RAO BULLETIN

15 November 2010

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VA Quality of Care: The Department of Veterans Affairs, which for years has touted the achievements of its health care system, is now highlighting a new study that shows its health outcomes are — about like everybody else's. The VA touted the study this week, saying in a press release that "VA Health System Shines in Quality-of-Care Study." VA Secretary Eric Shinseki said in the release, "This report is strong evidence of the advancements VA continues to make in improving health care over the past 15 years. The systems and quality-improvement measures VA actively uses are second to none, and the results speak for themselves." The study, just published in the journal Medical Care, synthesized the results of three dozen other studies that compared VA health care to care provided by non-VA providers. It concluded that the VA performed well on many measures of medical care, but that the VA had little impact on the key question of whether the patient lived or died. Most of the research it depended on to reach its conclusions, however, dates to when Bill Clinton was president. One source for the study is dated 1991, when George H.W. Bush was in the White House.

The issue of how good is VA care is a hot topic among veterans' advocates and Congress. Some recent studies have been used to make the case that VA care is not only pretty good, it's among the best in the country. That's a big turnaround from two decades ago, when the VA was widely derided for poor quality. Since then, the agency has transformed from a hospital-based system to an integrated network of hospitals and clinics that is commended for its emphasis on preventive care. What the latest study shows is that the VA performs well on what are known as "process" measures — whether a certain test was ordered, for example. But studies that compare health outcomes — do patients in the VA system do better or live longer? — are equivocal. Of 12 studies that compared mortality, for example, three showed a better outcome for VA patients, two showed a better outcome for non-VA patients, and seven showed no difference. That's very different from the process measures, which showed an overwhelming VA advantage. Researchers aren't sure what causes that disconnect. If veterans are taking their drugs and getting their tests done, the thinking goes, they should be living longer. But for the most part, the data don't show that. "When it comes to mortality, we found that the VA does no better and does no worse," said study author Amal Trivedi, an investigator at a VA medical center in Providence, R.I. It would be helpful to study other health outcomes — so-called "intermediate outcomes" that detail health status short of death — but those aren't often measured, Trivedi said.

There were some other caveats to the study. One is what's known as a "publication bias," since most of the studies researchers found were funded by the VA. But researchers weren't sure why that would show a VA advantage on process measure but not one on outcomes. The lack of fresh data was a central problem with the study. "We need more recent data," Trivedi said. "There have been a number of efforts in the private sector to improve care." But those efforts wouldn't have shown up in this analysis. Researchers initially combed through 175 VA quality studies, excluding most for a variety of design or other problems. They were left with 36. Of those, about 60% included data gathered only during the Clinton administration. One included data from 1991. The freshest data were five years old, collected from 2005. Joseph Francis, the VA health system's chief quality and performance officer, said the relative age of the research "was kind of surprising to me." Part of that has to deal with the length of time it takes to complete and publish rigorous research. He also said the VA is working to complete more studies on health outcomes, which will show how VA patients fare compared with non-VA patients. Other researchers have found it difficult to compare VA care to non-VA care, in part because so many veterans get care from different places. The Congressional Budget Office, for example, recently reported that 79% of veterans in the VA system also had health coverage elsewhere, typically Medicare but also private health plans. "I think we do have a challenge understanding the totality of care veterans receive — and that includes care rendered outside the walls of our system," Francis said. In 2008, the VA treated 5.5 million people in its system of about 150 hospitals, 900 outpatient clinics and other facilities. [Source: McClatchy Newspapers | Chris Adams article 12 Nov 2010 ++]

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Diabetes Update 07: People who lose even a little weight and exercise consistently reduce their risk of developing type 2 diabetes. Knowing the facts regarding the following five myths will assist in keeping those at risk on the right track for dealing with the disease:

FICTION: If you're at high risk for diabetes, you're going to get the disease.
FACT: The Diabetes Prevention Program — which followed more than 3,000 overweight, prediabetic men and women at 27 research centers — found that people who lost even a little weight and exercised consistently (a goal of 30 minutes five days a week) reduced their risk of developing type 2 diabetes by 58%. (People 60 and up cut their risk by a whopping 71 percent.) "If you're overweight, try to reduce your daily intake by 500 calories," says Christine Tobin of the American Diabetes Association (ADA).

FICTION: Diabetics need a special diet.
FACT: Not long ago diabetics were urged to forgo sweets and drastically limit their intake of carbohydrates. But a slew of new research suggests that diabetics are best served by following the same healthy guidelines everyone else does: plenty of fruits, vegetables, whole grains, lean meat and dairy products, and sparing amounts of heart-healthy fats.

FICTION: There's a cure for diabetes.
FACT: Halle Berry's claims to the contrary — in 2007 she announced she had been cured of her type 1 diabetes — there is no cure for either type 1 or type 2 diabetes, says Sue Kirkman, M.D., senior vice president at the ADA. According to a study published last year in the Annals of Internal Medicine, however, 56% of type 2 diabetics who followed a Mediterranean-style diet could control their blood sugar without medication.

FICTION: Being overweight causes diabetes.
FACT: Just because you're heavy doesn't mean you'll automatically get diabetes. In fact, 34 percent of adults 20 and older are obese, but just 10.7% have diabetes. Still, experts agree that being obese, especially combined with a genetic predisposition for diabetes, can trigger the disease. Research in The Journal of the American Medical Association showed that those who were obese at age 50 and gained 20 pounds were five times likelier to develop diabetes than those who weren't obese at 50.

FICTION: An insulin pill is right around the corner.
FACT: An insulin pill is not imminent, says the ADA's Tobin. There are alternatives to injections, though. One of the latest is the Finesse insulin patch-pen, expected to be available in late 2011. The patch-pen is disposable — and cheaper than an insulin pump.
[Source: AARP Magazine Holly St. Lifer article 1 Nov 2010 ++

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Mobilized Reserve 9 NOV 2010: The Department of Defense announced the current number of reservists on active duty as of 9 NOV 2010. The net collective result is 1756 fewer reservists mobilized than last reported in the 1 NOV 2010 RAO Bulletin. At any given time, services may activate some units and individuals while deactivating others, making it possible for these figures to either increase or decrease. The total number currently on active duty from the Army National Guard and Army Reserve is 73,247; Navy Reserve, 6,570; Air National Guard and Air Force Reserve, 10,923; Marine Corps Reserve, 5,072; and the Coast Guard Reserve, 798. This brings the total National Guard and Reserve personnel who have been activated to 96,610 including both units and individual augmentees. A cumulative roster of all National Guard and Reserve personnel who are currently activated may be found at http://www.defense.gov/news/d20101109ngr.pdf. [Source: DoD News Release No. 1040-10 dtd 10 NOV 2010 ++]

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Lame Duck Priorities

Legislation of Interest Update 13: The lame duck session will begins 15 NOV. Congress will have plenty of pressing issues to keep them busy in this brief post-election session. The top priorities for the lame ducks will be:

- Approving funds to keep the government running beyond December 1.
- Stopping a 23% cut in Medicare and TRICARE payments to doctors now scheduled for Dec. 1 (with an additional 2% cut due Jan. 1).
- Acting on legislation to extend some or all of the tax cuts due to expire Dec 31.
- Passing a defense authorization bill for our wartime military.

It seems likely that the first priorities of the lame ducks will be to address the continuing resolution to keep the government running, and addressing an extension of the Bush era tax cuts. That means the doc fix and the defense bill could become casualties of the short session, which would be a terrible outcome on several fronts. A 25% Medicare/TRICARE cut in doctor payments would cause many doctors to stop taking elderly and military patients. Failure to pass a defense bill would mean termination of all service recruiting and retention bonus authorities, loss of a needed manpower increase for the Army, loss of needed improvements in wounded warrior caregiver protections, and much more. Veterans who want to communicate with their legislators and encourage them to take action on these issue should click on the following links to send them a message:

- Stop the 23% cut to the Medicare/TRICARE reimbursement rate http://capwiz.com/moaa/issues/alert/?alertid=19417551.
- Pass the defense authorization bill http://capwiz.com/moaa/issues/alert/?alertid=19418501.

[Source: MOAA Leg Up 12 Dec 2010 ++]

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Debt Reduction Commission Update 03:

On 9 NOV the co-chairs of the President's Commission on Deficit Reduction and Reform startled legislators and the other 16 commission members by pre-emptively announcing a massive package of proposed spending cuts and tax reforms they said would be necessary to get the country back on the right fiscal track. Former Sen. Alan Simpson (R-WY) and former Clinton White House Chief of Staff Erskine Bowles jumped the gun on the Commission's scheduled 1 DEC report delivery date by announcing their own co-chairs' recommendation package, to the apparent consternation of some other commissioners. Under Commission rules, 14 of the 18 commissioners have to agree on whatever recommendations are included in the commission report. Apparently, the co-chairs thought achieving that level of consensus on the bipartisan but politically divided commission would be unlikely, and wanted to make public a sample package to illustrate the drastic sorts of actions that would be needed to fully address the nation's deficit problems. Their package envisions deep cuts in virtually every category of federal spending, as well as a dramatic simplification of the tax system that would eliminate many popular deductions for homeowner interest, capital gains, and more. Proposed initiatives affecting the military and veterans' community would, among many other things:

- Change the CPI to depress COLAs for all federal annuity programs.
- Require Medicare beneficiaries to absorb a greater share of health costs.
- Impose TRICARE fee hikes and implement enrollment fees for all TRICARE programs.
- Reduce COLAs for "early military retirees" (in previous proposals, such wording has meant "before age 60").
- Freeze military and federal civilian pay raises for three years (including housing/subsistence allowances).
- Consolidate commissaries and exchanges.
- Eliminate CONUS dependent schools.
- Raise the Social Security retirement age to 69 and the early retirement age to 64.
- Curtail future Medicare and TRICARE payments to doctors (but stop the immediate 25% cut).
- Require nondisabled vets to pay more to use VA facilities.
- Establish legislative requirements for mandatory across-the-board cuts if Congress doesn't act to keep federal spending growth below a specified level.

The co-chairs as much as admitted that their package, as a whole, would stand little chance of enactment. "We've harpooned every whale in the ocean," said Simpson, noting wryly that he and Bowles "might have to go in the witness protection program." Bowles called it "a starting point" for what's expected to be a protracted and (both fiscally and politically) painful budget battle. "America cannot be great if we go broke," the co-chairs said in their briefing. Any conscientious citizen must be concerned about America's increasingly severe deficit problems, and addressing those problems will require sober sacrifices on the part of every American. [Source: MOAA Leg Up 12 Dec 2010 ++]

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Aid & Attendance Update 05:

There has been a lot of press lately about the VA's striving to make the application process easier for our veterans or surviving spouses and addressing the 1 million + claims in backlog. Many of these simplifications unfortunately do not apply to making application for the Aid and Attendance level of the Improved Pension, so there are some areas that you need to avoid as it will actually make things more complicated and result in additional delays.

- **The VA is now allowing a Nurse Practitioner to complete the "Physician's Statement"** (VA Form 21-2680). At first glance this seems to be helpful as waiting for the actual doctor to complete the form can take longer than one may have time to wait on. This new ruling will only be helpful to those veterans or widows who are already receiving all their medical care from a VA Medical Facility, and not a private primary practice, as their treatments records are already in the VA's system. For those who do not go to the

VA for medical treatment and have a Nurse Practitioner complete the Physician's Statement, the VA will respond by requesting ALL treatment records from the doctor's office. This will ultimately cause a much longer delay in waiting for copies of all treatments and visits to support the claim. You are much better off waiting for the actual Physician to complete the Physician Statement form 21-2680 so you do not end up having to obtain and provide copies of medical records.

- **The VA is making a big push to make application on-line as a way to "streamline" the process.** A word of caution for those of you who are new to this process. The VA's VONAPP system is programmed to automatically process the claim for "Disability Compensation" and not for Pension Benefits. Aid and Attendance along with the other two levels of the Improved Pension (Basic & Housebound) are not based on service related injuries and should never be processed as Disability Compensation. If you file on line your claim will be processed incorrectly and will result in a delay of approval. You will be on hold until they rule the claim is denied for "Service Connected Disability" at which time you will have to get the claim processed for pension. You could lose a year+. If this has happened to you, do not file an appeal to the decision. What you need to do is to file a 21-4138 Statement in Support of Claim letting the VA know that the claim was incorrectly processed for "Compensation" rather than "Pension". If you do an appeal, you just bought yourself a minimum of a year's wait time.
- **Sending "Return Receipt" is the only recommended method for submitting for Pension Benefits and for any other correspondence to the VA.** The VA has established various processing centers across the country that do nothing but applications for Improved Pension. When mailing your application, you need to make certain that you send it to the appropriate center assigned for your state. Sending to local or state VA offices will delay in processing time as they will need to forward it on to the correct Pension Center. Listed below by state is the correct mailing address per state:
    - ❖ Milwaukee Pension Maintenance Center, Veterans Administration, 5400 West National Avenue, Milwaukee, WI 53214 Processes claims for IL, IN, OH, MO, KY, TN, AR, LA, MA, AL.
    - ❖ St. Paul Pension Maintenance Center, Veterans Administration, 1 Federal Drive, Fort Snelling, St. Paul, MN 55111-4050 processes claims for IA, ND, SD, NE, KS, OK, TX, MT, WY, CO, ND, ID, UT, AS, WA, NV, OR, CA, AK, HI.
    - ❖ Philadelphia Pension Maintenance Center, Veterans Administration, 5000 Wissahickon Avenue, Philadelphia, PA 19191 processes claims for MA, RI, CT, NY, PA, NJ, DE, MD, DC, WV, VA, NC, SC, GA, FL, PR.

[Source: VeteranAid.org Newsletter 12 Nov 2010 ++]

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Veterans College Services Programs:

New standards responding to real-time student needs for military service members, veterans, and their families transitioning from military service in higher education were released 12 NOV by the Council for the Advancement of Standards in Higher Education (CAS). CAS, composed of 39 collaborating professional associations representing over 100,000 professionals in higher education, has developed Veterans and Military Programs and Services (VMPS) Standards and Guidelines grounded in scholarship through the work conducted by experts within the field of veterans and military services. The new VMPS Standards and Guidelines is available at www.cas.edu. Comments regarding the new standards included:

- "The CAS standards and guidelines for Veterans and Military Programs and Services are a culmination of the work of several experts and scholars in the emerging study of and service to veterans in higher education," stated Douglas Franklin, Assistant Dean of Students at Ohio University and College Educators for Veterans Higher Education (CEVHE) Board Member.
- After many years of military conflict higher education has faced a wave of military service members requiring more consistent approaches to meet their unique educational needs. "Since the end of the Second

World War, many colleges and universities have provided services to military veterans, but not in ways that fully recognized the educational aims of those students," said Bob Ackerman, Professor of Educational Leadership at UNLV and Student Veterans of America (SVA) Board Member.

- "Consistent with the premise of the CAS Standards effort, these guidelines are intended to provide direction to campus leaders as they implement programs and services designed to support students, who are also military, veterans, and their families."
- "The CAS standards are a set of guidelines to assist schools in helping their student veterans help themselves. They are not a "one-size-fits-all" standardization but rather seek not to recreate the wheel on every campus as we can learn from the best practices of each other" said John Mikelson, President College Educators for Veterans Higher Education, Co-founder of the Student Veterans Association and the Director of Veterans Affairs at Association of Non-Traditional Students in Higher Education.
- CAS was established in 1979 to develop standards that promote college student learning and promote self-assessment for institutional effectiveness. There are now 42 CAS standards in diverse areas of the college student experiences. " I fully support the CAS standards and guidelines of the VMPS. The standards are greatly needed and a tremendous achievement that will ensure many veterans, service members, and their families receive the outstanding higher education that they deserve.", said Doug Herrmann, Emeritus Professor of Psychology, Indiana State University and Past President and Co-founder of CEVHE.

[Source: www.CAS.edu News Release 12 Nov 2010 ++]

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After the Battle: The wounds of war can go far beyond what meets the eye. From mental health issues to pain and illness that persist long after they've left the battlefield, veterans face a multitude of health troubles either unique to their service or more frequent among them than the general population. "Folks returning from combat have a constellation of health concerns, including physical issues, psychological issues and psychosocial issues concerning things like work and family," said Dr. Stephen Hunt, national director of the U.S. Department of Veterans Affairs Post Deployment Integrative Care Initiative. "This is a population that has unique health care needs that need to be addressed," added Hunt, who is based in Seattle. "It's something that really needs to be done by a team. We can't do it without the collaboration of other providers, and the knowledge and presence of the community." Some of the most common physical complaints of returning soldiers cannot be classified into a single disorder, Hunt said. They include nonspecific symptoms such as fatigue, pain and cognitive disturbances such as memory and concentration problems. "The interesting thing is, we see this after all wars," he said. "We think it's a reflection of the duress and intensity of the situation. They're worn out, hurting and it's kind of hard to think straight." Here are seven health conditions confronting veterans:

Musculoskeletal injuries and pain -- Just over half of all veterans' post-deployment health visits address lingering pain in their backs, necks, knees or shoulders, Hunt said. And according to an August study in the Journal of Pain, about 100,000 veterans of the Gulf War nearly 20 years ago have reported chronic muscle pain. Previous research indicated that regular, sustained exercise can help reduce that pain, which doctors encourage to help avoid disability.

Mental health issues -- While post-traumatic stress disorder (PTSD) among soldiers has been well publicized, other mental woes can also result from the trauma of war. A June study in the journal Archives of General Psychiatry found that one in 10 Iraq war vets develop serious mental problems, including violent behavior, depression and alcohol abuse. The study found that PTSD or depression seriously impaired daily functioning in 8.5 to 14% of these vets. Disabling on its own, PTSD is also linked to the development of physical illnesses for veterans as years pass. Researchers from Walter Reed Army Medical Center in Washington, D.C., reported this year that 54% of veterans with PTSD also had sleep apnea, compared with 20% of PTSD patients in the general population. PTSD in vets is

also associated with a greater risk of developing dementia, according to a June study in Archives of General Psychiatry.

Chemical exposure -- Research by the American Heart Association found that exposure to nerve agents such as sarin - which can trigger convulsions and death on the battlefield- may cause long-term heart damage in Gulf War veterans. The damage can include an enlarged left ventricle, heart rhythm abnormalities or a reduction in the pumping strength of the heart. "Environmental agents and toxic chemicals are very common in combat theaters," Hunt said, "and we need to watch [these vets] closely."

