2005 report (GAO-05-844T) that TAP funding requirements are based entirely on projected active duty separations. The Services separate about 200,000 active duty troops per year and TAP budgets were built on those estimates alone. But since 9/11 nearly 600,000 Guard and Reserve troops have served on federal active duty in the war on terror.

According to the GAO, 117,000 Guard and Reserve troops were de-mobilized in 2004, but no additional funds were earmarked by the Departments of Defense, VA, or Labor for TAP to support their reintegration to their communities and families.

MOAA recommends that TAP budgets for the reserve components be increased by 50% over current spending levels.

MOAA also endorses unofficial proposals from the National Guard Bureau that would benchmark best practices of state reintegration programs and authorize military duty status for TAP activities near hometown units.

Total Force Montgomery GI Bill for the 21st Century.

Our nation's active and reserve forces are operationally integrated on the battlefield but their educational benefits are not synchronized to maximize recruitment and retention purposes and to support our warriors' readjustment into civilian life. A new approach is needed to restructure the MGIB to meet the needs of our total armed forces team in the 21st century.

The Total Force MGIB has two broad concepts. First, all active duty and reserve MGIB programs would be consolidated under Title 38. DoD and the Services would retain responsibility for cash bonuses, MGIB "kickers", and other enlistment / reenlistment incentives. Second, MGIB benefit levels would be structured according to the level of military service performed.

The Total Force MGIB would restructure MGIB benefit rates as follows:

? Tier one - Chapter 30, Title 38 - no change. Individuals who enter the active armed forces.
? Tier two - Chapter 1606, Title 10 -- MGIB benefits for initial enlistment or reenlistment into the Guard or Reserve. Chapter 1606 would transfer to Title 38. Benefit rates would be set in proportion to active duty rates under Chapter 30. Historically, Selected Reserve benefits have

been 47-48% of active duty benefits.
? Tier three - Chapter 1607, Title 10 -- MGIB benefits for mobilized members of the Guard / Reserve on "contingency operation" orders. Chapter 1607 would transfer to Title 38 and be amended to provide mobilized servicemembers one month of "tier one" benefits (currently, $1075 per month) for each month of activation after 90 days active duty, up to a maximum of 36 months for multiple call-ups.

A servicemember would have up to 10 years to use remaining entitlement under Tier One or Tier Three programs upon separation or retirement. A Selected Reservist could use remaining Second Tier MGIB benefits only while continuing to serve satisfactorily in the Selected Reserve. Reservists who qualify for a reserve retirement or are separated / retired for disability would have 10 years following separation to use all earned MGIB benefits. In accordance with current law, in cases of multiple benefit eligibility, only one benefit would be used at one time, and total usage eligibility would extend to no more than 48 months.

MOAA appreciates the House Committee on Veterans' Affairs expression of support for a total force approach to the MGIB in its "Views and Estimates" to the Budget Committee for the FY 2008 budget. Unfortunately, the statement does not identify potential funding sources to implement a readjustment benefit under the MGIB for Guard and Reserve veterans of OIF / OEF. The root question and concern here is whether Congress recognizes that these service men and women indeed are veterans of the war on terror.

MOAA believes that a number of funding approaches are available to Congress to overcome mandatory spending hurdles for MGIB modernization. One approach is to make a modest adjustment to the VA home loan mortgage loan program to initiate earned readjustment benefits for Guard and Reserve veterans under the MGIB.

MOAA strongly supports enactment of S. 644 and H.R. 1102, bi-partisan companion bills that would consolidate military / veteran MGIB programs in Title 38, scale benefit rates according to the length and type of military duty performed, and establish a readjustment benefit for Guard and Reserve veterans of the War on Terror. MOAA also endorses H.R.1641, a bi-partisan cost-neutral bill that would take the first step towards these objectives by integrating the reserve MGIB programs into Title 38.

Other Educational Benefits Issues

In modernizing the MGIB to meet the needs of our 21st century armed forces, MOAA recommends follow-on consideration of unresolved MGIB issues including but not limited to the following.

