HEARING ON OPERATIONS WITHIN THE COMPENSATION AND PENSION SERVICE USING GPRA PRINCIPLES, ON THE PROCESSING OF PERSIAN GULF WAR CLAIMS, AND VA'S PROPOSED LEGISLATION TO LIMIT THE LIABILITY FOR SMOKING-RELATED ILLNESSES

HEARING

BEFORE THE

SUBCOMMITTEE ON BENEFITS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MAY 14, 1997

Printed for the use of the Committee on Veterans' Affairs

Serial No. 105–8

U.S. GOVERNMENT PRINTING OFFICE

43–213 CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-055510-8

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON VETERANS' AFFAIRS

BOB STUMP, Arizona, *Chairman*

CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
FLOYD SPENCE, South Carolina
TERRY EVERETT, Alabama
STEVE BUYER, Indiana
JACK QUINN, New York
SPENCER BACHUS, Alabama
CLIFF STEARNS, Florida
DAN SCHAEFER, Colorado
JERRY MORAN, Kansas
JOHN COOKSEY, Louisiana
ASA HUTCHINSON, Arkansas
J.D. HAYWORTH, Arizona
HELEN CHENOWETH, Idaho
RAY LAHOOD, Illinois

LANE EVANS, Illinois
JOSEPH P. KENNEDY II, Massachusetts
BOB FILNER, California
LUIS V. GUTIERREZ, Illinois
SANFORD D. BISHOP, Jr., Georgia
JAMES E. CLYBURN, South Carolina
CORRINE BROWN, Florida
MICHAEL F. DOYLE, Pennsylvania
FRANK MASCARA, Pennsylvania
COLLIN C. PETERSON, Minnesota
JULIA CARSON, Indiana
SILVESTRE REYES, Texas
VIC SNYDER, Arkansas

CARL D. COMMENATOR, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON BENEFITS

JACK QUINN, New York, *Chairman*

DAN SCHAEFER, Colorado
J.D. HAYWORTH, Arkansas
RAY LAHOOD, Illinois

BOB FILNER, California
FRANK MASCARA, Pennsylvania
SILVESTRE REYES, Texas

CONTENTS

Page

OPENING STATEMENTS

Chairman Quinn 1
Prepared statement of Chairman Quinn 41
Hon. Bob Filner 3
Prepared statement of Congressman Filner 44
Hon. Lane Evans, ranking democratic member, Full Committee on Veterans' Affairs 13
Prepared statement of Congressman Evans 46
Hon. Frank Mascara 53

WITNESSES

Backhus, Stephen, Director, Veterans' Affairs and Military Health Care Issues, General Accounting Office 23
Prepared statement of Mr. Backhus 72
Burns, Chuck, National Service Director, AMVETS 32
Prepared statement of Mr. Burns 96
Magill, James, Director, National Legislative Service, Veterans of Foreign Wars accompanied by John Muckelbauer, Military Claims Consultant 31
Prepared statement of Mr. Magill 94
Moffitt, Kristine, Director of Compensation and Pension Service, Department of Veterans Affairs 4
Prepared statement of Ms. Moffitt 61
Puglisi, Matthew, Assistant Director, National VA and Rehabilitation Commission, The American Legion 27
Prepared statement of Mr. Puglisi 85
Russo, William, Director, Veterans' Benefits Programs, Vietnam Veterans of America 29
Prepared statement of Mr. Russo, w/attachment 89
Violante, Joseph, Deputy National Legislative Director, Disabled American Veterans 25
Prepared statement of Mr. Violante, w/attachment 78

MATERIAL SUBMITTED FOR THE RECORD

Statement:
Non Commissioned Officers Association 100
Written committee questions and their responses:
Chairman Quinn to Department of Veterans Affairs 105
Chairman Quinn to Disabled American Veterans 154, 156
Congressman Evans to Disabled American Veterans 159
Chairman Quinn to The American Legion 161, 163
Congressman Evans to The American Legion 166
Chairman Quinn to Vietnam Veterans of America 169
Chairman Quinn to Veterans of Foreign Wars 171
Congressman Filner to Veterans of Foreign Wars 173
Congressman Filner to Non Commissioned Officers Association 175

HEARING ON OPERATIONS WITHIN THE COMPENSATION AND PENSION SERVICE USING GPRA PRINCIPLES, ON THE PROCESSING OF PERSIAN GULF WAR CLAIMS, AND VA'S PROPOSED LEGISLATION TO LIMIT THE LIABILITY FOR SMOKING-RELATED ILLNESSES

WEDNESDAY, MAY 14, 1997

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON BENEFITS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Jack Quinn (chairman of the subcommittee) presiding.

Present: Representatives Quinn, Hayworth, LaHood, Filner, Evans, Mascara, Reyes.

OPENING STATEMENT OF CHAIRMAN QUINN

Mr. QUINN. Good morning. The subcommittee will come to order and begin the hearing today on operations within the Compensation and Pension Service using the GPRA Principles. We'll also hear some testimony today on the VBA's processing of Persian Gulf claims and hear remarks as well about the Administration's legislative proposal to limit the VA's liability for smoking-related illnesses.

The Compensation and Pension Program distributes about $16 billion dollars annually to veterans and their survivors. Title 38 states that the mission of the compensation program is to provide monthly payments for disability resulting from personal injury or disease contracted in the line of duty, or for aggravation of a preexisting injury suffered, or a disease contracted in the line of duty in the active military, naval, or air service.

At the end of last fiscal year, there were about 2.6 million veterans receiving compensation and 305,000 survivors receiving Dependency Indemnity and Compensation and death compensation.

Section 1155 describes the method of determining these payments as a "schedule of reductions in earning capacity...based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations."

The current rating schedule provides monthly payments ranging from $94 to $1,924, plus a wide array of supplemental benefits that

may raise payments above the $5,000 mark for our most severely disabled veterans.

Title 38 is less clear about the purpose of the pension program. However, it is clear that Congress intended the program to provide non-service connected, totally disabled wartime veterans a minimum level of income—about $8,450 for single veterans. There were over 372,000 veterans receiving pension and about 200,000 survivors receiving death pension in September of 1996. Last year, the average pension program benefit was about $4,225. Clearly, as all of us know, nobody in the program is getting rich.

Judging from the VA's budget submission, as well as the meetings between the VA and Committee staff to discuss the Department's progress towards compliance with the Results Act, it's clear that the VBA has spent considerable effort on the project. And today we will hear about additional progress, I'm certain.

We are also planning to review the VA's handling of Persian Gulf claims. There appears to be considerable interest in decentralizing Persian Gulf claims processing. And all of us are interested in what the stakeholders have to say on this issue.

I want to point out that each of the VSO witnesses today will criticize the way the VA has handled these claims. I also hope that each of them will be prepared to go beyond the criticism of the centralized processing system that the VA appears to be backing away from and address the more substantive issues like consistency, timeliness, management, and direction.

We want to all be assured that the VA now has a handle on that processing. It is unfortunate that the processing of these Persian Gulf claims has been characterized by what appears to be a lack of strategic direction. At least that's the characterization.

There also appears to be a lack of training, some poor outreach, inconsistent development of evidence, and some failures in duty to assist. Therefore, I will ask the GAO to review processing, with an emphasis on duty to assist and development of Persian Gulf claims, and report their findings back to the subcommittee as soon as possible.

There continues to be a strong perception that the DOD and the intelligence agencies are not telling everything they know. We want to get to the bottom of this, and we'll hold as many hearings as necessary to solve this problem.

Trust is the glue that holds this society together, and I'm deeply disturbed about the continuing revelations regarding chemical weapons incidents.

I'd like to ask the VA to provide a list of all projects they are sponsoring concerning Persian Gulf Illness—the funding for each, a short description of the project and the name of the principle researcher. In addition, I would appreciate a strategic plan describing how all of the research programs fit together to solve this issue.

To borrow a Results Act phrase, "compensation is not the desired outcome." What we want are healthy veterans and their families, and research is critical to that effort.

To round out today's hearing, we have asked our witnesses to discuss the VA's proposed legislation on not compensating certain veterans for smoking-related illnesses. VA has sent a draft bill to

the Congress that will place significant restrictions on who may be compensated for these types of illnesses.

We're sure that this is not the last airing on the subject, and we look forward to an open discussion.

Having outlined at least three different areas for us to hear testimony today, I'll turn to Mr. Filner, our ranking member on the subcommittee, for his opening remarks, and remind all of us that we have a full plate here this morning—a wide array of witnesses and folks that will bring us some discussion to all three areas.

Mr. Filner.

[The prepared statement of Chairman Quinn appears on p. 41.]

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and good morning. It's so nice to see you at 8:30 in the morning. Put facetious in the remarks. I also would like to stress a few points after the Chairman's opening remarks.

I look forward to the discussion regarding VA's proposal to move the Persian Gulf War claims from the four Area Processing Offices to all the VA regional offices. This is a difficult issue. It will have profound effects on the lives of thousands of Persian Gulf War veterans and deserves, of course, very serious and forthright discussion.

In that discussion, I would like to know how VA reached its original decision to establish the adjudication responsibility for these claims in the four processing offices in spite of objections from Congress and veterans' service organizations at the time.

What actions did the VA take to ensure that the four APO's could do their jobs efficiently to guarantee their success? What additional staff and computer assistance were provided to these regional offices?

From our experience with educational—when the educational service designated four regional processing centers to adjudicate Montgomery GI Bill claims, these regional offices initially were not given the support they obviously needed to fulfill their responsibilities.

But within a year, the necessary assets were provided and it seems like the education RPC's have worked out reasonably well. Apparently the Persian Gulf APO's have not been given the tools and training necessary to meet their challenges, and I find that very, very disturbing.

And I want to know how and why this circumstance has developed. I'm additionally very skeptical, I guess would be the word, by assertions in your testimony today that the very complex problem of redistributing the thousands of Persian Gulf War claims to regional offices across the country can be accomplished by early June.

I'd like to know how you proposed to accomplish this because that's not described in your statement.

These are, I think, very important issues. I hope we'll get some satisfactory issues this morning because, as the Chairman said, in all issues surrounding Persian Gulf War veterans, we deserve candid, honest answers from the VA.

I noticed I had not heard the Chairman's opening remarks before he gave them. I had not read them earlier. But you provided, Mr.

Chairman, a list of things that you would like to have answers to. I thought that was a very good list.

And I would like to add, if you don't mind, in your questions about research and the programs—the research and questions involved with civilian—the civilians who have—now claiming that they have gotten Persian Gulf War Illness or some similar thing and would like a—some reasonable and candid, I think, approach to their problems.

When I was in my district this weekend, I had some particularly chilling meeting with some people who apparently, through casual contact with military during—military folks involved in the war, have come down with very similar, if not exactly the same, symptoms and illness and are regarded even with more skepticism by the military and apparently the VA then than originally was given to the—to our military people.

That is, it's taken some time to break through and get a serious examination of Persian Gulf War Illness amongst the military, and now we have at least a reasonable period of—presumptive period to deal with it. But it looks like the civilian situation might be equally as chilling and equally as—equal reluctance of the military and the VA to even look at it seriously.

So I would like to add that to your——

[The prepared statement of Congressman Filner appears on p. 44.]

Mr. QUINN. Absolutely. To the extent that the—you know, the VA can get involved in those civilians, I'd be happy to have that added to the list.

Thanks for the suggestion.

Before we hear testimony, Mr. Reyes, any opening remarks?

Mr. REYES. I don't have any.

Mr. QUINN. Mr. Hayworth?

Mr. HAYWORTH. No.

Mr. QUINN. Mr. LaHood?

Mr. LAHOOD. Nothing.

Mr. QUINN. So you've left Filner and me to do it all, huh? I'll tell you.

Thanks, gentlemen.

Our first witness is Ms. Kristine Moffitt, Director of the VA Compensation and Pension Service. She's joined by Assistant General Counsel John Thompson, and the VBA's Chief Financial Officer, Bob Gardner.

As we begin, Bob, we want to thank you and your staff for the way that you've dealt with the committee and the subcommittee on the Results Act. We appreciate it very much. And it's a chance for me publicly to say to—at least for me and on behalf of the subcommittee, say thanks for the briefing we held earlier this year over at your place where we were for a few hours. But it seemed like just a few seconds, it was so, you know, spellbinding.

Ms. Moffitt, please begin.

STATEMENT OF KRISTINE MOFFITT, DIRECTOR OF COMPENSATION AND PENSION SERVICE, DEPARTMENT OF VETERANS AFFAIRS

Ms. MOFFITT. Thank you.

Mr. Chairman, members of the subcommittee, I'm pleased to be here to discuss implementation of GPRA, the adjudication of Persian Gulf claims, and VA's proposed legislation on tobacco-related disabilities.

With me, as you noted, are Mr. Jack Thompson, Assistant General Counsel; and Mr. Bob Gardner, Director of VBA's Office of Resource Management.

The Government Performance Results Act is the primary vehicle though which the Compensation and Pension Service developed a business plan that was combined with the business plans of the other services within VBA into one comprehensive VBA business plan.

For fiscal year 1998, the VBA business plan was used as our annual budget request. We are now in the early stages of the fiscal year 1999 business plan process. The Compensation and Pension Service's fiscal year 1998 business plan was based upon our business processing reengineering project.

This established a vision of how compensation and pension claims will occur by the year 2002. We have developed a number of goals, performance objectives, and performance measures for fiscal year 1998.

For '98, we plan to achieve and maintain a 92 percent accuracy rate. Also for fiscal year 1998, we will reduce the time required to process claims. For example, our goal for original disability compensation claims is 106 days. We'll reduce the time required to prepare an appeal and reduce the remand rate.

We will improve communication and outreach and be responsive to our customers' needs. We plan to train all employees in their positions in order to maintain a highly skilled, motivated, and adaptable work force. And we will reduce the overall operating costs to ensure best value for the taxpayer's dollar.

Our visions and goals correlate directly with those of VBA and the Department. We designed an ambitious plan. Our goals are set high enough to inspire improvement, but not so high as to guarantee failure.

With regard to the Persian Gulf claims—in November 1994, the President signed Public Law 103–446 which authorized us to compensate Persian Gulf veterans for chronic disabilities resulting from undiagnosed illnesses. In February of '95, we published regulations to implement the statute.

By early 1996, after nearly a year's experience with undiagnosed illness claims, we reviewed a sampling of these claims denied because the disabilities first appeared after the two year presumptive period.

We found several instances where recent medical examination or lay statements had not been requested. We also found instances of incorrect information being provided in our Persian Gulf tracking system.

On the basis of these findings, in July 1996, we instructed our four Area Processing Offices to undertake a readjudication of some 10,700 cases identified in our tracking system. The purpose of the readjudication was to ensure that proper weight was being accorded to lay evidence and to be sure that the information in our tracking system was correct.

In our opinion, both of these goals are being met. As of April, we have completed readjudication on 4,966 cases. We awarded additional grants of service connection in 683 cases, 157 of those for undiagnosed illnesses.

The overall grant rate for service connection for undiagnosed illnesses has risen from 5 percent to 7 percent. We believe that this increase is due to more complete development for lay evidence and more thorough analysis of the lay evidence together with medical evidence.

On April 29, 1997, we published an interim final rule to implement the Secretary's decision to expand the presumptive period for undiagnosed illnesses through December 31, 2001. Because of this change, we have begun a further review of claims that were denied because of the two year presumptive period.

We expect a significant number of additional grants for undiagnosed illnesses. In December 1992, VBA consolidated the adjudication of Persian Gulf environmental hazard claims in the Louisville regional office.

Because of the unexpected high volume of cases, we redistributed them to four Area Processing Offices in October 1994. We also consolidated the undiagnosed illness claims in these four stations.

The purpose of the consolidation was to concentrate expertise in rating the complex issues and dedicate the resources to expeditious claims processing. However, the additional work imposed on these four stations has had an adverse impact on the other areas of their claims processing.

While they have given priority to Persian Gulf cases, a large amount, if not all, of their routine rating work has been transferred to other stations for processing. The percentage of claims pending over 6 months at the Area Processing Offices during the first 6 months of fiscal year 1997 shows a higher rate of increase over 1996 than has been seen nationally.

Therefore, in order to maintain overall claims processing efficiency, the Secretary just last night approved our recommendation that Persian Gulf claims be redistributed to the regional office of jurisdiction.

In making this decision, the Secretary took into account the views of the veterans, the veterans' service organizations, and members of Congress who had expressed concerns about the specialization of Persian Gulf claims.

We will now initiate this redistribution and will instruct the regional offices to stop sending Persian Gulf claims to the Area Processing Offices while we plan the implementation. We will schedule training to assist the regional offices in processing these claims.

These training sessions will focus on our experiences in developing and rating these cases that we have gained over the last 2 years. We believe that a transition from the Area Processing Offices to the regional offices will provide the customer-focused service that our veterans are asking for and will not adversely affect the quality improvements we have seen or the accuracy in updating our data base.

Lastly, with regard to tobacco-related claims, as our General Counsel interprets the current law, direct service connection may be established for disability or death resulting from tobacco use

during active service even if the disability or death did not occur until after service and after the expiration of any applicable presumptive period.

We have about 4,250 such claims pending adjudication.

In the 1990 Budget Reconciliation Act, Congress prohibited compensation for disabilities resulting from the abuse of alcohol or drugs. This action enhanced the integrity of our compensation program. In the same spirit, VA recently submitted proposed legislation to prohibit service connection due to tobacco use in service.

However, it would not preclude service connection where the disease or injury appeared or was aggravated during active service or during the applicable presumptive period.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions.

[The prepared statement of Ms. Moffitt appears on p. 61.]

Mr. QUINN. Thank you very much, Ms. Moffitt.

We appreciate the fact that the ranking member of the full committee, Congressman Lane Evans, has joined us here this morning and wonder if Mr. Evans might have some opening remarks or comments to make at this time before we begin any questioning. Lane.

Mr. EVANS. Thank you, Mr. Chairman. I'd just like to submit them for the record.

Mr. QUINN. Without objection, so ordered.

Mr. EVANS. Thank you.

[The prepared statement of Congressman Evans appears on p. 46.]

Mr. QUINN. Now we've got three areas that we're dealing with, so we're going to try to limit questions.

Thanks for being brief, Ms. Moffitt. We appreciate that. There's probably some questions certainly that will be generated.

I'd like to go to the Results Act portion first. You've talked about for 1998 some claims processing goals of being about 92 percent accurate and you talked about processing them in 106 days. We also know that there's been some cutbacks or at least some rearranging of staff at the same time.

Can you talk for a minute or two about—first of all, when you talk about a 92 percent accuracy rate and about processing claims in 106 days or so for 1998, what has it been the last couple of years? Is that an increase? And the larger question, how do you propose to do that with less people?

Ms. MOFFITT. With regard to the accuracy, we plan to measure accuracy in 1998 in a different way than we have done historically. If you—for the future, we will take the number of cases processed correctly divided by the universe of cases reviewed to determine the accuracy rate.

If you apply that math retroactively to the statistics we already have on hand and say well what is your accuracy rate right now, it is about 90 to 91 percent. So when we look to the future, we are hoping to improve our accuracy to 92 percent for 1998.