Infectious diseases -- As a rule, all military personnel are given routine vaccinations before deployment. Yet veterans suffer disproportionately from certain infections that civilians almost never experience for which vaccines are not available, according to the U.S. Department of Veterans Affairs. They include bacterial infections such as brucellosis, which may persist for years; campylobacter jejuni, which causes abdominal pain, fever and diarrhea; and Coxiella burnetii, which in chronic cases can inflame the heart. Leishmaniasis, a parasitic disease caused by the bite of a sand fly native to the Middle East, is a particularly brutal condition veterans experience. Those infected suffer weight loss, fevers, headaches, muscle pain and weakness, anemia, and enlargement of the spleen and liver. It can be fatal if untreated, according to the VA.

Noise and vibration exposure -- Hearing loss and impairment - including persistent ringing and buzzing in the ears - are common effects of harmful noise from gunfire, heavy weapons, noisy engine rooms and aircraft, Hunt said. Additionally, vets who regularly worked with machinery can suffer vibration exposure, which can prompt irreversible lower back pain or numbness and pain in the hands and fingers, according to the VA.

Traumatic Brain Injury (TBI) -- TBI, often brought on by a blow or jolt to the head, disrupts brain function and has been called the signature wound of the fighting in Iraq and Afghanistan, according to the National Academy of Sciences. Blast exposures and other combat-related activities put service members at greater risk for sustaining a TBI compared to their civilian counterparts, according to the Defense and Veterans Brain Injury Center. Common effects of TBIs include cognitive issues such as shorter attention span, language disabilities, and an inability to process information. Vets can also suffer from lack of motivation, irritability, anxiety and depression, headaches, memory loss and PTSD. "Between 70 and 80% of combat deaths are from blast-related exposure," Hunt said, "and of survivors, 20% report that they may have had an event that resulted in a mild concussion. Whether there will be any long-term effects is difficult to ascertain."

Urologic injuries -- Penetrating injuries to the groin area during battle are often treated only after life-threatening injuries have been dealt with, said Dr. Arthur Smith, a Medical College of Georgia urologist who spoke at the Warrior Health Symposium last month. Injuries to the bladder, ureters, kidneys and genitalia usually require complex surgery, Smith said, but complications often arise because treatment must be put off.
[Source: MyHealthNewsDaily Maureen Salamon article 2010 ++]

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Vet Cemetery Florida Update 07: The U.S. Department of Veterans Affairs is in an ongoing search for more available cemetery space throughout Florida because of the state's huge veteran population and the number of service members continuing to grow old and die, said Frank Kawulich, director of the VA's Memorial Service Network in the Southeast region. The VA is in the beginning stages of selecting sites for new cemeteries in Brevard County and Tallahassee. VA officials said plans are in the works to visit possible sites and sort through multiple offers made for available land. There is no timetable for opening either cemetery. Last year, the VA opened Jacksonville National Cemetery and Sarasota National Cemetery. Construction at the Sarasota cemetery of a

columbarium, a structure where cremated remains can be placed, is scheduled for completion in 2012. South Florida National Cemetery in Palm Beach County opened in 2007. There are also national cemeteries in Pensacola, St. Petersburg and St. Augustine — the latter two have no room for more gravesites.

The new Florida cemeteries are part of a national plan to continue to grant veterans their right to be buried in a military cemetery. Five traditional cemeteries are planned to be built nationwide in upcoming years, said Michael Nacincik, spokesman for the National Cemetery Administration. The VA is also looking for new ways to accommodate remains, including constructing facilities on small pieces of land in major cities for cremations only. This is so veterans in urban areas such as New York or Chicago can have their remains closer to home, Nacincik said. The Sumter County cemetery, meanwhile, expanded two years ago to make room for more burials and is using millions of dollars in stimulus funds to raise and realign headstones.

Nationwide, ensuring that there will always be enough space for veterans who want to be buried at a military cemetery has become somewhat of a challenge. Though a huge number of World War II veterans have died, the number of vets who served during the Korean and Vietnam wars is expected to increase in the next several years, according to VA projections. About 2.5 million veterans from the Korean War are alive, and about 7.5 million from Vietnam are living, VA estimates show. Despite the VA's continuous labor to manage the flow of veterans being buried, the agency will continue the benefit because of its importance to those who risked their lives for the U.S., Nacincik said. "It's a benefit that they were promised," he said. "Many people look at it as a sense of pride to be with fellow veterans." [Source: Orlando Sentinel Christine Show article 11 Nov 2010 ++]

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Stop-loss Pay Update 08: Time is running out to apply for retroactive bonus pay for 145,000 military personnel who were forced to remain on duty beyond their original discharge date, following the September 11th attacks. Congress has approved back pay of $500 for each month of involuntary service; the average lump-sum due is between $3,500 and $3,800. Applications must be submitted by December 3, 2010. The DoD is desperately trying to track down about 90,000 veterans. Congress ordered the military to dole out back pay to those affected by the policy dating to 2001. There are some exceptions. Soldiers who accepted re-enlistment bonuses, for instance, are ineligible. So far, the military had processed about 55,000 applications and approved $210 million in back pay, leaving $324 million left unclaimed. Submit your application online at www.defense.gov/stoploss. [Source: MilitaryConnection.com newsletter Nov 2010 ++]

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Medicare Rates Update 01: In early NOV 2010, the Centers for Medicare & Medicaid Services (CMS) announced the 2011 premiums and deductibles for Medicare Part A and Part B, as well as the additional premium amounts owed by individuals with higher income for Part B and Part D.

- **Medicare Part A.** Covers inpatient hospital, skilled nursing facility and home health care. Though approximately 99% of Medicare consumers do not have to pay a Part A premium, people are still responsible for the deductible, which will be $1132 in 2011, an increase of $32.
- **Medicare Part B.** Covers outpatient services, such as physician visits and durable medical equipment (DME). In 2011, people with Medicare may pay one of three premium amounts. The standard premium for 2011 is $115.40. However, because there is no Social Security cost-of-living adjustment (COLA) for 2011, most Medicare consumers will pay the same premium in 2011 as they paid in 2010. This is due to the "hold harmless" provision, a law that does not allow people's Part B premium to increase more than the COLA in a given year. If someone is eligible for "hold harmless" protection in 2011 and he or she paid $96.40 in

2010, he or she will continue to pay $96.40 in 2011. The same is true for those who paid $110.50 in 2010; if they are protected by the "hold harmless" provision, they will continue to pay $110.50 in 2011.

- **Part B and Part D Higher Income.** Individuals who earn above $85,000 per year will not only be responsible for an income-related adjustment to their Part B premium as in past years, but, beginning in 2011, will be subject to an adjustment to their Part D premiums as well. Under Part B, higher income individuals will owe between $46.10 and $253.70 in additional premium costs per month. Under Part D, those individuals with higher income will owe between $12 and $69.10 in additional premium costs. The extra amount owed is pegged to income levels.

Also, without Congressional action before the end of the 111th session, the QI program will expire in 2011. QI is a Medicare Savings Program (MSP) which helps Medicare consumers whose income is between 120 and 135% of the Federal Poverty Level (FPL) pay their Part B premiums, and can potentially save eligible individuals thousands of dollars per year. Also set to expire at the end of this year is the Medicare therapy caps exceptions process. Medicare coverage is limited to $1860 for combined speech and physical therapy services and $1860 for occupational therapy services, but currently, the exceptions process allows those who require medically necessary services to overcome those caps. For additional info refer to the 2011 Medicare Rights Center's fact sheet on Part B premiums at www.medicarerights.org/pdf/Part-B-Premiums-2011.pdf and CMS's fact sheet on premiums and deductibles at www.cms.gov/apps/media/press/factsheet.asp?Counter=3865&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date. [Source*:* Medicare Consumer Advocacy Update 11 Nov 2010 ++

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Supplemental Security Income:

Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income and It provides cash to meet basic needs for food, clothing, and shelter. Generally, the more income you have, the less your SSI benefit will be. If your countable income is over the allowable limit, you cannot receive SSI benefits. Some of your income may not count as income for the SSI program. Examples of payments or services not counted include but are not limited to:

- The first $20 of most income received in a month;
- The first $65 of earnings and one–half of earnings over $65 received in a month;
- The value of food stamps;
- Income tax refunds;
- Home Energy assistance;
- Assistance based on need funded by a state or local government;
- Small amounts of income received irregularly or infrequently;
- Interest or dividends earned on countable resources or resources excluded under other federal laws;
- Grants, scholarships, fellowships or gifts used for tuition and educational expenses;
- Food or shelter based on need provided by nonprofit agencies;
- Loans to you (cash or in–kind) that you have to repay;
- Money someone else spends to pay your expenses for items other than food or shelter (for example, someone pays your telephone or medical bills);
- Income set aside under a plan to achieve self–support (pass).
- Earnings up to $1,640 per month to a maximum of $6,600 per year (effective JAN 2010) for a student under age 22.

- The value of impairment–related work expenses for items or services that a disabled person needs in order to work.
- The value of work expenses that a blind person incurs in order to work.
- Disaster assistance;
- Certain exclusions on Indian trust fund payments paid to American Indians who are members of a federally recognized tribe.

In September 2010, the Social Security agency published final rules about the Heroes Earnings Assistance and Relief Tax (HEART) Act. The HEART Act changes the way some cash payments to members of the uniformed services and veterans are treated under the SSI program. As Social Security Commissioner Michael Astrue noted at the time, "This law allows the men and women of our armed forces, veterans, and their families to keep more of their military-related payments while also maintaining eligibility for valuable cash and healthcare benefits." The HEART Act does the following:

- Treats most cash military compensation as earned income for SSI purposes, which generally provides a higher it to the service member as a result of the SSI program's more favorable consideration of earned income.
- Excludes certain State annuity payments to disabled, blind or aged veterans from countable income and resources used to determine SSI eligibility.
- Excludes any cash or in-kind payments provided by AmeriCorps State and National and AmeriCorps National Civilian Community Corps from countable income.

Social Security also makes it easy to get information about benefits for wounded warriors. The first place to go is to their website designed specifically for wounded veterans: http://www.socialsecurity.gov/woundedwarriors. There can be found answers to a number of commonly asked questions, as well as other useful information about disability benefits and SSI. Pay special attention to the fact sheets available on that website, Disability Benefits for Wounded Warriors and Expediting Disability Applications for Wounded Warriors. You will also find a "webinar" that explains the Social Security disability application process and expedited processing available to wounded warriors. This outreach program provides general information about Social Security disability benefits as well as topics unique to wounded warriors, and is a great way to orient yourself to disability benefits for veterans and active duty military. It's important to note that benefits available through Social Security are different than those from the Department of Veterans Affairs and require a separate application. Military service members are covered for the same Social Security survivors, disability, and retirement benefits as everyone else. Military personnel have been covered under Social Security since 1957, and people who were in the service prior to that may be able to get special credit for some of their service. To learn more about Social Security for current and former military service members, read Military Service and Social Security. You can find the publication online at http://www.socialsecurity.gov/pubs/10017.html . [Source: Daily Courier Kari Sanderfer article 8 Nov 2010 ++]

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VA Fraud Waste & Abuse Update 31: According to dozens of civil suits and a 2010 federal court indictment, Joe B. Phillips, a 71-year-old Houston lawyer and former VA employee, stands accused of stealing more than $2 million from at least 28 Texas veterans and hiding those thefts with faked bank statements, padded expenses and even imaginary accounts verified with forged signatures, His 70-year-old wife and legal assistant, Dorothy Phillips, faces identical charges. The federal indictment claims Phillips ripped off veterans from 2003 to 2008. Attorneys say it's impossible to know exactly when the problems began since banks often don't keep records for more than five or 10 years and Phillips claims to have lost documents in a garage fire. Some veterans were denied money they needed for living expenses, according to interviews. The fraud appears to be the largest ever detected in the VA's enormous guardianship program. Individual disabled vets lost anywhere from a few thousand

dollars to more than $250,000. Collectively, the VA's guardianship program manages cumulative estates exceeding $3 billion and oversees benefit payments for about 108,000 veterans and other beneficiaries such as widows and children who, because of "injury, disease, or the infirmities of age" cannot manage their own financial affairs, according to recent congressional testimony. Only three cases of fraud exceeding $1 million have been detected in the program's history: in California, Texas and Minnesota, according to information VA officials provided to Congress in April.

Phillips has acted as a guardian for dozens of veterans for decades after leaving his job at the VA in Houston. The total number of victims and the scope of the fraud remains unknown. In addition to the guardianships, Phillips also managed estates of veterans who died and managed and received payments for other disabled veterans who did not have guardianships. A Houston VA field auditor first discovered that Phillips' client files were "incomplete, misleading or inaccurate" in a routine visit in NOV 07. A subsequent review in 2008 found a $2 million shortfall. Phillips and his wife were charged with 26 counts of conspiracy, tax fraud, misappropriation of veterans' funds and related crimes in June. A spokesman for the Houston VA Regional Office, Jessica Jacobsen, refused to say what actions the VA took to protect or compensate disabled Texas veterans during the 30 months that lapsed between the time the thefts were first detected in NOV 07 and when federal charges were filed in June. "VA's primary mission is to be an advocate for veterans, first and foremost," Jacobsen said, but she specified only that the Houston VA Regional Office "is fully cooperating with the U.S. Attorney's Office and the VA Office of Inspector General during ongoing investigation(s) into the alleged misappropriation of funds." Phillips has generally denied he committed theft or fraud. His trial on federal charges is set for April.

Most of the affected veterans have received only partial repayments from the VA so far but it is predicted that all vets will be fully compensated as a result of court battles that continue in five counties in Southeast Texas. Phillips filed bankruptcy in 2009 to try to protect his assets against claims filed on behalf of disabled veterans. Insurance companies that guaranteed his guardianship work have countersued Phillips to recoup their losses. In answers to lawsuits, Phillips has argued that the VA and U.S. taxpayers should pick up the tab for the debacle since under various laws federal officials are required to audit, review and approve all bills submitted by VA-approved guardians. The theft went undetected for years despite required reviews by VA officials and audits by Harris County probate courts, which oversaw many of the guardianship cases. Court officials and lawyers described the fraud as "sophisticated." Some bank statements and expenses appeared to have been expertly altered. In one case, the signature of a real out-of-state bank official was lifted from another document to falsely verify the existence of a phony bank account. A signature that appears to be Phillips' is on at least $1 million in checks payable to himself against the accounts of 20 veterans. [Source: Houston Chronicle Lise Olsen article 8 Nov 2010 ++]

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Kidney Disease Update 01: Putting people on dialysis early, while their kidneys still have adequate function, may increase the chances that they'll die in the year after the procedure is started, a new study suggests. Dialysis, which mechanically filters the blood, helps people with advanced kidney disease live longer, control their illness and improve their quality of life, the researchers say. "The question this research addresses is what is going on with regard to patients being put on dialysis at higher and higher levels of kidney function," said the lead researcher, Dr. Steven J. Rosansky, senior research fellow at the Dorn Research Institute of the William Jennings Bryan Dorn VA Medical Center in Columbia, S.C., and an adjunct professor at the University of South Carolina. The assumption is that people are put on dialysis because they have no kidney function, but that's not the case, Rosansky said. Though dialysis used to be used for people with 1 or 2% of their kidney function, he said, today people with more than 15% kidney function are receiving dialysis, and that number is increasing. But the question remains, he said, as to the optimum time for putting someone on dialysis: "Is it beneficial at higher levels of kidney function, over 5%t, say?" Apparently not, according to the study, published online 8 NOV in Archives of Internal

Medicine. "We found that there is a remarkably higher risk of death in healthy people that are being put on dialysis at higher levels of kidney function," Rosansky said.

For the study, Rosansky's team collected data on 81,176 people who started dialysis between 1996 and 2006. None of the participants had diabetes or any other medical condition except high blood pressure. The researchers found that about 9% of the participants died during the first year of treatment, and 7% died during the second year of dialysis. People who started dialysis early, based on their kidney function, were more likely to die in the first year than were those who started dialysis at a later stage of their disease: about 20% vs. 7%, the study found. In addition, those with the lowest levels of albumin -- a protein made by the liver --also were at an increased risk for dying in the first year, compared with those with the highest albumin levels (21% vs. 5%), the researchers noted. Other factors linked to an increased mortality risk were increasing age, being black or male and having a lower body mass index. Having higher levels of hemoglobin, being treated at a later stage, being Asian and having certain types of kidney disease were linked with better survival, the study found. Rosansky said that other studies have also found no benefit to early dialysis. "The bodies of physicians that write guidelines need to reexamine their recommendations for putting people on dialysis at higher and higher levels of kidney function since there is no benefit seen in any studies," he said.

Dr. Kirsten L. Johansen, a nephrology professor at the University of California, San Francisco, and the San Francisco VA Medical Center, who wrote an editorial that accompanied publication of the study, said that "we don't have a lot of data to show that it is beneficial to start dialysis earlier, and it may be harmful." Starting dialysis is a judgment call, Johansen said. "But, over the years we have been doing it earlier and earlier," she said. "We really need to step back and say that the question shouldn't be, 'Does the patient have symptoms of kidney disease?' but 'Does this patient have enough symptoms that they'd be better off on dialysis?'" Years ago, doctors tried to keep people off dialysis as long as possible, Johansen said. Now, she said, the pendulum had swung too far in the other direction. There are downsides to dialysis, such as infection and other problems, she noted, and "we need to think about [whether they] are sick enough that the downside is going to be justified in the improvement in their condition." Doctors and patients need to discuses dialysis, including when it would provide the most benefit, Johansen said. [Source: HealthDay Steven Reinberg article 8 Nov 2010 ++]

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National Cemetery Administration Update 03: Burial at a VA national cemetery is open to all active duty and veteran members of the military who meet minimum service requirements and are discharged honorably. Spouses, minor children and the parents of unmarried active duty troops killed in action are also eligible for burial. The National Cemetery Administration (NCA) provides a grave site, headstone or marker and flag at no cost to a veteran's family. Coffin burials costs taxpayers about $951; burying cremated remains costs $672, NCA said. Headstones are also provided at no charge to veterans and active duty troops buried at private cemeteries. Many burials are attended by just one or two people. Craig Lachance, 44, participated in more than 1,300 burials at Jefferson Barracks as a member of the military honor guard. "At the end of the day I'd usually have a lot of makeup and a lot of mascara on my dress blues, because at the smaller ones, you're the only one that came," he said. After working for the Veterans Benefits Administration, Lachance enrolled in the NCA's year-long management intern program held near the cemetery. This year, nine recruits are learning basic management skills and more specialized tasks such as how to mow cemetery grass, properly lay headstones, and deal with the emotional stress of daily burials. By July they'll be ready to serve as cemetery directors at any NCA site.

