S. HRG. 109–636

THE LEGISLATIVE PRESENTATION OF PARALYZED VETERANS OF AMERICA, THE BLINDED VETERANS OF AMERICA, THE NON-COMMISSIONED OFFICERS ASSOCIATION, THE MILITARY ORDER OF THE PURPLE HEART, AND THE JEWISH WAR VETERANS OF THE USA

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

MARCH 9, 2006

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MARCH 9, 2006

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THURSDAY, MARCH 9, 2006

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD–G50, Dirksen Senate Office Building, Hon. Larry E. Craig, Chairman of the Committee, presiding.

Present: Senators Craig, Burr, Akaka, and Salazar.

OPENING STATEMENT OF HON. LARRY E. CRAIG, CHAIRMAN, U.S. SENATOR FROM IDAHO

Chairman CRAIG. Good morning, ladies and gentlemen. The Committee on Veterans' Affairs will come to order.

It is my pleasure to welcome all of you. Your presence here today is a strong showing for your commitment and your advocacy to America's veterans. I am pleased that many of you have traveled great distances to carry on this tradition. I understand that several people who are here today have made that trip from my home State of Idaho, and I am going to offer them a very special welcome. Any Idahoans in the crowd?

Maybe that trip was just a little too long.

[Laughter.]

This past year has been an extremely gratifying one for me. My first as Chairman of the Veterans' Affairs Committee. I sincerely believe that this Committee and its Members, while sometimes differing in approaches, are all united in one common mission: ensuring that our Nation's veterans, particularly veterans wounded in the line of duty, receive the highest quality of health care and benefits that they need.

By any measure, we have had a busy and a productive first session, convening 21 hearings here in Washington, 9 field hearings, 4 mark-ups. More importantly, Committee-related activities have led to several important accomplishments.

About a year ago, I walked into my office to meet three marvelous young veterans of Operation Iraqi Freedom. One was miss-

ing a leg, another was missing both legs, and the third could no longer see. They brought me a legislative proposal to create a new insurance benefit for those who had suffered traumatic injuries such as theirs; mind you, a proposal not for them, but for their friends, for their comrades. I was impressed with their selflessness.

With Senator Akaka on board, I immediately took to the floor of the Senate with their proposal. With VSO support, many of you in this room supported us, it was signed into law a few weeks later, and there is a result there we can now measure and be proud of. As of last week, VA has paid almost 1,500 traumatically injured servicemembers from OIF and OEF.

[Applause.]

Thank you. These are young men and women with amputations, severe burns, total blindness, total deafness, paralysis, and a host of other disabilities, all of them sustained in defense of all of us. Going forward, wounded warrior insurance will fill a gap in financial help faced by these heroes and their families during convalescence.

Before I close, let me touch on what has consumed much of our attention of late, and that of course is something you are here to talk about today, the 2007 VA budget. I believe this record budget request is extraordinary, and shows that in this fiscal austere time the President has chosen to make veterans once again a top priority.

In fact, I just came from an early morning hearing on the Department of Agriculture's budget. That budget was cut by over $4 billion in real dollars from last year, and that is true of many budgets across our country and across our government.

I just came down from a hearing that is going on just above us, with Secretary Rice and Secretary Rumsfeld asking for a substantial supplemental to make sure that our men and women in uniform who are standing in harm's way at this moment are appropriately served.

The VA budget, by its current track, will double nearly every 6 years, and will soon collide with spending demands in all other areas of government. Although we may wish that VA funding existed in a vacuum, we all know it doesn't. Many of you have been here year after year, fighting for those you believe in and fighting for America's veterans, and this Committee will not take second place in that similar fight.

As I am sure everyone is aware, the President proposed one way for us to help in this fiscal austere time by asking priorities sevens and eights, with no service-related disabilities, to contribute about $21 per month to enroll in the VA health care system and to pay about $15 for a 30-day supply of medicine. Although I personally find this proposal reasonable, I know that many of you have voiced opposition; certainly many on this Committee have.

So I must reiterate my hope that your organizations and others will engage this Committee in a serious and candid discussion, if not about the President's proposals, then about other options. It is our collective responsibility to sustain this unparalleled VA health care system into the future. If we begin addressing these issues now, we can help assure that future veterans will not be faced with

even bigger challenges and more radical changes to meet those challenges.

Personally, I do not want to pass this issue on to the next guy or the next chairman. I want to pass on to tomorrow's veterans what we can collectively create for the future, because we know what we have done together is good. We have, by our investment and your advocacy—and I say "ours," the American taxpayers' investment—we have created one of the number one health care delivery systems in the world for America's veterans.

I hope you agree with my goals. I think they are shared by everyone. I think the next few years will be ones of progress and wisdom in handling veterans' issues. I look forward to hearing your testimony and a continued dialogue with you, your organizations, about the many important issues concerning veterans today.

Certainly in the spirit of that I once again extend a warm welcome to all of you for joining us today. And before I introduce our panel of the morning, let me turn to my colleague and Ranking Member on the Committee for any opening remarks he would like to make, Senator Danny Akaka.

Senator Akaka.

STATEMENT OF HON. DANIEL K. AKAKA, RANKING MEMBER, U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you, Mr. Chairman. It is certainly a pleasure to be with all of you today, and I want to add my welcome along with yours, Mr. Chairman, to all of you who have come this morning.

I want to thank the organizations here today, as well as all the veterans and their families who have made the journey to the Nation's Capital to express their concerns. This is, without question, truly democracy in action. Your organizations have a proud tradition of public service. This Committee relies heavily on your concerns and your agendas for the coming year.

I want to welcome Dr. Roy Kekahuna from the Blinded Veterans Association, who is from Hawaii. If you are here, will you raise your hand, Roy? Oh, there you go. Thank you so much for being here.

[Applause.]

I remember last month, Roy, that you testified before this Committee during the field hearings in our home State of Hawaii. After reviewing your testimony, I share many of your concerns and priorities.

During this time last year, many of us here in Congress were sounding the alarm that the VA budget was facing a crisis situation, and many months later the Administration acknowledged this fact, and Congress took action to provide emergency funding. I want to say that Chairman Craig kept his promise and was a driving force behind the emergency funding. I applaud him for his efforts.

When we started working together last year, we pledged to work in a bipartisan manner, and without question we have done so. There are times, however, when we agree to disagree. We both agree that veterans deserve to have the best health care services and benefits, though sometimes disagree on how we pay for it.

I want to be clear, however, that we have the same goal, and that is to ensure that VA is provided with the resources to provide quality care and service to our Nation's veterans. I remain dedicated to ensuring that VA has the resources and needs to care for our veterans. We must learn a lesson from last year's budget crisis and do everything we can to ensure that veterans and their families have access to the health care and benefits they have earned.

VA's budget has increased over the past 6 years, as it should. The cost of caring for our veterans is, in my opinion, a cost of war. If the Department of Defense's budget can grow as it has and be funded yearly out of supplementals, it only makes sense that VA's budget needs to grow equally as well. It is no secret that each servicemember that is funded out of DOD will eventually be seeking services from VA. It follows, then, that if DOD's budget grows steadily, VA's budget must grow steadily as well.

For me it is a matter of priorities. We must stand by our veterans and ensure that they receive the care and services that they have earned through their service to our country, and we must ensure that we care for all veterans. We cannot fund the VA system out of the pockets of the middle-income veterans, as many of these men and women make only as little as $26,902 a year. Higher copayments and enrollment fees I feel are not justified.

To date, over a quarter of a million veterans have been excluded from VA health care. Over 700 veterans in Hawaii have knocked on the doors of VA, asking for care, only to be denied. We must work to overturn this Administration's decision and open the VA system up to those who need it.

I also am concerned about the VA research program being slated for a cut under this budget. Since its inception, the VA research program has made landmark contributions to the welfare of not only veterans but the entire Nation, illustrating the unique importance of keeping it adequately funded. With thousands of military personnel engaged in conflict overseas, it is vital that Congress invest in research that could have a direct impact on their post-deployment quality of life.

With regard to the VBA budget, I am concerned whether or not this budget provides an adequate level of staffing for compensation claims rating. VA must be ready to adjudicate claims in a timely and accurate manner. Our veterans and their families deserve nothing less.

[Applause.]

I will continue to oppose efforts to reduce veterans' compensation as we say with the ill-fated PTSC review. Now the Institute of Medicine and the Veterans' Disability Benefits Commission are reviewing veterans' disability compensation. It is my hope that these groups will recommend new ways for Congress to improve benefits, and not call for cuts in current benefits.

My next priority is near and dear to my heart. As a veteran of World War II, I owe a great deal of where I am today to the GI Bill educational benefits I used as a young man. I should tell you in those days I received $113 a month, and it was good enough to take care of my needs and pay for all of my tuition. With this in mind, I will continue to look for ways to enhance and modernize

educational benefits to more adequately prepare veterans for the new challenges of our economy.

In closing, I would like to once again thank all of you for being here today. Your service and your dedication to this Nation and its veterans are unquestionable. I look forward to your presentation and working with you in the future.

Thank you very much, Mr. Chairman.

[Applause.]

Chairman CRAIG. Danny, thank you very much.

Now let's turn to Senator Ken Salazar of Colorado for any opening statement Ken may have.

STATEMENT OF HON. KEN SALAZAR, U.S. SENATOR FROM COLORADO

Senator SALAZAR. Thank you, Chairman Craig and Ranking Member Akaka. I appreciate the fact that you hold these hearings, and I also appreciate the leadership that you provide in this U.S. Senate and this Committee. I think the kinds of hearings that we have, including the one here today, demonstrate the kind of leadership that we have from both you, Mr. Chairman, as well as Senator Akaka, our Ranking Member.

I want to thank the members of the Paralyzed Veterans of America, the Blinded Veterans of America, the Non-Commissioned Officers Association, the Military Order of the Purple Heart, and the Jewish War Veterans of the USA, for coming to our Nation's capital today to talk about these critical issues. You are the reason we are here today, and you are the reason we work hard every day to ensure our veterans receive the best services our government can provide.

I want to also point out that in the audience today, from the Mountain States Chapter of the PVA, we have Jared Musik and Mark Shepherd, Sr., if they can show where they are. Join me in giving them a——

As we discuss the President's fiscal year 2007 budget proposal for the VA, there are a number of important issues which we need to examine in Congress. First and foremost, we need to do everything we can to ensure that funding for veterans' health care and services is there, not only for this year but for every year into the future. That is why last year's $1.2 billion shortfall for VA health care was so troubling, and it was a very good thing that Senator Craig, Senator Murray, Senator Akaka, and the rest of this Committee worked to restore the funding that was needed.

It is also why several of my colleagues and I have asked the Government Accountability Office to examine the process by which VA determines its budget requests every year. It still puzzles me as to why we ended up with the kind of shortfall that we ended up with last year. We are awaiting the final findings of that inquiry, and we will work to do everything we can to see that the problems are identified and addressed.

We see the symptoms of those problems in other efforts to generate revenue and to decrease costs by establishing enrollment fees and doubling prescription drug co-payments for Priority Seven and Eight veterans. While I certainly understand the need to focus our service on those veterans who need it most, I firmly believe that

the promise we made to our Nation's veterans obligates us to do everything we can to ensure that all veterans receive the services that they have earned.

[Applause.]

For that reason, I oppose the President's proposal, and will work with my colleagues to see whether we can readdress them and turn them back.

More troubling, however, is the recent revelation that the budget projects dramatic cuts in VA funding in the out-years. For sure, as Senator Craig said earlier, we have a proposed budget for next year which appears to give us about a 9 percent increase, but when you look out at the out-years, there are concerns that we should all be focused on.

Recent documents that have been shown from the Administration, from the White House, seem to assume that funding for VA health care would increase by 9 to 11 percent for fiscal year 2008, and then after that there would be cuts for the next 3 years in a row. We need to make sure that we have a sustained and long-term commitment for the funding for VA health care, which is the kind of sustained commitment that I hear both Senator Craig and the Members of this Committee talking about.

The answer, in my view, to dealing with some of these issues concerning the budget is to take it out of the whimsical annual atmosphere of Washington, D.C. and our budgeting process, and to make mandatory funding for VA health care.

[Applause.]

I am a cosponsor of legislation that would make that goal a reality, and I will work to see that it becomes law.

Finally, I want to talk about an issue that is near and dear to my heart and to the State of Colorado, and to all of us from places like Idaho and South Dakota and other places that are rural in nature, where you have to travel sometimes hundreds of miles to receive health care. Too often our Nation has focused, I believe, on policies in urban areas, that we sometimes forget the serious obstacles that exist for rural veterans seeking to obtain services they need and deserve.

Many veterans in my State of Colorado, both the northwest and the northeast, have to travel several hundred miles in order to get their medical care. Sometimes the round trip is 500 miles. This is not a choice that we ought to require any veteran to ever have to make. We need policies that recognize and address these challenges now, and I look forward to working to address the needs of veterans in rural America in this Congress.

Finally, Mr. Chairman and Senator Akaka, and to all of you who are assembled here, I sit here in my seat today as a U.S. Senator because so many members of my family have given both their life and their service to this country over many wars, and I don't take the freedom that we have here in America at all for granted, nor does this Committee. And I think that is why this Committee does the great work that it does, in a bipartisan way, to try to address the real needs of our veterans.

We have an additional challenge that we have to confront now because we face the reality of so many returning veterans from

Iraq and Afghanistan. This Committee will do its best, I am certain, to make sure that those needs are addressed.

Thank you very much, Mr. Chairman.

[Applause.]

Chairman CRAIG. Ken, thank you very much. And to our panelists, thank you for your patience. We do appreciate you being here, and let me introduce our panelists and ask them to begin.

Randy Pleva is the National President for the Paralyzed Veterans of America. Welcome, Randy.

Mr. PLEVA. Thank you, sir.

Chairman CRAIG. Larry Belote, who serves as the National President of the Blinded Veterans Association.

David Magidson, welcome.

Mr. MAGIDSON. Thank you, sir.

Chairman CRAIG. We didn't think you were going to make it.

Mr. MAGIDSON. No, I was here. I was sitting over there. I didn't know I was to sit up here, but I do now.

Chairman CRAIG. Well, we are glad you are here, the National Commander for the Jewish War Veterans.

And representing the Military Order of the Purple Heart is its National Commander, James Randles. Thank you very much for being here.

And, let's see, we have had a change. Richard Schneider, who is with us today, who is President and Chief Executive Officer for the Non-Commissioned Officers Association. Richard, thank you very much for being here.

Randy, we will start with you. Please proceed.

STATEMENT OF RANDY L. PLEVA, SR., NATIONAL PRESIDENT, PARALYZED VETERANS OF AMERICA

Mr. PLEVA. Thank you, sir. Mr. Chairman and Members of the Committee, as you well know, I am Randy Pleva, the National President of Paralyzed Veterans of America, and behind me are PVA's elected leaders of our chapters, legislation and advocacy directors. They represent all of our members in all 50 States and Puerto Rico.

Chairman Craig and Ranking Minority Member Akaka, you kind of took the wind out my sails here with all the support that you have shown through the years. Believe me, sir, I am so thankful that you gave us this time for us to talk to this Committee. The reason I say that is because I know of the support that you have given veterans. But, sir, there are still people out there that don't share what you share, sir.

For over 50 years the veterans' service organizations have been coming and testifying in front of Congress, voicing their concerns, voicing needing money for veterans, and a lot of times, sir, it has fallen on deaf ears. It really has.

And today some people that feel like veterans have too much already, I would like for them to take a look in this room, because I tell you the price of freedom has a very heavy price. It really does. Just look at the wheelchairs, and people that live on a daily basis with the scars and the horrors of war that they carry on.

Also for the last 50 years, like I said, the veterans have come to the table to ask, and sometimes, Mr. Chairman, they have received

crumbs off that table, the table of plenty. They really have. Veterans have protected that table, and to this day, with the—well, for example, the increase of co-payments and enrollment fees, PVA strongly opposes these proposals and we ask Congress to reject these items.

Also, sir, we are very appreciative that the nonservice-connected veterans with a catastrophic disability are already included in Category Four, but you know what? They still pay the co-payments. And they have to pay for the meds, and they have to pay for their in-patient and their out-patient care. That sometimes is just overwhelming and very costly. Again, Mr. Chairman, to me, I don't think that's a priority at all, I really don't.

Another concern, I know that Senator Akaka mentioned it, was on research. You know, one of these days we would kind of like to see wheelchairs be a thing of the past, but as long as they keep cutting the funds for research, that will never happen. It won't. It will just never happen.

Another concern that we have, sir, is with the SCI, the spinal cord injury physicians and nurses that we have in our VA hospitals. The VA has to come up with something, with substantial incentives and bonuses to keep these people.

When I was in Texas, I visited the hospital and talked with a young lady who has been a quadriplegic, high level quadriplegic, for 20 years. Came in for a 10-minute procedure, 10 minutes, and that lady had been in there for 90 days because over a 10-minute period no one knew how to handle her and her skin broke down. That is just unacceptable, sir. It really is. Ninety days that she was away from her family, when she thought she would be home within a half-hour of that procedure.

These are concerns that we have, sir. These are things that really concern our members and our organization.

Also, we have a lot of World War II veterans that have been pushing these chairs for 60 years, and who desperately need long-term care. And we would really ask that any legislation—reject anything, sir, that would reduce long-term care. Of course, we are not getting any younger ourselves. And as far as staffing, the beds, things of this nature, we just hope that people would reconsider.

And also, sir, we have another concern, and that is the VA contract health care out there, the providers. Just with the trouble I was telling you about, that we have trouble with our spinal cord doctors and nurses and the VA may take us out to someone that wouldn't be qualified to take care of us.

Mr. Chairman, I know we only have 5 minutes, sir, and I don't mean to cry wolf or anything of that nature. But, Mr. Chairman, I have a very serious concern, after talking to some of the people on the Hill, not like yourself, but you know a lot of these people—and I know you have heard this before—but they gave their all. I am sorry. They gave their all and, you know, Senator, it is like some people look you in the face and they are not afraid to tell you, "So what? So what? Who cares?" And that really disturbs me because, sir, I am not a smart man. I am no college graduate, but I know right is right and wrong is wrong.

And these people that are sevens and eights, you know what? They left their families, they left their jobs. They put their life on the line.

And I am telling you, sir, that is not—again, it is not—I hear gray areas. It is black and white, just that simple. And, Senator, again, I have these concerns. I see my time is up, but I appreciate you listening to us. Thank you ever so much, sir, for having this hearing. Thank you.

[The prepared statement of Mr. Pleva follows:]

PREPARED STATEMENT OF RANDY L. PLEVA, SR., NATIONAL PRESIDENT, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our legislative priorities for 2006 and this session of the Congress. PVA would like to thank you Chairman Craig and Ranking Member Akaka for allowing us to continue to present our testimony with PVA leadership and members in attendance. It is a great way for us to participate in the legislative process.

I would also like to thank you both for recognizing the accomplishments of The Independent Budget over the last 20 years by attending our anniversary reception recently.

PVA's budget recommendations are part of the joint policy statements contained in this year's Independent Budget. They are the combined recommendations of AMVETS, Disabled American Veterans, PVA and Veterans of Foreign Wars. This year, PVA and our fellow VSOs are proud to mark the 20th Anniversary of this joint effort presenting budget and policy direction to the Congress and the Administration for all benefits and services provided to the veterans of this Nation.

FISCAL YEAR 2007 VA HEALTH CARE BUDGET

With regard to the Administration's budget proposal, PVA is pleased to see that for the first time, a reasonable starting point was offered by the President to fund the VA health care system. For fiscal year 2007, the Administration has requested $31.5 billion for veterans' health care, a $2.8 billion increase over the fiscal year 2006 appropriation. Although this is a significant step forward, we still have some concerns about proposals contained within the request, as I will later explain. The Independent Budget for fiscal year 2007 recommends approximately $32.4 billion for veterans' health care, an increase of $3.7 billion over the fiscal year 2006 appropriation and about $900 million over the Administration's request.

We believe that the recommendations of The Independent Budget have been validated once again this year as the Administration indicated that it will actually take $25.5 billion to fund Medical Services, an amount very close to what we recommend. However, they only request $24.7 billion in appropriated dollars. The Administration hopes to raise an additional $800 million by instituting the new enrollment fee and the increase in prescription drug co-payments to achieve the necessary funding level.

I would like to single out this particular budget and policy recommendation that continues to receive a great deal of attention, both in the veterans' community and in the Congress. As it has for the past 3 years, the Administration is insisting on more than doubling fees for prescription co-payments and instituting an annual $250 enrollment fee for certain veterans in the lower eligibility categories.

I would like to take a moment to explain why PVA objects to the proposal. I would also like to explain why we believe this recommendation, if approved, will have a serious impact on many veterans with catastrophic disabilities whose only main health care resource is the VA health care system.

VA has cared for veterans with nonservice-connected disabilities for a long time. This is not a new phenomenon authorized by eligibility reform in 1996. Veterans health facilities admitted nonservice-connected veterans in large numbers following World War I. The Congress and the VA admitted the nonservice-connected, not just the poor and indigent, in large numbers as the VA health care system grew in size and scope through the middle of the 20th Century and beyond. VA used the rationale that its facilities were there to serve veterans who, because of nonavailability of comparable services, access, or cost, found VA a reasonable or unique resource for health care services they could not find elsewhere.

VA opened its doors to these veterans for many reasons, the main one being these men and women had served their country just as honorably as anyone else who had worn the uniform. They deserved no less.

