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STATEMENT
of the
MILITARY OFFICERS ASSOCIATION OF AMERICA
on
LEGISLATIVE PRIORITIES
for
VETERANS' HEALTH CARE and BENEFITS
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before the

SENATE VETERANS¡¦ AFFAIRS COMMITTEE

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Presented by

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Mr. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE, on behalf of the 360,000 members of the Military Officers Association of America (MOAA), I am honored to have this opportunity to present the Association¡¦s legislative agenda for veterans health care and benefits programs.

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

VETERANS HEALTH CARE

Health Funding Overview

MOAA is grateful to Congress for addressing a woefully inadequate VA health care budget for the past (FY 2005) and current fiscal year, FY 2006. Since 9/11, we have been particularly concerned that VA demand projections have not properly accounted for the increased number of veterans from the Iraq and Afghanistan conflicts (OIF / OEF). In accordance with VA¡¦s two-year ¡§open door¡¨ policy, more than 525,000 Guard and Reserve veterans are now eligible for VA care, in addition to the active duty veteran population. VA data show that greater numbers of active duty veterans than Guard / Reserve veterans are enrolled in the VA, but Guard-Reserve usage is higher. The GAO recently confirmed that the VA¡¦s demand model is inadequate for estimating projected costs for the VA health care system.

MOAA fully supports reforming the VA¡¦s enrollment projection model used to justify the VA health care budget and strongly endorses the President¡¦s Task Force recommendation that the

VA health care system should be fully funded by mandatory spending or by some other means that will ensure the full-funding objective is met.

The FY 2007 VA Medical Care Budget includes $31.5 billion in discretionary appropriations and $2.8 billion in increased collections for a total of $34.3 billion for VA medical care. The budget request recognizes the need to provide timely care to those who have served the nation in uniform and is in range of the budget estimate set forth in the Veterans Independent Budget for FY 2007, which MOAA endorses. Included in the spending plan is an estimated $795 million in collections that would come directly out of veterans' pockets, not the federal treasury.

MOAA recommends that Congress provide $33 billion for veterans' health care, an increase of $4.2 billion over the fiscal year 2006 appropriation, and approximately $1.5 billion over the administration's fiscal year 2007 budget request, without collections.

Usage Fees and Drug Co-pays

MOAA is surprised and disappointed to note that after twice being rejected by Congress, the Administration is again seeking enactment of a $250 usage fee for 2.3 million Priority Group 7 & 8 enrolled veterans.

The Administration is also reviving its proposal to increase pharmacy co-payments from $8 to $15 for these veterans. The fees would generate revenue of $251 million in FY 2007.

What¡¦s wrong with this picture? First, under the VA¡¦s two-year open door policy for OIF / veterans, many thousands of veterans are completing their ¡§trial¡¨ enrollment and, if they have not been determined to have a service-connected disability, are being assigned to PG-7 or 8 depending on income levels. We must ask if it is right that a nation that sent these veterans into harm¡¦s way in the War on Terror should now charge them a fee for their VA care? Second, the proposals fail to consider the lost revenue from PG 7 and 8 veterans who may have other health insurance (OHI).

Third, attempts to correlate the fees with TRICARE Prime fees are fallacious: the VA is not a health insurance system with managed care standards. TRICARE Prime is a managed care (HMO) component of the military health system. TRICARE Prime fees are optional for those who choose this coverage over TRICARE Standard. Participants pay modest annual fees in order to obtain assured access to TRICARE providers under established access standards. The fees the Administration seeks bring no reciprocal benefit in terms of access to care in a timely manner. Their only purpose is to depress demand and save money by driving veterans away.

MOAA is opposed to VA usage fees and higher drug copays. During this long and difficult 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.

Medical and Prosthetic Research

The budget request shows a $17 million increase in the research budget above the 2006 level. Additionally, the VA indicates that OIF/OEF research is a high priority and special research is

being done concerning PTSD, traumatic brain injury, prostheses and injuries associated with blast injuries. However, we are concerned that the $17M increase appears to be due only to funds from other federal and non-federal resources that may or may not actually be available.

MOAA strongly urges Congress to ensure a funding level of $460 million for medical research -- including traumatic brain injury, spinal cord injury, prosthetic devices, and burn therapies.

Polytrauma Centers funding

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 VA has four such polytrauma centers throughout the United States and the DoD is planning to establish three more. Senior MOAA leaders have been privileged to visit some of these facilities. We have seen first hand the need for facility modification and expansion in order to keep up with demand and enable the most efficient use of modern technology. But the need is not adequately addressed in the budget request, which proposes a $627 million cut in minor and major construction dollars.