Lachance joined the program after attending his father's military burial at a nearby private cemetery. "It was a poorly folded flag and a poorly done service," Lachance said. "I don't want a family member coming away from my services the way I came away from my father's service." The trainees seem singularly focused on ensuring perfect

burials. Instructors often remind them of NCA's 95% satisfaction rating from the American Customer Satisfaction Index. Dissatisfaction stems from families that may have wanted a military honor guard or chaplain when none is available. Or maybe they noticed cracks in a nearby headstone. "Until we get to 100%, we haven't done enough," said Donnie Sisk, 43, a management intern in the Army Reserves. "There's a tendency for it to be somewhat of a mechanical process," he said of the burial process. "The fear is that I would ever lose sight of that emotion and that I would not be able to convey that to my employees." Patrick K. Hallinan, a 30-year NCA veteran who developed the St. Louis training program and now serves as superintendent at Arlington National Cemetery said, "These people come in with a passion for the mission, they feel like they're helping their comrades," said He expects Arlington's operations to improve in the next three years. Upstairs from the St. Louis training center (daily for 11 1/2 hours) 39 telephone operators answer calls from funeral directors hoping to schedule a burial. Five cemeteries are under construction as part of a goal to ensure that 90% of veterans live no more than 75 miles from a burial site. The VA expects burials will increase annually until 2013 and then start declining as fewer veterans die each year. [Source: Washington Post Ed O'Keefe article 10 Nov 2010 ++]

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Disabled Veterans Memorial Update 04: Two Veterans Affairs secretaries and the Speaker of the House were among the dignitaries who joined a crowd of some 400 on 10 NOV at a groundbreaking ceremony for Washington's newest monument, the American Veterans Disabled for Life Memorial. On a strip of land hear the U.S. Botanical Garden with a sight line to the Capitol, the privately funded memorial will take the form of a star-shaped pool, ceremonial flame, panel of glass walls and four bronze sculptures. It is scheduled for completion by Veterans Day 2012. Veterans Affairs Secretary Eric K. Shinseki, in thanking the donors and the leaders of the Disabled American Veterans who first conceived the project 12 years ago, said, "The price of liberty has been paid by the vigilance and valor of the many young Americans" who put service to country above self and "displayed a courage at which we can only marvel." One of his predecessors, Anthony Principi, said, "Lifelong disabilities are part of veterans' contribution to the cost of war," and quoted the aphorism from Gen. John J. Pershing that "time will not dim the glory of their deeds."

House Speaker Nancy Pelosi, D-Calif., reviewed the bipartisan efforts in Congress to enact the New GI Bill and expanded veterans health care. She called the new memorial "a very specific step in recognizing those who are disabled but who continue to contribute to the strength of America." Vowing to "leave no veteran behind," Pelosi also warned against proposals to privatize the Veterans Affairs Department's health care system. Actor Gary Sinise, chosen as the memorial's national spokesman because of his activism on behalf of veterans since his breakthrough role as a troubled Vietnam veteran in the 1994 film Forrest Gump, told the crowd, which included numerous veterans, of how his character of Lt. Dan endured the pain and anger his mental and physical injuries caused "and eventually learns to accept and live with his injuries, stand tall and proud, put his injuries in perspective and move on."

The first-of-its kind memorial to the estimated 3 million American veterans now living with war-related disabilities received no federal funding, though its planners have cooperated with Veterans Affairs and the Defense Department. Efforts by a foundation started by philanthropist Lois Pope have raised some $82.5 million toward the $86 million projected costs, mostly from 1,058,000 individual donors. Because the site is federal property, planners were required to go through a 24-step approval process under the U.S. Commemorative Works Act, with signoffs from the U.S. Commission on Fine Arts, National Capital Planning Commission and National Park Service. [Source: GovExec.com Charles S. Clark article 10 Nov 2010 ++]

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VAntage Point Blog: The Department of Veterans Affairs (VA) is launching its first official blog, opening a new line of communication between the department and its stakeholders. The debut marks VA's latest outreach effort aimed at improving the way VA and its clients engage online. "As methods of communication change and evolve, we don't just want to keep up at VA. We want to lead the way. This tool will allow us to interact with Veterans, their families, and the public in ways we've never done before," said VA Secretary Eric K. Shinseki. "Instead of waiting for Veterans to find us, we're going to seek them out where they already are—which is, increasingly, online." The blog, called VAntage Point, will be edited by VA's Director of New Media Brandon Friedman. The blog will launch with two primary features: a main column of articles written each day by VA staff and a section comprised of guest pieces submitted by other stakeholders including employees and the public. Readers will be able to comment and participate on all articles.

The main column will initially be authored by two VA employees. VA staff writer Alex Horton, a former infantryman who began his writing career by blogging from Iraq, will address Veterans issues, while Lauren Bailey, special assistant to the chief technology officer, will provide readers with the latest on VA's information technology initiatives meant to modernize the department. Both writers will interact frequently with readers. VAntage Point's guest pieces will function as "letters to the editor." Whether from a VA physician, a student going school on the Post-9/11 GI Bill, or a representative from a Veterans Service Organization, all pieces will be considered for publication based on their rationale and reasoned points—not on how closely their views align with those of the department. "Communication between VA, Veterans, and their families is no longer a one way street," said Assistant Secretary for Public and Intergovernmental Affairs Tammy Duckworth. "Not only will VAntage Point improve our ability to get the right information to the right Veteran at the right time, but it will allow the department to hear directly from Veterans about their concerns."

VAntage Point is just the latest expansion of the department's outreach efforts to increase transparency, participation, and collaboration via social media. Since creating an Office of New Media in late 2009, VA has launched a presence on Facebook, Twitter, Flickr, and YouTube. Each major component of VA (health, benefits, and national cemeteries) has its own Facebook page and Twitter feed, while the department has simultaneously begun to roll out these platforms to all 153 VA medical centers. Currently, 55 medical centers maintain a presence on Facebook and 30 are operating Twitter feeds. The department currently has the largest Facebook subscriber base among cabinet-level agencies with over 70,000 subscribers. To view the blog, visit http://www.blogs.va.gov. For more information refer to http://www.va.gov. [Source: VA News Release 8 Nov 2010 ++]

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VA Veteran's Medical Benefits Package: In October 1996, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996. This legislation paved the way for the creation of a Medical Benefits Package - a standard enhanced health benefits plan generally available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services. VA places a priority on improved veteran satisfaction and maintains that their goal is to ensure the quality of care and service that veterans receive is consistently excellent, in every location, in every program. The Medical Benefits Package will generally be provided to all enrolled veterans regardless of your priority group. Public Law calls for VA to provide veterans hospital care and outpatient care services that are defined as "needed". VA defines "needed" as care or service that will promote, preserve, and restore health. This includes treatment, procedures, supplies, or services. This decision of need will be based on the judgment of your health care provider and in accordance with generally accepted standards of clinical practice. The following lists what eligible veterans can expect to receive under the Medical Benefits Package:

Basic Care

- Outpatient medical, surgical, and mental health care, including care for substance abuse.
- Inpatient hospital, medical, surgical, and mental health care, including care for substance abuse.
- Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.
- Emergency care in VA facilities.
- Emergency care in non-VA facilities in certain conditions: This benefit is a safety net for veterans requiring emergency care for a service connected disability or enrolled veterans who have no other means of paying a private facility emergency bill. If another health insurance provider pays all or part of a bill, VA cannot provide any reimbursement. To qualify for payment or reimbursement for non-VA emergency care service for a service-connected disability, you must meet all of the following criteria:
    - ✓ You were provided care in a hospital emergency department or similar emergency care facility .
    - ✓ You are enrolled in the VA health care system.
    - ✓ You have been provided care by a VA health care provider within the last 24 months.
    - ✓ You are financially liable to the provider of the emergency treatment for that treatment.
    - ✓ You have no other form of health care insurance.
    - ✓ You do not have coverage under Medicare, Medicaid, or a state program.
    - ✓ You do not have coverage under any other VA programs.
    - ✓ You have no other contractual or legal recourse against a third party that will pay all or part of the bill.
    - ✓ Department of Veterans Affairs or other Federal facilities were not feasibly available at time of the emergency.
    - ✓ The care must have been rendered in a medical emergency of such nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.

- Bereavement counseling.
- Comprehensive rehabilitative services other than vocational services.
- Consultation, professional counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran.
- Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids.
- Home health services.
- Reconstructive (plastic) surgery required as a result of a disease or trauma but not including cosmetic surgery that is not medically necessary.
- Respite, hospice, and palliative care.
- Payment of travel and travel expenses for eligible veterans.
- Pregnancy and delivery service, to the extent authorized by law.
- Completion of forms.

Preventative Care:

- Immunizations.
- Periodic medical exams.
- Health Care Assessments.
- Health education, including nutrition education.
- Screening Tests.

VA cannot provide the following services:

- Abortions and abortion counseling.

- Cosmetic surgery except where determined by VA to be medically necessary for reconstructive or psychiatric care.
- Drugs, biologicals, and medical devices not approved by the FDA unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.
- Gender alteration.
- Health club or spa membership.
- In vitro fertilization.
- Services not ordered and provided by licensed/accredited professional staff.
- Special private duty nursing.
- Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services.
- Additionally, VA cannot provide certain benefits to veterans and dependents identified as fugitive felons. For clarification on this refer to www4.va.gov/healtheligibility/Library/pubs/FFP/FFP.pdf

[Source: Military Times http://www.military.com/benefits/veterans-health-care/veterans-medical-benefits-package Nov 2010 ++]

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Aging: Here's how aging affects you on the inside --

- **Aging and Bones, Muscles and Joints:** We recognize changes in some people's posture as they age. Bone density can be lost, and spinal vertebrae can be compressed, making the trunk look shorter or curved. Joints may be stiffer and less flexible. Muscles can become less dense, making the arms and legs look thinner. Muscle tissue may also become less flexible, and muscles can lose tone, which is harder to replace. Exercise can help to slow or prevent bone and muscle loss, and good nutrition, including calcium, can help seniors maintain strength and good health. For details on bone, muscle, and joint changes, including a list of common problems and preventions, refer to www.nlm.nih.gov/medlineplus/ency/article/004015.htm.

- **Aging and Organs, Tissue and Cells:** Cells are the basic building blocks of tissue and with aging, cells grow larger and less able to reproduce. This can cause connective tissue (bones, blood, and lymph, for example), to become more stiff, which makes blood vessels and organs more rigid. Epithelial tissue (skin) loses fat, and can become thinner and more susceptible to injury. Muscle tissue can lose density, becoming less strong. As cells and tissues become more rigid, this affects internal organs, especially the heart, lungs and kidneys. Most important, organs can lose their reserve, or ability to increase function at higher levels. Heart failure is an example of an organ's failure to increase its level of functioning during a time of increased stress or activity. While the effects of aging on cells, tissues and organs are a normal part of aging, the good news is that these changes usually appear over a long period of time, and exercise and good nutrition can play an important part in keeping the body healthy longer. It's important to check with your health care provider if you have questions about your health or want to make changes to your diet or exercise program. For more detailed information on how aging affects tissues and organs, plus common problems that can result refer to http://www.dhmc.org/webpage.cfm?site_id=2&org_id=944&morg_id=0&sec_id=0&gsec_id=50006&item_id=50227

- **Aging and Hormones:** Hormones are natural chemicals produced in the organs of the endocrine system. They are secreted into the bloodstream to be used by other organs and systems in the body. Aging changes

the way hormones are used in the body; some hormone levels decrease, and some are metabolized more slowly. You'll find a detailed list of the glands in the endochrine system, the hormones they produce and how these processes are affected by aging in Aging Changes in Hormone Production at www.nlm.nih.gov/medlineplus/ency/article/004000.htm.

The most important thing to remember is that while aging causes natural changes in the body, your lifestyle plays a big part in optimizing your health. The best way to deal with aging if you want to live longer is to get regular checkups from your health care provider, eat a balanced diet, with good nutrition. get regular exercise and keep a positive mental attitude. [Source: About.com | Senior Living Sharon O'Brien article 9 Nov 2010 ++]

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Tricare Uniform Formulary Update 35:

The Beneficiary Advisory Panel (BAP) met in September to provide comments to the Department of Defense (DoD) Pharmacy and Therapeutics Committee's (P&T Committee) recommendations on formulary status, pre-authorizations, and the effective date for a drug's change from formulary to non-formulary status. Moving a drug to non-formulary status means it will still be available to beneficiaries, but usually at a higher price. It may also require medication authorization. Uniform Formulary Classes, recently approved drugs, and drugs affected by the Federal Ceiling Price were reviewed. Implementation time will be no later than 60-days following the Tricare Management Activity (TMA) Director approval. The BAP's recommendations follow.

Uniform Formulary Class Review for Renin Angiotensin Antihypertensive Agents (RAAs). The RAA drug class has been previously reviewed by the BAP. Angiotensin converting Enzyme (ACE inhibitors) were previously reviewed in 2005; fixed-dose combination ACE inhibitor/CCB products in 2006; and Angiotensin II Receptor Blockers (ARBs) in 2005 and 2007. RAAs are used to treat blood pressure. The BAP recommended all of the RAAs be designated as formulary on the Uniform Formulary (UF). However, some will require a prior authorization.

- *RAAs designated as formulary on the Uniform Formulary were*: Benazepril, Benazepril HCTZ, Benazepril/amlodipine, Captopril, Captopril HCTZ, Enalapril, Enalapril HCTZ, Fosinopril, Fosinopril HCTZ, Lisinopril, Lisinopril HCTZ, Quinapril, Quinapril HCTZ, Ramipril, and Trandolapril.
- *Generic ACEs designated as formulary on the Uniform Formulary were*: Moexipril (Univasc), Moexipril HCTZ (uniretic), Perindopril (Aceon), and Trandolapril/verapamil (Tarka).
- *RAAs designated as formulary on the Uniform Formulary (non-preferred) that will require a prior authorization were :* Aliskiren (Tekturna), Aliskiren/HCTZ (Tekturna HCT), Candesartan (Atacand), candesartan/HCTZ (Atacand HCT), Eprosartan (Teveten), Eprosartan/HCTZ (Teventen HCT), Irbesartan (Avapro), Irbesartan/HCTZ (Avalide), Olmesartan (Benicar), Olmesartan/HCTZ (Benicar HCT), Olmesartan/amlodine (Azor), and Valsartan/aliskiren (Valturna).
- *RAA "step preferred drugs" designated as formulary on the Uniform Formulary were:* Losartan, Losartan/HCTZ, Telmisartan (Micardis), Telmisartan/HCTZ (Micardis HCT), Telmisartan/amlodipine (Twynsta), Valsartan (Diovan), Valsartan/HCTZ (Diovan HCT), Valsartan/amlodipine (Exforge), and Valsartan/amlodipine/HCTZ (Exforge HCT).

Note: Prior Authorization requirement only applies to new patients. New patients will be required to try one of the "step-preferred drugs" prior to being offered a non-preferred RAA drug. Of course, the prior authorization requirement would be removed if a beneficiary had tried one of the preferred drugs and did not improve or had a reaction.

Uniform Formulary Class Review for Ophthalmic-1 drugs - The BAP reviewed Ophthalmic-1 drug class. This drug class has not been previously reviewed by the BAP. Ophthalmic-1s are used to treat allergic conjunctivitis

of the eyes. The BAP recommended all Ophthalmic-1s be designated as formulary of the UF. Implementation time was immediate because all of the Ophthalmic-1 drugs were designated as formulary on the UF. Ophthalmic-1 drugs include:

- *Antihistamines and dual action AH/MCS:* Azelastine (Optivar, generics), Bepotastine (Bepreve), Emedastine (Emadine), Epinastine (Elastat), Olopatadine 0.1% (Patanol), and Olopatadine 0.2%.
- *Mast Cell Stabilizers:* Cromolyn (generic), Lodoxamide (Alomide), Nedocromil (Alocril),and Pemirolast (Alamast).
- *Ophthalmic-1 NSAIDS*: Bromfenac 0.09% (Xibrom), diclofenac 0.1% (Voltaren, generic), Flurbiprofen 0.03% (Ocufen, generic), Ketorolac 0.4%, (Acular LS, generic), Ketorolac 0.45% (Acuvail), Ketorolac 0.5% (Acular, generic), and Nepafenac 0.1% (Nevanac).

For a complete list of formulary medications and the most updated list of Section 703 drugs, go tohttp://www.tricareformularysearch.org/dod/medicationcenter/default.aspx. For additional information on this or other BAP meetings, refer to http://www.tricare.mil/pharmacy/bap/. [Source: NMFA Newsletter 9 Nov 2010 ++]

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TMOP Prescription Orders Update 01:

Whenever possible it is to your and the government's benefit to use Tricare's contractor Express Scripts, Inc. (ESI) when ordering medications. If you do you will be able to obtain a 90 day supply of medicine for the same copay that you would have to pay a retail network for a 30 say supply of medicine. The government will benefit because they can order in larger quantities from the drug suppliers obtaining a lower per pill price than they would have to reimburse a retail network pharmacy for filling your prescription. The tradeoff is that to fill an initial prescription it will take a little longer. This is offset by not having to travel to a pharmacy and wait in line for refills if you sign up for ESI's automatic home delivery program. As with everything a little pre-knowledge on what to expect will reduce frustrations and enhance speedier delivery of your medications. Following is some guidance if you contact ESI by telephone:

- ✓ Call Express Scripts at 1-877-363-1303. Typically, Monday is the busiest day of the week for the Express Scripts call centers. If your issue isn't urgent, try calling Thursdays, the lightest day of the week. If you are concerned about being placed on hold before speaking to an advocate, try calling in the afternoon.
- ✓ Be sure to have your sponsor identification (ID) number or the sponsor ID number of the person you are calling for available when you call. This will make it easier to access your information in their computer system. If you don't have this information, the advocate can look you up by name and date of birth.
- ✓ Whether you are calling for yourself or someone else, you will need to provide three points of verification for the patient. This includes the name, date of birth and the sponsor's ID number. Any information about specific medications they are taking is considered to be protected health information (PHI), so you will need to provide the prescription number and/or drug name for each of the medications.
- ✓ Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), advocates can only discuss the prescriptions you specifically ask about by name, and only after verification has been completed.
- ✓ When calling for a minor, HIPAA rules state you must be the parent or legal guardian. Be prepared with a list of the minor's medications, the strengths and dosage form (e.g., tablet, syrup) you are calling about. Again, Express Scripts can only discuss the medications you ask about by name.
- ✓ Pharmacists are available 24 hours a day, seven days a week to answer questions about possible drug interactions and side effects associated with the medication you ordered through home delivery. Questions about the status of your order and about billing are handled by patient care advocates. Clinical questions about your prescription should be answered by your physician. These types of questions are typically about the dosage and directions for taking the medication.