Prior to 1986, all veterans, service-connected and nonservice-connected, over the age of 65 were eligible for VA health care. In 1986, Congress approved legislation which divided the veteran population into three eligibility categories. In 1996, Congress again revised that legislation with a system of seven priority ratings for enrollment. Within that context, PVA worked hard to ensure that those veterans with catastrophic disabilities, no matter if those disabilities were service-connected or nonservice-connected would have a higher enrollment category. If the three implied missions of the VA health care system were to provide for the service disabled, the indigent and those with special needs, the catastrophically disabled certainly fit in the latter priority Ranking. The VA had an obligation to provide care for these veterans. The specialized services, such as spinal cord injury care, unique to VA, should be there to serve them.

To protect their enrollment status, veterans with catastrophic disabilities were allowed to enroll in Category Four even though their disabilities were nonservice-connected and regardless of their incomes. However, unlike other Category Four veterans, if they would otherwise have been in Category Seven or Eight, they would still be required to pay all fees and co-payments, just as others in those categories do now for every service they receive from VA.

PVA believes this is unjust. VA recognizes their unique specialized status on one hand by providing specialized service for them in accordance with its mission to provide for special needs. The system then makes them pay for those services.

These veterans are not casual users of VA health care services. Because of the nature of their disabilities they require a lot of care and a lifetime of services. Private insurers and providers do not offer the kind of sustaining care for spinal cord injury found at VA even if the veteran is employed and has access to those services. Other Federal or state health programs fall far short of VA. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury and yet, these veterans, supposedly placed in a priority enrollment category, have to pay fees and co-payments for every service they receive as though they had no priority at all.

The Administration's new fees and new enrollment payments add even higher burdens to penalize these veterans for seeking the only source of the health care they need.

We strongly urge the committee to correct this financial penalty. If a veteran is in Category Four because of a catastrophic disability, then treat that veteran like all other Category Fours and exempt him or her from fees and co-payments.

Our health care recommendation does not include additional money to provide for the health care needs of Category 8 veterans being denied enrollment into the system. However, it is included in our bottom line for total discretionary dollars needed by the VA to provide health care to all eligible veterans. Despite our clear desire to have the VA health care system open to these veterans, Congress and the Administration have shown little desire to overturn this policy decision. The VA estimates that a total of over 1,000,000 Category 8 veterans will have been denied enrollment into the VA health care system by fiscal year 2007. Assuming a utilization rate of 20 percent, we believe that it would take approximately $684 million to meet the health care needs of these veterans, if the system were reopened. We believe that the system should be reopened to these veterans and this money appropriated on top of our medical care recommendation for this purpose.

Despite a reasonable request this year, the budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of how much money it is going to get and when it is going to get it. In order to address this problem, PVA, in accordance with the recommendation of The Independent Budget, proposes that funding for veterans' health care be removed from the discretionary budget process and be made mandatory.

MEDICAL, PROSTHETIC, AND REHABILITATION RESEARCH

For Medical and Prosthetic Research, the Administration has recommended $399 million, a cut of approximately $13 million below the fiscal year 2006 appropriation. The Independent Budget recommends $460 million. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in comparison to the growth rate of other Federal research initiatives. We call on Congress to finally correct this oversight.

We also believe that additional funding needs to be provided for rehabilitation research. The development of new and better techniques allows catastrophically dis-

abled veterans to become more active and independent in society. Furthermore, advanced rehabilitation can only lead to a happier and healthier life for these men and women.

One particular program that is currently taking place that we believe will be highly successful is the Spinal Cord Injury—Vocational Rehabilitation Program (SCI–VIP). This is a new 5-year research project that will attempt to greatly improve the employment rate of veterans with spinal cord injury. It will be conducted at four spinal cord injury/dysfunction (SCI/D) centers—Dallas, Milwaukee, San Diego and Cleveland—with control groups at the Houston SCI center and at the Hines SCI center in Chicago. In short, the project will inject vocational rehabilitation counselors (VRC) directly into the medical rehabilitation process to provide "hands-on" vocational assistance throughout rehabilitation. The VRCs will make employment a priority component of the rehabilitation process.

PVA has strongly supported this concept since it was first proposed by Dr. Lisa Ottomanelli at the Dallas SCI Center. We hope that the VA will see fit to expand this program to benefit spinal cord injured veterans across the country. We would also urge the Congress to make available additional funds within the research program to support this project.

PHYSICIAN AND NURSE SHORTAGE

PVA is concerned that the VA continues to experience a serious shortage of qualified, board certified spinal cord injury (SCI) physicians, making it difficult to fill the role of chief of an SCI/D service. Several major SCI/D programs are under acting management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged with acting chiefs assigned for indefinite time periods.

We are even more concerned about the continuing shortage of nurses, particularly in spinal cord injury units. PVA believes that the basic salary for nurses who provide bedside care to SCI veterans is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community.

Recruitment and retention bonuses have been effective at several SCI centers, resulting in an improvement in the quality of care for veterans as well as the overall morale of the nursing staff. Unfortunately, these are localized efforts by the individual VA medical facilities. We believe that the Veterans Health Administration (VHA) should authorize substantial recruitment incentives and bonuses.

PVA calls on Congress to conduct more oversight of the VHA in meeting its nurse staffing requirements for SCI units as outlined in VHA Directive 2005–001. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care. Furthermore, not all SCI centers are in full compliance with the regulation for the staffing ratio of professional nurses to other nursing personnel. With proper congressional oversight, these mistakes can be corrected.

LONG-TERM CARE AND ASSISTED LIVING

PVA is concerned with recent trends to reduce the ability of the VA to provide long-term care to a rapidly aging veterans population. We strongly oppose any proposal that would repeal the statute that requires the VA maintain bed and staffing levels at the same level established by P.L. 106–117, the "Veterans Millennium Health Care and Benefits Act." Despite an aging veteran population and passage of P.L. 106–117, the VA has continuously failed to maintain its 1998 VA nursing home required average daily census (ADC) mandate of 13,391. VA's average daily census (ADC) for VA nursing homes has continued to decline since 1998 and is projected to decrease to a new low of 9,795 in fiscal year 2006. The VA is ignoring the law by serving fewer and fewer veterans in its nursing home care program.

PVA was deeply troubled by efforts in Congress last year to eliminate the mandatory ADC requirement contained in the Millennium Health Care bill. This proposed change is not driven by current or future veteran nursing home care demand. In fact, the General Accounting Office (GAO) reported "the numbers of aging veterans is increasing rapidly, and those who are 85 years old and older, who have increased need for nursing home care, are expected to increase from approximately 870,000 to 1.3 million over the next decade."

PVA strongly feels that the repeal of the capacity mandate will adversely affect veterans and is a step toward allowing VA to reduce its current nursing home capacity. This is not the time for reducing VA nursing home capacity with increased veteran demand looming on the near horizon. We hope that this Committee will re-

ject any such legislation. Furthermore, we urge the Committee to conduct aggressive oversight to ensure that the VA is fulfilling its statutory obligation to provide long-term care.

We believe that assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADL) or the instrumental activities of daily living (IADL). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a home-like setting. Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care. Likewise, Congress should authorize the VA to expand its Assisted Living Pilot Program (ALPP) to include an initiative in each VA Veterans Integrated Service Network (VISN). This expanded effort will allow VA to gather important regional program cost and quality information.

Congress should call upon VA to conduct a cost and quality comparison study that compares the ALPP experience to cost and quality information it has compiled for VA nursing home care, community contract nursing home care, and state veterans nursing home care. When completed, this long-term care program cost comparison study should be made available to Congress and veterans service organizations.

MULTIPLE SCLEROSIS (MS) AND PARKINSONS CENTERS OF EXCELLENCE

The VA appropriations subcommittees in the House and Senate inserted language in their VA funding reports for fiscal year 2001 requiring VA to establish centers of excellence to conduct research and study in the field of neurodegenerative diseases. With that instruction, VA identified two fields of inquiry for the centers with particular bearing on medical conditions prevalent in the veteran population, Parkinsons Disease and Multiple Sclerosis. The VA, subsequently, on two different tracks, proceeded to establish the centers of excellence starting first with the Parkinsons Centers and later with the two MS Centers.

PVA has expressed concern that the centers, established only through VA good faith and resources available in any one budget cycle could eventually be in jeopardy. Therefore, last year an effort was launched to take what was only an authorization or recommendation for the centers and actually codify them. The House of Representatives approved H.R. 1220 which addressed the codification of the Parkinsons centers. Senator Daniel Akaka introduced S. 1537 which would codify both Parkinsons and MS Centers.

When both the House and Senate Appropriations Subcommittees directed VA to establish these centers they made no distinction between them. The report language in both Appropriations bills only directed VA to establish centers of excellence in neurodegenerative diseases to spur the Department along in research and treatment in this overall field of medicine. While studying uniquely different diseases, both Parkinsons and MS Centers serve together in the overall study of neuroscience. It would be inappropriate in our view to put the centers on separate tracks, codifying one and not the other.

We urge the committee to adopt legislation which can address and codify these centers in Title 38 U.S.C. once and for all.

CONTRACT CARE COORDINATION

I would like to address a trend that we believe could have a substantial negative impact on the VA health care system. We have serious concerns about the contract care coordination pilot program authorized in P.L. 109–114, the "Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act of 2006." The conference report accompanying this law requires the VA to establish a comprehensive managed care demonstration project in at least three Veterans Integrated Service Networks (VISNs). We oppose the VA's planned approach to this new requirement to establish additional, parallel contract programs on a broad scale.

VA's approach to this requirement seeks to contract health care services provided by non-VA providers on a broad basis. This only serves to dilute the quality and quantity of VA services for new as well as existing veteran patients. Ultimately, contract care is not more cost-effective or cost-efficient than care provided by the VA, and we certainly do not believe that the VA will find the same level of high-quality care in the private sector. There is no reason for VA to move into this arena on a broad basis.

The Secretary of Veterans Affairs, Jim Nicholson, recently testified to the remarkable success of the VA health care system and the positive media that it has recently received as a result of this success. He explained that it is a model for the rest of the country and private industry. In fact, Secretary Nicholson stated before the House Committee on Veterans' Affairs at a hearing on February 8, 2006 that

"for the sixth consecutive year, VA set the public and private sector benchmark for health care satisfaction based on the American Customer Satisfaction Index survey." This is true because the VA health care system operates as a fully integrated, government managed health care system.

BENEFITS RECOMMENDATIONS

PVA would like to offer a few improvements to benefits provided by the VA. PVA members are the number one beneficiary of the Special Adaptive Housing (SAH) grant and the adaptive automobile grant. Unfortunately, periodic increases in these grants have not kept pace with inflation. For both the SAH grant and the adaptive automobile grant, we believe that an automatic annual adjustment indexed to the rising cost-of-living should be applied. Furthermore, in accordance with the recommendation of The Independent Budget, the adaptive automobile grant should be increased to 80 percent of the average cost of a new vehicle to meet the original intent of Congress.

PVA would also like to recommend a change in the compensation provisions outlined in Title 38, Section 5111. Under current law, the effective date for a veteran's finding of service connection is the day after his or her date of military discharge. However, the effective date for his or her VA compensation payments is the first day of the month following the month when that service connection was granted. Because the veteran's compensation payment for a given month is not made until the end of the month, he or she could lose up to an entire months worth of pay under this current provision.

As an example, if SGT John Smith is medically retired on 01/31/06 from the Army for a C4 spinal cord injury from a sniper bullet, then his effective date for benefits is 02/01/06. However, his effective date for compensation payment is 03/01/06, and he would not receive his first payment until 03/31/06. Current law does not allow him to be compensated for the month of February in this case. We believe the law should be changed to make the veteran's effective date of service connection and effective date for compensation payment the same.

PVA appreciates the opportunity to present our legislative priorities and concerns for the second session of the 109th Congress. We look forward to working with the Committee to ensure that adequate resources are provided to the VA health care system so that eligible veterans can receive the care that they have earned and deserve. We also hope that this Committee will take the opportunity to make meaningful improvements to the benefits that veterans rely on.

Mr. Chairman, I would like to thank you again for the opportunity to testify. I would be happy to answer any questions that you might have.

Chairman CRAIG. Randy, thank you.

Larry, please proceed.

STATEMENT OF LARRY BELOTE, NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION

Mr. BELOTE. Yes, sir. On behalf of the Blinded Veterans Association, I want to thank you for allowing us this opportunity to testify today. Am I supposed to ask, can we have our testimony entered into the record, the written testimony?

Chairman CRAIG. Without objection, all statements and any accompanying material will be a part of the official record. Thank you.

Mr. BELOTE. Thank you, sir. The Blinded Veterans Association has a long history, and is the only congressionally chartered organization specifically set up to serve blinded veterans and their families. This month is when we are going to celebrate our 61st year of continuous service in doing that.

I think what that has resulted in is, we have a unique insight into the needs and services that we require from the Department of Veterans Affairs. There are three things about us, I think, that cause that.

Number one, we are providers of the services. We see what the people need on a daily basis. We are working now with the OIF/

OEF veterans, Ryan Wolfer Hall, and we are working with them in the BAMC, at Brooks Army Medical Center in San Antonio, for example. We are on conference calls with them and their families to give them support.

The people on our board are actively involved in the local community, State level. And we are staying involved, trying to share the learning experiences that we had overcoming sight loss, so it makes the road a little easier for these fellows and ladies when they come back to get back on their feet and restore their functioning and become active members of society.

We are also consumers. Obviously we use the benefits and goods of the VA to get back on our feet. Many of us have used the educational benefits, the rehab services, to become lawyers, physician's assistants, ministers. The people on our board all have achieved great heights because of the VA and the services we were provided to get us back on our feet, and we want to make sure that happens to the veterans following us.

The last thing that we are, and this is very important, we are also taxpayers. We are taxpayers, and we want to make sure it is not always how much we get, it is how much we spend and how we spend it. We want to ensure, as taxpayers, that the VA spends the money they get in the best way possible to meet our needs, and not spending it on something else that doesn't meet our needs but trying to sell it that way.

I want to now move into our legislative thing, and we want to only focus on three issues today. We provided our written testimony, which is quite, quite in depth.

The first one, I want to thank the Chairman and the Committee, and especially Senator Salazar, for helping us get our BROS, our Blind Rehab Outpatient Specialist legislation through the Senate, and it is now over at the House. This is an important part of our saving money, because we believe that having outpatient services, an outpatient model of service delivery goes a long way toward saving money over brick-and-mortar facilities which have been the historical way of providing services.

The second thing I want to bring up, and this directly relates to OIF/OEF veterans, is the paired organ legislation. Here we are seeking changes in the existing law which simply correct some inaccuracies in there which cause some restrictions that treat a blinded veteran differently than a Social Security recipient when it comes to determining disability.

Right now there are about 78 veterans from the OIF/OEF conflicts who are blind in one eye. This legislation would be something directly related to compensating them down the road, so we think it is very important. Right now we have over 70 bipartisan cosigners in the House, and we are seeking cosigners in the Senate, and we are hoping that someone will be able to step up to the plate and help us on this important legislation. We stand ready to clarify and to make it clear and work as your extenders to understand what this all means.

The third piece of legislation is actually a resolution which I think nobody can object to, since it costs nothing. We have a strong feeling that the white cane/guide dog law needs to be—not law—Resolution 71 should be supported and passed. This gives notice to

the States that the Senate, the House, supports them putting in their driver's license handbooks language that says, "When you see someone who is blind, with a dog or with a cane, pay extra caution." All the States have this in their laws but it is not in their handbooks.

And we think by seeing that—three of our Members almost got run over here, somebody turning right as we were trying to cross the street. Obviously they didn't know what the white cane was. Perhaps this could be helped in the future if we had this in the State handbooks. Again, it is free.

And we need a continuum of care. The best example I can give you of a continuum of care, and let's use an Iraqi veteran right now in San Antonio in the BAMC. A soldier from Mississippi is there receiving his rehab. He is totally blind, terribly injured. The VA blind rehab specialist, Bob Cozel, is going over to the BAMC, providing him rehab while he is active duty. He is teaching him how to use a cane. He wouldn't have a cane, he wouldn't have a talking watch to tell what time it was, if the VA hadn't gone over there and provided these support services.

So we are already working before, in the continuum of care. When he gets through with BAMC, he will come out, he will become part of the VA, he will go into a blind rehab center. When he gets out, this BROS position we are trying to get passed would take over the case and provide service to him back at his home, teaching him how to use the bus, get around, help him with his adjustment. When he gets into voc rehab, they continue to follow him. When he gets a job, they continue to follow him, help him with his adjustment to the workplace.

So we think these positions are very important in the field, and many areas of the country have no regional rehab services. So if veterans live in different areas, these positions will make a big difference in their lives, and we hope that it passes the whole Congress.

The other example of continuum of care is the elderly veteran who the doctor refers because he is a diabetic and can't see his medications, can't read his insulin syringes. He needs someone who knows about blindness and the devises and things, to get him hooked into the talking blood glucose monitors, the magnifiers, the low vision optometrist, to keep him in his home, so he doesn't end up having a fall or being unnecessarily admitted to the hospital or, God forbid, being put into a long-term facility unnecessarily.

These services in the local community we believe are very cost effective and will save money, and that is what we want, is to save money, looking at better ways to do things. We want the system to be a risk management model, where we are looking at solving problems in the field, solving risks, the right service at the right time with the right intervention.

It is not a good continuum of care for someone to be simply told, "There is nothing we can do for you locally. You are going to have to be put on a waiting list to go to a blind rehab center, and we don't know when you are going to get in, but you are just going to have to hold on until you go." We have found that inadequate and a very poor way of using money in the VA.

[Applause.]

We think that when it comes to blind rehab services——

Chairman CRAIG. We didn't cut you off, Larry. You are doing fine, but we would appreciate it if you would wrap up. Thank you.

Mr. BELOTE. Yes, sir. Thank you for this opportunity, and if you have some questions, I will be glad to address those.

Chairman CRAIG. Thank you very much, Larry.

Mr. BELOTE. Thank you, sir.

[The prepared statement of Mr. Belote follows:]

PREPARED STATEMENT OF LARRY BELOTE, NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION

Mr. Chairman and Members of the Senate Veterans' Affairs Committee, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative priorities for 2006. We believe it is imperative that Members of this Committee work in a bipartisan manner during the second session of the 109th Congress. We all strive for the same goal, that of improving access to a high quality, fully integrated system of health care and benefits for America's veterans.

The Blinded Veterans Association is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. Since the end of World War II, when a small group of blinded veterans formed BVA, our Association has grown to include blinded veterans from several wars and conflicts, and we will soon celebrate in March our 61st anniversary of continuous service to America's blinded veterans. It is vital that our issues and advice be included in this process so that we all can make a positive difference in the quality of life for the men and women who have sacrificed so much for our freedom.

BVA would like this Committee to know that the Walter Reed Army Medical Center staff alone has treated approximately 120 soldiers with either blindness or significant visual injuries. Twenty-seven of these soldiers have attended one of the ten VA Blind Centers, and others are in the process of being referred for admission. Seventy-eight servicemembers, according to Veterans Benefits Administration (VBA) data, are service connected for total blindness in one eye from Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) injuries. When BVA representatives meet with these brave soldiers who have suffered catastrophic, life-altering injuries, the latter ask what services and benefits are going to be there to help them recover. Recent research has also found that individuals with Traumatic Brain Injury have about a 20 percent occurrence of visual field loss, with over 2,000 TBI's from OIF, this suggests that the numbers mentioned above needing low vision screening and services will grow. It should be obvious to Members of this Committee that a new generation of young blinded veterans is returning home from Afghanistan and Iraq, and that our combined efforts will be extraordinarily important. We must insure that we fully support them with the continuum of care and blind rehabilitative resources necessary during their transition from active duty to veteran status.

Mr. Chairman, we feel compelled to alert this Committee to what we believe to be a significant failure or flaw in the "Seamless Transition" for visually impaired or blinded servicemembers. We learned that servicemembers who have lost total vision in one eye are not always being referred to VA for low vision assessment or services. We believe many of these individuals most likely have some visual impairment in their remaining eye and should receive a comprehensive low vision assessment by VA to determine if they meet the definition of legal blindness. Such a determination would make a substantial difference in the benefits and services for which they would be eligible for through VA. Even if they do not meet the definition of legal blindness, studies have revealed individuals with only vision in one eye, have functional loss of 30 percent of their visual field, which VA rehabilitation services could be of assistance in training them to compensate for this loss.

Throughout our 61 years of service, BVA has closely monitored VA's capacity to deliver high-quality rehabilitative services in a timely manner. Currently, approximately 41,700 blinded veterans are enrolled in VA. Demographic research projects that by the year 2010 there will be almost 55,000 veterans with blindness or significant low vision impairments enrolled. Census Bureau data, however, reveals that there are some 167,000 legally blind veterans in the United States. Research on blind and low vision Americans show they are at risk of falls, or making medication mistakes, resulting in costly hospital admissions every year, and of losing their independence to live at home. Falls are the sixth leading cause of death in senior

citizens and a contributing factor to 40 percent of all nursing home admissions with annual Federal costs over $45,000 for each nursing home bed. According to Framingham Eye Study, 18 percent of all hip fractures among senior citizens—about 63,000 hip fractures a year—are attributable to vision impairment. The cost of medical-surgical treatment for every hip fracture is over $39,000, if outpatient rehabilitation services prevented even 20 percent of these hip fractures, the annual Federal savings in health care costs would be over $441 million.

CRITICAL ISSUES

Mr. Chairman, 2 years ago BVA presented grave concerns about waiting lists of more than 2,500 blinded veterans awaiting entrance into one of 10 VA Blind Rehabilitation Centers (BRCs) across the country. Thanks to the previous Chairman of the Subcommittee on Health of the House Veterans Affairs Committee at that time, the General Accountability Office (GAO) investigated the VA blind rehabilitation program at every level. GAO then testified before this Committee on July 22, 2004 regarding the status of VA services for the blind.

