

RAO Bulletin Update
15 March 2008

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VA DISABILITY COMPENSATION UPDATE 01: Sen. Richard Burr (R-NC), the ranking Member on the Senate Veterans' Affairs Committee, introduced "America's Wounded Warrior Act," S. 2674, last week to overhaul DoD's disability retirement system and modernize the VA's disability compensation program.

These reforms are an upshot from last year's Dole/Shalala Commission recommendations and would impact veterans in varied ways dependent on their disability status. Some elements of the bill would:

- Reform the military disability retirement system and streamline the transition of disabled servicemembers from DoD to the VA. Basically, it would simplify the claims process by eliminating the need for duplicative DoD/VA ratings and disability examinations.
- Require DoD to determine a disabled servicemember's fitness for duty, and if found unfit, provide a lifetime annuity based on the member's rank and years of service. VA would then establish compensation for service-connected injuries, disease, or wounds. Under this proposal, the offset between DoD's annuity and future VA compensation would be eliminated.
- Revamped the VA compensation system into three elements - replacement value of average loss of earning capacity; a new payment for loss of quality of life; and a new transition payment provided to servicemembers who participate in treatment or vocational rehabilitation programs or who are within three months of their retirement from service.

However, the jury is still out on what the new DoD disability health care benefit and VA compensation levels would eventually look like. Currently, servicemembers who retire due to a 30% or higher military disability are eligible for lifetime family Tricare coverage (dependent children until majority age). However, the bill directs DoD to study and recommend to Congress new Tricare lifetime eligibility criteria under the new system. In the absence of a law change, the Secretary of Defense would establish eligibility by regulation effective the date of implementation of the new system. Additionally, the bill directs VA to study and provide a report to Congress within nine months and submit a proposal one year later detailing the new compensation and transition payment rate structure. Until the specific rate structure of the new VA compensation system is better understood, most veteran organizations and military advocates are withholding endorsement of this legislation. [Source: MOAA Leg Up 7 Mar 08 ++]

VA DISABILITY COMPENSATION UPDATE 02: The provisions of Senator Burr's America's Wounded Warrior Act (S 2674) and Representative Buyer's Noble Warrior Act (HR 5509), would drastically change the disability compensation system for America's veterans. These bills are loosely based on the recommendations of the President's Commission on Care for America's Wounded Warriors (Dole/Shalala Commission), but the USDR believes the specifics of these bills would do great harm to these veterans in the following ways:

- Will offset VA Disability Compensation by Social Security when the veteran ages 65.
- Applicable to all currently discharging veterans AND any veteran under VA's current compensation system who files a subsequent claim for additional benefits.
- Once under the new system the veteran cannot return to the current system.
- The present protection for ratings in effect for 10 or more years would no longer apply.
- Would require the VA Secretary to examine or consider:
 - (a) The extent to which disability compensation may be used as an incentive to undergo treatment.
 - (b) The appropriate injuries to be covered under the new disability rating system.
 - (c) Age as a determining factor when considering average loss of earnings capacity
- Amends the law to provide the Secretary with authority to adopt and apply a rating schedule for specific injuries. This provision would expressly limit VA authority over the Rating Schedule and places the authority in the hands of Congress. If the Congress can not correct the Sustained Growth Rate formula of Medicare Law how can it be expected the Congress would do any better with the much more complex Disability Rating Schedule?
- Provides for a quality of life payment, but only for those enrolled in the new compensation system.
- Allows or suggests: That VA "may take into account the effect on potential future earnings caused by the age of the veteran at the time a disability rating is assigned." This provision would allow VA to compensate an older veteran at a lower percentage of disability than a younger veteran for the exact same disease or injury. Is this not age discrimination?
- Provides that

(a) As frequently as [the VA] considers it appropriate, [the VA] must reevaluate and ... adjust the disability rating for any veteran receiving compensation;

(b) The VA must ... take into account any adjustments in the rating schedule that occurred since the last assignment of a rating;

(c) The frequency of reevaluations would be determined by an examining physician. This places physicians back in the rating business, allows for frequent adjustments to a veteran's rating based on perceived improvement, and further allows reductions based on a change in the rating criteria even when no improvement in the disability is shown

For these reasons, USDR is encouraging veterans to contact their legislators and strongly urge them to oppose S2674/HR5509 and any other legislation which is detrimental to and/or discriminatory against this nation's veterans. To facilitate doing this they have prepared a letter available at [http://capwiz.com/usdr/issues/alert/?alertid=11114251&queueid=\[capwiz:queue_id\]](http://capwiz.com/usdr/issues/alert/?alertid=11114251&queueid=[capwiz:queue_id]) which can be used as is or modified for forwarding to all legislators representing your zip code by the click of a button. [Source: USDR Action Alert 7 Mar 08 ++]

ANESTHESIA AWARENESS: It's easy to be squeamish about going under the knife, especially if you fear that the anesthesia might forsake you. Well over 20,000 people a year, by some estimates, experience "anesthesia awareness," in which they awaken during the operation, paralyzed but later able to bear witness to operating room chatter, the clanking of instruments, and the sucking, sawing, or slicing sounds of the surgical team at work. Most of the time (but not always), there is no physical pain and the patient later recalls only fleeting awareness. But sometimes the event leads to Post Traumatic Stress Disorder and lingering terror about hospitals and operations. Unfortunately, a study just out in the New England Journal of Medicine finds little value in a technology that might prevent this unhappy complication. The technology, called the BIS (short for bispectral index) monitor, measures the brain's electrical activity and comes up with a single number to represent the level of consciousness, ranging from 100 for fully awake to 0, no brain activity. Amid growing recognition that intraoperative awareness is a worldwide phenomenon, many countries, including the United States, have witnessed a proliferation in the use of such monitors to better titrate drugs, with reported success. But this new trial from the School of Medicine at Washington University in St. Louis of 1,941 patients at high risk for awareness showed no added value when BIS was used along with standard practice.

What the study shows, first and foremost, is that anesthesia is still more about clinical sense than gadgets, says Nagy Mikhail, an anesthesiologist and pain specialist at the Cleveland Clinic. Historically, it has been difficult to determine the depth of anesthesia. What may look like a gentle slumber is in fact a complex mix of states—unconsciousness, paralysis, insensitivity to pain, and inability to remember—that can vary inexplicably from one patient to another. It takes skill and judgment, says Mikhail, to determine the appropriate level of drugs. That means continuously looking at the whole patient, through physical examination; monitoring of oxygen levels, heart rate, blood pressure, and EKG; and tracking the concentrations of anesthetic gas in exhaled breath.

A racing heart or a flurry of irregular extra heartbeats, changes in the pupils, perspiration, or even a tear can signal inadequate depth of anesthesia in a paralyzed patient. But brain monitoring can be helpful as a complementary tool. It adds one more physiological measure and has proved to be particularly useful when intravenous sedation is the only anesthetic as compared with inhaled gas, which can be readily monitored. And a failure to promptly lower the BIS score into the range of 40 to 60 is certainly a sign that the anesthesia delivery equipment may be malfunctioning, one cause of intraoperative wakefulness.

Most hospitals have become vigilant about what previously might have gone unnoticed or been dismissed as a bad dream. Some regularly interview patients about their anesthesia experience, and the American Society of Anesthesiologists advises that in documented cases, awareness patients should be offered psychological counseling. The Joint Commission, which accredits hospitals, considers awareness a "sentinel event," calling for immediate investigation and response. This reinforces some obvious advice: If you are facing surgery, make sure you know the skill and experience of your anesthesiologist. However chilling, awakening during an operation has to be kept in context. There are over 20 million general anesthetics nationwide every year, and more than 99.8% of patients remain wholly unaware. [Source: US News & World Report Bernadine Healy M.D. article 12 Mar 08 ++]

VA BENEFITS GUIDE: The Department of Veterans Affairs recently published their Federal Benefits for Veterans and Dependents for 2008. An easy-to-read reference guide, it provides the most current information about your earned benefits. Be careful before hitting the print button--it is 153 pages and may take some time to print. However, you may want to hit your "Save to" tab and download it for future reference into a folder of your choice. You can download or

print your copy at <http://www1.va.gov/opa/vadocs/fedben.pdf>. [Source: EANGUS Minuteman Update 13 Mar 08 ++]

MOBILIZED RESERVE 12 MAR 08: The Army, Air Force and Marine Corps announced the current number of reservists on active duty as of 12 MAR 08 in support of the partial mobilization. The net collective result is 74 more reservists mobilized than last reported in the Bulletin for 27 FEB 08. At any given time, services may mobilize some units and individuals while demobilizing others, making it possible for these figures to either increase or decrease. The total number currently on active duty in support of the partial mobilization of the Army National Guard and Army Reserve is 74,419; Navy Reserve, 5,544; Air National Guard and Air Force Reserve, 7,127; Marine Corps Reserve, 8,654; and the Coast Guard Reserve, 344. This brings the total National Guard and Reserve personnel who have been mobilized to 96,088, including both units and individual augmentees. A cumulative roster of all National Guard and Reserve personnel, who are currently mobilized, can be found at <http://www.defenselink.mil/News/Mar2008/d20080312ngr.pdf>. [Source: DoD News Release 196-08 12 Mar 08 ++]

VA TRAVEL NURSE PROGRAM: To deal with a nationwide shortage of nurses and to improve the quality of care for veterans, the Department of Veterans Affairs (VA) has created a "Travel Nurse Corps" to enable VA nurses to travel and work throughout the Department's medical system. The Travel Nurse Corps, headquartered at the Phoenix VA Health Care System, is beginning as a three-year pilot program. Initially, it will place as many as 75 nurses at VA medical centers across the country. The goals of the program are to improve recruitment, decrease turnover of experienced nurses and maintain high standards of patient care. Under the program, participating nurses may be temporarily assigned to distant medical centers and clinics to help nursing staffs that have vacancies, to reduce wait times or the reliance upon contractors, or to maintain high-skill services and procedures.