Some beneficiaries prefer to take care of their prescription benefit needs online. From the Express Scripts website www.express-scripts.com/Tricare you can:

- View your prescriptions, sign up for home delivery and request refills.
- Check on the status of an order or a claim.
- Find a network pharmacy, including those that offer specialty medications or vaccines.
- Find out a medication's cost.
- Request an explanation of benefits (EOB) for your prescription history.
- Find out which medications are preferred under the Tricare pharmacy benefit.

Click the "Contact Us" link to access numbers to reach Express Scripts in the United States and overseas, the Express Scripts mailing address and the Fraud Tip Hot Line. Please note that many of the features on this site require a login. The first time you use the site, have your sponsor ID number handy to complete the registration process, which should only take a few minutes. The Tricare website http://www.tricare.mil contains information about all Tricare benefits. The pharmacy section of the website provides information about the Tricare Pharmacy Program, whether your medication is covered and the different options for getting your prescriptions filled. The website also has information about how your prescription drug coverage works when combined with other health insurance. You can find information about how and when to file a prescription claim, how to appeal a pharmacy decision or how to file a grievance. Information about the Medicare prescription drug program is available as well. [Source: Tricare Health Matters Issue 7, 2010 ++]

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Blood Thinners Update 03: Patients taking warfarin, a widely used blood-thinning pill that requires careful dose monitoring, have similar outcomes whether they come to a clinic or use a self-testing device at home, according to a recent Department of Veterans Affairs (VA) study. The findings, published in the 21 OCT issue of the New England Journal of Medicine, are good news for heart patients who live far from clinics or are homebound. "This study helps answer an important question for cardiologists, primary care physicians and other health providers, and will lead to improved care for their patients," says VA Chief Research and Development Officer Joel Kupersmith, MD, himself a cardiologist. "The results are significant for a great number of Veterans currently receiving care through VA." Traditionally, doctors, pharmacists and nurses monitor patients who are taking warfarin, sold as Coumadin, over several clinic visits. They test how fast the blood clots and adjust the dose accordingly: Too low a dose will not prevent dangerous blood clots and blood flow to the heart, brain or other areas of the body could be inadvertently blocked. Too high a dose could lead to dangerous internal bleeding.

Patients have the option of tracking their own blood response at home, using blood analyzers known as international normalized ratio (INR) monitors. Patients do a finger stick, apply a small amount of blood to a test strip and feed the strip into the device. The procedure resembles the one used by people with diabetes to check their blood sugar. Patients can then call in the results to their provider and get advice on dose adjustments without coming to the clinic. In some cases, they can even set the proper dose of warfarin on their own. The authors of the VA study expected home monitoring to work better than clinic monitoring, partly because self-testing can be done at home more frequently—weekly, compared with the typical monthly schedule of the best clinic-based monitoring. As a result, off-target INR values can be adjusted more regularly and more quickly. However, the VA study found little difference between weekly self-testing and monthly testing by clinic-based care teams in the measured outcomes, which are strokes, major bleeding incidents and death. The study did find, though, that self-testing at home may offer advantages in other areas: It moderately boosted patients' satisfaction with the medication and slightly increased the length of time they were in the appropriate dose range.

Study co-leaders were Dr. David Matchar, M.D., an internist with the Durham, N.C., VA Medical Center, Duke University School of Medicine and Duke-NUS Graduate Medical School, and Dr. Alan Jacobson, M.D., a cardiologist and researcher with VA and Loma Linda, Calif., University School of Medicine. They said the main message of the study is that patients who are systematically monitored—no matter by what means—are likely to have good outcomes. The study was sponsored by VA's Cooperative Studies Program, part of the VA Office of Research and Development. [VA News Release 4 Nov 2010 ++]

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Retirement Planning Update 01: If you're 40 or younger, it's tough to predict how much money you might need when retirement is decades away. A few key calculations, however, can help you make sure your savings plan is on track. How much you should save depends on your life stage. Rebecca Pace, a Cincinnati-based financial planner and CPA, recommends putting aside at least 10%t of your income when you're in your 20s and 30s -- and even more if you're single. "I wouldn't expect they could continue to add a lot to it while they're raising a family, but if they've put something aside early, it should continue to work for them until they can save again," she says. Another good reason to save aggressively now is the younger you are when you start, the longer your money will have time to grow. This means you'll need to set aside a lot less to reach the same goal than if you waited just a few more years to get started. For example, if you're 25, you need to invest only about $3,600 per year to end up with $1 million by the time you're 65 if your investments return 8% per year. But if you wait until you're 30 to start, you'll need to set aside about $5,400 per year to end up with the same $1 million at age 65. And starting at 40 requires $12,700 a year to reach the same magic $1 million. Finally, you'll need a whopping $34,000 per year to reach the same goal if you procrastinate until you're 50.

A recent study by T. Rowe Price reveals most people need to set aside at least 15% of their pretax salary for their investments to replace 50% or more of their current salary in retirement. This may be enough if you're getting an extra 20% or more of your preretirement income in Social Security and pension payouts. But you'll need to fill more of the gap yourself if you don't expect to receive a pension, you live in an expensive area, or you'll still have a mortgage or other housing payment after retirement. The reality is that it isn't always easy to set aside money for retirement when you're nowhere near your peak income and just trying to pay your regular bills. The good news: You have plenty of help. The IRS and most employers kick in some money, so you can set aside a substantial amount of money without taking much of a hit in your paycheck. For example, if your employer matches 50 cents on the dollar for up to 6% of your salary and you earn $40,000, you'd get the maximum match if you contribute $2,400 in a 401(k). In that case, you'd get $1,200 from your employer, bringing your total contribution up to $3,600. And that $2,400 doesn't lower your paycheck dollar for dollar either, since you're investing the money pretax. If you're in the 25% bracket, investing $2,400 would reduce your take-home pay by only $1,800 for the year. So it actually would cost you just $150 per month to end up with a $3,600 contribution every year. Start at age 30, and you'd have about $650,000 by age 65.

Even with all these benefits, you may not initially be able to afford to save 15% of your salary. And you shouldn't be setting aside that much until you cover your other bases first -- keeping three to six months' worth of living expenses in an emergency fund so you don't have to raid your retirement account (and pay steep penalties) if unexpected expenses crop up. It's also essential to pay off high-interest credit card debt first so you don't waste money on monthly interest charges. But once you've met these obligations, the best way to maximize your money is to get it into savings before you can spend it. With a 401(k), the money is subtracted from your paycheck before you see it. You can also make automatic investments into a Roth IRA. Even just $100 per month can add up to $1,200 a year. And if you're 30 now, keep saving at that pace for the next 35 years and your investments earn 8% annually, you'll have about $216,000 tax-free by the time you're 65. While you'll still need to increase your savings rate when you can afford to, these examples demonstrate it's never too early to start. And it's easy to increase your savings rate

whenever you get a raise, bonus, tax refund, gift or any other form of extra money. When you're used to living on less, it's easy to invest the extra cash before you can spend it. [Source: Monster.com Kim Lankford article Nov 2010 ++]

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Congress ~ 112th: One fifth of all members of Congress will be new in January. The Republican takeover of the House means a complete turnover in committee chairmen, with the new, and sometimes returning, GOP chairmen coming in armed with the promise from their leaders that they will no longer be an afterthought. Just who winds up where won't be made official until the new Congress takes office in January. But jockeying for key positions will be going on when the current Congress returns 15 NOV for a lame-duck session. Following are the projections for the House and Senate:

House Armed Services - Rep. Howard McKeon's major work has been on the Education and Labor Committee, but he has been active on military issues. The California lawmaker sought to make sure that Gen. David Petraeus had enough troops for his counterinsurgency strategy in Afghanistan. He wants an accurate measurement of the security and political situations in that country. He also seeks to make sure that U.S. and Iraqi forces sustain their security gains. He believes the U.S. should develop and fortify long-term security and economic relationships with Iraq.

House Veterans Affairs - Rep. Jeff Miller, a 51-year-old conservative from the Florida Panhandle, is seen as a leading candidate to head the Veterans' Affairs Committee. Miller, a former real estate broker and deputy sheriff, has a large veteran population in his district and since coming to Congress has championed legislation to improve benefits for military personnel, veterans and their families.

Senate Veterans Affairs - Sen. Daniel K. Akaka (D-HI) Sen. Akaka is Expected to continue chairing the senate veterans affairs committee. It is anticipated he will focus on improving adjudication of veterans' disability claims." Akaka, who has "already written a bill intended to make the process fairer and to reduce a backlog of claims numbering in the scores of thousands," also "plans legislation to enhance" the Post-9/11GI Bill. The committee will continue to monitor the signature effects of America's two current wars: traumatic brain injury and post-traumatic stress disorder, mental health issues, suicides, substance abuse and homelessness.

That said, the latest election results mean the military and veterans community will be losing some legislators who have been among the strongest supporters of military people issues in the past who will be missed, as well as the strong support of their staffs. They are:

- House Armed Services Committee Chairman Ike Skelton (D-MO), who has championed a long list of pay, health care, concurrent receipt, wounded warrior and survivor initiatives and had a powerful hand in virtually all of the major gains of the last decade (one of four 2008 recipients of MOAA's Arthur T. Marix Congressional Leadership Award).
- House Military Construction, VA and Related Agencies Appropriations Subcommittee Chairman Chet Edwards (D-TX), who has guided the addition of billions of dollars to meet growing VA program needs in recent years and sponsored legislation to protect against unfair Tricare fee hikes (one of five 2007 Marix Award recipients).
- Sen. Blanche Lincoln (D-AR), who has sponsored multiple initiatives in support of the Guard and Reserve and survivor communities (one of four 2010 Marix Award recipients).
- Rep. Gene Taylor (D-MS), long-time supporter of military health care and the Guard and Reserve community (one of four 2006 Marix Award recipients).

- Rep. Jim Marshall (D-GA), lead concurrent receipt (H.R.333) sponsor in the House (one of four 2004 Marix Award recipients).

There are 16 new Senators entering Congress from the 37 races this year. Of these new Senators only 2 have served in the military. They are:

- Richard Blumenthal (D-CT) Served in the U.S. Marine Corps Reserves and was "honorably discharged as a sergeant."
- Mark Kirk (R-IL) - Presently a Commander in the Navy Reserve and serves as an intelligence officer. He drew criticism for exaggerating his war record during the campaign having spent two stints in Afghanistan of less than a month each. Still, that brief service is more recent war experience than any other sitting senator except South Carolina's Lindsey Graham, an Air Force reservist who served similar tours in Iraq.

In the House two incumbent Republicans -- California Rep. Duncan D. Hunter, a Marine veteran who served in Iraq and Afghanistan, and Colorado Rep. Mike Coffman, a Marine veteran who served in Iraq -- easily won re-election in their races. Both sit on the House Armed Services Committee and have been key voices in defense debates for the GOP. In addition:

- In central Ohio, Republican Steve Stivers defeated Democratic Rep. Mary Jo Kilroy in a rematch of their 2008 contest. Stivers, an Ohio National Guardsman, served for nearly a year Iraq, Kuwait and Djibouti in a noncombat role.
- Adam Kinzinger, an Air Force captain who served three tours in Iraq and two in Afghanistan, defeated incumbent Democrat Rep. Debbie Halvorson in the Illinois 11th District. Chris Gibson, an Army colonel and veteran of four Iraq tours, ousted Democratic incumbent Rep. Scott Murphy in the New York 20th District.
- Retired Army Lt. Col. Allen West, who two years ago lost an election bid to Democrat Ron Klein, defeated him in their rematch Tuesday. West served in Iraq in 2003 but was forced out of the service in 2004, after a military panel chastised him for coercing an Iraqi detainee during an interrogation by firing his pistol near the man. He was allowed to retire with full benefits. Although admitting wrongdoing, he was unapologetic over the incident, saying the information could have helped save other soldiers' lives.
- Tim Griffin, an Army Reserve major who deployed to Iraq in 2006, won his House bid in Arkansas' 2nd District, and Army Reserve Col. Joe Heck, who served in Iraq in 2008, defeated incumbent Democrat Dina Titus.
- At press time, one race involving an Iraq veteran was too close to call. Marine Corps veteran Jesse Kelly, running as the GOP candidate in Arizona's 8th District, trailed incumbent Democrat Gabrielle Giffords by about 2,500 votes

Of the new Governors only 4 have any military service. They are:

- Robert Bentley (R-AL) - He joined the Air Force in 1969 as a doctor and was commissioned as a Captain and served as a general medical officer. He was stationed at Pope Air Force Base at Fort Bragg and became the hospital commander.
- Rick Scott (R-FL) - Enlisted in the Navy and served as a "radar man" aboard the USS Glover.
- Butch Otter (R-ID) - Served in Idaho's Army National Guard's 116th Armored Cavalry
- Tom Corbett (R-PA) - Served from 1971-1984 in Pennsylvania's Army National Guard's 28th Infantry Division

[Source: Various 4 & 5 Nov 2010 ++]

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PTSD Update 58: Many combat veterans try to handle the invisible but real psychological wounds of war by trying to tuck the memories away in a corner of their brain and never talking about them, an approach that leads to post-traumatic stress for months or years. Exposure therapy -- gradually reliving those events in a nonthreatening setting with a therapist -- can help the trauma of combat, but it requires easy access to a clinician, something not readily available to many veterans living in rural areas. For the past three years Peter Tuerk, a psychologist and associate director of the PTSD clinical team at the Charleston, S.C., VA Medical Center has used videoconferencing systems to conduct prolonged exposure therapy sessions with veterans who cannot make it to the hospital for face-to-face counseling. This week he received a VA national award for his pioneering work in recognition of his contributions in an area critical to the rehabilitation and improvement in the quality of life of war-injured veterans. VA Secretary Eric Shinseki said the department presented Tuerk with its Olin Teague Award, named after the former Texas congressman and World War II veteran, as his work "exemplifies the strides VA is taking in understanding and treating" combat stress.

Tuerk, also an assistant professor of psychiatry and behavioral sciences at Medical University of South Carolina in Charleston, said his remote counseling combines "old-school techniques" with technology to help veterans face their fears and learn that "memories will not hurt them." This pioneering effort by VA dovetails with plans by Gen. Peter Chiarelli, the Army vice chief of staff, to use telehealth systems to treat soldiers for combat stress. Asked if veterans expressed reluctance to tap into their fears and memories over a videoconference, Tuerk said only 1% of hundreds of post-traumatic stress patients his clinic treated opted for face-to-face sessions. "The technology fades into the background," as treatment progresses and the patients become comfortable with the technology, at which point "the machine is not a big deal." The technology -- Tuerk uses Tandberg videoconferencing systems -- also is more convenient for rural patients, relieving them of a long drive to weekly sessions. The combination of exposure therapy and telehealth does work, according to a paper Tuerk published on the remote treatment of a patient in the December 2009 issue of the Journal of Addiction Medicine. The patient, a 22-year-old Iraq war veteran, experienced multiple combat firefights, witnessed many dead and mutilated bodies, was seriously wounded twice by blasts from improvised bombs, and was diagnosed with traumatic brain injury. On returning home, this veteran, like many others, turned to alcohol to mask his memories, downing 10 or more drinks daily.

The veteran lived 100 miles from the nearest VA facility, but was able to receive remote exposure therapy treatment at a VA community-based outpatient clinic hooked up to the Charleston hospital by a videoconferencing link. The patient received 11 weekly 90-minute exposure therapy sessions, which included an imagined return to combat and the memories it triggered. After only two sessions, Tuerk said the veteran "reported a dramatic drop in intrusive memories and a lessening of the intensity of distress when awoken by nightmares." After the fifth session, according to Tuerk, the patient said, "It was amazing, it's like I'm better." At the end of the 11th session the patient also had cut back on alcohol consumption. The South Carolina VA hospital is the first Veterans Affairs hospital in the country to offer remote prolonged exposure therapy, but Tuerk believes his work has national implications. The technology allows VA to get veterans into treatment faster and closer to their homes than traditional in-person therapy sessions, he said, helping to ensure all veterans receive the treatment they need. [Source: GovExec.com Bob Brewin article 4 Nov 2010 ++]

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Senior Citizen Divorce: How do the issues of aging, retirement and health affect a marriage? And how do seniors cope when a marriage ends? The decision to divorce is critical, with consequences that can last a lifetime. Marital problems, pain in your relationship and frustration with it does not always mean divorce. Below are questions you should ask yourself before you get divorced. Go over these questions together, as a couple. Should you decide divorce is the answer for you, at least your spouse won't be blindsided by your feelings.

1. **Do you still have feelings for your spouse?** Have your feelings diminished or, are you feeling powerless over a problem in the marriage and due to this, there is a lack of emotional closeness. If there are still feelings of love and affection then you should work on the relationship before deciding on divorce. You do not want to get caught up in the emotions of a situation like divorce and then realize you've made a mistake. If there is any love left, seeking couples therapy will mean not suffering feelings of loss after an un-needed divorce.

2. **Was there even a marriage to begin with?** If your marriage has never been anything more than two people living together and getting their own needs met then divorce may be the answer. Marriage is a unified coupling of two people who work for the best interest of the relationship. Married couples work together for the good of the relationship. If there is no "couple," only two people fighting for their own needs then, now would be a good time to either commit to changing the dynamics of the relationship or parting ways.

3. **Is it divorce you want or, are you just threatening divorce?** Are you angry at your spouse and threatening divorce out of frustration over the problems in the marriage? Do you use threats of divorce to get your way or as a means of having power over your spouse? Are you frustrated and feel that threatening divorce will finally get your spouses attention and they will take you seriously? If it is solutions you are looking for, threatening divorce will not get you where you want to be. You need couples therapy for that. If it is divorce then stop threatening and take a mature, informed step in the right direction.