With regard to the 106 days for timeliness, right now we stand at overall average of 133 days for original disability compensation claims. We expect over the next 18 months to drive that down to 106 days if at all possible.

You asked how we will do that in the face of possibly some reductions in the work force. We are looking at overtime to assist in bringing that down, as well as some initiatives that we have under way that will assist us in doing a faster job of adjudicating original disability compensation claims.

Notably, we are going to contract exams to the private sector and plan to do that initially at military bases where veterans are being discharged so that we can get an examination as well as a rating decision within a day or so of the time a service person is being discharged.

That will help to improve our overall average time to complete.

Mr. QUINN. And you haven't done contracting out of this type before?

Ms. MOFFITT. No, sir.

Mr. QUINN. Will you be comfortable—are you comfortable with the process of selecting those folks that will help you at regional places?

Ms. MOFFITT. We have completed our statement of work. We have not gone on the street yet to find who those contractors will be. But I think that we have provided a very detailed plan of how that will occur.

Mr. QUINN. Okay. Thanks very much. I have some questions on the other part of your testimony, but I think we'll give the other members a chance.

Mr. Filner.

Mr. FILNER. Thank you, Mr. Quinn.

Ms. Moffitt, you know we have worked together both in San Diego and in Washington, and I think you know I have the highest regard for you. Given that background, I was, let me just say, very disappointed in your testimony and let me tell you why.

It seems to me that a number—and I'm going to read some of them to you. A number of criticisms of the way the system has operated up until this point have been made and are, I think, well known. And it doesn't look like you are recognizing these issues and dealing with them in a frank and open and honest way.

If there are mistakes that were made, let's deal with them, admit them, and correct them. If these criticisms are not valid, let's deal with those. But you're acting as if nobody has been concerned or nobody has brought up problems with this thing from a human perspective and dealing with these very real issues of people's life and death matters.

And I want to get it out of the bureaucratic language and this passive tense and this passive voice, and I want to talk about people; the people you serve and the people who work for you. People are either doing their job right or not. They are either doing it well or not.

If they are making mistakes, somebody is responsible. And I get from the testimony on this whole Persian Gulf War from, you know, past hearings that we've had before the full committee in this everything is—well, it happened or, you know, the process—there's no individuals ever responsible for anything it seems in dealing with these issues.

Let me just tell you some of the things—I'm new in this area. And let me tell you the things that I have heard or know about.

And it just doesn't seem that you are dealing with these in any honest way.

Veterans have not been informed as to the evidence needed to support their claims. The VA has not requested evidence concerning the continuity of symptoms. Since the presumptive period was originally only 2 years and many veterans did not obtain a medical evaluation until after that time period, they were denied because the presumptive period was not long enough for them to get to the date of the first evaluation.

And then the VA did not ask the veterans to submit lay evidence concerning the onset date of symptoms. In most cases, the VA examiner did not ask or record the date symptoms began. And since the veteran was not informed of the need to identify an onset date, they didn't do so.

They were not notified by the VA of the change in the law allowing lay evidence and nonmedical indicators such as time lost from work that could be submitted as evidence of an undiagnosed condition so they didn't submit such information.

The VA rating board did not request nonmedical evidence of undiagnosed conditions. The Persian Gulf registry was not used to assist in the development of claims. Although four specialized rating centers were established, no standard adjudication practices were developed and provided.

Irregularities were noted with violation of the VA's duty to assist traditional due process requirements in basing medical conclusions on medical evidence. The only staff which received special training in the adjudication of Gulf War claims was the staff of the Phoenix processing office.

I can go on. There's a list that has been—we've compiled based on both specific documentation and specific testimony, and it's as if this doesn't exist.

I need you and the VA and the people to address this stuff in very specific ways and tell us what's being done to make sure that this treatment of our veterans does not continue and find—and if they're responsible people or processes, deal with them in an open way.

I mean, I just—let's talk with some emotion and some humanity as opposed to this bureaucratic language which doesn't get to the heart of it and doesn't show how we are concerned, the veterans themselves are concerned, and I'm sure the people who work for you are concerned.

But let's get some emotion into this and correct the problems and take some responsibility for it.

Ms. MOFFITT. Mr. Filner, I think in recognition of many of the problems that you listed there, that we did note that errors had been made and we took responsibility by asking for a readjudication of nearly 11,000 cases.

We said that mistakes had been made in that the rating specialists and those people developing the claims were not fully aware of the uniqueness of this new legislation in that lay evidence needed to be fully developed and considered in the rating decision.

And so that readjudication of 11,000 cases was in recognition of the errors that had been made.

Mr. FILNER. Well, how did that happen? I mean, it sounds like a systemic—it doesn't sound like a mistake; it sounds like a systemic underestimation of the problem, a systemic casualness about the problem, a systemic—there's something going on wrong when you have that—if you're saying there are that many problems.

Wouldn't you say that there's a serious situation here? I mean, who is responsible for that? I mean, is there—are there people involved that made wrong decisions? How did the system break down with that kind of problem?

And again, everything isn't as passive—you know, well there were 11,867 or whatever errors. Who made the decision that led to that? How did we get to that situation? Because if you don't fix responsibility and if you don't take responsibility, why will these 11,000 be proven any—be fixed any better than the first time around?

Ms. MOFFITT. The readjudication of 11,000 cases was mandated by Jack Ross who was the acting Compensation and Pension Service Director at the time. As of November 1996, I take full responsibility for the actions with regard to Persian Gulf adjudications in the field.

Mr. FILNER. Let me—my time is up, but I want to come back. Kris, you're not getting at what I'm trying to answer, and I'll try to rephrase it in a way that maybe you can come to grips with it.

Mr. QUINN. Thank you, Mr. Filner.

Mr. Hayworth.

Mr. HAYWORTH. I thank the Chairman and Ms. Moffitt. Let me follow up on the comments of the ranking member in this regard. Because even as he mentioned some of the training being provided in Phoenix, I can offer cases to you and direct contact with many constituents that remain very concerned about Persian Gulf Syndrome.

And with the help and leadership of our colleague on this committee, Mr. Buyer of Indiana, we held a forum in October of last year where many of these people came forward. It is in that light then that I need to ask, even in the midst of the readjudication of some 11,000 cases, are we seeing Persian Gulf vets still filing initial claims for undiagnosed illnesses?

Ms. MOFFITT. Yes, sir; we are.

Mr. HAYWORTH. Has the rate of that application declined or increased or remained steady?

Ms. MOFFITT. It has remained fairly constant.

Mr. HAYWORTH. Again, to follow up on my colleague from California's concerns, granted that even as you stand to take responsibility—and I don't mean to put words in the mouth of my colleague from California who is quite articulate and can speak for himself.

But to prevent future problems like this and to come to grips with the problems that we have today, and even mindful of time constraints here, as you assess the situation which you inherited, as you assess the discrepancies, the inconsistencies of treatment—as the Chairman said in his opening statement, the fact that it just seems that for many sectors we have not gotten the full story on this syndrome.

What do you believe could have been done differently from the outset that would have avoided the problems we're seeing now?

Ms. MOFFITT. I guess that if we could have looked at a wider range of cases earlier, we may have seen that there were—the areas of discrepancy that you all are mentioning have to do with, in most instances, the hasty adjudication of these claims.

Had we looked at a broader spectrum of the sampling of cases earlier, we may have identified that earlier. What I mean by that is that this legislation asked that we look at lay evidence and consider it on an equal weight with medical evidence. That is not the criteria that has historically been used in weighing evidence in the past.

As those claims were being adjudicated, had we had full knowledge that that concept had not really been fully understood by the rating specialists, we probably should have taken earlier action to correct it.

But I applaud what Mr. Ross did in July of '96 to say even though the—we're not sure of the scope of the discrepancies, we will look at every single case and make sure that the veteran is given the opportunity to submit evidence from all sources, including lay evidence; and then we will make sure that we follow up on all leads to get that evidence.

Mr. HAYWORTH. I know that we all share the notion that we certainly hope that our fighting men and women never have to bear the burden of battle again. I think all of us are unanimous in that concept.

But God forbid, should there be a future conflict, as the VA deals with those veterans returning home from that conflict, do you think there should be a period of heightened examination?

And akin, indeed, almost to the after action reviews that so many branches of the military use in the wake of military action, should there be an intensive follow up, systematic, systemic plan for offering special scrutiny in the wake of a conflict—say a window from 18 months to 2 years to try and understand all the different maladies and situations that might develop, or has that already been adopted?

Is that standard operating procedure for you folks?

Ms. MOFFITT. Claims start to come in immediately in the aftermath of a conflict. What we need to do better is make sure that the people in the field are adequately trained to handle the cases that come realizing that medical science doesn't know, can't determine what the etiology of the illnesses are from the Persian Gulf.

So when you try to either legislate or rate something that we really don't have a good handle on, sometimes it is the passage of time that allows for better decisions to be made about that.

But as I talked about, what we expect in the reengineered process of the future is a highly trained work force that will have at its fingertips computer-based training that will very effectively teach them anything they need to know that is new with regard to rating practices.

That is not something we have right now. But to look to the future and how things could be done differently, I think that is within our plan. And to give the people on the front line of the VA, those people making the decisions, adequate training up front so that they can make good decisions is how I would approach a future conflict.

Mr. HAYWORTH. Thank you, ma'am.

Thank you, Mr. Chairman.

Mr. QUINN. Thank you, Mr. Hayworth.

Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman.

You know, Ms. Moffitt, I think one of the things that plays out in these hearings is that there's an overwhelming frustration on the part of not only members of Congress but people that have sought the services of the VA.

I have an ongoing concern that I would like for you to speak to, and that is the national standardization in terms of the types of—or the kind of service that veterans receive across the country in the different regional offices.

I think that in hearing your comments this morning about hasty adjudication and lack of training, I would go further and encourage that we sensitize people that provide these kind of services through the VA for our veterans should receive.

And I say that because oftentimes we have—I don't know if it's a policy, I don't know if it's an attitude or what it is that the first thing we're looking for is a reason to deny a veteran a benefit.

I mention that because, in my District where we have approximately 60,000 veterans, that is an overwhelming concern of theirs—that it's not so much people that are willing to help or trying to help or trying to determine how they can help, it's almost an endemic situation where they're trying to find a reason not to.

And I mention that to you this morning because it's been raised to me and to other members of this committee as well as the full committee because we've heard this continuously. I would like to ask if you can tell us this morning how do you monitor the standardization of services throughout the country?

What kind of institutional training program do you have to make sure that employees of the Department of Veterans Affairs that are working with veterans and that are making decisions and determinations about benefits that are provided for them—what kind of a system do you have in place that would give you a good grasp on any potential problem areas, any issues like the ones I've mentioned to you this morning?

Ms. MOFFITT. Well, first of all, our philosophy for dealing with claims is "grant if you can and deny if you must." I regret that your constituents feel that that is not how we view our job in the field.

With regard to standardization, GPRA looks at several areas in which we would measure our performance in outcomes to veterans—service to veterans. With regard to timeliness standardization, we look across the Nation to see if there—if claims are being processed timely.

In instances where there are serious workload problems where claims are not being processed timely, we look to broker work to remedy that situation. With regard to accuracy, we look at a cross section of cases from each regional office and the lessons learned from those reviews we share with all regional offices to ensure accuracy in Persian Gulf claims as well as other claims.

One of the tools we now have available to us with regard to standardized training is a national system for a satellite broadcast. This has fairly recently been brought online for us. And that allows

us to provide standardized training to all decision makers in the field so that the policies and procedures to be employed by them in their daily work are coming from a single source that they all can hear.

And as a matter of fact, that is the system that we plan to use to provide training to the regional offices who will take back the Persian Gulf cases on redistribution. We will use the satellite to give them standard policy procedures on how to work these claims based on our experience over the last 2 years.

Mr. REYES. Is there a system in place in terms of—I don't know if it's a rating system or an evaluation system to determine the consistency of service regionally and maybe perhaps a comparative analysis, you know, countrywide or nationwide so that you can identify problem areas or pockets of—or perhaps offices that are not up to the standard, whatever the standard may be?

Ms. MOFFITT. GPRA envisions that, as we determine the performance measures, those will be passed on from the national level, to the area levels, to the regional office directors, down to the managers, as well as the individual decision makers.

That is not in place now. But we do recognize that does need to be in place for an effective implementation of GPRA.

Mr. REYES. Okay.

Thank you, Mr. Chairman.

Mr. QUINN. Mr. Evans.

Thank you, Mr. Reyes.

Mr. EVANS. Thank you, Mr. Chairman. Mr. Chairman, I want to thank you for holding this very important hearing. I associate myself with some of the comments made by both sides of the aisle here today with one exception. I don't think it's frustration anymore it's growing anger at what the VA's response has been to this whole situation.

Based on the American Legion's testimony and VA documents, I believe VA has been remarkably passive in its efforts to obtain adequate and proper information from Persian Gulf veterans, so that it can process their claims.

The VA, over the objections of veterans' service organizations and to some degree Congress, implemented a policy under which Persian Gulf claims would be adjudicated at four regional—or four Area Processing Offices.

By July 1996, as we've talked about, the Compensation and Pension Service had to instruct the four APO's to take another look at nearly 11,000 Persian Gulf war veterans' claims because of the evidence that VA collected information related to these claims in a sloppy and incomplete manner.

It has also been demonstrated that too many of these cases have been improperly entered in the VA's tracking system for Persian Gulf veterans' claims.

After fighting tooth and nail to establish the four APO's to adjudicate these claims, the VA is now saying 2½ years later that it was wrong. What VA found is that the stakeholders, the veterans' service organizations, and Congress were right, and the 50-some VA regional offices should be adjudicating these claims.

I just wonder, as Bob Filner has asked, where does the responsibility ultimately lie? Why did these four APO's fail? Was it because they weren't given adequate support to ensure their success?

The VSOs assert that even with only four APO's, inconsistency of judgements regarding eligibility for compensation is a significant problem. Will this be a problem that will be resolved or at least exacerbated by decentralizing the Persian Gulf War claims through the regional offices?

Ms. MOFFITT. We will continue, as we redistribute the cases to the regional offices, to review the work that is done and provide—continue to provide training and analysis of the inconsistencies to gain consistency.

The decision to specialize the claims in the four Area Processing Offices was done to hopefully allow for quicker processing of Persian Gulf claims.

When the workload was such that they could not handle that in the expeditious fashion that we would like them to and taking into account the 11,000 claims that we took responsibility to readjudicate, we determined that the workload itself was going to mean that Persian Gulf veterans' claims, if left at the four Area Processing Offices, would take many, many more months to complete.

Mr. REYES. Well, we understand that.

Ms. MOFFITT. With regard to the resources that they have, to the extent that their Area Directors were able to add resources, we have—we had four Area Processing Offices plus two additional offices working those cases. Some 56 rating specialists working full time on those cases.

That is just not enough resources to bring to the issue. But importantly, as you have mentioned, veterans want their cases handled locally. And especially if we can't handle them expeditiously, the longer they sit thousands of miles away where they are not able to, on a day to day basis, find out the status of those claims, that only exacerbates the problem.

So veterans and their advocates have told the Secretary in town forums, have expressed to all of you, that they want those claims adjudicated locally. And in responding to that and the workload strains, I'm taking responsibility to move those cases back to the regional offices.

Mr. EVANS. Of the four APO's, were there any that stood out as being particularly efficient and accurate in processing claims?

Ms. MOFFITT. All of—to say the other way, I think definitely Nashville, because of the large numbers—they had some 45 percent of all Persian Gulf cases—struggled—has struggled the most to take care of that workload.

But with regard to the other issues, I think basically they've all handled them about the same.

Mr. EVANS. Are there any practices used by the APOs that did a good job, in this case Nashville, that could be applied to the RO's now processing Persian Gulf claims?

Ms. MOFFITT. We plan to use the experiences of the APO's and use the rating specialists, the section chiefs, other managers to help train the regional offices as they get these cases back so that lessons learned will be passed on now to those rating specialists and managers at the other regional offices.

Mr. EVANS. All right; thank you, Mr. Chairman.

Mr. QUINN. Thank you, Mr. Evans.

Second round. My question was the same, Lane, about going from area to regional and if that's going to create a problem.

Let me ask a straightforward question. You talked earlier about training to get this done. You just mentioned it in response to Mr. Evans' question. When and how long might that training take? When's it going to be done? Will it be ongoing?

Ms. MOFFITT. We plan our first satellite broadcast for all of the decision makers in the field on May the 29th. It will be basically a two hour session to go over the principles of rating undiagnosed illnesses.

On June the 2nd and 3rd, we plan to call in a representative from each RO to a central location for 2 days of training to go in-depth into the issues. In addition, the regional offices have hearing officers who are subject matter experts with regard to these Persian Gulf claims insofar as when veterans filed an appeal and asked for a hearing, those cases went back to those regional offices.

Those are the planned training sessions. Any other training that is necessary, either through nationwide conference calls, additional satellite broadcasts, Area training, we will undertake as we determine what the needs are of those regional offices.

Mr. QUINN. But for right now you're looking at the first week in June?

Ms. MOFFITT. Yes, sir.

Mr. QUINN. Which would be only 2 or 3 weeks from now?

Ms. MOFFITT. The first being actually May 29.

Mr. QUINN. Okay.

Ms. MOFFITT. And then in the first week in June.

Mr. QUINN. And this is not a question, before I yield to Mr. Filner my time, but more of an observation. One of the things we've heard time after time, in hearings here and in other issues when it relates to veterans, is the fact that there's miscommunication or a lack of communication.

And I think this is going to be one of those areas where when we make the move back to the regional offices, not only the training that you just outlined is going to be critically important, but the communication that takes place. That's why the VSO's want the claims, I believe, back to the regional offices—for the reasons you just mentioned—want them closer, not 3,000 miles away.

But communication will be a key. And I don't need an answer. I'm just saying for the record today that I hope we pay attention to that, as I know you're aware. But for me, it becomes more and more important every time we make a move like this and for some of the reasons we've already heard this morning.

This frustration and almost anger with the Persian Gulf situation I think lies in the whole communication effort or lack thereof.

Ms. MOFFITT. I agree with you, sir.

Mr. QUINN. Thank you. I yield the balance of my time to Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman.

Kris, are you aware of a VA White Paper on Persian Gulf Development? I don't know if it was done internally or——

Ms. MOFFITT. I'm not sure what you're referring to.

Mr. FILNER. Okay, I have a document that's labeled VA White Paper, Persian Gulf Development, and it's signed—it's apparently an internal review of the whole processes and it was undertaken last year signed by D. Rice, PGDEV. I don't know what that means.

Do you know what that means?

Ms. MOFFITT. Dale Rice is a member of the Compensation and Pension Service.

Mr. FILNER. I mean, he outlined a whole series of problems based on internal review of the process which—I mean, I'll read you a couple of things, but just incredibly—I will say incompetent work to get—to give the veterans the knowledge of what they have to do to make the claims and what kind of evidence is suitable and the time frames that they have to do this.