On 20 FEB the Department announced plans to create a Rural Health Care Advisory Committee to enhance VA services to veterans in rural areas. The Travel Nurse Corps will work with this national VA panel to support VA health care in rural areas. Those who become VA travel nurses are compensated for their time on duty and their travel. They also receive standard government per diem allowances, which include lodging, meals and incidentals. "This program is competitive with the private sector. VA has state-of-the-art facilities, high-tech computer systems and professional colleagues second to none," said Jacqueline Jackson, Travel Nurse Corps director at the Phoenix VA Health Care System. The program is also designed to establish a potential pool for

national emergencies, serve as a model for an expanded VA travel corps with nurses who have varying specialties, and to reduce the use of contracted nurses, thus preserving resources that can be used elsewhere to care for veterans. For additional info on VA's Travel Nurse Corps refer to www.travelnurse.va.gov, email travelnurse@va.gov or call (602) 200-2398. or (866) 664-1030. [Source: VA News Release 11 Mar 08 ++]

VA RATING SCHEDULES UPDATE 03: U.S. Senator Daniel K. Akaka (D-HI), Chairman of the Veterans' Affairs Committee, introduced legislation 10 MAR to expand legal recourse for veterans seeking compensation for service-connected disabilities. The Veterans' Rating Schedule Review Act S.2737 would expand the jurisdiction of the U.S. Court of Appeals for Veterans Claims (CAVC) to allow for review of cases challenging the Department of Veterans Affairs rating schedule, the tool VA uses to determine the degree of a veterans' service-connected disability. Under current law, veterans cannot bring a case challenging the Rating Schedule to the CAVC. The legislation Senator Akaka introduced would remedy this by allowing the court to consider whether the Rating Schedule violates provisions in Chapter 11 of Title 38 of the US Code, the body of law which covers veterans' compensation for service-connected disability or death. Senator Akaka said, "I expect VA to comply with all laws passed by Congress in developing and revising the Rating Schedule. However, our nation's veterans deserve a forum where they can challenge the Rating Schedule when they believe that a statute passed by Congress to provide compensation for the service-disabled is being violated". [Source: Sen. Akaka Press Release 10 Mar 08 ++]__._,_.__

PROSTHETIC LIMB DEVELOPMENT: Hundreds of veterans face the challenge of learning to live with a missing arm. To make that transition easier, the Defense Advanced Research Projects Agency (DARPA) launched a \$55-million project that pools the efforts of prosthetics experts nationwide to create a thought-controlled bionic arm that duplicates the functions of a natural limb. If all goes well, by 2009 the agency will petition the Food and Drug Administration to put the arm through clinical trials. This summer the team hit a critical milestone when it finished Proto 2, a thought-controlled mechanical arm -- complete with hand and articulated fingers -- that can perform 25 joint motions. This dexterity approaches that of a native arm, which can make 30 motions, and trumps the previously most agile bionic arm, the Proto 1, which could bend at the elbow, rotate its wrist and shoulder, and open and close its fingers. A person wearing a Proto 2 could conceivably play the

piano. The next steps are to shrink the battery, develop more-efficient motors, and refine the bulky electrodes used to read electrical signals in muscles. A video clip of this prosthetic device can be viewed

at <http://www.popularmechanics.com/technology/industry/4224764.html?series=37video>

Research on the use of Rockets to help power robotic arms, could help lead to "better, stronger, faster" bionic limbs. Strength is a major hurdle in overcoming the develop- challenge of building a usable device. A new prototype rocket powered arm can lift about 20 to 25 pounds—three to four times more than current commercial prosthetic arms—and can do so three to four times faster. "Our design does not have superhuman strength or capability, but it is closer in terms of function and power to a human arm than any previous prosthetic device that is self-powered and weighs about the same as a natural arm ... It has about 10 times as much power as other [robotic] arms", said researcher Michael Goldfarb, a roboticist at Vanderbilt University in Nashville. "The rocket-powered arm also has greater dexterity and freedom of movement than any other prosthetic to date. Conventional prosthetic arms have only two joints, at the elbow and the "claw." This prototype functions more naturally than previous models, with a wrist that can twist and bend, and fingers that open and close independently. A video clip of this prosthetic device can be viewed at

http://www.livescience.com/php/video/player.php?video_id=220807BionicArm.

In a separate effort Inventor Dean Kamen is developing an extraordinary prosthetic arm at the request of the US Department of Defense, to help the 1,600 who've come back from Iraq without an arm (and the two dozen who've lost both arms). His tasking is to develop a prosthetic with which vets could pick up a raisin or a grape off a table, put it in their mouth, without destroying either one, and be able to know the difference without looking at it. In other words a device that had efferent, afferent, and haptic response. With a team he put together 13 months ago, they have developed a prosthetic that has 14 out of the 21 degrees of freedom available to a normal arm. You don't need the ones in the last two fingers. It has an elastic set of 14 actuators, each one which has its own capability to sense temperature and pressure. It also has a pneumatic cuff that holds it on, so the more it is put under load, the more it attaches. When the load is reduced it becomes more compliant. In a video clip recorded MAR 07 that can be viewed at

<http://www.cnn.com/2007/TECH/science/09/05/bionic.arm/index.html> a

demonstration of the effectiveness of the arm is shown. A man wearing the prosthesis takes a bottle of water from a woman's hand, drinks from the bottle, raises the prosthetic arm to his face and scratches his nose, picks up a pen with his opposed thumb and index finger, and picks up a piece of paper, rotates it and raises it to read. [Source: Various Mar 08 ++]

VA BURIAL BENEFIT UPDATE 01: Often survivors are disappointed when they seek reimbursement of burial expenses for departed veterans. This is because retirees have not informed their loved ones what to do and how much to expect in the event of their demise. You may be eligible for a VA burial allowance if:

- You paid for a veteran's burial or funeral ; AND,
- You have not been reimbursed by another government agency or some other source, such as the deceased veteran's employer; AND,
- The veteran was discharged under conditions other than dishonorable.

Following are the maximum benefits currently available from the VA:

- Burial Allowance (SC): VA will pay a burial allowance up to \$2,000 if the veteran's death is service-connected. In such cases, the person who bore the veteran's burial expenses may claim reimbursement from VA. In some cases, VA will pay the cost of transporting the remains of a service-connected veteran to the nearest national cemetery with available gravesites. There is no time limit for filing reimbursement claims in service-connected death cases.
- Burial Allowance (NSC): VA will pay a \$300 burial and funeral allowance for veterans who, at time of death, were entitled to receive pension or compensation or would have been entitled if they weren't receiving military retirement pay. Eligibility also may be established when death occurs in a VA facility, a VA-contracted nursing home or a state veterans nursing home. In non service-connected death cases, claims must be filed within two years after burial or cremation.
- Plot Allowance: VA will pay a \$300 plot allowance when a veteran is buried in a cemetery not under U.S. government jurisdiction if: the veteran was discharged from active duty because of disability incurred or aggravated in the line of duty; the veteran was receiving compensation or pension or would have been if the veteran was not receiving military retired pay; or the veteran died in a VA facility. The \$300 plot allowance may be paid to the state for the cost of a plot or interment in a state-owned cemetery reserved solely for veteran burials if the veteran is buried without charge. Burial expenses paid by the deceased's employer or a state agency will not be reimbursed.
- Headstones or markers: VA will provide headstones or markers to memorialize veterans or mark the graves of veterans buried in national,

state, or private cemeteries as well as those whose remains have not been recovered or identified. This includes those buried at sea, those remains donated to science, and those cremated and whose cremated remains were scattered without burying any portion of them. VA will also provide markers for eligible family members interred in a national or State Veteran's Cemetery. When interment is in a private cemetery, the cemetery may require, and charge for, a foundation for the marker and installation of the marker. Such costs must be paid from private funds.

- Flag: VA will provide an American flag, upon request, for covering the casket; and a memorial certificate, bearing the President's signature, expressing our Nation's grateful recognition of the deceased veteran's service.
- Other: In addition to VA burial benefits, the surviving spouse or eligible child of a veteran may be eligible for a \$255 lump-sum death benefit from Social Security. Local Social Security Offices have details.