Accelerated Benefit Usage for Guard and Reserve Servicemembers. Guard and Reserve service men and women are ineligible for accelerated use of their reserve MGIB benefits as are active duty veterans. This is one of a number of disconnects among the MGIB programs for members of our armed forces.

Enrollment Option for Career Servicemembers who Declined "VEAP". MOAA continues to support enactment of legislation that would permit a one-time MGIB enrollment option for currently serving VEAP-'decliners'.

Benchmarking MGIB Rates to the Average Cost of Education. Department of Education data for the 2005-2006 academic year show the MGIB reimbursement rate for full-time study covers about 80%* of the cost at the average public four-year college or university (* percentage reflects average costs only for tuition, room, board; does not include actual expenses to veterans of commuting, living costs, or books and supplies).

MOAA urges Congress to benchmark MGIB benefit rates to keep pace with the average cost of education at a four-year public college or university.

Transferability of Benefits for National Guard and Reserve Servicemembers. Under current law, the Services may offer service men and women in designated skills the option of transferring up to half of their remaining MGIB entitlement to eligible dependents in exchange for a reenlistment agreement at the sixth year of service. The Army recently opened 'transferability' in certain skills. MOAA has long endorsed transferability but we believe the authority would be more useful for readiness as a career retention incentive at the 12 to 14 years' service point. Moreover, we note that transferability is not available to National Guard and Reserve service men and women with reserve MGIB entitlement.

$1,200 MGIB Enrollment "Tax". The MGIB is one of the only government-sponsored educational programs in America that requires a student to pay $1,200 (by payroll reduction during the first 12 months of military service) in order to establish eligibility. The payroll reduction is nothing more than a penalty that must be paid for before the benefit is received. Sadly, the fee causes some enlisted servicemembers to decline enrollment simply because they are given a one-time, irrevocable decision at a time when many have prior debts and are under the stress of adapting to the military. The practice sends a very poor signal to those who enter service expecting a world-class educational benefit.

MGIB Eligibility for Certain Officers. Under current law, officers commissioned from a Service Academy or Senior ROTC scholarship program are ineligible for the MGIB. To support the retention of junior officers in critical skills.

MOAA recommends the Committees establish MGIB entitlement for officers commissioned from a Service Academy or Senior ROTC Scholarship program who agree to an extension of their active duty service commitment.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Mobilized reservists are treated as "severed employees" with respect to their employer-based retirement plans such as 401k or 403b programs. Consequently, they are not authorized to contribute to them during a period of active military service. Temporary legislative authority to permit withdrawals and contributions to civilian retirement accounts sunsets this year.

MOAA urges support for H.R. 867, a bill that would make permanent a temporary authority for penalty-free withdrawals from IRAs, 401(k)s, and other similar retirement funds for National Guard and reserve servicemembers called to active duty for at least 179 days (or for an indefinite period).

‘Tax' on Disabled Military Retired Veterans' Pay - Concurrent Receipt

Disabled military retirees are extremely grateful for Congress' action to ease the unfair retired pay loss that has disadvantaged disabled retirees for over a century.

The concurrent receipt provisions enacted to date provided substantive relief for tens of thousands of disabled retirees; yet, an equal number are still excluded from the same principle that eliminates the disability offset for those with 50 percent or higher disabilities. The principle is the same for all disabled retirees, including those not covered by concurrent receipt relief enacted so far - they earned their retired pay through years of service and sacrifice, and should not be forced to forfeit their earned retired pay simply because they also suffered a service-connected disability.

The most severe inequity not yet addressed at all affects members who had their careers cut short by a combat-incurred or other service-caused disability and were forced into medical retirement before attaining 20 years of service. These retirees must fully fund their own VA disability compensation by giving up most or all of their military retired pay. It is impossible to explain to such a member why the government appears to award no compensation value for his or her service (perhaps as much as 19 years, 11 months).

Simply put, the imposition of a 20-year service requirement assumes a voluntary service continuation choice that simply does not exist in these cases.

MOAA believes strongly that, when a member is forced to leave service short of 20 years because that very service caused him or her to become disabled, then the government has an obligation to "vest" that member's retirement credit for whatever service is rendered. For Chapter 61 (disability) retirees forced out short of 20 years, that vesting formula should be the same formula now set in concurrent receipt law for Chapter 61 retirees with more than 20 years' service - 2.5% times years of service times the applicable pay base.