MOAA strongly urges the Committee to reverse the $627 million cut in construction allocations and restore construction funding required for needed upgrades to VA polytrauma centers and for other critical construction needs.

Seamless Transition Road Map

MOAA appreciates the leadership of the Committee in keeping up the pressure on the VA and DoD to accelerate accomplishment of ¡§seamless transition¡¨ policies, procedures, and supporting objectives for our nation¡¦s service men and women and their families.

What is seamless transition? In its 2003 report, the President¡¦s Task Force on DoD ¡V VA health care collaboration outlined the following objectives:

?á Single separation physical: ¡§The Departments [of Defense and Veterans Affairs] should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process.¡¨
?á Electronic Medical records: ¡§VA and DoD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards based.¡¨
?á Privacy: ¡§The Administration should direct the Department of Health and Human Services (HHS) to declare the two Departments to be a single health care system for the purposes of implementing HIPAA regulations.¡¨
?á Occupational and Hazard Exposure Data: ¡§VA and DoD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events.¡¨
?á Joint Health Surveillance and Reporting: ¡§The Departments [of Defense and Veterans Affairs] should: 1) add an ex officio member from VA to the Armed Forces Epidemiological

Board and to the DoD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue and annual report on Force Health Protection, and make it available to the public.¡¨

The record of accomplishment on these goals is mixed, though there is some progress. We offer the following observations on policy, procedures, and technologies supporting seamless transition objectives:

?á Transparency in oversight and policy coordination. MOAA commends Congress for enacting legislation that established a formal coordination process between the Departments of Defense and Veterans Affairs. The DoD-VA Joint Executive Council (JEC) and its subordinate Benefits Executive Council (BEC) and Health Care Executive Council (HEC) have the potential to spearhead greater progress on seamless transition initiatives.

MOAA recommends greater transparency and oversight of the DoD-VA Joint Executive Council activities.

?á Electronic Medical Records. The VA has fielded a standard-setting electronic medical records system for its hospital facilities and outpatient clinic networks. Known as VISTA, the VA system has received high marks in the medical community and is being adopted by a growing number of civilian provider networks. DoD is now fielding a military electronic medical records system called AHLTA. AHLTA is expected to be on line this year. The question, however, is whether VISTA and AHLTA can ¡§talk to each other.¡¨

MOAA continues to strongly urge accelerated development of bi-directional, interoperable standards-based electronic medical records between DoD and the VA.

?á Medical Evaluation Board (MEB) / Physical Evaluation Board (PEB). MEBs are conducted to determine suitability for continued service following an injury, wound, or illness. MEBs follow a ¡§period of observation¡¨ or ¡§time to heal¡¨ for ill or injured service men and women. MEBs average 121 days, but can vary considerably depending on the medical condition and healing process. For example, Army MEBs currently take 67 days to complete. The PEB is charged with making personnel decisions based on the input from the MEB. DoD requires a PEB in peacetime to be completed within 40 days following an MEB. The average PEB completion time since OIF and OEF is 87-280 days. Taken together, the convalescence, MEB and PEB processes appear to average between nine and fifteen and a half months for Army soldiers.

MOAA has recommended that the Veterans Disability Benefits Commission evaluate MEB-PEB policy and procedures to ensure fair treatment among the Services including members of the Guard and Reserve.

?á Single Separation Physical. MOAA remains concerned about known gaps in implementing a single separation physical. Some time ago, DoD and VA announced an agreement on a single separation physical protocol. Yet, at key medical treatment facilities like the Walter Reed Army Medical Center and the National Naval Medical Center neither facility has implemented a single,

systematic process for a separation physical under a joint DoD-VA protocol. That being the case at the Army and Navy¡¦s premier medical facilities, it¡¦s unlikely that a single separation physical has been implemented elsewhere.

MOAA continues to urges support for accelerated development of a single separation physical.

?á Seriously Wounded Transition Program. DoD and VA have made commendable progress in coordinating services for injured and ill service members. DoD has established a joint center to oversee care and services for injured and ill OIF and OEF service members. The VA has assigned caseworkers to major military medical facilities that are providing care and rehabilitation services to severely injured or ill troops. Last year, the GAO recommended improving information sharing between DoD and VA on seriously injured service men and women (Vocational Rehabilitation; More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Service Members (January 2005).
MOAA recommends continued emphasis on improving the coordination of care and information sharing between DoD ¡V VA for seriously wounded service members.