For example, "evidence of continuity was not routinely requested." So if it's not requested, it's not provided; and therefore no evidence, and therefore claim denied because the folks involved from the VA's perspective did not give the assistance—there's a term that you use for that—do assistance or—duty to assist apparently was never—not never—was not done in a great number of cases.

There was no proactive communication from the VA when the law changed. For example, as noted by—in this report, "Public Law 103–446 established a use of nonmedical indicators, for example, to—for the diagnose—as indications."

And yet, those changes in the law were published in the Federal Register and not otherwise publicized, according to this report. Now most of us do not read the Federal Register, even the congresspeople.

Mr. QUINN. Oh, I beg your pardon.

Mr. FILNER. I'm sorry. My Chairman reads the Federal Register.

But if you're not going—aside from the fact that it's so—you know, it's so ridiculously, you know, incomprehensible, you've got to translate what is going on into language that people can understand and act on, and apparently nothing was done in a general way for veterans to understand the change.

And therefore, says this report, should that be considered an error on our part—that is, the VA's part—because—that the veterans were denied due process because they weren't told of the information?

In studying the Louisville APO, it was decided that there was no standard adjudication practices that were done. Now this goes on and on. I mean, it is extremely—very difficult to understand how such lack of standardization, lack of communication, lack of understanding of the issue was so widespread.

And if you couldn't do the training that was necessary and the standardization and the communication at four offices, I agree with local—decentralization. But I can't figure out, unless you have figured out—I can't figure out from your testimony, unless you have figured out what was wrong with these four centers, how you're going to do it in 50-plus centers.

That is, the possibilities of non-standardization and lack of information and lack of communication, you know, are multiplied many hundreds of times now. And by the way, your response to why de-

centralization was good, I assume—I wasn't here at the time—but I would assume that congresspeople on this committee made the same arguments of why you shouldn't go to that process to begin with.

So apparently a mistake was made and now we're going back to the regional. But given all the—given the problems with four offices just in standardization and communication and in errors, how are you going, by June 1, with one—it sounds like one satellite conference you're going to solve these problems?

So are these real problems? Were they real problems? And how are you going to correct them so we don't have them again?

Ms. MOFFITT. The problems you outlined there sound like the very issues that brought Mr. Ross to the decision to review the 11,000 claims.

Mr. FILNER. Out of how many was that? What's 11,000 represent of percentage of—that you could have reviewed? All, 50 percent, 10 percent—I don't——

Ms. MOFFITT. That was—those were all of the cases that had been adjudicated by the four Area Processing Offices. Those were all of the denials.

Mr. FILNER. So every denial was readjudicated?

Ms. MOFFITT. Yes. And were redeveloped. A development letter went out to every claimant.

Mr. FILNER. That's a pretty significant statement, right, that you had to—you have to go back and look at every single one to—because there was a fear of error on those parts? I mean, I'm glad you did it, but it's a very significant admission.

Ms. MOFFITT. We wanted to make absolutely certain that the issue of lay evidence was being fully developed so that we would be fully considering it in our rating decisions.

Mr. FILNER. Was that the only thing that you were looking for to redo?

Ms. MOFFITT. Lay evidence was the primary reason.

Mr. FILNER. I mean, how about this evidence of continuity that the veterans didn't know about? That is, if they did not place—if the first evidence of the illnesses was more than 2 years afterward, then they would be denied also, right?

Unless they were asked about evidence of continuity. And if they weren't even asked about it or told that that's what they should do, then they would be denied also, right?

Ms. MOFFITT. We looked for evidence within 2 years and then continuity requires that it have a duration of at least 6 months or more to be a chronic condition. So based on the regulation at the time, we were looking for the condition within 2 years and that it was chronic.

Now, of course, with the extension of the presumptive period, we will be looking at all of those cases that we denied for being outside the two year period and readjudicating them again to see if we can't grant based on symptoms being shown outside the presumptive—outside the two year presumptive period.

Mr. FILNER. I interrupted you before you got—I mean, I mean, how—all right, so every case that was denied, we—you thought there might be an error. By the way, has that process been completed or how many have been overturned out of that?

Ms. MOFFITT. We've completed 4,966 cases.

Mr. FILNER. And how many——

Ms. MOFFITT. Out of the approximately 11,000.

Mr. FILNER. No, but how many of those are now—been deemed that——

Ms. MOFFITT. We granted service connection in an additional 683 cases and granted, for undiagnosed illnesses, in an additional 157 cases.

Mr. FILNER. So over 3,000 out of the 4,000 are denied again? Is that what you—I don't—am I using the right terminology here?

Ms. MOFFITT. Remain denied.

Mr. FILNER. They remain denied?

Ms. MOFFITT. After readjudication, they remain denied.

Mr. FILNER. Okay, maybe I'll get back to that. So tell me about all this standardization, communication, and proactivity. How are you solving those problems by June 1 now with these 50 regional centers?

Ms. MOFFITT. Like I said, we will engage in the satellite broadcast as well as an onsite training.

Your comments regarding outreach to the veterans as well as communication with them is an important one. In our regional offices, as we move to the reengineered environment, the employees in the regional office already realize the need to have close personal contact with veterans.

And they are, in many instances, in teams where they do just that: where they have a group of veterans that they take care of, communicate with, and offer the services that should be provided to those veterans.

With regard to other outreach efforts, we looked to the service organizations to include information in their magazines, as well as us taking the approach of getting out to the community in public forums, town meetings, and the like with regard to Persian Gulf——

Mr. FILNER. Who's doing the satellite thing, by the way? Who's actually doing the training by satellite?

Ms. MOFFITT. That will be provided by the Compensation and Pension Service as well as subject matter experts from——

Mr. FILNER. If I were you, Ms.—let me just—I mean, you have—we have said that there's a casualness. You know, there's a nontaking seriously, we're angry and frustrated. It seems to me you ought to do something dramatic to deal with this.

I mean, for example, if the Secretary not just—I mean, did this satellite training with full media treatment of it that the Secretary of your Department at Cabinet level—get the President in on it.

We take this thing so seriously that we want to make sure that we have the absolute—we're going to tell everyone of the regional people and every person in the staff of the VA that this is a serious issue that we are—and we want people to look at it seriously, understand it, etc.

And from the very top, this is not just a bureaucratic situation where, you know, somebody—I'll say a faceless administrator in the bureaucracy is doing the training. I want, you know, the Secretary of the VA, and I want the President of the United States to tell your people that this is serious and let them start the training,

let them start the—let them understand that from the top, this is a serious matter and we are not going to tolerate casualness.

We're not going to tolerate lack of understanding. We're not going to tolerate errors of the magnitude that we have seen here. So I mean, I would do something a little out of the ordinary for something as—for which you have been facing a lot of criticism on.

Just some advice from someone who has to deal with these issues all the time.

Mr. QUINN. Thank you, Mr. Filner.

Do you have any reaction to that?

Ms. MOFFITT. I'll take your comment back to him—to the Secretary.

Mr. FILNER. Thank you.

Mr. QUINN. You wouldn't mind if any of us or staff joined at those satellite sessions would you?

Ms. MOFFITT. No, sir. No problem.

Mr. QUINN. Might want to—Bob, that might be an idea too that some of our folks here could join, at least observe to see what's been done out there and maybe have some suggestions and constructive criticism for anything that follows up in June or the following weeks in June.

Ms. MOFFITT. Okay.

Mr. QUINN. Thanks.

Mr. Mascara has joined us this morning. Thanks for being with us. He missed the first round of questioning. So if it's okay with Mr. Reyes, I'll ask Mr. Mascara if he has a question this round?

Mr. MASCARA. Good. Thank you, Mr. Chairman. I have a statement I'd like placed on the record.

Mr. QUINN. Without objection, so ordered.

Mr. MASCARA. Thank you.

[The prepared statement of Congressman Mascara appears on p. 53.]

Mr. MASCARA. My question is the Philadelphia Area Processing Center has consistently reported a significantly lower allowance rate on the Persian Gulf claims concerning undiagnosed illnesses than the Phoenix center.

Do you know what—and the numbers are—the Phoenix center allowed 297 claims and denied 1,316 claims. The Philadelphia center allowed 100 claims and denied 1,388. Is there some rationale for or some reasoning behind those significant differences?

Ms. MOFFITT. When I got here in November and looked at many significant issues with regard to Persian Gulf claims, what I chose to attack first with regard to looking at the quality was to ensure the accuracy of the development on these 11,000 claims, as well as to look at the denials to determine if we were improperly denying claims.

So our reviews up to this point have focused on those two areas. We have now begun to call in cases that include grants of service connection and will now begin to be able to look at the differences in those grant rates and have an idea as to why there is a difference.

But I do not know that difference today.

Mr. MASCARA. They have not established why there is that significant difference between those two locations——

Ms. MOFFITT. Right.

Mr. MASCARA (continuing). Philadelphia and Phoenix?

Is there anything that you have seen in the results from ongoing research that would lead you to believe that we can service connect any specific cluster of symptoms exhibited by the Gulf War veterans suffering from undiagnosed illnesses?

Ms. MOFFITT. Could you rephrase—repeat the question?

Mr. MASCARA. Well, I guess the question is, is there anything you can point to as a result of service connect clustering of symptoms exhibited by Gulf War veterans?

Ms. MOFFITT. If we look at where cases have been granted, they do cluster around particular body systems.

If you'd give me just a minute.

I think generally about 50 percent of all PGW claims are granted for musculo-skeletal conditions. There's also a large number due to systemic conditions.

Hold on.

About 47 percent of all PGW claims that we have granted have had to do with a musculo-skeletal—joint pain, that sort of thing. Respiratory, as you would expect, for environmental hazards, as well as undiagnosed systemic conditions seem to be the main areas in which we are granting service connection.

Mr. MASCARA. Okay, I thank you.

Thank you, Mr. Chairman.

Mr. QUINN. Thank you, Mr. Mascara.

Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman.

Ms. Moffitt, based on the comments that you've heard from this panel here this morning, have these observations—have you not heard of the frustration out in the veteran community about these issues before? Is this a complete and total surprise for you this morning?

Ms. MOFFITT. Oh, no, sir. You know, we have definitely heard of the frustration of the veteran community. I think that's a key reason why the Secretary made the decision he did.

I happen to have accompanied him on several public forums dealing with Persian Gulf issues, and very definitely we heard the frustration of veterans as well as the veterans' service organizations with regard to these issues.

Mr. REYES. Given that, are there any plans to perhaps put together some working groups or advisory groups of veterans? You know, I have found in my experience that oftentimes the solutions to some of these problems come from the very people that are affected.

Has that been considered by the Secretary or your Department, putting together veterans' advisory committees that could possibly give you some solutions or some recommendations about these very issues that are so demoralizing to the veteran community?

Ms. MOFFITT. My understanding is that the Secretary does have a Persian Gulf Advisory Board.

Mr. REYES. Comprised of veterans, affected veterans?

Ms. MOFFITT. I'm really not sure about that, but I can provide that to you for the record.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The VA Persian Gulf Expert Scientific Committee was chartered in late 1993. The purpose of this standing federal advisory committee is to advise the VA Under Secretary for Health and the Chief Public Health and Environmental Hazards Officer on medical findings affecting Persian Gulf veterans and to make recommendations to the Secretary. The Committee consists of 18 members selected on the basis of high professional achievement and expertise in illnesses and research that might be related to Persian Gulf service. Currently, there are 3 representatives from Veterans' Service Organizations who are members of the Committee.

Mr. REYES. Well, more than anything I would offer that as a recommendation or as a suggestion.

Because, you know, in the previous round when I asked you—when I informed you about the frustration that exists out in the veteran community, you said the motto of the VA is "grant if you can, deny if you must."

Surely there is based again—and by your own admission, the frustration that you have heard prior to this morning, surely there's something wrong systemically that where so many veterans feel such a high and intense sense of frustration and, as my colleague Lane Evans mentioned, now escalated to anger.

Those kinds of issues, at least from my perspective and from the comments that have been made by veterans in my District, are not new. You know, it's something that I guess veterans feel they have had to deal with continuously and for years.

I offer that again in the context of we need to at least strive to better serve these people that have put their life on the line for this country.

Ms. MOFFITT. Let me just mention—in our business process reengineering, as we started out, we went to our stakeholders and interviewed them. We interviewed veterans, service organizations, members of Congress, people in the Department of Veterans Affairs and outside.

In that very issue, the disconnect between what we are trying to do for veterans and how veterans feel about what we actually do do, was a key communication issue, something that has been mentioned by others here today. In the reengineered process, what we expect is that the veteran will be able to talk directly to the decision maker.

So he wouldn't be calling in to a phone bank that couldn't get access to his record. He may be calling in to a phone center where they could directly connect him with the team that is handling his or her claim.

And that's that communication that veterans are looking for, that we are engineering into our process so that there will not be that disconnect between what the decision makers are trying to do for veterans and how veterans feel they're being treated.

We want those to be mutual in that we respect veterans and we want them to feel respected. We are granting wherever we can, and we want them to understand when we can't grant why it wasn't possible.

Mr. REYES. And this type of service which, you know, I certainly applaud you for this—striving for this goal, but this type of service is not limited in any way by the lack of staffing that you have mentioned this morning—or shortage of staffing?

Ms. MOFFITT. The reengineered process, you know, anticipates that there will be reductions in staffing over the next several years.

And you know, it's not simply what the—how the human resources will do their job, but it includes information technology initiatives that need to be in place so that our decision makers can get online access, for instance, to Veterans' Health Administration records so the decisions can be made online.

Or a veteran can be saying I was recently treated at a particular private hospital, and us being able to go through an online system and say yes, sir, that hospital record is available to us and we'll be able to make a decision on your claim.

So there's lots of things that go into it besides just the people knowing how to do their job. It includes, like I said, IT initiatives, telephone systems. It's a very detailed plan that needs to all be brought together to provide this service that we hope to provide.

Mr. REYES. So then if I understand your question, is that you do anticipate having sufficient staffing so that a veteran in Des Moines will get the same kind of service as in Tampa and Spokane and San Diego and El Paso and all these different areas?

Ms. MOFFITT. Yes; yes, sir.

Mr. REYES. Okay.

Thank you, Mr. Chairman.

Mr. QUINN. And Buffalo, right? You're going to mention Buffalo? Okay, thanks.

Thank you, Mr. Reyes.

If I may just move for a second. The final question for me has to do with the VA's proposed legislation to limit liability in smoking-related illnesses. That, after all, was part of our agenda and you testified to it earlier in your opening remarks.

Do you have any kind of estimate on the amount of compensation that will be paid over the 5 years if this bill isn't passed?

Ms. MOFFITT. I'm going to refer that to Mr. Gardner.

Mr. QUINN. Could you—I'm just looking for a ball park figure here.

Mr. GARDNER. We don't have that right now.

[The information follows:]

Based on a recent General Counsel decision, it is necessary to revise our estimates. As soon as the revised estimates are available, we will share the information with the subcommittee.

Mr. QUINN. Could you take a look at that and maybe get it over to us in the next couple of days or a week or so? I'd appreciate that.

Any further questions for Ms. Moffitt at this time?

Thanks very much for your answers and your preparation for today. We appreciate it very, very much. And I think we've at least, in summary here, tried to point out our willingness to help on the subcommittee and the full committee.

And call on us if you need us. We appreciate it very, very much.

Ms. MOFFITT. Thank you, sir.

Mr. QUINN. Thank you.

The second panel—Mr. Filner made me a little nervous when he asked me what I wanted on my cheeseburger. I think he's going to order lunch out here. Be here all day long.

Our second panel consists of Mr. Stephen Backhus, Director of Veterans' Affairs and Military Health Care Issues at the GAO.

He'll also be accompanied at the table this morning. We appreciate you coming over. Good to see you again.

We begin always by saying that any and all remarks that you have in the line of testimony will be accepted and submitted for the record. But as we operate under the 5-minute rule, we ask you to keep your opening remarks, if you could, to about 5 minutes.

Mr. BACKHUS. I think I can do that.

Mr. QUINN. And we appreciate it. And you may begin, sir.

STATEMENT OF STEPHEN BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

Mr. BACKHUS. Okay, it's good to see you again too. Thank you.

I'd like to introduce, if I could, Cindy—on my left, Cindy Fagnoni, our Associate Director for Veterans' Issues. And on my right, Irene Chu, our Assistant Director.

Mr. Chairman and members of the subcommittee, we are pleased to be here today to provide our views on the progress and the challenges facing the Veterans Benefits Administration in implementing GPRA.

As you know, the Act was passed in 1993 to require agencies to clearly define their missions, set goals, measure performance, and report on their accomplishments. It was designed to focus Federal agencies' attention on the results of the programs they administer, not just the program operations.

Instead of focusing on the amounts of money they spend or the size of their workloads, agencies are expected to rethink their missions in terms of the results they provide, develop goals based on their results-oriented missions, developed strategies for achieving their goals, and measure actual performance against the goals.

Perhaps most significantly though, GPRA also requires agencies to consult with Congress in developing their strategic plans. This gives the Congress an opportunity to work with agencies to ensure that their missions and goals are focused on results, are consistent with congressional intent, and are reasonable in light of fiscal constraints.

GPRA requires VA and other Federal agencies to complete their strategic planning by September 30 of this year, and in the future, submit annual performance plans and reports to OMB and the Congress.

As you know, VBA's responsible for administering the nonmedical programs of VA that provide financial and other benefits to veterans, their dependents, and survivors.

As you requested, Mr. Chairman, my statement will focus primarily on VBA's largest business line, the Compensation and Pension Program, which spends about $19 billion dollars annually or about 90 percent of the VBA appropriation.

The information I have today is based on our past work in the area, our review of the strategic plan, and of course our discussions with VA officials.

In summary, it's our view that VBA has taken an important first step in implementing GPRA, but the process is an evolving one and many challenges lie ahead.

VBA has developed a strategic plan with a mission and goals and has begun consulting with Congress, as we understand, as well as other stakeholders, to obtain their views on its plan.

For the Comp & Pen Program, VA has identified seven goals that are oriented toward the efficiency of claims processing, customer satisfaction, improving the accuracy rate for paid claims, reducing the time required to process claims, and reducing their cost—their operating cost.

It has also identified specific performance measures in these areas such as reducing processing time for the original compensation claims from 144 days to 53 days and achieving a 97-percent accuracy rate for claims by fiscal year 2002.

As the VBA continues its process of implementing GPRA, it faces some difficult challenges, however.

If the full intent of GPRA is to be achieved, VBA will need to develop a clear mission, goals, and measures—performance measures that are truly results-oriented, not just ones that are process-oriented.

For example, the purpose of the disability program, the Disability Compensation Program, is to compensate veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during military service.

Given this purpose, results-oriented goals would focus on issues such as whether disabled veterans are indeed being compensated for the average loss in earning capacity and whether VBA is providing compensation to all those who should be compensated.

VBA has not yet tackled these types of difficult questions and will need to do so in consultation with Congress in order to develop a truly results-oriented strategic plan. These are very sensitive issues.

VBA has told us that they have begun consulting with Congress and other stakeholders about appropriate goals and measures for the Comp & Pen Program. As VBA continues its strategic planning, it will also need to integrate its plans with those of the rest of VA, as well as those other Federal agencies that support veterans' benefits programs.