BVA was grateful to the House Committee for holding that hearing to receive the report of GAO, but we are here to report that while some progress has been made in reducing the waiting lists and times for admission, there are still 1,212 blinded veterans waiting an average of almost 19 weeks to enter one of these ten BRCs. Since then, the VA Visual Impairment Advisory Board (VIAB) has continued to evaluate VA's progress in implementing the recommendations of GAO. At the request of the VHA National Leadership Board (NLB) Health Services Committee, VIAB commissioned a Gap Analysis to determine where VA currently has vision rehabilitation service and where there are gaps in service delivery. Additionally, cost estimates were requested to determine funding needed to close the gaps identified.

VIAB is an interdisciplinary board that includes health care providers, the Blinded Veterans Association, rehabilitation research, prosthetics, and VA network representatives. Due to the increasing age of our veteran population and the known prevalence of age-related visual impairment, VIAB has identified the need for a uniform national standard of care. Along with the GAO report, VIAB also identified a need for increased outpatient blind rehab services. The Gap Analysis, mentioned above, revealed many areas of the country offer no outpatient vision rehabilitation services. There is a need to develop and implement a full continuum of vision rehabilitation care that augments the services already in place for legally blind veterans. The report envisioned the development of a full spectrum of visual impairment services.

To achieve such an objective, the GAO Testimony, the VIAB Report, and the VA Gap Analysis all strongly recommended the expansion of the Blind Rehabilitative Outpatient Service (BROS) program. As an example, Mr. Chairman, the BROS located nearest to us here, servicing both Baltimore and Washington, DC, has met with every newly blinded servicemember at Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda, Maryland. This single BROS is from the Baltimore VA Medical Center, where approximately 512 blinded veterans are already enrolled and who need his services. The Washington DC VA Medical Center, with 541 blind veterans, has no BROS and has depended on the Baltimore BROS. Only after almost 3 years of OIF/OEF causalities has a new part-time FTEE been established for both Walter Reed and for the Washington, DC VA Medical Center. It is time for all blinded veterans to receive the right service, at the right place, at the right time, without long delays because of tight budgets.

This early intervention is critical for both the soldier and family members in starting the process of learning about blind rehabilitation, which includes an introduction to early blind rehabilitation skills. The success of the process of adapting to traumatic blindness is dependent upon a seamless transition from Department of Defense Medical Treatment Facilities to VA Blind Centers. Despite some successes, BVA has found serious problems with three of the four VA Poly Trauma Centers of Excellence during the past year where there is no BROS on staff to facilitate the vital blind rehabilitation training that OIF soldiers should experience when they transfer to these centers. Only recently, after persistent questioning of the Veterans Health Administration (VHA), did they begin to advertise for a BROS FTEE. These visits are crucial to the continuum of care for returning veterans. Such visits encourage the veterans to continue using the skills learned and to adapt to new changes in prosthetics and constantly evolving adaptive equipment.

More than a year ago VIAB presented a proposal to the Health System Committee of the National Leadership Board (NLB). The proposal directed all Veteran Integrated Service Networks (VISNs) to implement a full continuum of care for visually impaired and blind veterans. The Committee received the proposal very positively

and has recently issued a report in November 2005 on the Financial Projections for the Expansion of Low Vision Services in the VA's Continuum of Care from the gap analysis. We are very pleased that as recently as Jan. 17, 2006, the Health Services Committee unanimously endorsed the full recommendations of VIAB, including the Gap Analysis and cost estimates. The recommendation for the full continuum of vision rehabilitation services has now been referred to the Finance Committee of the NLB to attempt to identify funding to implement the proposal. BVA supports the broad scope of this proposal and, as outlined further in this document, we request your oversight assistance in insuring that action is taken on these recommendations. Mr. Chairman, BVA believes the only way these recommendations can be implemented is for additional funding to be included in the VA fiscal year 2007 Appropriation directed for this initiative. We respectfully request additional funding be included in the "Views & Estimates" you will be submitting to the Committee on the Budget. VIAB does not dictate to the VISNs how this continuum of care should be implemented. BVA would point to successful VA models of unique programs across the country, such as the 60 percent increased utilization of contracting out Computer Assisted Training (CAT) for visually impaired veterans. Although these programs have contributed to the decrease in the veteran BRC waiting lists, there still needs to be further improvements. Additionally, the provision of a full continuum of Vision Rehabilitation Services is now included in the Network Five-Year Strategic Plans.

The independent Capital Asset Realignment for Enhanced Services (CARES) Commission recommended the establishment of new BRCs in VISN 16 and VISN 22. These centers have not yet opened. In 2005, another VAMC hosting a BRC was targeted for closure. A final decision regarding the VA medical center in Waco, Texas, is under review by an outside contractor. In light of the Hurricane Katrina devastation to the Biloxi, Mississippi VA Medical Center, where one of the new BRCs was to be constructed as recommended by the CARES report, BVA would suggest that it would be more prudent and cost effective to expand the BRC currently located in Waco. This facility would then handle the projected increased vision rehab workload in VISN 16. Of course, it would be necessary to keep the Waco VAMC open, which would run contrary to the recommendation of the CARES report.

Another recommendation set forth by the Commission states: "VA should develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes." GAO made a similarly strong recommendation in its testimony, indicating that when VA and GAO reviewed the waiting list of 1,500 veterans pending admission to BRCs, 21 percent of them could potentially be served if local BROS were available. Mr. Chairman, BVA appreciated the passage of "The Blinded Veterans Continuum of Care Act of 2005" (S. 1190) last session that would increase VA's ability to staff thirty-five new BROS personnel in many facilities where none currently exist. We are extremely grateful to Senator Salazar for introducing this vital legislation. Clearly, BROS provide a cost-effective model of outpatient service delivery.

BVA strongly supports the concept of assured funding for veterans. Our support was strengthened after the admission last June that VA was insufficiently funded by more than $1.2 billion in fiscal year 2005 and $1.9 billion in fiscal year 2006 because of the current funding model process. This admission and revelation were not surprising to the VSO's. They did, however, appear surprising to those in Congress who have been content with the current discretionary process. The Independent Budget (IB) has, for many years made accurate funding projections for the amount really needed for VA health care. IB members had projected the shortfall long before last March. As always when such shortfalls occur, veterans waiting times grew, veterans appointment lists expanded, and the bureaucracy pointed fingers at who was to blame. The reality is that discretionary funding leaves more room for partisan politics than it does for health care for veterans. As a member of the Partnership for Veterans Health Care Budget Reform, our membership strongly believes that Members of Congress must change the current modeling system that constantly leads to shortfalls. The Partnership supports moving VA health care from a discretionary to an assured funding method with a new model to prevent the shortages that occurred during the first session of this Congress. Assured funding would neither change the current eligibility requirements nor create a new entitlement benefit program. It would rather create a formula that would ensure necessary appropriations each year based on current enrollment, and the annual increased inflationary costs associated with the provision of excellent medical care.

The lack of predictability and accountability of the modeling used for the VA budget process allows only the status quo at best. The consequences can only be long waiting lists, decreased access, and risk of damage to the high quality of care that VA has built. If VISNs are receiving their budgets at the start of the second

quarter through a fiscal year, and are not sure when the year's funding will really be passed by Congress, why would they invest in any type of new initiative, never knowing when the money will catch up, or if any will be there during that budget year? Assured funding and implementation of a full continuum of care for blind and visually impaired veterans are inextricably linked.

BACKGROUND

We are all painfully aware of the aging veteran population and the increasing need and demand for health care services associated with aging. Mr. Chairman, aging is the single best predictor for blindness or severe visual impairment. As the overall population of veterans ages, more and more of them are losing their vision, requiring rehabilitative services. Because of all the other chronic medical problems associated with aging, more and more members of our blinded veteran population are either unable or unwilling to leave home to attend a comprehensive residential BRC. The primary obstacle is the fact that enrolling in the BRC often necessitates traveling hundreds of miles to the nearest facility. The Gap Analysis survey found that 47.4 percent of the older veterans on VIST rolls who would benefit from blind rehabilitation training actually declined to attend one of the ten blind centers. A common reason for a refusal to attend a BRC is a serious health problem or disability of a spouse. Consequently, the blinded veteran who has often been a long-term recipient of care himself/herself becomes, out of urgency and necessity, the primary caregiver. In such instances it is impossible for the blinded veteran to spend several weeks in an inpatient residential blind rehabilitation program.

Mr. Chairman, there is absolutely no question that comprehensive residential BRCs provide the most ideal environment to maximize a blinded veteran's opportunity to develop a healthy and wholesome attitude about his/her blindness and acquire the essential adaptive skills to overcome the many social and physical challenges of blindness. This is especially true for newly blinded young veterans such as those now returning from Iraq and Afghanistan. The BRC becomes even more important for many of these blinded servicemembers because they suffer from multiple traumas that include traumatic brain injury, amputations, and sensory loss. The training can also be advantageous to older veterans since intense repetitive training is often necessary to learn new skills. The BRC can bring the entire array of specialty care to bear on these severely wounded servicemembers, optimizing their rehabilitation outcomes and encouraging a successful reintegration with their families and communities. Frankly, Mr. Chairman, there is no better environment to facilitate the emotional adjustment to the severe trauma associated with loss of vision and to provide comprehensive initial blind rehabilitation.

CURRENT SERVICES

Mr. Chairman, I will now briefly describe each of the essential components offered by VA Blind Rehabilitation Service and the challenges each is facing. We believe strongly that each of these services is an integral part of the full continuum of blind rehabilitation services that VA should strive to provide.

A. Blind Rehabilitation Centers

VA currently operates ten comprehensive residential Blind Rehabilitation Centers across the country. The first blind center was established at the VA Hospital at Hines, Illinois, in 1948. Nine additional BRCs have been established and strategically placed within the VA system. The sites include VAMCs in Palo Alto, California (1967); West Haven, Connecticut (1969); American Lake, Washington (1971); Waco, Texas (1974); Birmingham, Alabama (1982); San Juan, Puerto Rico (1990); Tucson, Arizona (1994); Augusta, Georgia (1996); and West Palm Beach, Florida (2000). The mission of each BRC is to address the expressed needs of blinded veterans so they may successfully reintegrate back into a community and family environment. To accomplish this mission, BRCs offer a comprehensive and individualized training program accompanied by services deemed necessary for a person to achieve a realistic level of independence. The environment is residential but located within a VA facility in order to provide medical services to blinded veterans while they participate in the rehabilitation process.

Approximately 1,212 blinded veterans are waiting an average of more than 19 weeks to be admitted into one of these ten BRCs. The good news this year, however, is that the number has declined from the 1,500 in March 2004. Unfortunately, a majority of even the simplest services are not yet routinely made available at the local level. The recent Gap Analysis found that only 14 medical centers reported being able to provide advanced low vision care. Only 26 said they could provide intermediate low vision care. Some 78 facilities reported only basic or no outpatient

services for blindness or low vision care! For the more than 30 percent of the blinded veterans who do attend a comprehensive BRC, there is usually no continuum of outpatient care when they return home. In order to preserve the integrity of these BRCs, more outpatient and local services must be provided.

B. Visual Impairment Services Team (VIST)

The mission of each VIST program is to provide blinded veterans with the highest quality of adjustment to vision loss services and blind rehabilitation training. To accomplish this mission, VIST will establish mechanisms to maximize the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. The VIST concept was created in order to coordinate the delivery of comprehensive medical and rehabilitative services for a blinded veteran. The "teams" were created in 1967. In 1978, VA established six full-time VIST Coordinator positions. Currently, the VA system employs 93 full-time VIST Coordinators who usually work alone to take care of an average of 375 veterans. The VIST Coordinators serve as the case managers for the known 41,700 blinded veterans nationwide, a number that is estimated to increase to 54,000 within 10 years.

VIST personnel associated with a given VIST Coordinator are in the unique position of providing comprehensive case management services for the returning blinded OEF and OIF servicemembers for the remainder of their lives. They can assist not only the newly blinded veteran but also his/her family with timely and important information that facilitates psychosocial adjustment. The ideal of a seamless transition from DOD to VHA is best achieved through the dedication of VIST and BROS personnel.

A few of the VIST Coordinators have been very aggressive in identifying local resources capable of delivering needed services to blinded veterans in their homes. Regrettably, only a few are managing such dynamic VIST programs. The majority of the Coordinators rely on the BRC because many have no local BROS orientation or mobility services. If the veteran is unable to attend a BRC program, he/she goes without service in those circumstances. We find also that many rural remote regions have no local private blind services of any kind, leaving the veteran with no options. Full implementation of the continuum of vision rehabilitation services should remedy this shortcoming. Given the increasing numbers of severely visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility that has 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA has found that the lack of VIST services is often due to the actions of local facility managers who seek to avoid the cost of even one FTEE position. In such cases management has insisted that part-time positions manage these duties along with other collateral duties.

C. Blind Rehabilitation Outpatient Specialist (BROS)

The other highly specialized outpatient program offered by BRS is the BROS program. This relatively new (at least for BRS) approach to the delivery of services is provided to blinded veterans who cannot attend a BRC program. Veterans who attended a BRC and who would otherwise lack continuum of care follow-up are also beneficiaries of the program. Such veterans in the latter case often require some additional training due to changes in adaptive equipment or technology advances. Ten years ago, VA BRS did not possess the workforce to carry out effective follow-up to assess how effectively the veteran had transferred the newly learned skills to his/her home environment. Fourteen BROS were hired in 1995–1996, while a relatively small number of professionals, the creation of these initial BROS positions provided VA with an excellent opportunity to provide accessible, cost effective, quality outpatient blind rehabilitation services. The number of BROS has increased to 24 since the original appropriation.

The BROS is a highly qualified professional who, ideally, is dually certified; that is, he/she has a dual Masters degree both in Orientation and Mobility (living skills and manual skills) and Rehabilitation Teaching. In the absence of such dually credentialed professionals, masters level blind rehabilitation specialists should be selected for these positions and receive extensive cross training at one of the BRCs. Such training prepares these individuals to provide the full range of mobility, living, and adaptive manual skills that are essential in the veteran's home environment.

The delivery of such outpatient rehabilitative service is the most cost efficient method for those veterans who have rehabilitation needs but are unable to attend the residential program to receive care. Surveys in the Gap Analysis found that some medical centers were paying $90 per hour ($450 daily) for private blind training when it was available. Some centers had an average annual expenditure of more than $70,000 for contracted private blind services. Veterans must not be denied essential rehabilitative outpatient services simply to save a few dollars up front.

The rapidly growing older blinded veteran population, as mentioned previously, is clearly the therapeutic target for this type of service delivery. The highly skilled BROS professionals conduct comprehensive assessments of the newly identified blinded veteran's needs to determine if referral to a residential BRC is necessary. If residential training is the appropriate response, the BROS may also provide some initial training before admission, potentially reducing the length of stay in the BRC. Since it is more efficient to provide as much care as possible in an outpatient setting, according to GAO testimony is a statement that 21 percent of all veterans on waiting lists for admission to a BRC could receive care through local blind outpatient services. Under CARES, each admission to a BRC costs $28,900 per veteran therefore, even 240 veterans a year were instead provided local VIST/BROS services, the internal BRC inpatient cost saving would be an estimated $7,900,000 yearly.

D. Computer Access Training (CAT)

Because of the fiscal year 1995 VA appropriation of special funds earmarked for VA BRS, monies were made available to establish Computer Access Training (CAT) programs at the five major blind rehabilitation centers. Over the intervening years, CAT programs have been established at the remaining five BRCs. However, the demand for admission to these programs has dramatically increased to the point that an eligible blinded veteran has been waiting a year or more to be admitted. There are approximately 396 blinded veterans presently waiting for more than 21 weeks to attend a blind center for both rehabilitative and CAT "dual" training. The problem is that many veterans live in rural and remote regions where local services are not available. They must attend a blind center or be left without training.

Having to admit a blinded veteran to an inpatient VA BRC for this specialized computer training, which includes housing the blinded veteran in a hospital bed, is unnecessarily expensive. The good news is that, despite all of the obstacles, local training has increased. On May 5, 2004, 674 veterans were waiting for admission to a BRC for CAT training. This list was reduced by local CAT contracted services for 520 of these veterans by August 1, 2004. This successful result is due in large part to the GAO study of VA BRS service delivery and its subsequent recommendations. It involves the referring of most blinded veterans to local resources, if they can be appropriately located, for CAT training. The reduction in the BRC waiting lists from more than 2,500 veterans in 2003 to 1,212 at present involves a more effective utilization of CAT resources. Some BRCs have been, correspondingly, returning beds previously dedicated to CAT training back to the basic adjustment program. Continuing to contract services in a similar manner, greater progress could be achieved in decreasing the long waiting times for younger veterans who require the full services of the blind centers.

E. Visual Impairment Services Outpatient Rehabilitation (VISOR)

In 2000, VA Stars and Stripes Healthcare Network 4 initiated a revolutionary program to deliver services: Pre-admission home assessments complimented by post-completion home follow-up. An outpatient, 9-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) offers skills training, orientation and mobility, and low vision therapy. This new approach combines the features of a residential program with those of outpatient service delivery. A VIST Coordinator, with low vision credentials, manages the program. Staff consists of certified Orientation and Mobility Specialists, Rehabilitation Teachers and Low Vision Therapists.

VISOR is currently located at the VAMC in Lebanon, Pennsylvania, and treats patients in Network 4. This service outside the box delivery model is noteworthy. Patient satisfaction with the program is nearly 100 percent, according to the VA Outcomes Project. Two current documents, Gap Analysis: Vision Rehabilitation Services for Veterans Final Report (Atlanta VA Rehabilitation R & D Center of Excellence for Veterans with Vision Loss), and The Low Vision Services in the VA's Continuum of Care for Veterans with Visual Impairment (VIAB Final Report), recommend that this delivery model should be considered for replication within each Network. The program uses hospital beds to house veterans. The beds do not require 24-hour nursing coverage and are similar to staying in a hotel. Emergency care is available within the VAMC. The expenses associated with expanding this new cost-effective outpatient rehabilitation program from one facility to 11 facilities would be $5,474,733 for the initial year. Annual recurring costs to maintain these 11 programs, however, would be $4,700,883. This recurring cost works out to $427,353 per VISOR facility for all staffing, equipment, office supplies, and training. VISOR's annually projected caseload of 550 veterans (50 per VISOR facility) would

cost an estimated at $8,545 per veteran, one-third of the $28,900 for a month at one of the BRCs.

The VISOR program is providing functional outcome data to the Outcomes Project and will make possible the comparison of functional outcomes derived from this approach with that of the more traditional residential BRC. Early functional outcome data indicates that the approach is very effective. Profiles gathered from early data suggest that visually impaired elderly veterans relatively free from the health burdens typically seen in veterans attending the traditional BRC and who have relatively high degrees of residual vision, benefit the most from this rehabilitation approach. VA should be supported in its national leadership role in the field of blind rehabilitation services and must continue to explore additional alternatives in addressing the needs of blinded veterans.

F. Visual Impairment Center to Optimize Remaining Sight (VICTORS)

Another important model of service delivery that does not fall under VA Blind Rehabilitation Service is the VICTORS program. The Visual Impairment Center To Optimize Remaining Sight (VICTORS) is an innovative program operated by VA Optometry Service. This is a special program designed to provide low vision services to veterans who, though not legally blind, suffer from severe visual impairments. Generally, veterans must have a visual acuity of 20 over 70 or less to be considered for this service. The program is typically a very short (five-day) inpatient experience in which the veteran undergoes a comprehensive low vision evaluation. Appropriate low vision devices are then prescribed, accompanied by necessary training with the devices. It should be noted that one of the VICTORS programs has converted to a two and one-half day outpatient program and utilizes hospital beds for veterans who live too far away from the facility to commute daily.

VICTORS has achieved the same outcomes and objectives as its inpatient counterpart. Veterans who are in most need of these programs are those who may be employed, but, because of failing vision, feel they cannot continue. The program enables such individuals to maintain their employment and retain full independence in their lives. Unfortunately, Mr. Chairman, there are only three such programs currently within VHA. VIAB has recommended one VICTOR center in each Network where no programs exist. This would result in creating eleven of these special programs. We submit that there is a critical need for these programs to assist veterans in their quest to remain in the workforce. In fact, the expansion of VICTORS could further assist severely visually impaired (legally blind) or blinded veterans who have already attended a residential BRC, received low vision aids, and who now require only modifications. The effectiveness of new technology aids could be reviewed and researched. New prescriptions could be written when appropriate. Consequently, veterans would avoid the necessity of readmission to the much more expensive BRC for such reviews and evaluations.

EFFECTS OF VERA ON REHABILITATION

BRCs are admittedly resource intensive and costly. Currently, these programs are being viewed as potential revenue sources under the Veterans Equitable Resource Allocation (VERA) model. As previously mentioned, BVA is pleased with the introduction of VERA 10 as recently modified. Instead of a blanket rate of $42,000 for the higher reimbursement rate, BRCs will now be reimbursed in Group 7 at $29,737. A great deal of gaming occurred because of the high variance between the high and basic reimbursement rates.