[Source: VA Federal Benefits for Veterans & Dependents 2008 Edition ++]

MILITARY RECORDS/DD-214 UPDATE 02: The Department of Labor (DOL) National Office has notified all states that the Department of the Air Force is significantly backlogged in providing the Certificate of Release or Discharge from Active Duty, DD 214s to the separating servicemembers, the Veterans Administration, and the DOL Federal Claim Control Center (FCCC). The Air Force is now completing all DD 214s at a central location in Texas and the new completion procedures have caused delays in issuing the discharge forms. The DOL has spoken to both the Department of Defense and the Air Force, and they are diligently working to eliminate the backlog. In the interim, if an Air Force Ex-servicemember has not received his/her DD 214, orders to report, orders of release, or similar service and discharge letter from the Air Force, the servicemember may contact the unemployment compensation for ex-servicemen (UCX) Air Force Liaison, Gail Weber to obtain a letter for unemployment compensation use. The DOL has approved the Air Force's use of this official UCX Verification letter for the States to initiate the affidavit process and to make a determination for UCX eligibility and wages. This Air Force letter will be provided from the UCX Air Force Liaison, Gail Weber, on official Air Force letterhead and will contain all of the information usually supplied on the

DD 214 and Claims Control Record. She can be reached at: Gail Weber, DAFC, HQ AFPC/DPSOS, 550 C St. W. Ste. 3, Randolph AFB TX 78150-4713Tel: (210) 565-2461/3502F or via E-mail to gail.weber@randolph.af.mil. [Source: UIPN 08-008 10 Mar 08 ++]

FLORIDA TAXES: Veterans considering retirement in Florida should take into consideration the tax burden they will be undertaking as compared to where they presently reside. The following covers Florida's sales, personal income, property, inheritance and estate taxes as of MAR 08:

- Sales Taxes
 - a. State Sales Tax: 6 percent. (Food, prescription, and non-prescription drugs are exempt). There are additional county sales taxes that could make the combined rate as high as 7.5%.
 - b. Gasoline Tax: 32.6 cents per gallon.
 - c. Diesel Fuel Tax: *28.5 cents per gallon. Includes local county taxes. (Local taxes for gasoline and gasohol vary from 9.7 cents to 17.7 cents, and there is a 2.07 percent gasoline pollution tax.)
 - d. Cigarette Tax: 33.9 cents per pack of 20.
- Personal Income Taxes:
 - a. No state income tax.
 - b. Retirement Income: Not taxed. Starting in 2007, individuals, married couples, personal representatives of estates, and businesses are no longer required to file an annual intangible personal property tax return reporting their stocks, bonds, mutual funds, money market funds, shares of business trusts, and unsecured notes. For details refer to <http://dor.myflorida.com/dor/taxes/ippt.html>.
- Property Taxes: All property is taxable at 100 percent of its just valuation. In certain counties and cities, homeowners 65 and over can receive a homestead exemption from property tax is at or below \$26,763 (single) or \$30,046 (couples) per year (2007 figures). The income limitation is adjusted each year based on the COLA. In many instances the definition of household income excludes Social Security. Permanent residents may also be entitled to a homestead exemption regardless of age. Residents age 65 and older are entitled to both exemptions (\$50,000). The senior citizen's homestead exemption applies only to tax millage levied by the county or city and does not apply to millage of school districts or other taxing authorities. The homestead exemption for all residents applies to all property taxes not just city and county taxes. Annual increases in the assessment of homestead property are limited to 3 percent of the pervious year's assessed value, or if lower, the percentage change in the CPI for the prior, as long as there was no change in ownership. A 2006 law provides a property tax discount on homestead property owned by eligible veterans. To be eligible, a veteran must have an honorable discharge from military service, be at least 65 years old, be partially disabled with a permanent service connected disability all or a portion of which must be combat-related, and must have been a Florida resident at the time of entering military service. This discount is in addition to any other

exemptions veterans now receive. A 2007 law allows local governments to give those age 65 and above with low incomes an increased homestead exemption. Cities and counties have the option of doubling an existing homestead exemption on primary owner-occupied homes from \$25,000 to \$50,000. To qualify, taxpayers must have an annual income of \$20,000 or less. For more details on property taxes go to <http://dor.myflorida.com/dor/property/> and then find the link for the county property appraiser for the county in question. For more information on Florida's property tax exemptions refer to <http://dor.myflorida.com/dor/property/exemptions.html>

- Inheritance and Estate Taxes: There is no inheritance tax and only a limited estate tax.

For general information on Florida's taxes, to review information for new residents, or to access state tax forms refer to the Florida Department of Revenue site <http://dor.myflorida.com/dor> or call (800) 352-3671. [Source: MOAA 2008 Tax Guide Mar 08 ++]

DIET AND EXERCISE MYTHS: Many common diet and exercise myths could slow your weight loss. Every year, millions of Americans resolve to lose weight, whether on New Year's Day, their birthdays, or just some morning when their mirror or the bathroom scale seems particularly unkind. And every year, many get frustrated and give up before they reach their goals. Contributing to this problem is a host of bad information about diet and exercise that circulates through gyms, workplaces, and over the Internet. To help more people achieve and maintain a healthy weight, Julie Bender, a dietitian with Baylor University Medical Center at Dallas, and Phil Tyne, director of the Baylor Tom Landry Health and Wellness Center agreed to "weigh in" on ten of the most common diet and exercise myths.

- Myth #1: Crunches will get rid of your belly fat. "You can't pick and choose areas where you'd like to burn fat," Tyne says. "In order to burn fat, you should create a workout that includes both cardiovascular and strength training elements. This will decrease your overall body fat content."
- Myth #2. Stretching before exercise is crucial. False. Some studies have suggested that

stretching actually makes muscles more susceptible to injury. They claim that by stretching, muscle fibers are lengthened and destabilized, making them less prepared for the strain of exercise. "You might want to warm-up and stretch before a run, but if you are lifting weights wait until after the workout to stretch your muscles," Tyne suggests.

- Myth #3. You should never eat before a workout. False. "Fuel" from food and fluids is required to provide the energy for your muscles to work efficiently, even if you are doing an early morning workout. "Consider eating a small meal or snack one to three hours prior to exercise," Bender says. "Load up your tank with premium 'fuel' and choose some fruit, yogurt, or whole wheat toast."
- Myth #4. Lifting weights will make women bulky. False. "Most women's bodies do not produce nearly enough testosterone to become 'bulky' like those body builders on TV," Tyne says. If you do find yourself getting bigger than you would like, simply use less weight and more repetitions.
- Myth #5. Fat is bad for you, no matter what kind. False. Contrary to popular belief, there are plenty of "good fats" out there that are essential for good health and aid in disease prevention. "They are the ones that occur naturally in foods like avocados, nuts, and fish, as opposed to those that are manufactured," Bender says. "Including small amounts of these foods at meal times can help you to feel full longer and therefore eat less."
- Myth #6. Restricting calories is the best way to lose weight. False. Both cutting back on calories and moving more will help you lose weight and maintain the lean muscle mass needed to boost metabolism. People often think they must take drastic measures to lose weight, such as eating less than 1200 calories per day, but such diets usually do not provide adequate fuel for the body and may slow metabolism. "Drastic measures rarely equal lasting results, so start small and eliminate 100-300 calories consistently from your daily diet, and you will reap the reward," Bender says.
- Myth #7. As long as you eat healthy foods, you can eat as much as you want. False. A calorie is

a calorie. Although oatmeal is healthy, if you eat four cups of oatmeal, the calories add up.

"Healthy or otherwise, you still must be aware of portion sizes," Bender says. "You must limit your caloric intake in order to lose weight, however, understanding how to 'balance' calorie intake throughout your day can help you avoid feelings of deprivation, hunger and despair."

- Myth #8. Exercise turns fat into muscle. False. Fat and muscle tissue are composed of two entirely different types of cells. "While you can lose one and replace it with another, the two never "convert" into different forms," Tyne says. "So fat will never turn into muscle."

- Myth #9. Eating late at night will make you gain weight. False. "There are no 'magic' hours," Bender says. "We associate late-night eating with weight gain because we usually consume more calories at night. We do this because we usually deprive our bodies of adequate calories the first half of the day. Start the day out with breakfast and eat every 3-4 hours. Keep lunch the same size as dinner, and you will be less likely to over-indulge at night, yet you can enjoy a small late-night snack without the fear of it sticking to your middle."

- Myth #10. You have to sweat to have a good workout. False. "Sweating is not necessarily an indicator of exertion—sweating is your body's way of cooling itself," Tyne says. It is possible to burn a significant number of calories without breaking a sweat: try taking a walk, or doing some light weight training, or working out in a swimming pool.

[Source: Senior Living Sharon O'Brian article Jan 08 ++]

TRICARE IN THE PHILIPPINES: In a 18 FEB 08 in Manila the Tricare Area Office (TAO) Pacific Chief of Program Operations Lt Col Tony Ingram, provided some insight into the magnitude of the Tricare situation in the Philippines. Some facts that were brought out were:

- There are 10-12,000 retirees in the Philippines. Of which almost 70% are located in the

Pampanga, Olongapo, Zambales region. 13% of these retirees' location is unknown.

- 78% of the TRICARE claims in the Pacific are from the Philippines.
- In 2003 \$112 Million was billed to TRICARE and they paid out \$61 million.
- TRICARE had to take drastic measures in order to cut down on the fraudulent billing in recent years. At present they process up to a hundred requests monthly for individuals/facilities to be certified as TRICARE providers in the Philippines.

Col Ingram also revealed some of the improvements that his office have submitted up the chain

inclusive of:

- a) Pended time for claims changed from 35 to 90 days.
- b) Philippine Specific payment schedule
- c) Increased outreach by TAO-P
- d) Allow faxing of claims to secure fax server
- e) Allow EFT to the Philippines
- f) Opening of TAO-P branch office in the Philippines

[Source: FRA BR 82 Roberto Vicencio input 19 Feb 08 ++]

FAMILY CARE GIVING: The cost of providing care to a loved one who no longer can perform daily living activities is an emotional and financial challenge for everyone. Recently the Centers for Medicare and Medicaid Services (CMS) proposed new rules to give low-income Medicaid beneficiaries a cash allowance to hire their own personal care workers, including qualified family members. The cash allowance could be used to hire workers to help with activities such as bathing, preparing meals, household chores and related services that family members often provide. Hospitals and senior services agencies are offering training programs for caregivers, who upon completion of the program, may qualify to be paid for their services. In addition, if you don't qualify for Medicaid but have long-term care insurance, some newer policies pay for family to provide care after they have completed a care giving-training program. Adult day care is also becoming an increasingly important option.