For example, in determining the eligibility of a veteran for disability compensation, VBA usually requires the veteran to undergo a medical exam which is generally performed by the Veterans' Health Administration physicians.

Similarly, VBA looks to the Department of Defense for information about the medical conditions of veterans while they're in the military and to the Department of Labor for veterans' employment and training experiences. VBA will need to determine what impact these other entities have on their performance.

In conclusion, Mr. Chairman, VBA is aware that it has much work to do to fully implement GPRA. Its success in implementing the Act will depend on how successful it is in ensuring that its plan focuses on results, integrates with other VA components and other agencies, and that its performance is measured, assessed, and reported.

Congress plays an important role in consulting with VBA in developing a results-oriented goal and overseeing their efforts.

This concludes my testimony and I'll be glad, along with my colleagues, to respond to any questions that you or other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 72.]

Mr. QUINN. Thank you very much, Steve. We appreciate both this testimony and the briefing that Bob and I had some weeks ago. I have no questions at this point.

Third panel. Our third panel represents several veterans' service organizations. Today we're pleased to have with us Mr. Jim Magill, Legislative Director of the VFW; Mr. Chuck Burns, Service Director of AMVETS; Mr. Matt Puglisi, Assistant Director of the American Legion's VA and Voc Rehab Commission; Mr. Bill Russo, the Director of Veterans' Benefits Programs for the Vietnam Veterans of America; and Mr. Joseph Violante, Deputy Legislative Director for the DAV.

Gentlemen, thanks for joining us today. I'll note for the record that our letter of invitation to all of you requested that you submit written comments on Comp & Pen's Results Act testimony so that you would have a chance to review it thoroughly as well as the subcommittee.

Before you begin, I also want to congratulate the Legion for providing over $600,000 in grants to Persian Gulf veterans and their families. Well done, and we appreciate your assistance a great deal.

In no particular order, unless you guys have flipped a coin outside, Mr. Violante, how about if we start there and work our way across the table.

STATEMENT OF JOSEPH VIOLANTE, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. Thank you, Mr. Chairman and members of the subcommittee.

Since 1920, the Disabled American Veterans has been dedicated to one single purpose—building better lives for disabled veterans and their families. On behalf of the more than one million members of the DAV and its auxiliary, I wish to express our deep appreciation for this opportunity to provide our assessment of the processing of Persian Gulf War veterans' claims.

Mr. Chairman, the current system of processing these claims at the four regional offices is not working. It's apparent that the current system serves neither Persian Gulf veterans nor the local veterans very well. And I'm happy to hear that the VA is going to be moving towards decentralization of these claims.

The plight of the Persian Gulf veterans suffering from undiagnosed illnesses continues to be one of our foremost concerns. Recent VA statistics on the claims processing for these veterans only heightens our concerns.

Of the 11,806 environmental hazard claims considered, slightly more than 1,600 have been grated service connection; and only 803 have been granted service connection for undiagnosed illnesses.

The VA has denied almost 10,000 claims for undiagnosed illnesses, and these disallowed claims fall into six categories. And these are that there's a diagnosis; that the illness was not chronic; it was due to other etiology; that it was not manifest on active duty or during the two year presumptive period; it's not shown by the

evidence of record; and that, although it was undiagnosed, it wasn't to a compensable degree.

It was announced this morning that the VA will be reviewing only category four, and that's not manifest on active duty or within the two year period. However, it makes sense not only to review all of these categories, but to provide the veteran with an opportunity to present additional evidence to support a claim which is not in the claims folder.

And I'm not quite sure of the VA's rationale of only going with category four because, if I could, I'd like to discuss these other categories. If the illness was not chronic during that two year period, there's nothing to say that that illness is not chronic today. And I don't understand why the VA's not reviewing those.

Again, the same thing is true if it was not shown by the record during that two year period, who's to say that today it wouldn't demonstrate that this veteran is now suffering from an undiagnosed disability at a compensable level. And the same with the fact that it wasn't compensable at the time during that two year period.

All those categories certainly should be reviewed. With regards to category three, I'm somewhat concerned and confused. According to the VA, this category includes a condition that's undiagnosed and became manifested to a compensable degree but has an intercurrent cause or is due to the willful misconduct or alcohol or drug abuse.

I'm not a doctor nor am I an expert on undiagnosed illnesses, but I don't understand how you can say that you don't know what this person is suffering from, but you do know what has caused it. And I believe that what we're seeing here is something very akin to what our concerns are with regards to the smoking regulations.

And you know, the VA hangs their hat on the fact that this veteran may be abusing alcohol or may be abusing drugs. And the same is going to hold true with regards to smoking. It's a convenient way to deny a claim just because one of these elements are involved.

One of the frustrating aspects of dealing with Gulf War Illness is the medical community's desire to provide a diagnosis for these veterans' illnesses. Physicians are trained to provide a diagnosis. In other words, to pigeon hole the problem with their best guess. And that's category one, where there's a diagnosed illness.

Again, we believe that these should be reviewed for the same reasons. These need to be looked at now to determine whether or not those diagnoses were proper at the time and whether this veteran now has these symptoms considered to be Persian Gulf Illness.

Finally, adjudicating Persian Gulf War claims at the four regional offices has adversely impacted upon the adjudication of the local veterans' claims. These claims are being transferred out to other offices. It's creating a logistic nightmare for our service officers to keep tabs on their local veterans' claims.

Again, I think the VA's movement to decentralize will certainly take care of that problem.

The DAV supports the decentralization of the Persian Gulf claims and we're pleased to see that the VA will be focusing on a

nationwide training program for its rating specialists and adjudicators to provide them with the expertise that will be needed to adjudicate these claims.

Like you, Mr. Chairman, if it's possible, I'm sure DAV would like to have its people present to monitor these training sessions.

That concludes my statement and I'd be pleased to answer any questions.

[The prepared statement of Mr. Violante, w/attachment, appears on p. 78.]

Mr. QUINN. Thanks. We'll make that request for you to see if you could join or anyone else who is interested during those training sessions on behalf of all the VSO's. And Michael or somebody from the office will get back to you later.

Mr. VIOLANTE. Thank you.

Mr. QUINN. Mr. Puglisi.

STATEMENT OF MATTHEW PUGLISI, ASSISTANT DIRECTOR, NATIONAL VA AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. PUGLISI. Thank you, Mr. Chairman. And good morning to you and distinguished members of the subcommittee. And the American Legion appreciates the opportunity to offer testimony today regarding the processing of Persian Gulf War claims by the Department of Veterans Affairs.

We commend you, Mr. Chairman, for convening this hearing. The topic of Persian Gulf claims has received little media attention, but it's an important issue that lies at the heart of how the Federal Government aids disabled veterans of the Gulf War.

This hearing comes in the midst of a massive review of Gulf War undiagnosed illness claims by VA because of earlier widespread processing errors and the recent extension of the presumptive period.

This review and the extension of the presumptive period, although welcome by the American Legion, both exacerbate the inherent flaw of Gulf War environmental hazards processing system, of which undiagnosed illness claims are a major subset.

And that's the centralized processing of these claims which we just found out today will no longer be occurring. But the centralized processing has left us a legacy that we'll be dealing with for many months, if not years, and that's 14,000 claims are currently pending in that system.

That's a backlog, and that signals 14,000 disabled veterans who have been waiting to hear from VA concerning their claims. When VA initiated their plan to centralize Persian Gulf claims, the American Legion adamantly opposed this effort because of the possibility it would create such a backlog.

The American Legion has consistently encouraged VA to immediately end the practice of centralized processing and we therefore welcome Ms. Moffitt's announcement earlier this morning. And we are convinced that it signals better future service for disabled Gulf War veterans.

An environmental hazard claim is one where the veteran's current disability may have been caused by exposure to an environmental hazard in the Southwest Asia theater of operations. An

undiagnosed illness claim is one where the signs and symptoms of illness reported by the veteran go undiagnosed by a VA medical doctor.

Undiagnosed illness claims are a subset of environmental hazard cases. And approximately 90 percent of environmental hazard cases involve an undiagnosed illness. As of March 1997, the vast majority, 83 percent, of Gulf War disability claims have not involved an environmental hazard as a possible cause of the veteran's disability.

Most of the claims filed by Gulf War veterans, therefore, are adjudicated at VA regional offices that have jurisdiction for specific geographic areas in the U.S. or overseas.

In 1995, investigations conducted by the Department of Veterans Affairs, the U.S. General Accounting Office, and the American Legion's Gulf War Task Force found widespread errors in the processing of Gulf War undiagnosed illness claims.

And just as a note in reaction to some testimony given earlier this morning by Ms. Moffitt, out of the four Area Processing Offices in our investigation, and we made site visits to all four, the Phoenix Area Processing Office was clearly more better prepared to handle these claims.

The staff received extensive training. The allowance rate was sometimes three or four times greater than the other APO's. And the atmosphere within the Phoenix Area Processing Office was geared towards helping Gulf War veterans as much as possible.

That wasn't the case in the other places. So if VA wants to see how to do this right when it decentralizes these claims, we strongly recommend that they look at how the Phoenix regional office and its director ran that program.

VA undertook a review of the over 11,000 claims that had been adjudicated as of July 1996 in response to the findings and recommendations of those investigations. VA is currently seeking evidence from the veterans who filed these claims and will reconsider them if necessary.

The American Legion commends VA for initiating this massive review.

The recent extension of the presumptive period automatically added over 5,000 undiagnosed illness claims initially denied service connection because the symptoms reported by the veterans who filed those claims fell outside the original 2-year presumptive period.

Although welcomed by the American Legion, this increases the backlog of environmental hazards claims to over 14,000 cases. The American Legion believes the remedy to the backlog lies in ending the centralized processing of these claims, and apparently VA does as well.

In conclusion, Mr. Chairman, although long overdue, the decision to end adjudication of Gulf War environmental hazards claims at Area Processing Offices is a win for Gulf War veterans and a win for VA employees.

At town home meetings recently conducted by the Special Assistance for Gulf War Illnesses at the Department of Defense, Gulf War veterans, during the question and answer period, were encour-

aged to ask any questions or provide any comments that were at the top of their minds.

Nine times out of ten, these folks weren't talking about DOD's investigation, chemical weapons, "Sixty Minutes", whistles and bells, and things like that. They were talking about basic bread and butter things. How am I going to pay my bills? Who's going to take care of me? Am I eligible for health care?

Claims were number one on veterans' minds, and the fact that they had filed for compensation and hadn't heard from VA sometimes for months or years. This step that VA took today is only a first step. And this hearing, I believe, was the spark that caused VA to change the way it processed these claims.

And you deserve all the credit for that, Mr. Chairman.

That concludes my testimony and I'll be happy to answer any questions.

[The prepared statement of Mr. Puglisi appears on p. 85.]

Mr. QUINN. Thank you very much. Mr. Russo.

STATEMENT OF WILLIAM RUSSO, DIRECTOR, VETERANS' BENEFITS PROGRAMS, VIETNAM VETERANS OF AMERICA

Mr. RUSSO. Yes, Mr. Chairman and members of the subcommittee, Vietnam Veterans of America appreciates this opportunity to present our views on Persian Gulf claims and cigarette smoking related claims.

VVA strongly supports the VA's decision to relocate these Persian Gulf claims into the regional offices and we think it's long overdue. It's been mentioned by several of the members of the subcommittee this morning that it appears some Area Processing Offices have been granting claims at a higher rate.

And I've analyzed the statistics provided by VA current through March, and they're quite staggering. The western area office where Mr. Puglisi says the only actual training was done of the staff is granting 20 percent of the undiagnosed illness claims. The other offices are granting 5 percent and 7 percent.

So it appears that where the training has been done, the claims are being granted in a much more—much higher rate. There's been lots of evidence for the last several years that VA needs to do better training.

Our organization discovered a form letter a year and a half ago coming out of the Philadelphia Area Processing Office denying a Persian Gulf vet's claim for benefits that completely misstated the law on Persian Gulf benefits and used that misstatement to deny the guy's claim.

Now it so happens that we brought this case, this one isolated case, to the attention of VA and they fixed that one problem. But the fact that there's an erroneous form letter going out that completely misstates the law is very troublesome and it indicates that VA needs to train its staff as to what the law is before they can be expected to know how to apply the law in individual cases.

Lastly, we think that moving these cases back into regional offices will improve the processing of Persian Gulf claims for one important reason. The veterans' service organizations and their representatives act as a system of checks and balances on the VA.

And when these veteran service officers can do effective advocacy in individual claims by looking through the claims folder, by talking to the actual VA adjudicator who's going to decide the claim, they can bring mistakes to the attention of the VA staff on a day to day basis.

And that system of checks and balances is crucial to making the VA function well. Regarding cigarette smoking claims, VVA strongly opposed the proposed legislation to effectively bar cigarette smoking-related claims for compensation for the following reasons:

First, it's our position that the military encouraged cigarette smoking for years and years. As we stated and were quoted in the Wall Street Journal 2 weeks ago, "The Military gave free cigarettes to service members for decade and also subsidized GI's purchase of them at the commissaries."

There were often no health warning labels on these cigarettes in contrast to commercially available packs. Moreover, the military often sat aside a time and a place specifically for smoking; thus encouraging a culture in the military of "smoke 'em if you got 'em." And this encouragement by the military to smoke was specifically referenced by the VA General Counsel in its precedent opinion 2–93.

Secondly, the Clinton administration has consistently asserted that cigarette smoking is addictive, and that's in direct conflict, we believe, with the statements by Secretary Brown over the last several weeks including that quoted in the Washington Post that cigarette smoking ailments are the result of veterans' personal choice to engage in cigarette smoking.

If you accept that cigarettes are addictive, as the administration has said over and over, then it really isn't a matter of personal choice for them to have smoked.

Finally, regarding these cigarette claims, we don't expect a flood of these cases to come in to the VA under the current law. The fact is, the current law has been on the books for some time, and we have only 4,000 claims held in abeyance.

Most veterans are unable, we find, to get direct medical evidence of technical medical issues. And in these cases, a veteran would have to come in with medical proof from a doctor that his cigarette smoking in service or his addiction thereto was the cause of the cancer or whatever smoking-related ailment he's got as opposed to the 10 or 20 years of smoking the veteran did after service.

So we don't anticipate that VA will be forced to grant a large number of these claims. And we think it would be unfair to single out one particular group of veterans and say that their claims are barred.

Thank you.

[The prepared statement of Mr. Russo, w/attachment, appears on p. 89.]

Mr. QUINN. Thank you very much. Mr. Magill.

STATEMENT OF JAMES MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS ACCOMPANIED BY JOHN MUCKELBAUER, MILITARY CLAIMS CONSULTANT

Mr. MAGILL. Thank you. I would probably like now to be very brief in my comments. I can only echo what my colleagues have said at the table. What I would like to do is, with the remainder of my time, have Mr. John Muckelbauer of our staff who has dealt with the Persian Gulf Illness for quite some time to have comments on the previous testimony that we've heard.

The VFW certainly does support bringing the claims back to the regional offices. And what I would like to comment on is the outreach that we've not heard too much about. We believe the VA has made some great strides over the years in the way it reaches out to the veteran population.

But we have been hearing reports that the vast majority of the Persian Gulf veterans really do not know where to go to get the information. The VFW has conducted its own registry, and we have supplied that information to the VA.

We just can't stress enough that if we want to help these veterans, they have got to know where to go to get the help. At this point, I would ask, John, if you would like to make comments.

[The prepared statement of Mr. Magill appears on p. 94.]

Mr. QUINN. By all means. And I apologize for not introducing you with the rest of the panel, John, but please feel at home to comment with the time that remains from your colleague sitting next to you there.

Mr. MUCKELBAUER. Thank you, sir. And just to echo a couple of items from Jim, the VFW is encouraged by some of the VA's recent initiatives on this matter, particularly as it involves the extension of the presumptive period to a total of 10 years now and for the—finally the decentralization of the Gulf War claims back to the regional offices from the APO's.

We feel these two initiatives will go a long way to address the needs of the Gulf War issue, but it's not the final answer. There are still ways—issues that need to be improved; primarily I would say the adequacy of the exams.

It was addressed earlier by Mr. Mascara the clustering of symptoms. And I don't think that that issue was fully explored. It is a fact that a lot of the Gulf War veterans are exhibiting clusters of symptoms. And the problem, as addressed by some of my colleagues, is that some of these symptoms are being diagnosed, some of them are not.

Most often, it appears that they're not looked at collectively in rendering a decision as far as compensation is concerned. And I would submit that that has largely to do with the fact that the—on examinations, the doctors are not giving a determination as to the etiology or the cause of these symptoms.

That's in the regulations. The examining physician should make that decision, what's the cause of these symptoms in their opinion. If they were simply to do that, that would again go a long way to address these concerns.

Outreach efforts—certainly those could be extended. The fact is, there is a lot of information about the Gulf War Illness, but we

simply deal with too many veterans who do not know where to turn to get that information. I mean, there's Web sites, there's 800 numbers, there's bulletins.

But for the vast majority of the veterans that do not have access to it, we can't reach them and we need to address those issues.

Mr. QUINN. May I interrupt for just one second?

Do you have a suggestion on how we could do that better?

Mr. MUCKELBAUER. I would say more advertising in perhaps the national newspapers, perhaps public service announcements, more frequent public service announcements, things along those lines. Additionally, the Gulf War forums that we've held recently do go a long way in continuing that.

But finally, I would just like to add that one thing as far as lessons learned is that we should encourage the VA to listen to the veterans. It's now 6 years after the Gulf War and these regulations still are not ironed out.

And Mr. Chairman, I want to thank you for addressing this issue. It's not something that gets the glitz of a Khamisiyah or biological chemical exposure or the allegations of cover up. But to the veterans affected by this, it's clearly the most important.

And thank you for that.

Mr. QUINN. Thank you very much. Mr. Burns.

STATEMENT OF CHUCK BURNS, NATIONAL SERVICE DIRECTOR, AMVETS

Mr. BURNS. I do appreciate the opportunity to present our views. I am—fear I'm going to be the lone voice crying in the wilderness here this morning regarding I guess last night's decision by the Secretary to return these claims to the regional office.

AMVETS' opposition to returning them to regional offices is based solely on the fact that the expertise for processing these claims lies in the APO's. These APO's have had over 2 years of experience and expertise in putting these claims together and developing these claims.

It's my understanding in talking to the representatives at the four APO's that the backlog has not so much been generated by a lack of expertise or a lack of adequate training.

Much of the backlog can be laid directly at the feet of VA and the fact that, since these claims started being processed, they've sent out three new development letters telling the officers how to develop these claims resulting in the fact that each claim has to be redone again.

We have 56 rating specialists now around the country handling these claims. At the APO's, if the best trained VA personnel right now—if we are wound up with 11,000 claims being readjudicated, what is going to happen when these claims go back to the RO level?

I simply don't think that, as Ms. Moffitt indicated this morning, that 2 to 3—or 2 days of training via satellite or over a conference call is going to replace the 2 years of experience that's been gained at the Area Processing Offices.

It defies logic to assume that. I know in talking to the Phoenix office the comment that was made to our—to the AMVETS rep-

resentative in Phoenix by the VA regional director out there was "God help your claimants."