4. **Is your decision to divorce based on emotional reaction or true self awareness?** If you are ready for divorce you will have let go of any emotional attachments you have to your spouse. These are good feelings and negative feelings that often come into play during marital conflict. Deciding on divorce at a time when you are overwhelmed with emotions won't solve problems. It generates problems and compounds any hurt and frustration you may be feeling. Unless you can look at your spouse as an individual who deserves your respect, even during the divorce process you are asking for trouble. If you cannot, the divorce process will be riddled with frustration, anger and distrust of the motives of your spouse.

5. **What is motivating you to divorce?** Are you hoping that a divorce will mean your spouse will start treating you better? Maybe they will realize what they have lost and make the changes you need them to make. If so, you are divorcing for the wrong reasons. Divorce will only promote conflict, not resolve it. All a divorce will do is end your marriage and split apart your family. If you want a change in the dynamics between you and your spouse, it isn't divorce you want. Something to think about; once you have , your spouse is free to form emotional attachments to others. If that thought is uncomfortable, think twice before making a decision.

6. **Have you thought about the negative consequences of divorce?** Divorce can mean a loss of dreams and goals. Even if you are positive it is a divorce you want you need to have a support system in place to help you deal with the stress associated with divorce. You need to be able to face your children's pain and be there to help them cope. If you are the one wanting the divorce, you will have to deal with the pain of others. Don't let guilt over wanting a divorce stand in the way of helping those hurt cope with the divorce.

7. **Are you able to act in a mature way after the divorce?** Your attitude will determine what kind of life you will have after the divorce. Will you be strong, take responsibility and let go of any anger and resentment? Or, will you remain bitter, resentful and feel like a victim? The attitude you choose to live with will determine, not only the kind of divorce you have but the quality of life you have after you divorce.

Divorce brings with it many negative emotions. Some of these emotions can cause stress that will interfere in our ability to function in our every day lives. The biggest favor you can do yourself is to learn how to relax, let go of the stress and just let the "chips fall." Focus more on keeping yourself active, healthy and moving forward instead of staying stuck. All it takes is being willing to be good to yourself. Recognizing and dealing with stress is an

important aspect of living a healthy productive life. Following are some suggestions for ways of handling your stress during the difficult process of divorce:

- ✓ **Make sure you pay attention to your emotional needs.** Find a support group to participate in, a therapist to talk with. A little talk therapy can go a long way when you are feeling overwhelmed emotionally.
- ✓ 2. **Keep yourself physically fit.** Stay as active as possible by keeping a regular exercise routine. Nothing helps our emotions bounce back better than physical activity. It will help in relieving tense, anger and anxiety.
- ✓ 3. **Do things that will nurture you emotionally and physically.** Read a good book, get plenty of rest, take a hot bath, develop a new hobby, eat healthy and nutritious foods, and surround yourself with positive people. Put effort into living a lifestyle that will promote feelings of good self-worth.
- ✓ 4. **Let go of problems that are beyond your control**. If you are faced with an uncomfortable or painful situation learn to let it go, take some time to figure out what is best for you and then come back to it. Stay focused on what you have control over and let go of the rest.
- ✓ 5. **Give yourself permission to feel.** Emotions are normal, whether they are negative or positive emotions. What we do with the emotions we are feeling plays a big role in the quality of life we experience. Avoid destructive activities such as drinking or drugs when trying to deal with your feelings. Don't allow your feelings to cause you to seek revenge, play the victim or become abusive toward your spouse. If you are hurt or angry, it is best to find someone safe to vent to and get those feelings out.
- ✓ 6. **Change any expectations you have.** No one has any control over the feelings and actions of another person. We might think that during our marriage we had some control but we did not. Now that there is a divorce in process we have even less control than before. Let go of trying to control any aspect of what your spouse may feel or what actions they will take. Let go of what you feel the outcome should be and learn to accept whatever might happen.
- ✓ 7. **Don't make any hasty decisions.** When you are living through a highly stressful situation any decisions or changes to your life should not be made until you have thought of all the consequences. Take time to think things through and thoroughly weigh all your options.
- ✓ 8. **Be sure to make time for fun.** Remember to laugh and play. Schedule activities that bring you pleasure and participate in them regularly. Maintain a close circle of friends and socialize often. Do not isolate yourself from others.
- ✓ 9. **Let go and move on.** Take the time needed to heal from the divorce and those feelings of loss. Try to look inward and own your responsibility in the problems that led to divorce. Forgive yourself and your spouse and don't let the issues from this marriage follow you into new relationships.

[Source: About.com Cathy Meyer article 1 Nov 2010 ++]

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DoD Benefit Cuts Update 05: An influential lawmaker hinted 27 OCT that Congress could move to reduce the size of the Army and Marine Corps soon after the Obama Administration begins withdrawing from Afghanistan. Bowing to budget pressure on the Pentagon from a flagging economy and increased spending needs in other areas of the government, Sen. Jim Webb (D-VA) argued the two services that had done most of the heavy lifting in Iraq and Afghanistan had no reason to keep their end strength at wartime highs. "We eventually should and will reduce the size of the Army and Marine Corps as we wind down in Iraq and Afghanistan," Webb told a group of defense reporters at a breakfast meeting. "We go through these cycles when we have long-term land commitments where we ignore our strategic forces and our larger national strategy." Webb reinforced that despite Defense Secretary Robert Gates' call for a bottom-up review of Pentagon business to find cost savings in an increasingly constricted budget, reducing basic pay and health care coverage was off the table. Instead, the Vietnam-era Marine and former Navy secretary said he'd look for savings in targeted bonuses, military fellowship programs, and training contracts with civilian companies such as Xe Services, formerly known as Blackwater.

Webb's statements come as two of Europe's most powerful militaries are slashing their force structures due to economic crises, with Britain decommissioning its only aircraft carrier and cutting 40 percent of its tank force and Germany socializing plans to cut army end strength by nearly 30 percent, along with halting conscription. The debate continues to mount in the U.S., with lawmakers looking to the Pentagon for large cuts as troops continue to leave Iraq and the administration's planned drawdown of troops in Afghanistan begins next summer. The Army and Marine Corps plused-up their forces over the last three years by nearly 70,000 troops, in large part bending to pressure from Congress, which suggested the increase would help keep troops home for longer and reduce repeated deployments to Iraq. But the service chiefs and then-Secretary of Defense Donald Rumsfeld resisted end-strength increases, arguing they were too costly and fearing a repeat of the painful "reduction in forces" that crushed morale in the post-Gulf War era.

Before his death in February, then-chairman of the House Appropriations Committee's defense panel said repeatedly that the Democratic-controlled Congress would have to cut back on Army and possibly Marine Corps end strength by 2013 -- less than four years after the troop boost was fully implemented. "Personnel costs are so high we have to cut back on personnel. You can't cut the budget anyplace else," Murtha said in JUN 09. "We've got to cut back on personnel, and at some point we will." And though Murtha may have passed away and his influence over the Pentagon's purse strings with him, the same thinking behind where Congress can find Pentagon money to pay for other programs lives on. "We want to compensate our people well, but the end-strength numbers drive costs," Webb added. "Do we need this size of our ground forces if we are properly going to reshape our missions in Iraq and Afghanistan? I think you can cut back." [Source: Military.com Christian Lowe article 28 Oct 2010 ++]

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Stolen Valor Update 27: Lawyers for a California man who pleaded guilty to lying about getting a military medal are arguing that falsehoods sometimes have value. The case is one of two that are challenging the federal Stolen Valor Act, which makes it a crime to falsely claim to be a war hero.In California, Xavier Alvarez of Pomona pleaded guilty to falsely claiming he was awarded the Medal of Honor, but he also challenged the constitutionality of the law. A three-judge panel of the 9th U.S. Circuit Court of Appeals court sided with him and ruled the law violated the 1st Amendment. Prosecutors asked the full court to review the ruling, but the court hasn't said whether it will. Alvarez's lawyers filed documents last week arguing against another review. They cite John Milton, a 17th century writer, and John Stuart Mill, a 19th century philosopher, to argue that falsehoods can improve public debate by spurring the search for truth. They also said the three-judge panel's ruling was clear, that some lies are protected by the 1st Amendment and that Alvarez's false claim to have a medal posed no clear and present danger. The other challenge is in Colorado. A federal court in Denver ruled the law is unconstitutional, and prosecutors say they will appeal. [Source: AP article 1 Nov 2010 ++]

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Vet Insurance ~ Life Update 11: The American Legion, the largest U.S. veterans' service organization with 2.5 million members in almost 14,000 posts worldwide, asked permission to file a legal brief supporting a pending case in Springfield, Massachusetts, against Prudential Insurance Co. of America, a unit of Newark, New Jersey-based Prudential Financial. The pending lawsuit by the families of deceased veterans accuses the insurer of failing to pay beneficiaries in a lump sum as required by U.S. law and the language of the policies. Instead, the lawsuit says that Prudential strongly encourages beneficiaries to keep the money in accounts with the company, which pays them a small amount of interest. The "practice is unlawful and dishonest," the American Legion said in its court filing. "It is especially objectionable because sophisticated money managers are making an unwarranted and unlawful profit from the deaths of those who have given the most to preserve our nation's way of

life." Bob DeFillippo, a spokesman for Prudential Financial, declined to comment on the filing. He has previously said that the company informs beneficiaries of their payment options and that they may immediately withdraw the money from their Prudential Alliance Accounts and invest it wherever they choose.

Prudential held $662 million of survivors' money in its corporate general account as of 30 JUN, according to information provided by the Department of Veterans Affairs. Prudential's general account earned 4.2% in 2009, mostly from bond investments, according to regulatory filings. The company has paid survivors holding Alliance Accounts 0.5% in 2010. More than 100 insurance carriers earn investment income on $28 billion owed to life insurance beneficiaries, Bloomberg Markets magazine reported in July. Insurers keep the money in their general account, paying only when the beneficiaries write drafts, or "checks" on the account. The American Legion, which Congress chartered in 1919 to represent the interests of veterans, seeks permission in its submission yesterday to join the lawsuit and to file a brief opposing the so-called retained asset accounts used by Prudential. The brief was included as part of the filing. Prudential's "disingenuous practices take advantage of the grieving families of America's fallen heroes," the American Legion says. "This procedure is morally objectionable and unlawful. It should be stopped."

Prudential has asked the judge to dismiss the case, saying the insurer's delivery of a "checkbook" to beneficiaries complies with its legal obligation. Lawyers for beneficiaries who brought the case 1 NOV filed a separate brief opposing Prudential's request. The suit seeks class-action, or group, status on behalf of other beneficiaries. Prudential is also seeking to transfer this and a similar case in California to the federal court in New Jersey, where the insurer previously won a favorable ruling in another lawsuit over retained asset accounts. The case is Lucey v. Prudential Insurance Co. of America, 10-30163, U.S. District Court, District of Massachusetts (Springfield). [Source: Bloomberg David Glovin and David Evans article 2 Nov 2010 ++]

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Pain: Pain is a commonly reported symptom during the last few years of life, with reports of pain increasing during the final few months, a new study has shown. Just over a fourth of people reported being troubled by moderate or severe pain two years before they died, the researchers found. At four months before death, that number had jumped to nearly half. "This study shows that there's a substantial burden of pain at the end of life, and not just the very end of life," said the study's lead author, Dr. Alexander K. Smith, an assistant professor of medicine at the University of California, San Francisco, and a staff physician at the San Francisco VA Medical Center. "Arthritis was the single biggest predictor of pain," Smith said. Results of the study are published in the 2 NOV issue of the Annals of Internal Medicine. Smith and his co-authors pointed out that numerous studies have been done on pain associated with specific conditions, such as cancer, but that theirs may be the first to address pain from all conditions toward the end of life, a time when most people would say that being pain-free is a priority.

The study included information on more than 4,700 people who died while participating in a study of older adults called the Health and Retirement Study. The study participants averaged 76 years old, included slightly more men than women and were mostly (83%) white. Every two years, they were asked if they were troubled by pain. If they answered yes, they were asked to rate their pain as mild, moderate or severe. The study found that 26% of the participants had said they were in pain two years before they died. Their pain levels remained steady until about four months before death, when pain began to increase. By the last month before death, the number of people reporting moderate or severe pain had jumped to 46%. "That's a substantial burden of pain," Smith said. But in people with arthritis, 60% reported troubling pain in the last month of life, compared with 26% of those without arthritis, according to the study. Pain did not differ significantly among people with other conditions, such as cancer or heart disease, the study found.

"This is an important study that confirms what we have learned from smaller, more select studies, and it quantifies pain in the last months of life," said Dr. M.C. Reid, director of the Cornell-Columbia Translational Research Institute of Pain in Later Life, in New York City. "I think that one of the important findings to emerge is that the prevalence of clinically significant pain was separate from a terminal diagnosis," Reid said. "People with advanced illness are reporting significant levels of pain, but the mechanisms behind that pain aren't yet well understood." Both Smith and Reid said the study's findings show its important for all doctors to be able to effectively treat pain because it's so prevalent across all conditions. "It's really the responsibility of all physicians to attend to pain, not just pain doctors," Smith said. "Pain may not be why they're seeing their physician -- for example, someone with heart disease might see a cardiologist most often -- but the cardiologist should ask about pain." [Source: HealthDay News Serena Gordon article 1 Nov 2010 ++]

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TSP Update 17: All the offerings in the federal employee retirement program grew in October, though not at as fast a clip as the month before. While all three stock-based funds made a strong showing in October, they slowed considerably from the previous month, when the S Fund increased 11.47%; the I Fund, 9.81%; and the C Fund, 8.92%.

- The S Fund led the pack, with a 4.48% gain for October. The fund, which invests in small and midsize companies and tracks the Dow Jones Wilshire 4500 Index, also came in first for the year-to-date, boasting 16.7% growth.
- The C Fund -- invested in common stocks of large companies on the Standard & Poor's 500 Index -- came in second for October, with a 3.8% increase. Its 2010 returns were 7.84%.
- International stocks maintained their momentum as well, with the I Fund growing 3.63% for October and 4.91% for the year.
- Fixed-income bonds and traditionally stable government securities inched forward in October, with 0.36% and 0.18% returns respectively. The F Fund stood out more for its yearlong performance, with its 8.46% returns outpacing the C and I funds' 2010 growth. The G Fund gained 2.42% for the year.

TSP's life-cycle options -- designed to move investors to less risky portfolios as they get closer to retirement -- all posted at least small gains for October. Employees with longer investment horizons fared better for the month, with increases of 3.16% for the L 2040 Fund; 2.78% for the L 2030; 2.29% for L 2020; and 0.92% for both L 2010 and L Income, for people who have reached their target retirement date and are withdrawing money from their accounts. Younger employees with more aggressive life-cycle portfolios also did better for the year to date, with the L 2040 Fund earning 8.47% for 2010, the L 2030 up 7.76%, the L 2020 at 6.78%, the L 2010 at 4.15%, and the L Income at 4.23%. [Source: GovExec.com Amelia Gruber article 1 Nov 2010 ++]

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PTSD Update 56: U.S. Army researchers found combat veterans with post-traumatic stress disorder (PTSD) almost universally suffer sleep problems -- with more cases of sleep apnea than might otherwise be expected. In a group of 135 young, otherwise healthy combat veterans with PTSD, 98.5% reported sleep complaints, Nick Orr, MD, and colleagues at the Walter Reed Army Medical Center in Washington, D.C., reported at the annual international scientific meeting of the American College of Chest Physicians (CHEST). Despite their relatively young age (around 35) and slightly overweight physique, 54% of the PTSD patients who underwent polysomnography at Walter Reed were diagnosed with obstructive sleep apnea (OSA) -- whereas, in the general population, the rate of OSA is only 20%. It can be all too easy to dismiss daytime sleepiness and other symptoms as part of depression and PTSD, Orr explained. But these results argue for screening all military PTSD patients for

sleep apnea, Orr said in an interview. "You'll be darned if you just keep treating it with medications, cognitive behavioral therapy, and all the other modalities you use for PTSD, when you haven't addressed possible sleep apnea, which could get restorative sleep and kind of break the cycle for the PTSD symptoms." Andreea L. Antonescu-Turcu, MD, of the Medical College of Wisconsin and chief of pulmonology at the Zablocki VA Medical Center, both located in Milwaukee, agreed that the study results should justify the importance of screening for sleep problems in military patients with PTSD -- even when they don't fit the classical profile for OSA. "As the data are coming out it probably should be part of their routine evaluations to screen for sleep disordered breathing. Maybe this is part of their disorder that we have to address early on in patients with PTSD."

The reason for the well-recognized sleep problems in PTSD isn't clear, but recent reports have argued that these symptoms should be considered a central feature of the disorder and not just a consequence of it, Orr noted. His group retrospectively analyzed electronic medical records for all 135 service members (91.9% men, average age 35.3) with combat-related PTSD seen at the Walter Reed sleep clinic from MAR 06 through APR 2010. Orr noted that these returning soldiers were assigned to the Warrior Transition Brigades, which were asked to refer PTSD cases with traumatic brain injury to the sleep clinic. Not surprisingly, the majority of veterans in the current study had been injured (80 of the 135) and about 70% were traumatic brain injuries, primarily mild concussions from blast incidents. The average body mass index (BMI) was 28.91 -- putting most of the patients in the overweight but not obese category. Comorbid psychiatric illness was nearly universal with PTSD in the study patients; 88.9% suffered from depression and 44.4% were diagnosed with anxiety. Sleep complaints among the study patients included excessive daytime somnolence in 88.2% -- confirmed by an average Epworth Sleepiness Scale score in the "sleepy" range (10.7) -- as well as sleep fragmentation in 67.4% and difficulty falling asleep in 55.6%. Polysomnography done in 80.7% of the study patients diagnosed insomnia in 55% and OSA in 54%. Those patients with OSA were generally older, had a higher BMI, and were less likely to have suffered trauma or a traumatic brain injury compared with those who did not have sleep apnea (all P=0.001).