Medicaid generally will pay for adult day care. In 2007 CMS began a three-year pilot program that allows a portion of Medicare home health-care benefits to go toward adult day care. The program, if available in your area, could help those who don't qualify for Medicaid. The cost of adult day care, around \$60 for a day that can stretch to 11 hours, can be substantially less than hiring an in-home health care worker at an hourly rate of \$12 to \$17 an hour. States generally require that adult day-care centers be registered or licensed, though laws vary. Most centers have a registered nurse available during the day, particularly at centers providing medical treatments. Of particular value for worn-out family caregivers are the activities that many centers provide, ranging from cognitive games for dementia patients to gardening and art classes. However, availability of the programs and adult day care services vary by state and area you live in, To investigate caregiving programs in your area, contact your local Area Agency on Aging. Check the yellow pages of your phone book, or to find an agency near you call the Eldercare Locator 1(800) 677-1116 or refer to www.eldercare.gov/Eldercare/Public/Home.asp. [Source: TREA Social Security & Medicare Advisor 27 Feb 08 ++]

AGENT ORANGE STATESIDE USE UPDATE 01: In 1979, the Environmental Protection Agency banned the use of Agent Orange in the United States when a large number of stillbirths were reported among mothers in Oregon, where the chemical had been heavily used. During the testing phase of Agent Orange in prior years, use tests were carried out at Fort Detrick, Maryland, Eglin Air Force Base in Florida, and Camp Drum in New York. The Diamond Alkali Co. in Newark, New Jersey, was one of the major producers of Agent Orange for the government. It was not until 1983 that the state of New Jersey got around to testing the soil around the plant. It found hazardous levels of dioxin. New Jersey

Gov. Thomas Kean urged residents living within 300 yards of the plant to move. In Times Beach Missouri dioxin laced oil had been sprayed on the town's roads to keep down the dust. Times Beach was one of 28 eastern Missouri communities where the spraying had been done. But none of the others had the levels of dioxin contamination of Times Beach, parts of which had dioxin levels of 33,000 parts per billion, or 33,000 times more toxic than the EPA's level of acceptance. The contamination was so bad that the government decided the only way to save the town's residents from further damage from dioxin was to buy them out and move them out. In early 1983, the U.S. government spent \$33 million buying the 801 homes and businesses in Times Beach and relocating its 2,200 residents. The entire town was fenced in and guards were brought in to keep out the curious. "Caution, Hazardous Waste Site, Dioxin Contamination," read the signs leading into Times Beach. It remains a ghost town today because of dioxin contamination.

In DEC 83, the EPA announced a nationwide plan to clean up more than 200 dioxin contaminated sites in the U.S., including 50 plants where 2,4,5-T had been manufactured. The cost of the cleanup was put at \$250 million and was expected to take four years. However, two months later the U.S. Air Force released the first part of a three part study on Operation Ranch Hand pilots and crewmen which sidelined this plan. It concluded that the 1,269 pilots and crewmen involved in the herbicide spraying program in Vietnam suffered no higher death or serious illness rates than the general population. In DEC 85 the Air Force released the third of its Operation Ranch Hand studies. It confirmed the other two: that there was no evidence that Agent Orange had any adverse affects on those who handled it during the war. For more info on Agent Orange refer to www.usvetdsp.com/agentorange.htm. Following is a list of Rainbow Herbicides containing dioxins and their components that were manufactured in the U.S.:

- Agent Orange: 2,4-D and 2,4,5-T; used between January 1965 and April 1970.

- Agent Orange II (Super Orange): 2,4-D and 2,4,5-T; used in 1968 and 1969.
- Agent Purple: 2,4-D and 2,4,5-T; used between January 1962 and 1964.
- Agent Pink: 2,4,5-T; used between 1962 and 1964.
- Agent Green: 2,4,5-T; used between 1962 and 1964.
- Agent White: Picloram and 2,4-D.
- Agent Blue: contained cacodylic acid (arsenic).
- Dinoxol: 2,4-D and 2,4,5-T; used between 1962 and 1964.
- Trinoxol: 2,4,5-T; used between 1962 and 1964.
- Diquat: Used between 1962 and 1964.
- Bromacil: Used between 1962 and 1964.
- Tandex: Used between 1962 and 1964.
- Monuron: Used between 1962 and 1964.
- Diuron: Used between 1962 and 1964.
- Dalapon: Used between 1962 and 1964.

[Source: The U.S. Veteran Dispatch Mar 08 ++]

PENTAGON DATA BREACH: A top Defense Department technology official said this week that a JUN 07 network intrusion at the Pentagon resulted in the theft of an "amazing amount" of data, and the incident remains a national security concern, The Office of the Secretary of Defense detected malicious code in various portions of its network infrastructure while consolidating information technology resources in the middle of last year. Over the course of two months, the code infiltrated multiple systems, culminating in an intrusion that created havoc by exploiting a vulnerability in Microsoft Windows, according to Dennis Clem, OSD's chief information officer. During the attack, spoofed e-mails containing recognizable names were sent to OSD employees. When they opened the messages, user IDs and passwords that unlocked the entire network were stolen; as a result, sensitive data housed on Defense systems was accessed, copied and sent back to the intruder. "This was a very bad day," said Clem during a panel discussion at the Information Processing Interagency Conference 4 MAR. The breach continues to pose a threat, he added. "We don't know when they'll use the information they stole... including processes and procedures that will be valuable to adversaries."

Clem didn't give any indication that the source of the attack was identified, nor did he provide details about what data was accessed. He noted that the network used by the office of John Grimes, Defense CIO and assistant secretary of networks and information infrastructure, is maintained separately, and therefore was not compromised. The portion of the network infrastructure under assault was shut down soon after the attack was detected. Recovery, which took three weeks and cost \$4 million, involved the introduction of a new process of checking out temporary IDs and passwords for access to the network, stricter requirements about the use of common access cards for identity verification, and introduction of digital signatures to ensure that information comes from a valid source. "It made a big difference" in securing the OSD network, which currently gets 70,000 malicious attempts at access a day, Clem said. [Source: GOVExec.com Jill R. Aitoro article 5 Mar 08 ++]

PTSD UPDATE 18: VA's new PTSD policy previously reported in Update 17 applies only to those diagnosed as having PTSD while on active duty. For these vets there will no longer be a requirement to verify in writing that they have witnessed or experienced a traumatic event before filing a claim for post-traumatic stress disorder. However, for those not diagnosed on Active duty the present rules regarding verification still apply for VA to process a claim. [Source: VA Watchdog Org 20 Feb 08 ++]

NEBRASKA VETERANS CEMETERY: Nebraska's Senator Ben Nelson introduced legislation S.2701 on 4 MAR authorizing the establishment of a new national cemetery for eastern Nebraska in Bellevue. Current Veterans Affairs (VA) regulations require a threshold of 170,000 eligible veterans living within a 75-mile radius of a proposed cemetery site to merit the establishment of a new national veterans

cemetery. An independent analysis conducted by the Metropolitan Area Planning Agency in Omaha estimates the number to be near 172,500, while the VA estimate places the number of eligible people closer to 133,000. Nebraska veterans and local officials have pushed for the radius to be increased for the Bellevue cemetery due to differences in the rural region. The introduced legislation if approved would direct the Secretary of Veterans Affairs to establish a national cemetery in Bellevue. Both the Sarpy County Board and Omaha City Council have supported the establishment of a national cemetery in Bellevue. Both boards passed resolutions last year encouraging federal officials to do what is necessary to push the VA and authorize the cemetery. "By local estimation there are 33,000 World War II veterans in the Omaha metropolitan area. Taking from national statistics, the average age of these veterans is 83," said Steven Johnson, President of the Memorial Ridge of the Midlands Foundation. "With the great numbers of aging veterans, we feel an urgency to establish another national cemetery in eastern Nebraska. Not only is it necessary, but it would be a fitting gesture from a grateful nation as a final resting place of honor for our brave men and women who have served us. It would be instructive to present and future generations to provide a place locally to view nationally significant memorials permanently commemorating the importance of their great service to this country."