If these services are necessary, they should be provided in either a hospital environment or, even more appropriately, in the blinded veterans' home areas. More focused outpatient programs using hospital beds are not reimbursed at the higher rate. The incentive is to admit blinded veterans to the inpatient bed at the BRC. When BRCs institute shorter programs, veterans are shortchanged. Programs such as VISOR and VICTORS admit a population with typically high residual vision (usually macular degeneration) and few, if any, co-morbidities. BVA recommends that these services should be funded and provided in the local area. Our concerns are especially relevant now that DOD Military Training Facilities are referring more young service personnel who have been blinded totally and who need the comprehensive residential BRC program. The rehabilitative needs of this new population cannot be serviced in so-called short programs. There is no question that much longer stays should and must be anticipated for these very special veterans. Shortcuts for reimbursement advantages cannot be tolerated.

The inability to track funds allocated to the Networks through VERA is another frustrating aspect of the funding issue. It is even more difficult, if not impossible, to track dollars allocated to the individual facility within the Network. Dollars allocated to the host facilities are not fenced or earmarked for blind rehabilitation. Con-

sequently, facility directors and BRC managers cannot determine how much funding they have received to operate these special programs.

The decentralized resource allocation practice provides an apparent lump sum to each facility from which they have the discretion and responsibility to operate all the programs and services assigned to that facility. Mr. Chairman, there must be a more clearly defined method for tracking these resources to insure that the specialized programs for which the Network and facilities are receiving the high reimbursement rate are indeed being utilized for those purposes. Theoretically, VERA provides Networks with sufficient funds to operate the special disabilities programs. Unfortunately, BRCs are continually required to share in facility FTEE reductions or freezes because of funding shortfalls. Field managers strenuously resist demanding this degree of accountability. They complain that this will infringe upon their flexibility as managers to establish priorities and carry out their assigned missions. Priority has been given to establishing greater capacity for outpatient services and new Community Based Outpatient Clinics (CBOCs) at the expense of tertiary care capacity.

OVERSIGHT

Mr. Chairman, as previously mentioned, the last oversight hearing by the House Committee was held on July 22, 2004 to receive GAO's report on VA blind rehabilitation services. The comprehensive report examined the history and future issues surrounding such services to veterans. Consistent with BVA's concerns, GAO found that there were serious inconsistencies from BRC to BRC as to how waiting lists were managed and waiting times calculated. They found that several BRCs were not complying with program office directions and policies. Regarding the current delivery models, we can point to the GAO and VIAB recommendations that there must be greater utilization of outpatient services in new BROS and VISOR programs, along with supporting changes occurring in the CAT program.

BVA believes that significant progress has been achieved following the release of the GAO reports, but we are concerned that resistance remains among some management employees. Starting with VHA, the National Leadership Board, and the Medical Center Director level, a clear goal should exist to provide high quality, cost-effective blind rehabilitation services in the continuum to which we have continually referred. We have pointed out in the past that a culture change must occur if BRS is to modernize in delivering cost-effective, appropriate outpatient blind rehabilitation services. Therefore, Mr. Chairman, we believe it is essential for this Committee to investigate issues presented today, and to hold a follow-up hearing in the future to assess VA's progress in implementing the VIAB and GAO recommendations.

DEPARTMENT OF VETERANS AFFAIRS FISCAL YEAR 2007 BUDGET REQUEST

The Office of Management and Budget's fiscal year 2005 and fiscal year 2006 budget requests are prime examples of the urgent need for assured funding. The gaming must end, and old models that do not include the current thousands of returning OEF and OIF servicemembers requiring care must be changed. BVA urges the members of these Committees to support a new model that would assure adequate funding. Further hearings could then be limited to the budgetary issues only.

As in years past, we are deeply concerned the fiscal year 2006 budget request fell short by $1.9 billion, and we once again predict inadequacy in the fiscal year 2007 budget requirements to adequately address the health care needs of an aging veteran population. We all heard Under Secretary for Health Dr. Perlin when he testified last summer that VHA needed a $1.9 billion increase for fiscal year 2006, plus another $1 billion just to maintain current services once all the increased co-payments and other gimmicks were subtracted. As in past years, VA is being forced to rely more heavily on first and third-party collections to substitute for appropriation. These collections always fall short of their estimates.

To project a subsequent year's budget, the current discretionary appropriations process subjects' veterans health care to numerous political agendas rather than to (1) a real model calculated on the number of veterans currently enrolled this year, (2) an index for inflation, and (3) an average cost for each veteran using VA health care.

The fiscal year 2006 Military Construction and Veterans Affairs Appropriations bill allows for $1.2 billion in emergency funds to make up for shortfalls if they occur. BVA questions why, if the defenders of the status quo discretionary funding system are so sure of budget needs each year, is emergency funding even required? Why would implementation of a new model of assured funding be less attractive?

Clearly, there will be insufficient funds to enable VA to implement the full continuum of vision rehabilitation care as recommended by GAO and VIAB if the tradi-

tional discretionary modeling process continues. The fact is that because of the problems that occurred with the fiscal year 2006 budget process, some medical centers are already freezing levels of staffing and are not hiring replacements. Therefore, it is highly unlikely that medical centers will be able to consider hiring new employees qualified to provide vision rehab services. Local travel and educational funding are also being slashed as a result of the fiscal year 2006 budget.

Given the current budget climate, VA medical facilities will almost certainly restrict or eliminate the use of funding to contract for local fee services, again negatively affecting provision of a continuum of vision rehabilitation services. BVA is gravely concerned that funding for essential prosthetic services and equipment will be severely curtailed with this budget modeling process. Medical centers will, out of necessity and within the culture of cost efficiency, continue to confine operations rather than create new programs. This will affect not only blinded veterans but all disabled veterans. The President's fiscal year 2007 budget request will again prevent Category 8 veterans from being able to utilize VA, keeping thousands away from the VA health care system. The most interesting thing about this approach is that veterans with the least health care burden—those working and with their own health insurance who bring their own medical care dollars into the system—are the ones who will be denied access. Focusing solely on the so-called core veterans will certainly compromise VHA's ability to provide the full scope of preventive and acute care services. Those in the so-called core group benefit tremendously from the specialized services provided by VA, but they also need the full array of basic healthcare services. While Members of Congress decry the budgetary shortages last summer, the House and Senate have repeatedly failed to provide a new model of assured adequate appropriations to sufficiently fund the VA health care system. Responsibility for the constant under funding of VA health care through the discretionary process rests with both past and present Presidential administrations and the Congress.

Mr. Chairman, service in the Armed Forces of the United States must count for something more than a few laudatory speeches each year. Care for America's veterans must be one of our country's highest priorities. Clearly, the President wants to care for the heroes returning from Afghanistan and Iraq, but it must not be accomplished at the expense of those who have served in previous wars and conflicts. Similarly, we cannot forget about those who served honorably but did not have to be deployed into harm's Way, or who did not suffer traumatic emotional or physical disabilities as a direct result of their service. No matter what their circumstance, many have served our Nation and now need help. National policy must recognize that care of our veterans is an integral component of national defense.

BVA is also deeply disturbed by the proposed change in eligibility criteria for long-term care. The change would result in the elimination of substantial numbers of nursing home beds within VA and, even more importantly, substantially reduce the per diem payments currently made by VA to state veterans homes. The state veterans' homes have been extraordinarily successful. They have been important partners in VA's ability to provide long-term care. This change may very well cause veterans currently in state veterans' homes to be discharged. It is highly unlikely that the states can make up for the loss of the VA payments. Paradoxically, if funding remains the only driving force behind care, then funding issues will drive the culture of VA long-term care. Creation of the innovative programs that utilize technology and human resources will be de-emphasized.

What is most alarming Mr. Chairman, is that the current budgetary situation as I have described in terms of the blinded veterans, so called efficiencies saving games that can not be shown to GAO, profoundly negatively impact the budget, and results in shortages every year. The continuously negative budgets will influence the specialized programs for blinded veterans and will be reflected in other special disabilities programs that must fight for every single dollar. If VHA is not fiscally healthy, the specialized programs for the core veterans will not be healthy either.

VETERANS BENEFITS ADMINISTRATION

VBA is also facing major problems. After a few years in which the number of claims pending decreased, there has been a reversal. Some 400,000 are now in a logjam. BVA is painfully aware of the chronic backlogs for claims pending before VBA and the Board of Veterans Appeals, and the years of promises that the system is going to be fixed. Once again, this budget fails to provide the necessary resources to adequately assist VBA in its efforts to reduce these unconscionable backlogs. Veterans are literally waiting two or 3 years for claims to be adjudicated or appeals to be resolved. Shortages of qualified adjudication officials and rating specialists have resulted in inaccurate decisions leading to more appeals. Clearly, if claims

were properly developed at the local VA Regional Office (VARO), the number of appeals would drop dramatically. Unfortunately, the VAROs are not doing a good job of assisting veterans in developing their claims.

It is disconcerting that some blame the veterans and the VSO service officers for filing too many claims. Recent articles have revealed that a large percentage of phone calls from veterans to VA requesting information on benefits are answered incorrectly more than 25 percent of the time. The government should not depend on the VSOs to do their job of instructing veterans properly on the benefits they have earned. More resources are sorely needed to improve staffing and provide new computer systems that integrate servicemembers' medical records into both the VBA and VHA information technology processing system.

BVA members have been alarmed over many statements made over the past year that suggest or make accusations that veterans who are disabled are receiving too much compensation and therefore don't want to work. Public remarks that it is very easy in the current employment market to be employed imply that the disabled veteran must be lazy or uninterested in finding work! Recent multiple research studies have indicated that the labor force and employment trends for the disabled population have not been consistent with the trends of the non-disabled workforce population. The labor force rate of participation increased for the non-disabled population from 1970 to 2000 while it decreased for the disabled population.

The employment rate of the disabled did in fact decrease from 26 percent in 1996 to 19.5 percent in 2003. In addition, labor market earnings research during the past two decades has consistently found that the disabled earn less than non-disabled workers with many working at minimum wage jobs that offer few benefits. Literature reviews reveal that disabled persons suffer lost earnings capacity and that such loss of capacity is affected even further by such factors as age, education, and socioeconomic characteristics. The National Institute on Disability and Rehabilitation Research found that for people with no disability, the likelihood of having a job or business is 82.1 percent. For people with a mild disability, the employment rate is 76.9 percent. For those using a cane, crutches, or a walker, the rate is 27.5 percent while those relying on a wheelchair for mobility were able to find employment in 22 percent of the cases. For individuals with visual impairments (unable to read letters), the employment rate is only 30.8 percent. Instead of trying to develop plans to prevent disabled veterans from receiving compensation benefits, we recommend that the Members of this Committee first look at what can be done to improve vocational, rehabilitative, and educational programs or benefits for those needing assistance in finding employment. The incorrect assumption is that simply because the United States has gone from an agricultural or industrial-centered economy to one highlighted by telecommunications, high technology, and automation, the employment field is now level for every disabled person. A recent 55-page report from the Office of Personnel Management also revealed that the number of veterans employed in the Federal Government in 1994 (558,347 or 28 percent of the Federal workforce), decreased over the subsequent 10 years (453,793 or 25.1 percent) in 2004. If the aforementioned assumptions and assertions statements were even remotely true, the employment rates for the disabled would not have decreased since 1994.

BVA members also believe that disability benefits should cover loss of earnings and include compensation for quality of life. Because of the injuries they have sustained, veterans who have suffered catastrophically and have lost mobility, and independent ability to perform routine daily tasks, and opportunities for social interaction should receive benefits that include compensation for the change in their quality of life.

INDEPENDENT BUDGET

BVA is very proud to again endorse the Independent Budget, prepared by four of the major VSOs: AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars. This is the 21st consecutive year that BVA has endorsed the IB. Along with many other VSO's; we participated in the preparatory sessions and provided input to the formulation of this extremely important document. We trust that this Committee will read the document carefully. It contains many important and constructive suggestions regarding VA health care delivery. The IB outlines a clear blueprint for addressing VA medical care delivery, including policy decisions and funding. BVA believes that these suggestions are very sound and that they should receive serious consideration as the budget process moves forward.

The fiscal year 2007 budget must keep pace with the increased medical costs in salaries, benefits, goods, and services utilized. The recently passed fiscal year 2006

appropriations included $3.3 billion for operating and maintaining VA medical facilities, $464 million less than the 2005 level. While the medical and prosthetics research budget for fiscal year 2006 did include $412 million, a $10 million increase over 2005, BVA is concerned that the fiscal year 2007 budget will not keep pace with the urgent needs for expansion in this area. Additionally, the recommended funding level must also enable VA to more adequately fund congressionally mandated initiatives. It is vital to VHA's mission to have the research funding necessary for continued medical advances. These funds are critical to VHA's ability to attract and retain clinicians who are seeking the opportunity to conduct research in prosthetics.

PROSTHETIC SERVICE

As reported last year, BVA is very pleased with the outcome of the Prosthetic Clinical Management Program (PCMP) as it affects visually impaired and blinded veterans. The stated focus of the PCMP is the quality of prescriptions rather than only the dollars expended for the prescriptions.

The driving activity behind PCMP is the establishment of work groups composed of clinicians to review the prescription practices associated with an individual prosthetic device. As a result of efforts by BVA, DAV, and PVA, consumers were allowed to be members of the work groups. Were it not for the fact that BVA had an opportunity to actively participate in the work groups related to aids and appliances for the blind, visually impaired and blinded veterans would not have faired very well. The work groups have been tasked with developing specifications for the device in question and recommendations for issuance. The intent of the specification development is to facilitate the establishment of national contracts for a device if the majority of the devices are procured from one vendor.

BVA has some reservations regarding the potential for standardization that works on the premise that one size fits all. Severely disabled veterans need to be treated as individuals with unique needs who might not always benefit from a standard device. The opportunity must exist for clinicians to prescribe items not on national contract, even if they are more expensive, without fear of reprisal from local or Network management. The effort to standardize the purchasing practices of VHA with respect to prosthetic services has been successful in large part to centralized funding for prosthetics. The combination of centralized funding and improved prescription practices has clearly enhanced disabled veterans access to high quality state-of-the-art Prosthetic Sensory Aids and Appliances. Mr. Chairman, we do wish to commend PSAS for their outstanding efforts overall to insure a seamless transition for servicemembers transitioning from DOD to VA.

VA MEDICAL AND PROSTHETICS RESEARCH

BVA supports the Friends of VA Medical Care and Health Research (FOVA) request for $460 million for fiscal year 2007 for investments in veteran-centered research projects at VA. Such projects in the past have led to an explosion of knowledge that has advanced the understanding of many diseases and unlocked strategies for prevention, treatment, and cures. Additional funding is needed to take advantage of the burgeoning opportunities to improve quality of life for our veterans and the Nation as a whole. VA must concurrently address the needs of its longstanding patient base as well as the evolving challenges being presented by our newest veterans. With these funds, it is expected that VA would pursue the following in fiscal year 2007: prosthetics, PTSD, depression, neuromuscular diseases, and other specialized research. This funding level would also allow for an increase in funding for Rehabilitation Research & Development so desperately needed during this period of war. It would also allow the continuation of several RR&D initiatives in the area of retinal implants and/or prostheses.

BVA feels strongly that legislation should be initiated that would require the National Institutes of Health (NIH) to pay VA for the indirect cost of NIH-funded research grants. Currently, NIH pays for the indirect cost to almost everyone receiving NIH grants except for VA. Consequently, VA must utilize medical care dollars to cover the indirect costs. These are funds that could be used to provide medical care to veterans. We believe that this policy is grossly unfair to sick and disabled veterans in need of medical care and to a health care system already forced to operate with constrained funding. NIH has refused every effort by VA to seek payment for these indirect costs. We therefore believe that legislative action is required.

OTHER LEGISLATIVE PRIORITIES

BVA believes these issues are vital to the survival of VA and to services and benefits for blinded veterans. Some of these issues are unique to veterans and others are applicable to all blind Americans.

A. BVA strongly encourages passage of H.R. 515, The Assured Funding for Veteran's Health Care Act of 2005, which will institute mandatory funding for VA health care. We would encourage this committee to have a hearing on this issue.

B. Authorizing VA to retain third-party collection should be viewed as a supplement to, and not as a substitute, for Federal funding. Veterans and their insurance companies should not be required to pay for veterans' health care as this is clearly a moral obligation and a responsibility of the Federal Government.

C. BVA, along with the veterans and military organizations, supports legislation stopping the offset between the Survivor Benefit Plan (SBP) and Dependency and Indemnity Compensation (DIC). SBP is purchased by the retiree and is intended to provide a portion of retired pay to the survivor. DIC is a special indemnity compensation paid to the survivor when a member's service causes his or her premature death. In such cases, the VA indemnity compensation should be added to the SBP the retiree paid for, not substituted for it. It is also noteworthy as a matter of equity that surviving spouses of Federal civilian retirees who are disabled veterans, and who die of military service-connected causes, can receive DIC without losing any of their purchased Federal civilian SBP benefits.

D. BVA requests that this Committee hold a hearing on "The Disabled Veterans Equity Act" (H.R. 2963), which currently has 70 bipartisan co-sponsors. In 2002, Congress passed and the President signed P.L. 107–330. The law included a provision (Section 103) to correct a similar deficiency in the Paired Organ law. Currently, a veteran, who is service connected for loss of vision in one eye due to injury or illness incurred on active duty is denied additional disability compensation if they become legally blind in the remaining eye. Because the Paired Organ section on vision did not address the legally accepted definition of blindness, (visual acuity 20/200, or loss of field of vision to 20 degrees), some veterans are denied an increase in compensation if they become legally blinded in both eyes. This change in the law would only affect a small percentage of the 13,109 veterans who are service connected for loss of vision in one eye. We would argue that for the veteran with blindness in one eye who subsequently loses vision in his/her remaining eye, full paired organ benefits should not be denied. Research reveals that less than 5 percent of the current service-connected veterans for loss of vision in one eye would eventually lose vision in the remaining eye.

E. BVA strongly encourages Congress to adopt legislation that would provide full concurrent receipt for all military retirees who have suffered service-connected disabilities The VSOs responsible for development of the Independent Budget have urged Congress to correct this serious inequity. Congress should enact legislation that repeals the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their VA disability compensation.

F. BVA strongly supports the provision of a full Cost of Living Adjustment (COLA) for veterans receiving disability compensation and surviving spouses and dependent children receiving DIC. Further, we support this COLA being made effective December 1, 2006.

G. BVA encourages the U.S. Senate to adopt legislation introduced by Senator Specter. "The FAIR Act" (S. 852) establishes a national trust fund that would provide equitable compensation to Americans suffering from illnesses caused by exposure to asbestos. The national trust fund would replace the current tort system that is clearly broken and causes many disabled veterans to wait many years before ever receiving any compensation for suffering caused by asbestos exposure.

H. Medicare subvention is an issue critical to the future funding of VA health care programs. Considerable discussion of this issue has occurred over the years, with strong resistance coming particularly from the House Ways and Means Committee regarding a pilot Medicare subvention demonstration project for VA. We trust that legislative language can be crafted this year to move this legislation through the 109th Congress. Authorizing VA to bill Medicare for covered services provided to certain veterans seems to be a win-win situation. VA benefits from additional revenue to supplement core appropriations. The Medicare trust fund benefits at the same time since VA will be reimbursed at a discounted rate.

I. As evidenced by the vital emergency role that the VA played during the past hurricane season, VA should have the funding necessary to respond in the event of either a natural or terrorist attack. In addition, as the Federal Government seeks to strengthen homeland security, VA should receive an appropriate share of resources dedicated to this purpose. The importance of the VA's capacity to respond

with medical and human resources in times of national emergency cannot be underestimated.

J. BVA urges Members of the Congress to support passage of Senate Concurrent Resolution (S. Con. Res. 71), introduced by Senator Inouye, Senator Salazar, and Ranking Member Senator Akaka, it was adopted by the House of Representatives in June 2004, (H. Con. Res. 56). The resolution failed last year because there was no companion resolution on the Senate Transportation Committee. S. Con. Res. 71 states "that it is the sense of the Congress that each State should require any candidate for a driver's license candidates to demonstrate, as a condition of obtaining a driver's license, an ability to associate the use of the white cane and guide dog with visually impaired individuals and to exercise great caution when driving in proximity of a potentially visually impaired individual." We are grateful to Senator Akaka and Senator Salazar for introducing this important resolution again, and urge Members to co-sponsor this as method of improving pedestrian safety. We are pleased that companion H Con. Resolution 235 was introduced again in the House Transportation Committee and already has twelve co-sponsors.

K. As mentioned previously, aging is the single best predictor of blindness or severe visual impairment. Veterans are not the only ones who are growing old and losing their sight. BVA encourages Congress to enact legislation to fund categorical programs for the professional preparation of education and rehabilitation personnel serving people who are severely visually impaired and blind. There is a shortage of trained professionals in the field of blindness. The shortage may very well be further aggravated as a result of the President's fiscal year 2007 budget request. Contained within the request is a Department of Education, Rehabilitation Services Administration (RSA) initiative that would cut back on funding support for personnel preparations programs.

L. The Blinded Veterans Association has many members in Puerto Rico who served honorably in the U.S. Armed Services. BVA therefore encourages Congress to adopt legislation that would define the political status options available to the U.S. citizens of Puerto Rico and authorize a plebiscite to provide the opportunity for Puerto Ricans to make an informed decision regarding the island's future.

M. Once again this year, BVA urges this Committee to introduce legislation that would amend the Beneficiary Travel Regulation in Title 38. We believe that the law needs to be changed to allow VA to pay travel for catastrophically disabled veterans who are accepted to one of the VA special disabilities programs and who are not currently eligible for travel benefits. These veterans are already required to pay the Social Security Administration co-payment as well as a daily per diem rate during the rehabilitation experience. Adding the burden of paying their own travel, usually air transportation, serves as a strong disincentive for these veterans to take advantage of the world class service offered by VA.