Again, it's the AMVETS' position that the locality of the claim, while it's probably comforting to the claimant to have it close at hand, the veteran should get the best adjudication of his claim possible no matter where that adjudication takes place.

We simply cannot transfer the expertise and experience gained over the last several years back to the regional offices in a two day training session. We believe if VA would reallocate its resources, put more people in the Area Processing Offices, this backlog could be diminished.

To get to the smoking issue, while I haven't seen the proposed legislation the VA has—I don't know if anybody has seen it—I have a great deal of trouble with Ms. Moffitt's statement this morning that virtually equated smoking while on active duty with alcohol and drug abuse.

I am very troubled by that, not just because I am a smoker, but it seems like to me that VA is setting up a preemptive strike on proper processing of these claims. As has been mentioned by a couple of my colleagues here, cigarette smoking was fairly well encouraged when I was in the service.

We got free cigarettes in boot camp. I remember at Paris Island we had smoking circles. And for guys that had never smoked, it was a great excuse to get outside and not have to clean a rifle or shine boots.

The sea rations had been mentioned. VA also either furnished cigarettes for free or greatly discounted prices at their hospitals and the commissaries. We think, as part of my written testimony—which I'm sure if any of you have read, you probably thought I was smoking something else when I talked about this—perhaps VA and DOD should look to the private sector for funding sources for these claims since the tobacco companies are presently in negotiations with the several states to satisfy the claims.

Why shouldn't VA and DOD pursue this course using every legal means necessary to have the tobacco companies set up a trust fund to be administered by a third party to satisfy these claims? In essence, DOD and VA were acting as agents of the tobacco companies in distributing these cigarettes to active duty military personnel.

If they're going to be held liable to—if VA's going to be held liable to pay these claims, they should at least examine the possibilities of going to the tobacco companies and seeking their assistance in paying for these claims.

Mr. Chairman, that concludes my remarks. We appreciate again the opportunity to testify this morning.

[The prepared statement of Mr. Burns appears on p. 96.]

Mr. QUINN. Well, thank you very much, Mr. Burns. And you're in a great spot in case you get paged again. You can get out that door very quickly and no one will get in your way. Thanks for being with us.

Thank you all for your time today. And Mr. Puglisi, you mentioned the hearing scheduled today. We're not sure if it nudged the VA to make that decision last night or not. But certainly it doesn't hurt to have these scheduled and the content of what we're talking

about well known because that's how some of these decisions are made many times.

And thank you for your kind words.

I want to get back to the question that Mr. Mascara raised earlier and at least—I think Mr. Russo, Mr. Puglisi, and others may have mentioned it this morning about the difference between allowance rates at the western—the Phoenix APO compared to the others.

And I think you began to talk about it, but we of course limited your time here this morning.

Mr. Puglisi, you seemed to point out that you thought one of the reasons for the differences was that Phoenix, the western APO, received a lot more training. And you suggested further that if we're going to do training, that's the model that we should use.

I want to give you a couple of minutes now maybe to expand on that. Is it the fact that they're—do we know the difference between the training? And then I have a question of why it didn't take place at the other three sites, of course.

And Mr. Burns, in arguing his side of that matter, says that it's not going to be done and that's why all of us were concerned this morning as to when it's going to take place, when it's going to be finished. A couple hours on TV and the satellite makes me anxious, I know that much.

Could you comment for a couple of minutes on the success, if that's what it is, out in Phoenix and what we might learn from that?

Mr. PUGLISI. Yes, sir. There were a couple of things occurring in Phoenix that I think led to more success in Phoenix than perhaps the other Area Processing Offices.

Let me tell you what I know and what I don't know. What I do know is that the American Legion made site visits last spring in 1996 to all four Area Processing Offices.

We spent several days in each place where we reviewed a representative sample of claims that we had power of attorney for and looked for errors in adjudication, looked for errors in development—looked for good things as well, things that were going right.

And we also spoke with the adjudicating officer, the director of the regional office, and all the key players there to get a feel for how things were going at that APO.

Phoenix stood head and shoulders above the APO's for a number of reasons. At that time, only at the Phoenix APO had staff been trained. And as a matter of fact, they had been sent here, to Washington, DC, to the VA Central Office.

And our understanding was that Central Office offered training to the APO's, and the Phoenix director was the only one who took advantage of that training at that time.

Mr. QUINN. Excuse me. Why don't we make that training mandatory?

Mr. PUGLISI. That's up to VA. But that seems like that should have been done. Now since last spring, that training may have occurred, but we're not aware that it has occurred. So to be fair to VA, they may have trained these folks since then, but we're not aware that that training took place.

Another key factor of Phoenix is something that you can't really mandate, and that is the quality and the attitude of the director of the regional office. The director of the regional office at Phoenix had created a real positive atmosphere within the office.

The folks who were adjudicating Gulf War undiagnosed illness claims had a real positive attitude about the claims. They were getting the backing of their boss. He had ensured that they had gotten training. He was encouraging them to do the best job they could.

And the allowance rate at that time was 11 percent and has grown since then. That wasn't the case at the other APO's. We got the clear impression that—again, you can't really quantify this, but we got the impression that this was a real hassle.

You know, we've been cursed now with Gulf War undiagnosed illness claims at the APO. We might as well be declared a leper. And it's preventing us from doing other work that we have. And as a result, a thousand claims were sent from Nashville to Muskogee, OK and some other claims were sent from some of the other APO's, to Cleveland, Ohio, because of the backlog.

Mr. QUINN. Thanks.

Mr. Russo, a minute or two to respond.

Mr. RUSSO. Yes, I don't have too much to add to what Mr. Puglisi has said, but I think what occurs when you hand a VA adjudicator a claims file with no training and perhaps the only guidance he has is some VA manual provisions or the actual regulation itself——

Mr. QUINN. Or a form letter.

Mr. RUSSO (continuing). Or a form letter, they come up with results that are just going to be completely wrong.

And the fact that—moreover, the fact that there was no supervision of these claims that allowed the erroneous form letters to go out, that allowed claims to be incorrectly decided—and I think by Ms. Moffitt's own statistics she gave you, the rereview has shown a 10-percent error rate just so far.

I think that's reprehensible and that specific, specialized training ought to be mandatory as you said, Mr. Chairman, any time a new type of VA benefit is provided to veterans, as was the case with Persian Gulf veterans.

Mr. QUINN. Thanks very much. I'll yield to Mr. Filner. But before I do that, just for one second, I'd like to introduce Congressman Rodriguez who joins us this morning. He's not a member of the committee yet, but we're thrilled to have you.

He's taken Frank Tejeda's seat here in the Congress and we're very excited about your interest in the committee and being with us this morning. And if you feel like you want to join with any questions, just give me a wave. We'd love to have you.

Also, Mr. Burns, a quick response about the VA's legislation on the smoking. We have a copy here. And when we're finished, if you all want to stop by, we called over and made some copies, you can pick them up and take them with you.

Mr. Filner.

Mr. FILNER. Thank you. I thought it exceedingly clever of you, Mr. Chairman, to take Congressman Rodriguez and put him on the majority side. (Laughter.)

Get him over to the wrong party before he even starts here.

So Mr. Rodriguez, we, at a future time, invite you to join us on our side of the table. (Laughter.)

But he's—you've got to watch this guy. Quinn is clever, I just say.

Just very briefly—by the way, Mr. Burns, I thought your statement on the liability issue and using some creative technique—I would suggest, Mr. Quinn, that you and I send a letter to the Attorney General whoever is negotiating this stuff with the—I was going to say oil companies—the tobacco companies that we make this suggestion and get it on the table anyway.

I mean, we should not let them resolve that liability without getting our claim in also. So maybe we can get that onto the table.

Mr. BACKHUS. Just please don't give the tobacco companies my home address. (Laughter.)

Mr. FILNER. They're probably waiting outside now for both of us. I just briefly—you all heard the testimony of Ms. Moffitt. I was just—I mean, do you have confidence that they take—they have understood these problems and are going to act on them?

I think the error rate, by the way—it looked like higher to me of the—than 10 percent, which—I mean, and I'm not even sure that if you looked at them again there wouldn't even be more. It just sounds still that based on just anecdotal evidence that I have through my own constituents and letters that I get, that I would suspect that there ought to be an even higher turn around on some of these things.

But as you say and as I said earlier, to examine every one of them and then find 10 to 20 percent error is—it's just amazing to me. But anyway, are you confident—or what should we be watching as they go through this and try to correct for the past mistakes?

I mean, are you confident they're on the right track now or what should we be watching?

Anybody to——

Mr. PUGLISI. Well, sir, these hearings and oversight, congressional oversight, is a key part of helping VA stay on the right track. The VSO's, all of us, have service officers at the VA regional offices because we're congressionally chartered. So we're keeping an eye on things down at the grass roots level as you all do as well because of what you hear from your constituents.

But the VSO's have complained loudly and consistently about the APO's, and they didn't go away until late last night because today there was a hearing scheduled. I'm convinced of that and will be.

So regular oversight, staff meeting with VA, and hearings perhaps every once in a while, the ongoing GAO report, those are the only ways that the complaints that we have are validated about how VA does things. So that's my suggestion is maintaining the interest and this subcommittee and Congress is going to keep VA on the straight and narrow.

Mr. VIOLANTE. Mr. Filner, one of the things from DAV's perspective that would probably be helpful would be some form of accountability. When you identify an individual or regional office where there's a high error rate, you know, that needs to be looked at closely.

And one of the things we don't have is accountability. The VA has been able, over the years, to avoid that. Hopefully with GPRA and their business plan, there will be some accountability built into the system and some way to correct the problem areas.

Mr. FILNER. I assume there's still people from the VA here. I would like to get an analysis of those errors that were now admitted to by office or something. I think it's absolutely crucial that we don't just lose all this stuff of accountability and statistics.

I mean, if all those—if 800 or what, 900 or 1,000 errors, and they all came from one office, that would tell us something. That's probably not the way it was, but the distribution of claim allowances shows a significant variance.

So I hope we can get—we'll ask Ms. Moffitt formally. But if you'd let her know that that question is coming, that that analysis ought to be given to us too.

I'm sorry I interrupted.

Mr. MUCKELBAUER. If I may add—as far as correcting the issue, it seems that small aspects of the Persian Gulf Illness issue are being corrected, but only slowly and piecemeal. I think an example is the extension of the presumptive period.

That has been a significant and arbitrary obstacle in the consideration of Gulf War Illness claims. Now the VA is saying okay, we're going to look at just those claims that were denied because of that coding for symptoms outside of the presumptive period.

I agree with my colleague from DAV, Mr. Violante, that you have to look at the entire picture. Once again, you have essentially a change of the regulations. You may have claims that were considered that are not going to be—that should be—that will be affected by this change and that do not come under the—under that particular coding.

Just I think it's time for the VA to take a step back and put all of the changes into place now rather than basically do it again. Say okay, we have made some errors; now let's correct them all now and move on.

Mr. QUINN. Thank you.

Mr. Reyes and then Mr. Mascara.

Mr. REYES. Thank you, Mr. Chairman.

I don't actually have a question. I just want to, for the record, to note that all of these organizations have been a vital component in getting us the information for us to ask the questions to the VA about the many issues that affect our veterans. And I just wanted to compliment all the organizations for the great job you've done. Thank you very much.

Mr. QUINN. Thank you, Mr. Reyes.

Mr. Mascara.

Mr. MASCARA. Yes, thank you, Mr. Chairman.

I want to go back to a question I would have had to the first panel and maybe perhaps you can shed some light on it. That question would have been the VBA is recommending decentralization because of workload problems at the APO's.

However, that leads you to believe that the RO's, who have workload problems of their own, are better able to handle the demands of these claims. Do we need more claims processing and adjudication personnel at the APO's or the RO's to meet the workload?

I go back to what Mr. Violante said about the 14,000 claims that are pending. Anybody want to comment on the personnel structure? Is there a sufficient number of employees to handle these claims or not?

Mr. VIOLANTE. I think the simple answer to that is there is not. And under the current administration's proposed budget, they're looking to cut additional—I think up to 100 people from VBA, so that's a real concern.

It doesn't look like there's any hope in the future for getting this situation straightened out.

Mr. MASCARA. So we're not going to resolve the problem, whether it's the APO's, the RO's, or whatever it is. If we don't have the personnel to handle the claims, we're always going to have a huge backlog of claims. Is that what you're saying?

Mr. VIOLANTE. Yes, sir.

Mr. MASCARA. And I want to go off in another direction. So we've established that there's an insufficient amount of personnel to handle the claims. I mean, I'd like to cut to the chase.

I'm an accountant by trade and very structured, so all that other nonsense we can talk about; but if you don't have the people to process, they're not going to be processed.

The other is, and that really disturbs me, and I don't know whether it was Mr. Puglisi or Mr. Violante—a lot of names here, Russo, familiar to my ethnic background—is that in response to the question of why Phoenix did so much better than Philadelphia, which was a question of mine, is that somehow I heard somebody say that perhaps Phoenix did better because they had a director who was sensitive to the problems rather than directors at the other RO's who were not.

I mean, do you—are we to believe then that somehow these people were insensitive at the other RO's and that's the reason that Phoenix did much better than Philadelphia?

Mr. PUGLISI. Well, Congressman, I had actually made that observation based on a site visit—site visits to all the APO's. And I wasn't trying to suggest that folks were insensitive to the claims, but the director at the Phoenix regional office was very aware of the duties he had as now it being an Area Processing Office.

And he let the employees who were adjudicating the claims know that they had his support. They also just adjudicated those claims. It was a team, and all they were going to do was Gulf War environmental hazard claims, and that didn't occur at the other APO's.

Folks were given Gulf War claims, and other claims, and told: "just get to work, people." That was the attitude at the other places.

And just to comment on insufficient personnel, when you break up all these claims across all the regional offices across the country, in some states, there were very few Gulf War veterans who filed environmental hazards claims. In some states, just dozens.

So in Maine, for instance, they should only get several dozen extra claims for them to adjudicate. It shouldn't be a big deal for those folks in Maine. In North Carolina, in Alabama, in Georgia, those regional offices are going to get quite a few more—hundreds and very likely thousands more claims perhaps per regional office.

So VA should be smart in assessing what its needs are as far as full time employees or more full time employees. Every regional office isn't going to need more employees to adjudicate these claims. But some will.

Mr. MASCARA. Well, you're being very kind to the area offices by saying that the attitude was not a problem. Phoenix did much better because they had a director who was sensitive to the issues and set the stage for proper fairness and equity in adjudication.

Where the other three directors did—were not sensitive. But you're saying that that's not the case, and I say it is.

Mr. PUGLISI. Well, no, sir. I must not be making myself clear. There were problems at all four Area Processing Offices. There were gross errors at all four. There were just fewer errors in Phoenix. And one of the explanations perhaps can be the way the director ran that regional office.

Mr. MASCARA. Well, they did—I mean the claims are much greater there—the approval rates are much greater there than they were in the other three offices.

Mr. PUGLISI. Clearly.

Mr. MASCARA. And there's no standardization of training in these offices?

Mr. PUGLISI. Not that I'm aware of.

Mr. MASCARA. What it looks like then is we have a more—more of an opportunity here to be in error in all of the other regional offices if these people aren't going to be trained and a certain standard set.

I think, you know, we need to educate these people about what we're doing here rather than just leaving it up to their own devices as to how they should engage with the people that work for them whether or not a claim should be approved or not approved.

So I'm saying we need training across the board here. And maybe some of the directors need to be trained more thoroughly than some of the people that work for them.

Thank you, Mr. Chairman.

Mr. FILNER. Can I just follow up, Mr. Mascara, on just one point?

We didn't get an answer on this from Ms. Moffitt, I don't think. But at these area processing centers, were there additional personnel added to handle this or were they supposed to do it out of their own existing staff?

And as you said, at one of them, they set up a team just for the Persian Gulf War. But at the others, they didn't. So nobody was added at these—if you're designated as an area processing center, it would seem to me you should have had—they should have put additional resources to do that.

Mr. PUGLISI. I'm not aware that that occurred, Congressman. From the explanations that we received from VA, all the VSO's that—the Area Processing Offices were selected according to their workload. So they tried to pick four places that didn't have the kind of workload that some of the other stations did.

I don't know if any personnel were added. It wasn't apparent when we visited those sites that they were.

Mr. FILNER. I mean, it's just no wonder that it wouldn't work. But I mean, if you're going to designate an area site, you assume

that you have a well trained specialist group of people who are assigned to do that.

And I mean, the more I learn about this, the more I get angry at how it's designed for failure and it just shows not a very deep understanding of the problem at all. And therefore, what confidence are we going to have that when they just switch because they got criticized, now they're going to move to the other.

It's just disheartening, to say the least, to observe that. I would hope, by the way, that our oversight, as it were—and you have to get apparently into the nitty-gritty. I mean, if we are there at the—if we're watching the satellite training and we—I know from an office of just eight people here or 16 people or whatever that training has to be sustained and continuous and redone.

And I mean, new people come on. All the people forget some of the details. Somebody was sick that day, whatever. It's a constant process. And in a major organization, they'd got to keep doing it. And I guess we have to keep seeing what they're doing about that because if nobody has the information to even tell the veteran what evidence they need and how to present it, something's going wrong here.

So I appreciate, as Mr. Reyes said, your ongoing—you have the sustained oversight to help us do that job. Thank you.

Mr. QUINN. Thank you, Bob. And I think that we will join you as the year goes on in conducting possibly further hearings in an oversight role to make certain that when this June deadline comes and goes, there is some kind of continuation there not only for us to be present and we've invited—on our own, we've invited some others to go this morning.

But that is exactly what happens. So I'm suspecting that later on this year we'll be back talking about the Persian Gulf War veterans and the claims. Not so much as you said, Mr. Puglisi, the glitz and all the rest of those things, but the nuts and bolts, the bread and butter of what gets out to our veterans and their families out in the country.

So we'll be in touch with you I'm sure some more. I don't have any further questions. And I think the subcommittee is clear on their questions. We thank you all for coming today and for your input, and we appreciate, as always, your willingness to help.

Thank you. The hearing is adjourned.

[Whereupon, at 10:50 a.m., the subcommittee was adjourned.]

APPENDIX

Honorable Jack Quinn
Remarks
Oversight Hearing for Compensation and Pension
Government Performance and Results Act,
Persian Gulf Compensation, and Smoking-Related Illnesses

May 14, 1997

The Subcommittee will come to order. Today we are holding the second hearing focusing on veterans benefits and the Government Performance Results Act. We will also receive testimony on VBA's processing of Persian Gulf claims, and hear remarks about the Administration's legislative proposal to limit VA's liability for smoking-related illnesses.

The Compensation and Pension program distributes about $16 billion annually to veterans and their survivors. Title 38 states the mission of the compensation program is to provide monthly payments for disability resulting from personal injury or disease contracted in the line of duty, or for aggravation of a preexisting injury suffered or disease contracted in the line of duty, in the active military, naval, or air service. At the end of last fiscal year, there were about 2.6 million veterans receiving compensation, 305,000 survivors receiving Dependency Indemnity and Compensation (DIC) and death compensation. Section 1155 describes the method of determining these payments as a "schedule of reductions in earning capacity.... based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations." The current rating schedule provides monthly payments ranging from $94 to $1924 plus a wide array of supplemental benefits that may raise payments above the $5,000 mark for our most severely disabled veterans.