A cemetery at Bellevue would be the second site in Nebraska. At present the state only has the Fort McPherson National Cemetery, 12004 S Spur 56A, Maxwell, NE 69151-1031 Tel (308) 582-4433/4616F or (888) 737-2800. This 20 acre cemetery has space available to accommodate casketed and cremated remains. The number of internments through 2006 were 8,615. Records of burials (7643) on file with the VA are available at <http://www.interment.net/data/us/ne/lincoln/ftmcpnrat/index.htm>. The site can be viewed at <http://www.rootsweb.com/~nephtos/monumts/mcphercem1.htm>. For

additional info on this facility refer to
<http://www.cem.va.gov/CEM/cems/nchp/ftmcperson.asp>. [Source:
Sen, Ben Nelson Press Release 5 Mar 08 ++]

VA HEALTH CARE FUNDING UPDATE 12: Senator John Thune has co-sponsored S. 2639, a bipartisan bill to require mandatory funding for veterans health care. The bill was introduced by Senator Tim Johnson (D-SD) last month and is also cosponsored by Senators Olympia Snowe (R-ME), Byron Dorgan (D-ND), and Jon Tester (D-MT). "Mandatory funding for veterans health care means that veterans health programs will not be subject to the politics of the appropriations process," said Thune. "This legislation guarantees adequate funding for veterans health without annual wrangling over spending levels. I look forward to working with Senator Johnson and Senator Snowe to pass mandatory funding for veterans health care that fits within the budget and does not raise taxes." The bill would establish an annual formula of funding for the Veterans Health Administration (VHA) based on the number of enrolled veterans. It would prevent the VHA from spending health care dollars on construction or acquisition of medical facilities. Similar bills have been introduced in past congressional sessions without success. [Source: Sen. John Thune Press Release 7 Mar 08 ++]

VA HOMELESS VETS UPDATE 08: The number of veterans homeless on a typical night has declined 21% in the past year, thanks to the services offered by the Department of Veterans Affairs (VA) and its partners in community- and faith-based organizations, plus changing demographics and improvements in survey techniques. The reduction of homeless veterans from more than 195,000 to about 154,000 was announced as Secretary of Veterans Affairs Dr. James B. Peake was elected to chair the U.S. Interagency Council on Homelessness. Peake's election to head the council coordinating the federal response to homelessness came as VA released the fourteenth annual Community Homeless Assessment,

Local Education and Networking Group (CHALENG) report on homeless veterans. The decline in veterans' homelessness was attributed, in part, to VA's success in providing more services for homeless veterans and improved coordination of federal, state and local efforts. VA provides health care to about 100,000 homeless veterans, and compensation and pensions to nearly 40,000 annually. The Department offers homeless veterans employment assistance and help obtaining foreclosed homes and excess federal property, including clothes, footwear, blankets and other items. The Department has already approved funding for more than 12,000 beds in transitional housing programs, and provides about 5,000 veterans each year with residential services in VA hospital-based programs. Other factors in the decline of homeless veterans include the substantial reduction in the number of poor veterans -- from 3 million in 1990 to 1.8 million in 2000 -- and improvements in counting homeless people. The U.S. Interagency Council on Homelessness is the coordinating entity within the federal government composed of 20 cabinet secretaries and agency heads that creates partnerships at every level of government and the private sector to end homelessness. [Source: VA News Release 6 Mar 08 ++]

VETERANS DISARMAMENT BILL: An allegation is being passed around the Internet that a new law the President signed in JAN 08 would deny veterans diagnosed with PTSD or other mental health problems their constitutional right of gun ownership. The allegation is false; there is no legislation called the Veterans Disarmament Bill, and there are no validated instances of an otherwise eligible veteran being denied employment because of the new law, which signed 7 JAN 08. H.R. 2640 The NICS Improvement Amendments Act of 2007 to improve the National Instant Criminal Background Check System, and for other purposes was passed and became Public Law No: 110-180 A major supporter of H.R. 2640 was the nation's staunchest gun rights advocate, the National Rifle Association, who would

have never backed a bill that overly restricted ownership rights.
Bottom line: Gun ownership is a
Second Amendment right, but exercising that right comes with inherent
social responsibilities in a
democratic society. If a court of law rules someone as mentally unfit
and a danger to him/herself
and to others, then the rights of society must outweigh individual
rights. The new law is not
anti-veteran legislation; it is common sense legislation. For articles
of interest on this subject refer
to <http://www.nraila.org//Issues/Articles/Read.aspx?ID=246>,
http://www.military.com/opinion/0,15202,151321_1,00.html?wh=wh, and
<http://www.whitehouse.gov/news/releases/2008/01/20080108-7.html>.
[Source: VFW Washington Weekly 7 Mar 08 ++]

TRICARE CANCER TRIALS: To offer Tricare beneficiaries, and the health
professionals who care for
them, the latest in both cancer preventive care and treatment, the
Department of Defense (DoD)
joined forces last year with the National Cancer Institute (NCI)
through an interagency agreement,
known as the DoD/NCI Cancer Clinical Trials Demonstration Project.
Under this agreement, eligible
beneficiaries could participate in NCI-sponsored cancer prevention and
treatment studies as part of
their Tricare health care benefits. On 1 APR 08, this became a
permanent Tricare health care
benefit. It covers all Phase II and Phase III trials. Eligibility
extends to all beneficiaries
utilizing Tricare through its Prime, Prime Remote, Standard and Extra,
Tricare for Life, and U.S. Family
Health plans. The trials are not available overseas. Whether you
choose to participate in these
studies is a decision that you should make with help from your doctor.

Clinical trials are research studies that help find ways to
prevent, diagnose or treat
illnesses and improve health care. When enrolled in these studies,
people receive care that is
considered the latest medicine or therapy, but is not yet approved as
standard care. There are two types
of prevention clinical trials that study ways to reduce the risk of
getting cancer:

- Action studies which focus on finding out whether actions people take, such as getting more exercise or quitting smoking, can prevent cancer; and
- Agent studies, also called chemoprevention studies, which are designed to learn whether taking certain medicines, vitamins or food supplements can prevent cancer.

Cancer treatment trials, also known as research studies, test new treatments on people diagnosed with cancer. The goal of this research is to find better ways to treat cancer and help cancer patients. Cancer treatment trials study many types of strategies to fight cancer. These include testing new drugs, new approaches to surgery or radiation therapy, new combinations of treatments or new methods, such as gene therapy. The trials are carried out in three phases. Each phase is part of a careful process to determine whether the activity or medicine being studied is safe and effective. The DoD/NCI agreement covers NCI-sponsored phase II and phase III cancer prevention and treatment clinical trials. Phase II trials focus on learning whether a new therapy has an anticancer effect, usually focusing on a particular type of cancer. Phase III trials compare a promising new treatment against the standard approach. NCI-sponsored clinical trials take place in the same facilities where standard medical care is given.

There are more than 2,000 sites throughout the U.S., including military hospitals, clinics, comprehensive and clinical cancer centers, community hospitals and practices. While care can require patients to change physicians, there are times when their own doctors or specialists can administer certain care as part of the clinical trial. No patient receives a placebo when effective care exists. To find out about available trials you can call 1(800) 422-6239) or go online to <http://www.cancer.gov/clinicaltrials>. You can also find out more about the program at

www.tricare.mil/mybenefit/home/overview/SpecialPrograms/CancerClinicalTrials. The Tricare Contractors for

authorization are PGBA in the TRICARE North and South Regions and TriWest in the West Region. In the Tricare North region call 1(800) 395-7821; in the South call 1(800) 779-3060 and in the West Region call 1(866) 427-6610. [Source: TREA Washington Update Mar 08 ++]

TRICARE HEARING AIDS UPDATE 01: Tricare does not cover hearing aids for retirees or their family members. However, some military treatment facilities support the Retiree At Cost Hearing Aid Purchase Program (RACHAPP) for servicemembers in need of hearing aids. This program allows retired service members to purchase hearing aids at government cost. At <http://www.militaryaudiology.org/rachap/state.html> you can view facilities along with contact information and whether or not the facility provides hearing aids at cost to US military retirees. This information is subject to change at any time. It is recommended that you contact the appropriate facility before incurring significant travel expenses. Retirees can use any facility which will accept them; you don't need to return to your service affiliation to participate in this program. Dependents of military retirees are generally ineligible to participate in this program at the current time. [Source: NAUS Weekly Update 7 Mar 08 ++]

TSP UPDATE 10: TSP offers investors the chance for lower taxes each year they contribute with taxes deferred until they withdraw the account after retirement. TSP is a long-term retirement savings plan, which is an ideal supplement to military and civilian retirement plans. Investment money is deposited directly from each paycheck which makes it easy to 'pay yourself first' while only investing what you deem appropriate. In February the two most reliable funds in the Thrift Savings Plan posted minimal gains while all other funds lost ground. Following is a YTD status of each fund and how they performed in February:

- G Fund made up of short-term Treasury securities specially issued to provide a higher return

than inflation without any serious risk from market fluctuations, grew the most, with gains of 0.24%.

Its 12-month earnings were 4.66%.

- F Fund invested in fixed-income bonds, earned 0.16% in February. The fund posted the biggest long-term gains in the TSP, earning 7.52% in 12 months.
- I Fund made up of international investments experienced a slight drop from the previous month, falling 0.66%. It has dropped 0.22% in the past 12 months.
- S Fund which invests in small and mid-sized companies by tracking the Dow Jones Wilshire 4500 Index, dropped 2.05% in February. The fund posted losses of 5.85% for the year, the largest long-term losses of any fund in the TSP.
- C Fund, composed of common stocks on the Standard & Poor's 500 Index of the largest domestic companies, dropped the most in the last month, falling 3.28%. Its 12-month losses were 3.59%.
- L Fund life-cycle options (which are a blend of the five basic funds that automatically grow more conservative as investors near retirement) all experienced minor losses in February. L 2040, intended for employees with a target retirement date around the year 2040, dropped 1.80%; L 2030 fell 1.51%; L 2020 lost 1.25%; and L 2010 went down 0.59%. The L Income Fund, designed for employees with planned retirements in the very near future, lost 0.22%. Two L funds also posted losses for the year. The L 2040 Fund lost 1.11% and L 2030 lost 0.37%. L 2020 gained 0.57% in 12 months, L 2010 earned 2.80% and L Income made 3.50%.