N. BVA absolutely opposes any legislative initiative that would change the current Line of Duty standard for determining Service Connection to Performance of Duty.

CONCLUSION

Once again, Mr. Chairman, thank you for this opportunity to present BVA's legislative priorities for 2006. BVA is extremely proud of our 61 years of continuous service to blinded veterans and all of the accomplishments we have enjoyed. The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that depends in part on the willingness of our government to meet its obligation to them as veterans.

When BVA representatives meet the young servicemembers from OEF and OIF at Military Treatment Facilities, one of the first questions asked is the following: "Is VA going to be able to provide me with the long-term rehabilitation that I will need to adjust to my blindness?" We would like to ask that question of the members in this room. Again, Mr. Chairman, thank you for this opportunity. I will gladly answer any questions you or other Members of this Committee may have.

STATEMENT OF DAVID L. MAGIDSON, NATIONAL COMMANDER, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Mr. MAGIDSON. If I might, Senators, fellow veterans——

Chairman CRAIG. David, please proceed.

Mr. MAGIDSON. Yes, sir, if I might. Thank you.

Everyone has talked about specifics and we have specifics in the record. I could talk about, I am from Florida and we could talk

about the VA Hospital in Palm Beach, where we are told that the money that is used for capital has to be paid into salaries, and they have no money in capital, and this is supplemental budget. Or we can be walking around Congress, and we bump into the paralyzed veterans and be told that they do not have any parking in order to go to the hospital. But we are going to be talking in general because I want to talk about who we are and why we are here, if I might.

We are the Jewish War Veterans. We are the oldest active veterans' organization in our country, founded in 1896 by veterans of the Civil War to put to rest the lie that Jews did not fight in the conflagration. We did, by the thousands, and we still do.

Let me, if I might, read a letter that we received from a young girl from Arizona. We are all throughout the United States. And she says, to get the tenor of why we are here:

"I am a student in the 8th grade at Copper Ridge Middle School in Scottsdale, Arizona. All of the social studies classes are meant to write a letter to any veterans' organization of our choice, and I selected the Jewish War Veterans. I am Jewish."

"I never really thought about people who fought in wars, and never thought that people would have fought and died to protect the U.S.A. You made me begin to think about how lucky we are to live in America and have all the freedom that we have today."

"I also didn't realize how many American soldiers have died in so many wars over the past 100 years, not only fighting for our freedom but for the freedom of other countries, too. Because I am Jewish, I know that if Hitler hadn't been beaten in World War II, then maybe I wouldn't be here today, or my parents or my grandparents. I see things on TV about what happened to so many people during Hitler's rule, and it really makes me sad."

"I would like to thank you and all of the veterans for fighting so bravely for our country and keeping us free and safe. I hope the government takes care of all of the veterans and everybody remembers to always keep thanking you for everything you have done."

"I hope I never have to fight in a war, but if I do, I hope I can be as brave as all of you were. Please read this letter to all of the Jewish veterans and all veterans, so that they know how much I want to thank them for keeping me safe."

I think that is what we are about.

Let me just get a little personal at this time. My son, Captain Ben Magidson, just returned from Afghanistan after 1 year, and three-and-a-half years of active duty in the United States Army. He was at Scofield Barracks, and then with the 25th ID over at Afghanistan.

He was taking something out of his duffle bag and I asked him what it was. He said it was a Bronze Star. I swelled with pride, but then I realized what sadness and pain come with it. Ben to me is a representative of the hundreds and thousands of our men and women, parents and children, who went into combat and are now coming home.

To the Administration and Congress people who sent them in harm's way, never leave a veteran behind. And to the veterans' organizations such as ours, we have the eternal responsibility of assuring that no veteran will be left behind. For health care, for edu-

cation, for housing, please never leave a veteran behind, and keep it with you when you consider what we should do, because we agree with everything that is being said specifically.

And thank you very much, Mr. Chairman, sir.

[The prepared statement of Mr. Magidson follows:]

PREPARED STATEMENT OF DAVID L. MAGIDSON, NATIONAL COMMANDER, JEWISH WAR VETERANS OF THE UNITED STATES OF AMERICA

Chairman Craig, Ranking Member Akaka, Members of the Senate Committee on Veteran Affairs, and Members of the House Committee on Veterans Affairs who are present, my fellow veterans and friends, I am David L. Magidson, the National Commander of the Jewish War Veterans of the U.S.A. (JWV). JWV is Congressionally Chartered and also provides counseling and assistance to members encountering problems dealing with the Department of Defense (DoD), the Department of Veterans Affairs (VA), and other government agencies. JWV is an active participant in The Military Coalition, a group of over 30 military associations and veterans' organizations representing over five million active duty, reserve and retired uniformed service personnel and veterans on Capitol Hill.

I am accompanied today by the Chairman of our Coordinating Committee, PNC Robert M. Zweiman, who is also JWV's International Liaison, the President of our Ladies Auxiliary, Arlene Kaplan, the President of our National Museum of American Jewish Military History, PNC Jack Berman, Chairman of our National Executive Committee, PNC David Hymes and the Director of our National Service Office Program, PDC Ralph Bell, and our National Executive Director, Colonel Herb Rosenbleeth. In the audience today are those JWV members who are here to meet with their Senators and Representatives as part of JWV's Capitol Hill Action Day.

Members of the committee, it was a singular honor for me to present the JWV Medal of Merit to Senator Patty Murray (WA), at our Congressional Reception yesterday evening, in recognition of her truly outstanding work for America's veterans. It was equally rewarding to JWV to have so many of you participate with us!

Mr. Chairman, next week, on March 15th to be exact, we at JWV will celebrate JWV's 110th birthday. For these 110 years, JWV has advocated a strong national defense and a just and fair recognition and compensation for veterans. The Jewish War Veterans of the USA prides itself in being in the forefront among our Nation's civic and veterans groups in supporting the well-earned rights of veterans, in promoting American democratic principles, in defending universal Jewish causes and in vigorously opposing bigotry, anti-Semitism and terrorism both here and abroad. Today, even more than ever before, we stand for these principles. The Jewish War Veterans of the U.S.A. represents a proud tradition of patriotism and service to the United States of America.

As the National Commander of the Jewish War Veterans of the USA (JWV), I thank you for the opportunity to present the views of our 100,000 members on issues under the jurisdiction of your committee. At the conclusion of JWV's 110th National Convention in San Diego, CA our convention delegates adopted our resolutions for the 109th Congress. These mandates establish the legislative agenda for JWV during my year as National Commander.

JWV believes Congress has a unique obligation to ensure that veterans' benefits are regularly reviewed and improved to keep pace with the needs of all veterans in a changing social and economic environment. JWV salutes the Chairmen and Members of both the Senate and the House Veterans' Affairs Committee for the landmark veterans' legislation enacted over the past several years. Eligibility improvement, patient enrollment, long-term care, access to emergency care, enhanced VA/DoD sharing, improved preference rights of veterans in the Federal Government and other initiatives recognize the debt this country owes to those who have faithfully served our country.

We must improve access to veterans' health care, increase timeliness in the benefit claims process, and enhance access to national cemeteries and to state cemeteries for all veterans.

NO GOVERNMENT FUNDING

The Jewish War Veterans of the USA, Inc. does not receive any grants or contracts from the Federal Government.

VA BUDGET FOR 2007

The Administration's budget submission calls for a veterans' health care budget of $34.3 billion, "an increase of $3.5 billion more than 2006", according to a VA release on the budget. While this seems like a big increase, this budget proposal does not request enough to meet the Federal Government's obligation to veterans. In fact, this budget will force increasing numbers of veterans out of the health care system. Both the Administration and the VA have repeatedly underestimated the number and severity of wounded servicemembers returning from Iraq and Afghanistan, thereby repeatedly requiring supplemental appropriation requests.

The proposed VA budget for 2007 is another attempt to drive down demand, to further drive Priority 7 and 8 veterans out of the system. This is in addition to the more than a quarter of a million veterans who have already been shut out of the VA health care system. Denying earned benefits to eligible veterans is no way to solve the problems resulting from an inadequate budget.

MANDATORY FUNDING FOR THE VA

JWV's major legislative goal is the passage of Mandatory Funding for the VA, thus providing an assured adequate level of funding for veterans' health care. This legislation would require the Secretary of the Treasury to make available to the Secretary of Veteran Affairs for programs, functions, and activities of the Veterans Health Administration for fiscal year 2007, 130 percent of the amount obligated during fiscal year 2005. The current bill numbers are S. 331 and H.R. 515.

The Jewish War Veterans of the USA strongly endorses and supports the efforts of Senator Johnson and Congressman Evans and other Members of Congress to provide required funding for veterans' health needs through these measures.

The Jewish War Veterans of the USA agrees in the strongest possible terms with these friends of veterans' contention that "We can no longer allow the VA to be hostage to the Administration's misplaced priorities and the follies of the Congressional budget process. This bill would place veterans' health care on par with all major Federal health care programs by determining resources based on programmatic need rather than politics and budgetary gimmicks."

Under the current system, funding for veterans' health care is subject to reduction at any time due to political and programmatic pressures to take money earmarked for the care of those who have served the country, many on the field of battle, and divert those funds to other programs. In this way, the most deserving among us, those who have fought to defend our basic freedoms, are often denied the care which they have earned, which they have been promised, and which they deserve.

The lack of prompt access to the care they deserve and have earned is not acceptable. As the wounded come home in ever-increasing numbers from the battlefields of Iraq and Afghanistan, the problem will only worsen in the years to come. Therefore, it is imperative that all those who honor our brave fighting men and women come together to support Senator Tim Johnson's and Rep. Lane Evans' efforts.

It is not enough to mouth support for our current troops and those who fought the brave fight before them. We must all support mandatory funding to ensure their future needs as set out in the legislation proposed by our friends. The Jewish War Veterans of the USA urges everyone to contact his/her senators and representatives to urge their support for these bills. Our country owes health care to our veterans who must not be dependent on the whims of the political process to get the benefits they have earned.

USER FEES

The Administration's budget calls for increasing veterans' prescription co-payments from $8.00 to $15.00 and proposes an annual $250.00 VA health care user fee for Priority Groups 7 and 8. There are many veterans in these groups who have several prescriptions, sometimes ten or more, each month. Doubling their co-payments is too much for many of them to handle.

JWV adamantly opposes these proposals!

POST-TRAUMATIC STRESS DISORDER

JWV is also focusing on legislation to improve programs for the identification and treatment of post-deployment mental health conditions, including post-traumatic stress disorder, in veterans and members of the Armed Forces. The current bill number is H.R. 1588, introduced by Congressman Evans.

THE MILITARY COALITION

JWV continues to be a proud member and active participant of the Military Coalition (TMC). PNC Bob Zweiman, JWV's Chairman of the Coordinating Committee, serves on the Board of Directors of the Coalition and our National Executive Director, Colonel Herb Rosenbleeth, USA (Ret), serves as JWV's Washington representative and as Co-Chair of the Coalition Membership and Nominations Committee.

JWV requests that the House and Senate Committees on Veterans' Affairs do everything possible to fulfill the legislative priorities of the Military Coalition which are applicable to your committees. These positions are well thought out and are clearly in the best interests of our military personnel, our veterans and our Nation's security.

PRIORITY GROUP 8 VETERANS

Since January 17, 2003, access to Department of Veterans Affairs (VA) care for new Priority 8 veterans has been prohibited. More than 260,000 veterans have applied to receive VA health care but have been turned away because of the cost-cutting decision to limit veterans' access to VA hospitals, clinics and medications. Citing the words of our National Commander, David L. Magidson: "There is no reason for the VA to deny health care to veterans who have served our country honorably. We should never leave any veteran behind."

SUPPORT FOR THE NATIONAL GUARD AND RESERVE

The Jewish War Veterans of the USA recognizes the National Guard and Reserve as being essential to the strength of our Nation and the well-being of our communities.

In the highest American tradition, the patriotic men and women of the National Guard and Reserve serve voluntarily in an honorable and vital profession. They train to respond to their community and their country in time of need. They deserve the support of every segment of our society.

If these volunteer forces are to continue to serve our Nation, increased public understanding is required of the essential role of the National Guard and Reserve in preserving our national security. Their members must have the cooperation of all American employers in encouraging employee participation in National Guard and Reserve training programs.

The Jewish War Veterans of the USA encourages all employers to pledge that:

1. Employment will not be denied because of service in the National Guard or Reserve;

2. Employee job and career opportunities will not be limited or reduced because of service in the National Guard or Reserve;

3. Employees will be granted leaves of absence for military training in the National Guard or Reserve, consistent with existing laws, without sacrifice of vacation;

4. Employers must recognize that their employees' rights must be protected when their workers are activated in the war against terrorism, regardless of whether that activation was for State or Federal service; and

5. Leading by example, the Jewish War Veterans of the USA, as an employer, has signed a pledge under the auspices of the National Committee for the Employer Support of the Guard and Reserve, to be a good employer. We ask our members who are employers to do so as well.

The Jewish War Veterans of the USA demands that all members of the National Guard and Reserves be treated as equal partners in America's total force structure entitled to all of the rights and benefits afforded to those in the active components and that they be equipped with all assets necessary to perform their mission.

WELCOME HOME GI BILL

The Jewish War Veterans of the USA enthusiastically supports a new veterans' rights bill now known as the "Welcome Home GI Bill" as "must" legislation currently pending before the Congress. Our Nation owes a debt of gratitude to all who are currently serving as they protect our Nation from the ravages of terrorism. This bill will go far in paying this Nation's debt to our brave men and women in uniform.

The bill should provide benefits to anyone who has served at least six consecutive months in a combat zone since 9/11 or was injured as a result of his/her service regardless of duty station. This bill must address the areas of improved health care, education, job-training assistance and housing, and include a tax-free $5,000 down payment on a home in addition to other existing VA home loan guarantees.

One of the most important aspects of any bill is that it ensures benefits for all who have served, not just for members of the active duty component. Under the cur-

rent benefits structure, those benefits due to Reserve and National Guard troops are far fewer than those given to members of the active duty components. This disparity has resulted in a system wherein the National Guard and Reserve troops have come to be treated as second-class citizens even as they are putting their lives on the line to defend our country in the same way as the active duty personnel.

The Jewish War Veterans of the USA urges the Congress to pass appropriate legislation immediately.

PRESUMPTION OF SERVICE-CONNECTION FOR GULF WAR VETERANS

A well known study conducted in the state of Kansas on the Gulf War veterans found that certain medical conditions exist among Gulf War veterans that do not exist in non-Gulf War veterans.

The National Gulf War Resource Center can substantiate and confirm that these medical conditions exist among Gulf War veterans. The U.S. Army Medical Research Institute of Chemical Defense also conducted studies that support the premise that low-level Sarin exposure causes long-term health effects. The studies reveal abnormal changes in the brain as well as suppression of the immune system in laboratory testing. The Government Accountability Office has estimated that as many as 35,000 U.S. military personnel may have been exposed to nerve agents released from the demolition of an Iraqi munitions storage complex at Khamisiyah.

The Jewish War Veterans of the USA urges that the U.S. Department of Veterans Affairs recognize the following medical conditions as a presumptively service-connected for Gulf War veterans: Skin Condition(s) other than Skin Cancer, Stomach or Intestinal Condition(s), Depression, Arthritis, Migraine Headaches, Bronchitis, Asthma, Heart Diseases, Lung Diseases, Thyroid Condition(s), Seizures, Disease of the Nervous System, and any other related conditions.

The Jewish War Veterans of the USA also requests that the Secretary of Veterans Affairs add the aforementioned illnesses to the list of presumptions of service-connection for Gulf War veterans under P.L. 103–446.

WOMEN IN THE MILITARY

Sexual assaults have not been eliminated in Department of Defense facilities. These assaults have taken place at such bases as the Air Force Academy in Colorado Springs and have become only too common in war zones such as Afghanistan and Iraq.

The military fails to recognize that women have become a major source of military strength at the war fronts and make up a considerable percent of students at the academies. As proof of the destructive effects of assaults we now know that over 40 percent of our homeless women veterans were victims of such assaults.

Women in the Military are giving their lives for their country just as well as are men. By June, 2005 there were over 40 women's deaths reported in Iraq and Afghanistan and the number is growing rapidly.

The Jewish War Veterans of the USA acknowledges that women in the military are frequently not given fair treatment at the resulting hearings. The Jewish War Veterans of the USA demands that adequate measures be taken to give women a proper degree of respect and when these measures are violated that a fair and just hearing be convened without any derogatory fanfare surrounding such hearings. The military must take measures to ensure that women are not intimidated so that they hide these assaults.

MEETING THE SPECIAL NEEDS OF WOMEN VETERANS

The Jewish War Veterans of the USA (JWV) recognizes that there are service-related problems unique to the woman veteran which continues to be inadequately met by the Department of Veteran Affairs. JWV supports the allocation of VA resources to fully fund women's centers at all major VA medical facilities and provide specially trained medical professionals at each veteran's outreach clinic. The services required include access to gynecologists, mammograms, mental health and rape counselors, as well as PTSD and Agent Orange screening.

STATE VETERANS HOMES

State veteran homes were founded for Civil War veterans in the late 1800s and have served veterans for over 100 years. Under the provision of Title 38, United States Code, the United States Department of Veterans Affairs (VA) is authorized to make aid payments to states maintaining state veteran homes subject to the provision of 38 CFR 18.13, Part 3, Section 51.40 (1).

Currently there are 119 state veteran homes operating in a total of 48 states and territories, providing hospital, skilled nursing, skilled rehabilitation, long-term care, Alzheimer's care, domiciliary care, respite care, and end of life care to veterans and their families.

The VA promotes the care and treatment of veterans in state veteran homes as one means to attain the goal of developing and maintaining the highest possible quality of patient care for eligible veterans. The VA can increase its share of state home per diem to 50 percent of the national average cost of providing care in a state veteran home.

Title 38, United States Code, authorizes the State Home Construction Grant Program which is funded by VA at 65 percent of total costs for construction of new state veteran home and renovation of existing facilities. The VA has not even kept pace with states' grant applications for construction of new state veteran homes and renovation projects, which VA itself considers to be top priority projects.

Furthermore, Title 38, United States Code, authorizes VA to make per diem payments for veterans residing in state veteran homes, and the State Veteran Home Program is recognized as a low cost alternative among all nursing care alternatives available to VA.

Recognizing the growing long-term health care needs of older veterans, the State Veterans Home Program must continue to be a vital health care provider and a low cost but high quality alternative for veterans needing long-term nursing care.

The Jewish War Veterans of the USA fully supports the legislative objectives of the National Association of State Veteran Homes (NASVH) that the States receive from VA a per diem payment for veteran residents that equals 50 percent of the national average cost of providing care in a state veteran home.

The Jewish War Veterans of the USA urges the Congress of the United States to fully fund state veterans home construction grant priority one projects for fiscal year 2006 and we urge the President and Congress to pledge their full support to the State Veteran Home Program as it is the most cost-effective nursing care alternative available to VA.

THE INDEPENDENT BUDGET

Jewish War Veterans is an endorser of the Independent Budget and we want to continue to emphasize the following points from the writers of this document:

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA) medical system.
- VA's mission to support the military medical system in time of war or national emergency is essential to the Nation's security.
- VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veteran's health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

BACK-UP TO DOD

VA Hospitals must be adequately funded, staffed and equipped to perform their vital role as this Nation's only back-up for DoD medical facilities. U.S. military personnel could possibly suffer casualties exceeding the capacity of the combined military medical treatment facilities.

In such a case, the VA would be vital to the Nation. JWV strongly urges the Congress to fund the VA to handle this potential workload.

HOMELAND SECURITY

In addition to being the back-up for DoD, VA medical facilities are the Nation's primary medical resource for Homeland Security. Should there be another catastrophic terrorist attack, especially in more than one location as occurred on 9/11, the VA would be utilized by the Department of Homeland Security.

Already, VA hospitals are preparing to handle mass casualties as well as victims of chemical, biological or radiological attack. JWV urges the Congress to fully recognize this mission of the VA and to fund the VA accordingly.

VETERANS HEALTH ADMINISTRATION

With young American servicemembers continuing to answer the Nation's call to arms in every corner of the globe, we must now, more than ever, work together to honor their sacrifices. Those men and women who return from battle with career ending injuries and life changing memories will turn to VA for their health care; health care they have earned through their service to this country. VA must be funded at levels that will ensure that all enrolled eligible veterans receive quality health care in a timely manner.

Today, there are nearly 26 million veterans. As more veterans choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. JWV fully supported the enactment of Public Law (P.L.) 104–262, the Veteran's Healthcare Eligibility Reform Act that established an enrollment system and uniform benefits package in the VA health care system. All eligible veterans should again be entitled to enroll. Veterans recognize that VHA provides affordable quality care that they cannot receive anywhere else.

THIRD PARTY REIMBURSEMENT AND MEDICAL CARE COLLECTIONS FUNDS

Many veterans, especially those in Priority Groups 7 and 8, have private health insurance through employment and many of those veterans would choose VA as their primary health care provider were they able to do so. VHA is now authorized to bill most fee-for-service and point-of-service insurance carriers, such as Blue Cross/Blue Shield. Not so with Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These payers simply reject VHA claims for reimbursement as "out of network". If these providers are Federal contractors, they should not be allowed to reject VA care as part of their network.

As do all working citizens, veterans pay into the Medicare system without choice. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system they cannot use their Medicare benefits at any VA health care facility. VA cannot bill Medicare for the treatment of Medicare eligible veterans' nonservice-connected medical conditions. JWV does not agree with this policy and supports Medicare reimbursement for VHA for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. As a Medicare provider, VHA would be authorized to bill and collect allowable third-party reimbursements from the Medicare Trust Fund for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

LONG-TERM CARE

JWV believes that VA should take its responsibility to America's aging veterans seriously and provide the care mandated by Congress. Congress should do its part and provide adequate funding to VA to implement its mandates.