Orr's group cautioned that they were unable to determine how many of the service members in the study had OSA before being deployed -- but the researchers assumed that it was largely preexistent. High medication use, including painkillers and sedatives, might have contributed to the sleep characteristics of these populations, the investigators noted. But Orr pointed out that comorbid depression and use of medication were similar in PTSD patients with and without OSA. Also, "the injured population had less obstructive sleep apnea, so if the narcotics were causing central apneas then why was it the opposite?" he asked. The study was limited to service members returning from combat situations. But in terms of generalizability, Orr noted that sleep disordered breathing was almost universal in a prior study of female sexual assault victims and in another study conducted among crime victims with sleep problems -- most of whom also had PTSD. One problem with finding sleep apnea in this fairly young PTSD population was that compliance with treatment -- continuous positive airway pressure (CPAP) -- is a problem, cautioned co-author Jacob Collen, MD, also of Walter Reed. Whether CPAP -- if adhered to -- can actually reverse some of the symptoms of PTSD still remains to be seen. [Source: Medpage Today Crystal Phend article 31 Oct 2010 ++]

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PTSD Update 57: After years of research and months of fine tuning, researchers at the University of Minnesota said they have found a definitive way of identifying post-traumatic stress disorder. Last January, researchers at the University and the Minneapolis VA Medical Center were able to recognize difference in brain activity between those with PTSD and control subjects without the disorder. Now, the same researchers have found that it is increased activity in the right side of the brain that may be responsible for the involuntary flashbacks, recurring nightmares or anger that often stems from war. To get the images, subjects are placed in a large helmet for 60 seconds and asked to focus on a point in front of them without any other stimulation. During that time, the

interactions between 248 points in the brain are measured with a technique called magnetoencephalography, or MEG. In subjects with PTSD, these interactions are highly active, especially in an area on the right side of the brain. Because of the varying amount of activity, researchers can also detect the degree to which a person is suffering from the disorder, which could lead to better diagnosis and better treatment, said Apostolos Georgopoulos, a co-leader of the study and a director of the Brain Sciences Center at the VA. Researchers were able to see the activity while subjects were in a "task-free state," supporting the idea that those with PTSD are prone to relive painful memories regardless of what they are currently doing. And while Georgopoulos anticipates that the findings will result in major changes in the way that PTSD is handled, he said it is time to continue to "beef up the numbers" and prove to the VA, which has funded the research, that the MEG is essential medical equipment. Towards that attempt since January, they have been able to increase the% of healthy people they correctly classified from 88% to 95% accuracy. They're even better at identifying those with PTSD, doing so with 96% accuracy. The team of researchers also hopes to round out their study with subjects who are not only suffering from PTSD but also depression and traumatic brain injury. [Source: Minnesota Daily Luke Feuerherm article 1 Nov 2010 ++]

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VA Presumptive VN Vet Diseases Update 15: The Department of Veterans Affairs (VA) has begun distributing disability benefits to Vietnam Veterans who qualify for compensation under recently liberalized rules for Agent Orange exposure. Up to 200,000 Vietnam Veterans are potentially eligible to receive VA disability compensation for medical conditions recently associated with Agent Orange. The expansion of coverage involves B-cell (or hairy-cell) leukemia, Parkinson's disease and ischemic heart disease. VA has launched a variety of initiatives - both technological and involving better business practices - to tackle an anticipated upsurge in Agent Orange-related claims. "These initiatives show VA's ongoing resolve to modernize its processes for handling claims through automation and improvements in doing business, providing Veterans with faster and more accurate decisions on their applications for benefits," Secretary of Veterans Affairs Eric K. Shinseki said.

Providing initial payments - or increases to existing payments - to the 200,000 Veterans who now qualify for disability compensation for these three conditions is expected to take several months, but VA officials encourage all Vietnam Veterans who were exposed to Agent Orange and suffer from one of the three diseases to make sure their applications have been submitted. VA has offered Veterans exposed to Agent Orange special access to health care since 1978, and priority medical care since 1981. VA has been providing disability compensation to Veterans with medical problems related to Agent Orange since 1985. In practical terms, Veterans who served in Vietnam during the war and who have a "presumed" illness do not have to prove an association between their illnesses and their military service. This "presumption" simplifies and speeds up the application process for benefits. The three new illnesses - B-cell (or hairy-cell) leukemia, Parkinson's disease and ischemic heart disease - are added to the list of presumed illnesses previously recognized by VA. Veterans interested in applying for disability compensation under one of the three new Agent Orange presumptives should go to http://www.fasttrack.va.gov or call 1(800) 827-1000. Other recognized illnesses under VA's "presumption" rule for Agent Orange are:

* Acute and Subacute Transient Peripheral Neuropathy
* Chloracne
* Chronic Lymphocytic Leukemia
* Diabetes Mellitus (Type 2)
* Hodgkin's Disease
* Multiple Myeloma
* Non-Hodgkin's Lymphoma
* Porphyria Cutanea Tarda
* Prostate Cancer
* Respiratory Cancers

* Soft Tissue Sarcoma (other than Osteosarcoma, Chondrosarcoma, Kaposi's sarcoma, or Mesothelioma)
* AL Amyloidosis

[Source: VA News Release 1 Nov 2010 ++]

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VA Presumptive VN Vet Diseases Update 16: Many Vietnam veterans with ischemic heart disease, Parkinson's disease or B-cell leukemia expected VA compensation for their illnesses to begin soon after a 60-day congressional review period ended 30 OCT. Though the first batch of payments went out in early NOV, the relatively small number — about 1300 claims worth $8 million — reinforced the fact that the process for calculating retroactive payments is lengthy and complex. VA expects to produce a steady stream of rating decisions and payments each week for these diseases, but there will not be a flood of checks as some veterans had hoped. Most of 163,000 veterans or survivors with pending claims for these diseases should expect a longer wait, at least several more months. The VA goal is to have all these claims processed and paid by OCT 2011. After VA published its final regulation 31 AUG to add these diseases to its list of ailments presumed caused by herbicide exposure in Vietnam, Congress had 60 days to block it. To veterans' relief, it chose not to do so. VA used that time to do preliminary work on many claims but had to stop short of assigning disability ratings. That's because VA computers are programmed to assign a payment date with each rating and, by law, none of these claims could be paid before the 60 days had passed.

Claim specialists don't have all the information they need yet to rate many of the older claims. Many veterans and survivors in line for retroactive payments, some going back 25 years, are being asked to provide letters from private physicians explaining when the ailments first were diagnosed. VA also will try to develop timelines for a disease's progression in individuals so appropriate disability ratings can be assigned at different stages, and back payments are calculated as accurately as possible. For ischemic heart disease, for example, a patient initially needing medication might have been rated 10%. Years later when an x-ray showed an enlarged heart, the rating could have been raised 30%. As stress tests showed the disease progressing, higher ratings and higher compensation would be made. Barton F. Stichman, co-director of the National Veterans Legal Services Program, said he doesn't know how many claims will need to be developed this way or how many can be paid without VA waiting for more information. His organization, NVLSP, is certified counsel for the class of veterans filing Agent Orange claims.

More than 1,000 claim specialists in nine VA resource centers are working on 93,000 claims filed for these diseases between 25 SEP 85 and 13 OCT 09. The end date is when VA Secretary Eric Shinseki announced his decision to add these diseases to the list of presumptive diseases for Agent Orange exposure. The earlier date is when VA first published a regulation on presumptive Agent Orange diseases, sparking a successful court challenge on behalf of ailing Vietnam vets. This resulted in an appeals court ruling, Nehmer v. Department of Veterans Affairs, ordering that VA compensate veterans retroactively for any claim they filed for a disease later deemed service-connected because of new medical evidence linking it to herbicide exposure in Vietnam. Shinseki's announcement triggered Nehmer protection for 93,000 previously denied claims. Since then, 70,000 more veterans and survivors have filed new claims for these diseases. The more recent claims are being worked at VA regional offices. VA has trained hundreds of rating specialists specifically for these new claims. These retroactive claims often require complicated calculations and, if veterans have died since claims were filed, often long searches for next of kin.

Veterans or survivors who want to be sure their denied claim is being reviewed can call their VA regional office to learn if they are among the 93,000 being eyed for retroactive compensation. "There's no time limit on this," said a VA official. "So if they don't get some notice that we are working on their claim in the next six months or so they should say 'Hey, what about me?' "About 10,000 of the older claims were filed by veterans now deceased. For

these, award notices will be mailed to last known addresses. If past experience is an accurate guide, 90% will be returned as undeliverable. VA will take a few more steps to reach next of kin and then pass on these files to the NVLSP to continue the search. "We've been able to locate a lot of these people in the past" for VA, Stichman. But for some cases "it's taken us a few years." As certified counsel for the class, the NVLSP also gets a copy of every Agent Orange claim decided so it can monitor VA compliance. Given the resources VA has committed to these claims, Stichman believes the VA is trying to pay claims as quickly and carefully as it can. He also isn't concerned that VA's own completion deadline is 11 months away. "That doesn't surprise me. It's a hell of atom lot of cases," he said. "We're not going to complain when they are putting this much effort into it." [Source: Stars & Stripes Tom Philpott article 4 Nov 2010 ++]

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Food Myths:

Here are the details of food myths that just won't die.

Myth 1: Eggs are bad for your heart.
The Truth: Eggs do contain a substantial amount of cholesterol in their yolks—about 211 mg per large egg. And yes, cholesterol is the fatty stuff in our blood that contributes to clogged arteries and heart attacks. But labeling eggs as "bad for your heart" is connecting the wrong dots, experts say. "Epidemiologic studies show that most healthy people can eat an egg a day without problems," says Penny Kris-Etherton, Ph.D., R.D., distinguished professor of nutrition at Penn State University. For most of us the cholesterol we eat doesn't have a huge impact on raising our blood cholesterol; the body simply compensates by manufacturing less cholesterol itself. Saturated and trans fats have much greater impact on raising blood cholesterol. And a large egg contains only 2 grams of saturated fat and no trans fats. The American Heart Association recommends limiting cholesterol intake to less than 300 mg daily—less than 200 mg if you have a history of heart problems or diabetes or are over 55 (women) or 45 (men). "That works out to less than an egg a day for this population—more like two eggs over the course of the week," notes Kris-Etherton.

Myth 2: High-Fructose Corn Syrup (HFCS) is worse for you than sugar.
The Truth: The idea that high-fructose corn syrup is any more harmful to your health than sugar is "one of those urban myths that sounds right but is basically wrong," according to the Center for Science in the Public Interest, a health advocacy group. The composition of high-fructose corn syrup is almost identical to table sugar or sucrose (55% fructose, 45% glucose and 50:50, respectively). Calorie-wise, HFCS is a dead ringer for sucrose. Studies show that HFCS and sucrose have very similar effects on blood levels of insulin, glucose, triglycerides and satiety hormones. In short, it seems to be no worse—but also no better—than sucrose, or table sugar. This controversy, say researchers, is distracting us from the more important issue: we're eating too much of all sorts of sugars, from HFCS and sucrose to honey and molasses. The American Heart Association recently recommended that women consume no more than 100 calories a day in added sugars [6 teaspoons]; men, 150 calories [9 teaspoons].

Myth 3: A raw-food diet provides enzymes that are essential to healthy digestion.
The Truth: "Raw foods are unprocessed so nothing's taken away; you don't get the nutrient losses that come with cooking," says Brenda Davis, R.D., co-author of Becoming Raw: The Essential Guide to Raw Vegan Diets (Book Publishing, 2010). But the claim by some raw-food advocates that eating raw boosts digestion by preserving "vital" plant enzymes, Davis explains, just doesn't hold water. "Those enzymes are made for the survival of plants; for human health, they are not essential." What about the claim by some raw-foodistas that our bodies have a limited lifetime supply of enzymes—and that by eating more foods with their enzymes intact, we'll be able to spare our bodies from using up their supply? "The reality is that you don't really have a finite number of enzymes; you'll continue to make enzymes as long as you live," says Davis. Enzymes are so vital to life, she adds, "the human body is actually quite efficient at producing them."

Myth 4: Your body can't use the protein from beans unless you eat them with rice.
The Truth: Proteins—which our bodies need to make everything from new muscle to hormones—are made up of different combinations of 20 amino acids. Thing is, our bodies can make only 11 of these amino acids; we must get the other nine from food. Animal-based protein-rich foods like eggs and meat provide all nine of these "essential" amino acids, but nearly all plant foods are low in at least one. Experts used to say that to get what your body needs to make proteins, you should pair plant-based foods with complementary sets of amino acids—like rice and beans. Now they know that you don't have to eat those foods at the same meal. "If you get a variety of foods throughout the day, they all go into the 'basket' of amino acids that are available for the body to use," says Winston J. Craig, Ph.D., R.D., nutrition department chair at Andrews University in Berrien Springs, Michigan.

Myth 5: Microwaving zaps nutrients.
The Truth: This is misguided thinking, says Carol Byrd-Bredbenner, Ph.D., R.D., professor of nutrition at Rutgers University in New Brunswick, New Jersey. Whether you're using a microwave, a charcoal grill or a solar-heated stove, "it's the heat and the amount of time you're cooking that affect nutrient losses, not the cooking method," she says. "The longer and hotter you cook a food, the more you'll lose certain heat- and water-sensitive nutrients, especially vitamin C and thiamin [a B vitamin]." Because microwave cooking often cooks foods more quickly, it can actually help to minimize nutrient losses.

Myth 6: Radiation from microwaves creates dangerous compounds in your food.
The Truth: Radiation might connote images of nuclear plants, but it simply refers to energy that travels in waves and spreads out as it goes. Microwaves, radio waves and the energy waves that we perceive as visual light all are forms of radiation. So, too, are X-rays and gamma rays—which do pose health concerns. But the microwaves used to cook foods are many, many times weaker than X-rays and gamma rays, says Robert Brackett, Ph.D., director of the National Center for Food Safety and Technology at the Illinois Institute of Technology. And the types of changes that occur in microwaved food as it cooks are "from heat generated inside the food, not the microwaves themselves," says Brackett. "Microwave cooking is really no different from any other cooking method that applies heat to food." That said, microwaving in some plastics may leach compounds into your food, so take care to use only microwave-safe containers.
[Source: The Editors of EatingWell Magazine 16 Sep 2010 ++]

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VA Home Loan Update 23:

With mortgage rates at historic lows, Veterans and military personnel continue to use the Department of Veterans Affairs (VA) home loan program in record numbers to purchase a home or refinance their existing loans. "Home ownership is one of the foundations of the American dream," said Secretary of Veterans Affairs Eric K. Shinseki. "VA is honored to administer a benefit that for two-thirds of a century has profoundly affected the lives of our Veterans, our military Servicemembers, and their families." Since the VA Home Loan program began in 1944 as part of the Montgomery GI Bill, VA has helped Veterans by guaranteeing more than 19 million home loans, valued at more than $1 trillion. During the past four years, the number of Veterans VA has helped purchase a home has risen by 63%t. VA's foreclosure rate for the last nine quarters and serious delinquency rate for the last six quarters have been the lowest in the housing industry, even when compared to prime loans, according to the Mortgage Bankers Association's National Delinquency Survey. In a time where other no down payment programs are virtually non-existent and mortgage credit can be difficult to obtain, Veterans and Servicemembers have an avenue to obtain financing and take advantage of historically low rates through the VA home loan program.

Most Veterans, Servicemembers, Reservists and National Guard members, as well as some surviving spouses, are eligible for the program, which provides an opportunity for borrowers to qualify for no-down payment home loans as well as regular and interest-rate-reduction refinance home loans. VA-guaranteed home loans are made by banks and mortgage lenders, with VA ensuring payment of a portion of the loan if the borrower fails to repay the balance. A unique aspect of VA's program is a commitment to help borrowers keep their homes if they encounter financial difficulties. During the past decade, VA loan specialists have helped more than 150,000 families hold onto their homes when threatened by foreclosure. Shinseki attributed the "professionalism and savvy" of VA employees and the "unshakeable sense of responsibility" among Veterans and military personnel as key factors for maintaining a low foreclosure rate on VA-backed home loans. VA's loan specialists can intervene on a Veteran's behalf with the loan servicer to explore home-retention options, including repayment plans, loan modifications, and forbearance. When home retention is not an option, VA can help arrange a compromise sale or a deed-in-lieu of foreclosure, both of which are less detrimental to borrowers than foreclosure. More information about VA's Home Loan program is available online at http://www.homeloans.va.gov or by calling 1-877-827-3702. [Source: VA News Release 1 Nov 2010 ++]

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VA Home Loan Update 24: If you're an honorably discharged veteran looking for a new mortgage or a refinancing, be sure to check with the VA for their special deals for vets. You can use VA mortgage programs more than once in your lifetime. So if you closed on your VA loan in 2009 or earlier, your interest rate is likely at least 5%. Today's VA rates are 4.25%, so it's worth a refi. For a $250,000 loan, dropping your rate from 5% to 4.2% will save you more than $100 a month. And over the long run, you'll save a fortune in interest charges. That three-quarter point rate cut would save you $40,000 in interest over 30 years. VA loans have been a good investment for the government. Statistics show that VA loans have the second-lowest default rate of any mortgage loan, second only to USDA farm loans. For qualified veterans who want to refinance a previous VA mortgage, the VA automatically approves those who have made all VA mortgage payments on time and have a credit score of 620 to 640. Many lenders offer a no cost automatic appraisal, requiring a value of 95 to 105%t of your mortgage balance. There are VA lenders who allow you to refinance even if you are slightly upside down on your mortgage. The VA charges a 0.5% funding fee, which can be rolled into the new loan amount. For more information on the VA's "Interest Rate Reduction Loan," go to www.benefits.va.gov/homeloans/ eligibility.asp or contact VA mortgage expert Daniel Chookaszian at (312) 376-3760 or e-mail him at dchooks@americanstreet.com. [Source: Chicago Sun-Times Terry Savage article 11 Nov 2010 ++]

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Saving Money: You've probably heard of Doctors Without Borders. Now get ready for doctors without insurance. Thanks to a little-known provision of the Patient Protection and Affordable Care Act, otherwise known as healthcare reform, beginning in 2014, a new type of medical practice will be allowed to compete within state-based insurance exchanges. They're called Direct Primary Care practices, or "medical homes." By eliminating insurance companies from the health care equation, these practices promise to lower the cost of medical care by up to 40%– according to some experts, the amount sucked up by insurance company profit and overhead. Rather than paying an insurance company every month for health coverage, you cut out them out entirely and pay a doctor or group directly. It's like a gym membership – you pay every month whether you go or not, but you can go as often as you want, whenever you want. No insurance, no deductible, no paperwork, no bill. The cost? $50 – $150 per month, depending on your age. And not only is this idea a money-saver, its proponents claim that it could also radically improve the quality of care you receive, because the doctors will be able to spend time with patients that's now spent on paperwork.