[Source: GOVExec.com Brittany Ballenstedt article 3 Mar 08 ++]

IRR MUSTERS: About 10,000 members of the Individual Ready Reserve (IRR) will be briefly activated this spring to participate in one-day musters at Army Reserve Centers throughout the United States, and some overseas locations. Soldiers typically become members of the IRR upon successful completion of a tour of duty with the Regular Army or Army Reserve. They remain members until their military service obligation expires. Veterans who are unsure of their status in regard to the IRR

should call the Human Resources Command Communications Hub at 1(800) 318-5298. While the Army is required by law to continuously screen and provide training to members of the IRR, it did not conduct a major physical muster of the force until 2007 because of a lack of funding. Three types of musters will be conducted this year by the Human Resources Command in coordination with the Army Reserve Command as follows:

- **Readiness Musters:** During MAR through JUN 08, readiness musters for soldiers who have been in the IRR for 12 months or more will be held at Fort Devens MA; Los Alamitos CA ; Fort Lawton WA; Fort Totten NY; Decator GA; Arlington Heights IL; Grand Prairie TX; and Fort Meade MD. The one-day muster will consist of a reserve components briefing, record review, security clearance updates, medical and dental screening, ID card issue and briefings on training and unit opportunities.
- **Personnel Accountability Musters:** Beginning in March, selected soldiers who were assigned to the IRR within the past year will be mustered at 450 stateside and overseas reserve centers to receive briefings on IRR participation requirements, and training and unit opportunities. They also will be offered the Post Deployment Health Reassessment Program, and will be required to update their personal information.
- **Unit Affiliation Muster:** New this year as a pilot, this program will require selected IRR soldiers to visit a local reserve unit in addition to participating in regular muster activities. They will be paid \$190 for successfully completing the muster.
[Source: ArmyTimes article 5 Mar 08 ++]

MEDICARE HOSPITAL DISCHARGE: Most of the time, doctors and nurses are the best judges of your progress and recovery when in the hospital. However, it's possible that in certain situations they may ask you to leave the hospital before you feel well enough to go. If this happens and you feel you are being discharged too early, you have the right to ask for an independent, immediate review

of your case. If you make a formal request for an immediate review within the proper time frame, the hospital cannot force you to leave before a decision has been made. You should be able to stay in the hospital with Medicare coverage while your case is being reviewed. At the very least, this should give you a few extra days in the hospital to sort out a care plan for when you leave. Since 1 JUL 07, the steps for the first level of appeal (requesting a review) are the same whether you are in Original Medicare or a Medicare private health plan like an HMO, PPO or PFFS (also known as Medicare Advantage). The following steps apply:

1. First, before you leave the hospital, you should receive a copy of a notice called an "Important Message from Medicare" that describes your rights as a patient. The notice explains your rights to receive Medicare coverage in the hospital, to be involved in decisions about your hospital stay and to know who will pay for your stay. It also explains your rights to discharge planning and to appeal an early hospital discharge without financial risks. The hospital must provide this the notice when you are admitted, and again no more than two calendar days before your discharge date and no fewer than four hours before you must leave the hospital. This notice is the same document you should have been asked to sign within two days of being admitted to the hospital. If you have a short stay, you may only get one copy of the notice.
2. Follow the directions in the notice and request an immediate review (expedited determination) of the hospital's decision to discharge you from the Quality Improvement Organization (QIO). A QIO is an independent group of doctors and other professionals that contracts with Medicare to ensure that you receive quality care. To get an expedited review, you must contact the QIO by midnight on the date you are set to be discharged. If you miss the deadline for filing, you can still request a review by the QIO before you leave the hospital. However, you will have to pay for the full cost of your additional days in the hospital if the QIO denies your appeal.

3. The hospital (or your plan, if you are enrolled in a Medicare private health plan) must give you a "Detailed Notice of Discharge," which includes an explanation of why services will no longer be covered, a description of Medicare coverage rules and an explanation of how those rules apply to your case. It is important that you read this notice so that you are prepared when you have your QIO review.

4. The hospital must give the QIO all the information it needs for the review no later than noon of the day after it is notified by the QIO that you are appealing the discharge. If you ask, the hospital also must give you a copy of what it gives the QIO. Once the QIO has all the relevant information from the hospital, you (or your representative) must be available to discuss your case with the QIO (generally by phone). You should have your doctor present for the call. Based on the evidence, the QIO will decide if continued hospital care is reasonable and necessary or the needed care could be safely delivered in another setting, like a skilled nursing facility or in your home.

The QIO must contact you and the hospital by telephone and then in writing of its decision within one calendar day after it receives all information. If the QIO agrees with you, you can stay in the hospital with Medicare coverage. You will still be responsible for any Part A coinsurances that might apply. If the QIO does not agree with you, you can either leave the hospital or advance to upper levels of appeal. This involves contacting another independent entity called the Qualified Independent Contractor (QIC) if you have Original Medicare, or asking the QIO for a reconsideration if you have a Medicare private health plan. However, you may be responsible for all costs after the QIO made its original decision. To prevent an unnecessary appeal, speak to your (or your loved one's) doctor on a regular basis to make sure each of you understand the extent of progress and recovery as well as the terms of your Medicare coverage. [Source: [Source: The Medicare Counselor Mar-Apr 08 issue ++]

MEDICARE INSURER STATUS: One of the factors to consider when making you Medicare A or B election decision is whether or not it will become your primary or secondary insurer. Your primary insurer always provides the bulk of your health insurance. Three months before become eligible for Medicare a letter is sent to help you determine A or B election. Whether your employer insurance is primary or secondary will help you decide if you should take Medicare Part A (inpatient/hospital insurance) and/or Part B (outpatient/medical insurance). The rules for primary versus secondary Medicare coverage depend on:

- 1.) If your eligibility is due to age (over 65) or disability;
- 2.) Whether you are currently working or retired; and, if you are working,
- 3.) The size of the company you work for.

Most people should take Part A when they first become eligible regardless of whether their employer insurance is primary or secondary. This is because most people with Medicare receive premium-free Medicare Part A if you or your spouse (but not a domestic partner) has worked and paid into Social Security for 10 or more years. Everyone with Medicare must pay a premium for Part B. If your Medicare coverage is primary, but you fail to take Part B, you will likely have no or very limited coverage for Part B-covered services; secondary insurers generally only pay after the primary insurer (in this case, Medicare) pays. Check with your employer to find out how your coverage coordinates with Medicare. In most cases, if your employer insurance is secondary to Medicare, you should take Parts A and B to have full coverage.

With Part B, you should also keep in mind the possibility of a late-enrollment penalty if you do not make the election when first eligible. However, if you have insurance from a current employer, you may be able to enroll in Part B after you are first eligible without penalty. If you

have retiree insurance and do not take Part B when you are first eligible, you will pay a penalty for late enrollment. With Retiree insurance (from your own or your spouse's former employer)

Medicare could be your Primary or Secondary insurer when:

- Primary if you are 65 or older, have insurance from a current employer (yours or your spouse's) and the company has fewer than 20 employees. You should enroll during your Initial Enrollment Period (IEP), the seven month period surrounding the month in which you turn 65. This includes the three months before the month in which you turn 65, the month of your birth, and the three months following your birth month.
- Secondary if you are 65 or older, have insurance from a current employer (yours or your spouse's) and the company has 20 or more employees. Your employer plan is your primary coverage. You do not need to enroll in Medicare if you are satisfied with your job coverage.
- If your employer insurance coverage is very limited you may want to consider whether paying for Part B might save you more in the long run. You would need to contact your employer human resources office to see how your employer coverage would work with Part B.
- Primary if you are under 65 but eligible for Medicare due to a disability or amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), and have insurance from a current employer (yours or your spouse's) and the company has fewer than 100 employees. You will be automatically enrolled when you have received Social Security Disability Insurance (SSDI) for 24 months or have been diagnosed with ALS.
- Secondary if you are under 65 and eligible for Medicare due to a disability or ALS, have insurance from a current employer (yours or your spouse's) and the company has 100 employees or more. You don't need to enroll in Medicare Part B if you are satisfied with your employer coverage. If not you have the option of enrolling in Part B.
- If you have end-stage renal disease (ESRD), Medicare will be primary or secondary depending on

how long you have had Medicare.
[Source: The Medicare Counselor Mar-Apr 08 issue ++]

VA LAWSUIT (LACK OF CARE) UPDATE 02: The US Department of Justice is arguing that Iraq and Afghanistan veterans have no right to specific types of medical care and that Congress and veterans don't have any say in the matter. The Administration's argument comes in response to a lawsuit filed by Veterans for Common Sense and Veterans for Truth which alleges that veterans from Iraq and Afghanistan are being denied access to critical services. The veterans organizations argue that:

- vets are arbitrarily denied access to mental health and other services.
- vets are kept waiting for months or years for treatment or compensation benefits.
- vets are denied fair procedures for appealing denials of their claims.

To support their argument, the veterans organizations cite the VA's backlog of 600,000 disability claims and that "120 veterans commit suicide each week." Veterans returning from Iraq and Afghanistan are supposed to be provided five years of VA health care from the date of their discharge, but the Government is arguing that the law does not create an entitlement to any particular medical service. Furthermore, DOJ lawyers are arguing that the VA should only provide needed medical services to the extent that funds are available. The United Spinal Association (USA) reports there will be more arguments in this case on 7 MAR 08. The USA is a national 501(c)(3) nonprofit membership organization formed in 1946 by paralyzed veterans. Our mission is to improve the quality of life of Americans with spinal cord injuries and disorders (SCI/D). Membership is free and open to all individuals with spinal cord injuries and diseases. [Source: Vets 1st article
<http://www.unitedspinal.org/publications/vetsfirst/> Mar 08 ++]

MEDICARE NEWS UPDATE 01: The Recovery Audit Contractor (RAC) demonstration program was designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund. In coming weeks, private audit companies will begin scouring mountains of medical records. to determine if health care providers erred when billing Medicare and require them to return any overpayments to the federal government. The auditors will keep a tidy percentage for their services. The contractors have shown they're pretty good at their work. In just three years, they've returned more than \$300 million to the federal government -- and that's just from three states. That experiment is winding down. But a larger, national program will soon take its place. The rollout of recovery audit contractors will be gradual. They'll monitor health care providers in 19 states beginning this spring. In October, an additional five states will join. Health care providers are nearly unanimous in their dislike of the program's continuation, much less its expansion. Many lawmakers have similar sentiments, though it was Congress in 2006 that made the program permanent. A bill sponsored by Rep. Lois Capps (D-CA) calls for a one-year moratorium.