Expansion of Mental Health Services
Recent studies project that 1 out of 6 servicemembers returning from Iraq and Afghanistan will need care for PTSD and other mental health conditions. The budget request increases funding for mental health services from $2.8 billion to $3.2 billion. 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.

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.
?á About one out of eight enrolled veterans is a dual-eligible veteran.
?á One out of ten users (¡§unique patients¡¨) of VA care is a dual-eligible veteran.
?á Enrollment of military retired veterans has increased by a little over one-third since June 2000 when VA began tracking the data (600,870 retired veteran enrollees to 970,549 as of Sep 2005).

Source: VHA. Data as of 30 September 2005.

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The more severe a disability, the more likely it is that a veteran would seek VA care:

?á 77% of dual-eligibles with disabilities rated at 50% or greater (PG-1) used VA care last year
?á 54% of dual-eligibles with disabilities rated 40-50% (PG-2) used VA care last year down
?á 44% of dual-eligibles with disabilities rated 10-30% (PG-3) used VA care last year down
?á By contrast, only 26% of PG-8 retired veterans used VA care last year down from 29% in 2004.

In 2005, 53% of enrolled military retired veterans used VA health care in some way.

Because many enrolled retired veterans have serious disabilities, it is imperative that they have assured access to the VA¡¦s spectrum of health care services including its well-regarded specialty care capabilities.

As we have noted in past testimony, military retired veterans often prefer to obtain their routine health care locally from the TRICARE network, but are willing to travel some distance to have access to VA specialty care services.

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.

Capital Assets for Enhanced Services (CARES)

MOAA and other military and veterans organizations have noted that the CARES planning process does not include planning for mental health services and long-term care. MOAA continues to urge inclusion of mental health care and long term care services in ongoing facilities decisions resulting from the CARES process.

VETERANS BENEFITS

Overview. The 2007 VA Budget Request includes $42.1 billion for entitlement costs associated with benefits administered by the Veterans Benefits Administration (VBA). The total includes an additional $4 billion for disability compensation for veterans and their survivors for disabilities or diseases incurred or aggravated in military service.

Disability Claims: Quality and Process Improvements Needed

The workload and complexity of VA disability claims continues to increase. The VA projects over 900,000 claims this year. The estimate includes almost 100,000 claims from ¡§special outreach¡¨ programs mandated by Congress last year. Disability claims processing time rose to 167 days on average in 2005. The VA¡¦s performance goal for claims processing is 100 days. In addition to increased workload, a continuing challenge is replacing retiring claims workers with highly trained individuals and providing them with the tools, policies and procedures to improve the quality and timeliness of production. The VA ¡§tiger team¡¨ model, which is used to adjudicate claims of WWII and other older veterans, should be used throughout the system. Additional investment in training, full time positions, and technology also will be needed to reach sustainable quality and timeliness goals.

MOAA continues to urge additional claims-workers, technology upgrades, and training to reach and sustain the VA¡¦s original strategic performance goal of 100 days on average per VA claim.

Seamless Transition - TAP / DTAP Programs and Related Issues. MOAA appreciates that this Committee held a hearing on 2 February 2006 to examine the issue of rising unemployment among veterans recently separated from military service. The rate of unemployment among

veterans aged 20-24 is 15%, almost double that for non-veterans (8% unemployment). Since 2001 the active Armed Forces have separated an average of 200,000 service men and women each year. In addition, the call-up of more than 525,000 Guard and Reserve service men and women since 9/11 has increased the demand on transition assistance programs (TAP). MOAA believes there is a link between strong military TAP programs and the goal of reducing unemployment among young veterans.

A GAO report issued last year stated that TAP resources have been ¡§flat since fiscal year 1995¡¨ and that DoD¡¦s budget has not taken into account the needs of separating veterans from the National Guard and Reserve.

MOAA recommends that the Committee support policy and funding initiatives to:
?á Enable TAP services to be delivered in local communities for separating Guard and Reserve veterans
?á Expand VA outreach to provide "benefits delivery at discharge" services in local settings convenient to de-mobilizing Guard and Reserve veterans

MOAA urges the Committee to support seamless transition initiatives that underwrite TAP / DTAP programs in order to reduce the potential of unemployment and homelessness among veterans of the war on terror.

Total Force Montgomery GI Bill

Congress intended that the all-volunteer force Montgomery GI Bill would support DoD recruitment and retention programs, enable a smoother readjustment to civilian life, and enhance the nation¡¦s competitiveness.