ASBESTOS TRUST FUND

The Jewish War Veterans of the USA supports the establishment of a Trust Fund that would include veterans, their dependents and survivors which will ensure that claimants are adequately compensated for the illnesses and deaths arising out of their exposure to asbestos. Moreover, we believe it is only appropriate that any payments received from such Fund be in addition to and not offset by any compensation received from the Department of Veteran Affairs for service-connected disability.

JWV supports the Fairness in Asbestos Injury Resolution (FAIR ACT) (S. 852) that will establish a Trust Fund for victims, including veterans, who were exposed to asbestos during their military service.

The FAIR Act offers sick veterans a way to receive the compensation they deserve. Presently, it is difficult for veterans to turn to the courts for help with their asbestos related medical costs. Veterans are barred by law from suing their employer (the Federal Government) for compensation. By taking asbestos claims out of the court system, the FAIR Act will ensure veterans will have a speedy and just avenue for receiving compensation.

SENATE ACTION ON FLAG AMENDMENT

Mr. Chairman, JWV strongly supports the passage of the Flag Amendment, Senate Joint Resolution [S.J. Res.] 12, which is now only one vote away from approval.

JWV asks those in the Senate who have not yet endorsed the Amendment protecting our flag to do so immediately! Let's move the amendment to the states for ratification!

VETERANS BENEFITS ADMINISTRATION

The Department of Veterans Affairs has a statutory responsibility to ensure the welfare of the Nation's veterans, their families, and survivors. Each year, the 58 regional offices of the Veterans Benefits Administration (VBA) receive over 100,000 new and reopened benefits claims. A majority of these claims involve multiple issues that are legally and medically complex and time consuming to adjudicate. Whether a case is complex or simple, these offices are expected to develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner.

VBA has, over the last 3 years, begun aligning its policies and procedures and has directed most of the regional offices' time and effort toward reducing claims processing time and reducing the backlog of pending claims. Achievement of former VA Secretary Principi's stated goal of 100 days to process a claim, on average, and a backlog of 250,000 pending claims has been and continues to be VBA's number one priority. To fulfill mandated production quotas, regional office management and adjudicators have been put in the difficult and unenviable position of having to choose between deciding thousands of cases as quickly as possible or going through more time consuming steps and provide the claimant full due process.

Unfortunately for thousands of veterans and their families, their rights have been subordinated to bureaucratic convenience for the sake of an arbitrary administrative goal. This persistent disregard of the law prompted thousands to file otherwise unnecessary appeals. Since judicial review of veterans' claims was enacted in 1988, of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC), the remand rate has been above seventy percent. In a series of precedent setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, the courts have invalidated a number of longstanding VA policies and regulations because they were not consistent with the statute. In response to these decisions, VBA, less than a month ago, provided the regional offices with revised templates to conform to the directives of the court.

These court decisions added thousands of cases to regional office pending workloads, since they require the review and reworking of tens of thousands of completed and pending claims. As of February 25, 2006, the number of pending rating claims was 370,428 with a total of pending workload (including non-rating claims) of 580,378. While the number of claims has been increasing, the percentage of claims appealed has also increased. As of February 25, 2006, the number of appeals pending in the regional offices was 152,303. Data on regional office performance appear to contradict VBA's description of improvements in service to veterans.

JWV urges the Committee Chairmen and Secretary of the VA to give this issue their highest attention possible.

CONCURRENT RECEIPT

JWV greatly appreciates Congress' action to date, but strongly urges Congressional leaders and Members to be sensitive to the thousands of disabled retirees who are not yet included in concurrent receipt legislation enacted over the past years. Specifically, as a priority, JWV urges the Congress to expand combat-related special compensation to disabled retirees who were not allowed to serve 20 years solely because of combat-related disabilities.

Additionally, JWV urges the Congress to ensure the Veterans' Disability Benefits Commission protects the principles guiding the DoD disability retirement program and VA disability compensation system.

JWV applauds the Congress for all of the work that resulted in the landmark provisions in the fiscal year 2004 National Defense Authorization Act that expand combat related special compensation to all retirees with combat-related disabilities and authorizes—for the first time ever—concurrent receipt of retired pay and veterans' disability compensation for retirees with disabilities of at least 50 percent. The fiscal year 2005 National Defense Authorization Act provided additional relief to those with disabilities rated at 100 percent by immediately authorizing these retirees full concurrent receipt, effective January 2005. Disabled retirees everywhere are extremely grateful for this action to reverse an unfair practice that has disadvantaged disabled retirees for over a century.

While the concurrent receipt provisions enacted by Congress benefit tens of thousands of disabled retirees, a greater number are still excluded from the same program that eliminated the disability offset for those with 50 percent or higher disabilities. The fiscal challenge notwithstanding, the principle behind eliminating the disability offset for those with disabilities of 50 percent is just as valid for those with 40 percent and below, and JWV urges Congress to be sensitive to the thousands of disabled retirees who are excluded from current provisions.

As a priority, JWV asks the Congress to consider those who had their careers cut short because they became disabled by combat, or combat-related events, and were medically retired before they could complete their careers. For these retirees, the disability offset still exists and it is difficult to explain to a lengthy career servicemember, disabled in combat, why his or her service (perhaps as much as 19 years) seems to have had no value. JWV urges the Congress to expand Combat Related Special Compensation to those medically retirees who had less than 20 years of service.

FILIPINO VETERANS

The Jewish War Veterans fully supports the passage of H.R. 302 and S. 146, the "Filipino Veterans Equity Act" introduced by Congressmen Issa and Filner in the House and Senator Inouye in the Senate. This legislation will restore to all Filipino World War II veterans their benefits that were rescinded by Congress in 1946.

It is sixty years since the war in the Pacific ended. Sixty long years in which the Filipino World War II veterans and their sons and daughters have waited for equity. These are the soldiers who lived in a territory of the United States, who were drafted into service by President Franklin D. Roosevelt, and who fought along side American forces in the titanic battles of World War II—Bataan and Corrigidor. Their courage and bravery must be recognized.

Progress was made in the 108th session of Congress with the passage of legislation to improve health care and compensation for Filipino World War II veterans living in the United States. The Jewish War Veterans applauds this action and urges Congress to pass further legislation that lives up to the promises made to Filipino World War II veterans.

Bills introduced in the 108th Congress to grant benefits to Filipino World War II veterans were supported by 21 Senators and 207 Congress Members. The bills in the 109th session are quickly gaining co-sponsors. The Jewish War Veterans urges Congress to pass both bills—H.R. 302 and S. 146.

EX-PRISONERS OF WAR

Mr. Chairman, JWV asks the Committees' support for our ex-prisoners of war! Illness such as diabetes and osteoporosis should be presumed to be service connected for ex-POWs as they are Vietnam Veterans.

JWV supports the passage of H.R. 1598 and S. 1271 which would accomplish the above goals.

POW-MIAS

There is one issue that has long been the focus of our attention, and that is the POW/MIA accounting issue. Initially begun with sole focus on those missing and unaccounted for from the Vietnam War, the effort has expanded dramatically over the years since President Reagan raised the priority, thanks in no small measure to the National League of POW/MIA Families, our JWV and other veteran-related NGO's. We in the JWV fully support the POW/MIA families who have remained vigilant and serve as the conscience of our Nation in this regard.

We urge Congress to give thoughtful oversight to this issue of national concern. Together, we must work to ensure that assets and resources needed are in place to account for those who serve—past, present and future. Our commitment to the principles of the POW/MIA mission is a signal to the world that we, as a Nation stand fully with those who are fighting for the cause of freedom and against terrorism around the world.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery Administration (NCA) is charged with meeting the interment needs of the Nation's veterans and their dependents. There are approximately 14,200 acres within established installations in NCA. Just over half are undeveloped and, with available gravesites in developed acreage, have the potential to provide more than 3.6 million gravesites. More than 301,050 full-casket gravesites, 58,500 in-ground gravesites for cremated remains, and 37,900 columbarium niches are available in already developed acreage in our 120 national cemeteries. JWV commends the NCA in its efforts to meet its accessibility goal of 90 percent of all veterans living within 75 miles of open national or state Veterans cemeteries.

CONCLUSION

Senator Craig and Senator Akaka, on behalf of the Jewish War Veterans of the USA, we sincerely thank you for scheduling our presentation at a time when our National Executive Committee members will be present.

At our annual national conventions our members work diligently to develop our legislative priorities. Our dedicated resolutions chairman, PNC Michael Berman, works hard to develop our resolutions and to bring them before our convention delegates. Following further fine-tuning by our convention delegates, our resolutions are finalized, and become our legislative priorities for the coming year. We thank you for the opportunity to present them to you today.

Chairman CRAIG. David, thank you very much.

Now let us turn to Richard Schneider, Executive Officer for Governmental Affairs, Non-Commissioned Officers Association.

STATEMENT OF RICHARD C. SCHNEIDER, EXECUTIVE OFFICER FOR GOVERNMENTAL AFFAIRS, NON-COMMISSIONED OFFICERS ASSOCIATION

Mr. SCHNEIDER. Thank you very much, Chairman Craig, Ranking Member Akaka, Members of the Committee. It is a great opportunity to be here, and I want to say something about this Committee. You have made a difference with your leadership in representing veterans since you have come into office and made this a responsible, responsive Committee to the veterans of America, and we thank you for that.

I will also tell you we don't always agree with everything that is going on, and that is our job, to come here and tell you that. We don't agree that the budget is adequate. We don't agree it was adequate in 2006. We don't believe the proposed budget is adequate in 2007. And we question the management efficiencies that are part of that budget, and we question the number, and we articulate that it is probably going to be low, and that is a tragedy.

Mr. Salazar mentioned that there is going to be a planning of the budget, and it is going to start to spiral down after 2008. Well, I will tell you something, sir. That budget cannot go down after 2008 because medical costs are going up, and you still have all of these veterans behind me and those coming today who you have to take care of. So we need to look at that budget.

And I will tell you something, sir. We are not that old that we are forgetting who we are and what we are, and by that I mean it was only two or three years ago when a former Secretary of VA told us, "You will have Medicare Plus Choice to take care of the sevens and eights, and we are working that." Well, that has gone down the tube somewhere, and we would like to see it resurrected, and we would like to see this Committee ask the question, "What about Medicare Plus Choice that you said was coming?"

We would also like to know, what about TRICARE reimbursement? Why aren't we collecting more money from TRICARE and the DOD for the services that are being provided? Maybe there are ways to bring additional money into the VA without trying to put co-payments on the backs of the veterans who served America.

In that regard, sir, I would tell you we met with the Secretary of VA and we met with the Secretary of Health and Human Services less than 10 days ago, and we asked the question about Medicare Plus Choice. The Secretary of Health and Human Services said, "That is not our job. That is Congress's job. Go ask them."

And so we are here today and we are asking that question. We would like you to tell us.

But you know we are here for a number of reasons, and some of the reasons we are here for is to talk about the issues that most concern us. Mr. Akaka addressed the GI Bill and what it meant for him to continue in his life and career.

Well, we recognize as an enlisted organization of non-commissioned petty officers and all enlisted grades of the active, the Guard, and the Reserve, that we have on active duty today, active duty people who have served continuously from the era of the VEEP educational program, who were counseled not to sign up for VEEP and, as a result of not signing up, have never become eligible for the Montgomery GI Bill, and we believe that is a tragedy. We would like to see an open season for VEEP people in the service who would have been eligible, who either established or didn't establish an account, to have an opportunity to sign up for the Montgomery GI Bill.

We would also like to look at the Armed Services side and look at the Guard and Reservists who come into the service, who go and are deployed, come back with a tremendous benefit, but if they opt to go after the education, they leave the benefit on the table. They don't carry it with them. It is not portable. It terminates when they terminate their Reserve and Guard commitment, and by God, we think that is wrong. We think they ought to have the same opportunity that Mr. Akaka and all of us had with our GI Bill.

We would also like to recognize and speak for a moment about DIC and SBP offset. By God, there shouldn't be an offset. That is a tragedy.

If one of these people who took SBP while they were on active duty and later qualify for DIC, either lose their SBP benefit—they don't lose it. Now, get this technical apportionment. OK? If their DIC payment is higher than their SBP, they get a refund of all of the premiums that they paid in for the benefit that they wanted to have for their families. A refund.

That is not what they asked for. They paid in. They wanted a payment from their SBP account for their survivors. DIC only happened because something that happened to them in the military service from which they would later die qualified them for a DIC payment. And if the DIC payment is lower than the SBP, then they get the difference from SBP and they get a refund of some of the premiums that they paid.

We believe that is wrong. They ought to receive SBP and they ought to receive their DIC benefit, and we argue that position, and we bring it to your attention today.

We can go on, and I have got a red light. I hate red lights. I tend to ignore them except when I am driving.

Mr. RANDLES. I am not yielding any of my time.

Mr. SCHNEIDER. All right, don't yield any of your time.

But I would go back and I would say, sir, we appreciate who you people are. We appreciate what you do. We have a number of concerns, and I would like to just mention two, and then I will stop.

The Asbestos Trust Fund, we want that passed. We want the people who served not only years ago, but who have been exposed to asbestos right in that five-sided building across town, and in

Iraq in the past year, to have the opportunities of that Asbestos Trust Fund if they need it. We want that done.

The other thing we want done is, we don't want anyone—and I almost said the nasty word—pulling some horse pooky trick and doing something that would change VA's ability to buy discounted drugs, and move them up in their purchase price of drugs for the Department of Veterans Affairs and for all veterans by bringing the opportunity to Medicare-eligible.

We have nothing against Medicare-eligible, but we don't want the Federal Supply Schedule reviewed with the impact being we are going to change the Federal Supply Schedule and adjust the cost, which is then going to increase the co-payments all the way around. And in case you didn't get my earlier point, no co-payments.

[The prepared statement of Mr. Schneider follows:]

PREPARED STATEMENT OF RICHARD C. SCHNEIDER, EXECUTIVE OFFICER FOR GOVERNMENTAL AFFAIRS, NON-COMMISSIONED OFFICERS ASSOCIATION

Chairman Craig, Ranking Minority Member Akaka and Members of the Senate Committee on Veterans Affairs, the Non-Commissioned Officers Association of the USA (NCOA) is very appreciative for the opportunity to formally present its 2006 Legislative Agenda to the Senate Committee on Veterans Affairs. The fact that the leadership of this Committee determined on short notice to provide this hearing opportunity when the concept of an historical Joint Hearing was abandoned is in the judgment of NCOA indicative of your support of America's veterans, their families and survivors.

I am Gene Overstreet, 12th Sergeant Major of the United States Marine Corps (Retired), President and Chief Executive Officer of the Non-Commissioned Officers Association. I am joined today by CMSgt Richard C. Schneider, USAF (Retired), NCOA Executive Director of Government Affairs; and MSG Matthew H. Dailey, USA (Retired), Military Affairs Associate of the Association's National Capital Office.

INTRODUCTION

NCOA is privileged to represent active duty enlisted servicemembers of all military services, the United States Coast Guard, associated Guard and Reserve Forces as well as veterans of all components. We are in 2006 ever cognizant and vigilant of the sacrifices associated with duty in the Uniformed Services of the United States of America during the Global War on Terrorism.

NCOA representation of enlisted members from all services and components makes it unique and enables it to provide a full and comprehensive perspective on active duty, veteran and survivor issues for the Administration and this Congress.

The Association provides for these members and their families through every stage of their military career from enlistment to eventual separation, retirement and on to their final military honors rendered on behalf of a grateful Nation. The Association defines well its membership service as cradle, or enlistment, to grave and than continues to provide services to the veterans surviving family members.

NCOA is guided in its legislative role by resolutions adopted annually by its worldwide membership. We take those resolutions very seriously recognizing vital responsibilities to be in the forefront of issues impacting the large numbers of active duty, Guard and Reserve members currently in harm's way deployed around the world in America's War against Terrorism. In military parlance, this non-commissioned officer leadership team is standing on point here on Capitol Hill to articulate entitlement issues, protecting benefits as necessary, extending value to those benefits that have failed to keep pace in a 21st Century America, and last, to achieve new entitlements to meet the needs of today's warriors and their family members. The promises of a grateful Nation must be honored and held sacred by its institutions for those who risk their very lives fulfilling their commitment to America.

The words of the Oath of Military Enlistment are simple but provide the very essence of service for every military man and woman by their ultimate declaration. These twelve words are the same for all who answer the Clarion Call to Duty:

". . . to support and defend the Constitution of the United States of America."

Please note that in the Enlistment oath there is no qualifying comment or words such as funds and resources permitting. There is the belief by those who serve that they will have the finest war fighting equipment, support services, health care, and all necessary institutional support while on active duty to include active and veteran health care support and should they fall in the line of duty the institutional support of a grateful Nation for their survivors. Granted, the War on Terrorism is somewhat different than a conventional war, but the words finest war fighting equipment has certainly been questioned and challenged not only by deployed personnel but by this Congress on the issues of personnel body armor and adequately armored vehicles.

We are also pleased for the spaciousness of this meeting assembly that allows you to look into the faces of active duty members and veterans who served in every national conflict and attend this hearing to support their organization's comments on veteran needs presented in their Legislative recommendations. There is no doubt that in this room there are those who could speak of their own personal experiences and question the adequacy and timeliness of benefit claim processing, challenge whether or not the discretionary VA health budget is adequate based on their access to needed specialized health care services or just plain primary care clinic appointments. I am humbled at the opportunity to raise my voice on their behalf and like you, I am so very proud of each man and woman who has worn a service uniform of this great Nation.

Military members deployed or stationed around the world today leave on the home front their spouses and family members. These marvelous military families live with not only the heartbreak and frustration of separation but the reality that separation may be compounded by sacrifices of overbearing personal consequence. Daily the news media brings in real time the sights, sounds and horrors being experienced by military members to the living rooms of their spouses and children. Soldiers are vividly seen weeping over a dead or wounded comrade and are joined countless thousands of miles away by the emotion and tears of family and friends who share the wounding or loss of an American Patriot.

The Association makes note that Non-Commissioned Officers Association is a member of The Military Coalition, a forum of nationally prominent uniformed services and veterans' organizations that shares collective views on veteran and active duty issues. The Association is also a veteran organizational supporter of the 2007 Independent Budget.

VA FISCAL APPROPRIATIONS

The past twelve fiscal years of funding for the programs of the Department of Veterans Affairs have been characterized by five (5) years where fiscal growth was nearly steady state yielding an increase of less that 3 percent. Following those early years were by 6 years including the past fiscal year of notable budget growth which while significant paled in comparison to the events of a nearly completed decade in which the number of veteran users and medical cost increases outpaced budget gains.

FISCAL YEAR 2006 APPROPRIATION

NCOA recognizes that the availability of an adequate annual appropriated budget for the Department of Veterans Affairs directly impacts VA programs and the legislative priorities approved by Congress. It was evident to veteran service organizations that the Department's current fiscal year 2006 Budget would be inadequate without additional appropriations.

Today, GAO–06–359R issued on February 1, 2006, Subject: Limited Support for VA's Efficiency Savings has brought into serious question budget assumptions used by the VA in formulating its Appropriated Budget for the past three fiscal years. It appears from this report that the documented creative accounting of Management Efficiencies totaling billions of dollars used to offset and directly lower the VA budget requirement in support of veteran health care in the current operating year was flawed. Those same management efficiencies contributed to the development of the VA fiscal year 2007 Proposed Budget.

FISCAL YEAR 2007 APPROPRIATION

NCOA supports Mandatory Funding for Veteran Health Care. All veterans that Congress approved as eligible and VA approved for health care enrollment should be included in the Mandatory Appropriated Budget Process.

The fiscal year 2007 Budget is signaled as representing the largest proposed increase in health care appropriation, an increase over fiscal year 2006 of $3.5 billion. NCOA reserves comment in lieu of the high probability that VA health care may

have been inappropriately limited by cost efficiencies that masked actual fiscal requirements for health care approved for the past year (re: GAO 06–359R).

The Proposed 2007 Budget Request again advances increased proposed pharmacy co-pays and enrollment fees.

NCOA Opposes Increased Co-Pays and Enrollment Fees

We take exception to those who would comment on how well off financially MOST veterans and military retirees are that they could well afford the modest increases proposed. We also note that many military retirees take reduced Survivor Benefit Program (SBP) premium based benefits or fail to enroll in the program for any survivor benefits because their retired pay is at that level that their personal fiscal reality dictates that every retirement penny is needed just to live. That decision to delay the security of their surviving families has many of them still at risk today.

Proposed increase in the existing pharmacy veteran co-payments of $8.00 to $15.00 per month.—NCOA recognizes that many aging veterans on fixed incomes could easily end up with a pharmacy co-payment costing an additional $100.00 or more per month. An increase of just $20.00 per month could dramatically negatively impact senior veterans.

And again a proposed enrollment or user fee of $250.00 for higher income Priority Groups 7 and 8.—This Association will continue as in the past to articulate that no "user" taxes in the form of any enrollment fee be required of any veteran.

The authority for Veterans Health Care provided to returning veterans from the war on terrorism for 2 years after their return. One use of VHA health services for any reason makes them eligible for continued enrollment for VA Health Care. NCOA supports that concept. At the same time, NCOA recognizes that veterans from earlier conflicts (WWII, Korea, Vietnam) or periods of service prior to the War on Terrorism cannot easily be enrolled and based on circumstance may never be enrolled unless VA succeeds in its enrollment fee plan or a Medicare + Choice Program for eligible veterans.