The program's critics say that contractors have too much incentive to question as many claims as possible. That's because they get to keep about 20% of the overpayments. "What we have here is bureaucrats and government contractors coming in and trying to second guess what doctors and nurses have done in a hospital setting," said Don May, vice president for policy at the American Hospital Association. "They're playing Monday morning quarterback." While the contractors are often described as overzealous, that's a compliment as far as one watchdog group is concerned. "A little zealotry is what were looking for on the part of the taxpayers," said Leslie Paige, spokeswoman for Citizens Against Government Waste. "We think it's about time." The government will spend about

\$430 billion this year on Medicare, which provides health coverage to 44 million elderly and disabled people. The sheer size of the program, with more than 1.2 billion claims filed each year, not only makes it ripe for fraud but for mistakes. The Office of Management and Budget estimates that payment errors total about \$10.8 billion a year. To put the number of Medicare claims in perspective, that's 4.5 million claims each work day and 9,579 claims per minute. Rarely does the government and its contractors give those claims a detailed review. The agency has contractors that process claims. It also has an inspector general. But, now, auditors will routinely review patient's medical records as well as the claim.

It's the contractors' job to find both overpayments -- and underpayments. Besides returning overpayments to the government, they return underpayments to health care providers. So far, they've returned \$20 million, mostly to hospitals. A report from the Centers for Medicare and Medicaid Services shows that contractors reviewed about 930 million claims in Florida, California, and New York during the program's first 2 1/2 years. They identified errors in less than 0.2 percent of the claims reviewed. Hospitals appealed in about 11% of the overpayment cases. Only 5% were fully or partially overturned. Those statistics tell Medicare officials that the program is working. Health care providers say the CMS statistics are misleading. Many appeals have not been completed. Also, many providers won't appeal because of the amount of money and time it takes. "It costs at least \$2,000 to run an appeal all the way through the process," May said. When providers overcharge the government, they also have to refund any overcharged copayments or deductibles to the patient. If providers need more time to repay the government, they can apply for a repayment plan. If a provider just refuses to pay, the Medicare contractor processing their claims will deduct from future payments until the debt is paid. Hospital officials said the repayments make the job of providing

care more challenging and have the potential to force them to reduce services or charge customers more to make up the expense.

CMS said it also has safeguards in place to ensure that patient information is handled securely. Providers, when they sign up for Medicare, also agree to make any necessary information available to the agency or its contractors. When the program goes national, all contractors must have a medical director on staff. The agency also is limiting how far back auditors can look when reviewing patient records. The limit will be three years, but under no circumstances, before 1 OCT 07.

Finally, the agency is working on regulations that would defer repayment until after the appeals process is completed. Currently, the money is taken back regardless of the appeal status, which providers say is a financial burden and akin to guilty until proven innocent. But what gets health care providers most upset is when auditors determined a procedure or hospital admission was not medically necessary. May said that there's a "lot of gray area" when it comes to whether a patients needs to be admitted to a hospital or rehab facility. Often the patients have diabetes or other complicating factors that prompt a physician to want closer monitoring. "You need a physician looking at these daily if not more so to make sure the patients are being managed effectively," May said. For more info on RAC refer to <http://www.cms.hhs.gov/RAC>. [Source: AP Kevin Freking article 1 Mar 08 ++]

SHAD UPDATE 05: The Government Accountability Office (GAO) said in a new report that the he Pentagon and Veterans Affairs Department must work harder to find tens of thousands of veterans involved in military chemical and biological weapons tests since World War II. "As this population becomes older, it will become more imperative for DoD and VA to identify and notify these individuals in a timely manner because they might be eligible for health care or other benefits," according to

the report. The classified tests exposed people to various agents. Some were simulated, but many were not. The list included blister and nerve agents, biological agents, PCP and LSD, in a series of tests over several decades known as "Project 112." According to the GAO, the military also exposed healthy adults, psychiatric patients and prison inmates in the experiments. In some cases, service members volunteered for the tests but were misled about what they would be asked to do. "Precise information on the number of tests, experiments and participants is not available, and the exact numbers will never be known," the report states.

Still, in 1993, the Defense Department began trying to find as many as it could. They identified almost 6,000 veterans and 350 civilians who may have been exposed. That search effort ended in 2003. But in a 2004 study, GAO said the Pentagon should review further data and see if it would be feasible to find more people who may have been exposed. Defense officials decided that looking further would not yield significant results, but GAO said that decision was "not supported by an objective analysis of the potential costs and benefits," and that the Pentagon had not documented the criteria for its decision. Since 2003, the Institutes of Medicine as well as other non-military agencies have found 600 more people. GAO found that the Defense Department efforts in this area lack consistent objectives and adequate oversight, and officials have not used information gained from previous research that identified exposed people. GAO also said the process lacks transparency because it has not kept Congress and veterans groups informed of its progress.

The Pentagon hired a contractor to try to identify more veterans, but GAO found the project lacked sufficient oversight. For example, in 2007, a contractor identified 2,300 people exposed to biological tests at Fort Detrick MD in "Operation Whitecoat," which ran from the early 1950s to the early 1970s. But the contractor did not give those names to the Pentagon because it is adding

more information, such as a test objective and summary. In the meantime, most of those 2,300 people don't know they were exposed. GAO also found that the Pentagon and VA have no standard process for exchanging information, and new names come through in haphazard batches. VA officials sent letters to only 48% of the names provided by the Pentagon because those were the only ones for whom they could find addresses. At least 16,269 known to be living still need to be notified. Some records have been lost or destroyed, but GAO said VA does not work with the Social Security Administration or the Internal Revenue Service to obtain contact information for veterans.

GAO recommended that the Pentagon do a cost/benefit analysis about continuing search efforts, and work with veterans organizations to determine other projects that may have exposed veterans to harmful materials, as required by the 2003 Defense Authorization Act. In response to the report, VA Secretary James Peake concurred that efforts to identify and notify exposed personnel must be improved. Defense officials agreed with GAO's recommendations, except for the one calling for a cost/benefit analysis. However, Arthur Hopkins, principal deputy assistant to the secretary of defense, said the Defense Department has made a "full accounting" of the project and has no more credible leads to pursue, although it is willing to "pursue any new leads" that come to light. The GAO, however, stuck with its assertion that Congress should consider "requiring the Secretary of Defense to conduct and document an analysis." [Source: NavyTimes Kelly Kennedy article 2 Mar 08 ++]

REAP UPDATE 01: Some members of the National Guard and the Reserves who serve on active duty will see a significant increase in their educational benefits, thanks to improvements announced 3 MAR by the Department of Veterans Affairs (VA). "Reservists and National Guardsmen who serve multiple tours on active duty may get an increase in their educational benefits, in keeping with the value

of their service to our nation," said Secretary of Veterans Affairs Dr. James B. Peake. Under

new provisions, members who accumulate three years on active duty, regardless of breaks in service, may be eligible for the maximum payment under the Reserve Education Assistance Program (REAP).

Previously, reservists and guardsmen had to serve two continuous years on active duty to receive the highest payment. The new eligibility rules are retroactive to 1 OCT 07. The top payment under REAP is currently \$880.80 per month.

The new law, part of the National Defense Authorization Act, also expands the period of eligibility for certain Guard and Reserve members who complete their service obligation before separation from the selected reserve. Members meeting these criteria may be eligible to use REAP benefits for a period of ten years following discharge. Benefits typically end upon separation for members who do not complete their full, obligated service. Additionally, some REAP-eligible National Guard and Reserve members may now make an extra contribution to the Department of Defense to increase their monthly benefit rates. Service members receive an additional \$5 per month for each \$20 contributed. With the maximum \$600 contribution, this option can add up to \$5,400 to a member's total 36-month education benefit package. Beginning on 1 OCT 08, participants in REAP and the Montgomery GI Bill program for the Selected Reserve who pursue non-degree programs lasting less than two years may also be eligible to receive accelerated payments. During FY 2007, more than 60,000 National Guardsmen and reservists were paid under REAP, more than 41,000 were paid under the Montgomery GI Bill program for the Selected Reserves, and approximately 344,000 participants were paid under the Montgomery GI Bill for active-duty members. For more information on changes to VA's GI Bill benefits, refer to www.GIBILL.va.gov or contact VA directly at 1(888) 442-4551. [Source: VA News Release 3 Mar 08 ++]

MILITARY RETIREMENT PLAN: Service members who remain on active duty or serve in the Reserves or

Guard for a sufficient period of time may retire and receive retired pay, retain use of base

facilities, and retain health care coverage under Tricare. Members who become disabled while on duty

may be medically retired and receive a disability retirement. All retirees may choose to

participate in the Survivor Benefit Plan (SBP) or the Reserve Components Survivor Benefit Plan (RCSBP),

which protects the retiree's family financially in the event of his or her death. Social Security does

not affect retirement pay. Members who remain on active duty for 20 or more years are eligible

for retirement in one of the three non-disability retirement systems currently in effect. These are

Final Pay, High-3 Year Average, and Military Retirement Reform Act of 1986 (more commonly

referred to as REDUX). REDUX was revised by the FY2000 National Defense Authorization Act. A \$30,000

Career Status Bonus (CSB) has been added for those who accept the REDUX retirement system. Individuals

formerly under REDUX may now choose between the High-3 and CSB/REDUX systems. The date you first

entered the military determines which retirement system applies to you and whether you have the

option to choose your retirement system.