Title 38 is less clear about the purpose of the pension program. However, it is clear that Congress intended the program to provide non service-connected, totally disabled wartime veterans a minimum level of income - about $8,450 for single veterans. There were 372,094 veterans receiving pension and about 200,000 survivors receiving death pension in September 1996. Last year, the average pension program benefit was $4,225. Clearly, nobody is getting rich.

Judging from the VA's budget submission as well as the meetings between VA and Committee staff to discuss the Department's progress towards compliance with the Results Act, it is clear VBA has spent considerable effort on the project. Today, I hope we will hear about additional progress.

We are also going to review VA's handling of Persian Gulf claims. There appears to be considerable interest in decentralizing Persian Gulf claims processing, and I am very interested in what all the stakeholders have to say on the issue. I want to point out that each of the VSO witnesses today will criticize the way VA has handled these claims. I hope each of them will be prepared to go beyond their dislike of the centralized processing system that VA appears to be backing away from and address the more substantive issues like consistency, timeliness, and management direction. For my part, I want to be assured that VA now has a handle on the processing.

It is unfortunate that the processing of Persian Gulf claims has been characterized by what appears to be a lack of strategic direction, a lack of training, poor outreach, inconsistent development of evidence, and failures in duty to assist. Therefore, I will ask the GAO to review processing, with an emphasis on duty to assist and development, of Persian Gulf claims and report their findings as soon as possible.

There persists a strong perception that DoD and the intelligence agencies are not telling everything they know. I want to get to the bottom of this, and we will hold as many hearings as necessary to solve this problem. Trust is the glue that holds a society together, and I am deeply disturbed about the continuing revelations regarding chemical weapons incidents.

I would like to ask VA to provide a list of all projects they are sponsoring concerning Persian Gulf Illness - the funding for each, a short description of the project and the name of the principle researcher. In addition, I would appreciate a strategic plan describing how all of the research programs fit together to solve this issue. To borrow a Results Act phrase, compensation is not the desired outcome. What we want are healthy veterans and their families, and research is critical to that effort.

To round out today's hearing, we have asked our witnesses to discuss VA's proposed legislation on compensation for smoking-related illnesses. VA has sent a draft bill to the Congress that will place significant restrictions on who may be compensated for those types of illnesses. I am sure this will not be the last airing of this subject, and I look forward to an open discussion of the subject.

I will now recognize my distinguished ranking member, Bob Filner for any remarks he may have.

Our first witness is Ms. Christine Moffitt, Director of the VA Compensation and Pension Service. Today, she is accompanied by the Assistant General Counsel, Mr. John Thompson and VBA's Chief Financial Officer, Mr. Bob Gardner. Before we begin, I would like to compliment Bob Gardner and his staff for the forthright manner in which they have dealt with this Subcommittee on the Results Act. Ms. Moffitt, please begin.

I want to thank the panel for being here today and I look forward to a continuing open dialogue with the Department on all of VBA's business lines.

May we have the next panel, please. Mr. Stephen Backhus, the Director of Veterans Affairs and Military Health Care Issues will speak on behalf of the GAO. He is accompanied by his Associate Director, Ms. Cynthia Fagnoni and Assistant Director, Irene Chu. Welcome back Steve, and please begin.

The Third panel represents several veterans service organizations. Today we have Mr. Jim Magill, Legislative Director for the VFW, Mr. Chuck Burns, Service Director of AMVETS, Mr. Matt Puglisi, Assistant Director of the American Legion's VA and Voc Rehab Commission, Mr. Bill Russo, the Director of Veterans Benefits Programs from the Vietnam Veterans of America, and finally, Mr. Joseph Violante, Deputy Legislative Director for the DAV. Gentlemen, I'll note for the record that our letter of invitation to you requested that you submit written comments on C&P's Results Act testimony so that you would have a chance to review it thoroughly. Before you begin, I would like to congratulate the Legion on providing $600,000 in grants to Persian Gulf veterans and their families. Well done. Let's begin.

I would like to thank all of today's witnesses for their appearance. These are difficult issues and I am optimistic about progress. I hope each of you shares that feeling. The Subcommittee stands adjourned.

Congressman Bob Filner
Subcommittee on Benefits – May 14, 1997
Opening Statement

Good morning and thank you for joining us today.

We have a very full agenda, so I will keep my remarks short. I do, though, want to stress a few points. First, I look forward to the discussion regarding VA's proposal to move Persian Gulf War [PGW] claims from the 4 Area Processing Offices [APOs] to all VA regional offices. This difficult issue, which will have profound effects on the lives of thousands of Persian Gulf War veterans, deserves very serious and forthright discussion.

I also want to know how VA reached its original decision to establish the adjudication responsibility for these claims in 4 area processing offices, in spite of objections from Congress and veterans' service organizations. What actions did the VA take to ensure that the 4 A-P-Os could do their jobs efficiently – to guarantee their success? What additional staff and computer assistance were provided to these regional offices? I know that when the Education Service designated 4 regional processing centers [RPCs] to adjudicate Montgomery GI Bill claims, these regional offices initially were not given the support obviously needed to fulfill their responsibilities. Within a year or less, however, the necessary assets were provided, and the education R-P-Cs have worked reasonably well.

Apparently, the Persian Gulf A-P-Os have not been given the tools and training needed to meet their

challenges – and I find this very, very disturbing. And I want to know how, and why, this circumstance has developed.

Additionally, I am bemused by assertions in the VA testimony that the very complex problem of redistributing the thousands of Persian Gulf War claims to regional offices across the country can be accomplished by early June!! How exactly does the VA propose to accomplish this? The procedure is not described in the VA statement.

These, and other related issues, greatly concern me, and I hope we will get some satisfactory answers this morning. This Subcommittee and, most importantly, our Persian Gulf War veterans, deserve candid, honest answers from the VA this morning to our many questions.

Thank you, Mr. Chairman.

STATEMENT OF HONORABLE LANE EVANS

SUBCOMMITTEE ON BENEFITS

MAY 14, 1997

THANK YOU, MR. CHAIRMAN. I HAVE A STATEMENT TO SUBMIT FOR THE RECORD. THE GOVERNMENT PERFORMANCE AND RESULTS ACT REQUIRES VA TO CONSULT WITH CONGRESS, VETERANS AND OTHER STAKEHOLDERS. TODAY'S HEARING WILL HELP THE SUBCOMMITTEE EVALUATE THE RESPONSE BY VA TO THE GPRA.

I ENCOURAGE THE VETERANS BENEFITS ADMINISTRATION AND THE COMPENSATION AND PENSION SERVICE TO CONTINUE TO WORK WITH MEMBERS OF CONGRESS AND THE STAFF OF THE HOUSE COMMITTEE ON VETERANS AFFAIRS TO IMPLEMENT THE GRPA LEGAL REQUIREMENTS. THE COMPENSATION AND PENSION SERVICE HAS PROVIDED A NUMBER OF BRIEFINGS TO STAFF WHICH ARE APPRECIATED.

AS YOU KNOW, CONSULTATION WITH CONGRESS, THE COMMITTEE, VETERANS AND OTHER STAKEHOLDERS IS AN IMPORTANT PART OF GPRA. IN ORDER FOR THIS CONSULTATION TO BE MEANINGFUL, IT IS ESSENTIAL THAT THE VA PROVIDE SUBSTANTIVE, TIMELY AND ACCURATE INFORMATION TO THE COMMITTEE. FOR EXAMPLE IN THE SERVICE'S GOAL TO ACHIEVE AND MAINTAIN A 92% ACCURACY RATE IN THE ADJUDICATION OF CLAIMS, IT IS CRITICAL THAT PERFORMANCE CRITERIA BE DEVELOPED WHICH DOES NOT MERELY REFLECT A MINIMAL STANDARD OF TECHNICAL CORRECTNESS. THE EXCELLENCE WHICH VETERANS HAVE A RIGHT TO EXPECT IN THE ADJUDICATION OF THEIR CLAIMS SHOULD BE MEASURED IN A MANNER WHICH WILL ALLOW SPECIFIC PATTERNS OF DEFICEINCIES, SUCH AS THE FAILURE TO INFORM THE VETERAN OF THE EVIDENCE NEEDED TO PURSUE A CLAIM OR A

VIOLATION OF THE DUTY TO ASSIST CAN BE IDENTIFIED AND CORRECTED.

IN ANY NEW ENDEAVOR, UNEXPECTED MATTERS WILL ARISE. SOME OF THESE MAY REQUIRE CONGRESSIONAL ACTION. THE EARLIER THE MEMBERS OF THE SUBCOMMITTEE AND THE FULL COMMITTEE ARE MADE AWARE OF SUCH SITUATIONS, THE MORE APPROPRIATELY AND EXPEDITIOUSLY WE WILL BE ABLE TO RESPOND.

CONGRESSIONAL AND EXECUTIVE INITIATIVES, SUCH AS THE EXTENSION OF PERIODS OF PRESUMPTIVE ELIGIBILITY FOR GULF WAR VETERANS AND COMPENSATION BENEFITS FOR CHILDREN OF VIETNAM VETERANS WITH SPINA BIFIDA WILL IMPACT ON HANDLING NOT ONLY OF THOSE CLAIMS, BUT ALL OTHER PENDING CLAIMS WITHIN THE SYSTEM. I WISH TO EMPHASIZE THAT THE COMMITTEE IS CONCERNED WITH

IMPLEMENTATION OF THE GRPA IN A MANNER WHICH ADDRESSES BOTH THE PERFORMANCE OF THE VA AS WELL AS THE MEASURABLE RESULTS SOUGHT.

THE RESULTS THE VA PLAN IS DESIGNED TO ACHIEVE SHOULD IMPROVE THE LIVES OF THE VETERANS VA IS MANDATED TO SERVE.

I AM PLEASED THAT WE WILL ALSO BE ADDRESSING THE ADJUDICATION OF CLAIMS INVOLVING PERSIAN GULF VETERANS AND OBTAINING MORE INFORMATION CONCERNING SMOKING RELATED CLAIMS. ISSUES CONCERNING PERSIAN GULF VETERAN CLAIMS ARE ESPECIALLY TIMELY SINCE THE VA IS ABOUT TO DECENTRALIZE THE ADJUDICATION OF THESE CLAIMS. HOPEFULLY THE LESSONS WHICH HAVE BEEN LEARNED TO DATE CAN BE USED TO IMPROVE THE QUALITY OF ADJUDICATION OF THESE CLAIMS.

UNFORTUNATELY, A NUMBER OF PROBLEMS HAVE BEEN IDENTIFIED IN THE VA'S HANDLING OF PERSIAN GULF WAR CLAIMS IN GENERAL AND THE UNDIAGNOSED ILLNESS CLAIMS IN PARTICULAR. THESE INCLUDE:

- THE FAILURE TO INFORM VETERANS AS TO THE EVIDENCE NEEDED TO SUPPORT THEIR CLAIMS;
- THE FAILURE OF THE VA TO REQUEST EVIDENCE WHICH MAY SUPPORT THE VETERANS CLAIMS;
- THE FAILURE TO NOTIFY VETERANS OF CHANGES IN THE LAW ALLOWING LAY EVIDENCE AND NON-MEDICAL INDICATORS, SUCH AS TIME LOST FROM WORK, TO BE SUBMITTED AS EVIDENCE OF AN UNDIAGNOSED CONDITION;
- THE FAILURE TO PROVIDE SPECIALIZED TRAINING TO ALL AREA OFFICES RESPONSIBLE FOR PROCESSING THESE CLAIMS; AND

- THE FAILURE TO UTILIZE THE PERSIAN GULF REGISTRY IN THE DEVELOPMENT OF CLAIMS.

GIVEN THE EXTENT OF THESE PROBLEMS, I ENCOURAGE THE COMPENSATION AND PENSION SERVICE TO SEND A LETTER TO EACH VETERAN WHO SUBMITTED A CLAIM RELATED TO SERVICE IN THE PERSIAN GULF, AS WELL AS EACH VETERAN IN THE PERSIAN GULF REGISTRY ADVISING THEM OF THE CHANGES MADE BY THE EXTENSION OF THE PRESUMPTIVE PERIOD AND PRIOR LEGISTLATION ADDRESSING UNDIAGNOSED CONDITIONS. THESE LETTERS SHOULD CONTAIN DETAILED INFORMATION CONCERNING THE CRITERIA FOR CLAIMING SERVICE CONNECTION AND THE EVIDENCE NEEDED TO ESTABLISH A CLAIM. SPECIFIC ATTENTION SHOULD BE GIVEN TO LAY EVIDENCE AND OTHER NON-MEDICAL EVIDENCE CONCERNING THE ONSET OF FREQUENCY OF SYMPTOMS.

I ALSO LOOK FORWARD TO HEARING FROM VA, THE DEPARTMENT'S EXPLANATION FOR THE PROPOSED CHANGES PROPOSED CONCERNING TO SMOKING RELATED ILLNESSES AND THE RATIONALE FOR PROPOSED CHANGES.

FINALLY, I WANT TO THANK THE GENERAL ACCOUNTING OFFICE AND THE VETERANS SERVICES ORGANIZATION FOR CONTRIBUTING THEIR PERPSECTIVE TO THESE IMPORTANT ISSUES.

REMARKS BY CONGRESSMAN FRANK MASCARA

BENEFITS SUBCOMMITTEE HEARING

VA CLAIMS PROCESSING

MAY 14, 1997

THANK YOU MR. CHAIRMAN. GOOD MORNING TO OUR THREE PANELS. I LOOK FORWARD TO HEARING YOUR TESTIMONY AND HOPE IT WILL MARK THE BEGINNING OF TRULY TURNING AROUND THE VA BENEFITS CLAIMS PROCESS.

HAVING PERSONALLY HELPED SEVERAL PERSIAN GULF WAR VETERANS OBTAIN THEIR DISABILITY BENEFITS, I MUST SAY I AM DEEPLY TROUBLED BY THE PICTURE OF THE BENEFIT PROCESS THAT WILL BE PAINTED HERE TODAY.

I UNDERSTAND THAT EARLIER THIS WEEK, SECRETARY BROWN STATED IN FLORIDA THAT THE PERSIAN GULF CLAIMS WILL NOW BE HANDLED BY

THE 50 SOME VA REGIONAL OFFICES. WHILE THIS IS THE ROUTE THE VETERANS' SERVICE ORGANIZATIONS AND CONGRESS ORIGINALLY PUSHED FOR, I WONDER HOW THOUSANDS OF CLAIMS MISHANDLED BY FOUR OFFICES WILL NOW SUDDENLY BE PROPERLY HANDLED BY THE REGIONAL OFFICES WHICH ARE NOT USED TO HANDLING THE UNIQUE PROBLEMS OF PERSIAN GULF VETERANS.

THE VETERANS' CLAIMS PROCESS HAS NEVER BEEN A PRETTY PICTURE, BUT I MUST SAY THE HANDLING OF THE PERSIAN GULF CLAIMS SEEMS TO HAVE SET A NEW LOW.

I AM TOLD AN AMERICAN LEGION STUDY CONDUCTED LAST YEAR SHOWED THAT THE VA WAS DENYING 95 PERCENT OF THE PERSIAN GULF CLAIMS BEING FILED. WHAT IS EVEN MORE DISTURBING IS THAT THE LEGION FOUND THAT OF THE FIVE

PERCENT AWARDED, MORE THAN HALF OF THE APPROVED CLAIMS RECEIVED A ZERO DISABILITY RATING. WHAT A DISGRACE!

WHAT IS PERHAPS EVEN MORE TROUBLING TO ME SINCE I REPRESENT A DISTRICT IN PENNSYLVANIA IS THAT THE PHILADELPHIA OFFICE APPARENTLY HAD ONE OF THE WORST RECORDS FOR APPROVING CLAIMS AND EVEN USED PREPRINTED AND PRESTAMPED FORMS TO ADVISE VETERANS THEIR CLAIMS WERE DENIED. THE ARIZONA OFFICE, WHICH RECEIVED SPECIFIC TRAINING TO HANDLE THE PERSIAN GULF CLAIMS, APPROVED THREE TO FOUR MORE TIMES THE NUMBER OF CLAIMS THAN THE OTHER THREE AREA PROCESSING OFFICES.

I HAVE SEEN FIRST-HAND THE RAVAGING EFFECT THAT BROAD ARRAY OF ILLNESSES CALLED THE PERSIAN GULF SYNDROME HAVE HAD ON THE YOUNG MEN AND WOMEN WE SENT TO FIGHT THE

GULF WAR.

THIS CLAIM PROCESS IS A DISGRACE AND BEFORE WE LEAVE TODAY I HOPE WE WILL GET AN ASSURANCE FROM THE VA THAT THE SITUATION WILL IMPROVE AND IMPROVE NOW--NOT TWO OR THREE YEARS FROM NOW!

I ALSO WANT TO COMMENT BRIEFLY ON THE IMPLEMENTATION OF THE GOVERNMENT PERFORMANCE AND RESULTS ACT BY THE VA COMPENSATION AND PENSION SERVICE AND THE VA'S EFFORT TO LIMIT ITS LIABILITY IN SMOKING-RELATED DISABILITY CLAIMS.

AS MANY OF YOU KNOW, THE FIRST SEVERAL MONTHS I SERVED IN CONGRESS I WAS A MEMBER OF THE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE WHICH HAS JURISDICTION OVER THE GOVERNMENT PERFORMANCE AND RESULTS ACT.

WE HELD MANY HEARINGS TO LEARN HOW THIS ACT, WHICH IS DESIGNED TO MAKE AGENCIES PROVE THEY ARE PERFORMING THEIR JOBS AND PRODUCING QUALITY RESULTS, WAS GOING TO BE IMPLEMENTED.

APPARENTLY, THE TESTIMONY BEING PRESENTED TODAY WILL INDICATE THAT THE VA COMPENSATION AND PENSION SERVICE IS FOCUSING TOO MUCH ON PROCESSING TIMES AND PROCEDURES RATHER THAN TRYING TO ENSURE VETERANS ARE RECEIVING QUALITY SERVICE AND BEING TREATED WITH THE DIGNITY AND RESPECT THEY RIGHTFULLY DESERVE.

IF A RECENT CONSTITUENT CASE THAT CAME TO MY ATTENTION IS ANY INDICATION, THE COMPENSATION AND PENSION SERVICE HAS A LONG , LONG WAY TO GO.

THIS GENTLEMEN, WHO SERVED FOR MANY YEARS AS A MILITARY PILOT, IS SUFFERING FROM A HEARING LOSS WHICH IS DETAILED IN GREAT SPECIFICITY IN HIS MILITARY HEALTH RECORDS.