But these goals are not being fully realized especially for mobilized members of the National Guard and Reserve forces. Ongoing challenges include:

?á Delayed implementation of MGIB benefits for mobilized reservists authorized under Chapter 1607 of Title 10 USC. Only a handful of educational benefits claims have been processed ¡V and these, manually ¡V for the more than 525,000 Guard and Reserve troops who have served on active duty under contingency operation orders since 9/11.
?á Lack of a readjustment benefit for mobilized reservists. After serving the nation on active duty in the war on terror and successfully completing a Guard or reserve service commitment, reservists are not authorized any readjustment benefit. They must leave behind remaining MGIB benefits upon separation unless the separation is for disability.
?á Benefit disparities. For the first 15 years of the MGIB, benefits earned by individuals who initially joined the Guard or Reserve paid 47 cents to the dollar for active duty MGIB participants. Since 9/11, however, the ratio has dropped to 29 cents to the dollar.
?á Administrative difficulties. DoD and VA officials report enormous challenges in de-conflicting and coordinating the oversight and management of MGIB programs. Policy and procedural challenges are compounded by outmoded information management and information technology support for the MGIB.

The Total Force MGIB for the 21st Century. The Total Force MGIB has two broad concepts. First, all active duty and reserve MGIB programs would be organized under Title 38. (The responsibility for cash bonuses, MGIB ¡§kickers¡¨, and other enlistment / reenlistment incentives would remain with the Department of Defense under Title 10). 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:

?á Tier one ¡V Chapter 30, Title 38 ¡V no change. Individuals who enter the active armed forces would earn MGIB entitlement unless they decline enrollment.
?á Tier two ¡V Chapter 1606, Title 10: MGIB benefits for initial entry into the Guard or Reserve. Chapter 1606 would transfer to Title 38. No other change is envisioned at this time. In the future, the Committee should consider adjusting benefit rates in proportion to the active duty program. Historically, Selected Reserve benefits have been 47-48% of active duty benefits.
?á Tier three ¡V Chapter 1607, Title 10, amended -- MGIB benefits for mobilized members of the Guard / Reserve on ¡§contingency operation¡¨ orders. Chapter 1607 would transfer to Title 38 and be amended. Mobilized servicemembers would receive one month of ¡§tier one¡¨ benefits (currently, $1034 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 may be used at one time, and total usage eligibility extends to no more than 48 months.

MOAA strongly supports enactment of a ¡§Total Force Montgomery GI Bill¡¨.

Other Educational Benefits Issues

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 61% of the cost at the average public four-year college or university. MOAA recommends the Committee increase MGIB benefit rates to keep pace with the average cost of education at a four-year public college or university.

Enrollment Option for Career Servicemembers who Declined ¡§VEAP¡¨. Approximately 50,000 career servicemembers who continue to serve on active duty declined to enroll in the precursor to the MGIB known as ¡§VEAP¡¨, the Post-Vietnam Era Veterans Education Assistance Program (Chapter 32, Title 38). Many declined VEAP on the advice of military counselors. They were told that they would do better to invest the VEAP enrollment fee of $2700 and wait to enroll in the coming Montgomery GI Bill. MOAA supports enactment of H.R.269.

Transferability of Benefits. About two-thirds of today¡¦s force is married. Many reenlistment decisions are based on family needs. MOAA supports enactment of legislation to permit a

servicemember to transfer up to one-half of remaining MGIB-AD entitlement to immediate family members in exchange for a career commitment (e.g., those who commit to serve at least 14 years normally will later complete 20 or more years service).

MGIB Eligibility for Certain Officers. Under current law, officers commissioned from a Service Academy or Senior ROTC scholarship program are ineligible for the MGIB. Most officers today are required to obtain advanced degrees for future assignments and promotion competitiveness. But Service tuition assistance programs are limited to a discrete number of designated specialties. MOAA recommends the Committee consider establishment of MGIB entitlement for officers commissioned from a Service Academy or Senior ROTC Scholarship program in exchange for extension of their active duty service commitment.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

MOAA is grateful to Congress for enacting legislation that requires the posting of USERRA rights and responsibilities in the workplace.

We are also grateful for Veterans Affairs Committees¡¦ past support in urging that the Department of Labor issue implementing regulations and guidance for the USERRA. The new USERRA rule explains the law using a ¡§question and answer¡¨ format that is clear and understandable.

Other adjustments to the USERRA are still needed, however. It is our understanding that 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 retirement plans during the period of activation. Although employers must match any 401k contributions that would have been made during the absence upon the return to the workplace, the reservist is prohibited from making personal contributions during the period of lengthy active duty. MOAA recommends the Committee endorse a change to the USERRA that would permit optional contributions to reservists¡¦ 401k plans during a call-up.