How can the simple act of eliminating an insurance company offer both lower costs and better care? To get an idea, consider your car insurance. Suppose that whenever you needed an oil change, an insurance company was going to pay the bill. You don't care how much an oil change costs – that's the insurance company's problem. But because they're paying, the insurance company only allows you to see a mechanic with whom it has negotiated rates and otherwise approved in advance. When you go to the shop, the mechanic has to keep detailed records of exactly what was done to your car and why. In order to get paid for their services, the mechanic will have to submit the proper forms – different for each insurance company they work with – then await approval. If the insurance company reviews the file and decides your car didn't really need an oil change, the mechanic provided services that may not have been necessary, or there's a deductible in your policy, they'll disallow the payment. The mechanic will then be forced to start over and collect their money from you.

Result? Your mechanic is going to spend a lot more time adhering to insurance company guidelines, filling out paperwork, and trying to collect their money – and a lot less time changing oil. Since they don't get paid for doing paperwork, they'll have to work longer hours, charge more, and/or spend less time with your car. In addition, they may find their job less rewarding, since rather than doing what they think is right, they'll instead be doing only what an insurance company mandates. The reason you don't have insurance for things like oil changes is that you don't need it. An oil change isn't a big enough expense to justify the added hassle, overhead and paperwork of working through an insurance company. Proponents of direct primary care offer the same logic for doctor visits. Forget the insurance – just pay a monthly fee and go see a happier doctor as often as you want. And that's where 90% of health care happens: in a doctor's office.

But what about the other 10% of healthcare that happens at a specialist's office, an emergency room or in a hospital? For potentially catastrophic costs, you'll still need insurance – just like you do for your car. So in addition to joining a direct primary care group, you'll still need insurance to cover hospital visits. But since that's all that's covered, it's theoretically much less expensive. Direct primary care isn't for everyone. For example, if you never go to the doctor, maybe you'd prefer to just get a high-deductible policy and skip the $50-$100 month cost of a direct primary care practice. There will also be people (or employers) to whom even $50 a month per person is unaffordable. But this type of innovation could be a partial solution for some employers, as well as the millions who now pay for their own insurance. If you'd like to see what this kind of health care solution looks like, you don't have to wait till 2014. Direct Primary Care practices exist right now. A nationwide list of direct primary care doctors can be seen at. http://www.dpcare.org/practices. For additional info on the concept refer to http://www.dpcare.org. [Source: Money Talks News Stacy Johnson article 1 Nov 2010 ++]

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Notes of Interest

- **Gulf War Syndrome.** The Australian government has rejected the pleas of war veterans to recognize the existence of Gulf War Syndrome, thwarting the hopes of hundreds for extra medical aid and compensation. Despite being recognized in both the United Kingdom and the United States, an investigation by the Repatriation Medical Authority, the results of which were announced in the authority's annual report, found the syndrome was not an injury or disease as defined by Veterans' Entitlements Act.
- **myPay Website.** The myPay online pay account management system features new user improvements designed to streamline user account creation and updating, and to make the website's homepage easier to navigate. The revised homepage now includes easy-to-find helpful links as well as planned system maintenance schedules. **The requirement to recertify e-mail addresses every 180 days has also been eliminated**. Users logging into myPay will now receive a message reminding them to keep their e-mail addresses current. myPay officials are encouraging customers to send in their comments and suggestions about the system. For more information, visit the myPay website https://mypay.dfas.mil/mypay.aspx.

- **Windows XP.** The US Air Force "and the Veterans Affairs Department are leading the way in migration to Microsoft's Windows 7 operating system for personal computers, with the Air Force planning to complete the move by December 2011, while VA last week solicited bids to support what will be a five-year transition project." After noting that Microsoft will "end support for the Windows XP operating system in April 2014
- **Military Family Month.** On 1 NOV 2010 President Barack Obama signed a proclamation designating November as Military Family Month. "I call on all Americans to honor military families through private actions and public service for the tremendous contributions they make in support of our service members and our nation".
- **Wreaths Across America.** Now is the time to start your preparations to participate in the annual Wreaths Across America tradition. Click on http://www.wreathsacrossamerica.org to find a local cemetery where you can participate and order your own wreaths to be donated. This year the wreath placements are scheduled for Saturday, December 11. If you have questions, call 877-385-9504.
- **Security X-ray screening.** The FDA has concluded that the security screening devices used in airports, courts, and other places pose very little risk because the amount of radiation involved is very small. Two types of devices are used. X-ray screening devices deliver less ionizing radiation in a single screening than the amount individuals receive from background radiation in one hour. Millimeter wave technology devices use non-ionizing electromagnetic waves that have no known adverse health effects.
- **Arlington National Cemetery.** The Army's Criminal Investigation Command has launched another investigation into Arlington prompted after Kathryn Condon, executive director of the Army Cemeteries Program, 'recently became aware of questionable practices that took place' at Arlington. This would be at least the third criminal investigation into the cemetery in recent years; none has yet resulted in criminal charges.
- **112th Congress.** Wednesday, 5 JAN, will be the opening day of the 112th Congress. The Constitution says it's supposed to be Jan. 3, but that day is routinely shifted. This time, leaders of both parties agreed to allow lawmakers a little extra travel time after the New Year's holiday.
- **Veteran Cemeteries.** VA has allocated a $6 million grant *to* establish a new state veterans cemetery near Fort Polk, Louisiana. Currently, the closest one is 125 miles away in Natchez, Mississippi.
- **Information Source.** For those who would like to read the news regarding World & U.S. Events, Economics, Sports, Entertainment, and science in the year they were born go to born at http://www.infoplease.com/yearbyyear.html and click on that year.
- **OOPS!** Cartoonist Jim Davis is apologizing for a Garfield strip that some veterans may have found offensive. The strip ran on Veterans Day in newspapers across the country. It shows a spider daring the pudgy orange cat to squash it. The spider tells Garfield that if he is killed, "they will hold an annual day of remembrance in my honor." The final panel shows a spider-teacher asking its class if they know why spiders celebrate "National Stupid Day." In a statement on his website, Davis of Muncie, Ind., says he didn't know the strip would appear on 11 NOV and "it absolutely, positively has nothing to do with this important day of remembrance." He says his brother and son served in the military.

[Source: Various Oct 2010 ++]

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Medicare Fraud Update 52:

- **Los Angeles CA** - Drs. Rodney Barron, 58, and Eleanor Arthur, 72, were arrested 29 OCT and along with five others charged with misdemeanor conspiracy, fraud and taking illegal kickbacks. City prosecutors said homeless people were recruited and taken in a van from various parts of Los Angeles County to RSB Medical Group in the San Fernando Valley. The so-called patients were given abdominal ultrasounds and had blood drawn, regardless of their condition. In exchange, they received $100, authorities said.

Investigators also said the blood was often dripped into open jars and packaged for sale. The clinic allegedly charged the medical programs up to $1,000 per doctor for between 30 and 50 patients daily from December 2009 to June 2010. Prosecutors estimate the scam bilked Medicare and Medi-Cal out of $5 million. The charges were the latest in a string of patient recruiting scams that have cropped up in Los Angeles. Earlier this month, federal prosecutors charged more than 70 people accused of having ties to Armenian mobsters and trying to defraud Medicare of $163 million for services never provided.

[Source: Fraud News Daily reports 1-15 Nov 2010++]

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Medicad Fraud Update 25:

- **Lufken TX** - Dr. Alexander Orlov, 46, pleaded guilty to the charge of conspiracy to defraud Medicare and Medicaid 1 NOV. Since his June arrest, he had continued practicing medicine, accepting only cash, check or credit card as payment. From NOV 08 to APR 2010, Orlov and an employee, Haseeb Rehman, submitted claims for physicians' services to Medicare and Medicaid for services provided by Rehman, who was not a licensed medical professional. Rehman treated patients, prescribed medication, performed minor surgical procedures and operated within Lufkin Urgent Care as if he were a licensed medical professional. Claims were submitted to Medicare and Medicaid for Rehman's services representing that the services were provided by a physician. As a result of these claims, Orlov unlawfully obtained more than $250,000 from Medicare and Medicaid.

[Source: Fraud News Daily reports 1-15 Nov 2010++]

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State Veteran's Benefits:

The state of Hawaii provides several benefits to veterans as indicated below. To obtain information on these refer to the "**Veteran State Benefits – HI**" attachment to this Bulletin for an overview of those benefits listed below. Benefits are available to veterans who are residents of the state. For a more detailed explanation of each click on "**Learn more about** …" wording highlighted in blue on the attachment.

- Housing Benefits
- Financial Assistance Benefits
- Employment Benefits
- Other State Veteran Benefits

[Source: www.military.com/benefits/veteran-benefits/hawaii-state-veterans-benefits Nov 2010 ++]

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Military History:

U-234 was originally constructed as a German mine laying submarine. However, following the loss of U-233 in July 1944 it was decided not to use U-234 as a mine layer and she was instead completed as a long-range cargo submarine with Japan missions in mind. The cargo, to be carried (German advanced weapons technology) was determined by a special commission, the Marine Sonder Dienst Auslands, established towards the end of 1944, and she was directed to make a special voyage to Japan. When loading was completed, they were carrying 240 tons of cargo plus sufficient diesel fuel and provisions for a six-to-nine month voyage. The cargo included technical drawings, examples of the newest electric torpedoes, one crated Me 262 jet aircraft, a Henschel Hs 293 glide bomb, and what was listed on the U.S. Unloading Manifest as 560 kg of uranium oxide. The exact characteristics of the uranium remain unknown; it has been suggested that it may not have been weapons-grade material and was instead intended for use as a catalyst in the production of synthetic methanol for

aviation fuel. When the cargo had been loaded, U-234 carried out additional trials near Kiel, then returned to Kiel where her passengers came aboard.

The twelve passengers, included a German general, four German naval officers, civilian engineers and scientists, and two Japanese naval officers. The German personnel included General Ulrich Kessler of the Luftwaffe, who was to take over Luftwaffe liaison duties in Tokyo; Kai Nieschling, a Naval Fleet Judge Advocate who was to rid the German diplomatic corps in Japan of the remnants of the Richard Sorge spy ring; Dr. Heinz Schlicke, a specialist in radar, infra-red, and countermeasures and director of the Naval Test Fields in Kiel (later recruited by the USA in Operation Paperclip); and August Bringewalde, who was in charge of Me 262 production at Messerschmitt. The Japanese passengers were Lieutenant Commander Tomonaga Hideo of the Imperial Japanese Navy, a naval aviator and submarine specialist who had come to Germany in 1943 on Japanese submarine I-29, and Lieutenant Commander Shoji Genzo, an aircraft specialist and former naval attaché. U-234 sailed from Kiel for Kristiansand, Norway in the evening of 25 MAR 1945 and subsequently for Japan on 15 APR, running submerged at schnorchel (air passage provided by a retractable device containing intake and exhaust pipes which allows a submarine to stay submerged for extended periods of time) depth for the first 16 days, and surfacing after that only because her commander Kapitänleutnant Johann-Heinrich Fehler considered he was safe from attack on the surface in the prevailing severe storm. From then on, she spent two hours running on the surface by night, and the remainder of the time submerged. The voyage proceeded without incident, and the first sign that world affairs were overtaking the voyage was when the German Navy's Goliath transmitter stopped transmitting, followed shortly after by the Nauen station; Fehler did not know it, but Germany's naval HQ had fallen into Allied hands.

Then, on 4 MAY, she received a fragment of a broadcast from British and American radio stations announcing that Admiral Karl Dönitz had become Germany's head of state following the death of Adolf Hitler. U-234 finally surfaced on 10 MAY in the interests of better radio reception and received Dönitz's last order to the submarine force, ordering all U-boats to surface, hoist white flags, and surrender to Allied forces. Fehler suspected a trick and he was practically equidistant from British, Canadian and American ports. He decided not to continue his journey, and instead headed for the east coast of the United States. Fehler thought it likely that if they surrendered to Canadian or British forces, they would be imprisoned and it could be years before they were returned to Germany, and believed that the U.S., on the other hand, would probably just send them home. He consequently decided that he would surrender to US forces, but radioed on 12 MAY that he intended to sail to Halifax, Nova Scotia to surrender to ensure Canadian units would not reach him first. U-234 then set course for Newport News, Virginia, Fehler taking care to dispose of his Tunis radar detector, the new Kurier radio communication system, and all Enigma related documents and other classified papers. On learning that the U-boat was to surrender, the two Japanese passengers who had been placed under arrest, committed suicide by taking an overdose of Luminal (a barbiturate sleeping pill).

The difference between Fehler's reported course to Halifax and his true course was soon realized by U.S. authorities who dispatched two destroyers to intercept him. On 14 MAY she was encountered south of the Grand Banks by the USS Sutton. Members of the Sutton's crew took command of the U-boat and sailed her to the Portsmouth Naval Shipyard, where the U-805, U-873, and U-1228 had already surrendered. News of the U-234's surrender with her high-ranking German passengers made the event a major news event. Reporters swarmed over the Navy Yard and went to sea in a small boat for a look at the submarine. The fact that she had a half ton of uranium oxide on board was covered up and remained classified for the duration of the Cold War. A U.S. intelligence summary of 19 May merely listed U-234's cargo as including "a/c [aircraft], drawings, arms, medical supplies, instruments, lead, mercury, caffeine, steels, optical glass and brass." The uranium subsequently disappeared, most likely finding its way to the Manhattan Project's Oak Ridge diffusion plant; it has been calculated that it would have yielded approximately 7.7 pounds (3.5 kg) of U-235 after processing, around 20% of what would have been required to arm a contemporary fission weapon.

The idea that the uranium oxide might have been intended to be used by Japan for the development of atomic weapons does not hold up to scrutiny. Germany, whose atomic program was far more advanced than Japan's, had themselves given up any attempt to make an atom bomb by 1943. Also, of the German scientists on board U-234 none were nuclear scientists. Most likely the uranium oxide was to be used by the Japanese as a catalyst for the production of synthetic methanol used for aviation fuel, not a bomb. As she was unneeded by the U.S. Navy, U-234 was sunk off Cape Cod as a torpedo target. She was destroyed by the USS Greenfish (SS-351) on 20 NOV 1947. [Source: http://en.wikipedia.org/wiki/German_submarine_U-234 Nov 2010 ++]

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Military History Anniversaries:

Significant November Events in U.S. Military History are:

- Nov 16 1944 - WWII: Dueren, Germany is completely destroyed by Allied bombers.
- Nov 16 1945 - Cold War: Operation Paperclip - The United States Army secretly admits 88 German scientists and engineers to help in the development of rocket technology.
- Nov 17 1913 - The first ship sails through the Panama Canal, which connects the Atlantic and Pacific oceans.
- Nov 17 1970 - Vietnam: Lieutenant William Calley goes on trial for the My Lai massacre.
- Nov 19 1861 - Civil War: Julia Ward Howe writes "The Battle Hymn of the Republic" while visiting Union troops.
- Nov 19 1861 - Civil War: The Confederate raider Nashville captured and burned the Union clipper ship Harvey Birch in the Atlantic Ocean.
- Nov 19 1863 - Civil War: Lincoln delivers the "Gettysburg Address" at the dedication of the National Cemetery at the site of the Battle of Gettysburg
- Nov 20 1943 - WWII: U.S. Marines landed on Tarawa in the Gilbert Islands, one of the bloodiest campaigns waged by American forces against the Japanese in the Pacific.
- Nov 20 1950 - Korea: U.S. troops push to the Yalu River, within five miles of Manchuria.
- Nov 21 1864 - Civil War: From Georgia, Confederate General John B. Hood launches the Franklin-Nashville Campaign into Tennessee
- Nov 23 1863 - Civil War: Union forces win the Battle of Orchard Knob, Tennessee.
- Nov 23 1863 - Civil War: The Battle of Chattanooga in Tennessee, one of the most decisive battles of the War, begins.
- Nov 23 1941 U.S. troops move into Dutch Guiana, by agreement with the Netherlands Government in exile, to guard the bauxite mines to protect aluminum ore supplies from the mines in Surinam.
- Nov 23 1968 - Vietnam: Battle of Nui Chom Mountain. The 4th Bn, 31st Infantry, 196th Inf Bde fought and destroyed the 21st NVA Regiment on Nui Chom Mountain southwest of Da Nang in a fierce six day battle.
- Nov 24 1943 - WWII: The USS Liscome Bay is torpedoed near Tarawa and sinks with nearly 650 men killed.
- Nov 23 1944 - WWII: The first bombing raid against Tokyo is carried out by 88 American aircraft from Saipan.
- Nov 24 1979 - The United States admits that thousands of troops in Vietnam were exposed to the toxic Agent Orange.
- Nov 25 1940 - WWII: First flight of the deHavilland Mosquito and Martin B-26 Marauder.
- Nov 26 1941 - WWII: The Japanese fleet departs from the Kuril Islands en route to its attack on Pearl Harbor.
- Nov 27 1950 - Korea: China sent 200,000 troops across the border of Korea at Chosin Reservoir to attack U.N. forces..

- Nov 27 1950 East of the Choosing River, Chinese forces annihilate an American task force.
- Nov 28 1941 - WWII: The aircraft carrier USS Enterprise departs from Pearl Harbor to deliver F4F Wildcat fighters to Wake Island. This mission saves the carrier from destruction when the Japanese attack.
- Nov 30 1782 - American Revolution: The British sign a preliminary agreement in Paris, recognizing American independence
- Nov 30 1942 - WWII: Guadalcanal Campaign Battle of Tassafaronga - A smaller squadron of Japanese destroyers defeats a US cruiser force.
- Nov 30 1950 - Korea: President Truman declares that the United States will use the A-bomb to get peace.
- Nov 30 1995 - Official end of Operation Desert Storm.

[Source: Various Nov 2010 ++]

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Military Trivia 16:

1. The US Merchant Marine is a civilian cargo fleet in peacetime. It only becomes a naval auxiliary force in times of war. The most extensive nationalization of the US fleet was during World War II. Naval military personnel (officially referred to as the US Naval Armed Guard) were posted to Merchant Marine ships, and mariners received special training in naval weapons systems of the day. Mariners themselves continued to be paid by the owners of these civilian ships, a fact not lost on the Civilian Review Board when mariners would apply for veterans benefits years later.