FOR SOME YEARS, HE WOULD TRAVEL FROM THE PITTSBURGH AREA TO DAYTON TO RECEIVE CARE AND NEW HEARING AIDS AT THE WRIGHT-PATTERSON AIR FORCE BASE. RECENTLY, WRIGHT-PATTERSON TOLD MY CONSTITUENT THAT THEY WOULD NO LONGER BE ABLE TO HELP HIM AND HE SHOULD GO TO THE VA IN PITTSBURGH.

UNFORTUNATELY, THE VA HAS TREATED HIM RUDELY, CONTESTING HIS CLAIM AT EVERY TURN DESPITE THE FACT HIS MILITARY RECORDS CLEARLY DEMONSTRATE HIS HEARING LOSS IS DUE TO YEARS OF FLYING IN VERY NOISY AIRCRAFT. HIS CLAIM HAS BEEN DENIED AND NOW WILL GO THROUGH THE APPEALS PROCESS.

HE FLEW COUNTLESS MISSIONS FOR OUR COUNTRY INCLUDING DANGEROUS INCURSIONS INTO VIETNAM. HE DOES NOT DESERVE TO BE TREATED LIKE THIS.

FINALLY, I FIND IT ODD WHEN THE PRESIDENT IS LEADING THE CHARGE AGAINST TOBACCO COMPANIES AND ENCOURAGING STATES TO FILE SUITS TO WIN DAMAGES FOR CARING FOR MEDICAID PATIENTS SUFFERING FROM ILLNESS DIRECTLY ATTRIBUTABLE TO SMOKING THAT THE VA REALLY THINKS CONGRESS WILL PASS LEGISLATION LIMITING ITS LIABILITY FOR PUTTING CIGARETTES IN ~~SEA~~ C-RATION PACKETS.

I WOULD URGE THE VA TO HUDDLE WITH ITS LEGAL COUNSEL AND PERHAPS TRY TO FIND SOMEWAY TO BECOME PART OF THE BIGGER EFFORT TO FORCE TOBACCO COMPANIES TO SET UP A FUND TO COVER THESE CLAIMS.

AGAIN, THIS IS AN EXTREMELY IMPORTANT HEARING AND I AM GLAD MR. CHAIRMAN YOU HAVE HAD THE WISDOM TO CALL IT.

AS I SAY TIME AND TIME AGAIN, OUR VETERANS DESERVE BETTER!

MR. CHAIRMAN I YIELD BACK THE BALANCE OF MY TIME.

STATEMENT OF

KRISTINE A. MOFFITT, DIRECTOR

COMPENSATION AND PENSION SERVICE

VETERANS BENEFITS ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON BENEFITS

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

MAY 14, 1997

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Compensation and Pension Service's implementation of the Government Performance and Results Act (GPRA), the adjudication of Persian Gulf compensation claims based on environmental hazards and undiagnosed illnesses, and the Department's proposed legislation to prohibit compensation to veterans with tobacco-related diseases or injuries. With me today are Mr. Jack Thompson, Assistant General Counsel, and Mr. Bob Gardner, Director of the Veterans Benefits Administration's (VBA) Office of Resource Management.

GPRA

Earlier this year we briefed staff members of this Subcommittee on our plan for implementing the requirements of the Government

Performance and Results Act of 1993 (GPRA). I am happy to have this opportunity to provide Subcommittee members with details of the plan. GPRA is the primary vehicle through which the Compensation and Pension Service is developing and refining goals, objectives, and performance measures. We developed a business plan that was integrated and combined with Business Plans from four other Services (Education, Loan Guaranty, Vocational Rehabilitation and Counseling, and Insurance) into one comprehensive VBA Business Plan. For FY 1998, the VBA Business Plan was used as our annual budget request, which, to the extent possible, tied our program goals, objectives, and performance measures to our request for resources. We are currently in the early stages of the FY 1999 business plan and resource development process. The FY 1999 business plans will contain further enhancements compared to the FY 1998 plans and will satisfy the annual performance plan requirement contained in the GPRA.

The Compensation and Pension Service's FY 1998 Business Line Plan was based upon our Business Process Reengineering (BPR) project, which created a strategic vision of the way compensation and pension claims processing should occur by the year 2002. The main principles that guide our vision emphasize closer, more personal, and more frequent contacts with the veterans and greater responsiveness to their concerns. Veterans' needs and expectations drive the changes that we will make now and in the future.

We have developed a number of business line goals and performance objectives, as well as performance measures that will tell us

how well we are achieving our goals, for FY 1998, one year in advance of the GPRA requirement.

Objective #1 - Accuracy

For FY 1998, we plan to achieve and maintain a 92 percent accuracy rate.

The performance measure, National Accuracy, will be based upon the random selection and review of completed rating cases. The National Accuracy Rate will be determined by dividing the number of cases determined to be technically accurate by the total number of cases reviewed. This GPRA measure will be in place by September 30, 1997.

Objective #2 - Timeliness

We intend to reduce the time required to process claims. Our current goals for the end of FY 1998 are 106 days for original compensation claims, 73 days for original DIC claims, 71 days for original disability pension claims, and 20 days for original death pension claims.

Objective #3 - Appeals

We intend to do our part to shorten how long it takes to complete an appeal by reducing the time it takes to prepare an appeal and by

reducing the remand rate.

We will measure our performance using appeals timeliness data maintained by VBA and BVA in a single, joint tracking system. Goals and measures are now in development and will be in place by September 30, 1997.

Objective #4 - Customer Satisfaction

We intend to improve communications and outreach and be more responsive to customer and stakeholder needs. Specific goals are to respond to telephone calls within three minutes; to conduct office interviews within 20 minutes of arrival time; to answer Veterans Assistance Inquiries within 10 workdays; and to answer or acknowledge written correspondence within 10 workdays. We also will measure the percentage of veterans or family members who feel that VA kept them informed of the benefits and services available; explained the steps necessary to process the claim; kept them informed of the status of their claim; and provided a realistic estimate of how long it would take to process the claim.

We will use data from computer-generated management reports, as well as results from the Survey of Veterans' Satisfaction with the VA Compensation and Pension Claims Process to measure our performance in this area.

Objective #5 - Employee Satisfaction

With full implementation of BPR in 2002, we will ensure that all employees are trained and certified in their positions in order to maintain a highly skilled, motivated, and adaptable workforce.

We will be checking the percentage of our workforce trained and certified and using an employee climate survey to monitor our progress.

Objective #6 - Unit Cost

We plan to reduce overall operating costs and ensure the best value for the taxpayers' dollar with the implementation of BPR.

Our performance measure will be full Unit Cost. Initially, only direct labor costs will be considered in determining Unit Cost. VBA is, however, currently developing a full cost accounting system. Direct, indirect, and overhead costs will be allocated to derive total costs when this accounting system has been implemented. We expect to have our full unit cost system implemented by the year 2000.

Our vision and goals correlate directly with those of VBA and the Department. Through our GPRA-based goals and performance measures we support core values developed by VBA. We designed an ambitious plan with goals set high enough to inspire improvement, but not so high as to guarantee failure. We are working hard to develop GPRA goals and

the measurement system to track our progress.

Persian Gulf War Claims

In November 1994, the President signed Public Law 103-446, which authorized us to pay compensation to Persian Gulf veterans suffering from chronic disabilities resulting from undiagnosed illnesses. In February 1995, we published 38 CFR 3.317 to implement the statute.

In early 1996, after nearly a year's experience with undiagnosed illness cases, we reviewed a sample of claims denied because the disabilities first appeared after the 2-year presumptive period originally established by the regulation. We found several instances where recent medical examinations or lay statements that might have proved important to veterans' claims were not requested. We were concerned that these veterans had not received proper information about sources of information that might establish the merits of their claims. We also found numerous instances of incorrect information about denied claims in our Persian Gulf tracking system, raising concerns about the overall accuracy of our available data.

On the basis of these findings, in July 1996, we instructed our four Area Processing Offices (APOs) to undertake a readjudication of 10,736 cases identified from our tracking system. The purpose of the readjudication is twofold. The first goal is to

ensure that proper weight is being accorded to less traditional types of evidence. Specifically, we want to ensure that lay evidence attesting to signs and symptoms of illness is fully considered, since probative medical findings in these cases may not be available. The second goal is to ensure that information about the claims is properly entered into our tracking system. In our opinion, both of these goals are being met.

As of the end of April, we completed 4,966 cases (about 46 percent of the total readjudication workload). We awarded additional grants of service connection for newly considered or previously denied disabilities in 683 cases. Of these new grants, 157 were for undiagnosed illnesses. The overall grant rate of service connection for undiagnosed illnesses has risen from 5 percent prior to the readjudication to nearly 8 percent as of April. We believe that this increase can be attributed to more complete development for lay evidence and a more thorough analysis of lay evidence in conjunction with medical evidence. We expect to have the readjudication completed by the end of this year.

On April 29, 1997, we published an interim final rule implementing the Secretary's recent decision to expand the presumptive period for undiagnosed illnesses through December 31, 2001. Because of this change, we have begun a further review of claims that were denied because the disability first appeared more than 2 years following service in the Persian Gulf. As of the end of April, there were 4,435 cases coded as such in our tracking

system. While it is too early to offer a definite projection about the impact of extending the presumptive period, we expect a significant number of additional grants of service connection for undiagnosed illnesses.

In December 1992, VBA consolidated the adjudication of Persian Gulf environmental hazard claims in the Louisville Regional Office. As the volume of these cases began to outstrip that office's resources to handle them, in October 1994, we redistributed them to four regional offices (the APOs), Louisville, Philadelphia, Nashville, and Phoenix. When Public Law 103-446 was enacted, we also consolidated undiagnosed illness claims at these four stations. The purpose for consolidation of the Persian Gulf claims was to concentrate the expertise in rating these complex issues and dedicate resources to expeditious claims processing. The consolidation, however, has not been without problems.

The additional workload imposed on these four stations has had an adverse effect on other areas of their claims processing. To accommodate Persian Gulf cases, the APOs have had to "broker out" increasingly larger portions of their other work. This means that while the APOs have given priority to Persian Gulf cases, a large amount of the APOs' routine rating work has been temporarily transferred to other stations for processing. During the period October to April of FY 96, the APOs brokered out 3,625 cases. During this same period in FY 97, that number increased to 9,708, an increase of nearly 167 percent. Nationally, brokered work for

these two periods increased by just slightly more than 50 percent, from 13,385 cases to 20,464. Brokered work from the APOs has accounted for nearly half the total so far in FY 97. Moreover, Nashville's share of the Persian Gulf cases has itself proved to be so great that earlier this year we enlisted the assistance of the Cleveland and Muskogee regional offices to help with the readjudication. The percentage of claims pending over 180 days at the APOs during the first 6 months of FY 97 shows a tremendous increase over FY 96. Philadelphia's percentage has gone from 9.0 to 19.2 percent; Nashville's from 10.4 to 30 percent; Louisville's from 5.6 to 29 percent; and Phoenix's from 5.3 to 21.3 percent. By contrast, the national percentage has gone up from 8.4 to only 11.8.

Therefore, in order to maintain overall claims processing efficiency at the APOs and meet VBA performance goals, we recently recommended to the Secretary that Persian Gulf claims be redistributed to the regional offices of jurisdiction. In making this recommendation, we also took into account the views of those veterans, veterans' service organizations, and Members of Congress who had expressed concerns about consolidation of Persian Gulf claims.

When the Secretary gives his approval, we would then initiate procedures to return Persian Gulf cases from the APOs to the regional offices, including cases pending consideration under the readjudication. Pending approval, we have also instructed the regional offices to stop sending Persian Gulf claims to the APOs.

We would then prepare each regional office to process its own Persian Gulf environmental hazard and undiagnosed illness claims by scheduling at least two training sessions to assist them in approaching this task. We believe that a transition from APOs to the regional offices would not adversely affect the improvements we have been seeing in either the overall quality of Persian Gulf claims processing or the accuracy of data available from our tracking system.

Tobacco-Related Claims

As our General Counsel interprets current law, direct service connection of a disability or death may be established if the evidence establishes that the underlying injury or disease resulted from tobacco use during active service, even if the disability or death did not occur until after service and expiration of any applicable presumptive period. We have approximately 4,250 such claims pending adjudication under current law, some involving contentions that smoking in service was the cause of post-service disease, and others in which it is contended a veteran became nicotine dependent in service and therefore the Government bears responsibility even for the adverse health effects of the veteran's post-service smoking.

In the Omnibus Budget Reconciliation Act of 1990, Congress prohibited compensation for disabilities which are the result of veterans' abuse of alcohol or drugs. This was fiscally responsible

action which enhanced the integrity of our compensation program. In the same spirit, VA recently submitted to Congress proposed legislation that, among other things, would add a new section to title 38, United States Code, prohibiting service connection of a death or disability on the basis that it resulted from injury or disease attributable, in whole or in part, to the use of tobacco products by the veteran during his or her service. Our proposal regarding tobacco use would apply only with respect to claims filed after the date of its enactment, and would not preclude establishment of service connection where the disease or injury became manifest or was aggravated during active service or became manifest to the requisite degree of disability during any applicable presumptive period specified in section 1112 or 1116 of title 38, United States Code.

Mr. Chairman, this concludes my testimony. I will now be happy to answer any questions you might have.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Benefits, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 8:30 a.m.
Wednesday, May 14, 1997

VETERANS' AFFAIRS

Veterans Benefits Administration's Progress and Challenges in Implementing GPRA

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-131

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to provide our views on the progress made and challenges faced by the Veterans Benefits Administration (VBA) in implementing the Government Performance and Results Act (GPRA). As you know, over the past several years, the Congress has taken steps to fundamentally change the way federal agencies go about their work. The Congress took these steps in response to management problems so common among federal agencies that they demanded governmentwide solutions. GPRA was passed in 1993 to require agencies to clearly define their missions, set goals, measure performance, and report on their accomplishments.

VBA is responsible for administering the Department of Veterans Affairs' (VA) nonmedical programs that provide financial and other benefits to veterans, their dependents, and survivors. These benefits include disability compensation, pensions, rehabilitation assistance, education benefits, home loan benefits, and insurance coverage. As requested by the Subcommittee, my statement will center primarily on VBA's largest program–the compensation and pension program–which accounts for more than 90 percent of VBA's $20 billion appropriation for fiscal year 1996 and provides compensation and pensions to over 3 million veterans and their survivors. My statement will address the purpose and requirements of GPRA, the progress VBA has made, and challenges it faces in implementing the act. The information in this statement is based on our past work in the area, a review of VBA's strategic plan, and discussions with VBA officials.

In summary, VBA has taken an important first step in implementing GPRA, but this process is an evolving one. To date, VBA has developed a strategic plan with a mission and goals and has begun consultation with the Congress and other stakeholders to obtain their views on its plan. For the compensation and pension program, VBA has identified specific performance measures for such factors as timeliness and accuracy in processing claims. However, these measures are primarily process oriented. As it continues through the planning process, VBA also needs to ensure that its strategic plan focuses on results, as required by GPRA, such as those related to the overall purpose of the program, and not merely on the process used to administer the benefits. In addition, to help ensure quality service, VBA needs to integrate its strategic plan with VA's overall plan and with the plans of other key federal agencies, such as the Department of Defense and the Department of Labor's Veterans' Employment and Training Service. Down the road, VBA will also need to ensure that it effectively measures and assesses its performance, as mandated by GPRA, to determine how well its programs are meeting their goals and making improvements. Our prior work suggests that VBA will be challenged in implementing GPRA because it has had difficulties in the past in bringing about program improvements.

PURPOSE AND REQUIREMENTS OF GPRA

GPRA is the centerpiece of a statutory framework provided by recent legislation to bring needed improvements to federal agencies' management activities. (Other parts of the framework include the 1990 Chief Financial Officers Act, the 1995 Paperwork Reduction Act, and the 1996 Clinger-Cohen Act.) Under GPRA, executive branch agencies are to set strategic goals, measure their performance, and use that performance information to make improvements.

GPRA was designed to focus federal agencies' attention on the results of the programs they administer–not just on program operations. Instead of focusing on the amounts of money they spend or the size of their workloads, agencies are expected to rethink their missions in terms of the results they provide, develop goals based on their results-oriented missions, develop strategies for achieving their goals, and measure actual performance against the goals.

Our reviews of federal programs have found numerous examples of management problems that GPRA is intended to correct.[1] Several examples follow:

- Some agencies do not have clear understandings or statements of what their missions are. GPRA requires agencies to articulate their missions.

- In some program areas, responsibilities are fragmented among several agencies, which wastes scarce funds, confuses and frustrates customers, and limits the overall effectiveness of federal efforts to serve customers. GPRA aims to help agencies to address the fragmentation of program areas, and to coordinate their strategic planning efforts with other agencies.

- Many agencies measure performance on the basis of their workloads, rather than on the results of their programs. Instead of the more difficult task of measuring how well programs are serving customers and achieving the results intended by the Congress, agencies focus on such measures as how many applications they process and how quickly they process them. Thus, agencies do not know, and cannot inform the Congress, how well their programs are actually achieving their purposes. GPRA requires agencies to develop results-oriented performance measures.

- Many agencies lack coherent strategies for achieving their missions. In a time of budget constraints, agencies need to rethink how they manage their programs, and they need strategies for achieving their missions more efficiently and effectively. GPRA requires agencies to develop such coherent strategies.

- Many agencies lack adequate information on program results and costs. Without such information, the Congress has difficulty making informed policy and budget decisions. GPRA requires agencies to develop results-oriented performance measures and to report annually on their performance. As we noted in a recent report, GPRA aims for a closer and clearer linkage between spending decisions and the results of federal programs.[2]

Also, GPRA requires agencies to consult with the Congress in developing their strategic plans. This gives the Congress the opportunity to work with agencies to ensure that their missions and goals are focused on results; consistent with the Congress' intent in establishing programs; and reasonable, in light of fiscal constraints. The products of this consultation should be clearer guidance to agencies on their missions and goals and better information to help the Congress make choices among programs, consider alternative ways to achieve results, and assess how well agencies are achieving the results the Congress intended for programs.

GPRA requires VA and other agencies to complete their strategic plans by September 30, 1997. Future actions required under GPRA include the following:

- Beginning in the fall of 1997 (for the fiscal year 1999 budget cycle), agencies will submit an annual performance plan to the Office of Management and Budget (OMB).

- Beginning with the fiscal year 1999 budget, OMB will include a governmentwide performance plan in the President's budget submission to the Congress.

- On March 31 of each year, beginning with 2000, agencies will submit annual performance reports, comparing their actual performance with their goals, to the Congress and OMB.

---

[1]Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

[2]Performance Budgeting: Past Initiatives Offer Insights for GPRA Implementation (GAO/AIMD-97-46, Mar. 27, 1997).

PROGRESS VBA HAS MADE IN IMPLEMENTING GPRA

In implementing GPRA, VBA's planning process has been evolving. VBA first developed a strategic plan in December 1994 covering fiscal years 1996-2001. The plan laid out VBA's mission, strategic vision, and goals. For example, the compensation goal was to provide compensation benefits to veterans who were disabled while in the service and to their eligible dependents upon the veterans' death. The pension goal was to provide pension benefits to veterans of wartime periods who are disabled and do not meet minimum income requirements, and to their eligible dependents upon the death of the veterans. However, in a 1995 report, VA's Inspector General stated that the goals in the strategic plan could not be measured because the plan did not contain specific performance information.[3]

In fiscal year 1995, VBA established a new GPRA strategic planning process. VBA began developing five "business line" plans corresponding with its major program areas: compensation and pension, educational assistance, loan guaranty, vocational rehabilitation and counseling, and insurance. These business plans were to supplement the overall strategic plan and to specify program performance objectives and measurements.