Servicemembers Civil Relief Act (SCRA)

MOAA has heard from active duty service families regarding tax problems that arise from changing duty stations. States of residence often treat military spouses differently than their sponsors with respect to the tax code and on matters such as the joint registration of vehicles at the new duty station. MOAA supports a review of these type issues with the goal of providing fair tax treatment of military families who are compelled to make frequent relocations.

Arlington National Cemetery Interment Rules

On multiple occasions since 1998 the House of Representatives by unanimous or near-unanimous vote favorably reported legislation that would codify the rules governing interment in our nation¡¦s most hallowed ground for its military heroes. In addition, this Committee has previously endorsed legislation that would authorize burial in ANC for reservists on inactive duty and for retired reservists eligible to retire but not yet 60 years of age.

The most recent House-passed legislation would authorize an in-ground burial to:

?á Members of the Armed Forces who die on active duty.
?á Retired members of the Armed Forces, including Reservists who served on active duty.
?á Former members of the Armed Forces who have been awarded the Medal of Honor. Distinguished Service Cross, Air Force Cross, or Navy Cross, Distinguished Service Medal, Silver Star, or Purple Heart.
?á Former prisoners of war.
?á Members of the National Guard / Reserve who served on active duty and are eligible for retirement, but who have not yet retired.
?á Members of the National Guard / Reserve who die in the performance of inactive duty training.
?á The President or any former President.
?á The spouse, surviving spouse, minor child and at the discretion of the Superintendent of Arlington, unmarried adult children of the above categories.

MOAA understands that many members of the Senate support codification of these rules, but also want to maintain longstanding tradition and practice of considering certain exceptions in the case of individuals who have made extraordinary contributions to the nation.

MOAA continues to recommend codification of the rules governing interment in Arlington National Cemetery.

Presumption of Service Connection for Hepatitis-C Infection

Medical research has established that there is a significantly higher rate of Hepatitis-C (HCV) infection among veterans than in the general population.
Before development of a reliable HCV screening test in the early 1990¡¦s, many thousands of servicemembers were exposed to HCV through air-gun inoculations, surgery, other medical procedures, and battlefield exposure. Accordingly, it is reasonable to presume service-connection for servicemembers exposed to the HCV virus prior to development of definitive screening tools.
MOAA recommends legislation adding presumption of service connection for Hepatitis-C in servicemembers determined to have been exposed to this disease prior to development of definitive screening protocols in 1992.

Survivors Issues

MOAA is extremely grateful to the Committee and Congress for passage of legislation last year to raise Servicemembers¡¦ Group Life Insurance (SGLI) to $400K, enact a Traumatic Injury Insurance rider to SGLI, and affirm the ¡§24-7¡¨ principle for service-connected disabilities.

SBP-DIC Offset. MOAA was extremely disappointed that House and Senate conferees failed to make at least some progress in the FY2006 Defense Authorization Act to ease the unfair law that reduces military Survivor Benefit Plan (SBP) annuities by the amount of any survivor benefits payable from the VA Dependency and Indemnity Compensation (DIC) program.

Under current law, the surviving spouse of a retired member who dies of a service-connected cause is entitled to DIC from the Department of Veterans Affairs. If the military retiree was also enrolled in SBP, the surviving spouse¡¦s SBP benefits are reduced by the amount of DIC (about $1,000 per month). 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. The offset also affects all survivors of members who are killed on active duty. There are approximately 60,000 military widows/widowers affected by the DIC offset.

MOAA believes SBP and DIC payments are paid for different reasons. SBP is 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 premature death. In such cases, the VA indemnity compensation should be added to the SBP the retiree paid for, not substituted for it. It¡¦s also noteworthy 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 purchased federal civilian SBP benefits.

In the case of members killed on active duty, a surviving spouse with children can 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 ¡V leaving the spouse with only a $1,000 monthly annuity from the VA.

MOAA notes that most large city fire departments continue 100% of pay for survivors of firefighters killed in the line of duty, in addition to far larger lump sum payments than military members¡¦ survivors receive. Military members whose service costs them their lives deserve fairer compensation for their surviving spouses.

MOAA strongly supports legislation to repeal the SBP-DIC offset introduced by Sen. Nelson (D-FL) (S. 185).

Retain DIC on Remarriage at Age 55. Legislation was enacted in 2003 to allow eligible military survivors to retain Dependency and Indemnity Compensation (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 greatly appreciates the opportunity to present the Association¡¦s legislative priorities on veterans¡¦ health care and benefits issues for the second session of the 109th Congress.