MOAA strongly supports legislation introduced this year by Rep. Gus Bilirakis (R-FL) (HR 89 and HR 303), Rep. Jim Marshall, (D-GA) (HR 333), and Sen. Harry Reid (D-NV) (S 439).

MOAA recognizes that the Veterans Disability Benefits Commission has an ongoing review in this area. But we believe these two inequities are so obvious as to require immediate redress.

MOAA urges the Committees' membership to support legislation to authorize concurrent receipt of retired pay and VA disability compensation at the earliest possible time, with particular priority for immediate "vesting" of earned military retired pay for Chapter 61 retirees forced into medical retirement before attaining 20 years of service and full, immediate concurrent receipt for retirees deemed "unemployable" by the VA.

Survivor Issues

MOAA is extremely grateful to Congress for establishment of Traumatic Injury Insurance coverage, raising Servicemembers' Group Life Insurance (SGLI) to $400K and authorizing premium-free coverage for SGLI in theatres of operation.

MOAA is grateful also for recent improvements to the Survivor Benefit Plan (SBP), especially the phase-out of the age-62 annuity reduction and expansion of SBP coverage options for active duty deaths since 7 Oct 01.

One SBP inequity that remains is the offset of SBP amounts by VA Dependency and Indemnity Compensation (DIC).

SBP-DIC Offset

MOAA believes strongly that current law is unfair in reducing military Survivor Benefit Plan (SBP) annuities by the amount of any survivor benefits payable from DIC.

If the surviving spouse of a military retired veteran who dies of a service-connected cause is entitled to DIC from the Department of Veterans Affairs and if the retiree was also enrolled in SBP, the surviving spouse's SBP benefits are reduced by the amount of DIC. A pro-rated share of SBP premiums is refunded to the widow upon the member's death in a lump sum, but with no interest. This offset also affects all survivors of members who are killed on active duty.

Statutory authority is clear that SBP and DIC payments are structured for different purposes. SBP is analogous to an insurance plan purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the VA indemnity compensation should be added to the SBP the retiree paid for, not substituted for it.

It should be noted as a matter of equity that surviving spouses of federal civilian retirees who are disabled veterans and die of military-service-connected causes can receive DIC without losing any of their federal civilian SBP benefits.

In the case of members killed on active duty on or after October 7, 2001, a surviving spouse who has children can temporarily avoid the dollar-for-dollar offset only by assigning SBP to the children. But that forces the spouse to give up any SBP claim after the children attain their majority - leaving the spouse with just a $1,067 monthly annuity from the VA. And that provision offers no relief at all to survivors of members who died before 10/7/01 or who have no children.

Unfortunately, some have a misconception that Congress "solved the SBP problem" by authorizing the recent lump sum increases in SGLI and the death gratuity. Nothing could be further from the truth. In fact, 94% of the more than 61,000 survivors affected by the SBP/DIC offset got no benefit from those recent changes. That's because only 4,000 SBP/DIC -eligibles had sponsors who died on active duty since 10/7/01.

The vast majority of the affected survivors received far smaller payments - as little as $50,000 in SGLI or $3,000 as a death gratuity.

MOAA strongly supports passage of S.935 and H.R. 1589, bills that would provide relief for military survivors of this war and earlier conflicts.

Retain DIC on Remarriage at Age 55. Legislation was enacted in 2003 to allow eligible military survivors to retain DIC upon remarriage after age 57. At the time, Congressional staff advised that age-57 was selected only because there were insufficient funds to authorize age-55 retention of DIC upon remarriage. MOAA's goal remains age 55 retention of DIC upon remarriage in order to bring this benefit in line with rules for the military SBP program and all other federal survivor benefit programs.

Conclusion

The Military Officers Association of America is very grateful to the members of the Senate and House Veterans Affairs Committees for your leadership in supporting our nation's veterans, their families and survivors, and our nation's future veterans and who continue to serve on active duty, the National Guard and Reserve forces.