VA Medicare Subvention

A significant number of veterans are eligible for Medicare Health Benefits based on credits earned during their years of employment. These veterans by law cannot receive Medicare reimbursed health care services for nonservice-connected care from the Veterans Health Administration.

- In 2002, VA proposed a VA Medicare + Choice Plan for Medicare-eligible Priority Group 8 Veterans.
- NCOA suggests that this Committee request that the Secretaries of VA and Health and Human Services resurrect the promised envisioned VA Medicare + Choice Plan for eligible Priority Group 7 and 8 veterans.

Recommendations:

- That VA Appropriated Budget requires mandatory, vice discretionary, funding for veterans health care programs.
- That VHA work to secure and implement VA + Choice Medicare health services for Priority 7 and 8 veterans for nonservice-connected VA health care.
- That VA implements its long-standing initiative to become a TRICARE provider eligible for reimbursement for services provided.

SEAMLESS TRANSITION VITAL

- One stop DoD/VA separation physical examination.
- VA Benefits determination before discharge.
- Detailing of military occupational exposures.
- Consistent and equitable medical and physical evaluation boards
- Implement the Electronic Medical Record for military personnel for use by DoD and VA throughout and following the member's military service.
- ACCESS to VA health care and benefits.

THE TRANSFORMATION OF VHA REMAINS INCOMPLETE

NCOA has long maintained before this Committee that the transformation of VHA remains incomplete as long as Mental Health is not fully integrated into its total health delivery system. The projected $3.2 billion in the fiscal year 2007 VA Budget for Mental health Services will significantly contribute to the NCOA envisioned health care transformation within VHA.

NCOA strongly believes the future of VA Health Care demands the dynamic expansion of Mental Health Programs into all primary medical care clinics. Recent studies reveal mental health intervention starting in the health care clinic can significantly reduce costs associated with both medical intervention and use of pre-

scription medications. The completed Transformation will ultimately contribute to the direct productivity and cost effectiveness of VA. This is the potential margin in which the future VA can significantly capitalize on its existing fiscal resources while reducing health care costs.

The Association applauded the VA Mental Health Strategic Plan designed to improve mental health services in CBOCs and rebuild substance abuse programs with $100 Million authorized in fiscal year 2005 and all Networks to receive Enhancement Funds in fiscal year 2006. Mental Health professionals are transitioning into the CBOCs to provide an integrated VA clinic concept, substance abuse (drug and alcohol) programs, homeless veterans, rehabilitation programs, and geriatric programs.

These programs will be effective if the mental health resource is a full time practitioner in the CBOC and not used as a part time resource to provide service at other locations, including other CBOCs, Homeless Grant and per Diem Locations, and fill other VA service requirements.

Recommendations

- Continue the resource commitment to fund and extend the strategic mental health plan by the integration of mental health professionals throughout VHA.
- Backfill vacancies created by the movement of mental health resources to CBOCs.

HOMELESS VETERAN PROGRAMS

Homeless Grant and Per Diem Programs

The VA Homeless Grant and Per Diem Program have effectively established community based programs to furnish outreach, supportive services, and transitional housing to homeless veterans. The program provided 2,180 operational community beds in fiscal year 2000 and through incremental increases a total of 7,820 beds in fiscal year 2005. NCOA recognizes the effectiveness of these 400 community based programs approved and funded by VA.

VA has been effective in managing the growth of the HOMELESS Grant and Per Diem program to ensure necessary support services are available. It is time for the controlled growth to be expanded to provide for these veterans. It is readily apparent that the Homeless Veteran population now estimated in excess of 180,000 requires a ramp-up in provider networks and support functions.

Priority for Homeless Veteran Providers in CARES/BRAC Decisions

The need for Community-Based Provider Support for Homeless Veterans is apparent across the Nation as is the number of Federal locations with surplus property that could be effectively used by communities to develop Homeless Grant and Per Diem facilities. Every effort should be made to give Community Homeless Veteran Programs priority in the reuse designation of surplus community property. Likewise, these special homeless veteran service programs should be given special fiscal consideration in reduced lease contracts.

Dental Care for Homeless Veterans

Dental Care was authorized IAW 38 U.S.C. 2062 for certain homeless veterans in approved VA programs. At issue are homeless veterans resident at approved community locations across the Nation. Authority for dental care lacks necessary funding to make the program a solid reality.

Recommendations:

- VA increase the annual number of homeless beds available through the Community Grant and Per Diem Program over the next 5 years to the existing authorization of $200 Million.
- That CARES and BRAC decisions on excess Federal property give exclusive priority to Community Homeless Veteran Providers and that lease contacts be significantly below enhanced rates established for the location.
- That Home Dental Care programs be funded in the Appropriated Budget cycle.

VETERANS BENEFITS ADMINISTRATION

Veteran Claim Processing

NCOA recognizes that current budget programs and number of full time employees processing claims within the Veterans Benefits Administration is inadequate to the task at hand. The Global War on Terrorism and commitment of military forces is substantially contributing to an increased workload in new claims. Concurrently, an aging veteran population seeks reevaluation of deteriorating service connected

medical conditions and related secondary health issues that further contribute to the claim process workload.

While significant initiatives have been developed to implement improved information technology systems they have neither expedited the management of the claim process, increased productivity through technology, nor reduced errors through intelligent systems, or provided needed time for the quality training of service representatives. A recent sampling of responses to inquiries at VA Regional Offices resulted in inappropriate responses to benefit eligibility questions which could deter a veteran from pursuing a claim.

NCOA recommends immediate funding be provided to hire, train and keep in place sufficient claim representatives to process the growing number of claims both backlogged and those just arriving in the system.

Recommendations:

• Accelerate recruitment and training to replace a growing retirement eligible workforce.

• Develop self-service computerized access to benefit and entitlement processes via email where centralized work centers could process the inquiries, respond to questions, or secure information for continuation of the claim process.

• NCOA strongly believes that time needs to be made available for both quality training and supervisor review for quality control.

• VBA should determine the feasibility to have selected retired VBA employees return to the workforce for a contract period during which time new employees could be effectively trained and integrated into claim production centers.

Retention of DIC Benefits after Remarriage

The 108th Congress authorized Dependency and Indemnity Compensation (DIC) widows who remarry after age 57 to retain their DIC benefits. This was a major change in policy, which previously did not permit reinstatement of any DIC benefit if the DIC widow remarried. It also established an arbitrary age of 57 where other similar Federal programs allow remarriage at age 55. NCOA urges the Committees to change reinstatement of this benefit for a widow(er) who remarries at age 55.

Recommendations:

• That Congress provide authority to permit a DIC widow(er) to remarry after the age of 55 (vice 57) and retain DIC status and benefits.

Concurrent Receipt of DIC and SBP

It is time to end the fiscal offset of VA Survivor DIC from the DoD Survivor Benefit program. NCOA believes that DIC and SBP entitlements are separate and distinct programs. SBP represents an election by the servicemember with concurrence by the member's spouse at time of retirement for which a monthly premium is paid to provide a spousal annuity. The DIC benefit is authorized based on the veteran's death from a service-connected disability. Clearly, these two programs SBP administered by the Department of Defense and DIC administered by the Department of Veterans Affairs are separate and distinct entitlements and each should be available without offset. The current offset is widely regarded as a widow's tax reducing the military member's elected SBP entitlement. NCOA urges the Committee to allow concurrent receipt of these distinctly different entitlements.

Recommendation:

• That DIC and SBP entitlements are provided the surviving spouse without offset.

Revise DIC Payment Policy

DIC benefits are paid monthly for the preceding month. If the DIC recipient dies at any time in the preceding month, that month's DIC payment is recouped by the Department of Veterans Affairs. Example: VA recoups the entire payment made for the month in which the recipient died regardless of when the recipient died (the 1st day, 15 day or last day of the month). VA, if notified of the death promptly, will make a reverse electronic debit from the account of the electronic deposit. This action has many times resulted in financial hardship caused by former recipient's family members using all resources available to make funeral and estate arrangements without awareness of the debit that occurred. Similarly, written checks received and deposited to the deceased member's account will inevitably result in an overpayment collection notice. Most DIC recipients and their family members have spent a lifetime augmenting VA health care and the physical day-to-day life style needs of their disabled veteran. Creating a negative financial impact on the children and/or estate of a widow(er) of a former disabled veteran is in NCOA judgment patently wrong.

Recommendation:

• Allow the family (estate) of a widow(er) to retain the entire month's DIC payment in which the recipient's death occurred.

EDUCATIONAL BENEFITS

Open Enrollment for VEAP-Era Non-Participants

A significant number of servicemembers who entered the military during the Veterans Educational Assistance Program (VEAP) era initially declined VEAP enrollment and remain on active duty and have no post-service educational assistance. The Defense Manpower Data Center reports that as of September 2004 that are 61,980 active duty servicemembers in the force who declined VEAP upon entering military service. They have not been given the same opportunity to enroll in the Montgomery GI Bill (MGIB) as other VEAP-era entrants who actually enrolled in VEAP.

The Association recognizes that there have been two opportunities for VEAP enrollees to convert to the MGIB; however, there has never been an opportunity for those who did not enroll in VEAP to do so. The first VEAP conversion program was offered only to those enrolled in VEAP with active accounts of at least $1.00. This conversion was conducted from October 1996 through October 1997 and yielded approximately 30,000 enrollees. A second VEAP conversion was authorized for those enrolled in VEAP with zero-balance accounts from October 2000 to November 2001. 2,698 (2 percent) of the 108,792 eligible actually enrolled in the MGIB. With such historically modest conversion numbers, it is highly unlikely that an open-enrollment opportunity for this group of career servicemembers would require more than a modest projected increase in the MGIB fund. With the Nation at war, these future veterans should be given the same opportunity to enroll (or decline) the MGIB as all other servicemembers.

Recommendation:

• That a one-time MGIB open-enrollment opportunity be authorized for all servicemembers to include VEAP-era non-participants.

Removal of MGIB Delimiting Date

Many active duty members separate or retire from the military and because of financial circumstances and need for employment to support their families never use their Montgomery GI Bill entitlement. Their education entitlement expires 10 years following separation from the military. Members contribute $1,200 to be eligible for the MGIB. Many of these veterans are only able to pursue educational programs or special classes later in life when their own children are grown and independent of parental financial support.

Recommendations:

• That all military retirees have utilization of their MGIB entitlement to a delimiting date equal to 10 years after separation from service, or if higher, the number of years served in the military.

• That veterans have access to the unused portion of their $1,200.00 enrollment fee after the authorized delimiting period to pursue educational endeavors.

Integrate MGIB Authority for Active, Guard, and Reserve

NCOA strongly recommends that the Montgomery GI Bill be consolidated into a single Law to provide those educational benefits deemed appropriate for members of the Active, Guard, and Reserve personnel.

Having all educational entitlements in such a format would cause review of entitlements, expanded benefits, benchmark benefits to cost of education, parity between components, and reviews to be done concurrently vice separate actions over an extended period of time.

Recommendation:

• Consolidate all MGIB Programs within one Law.

CONCLUSION

The Non-Commissioned Officers Association has appreciated this opportunity to provide this Committee with the Association's 2006 Veteran Legislative Goals and comment on the VA fiscal year 2007 Budget Request.

Your work is in fact the driving force to improving the lives of the men and women who serve or have served their country in the armed services. Your efforts signal that those who answer the call to protect all American citizens by serving in the armed services is appreciated and valued. Our Nation must reward freedom's protectors with significant, substantive benefits. Your Committee in our judgment wears the mantel that fulfills the promises of Lincoln and a grateful Nation to care for those who have borne the battle . . .''

Chairman Craig, Ranking Minority Leader Akaka, and Members of the Senate Veterans Committee, the Non-Commissioned Officers Association requests that you maintain a comprehensive vision for veterans that by necessity extend to programs

that do not fall under your Committee's jurisdiction but clearly impacts veterans and their survivors. As advocates for veterans' issues, NCOA asks that you take an aggressive leadership role on such issues as:

Concurrent Disabled Retired Pay

Authorize concurrent receipt of all military retired pay and VA disability compensation without offset.

Authorize concurrent receipt for those veterans retired because of physical disabilities prior to the completion of 20 years of military service and those offered early retirement at 15 years of service as a force reduction program.

Combat Related Special Compensation

Include Individual Unemployability in rating decisions for CRSC.

S. 852—Fairness in Asbestos Injury Resolution Act

As citizens and colleagues urge support of legislation in the Senate (establishment of the Asbestos Trust Fund) to provide immediate settlement for countless Americans including significant numbers of military and DoD personnel exposed to asbestos and whose lives today or in the future are terminal from medical conditions such as mesothelioma, pneumoconiosis, pulmonary fibrosis, lung disease, bronchogenic carcinoma, malignant mesothelioma. Naval personnel historically have been associated with asbestos exposure resulting from use in the construction of naval vessels for fire protection but in recent years the Nation's military have been exposed to asbestos not only on ships, but buildings including the Pentagon and barracks in Iraq.

Codifying Burial Rules for Arlington National Cemetery

NCOA strongly believes that the existing rules for internment at Arlington National Cemetery should be changed to allow burial of retirement eligible reservists, without regard to an age limitation, reservists on active or inactive duty for training, and their eligible dependents family members should all be entitled to burial at ANC. It is reprehensible to bar any reservist the right to be buried based on an arbitrary age requirement or deny when the death results during an authorized active or inactive training period. Members of the Reserve Components need to be fully recognized as a vital element of the Armed Forces and their training periods prepares them for war and other hostilities where they are placed in harm's way. Recommend the following provisions be so codified:

- The burial entitlement of a retirement eligible member of a Reserve Component who at the time of death was under 60 years of age and who, but for age would have been eligible at the time of death for retired pay under 1223 of Title 10 may be buried at ANC on the same basis as the remains of members of the Armed Forces entitled to retired pay under that chapter. The remains of the dependents of a member whose remains are eligible for burial at ANC on the same basis as dependents of members of the Armed Forces entitled to retired pay under such chapter 1223.
- The remains of member of a Reserve component or National Guard of the Armed Forces who dies in the line of duty while on active duty for training or inactive duty training my be buried at ANC on the same basis as the remains of a member of the Armed Forces who dies while on active duty. Provide for the remains of the dependents of a member on the same basis as dependents of members of active duty.

100 Percent Disabled Veteran Space Available Travel

Seek and support legislation that will establish a Space Available (Space A) category for 100 percent service connected disabled veterans on military aircraft or government transportation afforded military retirees

Thank you for the opportunity to present the Association's legislative initiatives on behalf of the membership of the Non-Commissioned Officers Association of the United States of America.

Chairman CRAIG. Richard, your message has been delivered, very clearly.

Mr. SCHNEIDER. Thank you, sir.

Chairman CRAIG. Thank you so much. Now—and if you will all notice, probably the good news is I am losing my voice, so you won't have to put up with me much longer today—now let me turn to James Randles, National Commander, Military Order of the Purple Heart. Jim, welcome.

STATEMENT OF JAMES RANDLES, NATIONAL COMMANDER, MILITARY ORDER OF THE PURPLE HEART OF THE U.S.A., INC.

Mr. RANDLES. Chairman Craig, Ranking Member Senator Akaka, Members of the Committee, ladies and gentlemen, I always love following an NCOA speaker because they have this eloquence with their language, and they always get their point across because somehow they never need a microphone.

[Laughter.]

I am proud to be here today in front of this distinguished body on behalf of the members of the Military Order of the Purple Heart. I am accompanied today by our National Service Director, Jack Leonard, and our National Legislative Director, Herschel Gober.

I would like to begin by thanking Congress for doing the right thing by increasing the death gratuity and other benefits for the servicemen and women who are serving our country in uniform. This was one of our legislative goals from last year. We cannot ask our military personnel to put themselves in harm's way without committing to the welfare of their survivors.

My next point is about adequate funding for the VA. I think everybody has expressed their feelings and how their organization feels, but we strongly support the independent budget, and we have for years, that is presented to Congress every year by the PVA and DAV and the VFW and the——

Mr. SCHNEIDER. AMVETS.

Mr. RANDLES [continuing]. AMVETS. Thank you. I had one of those senior moments, Dick.

But I can best describe our support by repeating what I told a group in February when I was up here, the Democratic Senators that had us over, that when somebody in Congress has asked me what I think the appropriate level for adequate funding would be, I have to quote what my wife tells me every year when I ask her what she wants for Christmas, and she says, "I want it all."

So that is the way I feel, how we should take care of—because we are not just talking about the ones that are "We have been there, done that." We are talking about the ones that are there now. And if the money is not there, what are we going to do with them? You know, we send them over there, and we have got to take care of them when they come back. You know, serving in the military, and not just serving in war, you are going to have casualties and you are going to have disabilities, so we have to take care of the troops.

One of the points, and we of the Purple Heart support, and we have fought this and we have discussed this several years in our national convention, is Senate Bill 2157, which is the award of the Purple Heart medal to those POWs who died in captivity. We strongly support that issue, and we think because of their suffering and so forth that they received while they were interned and their subsequent death, because of that that they deserve to receive the Purple Heart medal.

We also strongly support Senate Bill 558, which is of course the proverbial concurrent receipt, and we have been beating that one to death forever. I don't think I need to go into a long explanation.

We also would like to ask that the Senate along with the House, and the House has a bill, House Resolution 995, which provides for the payment of combat-related service compensation to the members of the Armed Forces who were retired prior to 20 years because of the disability they received while they were in the service.

Dick talked about SBP and DIC offset. I am an example. I am one of those guys at the table that falls into that category. I retired in 1987. I took out the SBP at that time because I wanted, if something happened to me, I wanted my wife to have part of my retired pay. Personally, I think she deserves all of it because she was just about as in the military as I was.

Well, we started looking at it, and SBP/DIC. Well, I have got, I am 90 percent disabled from the VA. I have been diagnosed with, perhaps I am coming down with diabetes now, as a result of Agent Orange. So the chances of me dying from a service-related disability are pretty good. Well, when you take that money that I put in, and like Dick said, if I die from that, she gets the choice, DIC or SBP, whichever is the greater.

Well, I compound that with, she is a retired school teacher in the State of Georgia, 32 years. She receives the State of Georgia retired pay. They have a law in the State of Georgia which I am dealing with in the State Legislature, that since she is a retired school teacher, she cannot receive any of my Social Security. So her only answer to me, her only response to me after she heard all of this is, "You can't die."

[Laughter.]

I can't die until you change the law. So, you know, kind of hurry, if you don't mind——

[Laughter.]

Mr. RANDLES [continuing]. Because I don't know. Getting on the streets of Washington, you have got to watch where you walk even when the light says go.

One of the issues that really gets to us is Senate Bill 1998. This is the Stolen Valor Act. I heard somebody tell me 1 day of statistics about the Vietnam veterans, that of the 1.6 million Vietnam veterans that served in Vietnam, 12 million of them are left.

[Laughter.]

Now, I don't know how we did that, but we suddenly multiplied. The Stolen Valor Act looks directly at those wanna-bes—I can't call them anything but that—that want to be recognized as wearing the Purple Heart medal, or the Silver Star, or the Medal of Honor, or whatever.

I want to take them to—well, for the lack of an NCO term, I want to take them to the mat. I want to put their rear ends in jail because I don't think it is right. I don't think it serves credibility for those of us who did serve and are sitting in this room today, for some guy to go running around out there saying he has got this, that, and the other thing, and getting awards for it.

Let me give you an example. In Georgia, if you have a Purple Heart, you get one free license plate for that car, for a car in your house. You don't pay any taxes or anything. That car is free. Well, if you say you have the Purple Heart, and you can get the Purple Heart thing off the Internet, and show it to the DMV, they have no idea whether you received the Purple Heart or not. That con-

stitutes fraud in my eyes, so I want to put that little sucker in jail. I am upset about that.

Federal supply thing, I support what Dick said. You know, I don't mind giving lower drugs, but I will be darned if I want the veterans have to be the recipient of everybody else getting lower cost of drugs. Find another way. You have just got to do that.

Asbestos Trust Fund, we strongly support that you pass that Asbestos Trust Fund. That is kind of like the wanna-bes. You know, you have got the guy who says, "Well, I was exposed to asbestos," but he has no symptoms of any of the illnesses, and the courts are clogged with those. That is the reason why it is taking so long, and we need to take care of those people that actually have disabilities because of their exposure to asbestos, not because they think they have.

Thank you very much.

[The prepared statement of Mr. Randles follows:]

PREPARED STATEMENT OF JAMES RANDLES, NATIONAL COMMANDER, MILITARY ORDER OF THE PURPLE HEART OF THE U.S.A., INC.

Chairman Craig, Ranking Member Senator Akaka, Members of the committee, ladies and gentlemen:

I am James D. Randles, National Commander of the Military Order of the Purple Heart (MOPH). It is an honor to appear before this distinguished body on behalf of the members of MOPH. MOPH is unique among veteran service organizations because our entire membership is comprised entirely of combat-wounded veterans who shed their blood on the battlefields of the world while serving America in uniform. For their sacrifices they were awarded the Purple Heart Medal.

National Service Director Jack Leonard and National Legislative Director Hershel Gober accompany me today.

This committee is extremely important to MOPH and its members. We look to you to represent the veterans of our country and to ensure that all Members of Congress understand that America must keep its promises to those men and women who have served and are now serving in uniform if we are to maintain a viable military and continue to enjoy the freedoms that we have. Veterans have earned their entitlements and benefits.