2. People who serve in the Merchant Marine cannot be referred to as Marines. The term "marine" refers to those serving in the branch of the armed forces ostensibly dedicated to amphibious warfare. People in the Merchant Marine are usually referred to as mariners, though terms like seamen, seafarers, and sailors are also used. Neither the USMC nor the Merchant Marine are too crazy about mariners being called marines.

3. Many historians of the Merchant Marine trace its origins back to the American Revolution, but this force was not officially chartered until Japanese imperialism in the 1930s made large-scale maritime war an imminent possibility. There is a valid case to be made that the antecedents of the Merchant Marine can indeed be found in the private fleets that were dedicated to Revolutionary service in 1775. More specifically, mariner partisans trace their origins to a group of Maine sailors who captured the HMS Margarita in the wake of the Battle of Lexington, thus the claim that this service predates the US Navy. The Merchant Marine was not officially chartered, however, until the Merchant Marine Act of 1936, decades after cession of hostilities with Spain.

4. Though usually not included as a branch of military service, the Merchant Marine had (by most accounts) a higher percentage of war dead during World War II than any of the armed forces. Out of approximately 243,000 mariners who served during World War II, the Merchant Marine had 9,497 war dead, including those killed at sea and those killed in POW camps, for a ratio of 1 in 26. In comparison, the Marine Corps had 19,733 war dead out of 669,108 serving (1 in 34), the army lost 234,874 out of approximately 11,288,000 (1 in 48) and the Navy had 36,958 war dead out of 4,183,466 serving (1 in 114).

5. During World War II, Merchant Marine ship masters were under standing orders to scuttle their ships whenever capture appeared inevitable. As a result, only one Merchant Marine craft was captured during the conflict. The only Merchant Marine ship captured during the conflict was the SS City of Flint, taken by a German pocket battleship in 1939, a full two years before the United States entered the war. She was eventually released.

6. During the Battle of Guadalcanal, mariners did not refused to unload ships under fire. This duty was taken up grudgingly by US Marines who were too ill for combat duty. This rumor was started by notoriously unreliable

gossip columnist Westbrook Pegler. Following the war, Pegler and fellow columnist Walter Winchell, who had also disparaged the Merchant Marine in his columns, lost numerous libel suits over the false Guadalcanal claims, and were forced to print retractions and pay damages. These refutations were bolstered by the public affirmations of Admiral William Halsey, who praised the mariners for their cooperation and courage. Winchell in particular would further lose credibility following the war for his strident McCarthyism; his bias against the unionized mariners may have stemmed from his association of labor unions with communism. On a related note, mariners were subject to court martial under the Articles of War all through the conflict. Though dozens of mariners were court-martialed during the war (mostly for offenses such as AWOL, assault, and theft), none were charged with cowardice at Guadalcanal.

7. All retired mariners have not been routinely eligible for full veterans benefits after a requisite time of service. This is a bone of contention within the Merchant Marine community. During World War II, President Roosevelt (a former Secretary of the Navy) repeatedly seemed to pledge full veteran status for merchant mariners. After the war, however, most of these sailors were denied veterans benefits by the Civilian Review Board. Some WWII-era mariners were granted veterans benefits in 1988, and another group was given this status ten years later. At present the World War II Merchant Marine Service Act (H.R.5829), which seeks to expand which documents are accepted by the U.S. Secretary of Defense in determining Merchant Marines' eligibility for veterans benefits has only 35 cosponsors. In sum, the veteran status of Merchant Marines can best be described as inconsistent. More information on this topic can be found at the U.S. Maritime Service Veterans website, http://www.usmm.org

8. The US Merchant Marine Academy is not governed or regulated by the US Naval Academy at Annapolis, VA. The US Merchant Marine Academy has been located at Kings Point, NY since the facility was completed in 1943. The academy boasts a full academic curriculum, and even features a lengthy roster of intercollegiate varsity sports teams.

9. The US Merchant Marine Academy began admitting female students in 1974, two years before its Army and Navy counterparts at West Point and Annapolis. The US Military Academy and the US Naval Academy, as well as the Air Force Academy at Colorado Springs and the Coast Guard Academy in New London, CT, did not admit women until 1976. Unlike these other academies, however, graduates of the Merchant Marine Academy fulfill their service on their own, either with US government services or in approved private sector jobs, rather than being assigned a post. For more information on the Academy, visit their website at http://www.usmma.edu/

10. Notable attendees of the Merchant Marine Academy include former George W. Bush and Chief of Staff Andrew Card who was stuffed in a duffel bag and run up a flagpole as a young plebe. This story was related by President Bush during his commencement address at the Academy in 2006. Perhaps because of the duffel bag incident (at least in part), Card later transferred to the University of South Carolina, where he earned a degree in Engineering. Card left the Bush administration in April of 2006.
[Source: http://www.funtrivia.com/quizzes/world/military_matters/us_military.html Nov 2010 ++]

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Tax Burden for South Carolina Retirees:

Many people planning to retire use the presence or absence of a state income tax as a litmus test for a retirement destination. This is a serious miscalculation since higher sales and property taxes can more than offset the lack of a state income tax. The lack of a state income tax doesn't necessarily ensure a low total tax burden. Following are the taxes you can expect to pay if you retire in South Carolina**:**

Sales Taxes

State Sales Tax: 6% (prescription drugs and unprepared food items exempt); 25 counties impose an additional 1% local option sales tax; a number of counties impose a 2% sales tax. Seniors 85 and older pay 4%.
Gasoline Tax: 16.8 cents/gallon.
Diesel Fuel Tax: 16.8 cents/gallon.
Cigarette Tax: 7 cents/pack of 20

Personal Income Taxes
Tax Rate Range: Low - 3.0%; High - 7%; No tax on the first $2,630 of taxable income in tax year 2007.
Income Brackets: Six. Lowest - $2,670; Highest - $13,350
Personal Tax Exemptions: Single - $3,500; Married - $7,000; Dependents - $3,500. State allows personal exemption or standard deductions as provided in the Internal Revenue Code.
Standard Deduction: Single - $5,450; Married filing jointly - $10,900
Medical/Dental Deduction: Federal amount
Federal Income Tax Deduction: None

Retirement Income:
Retirement Income Taxes: Retirement income is taxed. Social Security exempt. You can take this deduction for income received from any qualified retirement plan. If both spouses receive retirement income, each spouse is entitled to an individual deduction. At 65, the deduction is $15,000. The $15,000 deduction must be offset by any other retirement deduction that is claimed. A surviving spouse may continue to tackle a retirement deduction on behalf of the deceased spouse. Some taxpayers age 65 and older may not have to file a tax return if they meet certain conditions. For more information refer to http://www.sctax.org/Tax+Information/Individual+Income+Tax/IIT_FAQs.htm#Retirees.
Retired Military Pay: Retirees with 20 or more years of active duty can deduct up to $3,000 annually until age 65 and up to $10,000 per year after age 65. This deduction extends to the surviving spouse. Pension or retirement income received for time served in the National Guard or Reserve components is not taxable. Survivor benefits are taxed following federal tax rules.
Military Disability Retired Pay: Retirees who entered the military before Sept. 24, 1975, and members receiving disability retirements based on combat injuries or who could receive disability payments from the VA are covered by laws giving disability broad exemption from federal income tax. Most military retired pay based on service-related disabilities also is free from federal income tax, but there is no guarantee of total protection.
VA Disability Dependency and Indemnity Compensation: VA benefits are not taxable because they generally are for disabilities and are not subject to federal or state taxes.
Military SBP/SSBP/RCSBP/RSFPP: Generally subject to state taxes for those states with income tax. Check with state department of revenue office.

Property Taxes
Property tax is assessed and collected by local governments. Both real and personal property are subject to tax. The market value of a legal residence and up to 5 acres of surrounding land is assessed at 4%. For homeowners 65 and older, the state's homestead exemption allows the first $50,000 of their property's fair market value to be exempt from local property taxes. South Carolina imposes a casual excise tax of 5% on the fair market value of all motor vehicles, motorcycles, boats, motors and airplanes transferred between individuals. For more information refer to http://www.sctax.org/NR/rdonlyres/697481DB-B8B7-4FF2-93E0-3DC59231B700/0/HomeownersGuidetoPropertyTaxes.pdf & http://www.sctax.org/NR/rdonlyres/A2658985-25CB-4080-8999-97EE0C98F79F/0/SCPropertyTaxBook2008.pdf

Not found on the state's web site is a reassessment provision called "Point of Sale" introduced during the property tax reform of 2006 enacted by the General Assembly. According to this provision, when a property is purchased the assessed value of the property becomes the sale price. The South Carolina Association of Realtors and the state

Chamber of Commerce are joining forces to lobby lawmakers for property-tax assessment modifications in 2010.

Inheritance and Estate Taxes - There is no inheritance tax and the estate tax is related to federal estate tax collection.

For further information, visit the South Carolina Department of Revenue site http://www.sctax.org/default.htm or 800-763-1295. If you are planning to move to South Carolina, the link http://www.sctax.org/NR/rdonlyres/F2D93705-474A-4ECB-8577-BE4D7B513946/0/MovingtoSouthCarolina.pdf will provide you with some helpful information.
[Source: www.retirementliving.com Nov 2010 ++]

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Congressional Alphalist:

To better understand what is happening to veteran legislation as it proceeds through Congress it is useful to know the language used by our representatives as they conduct business. Following are some of the words or expressions you will see while reading about or listening to House and Senate sessions:

- ***PAGES.*** high-school age students who perform messenger and other duties for members of Congress. Pages are required to attend daily classes, live in supervised dorms, and work in shifts on the floor.
- ***PAIRED VOTE.*** A Paired Vote is an agreement between two members to be recorded on opposite sides of an issue. Pairing is used when one or both members will be absent in order to cancel the effect of the absence. Paired votes are not counted in the vote total. However paired members' positions do appear in the record.
- ***PARLIAMENTARIAN.*** Both the House and Senate employ a Parliamentarian to advise the chair on proper parliamentary procedure. The Parliamentarian is a non-partisan employee who also gives guidance and advice to individual members.
- ***PARLIAMENTARY INQUIRY.*** A Parliamentary Inquiry is posed by a member on the floor to the chair asking for procedural clarification.
- ***PASTORE RULE.*** The Pastore Rule requires all debate be relevant to the pending bill for the 1st 3 hours of a day's session. The rule is now seldom enforced, and is named for Sen. John Pastore (D-RI) who served from 1950-1976.
- ***PAYGO.*** The PAYGO or pay-as-you-go rule compels new spending or tax changes to not add to the federal deficit. New proposals must either be "budget neutral" or offset with savings derived from existing funds.
- ***PENNSYLVANIA AVENUE.*** The downtown Washington, DC street connecting the U.S. Capitol with the White House. Members will often refer to "the other end of Pennsylvania Ave." when speaking of the White House.
- ***POCKET VETO.*** A Pocket Veto is when the President fails to sign a bill within the 10 days allowed by the Constitution. Congress must be in adjournment in order for a pocket veto to take effect. If Congress is in session and the president fails to sign the bill, it becomes law without his signature.
- ***POINT OF ORDER.*** A Point of Order is made during floor proceedings to assert that the rules of procedure are being violated. A point of order halts proceedings while the presiding officer rules on whether or not it is valid. In the Senate, the chair's ruling may be appealed by any Senator. The Senate votes on the appeal and the chair has been frequently overturned. In the House tradition, appeals are also possible, but rarely entered and almost never succeed.
- ***POINT OF PERSONAL PRIVILEGE.*** A Point of Personal Privilege is asserted by a member to defend his/ her rights, reputation, or conduct. If the chair determines the point is valid, the member is given one hour of debate time. No vote is held.

- ***PORK BARREL LEGISLATION.*** "Pork barrel" came into use as a political term in the post-Civil War era. It comes from the plantation practice of distributing rations of salt pork to slaves from wooden barrels. When used to describe a bill, it implies the legislation is loaded with special projects for Members of Congress to distribute to their constituents back home as an act of largesse, courtesy of the federal taxpayer.
- ***POSTAL PATRON.*** Anyone with a mailing address recognized by the U.S. Post Office. Members of Congress are permitted to mail newsletters and notices addressed only to "postal patron."
- ***POWER OF THE PURSE.*** Refers to the constitutional power given Congress to raise and spend money.
- ***PRECEDENTS.*** Refers to rulings of the chair in earlier Congresses which clarify legislative procedures.
- ***PRESIDENT OF THE SENATE.*** The Vice-President of the United States, according to the Constitution.
- ***PRESIDENT PRO TEMPORE.*** The senator who presides over the Senate in the absence of the V-P. The position is usually given to the most senior senator of the majority party. The Constitution names the Vice-President as the "president" of the Senate but he rarely presides.
- ***PRESIDING OFFICER.*** A majority party senator who presides over the floor for a shift of about one hour. The chair is addressed as "Mr. President." First-term senators serve in the chair most often. Duties while in the chair include keeping order, recognizing senators to speak, and ruling on procedure.
- ***PREVIOUS QUESTION.*** A motion to end debate and bring the pending matter to an immediate vote. If the previous question loses, the pending matter could be amended and debated for another hour.
- ***PRIVATE BILLS.*** Bills introduced on behalf of an individual citizen for a limited and unique purpose. If enacted by both the House & Senate and approved by the president, they become private, not public, law.
- ***PRIVATE CALENDAR.*** The Private Calendar is called twice a month in order to consider private bills under expedited procedures.
- ***PRIVILEGE.*** Refers to the priority granted specific bills and motions compared to others. Privileged questions may be called up for floor consideration ahead of other matters.
- ***PRO FORMA AMENDMENT.*** An amendment "in form only." It is offered not to truly amend the language of a bill but to qualify for 5 minutes of debate time. Examples of pro forma amendments include motions to "strike the last word," or "strike the requisite number of words."
- ***PRO FORMA SESSION.*** A daily meeting of the House or Senate during which no votes are held and no legislative business is conducted. The session "in form only" is held for purposes of meeting the 3-day rule in the Constitution. It requires each House to gain the permission of the other for recesses longer than 3 days. When the permission is not forthcoming, or not requested in time, the affected chamber convenes briefly with hardly anyone in attendance [the opening prayer, routine announcements, and sometimes short non-legislative speeches are conducted], and then adjourns.
- ***PROXY - HOUSE.*** A vote cast by one member for another who is absent. The House no longer permits any proxy voting, either in committee or on the House floor.
- ***PROXY - SENATE.*** A vote cast by one member for another who is absent. The Senate allows proxy voting in committee but not on the floor.
- ***THE PUBLIC DEBT.*** The maximum level of debt which existing law permits the federal government to incur. Once the debt limit is reached, Congress must enact a new law raising the permissible ceiling. The federal government borrows money from many sources: e.g. The public, trust funds & foreign governments.
- ***PUBLIC LAW.*** A Public Law, or P.L., is designated by the number of the Congress and the order in which it is enacted. For example, P.L. 106-10, is the tenth law enacted during the 106th Congress.
- ***TO PUT THE QUESTION.*** To place the question of final passage before the House or Senate for a vote.

[Source: C-SPAN Congressional Glossary Nov 2010 ++]

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Veteran Legislation Status 13 NOV 2010:

Congress returned from its election recess 15 NOV and begin its post-election lame duck session. The lame duck session breaks for one-week on 22 NOV for Thanksgiving, and returns 29 NOV. For or a listing of Congressional bills of interest to the veteran community that have been introduced in the 111th Congress refer to the Bulletin's "**House & Senate Veteran Legislation**" attachments. 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. Any number of members may cosponsor a bill in the House or Senate. At http://thomas.loc.gov you can 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/d111/sponlst.html.

Grassroots lobbying is perhaps the most effective way to let your Representative and Senators know your opinion. Whether you are calling into a local or Washington, D.C. office; sending a letter or e-mail; signing a petition; or making a personal visit, Members of Congress are the most receptive and open to suggestions from their constituents. The key to increasing cosponsorship on veteran related bills and subsequent passage into law is letting legislators know of veteran's feelings on issues. You can reach their Washington office via the Capital Operator direct at (866) 272-6622, (800) 828-0498, or (866) 340-9281 to express your views. Otherwise, you can locate on http://thomas.loc.gov your legislator's phone number, mailing address, or email/website to communicate with a message or letter of your own making. Refer to http://www.thecapitol.net/FAQ/cong_schedule.html for dates that you can access your legislators on their home turf. [Source: RAO Bulletin Attachment 13 Nov 2010 ++]

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Have You Heard?

An old prospector shuffled into the town of El Paso, Texas leading an old tired mule. The old man headed straight for the only saloon in town, to clear his parched throat. He walked up to the saloon and tied his old mule to the hitch rail. As he stood there, brushing some of the dust from his face and clothes, a young gunslinger stepped out of the saloon with a gun in one hand and a bottle of whiskey in the other. The young gunslinger looked at the old man and laughed, saying, "Hey old man, have you ever danced?" The old man looked up at the gunslinger and said, "No, I never did dance... never really wanted to."

A crowd had gathered as the gunslinger grinned and said, "Well, you old fool, you're gonna' dance now," and started shooting at the old man's feet. The old prospector, not wanting to get a toe blown off, started hopping around like a flea on a hot skillet. Everybody was laughing, fit to be tied. When his last bullet had been fired, the young gunslinger, still laughing, holstered his gun and turned around to go back into the saloon. The old man turned to his pack mule, pulled out a double-barreled shotgun, and cocked both hammers. The loud clicks carried clearly through the desert air.

The crowd stopped laughing immediately. The young gunslinger heard the sounds too, and he turned around very slowly. The silence was almost deafening. The crowd watched as the young gunman stared at the old timer and the large gaping holes of those twin barrels.. The barrels of the shotgun never wavered in the old man's hands, as he quietly said, "Son, have you ever kissed a mule's ass?" The gunslinger swallowed hard and said, "No sir..... but I've always wanted to." There are two lessons for us all here:

1. Don't waste ammunition.
2. Don't mess with old people.

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"Anyone who likes golf on television would enjoy watching the grass grow on the greens"
--- **Andy Rooney of 60 minutes fame**

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Lt. James "EMO" Tichacek, USN (Ret)
Associate Director, Retiree Assistance Office, U.S. Embassy Warden & IRS VITA Baguio City RP
PSC 517 Box RCB, FPO AP 96517
Tel: (951) 238-1246 in U.S. or Cell: 0915-361-3503 in the Philippines.
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