To decide which system applies to you, you must determine the date that you first entered the

military. This date is called the DIEMS (Date of Initial Entry to Military Service) or DIEUS

(Date of Initial Entry to Uniformed Services). The date you first entered the military is the first

time you enlisted or joined the active or reserves. This date is fixed. Departing the military and

rejoining does not affect your DIEMS. Some unique circumstances that impact on what the Diems will

be are:

- The DIEMS for Academy graduates who entered the Academy with no prior service is the date they reported to the Academy, not the date they graduated.

- Beginning an ROTC scholarship program or enlisting as a Reserve in the Senior ROTC program sets the DIEMS, not the graduation or commissioning date.

- Members who entered the military, separated, and then rejoined the military have a DIEMS based on entering the first period of military service.
- The DIEMS for members who enlisted under the delayed entry program is when they entered the delayed entry program, not when they initially reported for duty.
- For those who joined the Reserves and later joined the active component, their DIEMS is the date they joined the Reserves.

Your pay date may be different than your DIEMS. Also, your DIEMS do not determine when you have enough time in the service to retire. It only determines which retirement system applies to you.

Not all Services have their DIEMS dates properly defined in their personnel records. If you have unusual circumstances and are unsure of when your DIEMS date is or believe your records show an incorrect DIEMS date, contact your personnel office to discuss your particular situation.

Based upon the date you initially entered the military, you can determine which of the following retirement system applies to you:

- **FINAL PAY:** Entry before 8 SEP 80. Each year of service is worth 2.5% toward the retirement multiplier.
- **HIGH-3:** Entry on or after 8 SEP 80, but before 1 AUG 86 or entered on or after 1 AUG 86, and did not choose the Career Status Bonus (CSB) and Military Retirement Reform Act (REDUX) of 1986 retirement system. Computation is at 2.5% per year of service based on the average of the highest pay received over any consecutive 36 months of service.
- **CSB/REDUX:** Entered on or after 1AUG 86 and elected to receive the Career Status Bonus of \$30,000 given at the 15th year of service with commitment to complete 20 year career. Each year of service is worth 2% of the highest pay received over any consecutive 36 months of service for the first 20 years; 3.5% for each year beyond 20, up to 75%. Annual COLA is based on CPI less 1% until age 62. At that time yearly multiplier becomes 2.5% and 1% reduction in COLA is eliminated.

Retired pay is based on a percentage of base pay. Allowances and special pay are not included in base pay computation. The maximum percentage anyone can receive is 75%. Cost of Living Adjustments (COLAs) are given annually based on the increase in the Consumer Price Index (CPI), a measure of inflation. Under the High-3, the annual COLA is equal to CPI. This is a different index than the one used for active duty annual pay raises. The index used for active duty pay raises are based upon average civilian wage increases.
[Source: www.dod.mil/militarypay/index.html Feb 08 ++]

VA VETERAN SUPPORT UPDATE 01: In support of the nation's veteran community the Department of Veteran Affairs (DVA) reported the following Benefit statistics as of FEB 08:

- More than half of Department of Veterans Affairs' (VA's) budget (nearly \$86 billion in obligations in 2007) is paid directly to veterans in the form of statutory benefits.
- Over 3.7 million veterans and beneficiaries receive compensation or pension benefits from VA. In 2007, VA processed nearly 825,000 claims for disability benefits and added almost 250,000 new beneficiaries to the compensation and pension rolls.
- Approximately 523,000 students received education benefits in 2007; 20 percent of them are first time recipients of VA education benefits.
- VA guarantees an average of 11,109 loans a month for veterans realizing the American dream of home ownership. VA currently guarantees 2.2 million active home loans to veterans. Those loans total \$243 billion.
- Over half of VA's home loan guarantees went to first-time home buyers. Approximately 90% of the loans use the "no down payment" feature that makes the VA loan guaranty so effective.
- VA will pay 1.2 million veterans insurance policy holders \$369 million in dividends this year. VA will also pay \$2.5 billion in life insurance beneficiary claims to 105,000 survivors of veterans

and service members.

- Approximately 200 children and widows of Spanish- American War veterans still receive VA survivor benefits. There are three survivors of Civil War veterans still receiving VA benefits.
- There are 4 million veterans or service members insured under VA-administered life insurance programs. The average basic insurance amount is \$240,000. All policies have a total face value of \$1 trillion, an amount higher than the gross domestic product of most countries.
- Average annual amounts paid to veterans or survivors under various benefits programs: disability compensation, \$9,811; pension, \$8,509; Dependency and Indemnity Compensation, \$13,612; and death pension, \$3,829.
- As of September 2007, 223,564 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans filed for disability claims, 89% received claims decisions and 11% are waiting for claims decisions.

[Source: VA Fact sheet Feb 08 ++]

SOCIAL SECURITY TAXATION UPDATE 05: Non-resident alien green card holders residing in countries that do not have a tax treaty with the U.S. can claim exemption from alien tax on their Social Security benefits per IRS Pub 915. To claim the exemption from withholding and/or apply for a refund three things are required:

1. A copy of Form SSA-1042S Social Security Benefits Statement
2. A copy of the "green card," and
3. A signed declaration that includes the following statement:
"The SSA should not have withheld federal income tax from my social security benefits because I am a U.S. lawful permanent resident and my green card has been neither revoked nor administratively or judicially determined to have been abandoned. I am filing a U.S. 1040 income tax return for the tax year as a resident alien reporting all my worldwide income. I have not claimed benefits for the tax year under any income tax treaty as a nonresident alien."

For residents of countries that have a tax treaty who want to escape from paying U.S. tax on their social security the inclusion of the tax treaty reference is important. Not all tax treaties are the same. In the case of Korea, the distinction is important because SS benefits are taxable by the U.S. whereas other U.S. government annuities are not taxable by the U.S. because they are taxable by the country of residence (Korea). Thus, a widow who receives SBP and/or OPM annuities cannot exempt these from U.S. income tax if they try to claim exemption from taxation of their SS benefit. They must decide which is the more beneficial to them. To cancel the SS tax withholding and lose the exemption on any other annuities or take the exemption on other annuities and pay the U.S. tax on their SS benefits. In Korea widows most affected by the exemption eligibility would be those who are younger with minor children for which the mother is receiving both the mother's and child's SS benefits. Taxes are not withheld on the children's benefits because they're U.S. citizens but would be withheld on the mother's benefit. In the case of Japan, who also has a tax treaty with the U.S., this is not a factor since SS and other benefits are considered taxable by the country of residence (Japan) rather than the country of origin of the benefits (U.S.).

Although a green card holder who has remained outside the U.S. for one year or more is normally denied reentry with that card it is not considered invalid as long as the holder has not voluntarily relinquished it. If the holder applies for a Tourist, work, or other type of visa for future visitation to the U.S. he/she must relinquish it before that new visa can be issued. For a holder to claim tax exemption on other U.S. sourced annuities the card must normally be relinquished to the nearest U.S. Consular office, Embassy, or mailed to INS in the states. An annotation will then be entered in that person's records that the card was voluntarily relinquished. [Source: RAO Osan
8 DEC 06 ++]

VETERAN LEGISLATION STATUS 14 MARCH 08: For a listing of Congressional bills of interest to the veteran community that have been introduced in the 110th Congress refer to the Bulletin's House & Senate attachments. By clicking on the bill number indicated you can access the actual legislative language of the bill and see if your representative has signed on as a cosponsor. Support of these bills through cosponsorship by other legislators is critical if they are ever going to move through the legislative process for a floor vote to become law. A good indication on that likelihood is the number of cosponsors who have signed onto the bill. A cosponsor is a member of Congress who has joined one or more other members in his/her chamber (i.e. House or Senate) to sponsor a bill or amendment. The member who introduces the bill is considered the sponsor. Members subsequently signing on are called cosponsors. Any number of members may cosponsor a bill in the House or Senate. At <http://thomas.loc.gov> you can also review a copy of each bill's content, determine its current status, the committee it has been assigned to, and if your legislator is a sponsor or cosponsor of it. To determine what bills, amendments your representative has sponsored, cosponsored, or dropped sponsorship on refer to <http://thomas.loc.gov/bss/d110/sponlst.html>. The key to increasing cosponsorship on veteran related bills and subsequent passage into law is letting our representatives know of veteran's feelings on issues. At the end of some listed bills is a weblink that can be used to do that. Otherwise, you can locate on <http://thomas.loc.gov> who your representative is and his/her phone number, mailing address, or email/website to communicate with a message or letter of your own making. [Source: RAO Bulletin Attachment 14 Mar 08 ++]

HAVE YOU HEARD: A man rushed into a busy doctor's office and shouted 'Doctor! I think I'm shrinking!!' The doctor calmly responded, 'Now, settle down. You'll just have to be a little patient.'

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