I would like to begin by thanking Congress for doing the right thing by increasing the death gratuity and other benefits for the service men and women who are serving our country in uniform. This was one of our legislative goals last year. We cannot ask military personnel to put themselves in harm's way without committing to the welfare of their survivors.

ADEQUATE FUNDING FOR THE VA HEALTH ADMINISTRATION

The Military Order of the Purple Heart (MOPH) is on record as supporting the Independent Budget, which is developed and submitted to Congress by the Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and American Veterans (AMVETS).

I am the third MOPH National Commander in a row to present as our number one priority Adequate/Assured funding for the VA Health Administration. MOPH joins our fellow VSOs in urging Congress to find a long-term solution to the annual funding crisis at the VA. The VA deserves a system that delivers funds on time to allow for long-term planning. With the ongoing War on Terror and our servicemembers returning home from war with medical conditions requiring treatment at VA hospitals, the VA needs the capability to meet their needs. The funding problem was demonstrated last year when the need to provide $1.5 billion in emergency supplemental appropriations for fiscal year 2005 surfaced, and the need to amend the fiscal year 2006 budget with an additional $1.977 billion. MOPH supports Senate Bill 331.

THE AWARD OF THE PURPLE HEART MEDAL TO THOSE POWS WHO DIED IN CAPITIVITY

The MOPH believes that those military personnel who suffered hardships and wounds or illnesses while held in POW camps and died as a result of their interment should be considered as combat casualties and eligible for the award of the

Purple Heart Medal. MOPH supports legislation that has been introduced in both houses of Congress (H.R. 2369 and S. 2157) that would authorize the award.

RETIRED PAY RESTORATION

MOPH is pleased that Congress has enacted legislation that authorizes some military retirees to concurrently receive both full military retired pay and any VA compensation to which they are entitled. MOPH's position is that ALL those eligible for concurrent receipt should receive it. MOPH supports Senate Bill 558.

COMBAT MILITARY RETIRED VETERANS

MOPH supports legislation to provide for the payment of Combat-Related Special Compensation to members of the Armed Forces retired for disability with less than 20 years of active military service. MOPH supports H.R. 995.

SURVIVOR BENEFIT PLAN (SBP) AND DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

MOPH supports legislation that will repeal the requirement for the reduction of SBP annuities by the amount of DIC compensation. Survivors of retirees who die of service connected causes and paid into SBP, and survivors of members killed on active duty, should receive both SBP and DIC without the current dollar for dollar offset. MOPH support Senate Bill 185.

STOLEN VALOR ACT OF 2005

MOPH supports S. 1998. It is unfortunate, especially with our country engaged in ongoing conflicts, that there are citizens in this country who lie about the medals that they received while serving in the military. This is not just an occurrence now and then but regrettably it is a huge problem. This legislation would provide for fines and imprisonment for those wannabees that dishonor the medals for valor and the Purple Heart Medal and those brave men and women who have legitimately received these medals. MOPH urges passage of this legislation.

PROTECTING THE FEDERAL SUPPLY SCHDULE (FSS)

The VA purchases approximately 24,000 pharmaceutical products at discounts ranging from 24 to 60 percent below drug manufacturers' most favored non-Federal, non-retail customer pricing through the FSS. Efforts have been made to open the FSS to other entities which would/could have the effect of the VA losing the favorable pricing and cost the VA hundreds of millions of dollars in unbudgeted funds, funds which they do not have and would have to divert from medical services that could deny veterans treatment. MOPH supports lower priced pharmaceuticals for all Americans but not at the expense of veterans.

ASBESTOS TRUST FUND

Many of our Nation's veterans were exposed to asbestos during their military service up until the mid-seventies when its use was discontinued. There is data that indicates the 26 percent of all mesothelioma cases, the most deadly form of this disease, are veterans. Further 16 percent of all other lung cases and 13 percent of all disabling lung disease cases again are veterans. Veterans cannot sue their employer, the U.S. Government and getting their day in court is difficult because most of the corporate manufacturers are bankrupt or no longer exist. MOPH supports Senate Bill 852 which would create a trust fund that would give just compensation to veterans. The current court system is not working for veterans.

Mr. Chairman this concludes my testimony. I will be pleased to answer your questions.

Chairman CRAIG. James, thank you very much for your testimony. We are going to work hard to keep you alive.

Mr. RANDLES. Thank you, sir.

Chairman CRAIG. Again, let me thank all of you for your testimony this morning. The reason in my opening statement I challenged you all is not because this Committee and the Members of the Committee are not going to work overtime to deliver this budget and beyond. We are.

But the reason this year I couldn't walk away from a revenue enhancement proposal is because I do believe it is time once again

that this community of interest and others begin to look at that freight train coming down the track at us. And I say that because, while this Congress has demonstrated its willingness, and I think they have, to fund VA—year after year they have outperformed Presidents and outperformed proposals in almost all instances by some amount.

Why? Because of our commitment to veterans. I hope that is not questioned. It may not have been at the level or it may not have been where you wanted it, but it was almost always greater than, for a variety of reasons. And the reason I say that is because there are some tremendously looming statistics on the horizon. For many here in this room they won't pertain, but for many of you they will.

And that is a simple and obvious fact that both conservative and liberal economists agree on, that if two norms continue, and that is, a growing economy and a tax base for the Federal Government that reflects about 14 percent of GDP, for those who say, "Well, we are not taxing enough," we are taxing right now at a historic norm, that is between 14 and 16 percent GDP, and that is on an average that has spread across time for a long while.

You find that if you tax too much above it, you begin to impact the economy and growth and all of those things, and job creation, so that has been a norm that, while we don't talk about it a lot, we try to sustain. So if we sustain that norm out there for another 20 years or 30 years, and of course we assume the economy is going to grow, there is going to be new jobs, therefore there will be new revenue. Right now we are taking in more revenue, right now, than when the tax cuts, the Bush tax cuts came along that I supported some years ago.

But having said all of that, by the year 2030 Social Security and Medicare and Medicaid will consume all of the Federal budget, all of it. Doesn't include you. Doesn't include Defense. Doesn't include Agriculture and Interior and Commerce and all of the other agencies of government, and Education. And there are few in this city who disagree with that statement. Now, that is 2030. That is a ways out there, but it isn't far.

And so no matter what we do this year, we are going to come in at or above what the President has proposed, would be my guess.

And I will support that and work to get it. But I am going to progressively challenge all of you to look beyond where your headlights are now shining. Why? In large part not for you, but for those young men and women coming out of Iraq and Afghanistan, and the future. Sustainability is what we are talking about here, and that is tremendously important, I think.

Thank you all for your testimony. Let me turn to Senator Richard Burr for any comments he has, or questions. Richard, thank you for joining us.

STATEMENT OF HON. RICHARD M. BURR, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you. Thank you, Mr. Chairman. More importantly, thank you for your leadership. And thank you to those on the panel today for your service, and more importantly, for your

passion, and to those in the audience for your service and your willingness to be here in support of those individuals who testified.

Mr. Chairman, I can't not take the lead that you have headed on, and that is the realities of what we deal with up here. Let me say if all five of you had not come and suggested that more was needed, then I would question why your associations chose you to be their spokesperson. I have yet to have anybody come to Washington, in the 12 years that I have been here, and suggest that we provide enough funding. But I have always expected that when I hear from you, I will see and hear the examples that back up the need for additional monies.

I think it is safe to say that, as Chairman Craig has already stated, every Member of this Committee is interested in getting it right. We will never provide everything, but the directional change that we have had in the last several years is a positive one, one where I think Members are engaged in education and, more importantly, the opportunity for you to share with us those stories has been available.

I think without the leadership of the Chairman and the Ranking Member, quite frankly we would not be here. We continue to work to try to make sure the items that each of you covered, which was sufficient funding, an efficient VA, one that did supply the services that were needed, that we work in concert with the Secretary and others at VA to make sure that in fact we are trying to complete the package as best we can.

We need your help. The Chairman did a good job of explaining what we see down the road as the fiscal challenges of this country, and we have an obligation that spreads far outside of the table you are at and the groups that are here, and it does extend from this generation to the next.

We need the same passion you display on your issues to be displayed on the fiscal crisis that the country is headed on. Just like 5 years ago there may not have been on your list asbestos as it related to your membership, today it is real, we know it is, and you are passionate and you are vocal on it, so should your interest in us reforming Medicare and Medicaid, so should your interest in us finding something that is sustainable for Social Security, because without it we are all affected.

So I implore all of you today, help us with this challenge that we have got. It is not Republican or Democrat, it is American, and it will dictate our flexibility in the future.

Mr. Schneider, if I could end on one thing, the next time you go to meet with the Secretary of HHS, would you come here first and let us give you questions for him, versus——

Mr. SCHNEIDER. Let me tell you, I will be over here and I will be looking for you when I go to see him again.

Senator BURR. I will assure you I will start on my list today.

Mr. SCHNEIDER. Start it now.

Senator BURR. The one thing that it terrifies me to hear is the territorial boundaries that seem to be established within the Federal Government. We represent the Congress, but I think that we stand beside the Administration regardless of what party they are in because the two have to work together.

And what is an issue that may affect you and may be the direct result of this Committee, I would hate for a Secretary to say, "I have no obligation, no responsibility. Go see the people that matters." The welfare of the American people should be the interest of Congress and the Administration, regardless of who they are, and I will assure you this Committee will always work to try to make sure that that level of cooperation exists for you and for everybody.

Once again, I thank you five for your testimony.

Chairman CRAIG. Richard, thank you very much. That was well spoken.

Let me close on this note: It is always amazing what you find when you dig through the files. I am looking at a Committee report from 1996 for the 1997 VA budget, and this is a dialogue that I am having with then the Secretary of VA, Jesse Brown. Many of you remember Jesse very well.

Jesse and the Clinton Administration had proposed a VA budget not unlike this one, in the sense there was growth in it but in the out-years there appeared to be a dramatic decline. And of course history would suggest that never happened, but what I found interesting is this, and I think the Secretary was being tremendously honest when I asked him that question: "How do we sustain this budget? And in the out-years it turns flat and it steeply declines. What is the Administration going to do about it?"

Here is his response: "The numbers that you have reflected in that chart"—he is talking about a chart I was using at that time—"do not have any policy behind them at this point." He has basically said that each and every year veterans will have a chance to come in and sit down and negotiate a budget.

And I thought that is a pretty clear statement, when you look back now at where we were then and where we are today, because that is exactly what has happened. Veterans' organizations like yours, advocates that you are, as well as you do it, obviously changed all of that. That was then, and that was 1996, and this is now, and we will work through it.

What I am going to ask of you in the coming year, as we get beyond the budget and get the numbers in place, is to dialogue with me and other Members about the future, not the 2008 budget, not the 2009 budget, but 2010 and beyond. We will ask this Administration to squeeze the numbers hard, and they are squeezing them now because they recognize the challenge. Secretary Nicholson was as frustrated last year as this Committee was angry about the numbers that he brought, that fell out from under him very rapidly.

As a result of that, this Committee has asked him to report back to us every quarter, and he is now doing that. We are tracking dollars and cents and people and services and programs on a quarterly basis, as is he.

That will give us a much more accurate reality check as we move into budget cycles than the kind that we fell into last year. That simply was no way to run an organization, and you all know it. You have seen it, and some of you have spoken to it today. What I am proposing to you is that at least as long as I have my hands on the tiller, folks at VA are going to hustle, and we are going to do everything we can to make sure that the dollars we get are spent wisely and appropriately for America's veterans.

So thank you all very much for being here today.

[Whereupon, at 11:14 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THEODORE G. STROUP, VICE PRESIDENT, ASSOCIATION OF THE UNITED STATES ARMY

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the 2006 legislative agenda of the Association of the United States Army (AUSA) as it deals with veteran's issues. Both in personal testimony and through submissions for the record, there exists a long-standing relationship between AUSA and the Senate Committee on Veterans' Affairs. We are honored that we have been asked to express our views on behalf of our members and America's veterans.

The Association of the United States Army is a diverse organization of over 100,000 members—active duty, Army Reserve, Army National Guard, Department of the Army civilians, retirees and family members. An overwhelming number of our members are entitled to veterans' benefits of some type. Additionally, AUSA is unique in that it can claim to be the only organization whose membership reflects every facet of the Army family. Each October, at our Annual Meeting, our membership has the opportunity to express its views through the consideration and approval of resolutions for the following year. These resolutions provide the base upon which the Association's leadership builds its legislative agenda.

Each year, the AUSA statement before the committee seeks to stress that America's veterans are not ungrateful. Much of the good done for veterans in the past would have been impossible without the commitment of many who serve on this committee and the tireless efforts of their professional and personal staffs.

The inherently difficult nature of military service has never been more self-evident than during the current conflict. While grateful for the good things done for veterans, AUSA reminds our elected representatives that we consider veterans benefits to have been duly earned by those who have answered the Nation's call and placed themselves at risk.

AUSA is heartened that Congress has expressed a commitment to support America's veterans. Despite this, many are concerned that the declining number of veterans in Congress might in some way lessen the value this institution places on veterans and their service to the Nation. We, at AUSA, do not share this opinion. AUSA is confident that you—well-intentioned, patriotic men and women—will faithfully represent the interests of America's veterans during fiscal deliberations.

As elected representatives, you must be responsible stewards of the Federal purse because each dollar emanates from the American taxpayer. AUSA emphasizes that the Federal Government must remain true to the promises made to her veterans. We understand that veterans' programs are not above review, but always remember that the Nation must be there for the country's veterans who answered the Nation's call.

Veterans seldom vote in a block, despite their numbers. This is one reason AUSA seeks this forum to speak for its members about veterans' issues. Our veterans have lived up to their part of the bargain; the Congress must live up to the government's part.

Those who have volunteered to serve their country in uniform deserve educational benefits that support their transition to civilian life. It is imperative that the Montgomery GI Bill (MGIB) remain relevant—that its benefit levels parallel the rising cost of education.

Currently, educational benefits under the MGIB do not reflect policy nor match benefits to service commitment. Basic benefits for active duty troops authorized under Chapter 30 of Title 38 have not kept pace with the rising costs of education and training.

AUSA strongly supports the goal to index the monthly MGIB stipend to the average annual cost of a 4-year public college or university. The proposal would benchmark the total benefit to about $37,000 and it would be adjusted automatically each

year based on a government index of college costs. Since the MGIB for some time has been one of the Services' best recruiting incentives, it is imperative that its buying power remain comparable to education costs.

AUSA strongly encourages Congress to raise education benefits for National Guard and Reserve servicemembers under Chapter 1606 of Title 10. For years, these benefits have only been adjusted for inflation. Currently, Reserve GI Bill benefits have fallen to less than 29 percent of the active duty benchmark. Additionally, Reserve benefits have no-post service value as a veteran benefit, even though almost half of the Select Reserve has served on lengthy combat tours since September 11. Further, a transfer of the Reserve MGIB-Select Reserve authority from Title 10 to Title 38 will permit proportional benefit adjustments in the future.

AUSA applauds Congress' effort to address the gap by authorizing a new MGIB program (Chapter 1607, Title 10 USC) for Guard and Reserve members mobilized for more than 90 days in a contingency operation. However, more than a year after the law was changed, the program has still not been implemented.

AUSA also believes it's time to revisit the need to dock volunteer force recruits $1200 of their first year's pay for the privilege of serving their country on active duty. Government college loan programs have no upfront payments; thus, it is difficult to accept any rationale for our Nation's defenders to give up a substantial portion of their first year's pay for MGIB eligibility.

Further, AUSA urges the committee to authorize greater flexibility in MGIB usage by amending Title 38 to permit use of MGIB benefits for up to 20 years post-separation or retirement in order to keep pace with market demands and to encourage veterans to acquire lifetime skills and knowledge during their working years.

AUSA strongly encourages Congress to allow all participants of MGIB's predecessor, the Veteran's Education Assistance Program (VEAP), as well as those servicemembers who were on active duty but did not enroll in VEAP, to receive MGIB educational benefits. There are about 63,000 non-commissioned officers and officers bravely serving their country in the war against terrorism at home and abroad in this situation. However, when they exit the service, they will have no education benefits to help them achieve their post-service goals like all other veterans. These servicemembers should be given the opportunity to take the MGIB or decline it.

AUSA continues to support giving MGIB participants who serve a full military career the option of transferring their benefits to dependents as a career retention initiative.

Members of the National Guard called to active duty under Title 32 in support of the current crisis do not receive veteran's status for their active duty military time. Those called to active duty under Title 10 do receive veteran's status. This inequity must be addressed. Your support in allowing Guardmembers to earn veterans' status on equal footing with their active duty and Reserve counterparts will send the message that National Guard personnel are part of the Total Force.

Veterans' medical facilities must remain expert in the specialties which most benefit our veterans. These specialties relate directly to the ravages of war and are without peer in the civilian community. Demand for VA health care still outpaces the capacity to deliver care in a timely manner. AUSA believes that full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism or by some other changes in the process that achieve the desired goal.

AUSA supports legislation that establishes a presumption of service connection for veterans with Hepatitis C (HCV).

AUSA applauds the unprecedented and historic legislation which authorized the unconditional concurrent receipt of retired pay and veterans' disability compensation for retirees with disabilities of at least 50 percent and the legislation that removed disabled retirees who are rated as 100 percent from the 10-year phase-in period.

However, we cannot forget about the thousands of disabled retirees left out by this legislative compromise. The principle behind eliminating the disability offset for those with disabilities over 50 percent is just as valid for those 49 percent and below. AUSA urges that the thousands of disabled veterans left out of recent legislation be given equal treatment and that the disability offset be eliminated completely.

Two other critical areas need to be addressed. For chapter 61 (disability) retirees who have more than 20 years of service, the government recognizes that part of that retired pay is earned by service, and part of it is extra compensation for the service-incurred disability. The added amount for disability is still subject to offset by any VA disability compensation, but the service-earned portion (at 2.5 percent of pay times years of service) is protected against such offset.

AUSA believes that a member who is forced to retire short of 20 years of service because of a combat disability must be vested in the service-earned share of retired pay at the same 2.5 percent per year of service rate as members with 20+ years of service. This would avoid the all or nothing inequity of the current 20-year threshold, while recognizing that retired pay for those with few years of service is almost all for disability rather than for service and therefore still subject to the VA offset.

Recent legislation restored full retired pay for members designated as unemployables in 6 years rather than 10 years as originally legislated. While AUSA is appreciative of the accelerated schedule, we would like to see the disability offset to retired pay end immediately.

Legislation provided in previous defense bills authorized Combat Related Special Compensation (CRSC) for certain retirees with combat- or operations-related disabilities. Unfortunately, CRSC has been slow in implementation because of the requirement to connect retirees' disabilities directly to combat, a combat-related event or combat-type training. This validation requires retrieval of VA medical records, an excruciatingly slow process. Many qualifying retirees are still waiting for compensation authorized to them. AUSA urges the Committees to authorize proper funding to ensure timely processing of any expected increase in disabled veterans' claims for this or other reasons.

The rules for interment in Arlington National Cemetery (ANC) have never been codified in public law. Twice the House has passed legislation to codify rules for burial in Arlington National Cemetery. However, the legislation has not passed in the Senate. AUSA supports a negotiated settlement of differences between the House and Senate concerning codification of rules for burial in Arlington National Cemetery. Further gray area reservists eligible for military retirement should be included among those eligible for interment at Arlington National Cemetery.

AUSA is opposed to the Administration's request to impose an annual deductible on veterans already enrolled in VA health care and the proposed increase in the copayment charged to many veterans for prescription drugs.

AUSA supports continuing congressional efforts to help homeless veterans find housing and other necessities, which would allow them to re-enter the workforce and become productive citizens.

Terminally ill veterans who hold National Service Life Insurance and U.S. Government Life Insurance should, upon application, be able to receive benefits before death, as can holders of Servicemembers Group Life Insurance and Veterans Group Life Insurance. AUSA supports legislation to amend the U.S. Code appropriately.

Much more needs to be done to ensure that returning combat veterans, as well as all other service men and women who complete their term of service or retire from service receive timely access to VA benefits and services. This issue encompasses developing and deploying an interoperable, bi-directional and standards-based electronic medical record; a one-stop separation physical supported by an electronic separation document (DD–214); benefits determination before discharge; sharing of information on occupational exposures from military operations and related initiatives. AUSA strongly recommends accelerated efforts to realize the goal of seamless transition plans and programs.

We encourage the positive steps toward mutual cooperation taken recently by the Department of Defense (DOD) and the VA. The closer we can come to a seamless flow of a servicemember's personnel and health files from service entry to burial, the more likely it will be that former servicemembers receive all the benefits to which they are entitled. AUSA supports closer DOD–VA collaboration and planning including billing, accounting, IT systems, patient records, but not total integration of facilities nor of VA/DOD healthcare systems.

AUSA strongly supports preservation of dual eligibility of uniformed service retirees for VA and DOD healthcare systems. We applaud Congress' opposition to "forced choice" in the past and encourage you to hold the line in for the future.

AUSA recognizes that significant progress has been made in reducing the unacceptably high numbers of backlogged disability claims. The key to sustained improvement in claims processing rests on adequate funding to attract and retain a quality workforce supported by investment in information management and technology.

Your committee safeguards the treatment of America's veterans on behalf of the Nation. AUSA knows that you take this responsibility seriously and treat this privilege with the gratitude and respect it deserves. Although your tenure is temporary, the impact of your actions lasts as long as this country survives and affects directly the lives of a precious American resource—her veterans. As you make your decisions, do not forget the commitment made to America's veterans when they accepted the challenges and answered the Nation's call to serve.

Thank you for the opportunity to submit testimony on behalf of the members of the Association of the United States Army, their families, and today's soldiers who are tomorrow's veterans.