In VA's fiscal year 1998 budget submission, VBA has set forth its business goals and measures. VBA has identified seven goals for the compensation and pension program that are oriented toward the efficiency of claims processing and customer satisfaction.

- Be responsive to customer and stakeholder needs.
- Maintain a 97-percent accuracy rate for claims processing.
- Reduce the time required to process claims.
- Reduce operating costs.
- Ensure the best value for the taxpayers' dollar.
- Maintain a highly skilled, motivated, and adaptable workforce.
- Improve communications and outreach.

VBA has also identified specific performance measures for the compensation and pension program. For instance, the measures include reducing processing time for original compensation claims from 144 days to 53 days and achieving a 97-percent accuracy rate for claims processing by fiscal year 2002.

CHALLENGES VBA FACES

As VBA continues its process of implementing GPRA, it faces some difficult challenges. If the full intent of GPRA is to be achieved, VBA will need to develop a strategic plan with a clear mission, goals, and performance measures that are truly results oriented. In addition, VBA will need to integrate its strategic plan with those of VA and other federal agencies to ensure quality service, since VBA is not the only agency providing veterans' benefits. Furthermore, VBA will need to effectively measure and assess its performance to fully complete the process that GPRA mandates for improved federal programs.

Focusing on Results

VBA has identified specific goals and measures in its current strategic plan, but again, they tend to be process oriented. While these goals and measures are important, they do not reflect program results. For example, the purpose of the disability compensation program is to compensate veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during military service. Given this program purpose, results-oriented goals would focus on issues such as whether disabled veterans are indeed being compensated for average

[3]Office of the Inspector General, Review of the Implementation of VBA's Strategic Plan and Performance Measurements, 5R1-B18-100 (Washington, D.C.: VA, Aug. 25, 1995).

loss in earning capacity and whether VBA is providing compensation to all of those who should be compensated. VBA has not yet tackled these types of difficult questions and will need to do so in consultation with the Congress in order to develop a truly results-oriented strategic plan. VA officials told us that these issues are particularly sensitive and that they have begun consultations with the Congress and other stakeholders about the purpose of the compensation and pension program. However, no final agreements have been made to date.

In the past, VBA has not focused on results. For example, in 1984, 1992, and again in 1996, we reported that VBA's vocational rehabilitation program did not focus on helping disabled veterans find jobs, despite a 1980 law (P.L. 96-466) requiring it to do so.[4] Instead, VBA continued to focus on sending veterans to training, an intermediate step in finding jobs. Consequently, VBA has placed relatively few disabled veterans in jobs.

VBA is aware that it needs to focus more on its benefits programs' outcomes for veterans rather than only on the process used to administer the benefits. In its fiscal year 1998 budget submission, VBA stated that, historically, VA has engaged in little policy or program analysis of its benefits programs and that this work is needed if the intended results of GPRA are to be fully achieved. VBA acknowledges that additional data and research will be required, including formal program evaluations and extensive consultation with stakeholders.

Integrating Strategic Plans

As VBA continues its strategic planning, it will need to integrate its plan with those of the rest of VA and those of other federal agencies that support the veterans' benefits programs. For example, in determining the eligibility of a veteran for disability compensation, VBA usually requires the veteran to undergo a medical examination, which is generally performed by a Veterans Health Administration physician. Similarly, VBA looks to the Department of Defense for information about the medical conditions of veterans while they were in the military and to the Department of Labor for veterans' employment and training experiences. VBA will need to determine what impact these other entities will have on the success of VBA's performance.

Currently, VA is in the process of developing a departmentwide strategic plan. VBA is participating in this planning effort. In addition, VA has initiatives under way to improve its information exchange with the Department of Defense. Furthermore, as we recently testified before this Subcommittee, the Department of Labor's Veterans' Employment and Training Service has developed a draft strategic plan and performance measures.[5] VBA will need to continue to coordinate with these agencies that are critical to veterans' benefits programs to ensure overall high quality service to veterans.

Measuring and Assessing Performance

Once VBA has identified results-oriented goals, it will need to effectively measure and assess its performance. As mandated by GPRA, federal agencies are required to link

---

[4]VA Can Provide More Employment Assistance to Veterans Who Complete Its Vocational Rehabilitation Program (GAO/HRD-84-39, May 23, 1984); Vocational Rehabilitation: Better VA Management Needed to Help Disabled Veterans Find Jobs (GAO/HRD-92-100, Sept. 4, 1992); and Vocational Rehabilitation: VA Continues to Place Few Disabled Veterans in Jobs (GAO/HEHS-96-155, Sept. 3, 1996).

[5]Veterans' Employment and Training Service: Focusing on Program Results to Improve Agency Performance (GAO/T-HEHS-97-129, May 7, 1997).

their performance measures to their annual budget requests. Federal agencies are expected to limit their performance measures to a few that

- best demonstrate how the agency's goals are met;
- allow agency managers to balance quality, costs, customer satisfaction, stakeholder concerns, and other matters; and
- are linked directly to the offices in each agency that are directly responsible for making programs work.

The Congress, in enacting GPRA, recognized that measuring the results of many federal programs will be difficult and, as a result, permitted GPRA to be phased in over several years. Measuring results will be a challenge because the link between program operations and results can be difficult to establish. Also, a result may occur years after an agency has completed a task (for example, awarding a research grant). Nevertheless, agencies are expected to use the performance and cost data they collect to continuously improve their operations, identify gaps between their performance and their performance goals, and develop plans for closing performance gaps.

VBA will need to develop appropriate performance measures and collect adequate and reliable performance and cost data to effectively measure and assess its performance. VBA will have to balance the costs of data collection against the need for complete, accurate, and consistent data.

CONCLUSION

VBA is aware that it has much work to do to fully implement GPRA. VBA's success in implementing the act will depend on how successful it is in ensuring that its strategic plan focuses on results, how well it integrates its plan with the plans of VA and other key agencies, and how effectively it measures and assesses its performance in meeting its goals and bringing about program improvements. The Congress will play an important role in consulting with VBA in developing results-oriented goals and overseeing VBA's efforts to implement GPRA.

- - - - -

Mr. Chairman, this completes my testimony this morning. I would be pleased to respond to any questions you or Members of the Subcommittee may have.

For more information on this testimony, call Cynthia M. Fagnoni, Associate Director, at (202) 512-7202 or Irene P. Chu, Assistant Director, at (202) 512-7102. Gregory D. Whitney and Mark Trapani also contributed to this statement.

(105752)

STATEMENT OF
JOSEPH A. VIOLANTE
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON BENEFITS
MAY 14, 1997

MISTER CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Since 1920, the Disabled American Veterans (DAV) has been dedicated to one single purpose: building better lives for disabled veterans and their families. On behalf of the more than one million members of the DAV and its Auxiliary, I wish to express our deep appreciation for this opportunity to provide the Subcommittee with the DAV's assessment of the processing of Persian Gulf War veterans' claims.

In your invitation to appear, you asked for our written response to the Department of Veterans Affairs' (VA's) testimony on the Government Performance and Results Act. We will have our written response to you by May 26, 1997, as requested. You also have requested that we include in our testimony our opinion regarding the VA's proposed legislation to limit its liability for compensation and medical treatment for veterans with smoking-related diseases. Since the VA's proposed legislation has not been disseminated at this time, our remarks will be general in nature, setting forth our position at this time.

Mr. Chairman, the current system of processing Persian Gulf War claims at four regional offices, Phoenix, Arizona, Louisville, Kentucky, Philadelphia, Pennsylvania, and Nashville, Tennessee, is not working. After numerous conversations with DAV supervisory National Service Officers at the four Persian Gulf War claims processing centers, it is apparent that the current system serves neither Persian Gulf War veterans nor the local veterans very well. While the concept of developing expertise in handling Persian Gulf War claims by rating specialists and adjudicators was a worthy goal, its application has proven unworkable for reasons discussed below.

The issue of Persian Gulf War illness is a serious problem made more difficult because of its complexity, the lack of scientific/medical evidence, the failure to maintain complete military and medical records, the failure of the Department of Defense (DoD) to come forward with critical evidence establishing the possible exposure to chemical agents by U.S. troops, and the conflicting reports and conclusions being reached by various scientific/medical commissions and individuals. These are not new dynamics for veterans. Veterans returning from all our Nation's wars and military conflicts have been faced with similar problems in attempting to establish the foundation for recognizing the onset of certain conditions as service-connected; however, Persian Gulf War veterans, as a group, appear to be sicker and more severely disabled as a result of their service in the Persian Gulf than their predecessors. The fact that there are still many unanswered

questions and conflicting medical opinions surrounding Persian Gulf illness only serves to exacerbate the situation.

Mr. Chairman, the plight of Persian Gulf War veterans suffering from undiagnosed illnesses continues to be one of our foremost concerns, as it is with this Subcommittee. Recent VA statistics on claims processing for these veterans only heighten our concerns. The VA notes that slightly more than three-quarters of Persian Gulf veteran claims have been allowed. Of the 85,402 Persian Gulf claims, service connection has been granted in approximately 66,277 claims; however, only 28,285 veterans are receiving compensation for service-connected disabilities. Further, of the 11,806 environmental hazard claims considered, slightly more than 1,600 have been granted service connection and only 803 have been granted service connection for undiagnosed illnesses.

Although the VA is proud of its 78% allowance rate, we are still concerned that many veterans do not receive service connection for their most debilitating ailments. For example, a veteran files a claim for Persian Gulf illness with symptoms such as joint pain, fatigue, a respiratory condition, memory loss, headaches, and gastrointestinal problems, and for an in-service back injury. Service connection is granted at a non-compensable rate for the in-service back injury residuals and denied for the other disabilities. Statistically, this veteran would fall into the category of claims allowed (78%); yet, his or her most debilitating disabilities are adjudicated as nonservice-connected. We have asked the VA to look at those claims allowed to determine what disabilities have been denied.

The VA has reviewed Persian Gulf War claims on three separate occasions and will conduct its fourth review based on the recent expansion of the presumptive period. Yet, as the VA embarks on its fourth review of Persian Gulf War claims, DAV National Service Officers (NSOs) in the four processing centers anticipate an onslaught of cases from the rating board. In fact, one of our NSOs has likened the situation to being in the eye of a hurricane because very few Persian Gulf War claims are being adjudicated at this time; however, it is expected that the pace will increase to the point of near chaos once the review begins. Both the VA and our NSOs will be adversely impacted as this process begins.

Mr. Chairman, the VA has denied almost 10,000 claims for undiagnosed illness. These disallowed claims for undiagnosed illnesses fall into six separate categories. These categories are:

1. Diagnosed illness,
2. Illness not chronic,
3. Due to other etiology,
4. Not manifest on active duty or during the two-year presumptive period,
5. Not shown by the evidence of record, and
6. Undiagnosed, but less than 10% disabling.

There appears to be some question as to which claims will be reviewed during the VA's fourth review. It appears that the VA will review all claims that were denied because the undiagnosed

illness was not manifest during the two-year presumptive period. However, it is not clear whether the VA intends to review category two, illness not chronic, category five, not shown by the evidence of record, or category six, undiagnosed, but less than 10% disabling.

It makes sense to not only review these three categories, but to provide the veteran with notice and opportunity to present any additional evidence that may not be in the claims folder to establish that the undiagnosed illness is presently shown to be chronic, that an undiagnosed disability currently exists, or that the undiagnosed illness is disabling to a compensable degree. The VA would be doing a great injustice to those veterans who fall into these categories if it does not provide them with the opportunity to update their medical evidence. Further, to not review these claims now might result in a fifth review at some later date.

Category three, due to other etiology, is somewhat confusing. According to the VA, this category includes a condition that is undiagnosed and became manifested to a compensable degree but has an intercurrent cause or is due to willful misconduct, or alcohol or drug abuse. In other words, the physician does not know what the illness is, but either the physician or the VA rating specialist knows that it is not the result of the veteran's service in the Persian Gulf. These cases, a total of 92 in all, should receive special scrutiny to ensure that these claims are being properly adjudicated.

As of March 1997, there were more than 10,000 Persian Gulf War claims pending at the four area processing offices, more than half, 5,351, were pending in the Southern area. According to the DAV's supervisory National Service Officer in the Southern area office, the pending claims workload actually equates to 18,000 issues at this processing office. Reportedly, some Persian Gulf War claims contain as many as 30-40 issues per claim. In the Southern area, new claims are coming in at a rate of 450 cases per month. Nationwide, there are an additional 4,100 claims pending development at regional offices. This is certainly a prescription for disaster if only four processing centers are responsible for all of these claims, in addition to reviewing previously disallowed undiagnosed illness claims.

Mr. Chairman, another concern we have is with the large number of service-connected veterans who are receiving no compensation. Of the more than 66,000 claims where service connection was granted, almost 38,000, or 57%, are rated less than 10% disabled and receive no disability compensation. Of those veterans rated 10% or higher, the vast majority are rated less than 30% disabled. Our NSOs believe that many Persian Gulf veterans are underrated.

Mr. Chairman, in addition to not receiving adequate compensation for their disabilities or illnesses, Persian Gulf veterans face many other dilemmas. Although most experts concede that these veterans were exposed to a wide range of environmental hazards, such as experimental drugs, high levels of toxicity in substances from oil field fires, radioactive residue, parasites, pesticides, lead paint, and chemical agents, there is little consensus in the medical/scientific community as to the residuals, if any, from these exposures. Due to the confusion surrounding Persian Gulf illness, we question whether these veterans are receiving adequate medical care from the VA or DoD.

One of the most frustrating aspects of dealing with Persian Gulf War claims is the medical community's desire to provide a diagnosis for these veterans' illnesses. Physicians are trained to provide a diagnosis, in other words, to "pigeonhole" the problem with their best guess; thereby preventing a veteran from establishing a claim for service connection for undiagnosed illnesses. There appears to be some inconsistency in whether a veteran is provided with a diagnosis for his illness or whether the illness goes undiagnosed. In other words, two veterans with similar symptoms may find themselves treated very differently by the VA if one is provided with a diagnosis and the other is determined to be suffering from an undiagnosed illness.

A potential problem also exists for a veteran service-connected and rated for an undiagnosed illness and who is later diagnosed with a particular disability. It would appear that once a diagnosis is made, the veteran is no longer eligible for service connection pursuant to 38 U.S.C. § 1117. Apparently, there is no mechanism in place to quickly establish service connection for the diagnosed illness under a different statute or regulation. Reportedly, a number of such cases are pending VA Central Office review.

Another frustrating aspect of Persian Gulf illness is that many of these veterans are not only underrated but, when they seek medical care, VA physicians or private physicians are unable to adequately treat them because of the unknown nature of their disabilities. In many cases, these brave young men and women are unemployed because of their debilitating illness, yet they are unable to receive adequate compensation or meaningful medical care because of the confusion surrounding their illness.

Finally, adjudicating Persian Gulf War claims at four regional offices has adversely impacted upon the adjudication of other claims in those four regions. For example, in the Central Region, more than 5,300 cases have been sent out to other regional offices for adjudication since December 1995, and another 1,000 are in the process of being shipped. In the Southern Region, there are approximately 400 cases per week being farmed out to other regional offices for adjudication. This has created long delays in the adjudication of non Persian Gulf War claims. Many of these older veterans are experiencing longer delays in the adjudication of their claims and are frustrated by the fact that their local NSO is unable to provide them with the status of their claim since it is not being adjudicated at the agency of original jurisdiction. Our NSOs are also frustrated because they have, at best, an extremely difficult time maintaining control of their local veterans' claims.

In summary, it is obvious that the current claims processing of Persian Gulf War claims is not producing the desired results. It is our understanding that the VA is currently considering the decentralization of Persian Gulf War claims. The DAV supports such a move, and we have recommended that the VA decentralize its claims processing in a letter to Secretary Brown. We hope that this Subcommittee would also encourage the VA to decentralize its claims processing of Persian Gulf War claims. At the same time, the VA needs to focus on a nationwide training program of its rating specialists and adjudicators to provide them with the necessary expertise to properly adjudicate these claims. Once this has been accomplished, the DAV believes that all veterans would be better served by having their claims adjudicated at the agency of original jurisdiction.

With regards to the VA's proposal to limit its liability for compensating and treating veterans with smoking-related diseases, the DAV does not support the VA's proposal to exclude smoking-related disabilities and deaths from eligibility for service connection or health care. One concern is the fairness of this, given that the harmful effects of smoking were not widely known until more recently. Indeed, the Armed Forces provided free cigarettes to servicemembers in certain circumstances, such as in C Rations issued to many of our combat soldiers. Another concern is that smoking is sometimes the convenient reason given for respiratory disorders and cancers where the etiology is uncertain and where there could have been other factors, either alone or in concert with smoking, that caused the disorder. The proposed legislation could lead to unfair denials of service connection. In any event, from the information provided, the implications of this change cannot be fully understood. If the Committee entertains some action on this proposal, it should first hold hearings so that the reasons for and effects of the measure can be clarified.

This concludes my statement. I would be pleased to answer any questions you or members of the Subcommittee may have.

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

Joseph A. Violanto, Esq.
DISABLED AMERICAN VETERANS
Deputy National Legislative Director

807 Maine Ave. SW
Washington, D.C. 20024

Phone (202) 554-3501
Fax (202) 554-3581

EDUCATION:

1981	Juris Doctorate, University of La Verne, College of Law
1975	Bachelor of Arts, History and Political Science, University of New Mexico

MILITARY SERVICE

1969-1972	*United States Marine Corps, separated as Sergeant, E-5*

EMPLOYMENT:

1996-Current	***Deputy National Legislative Director, Disabled American Veterans (DAV)***
1992-1996	***Legislative Counsel, DAV***
1990-1992	***Staff Counsel, DAV***
1985-1990	***Attorney, Department of Veterans Affairs, Board of Veterans' Appeals***
1981-1985	***Attorney, Sole Practitioner***

ORGANIZATIONS AND AFFILIATIONS:

Member, State of California and District of Columbia Bars
Member, Presidential Delegation (POW/MIA's) to Southeast Asia, March, 1996
Co-chair, Veterans' Appeals Committee, Federal Circuit Bar Assoc., 1992-1996
Co-chair, Legislative Committee, Federal Circuit Bar Assoc., 1996-present
Vice chair, Veterans' Benefits Committee, American Bar Association, 1991-present
At-large board member, Veterans' Law Section, Federal Bar Association, 1991-1992
Life member, Disabled American Veterans, Chapter Commander, 1990-1991
Life member, Veterans of Foreign Wars, Post Commander, 1984-1985
Life member, 3d Marine Division Association, Chapter Secretary, 1986-1987
Member, American Legion, Marine Corps League, and 2nd Bn, 4th Marines Assoc.
Member, Knights of Columbus, Fourth degree
Member, National Italian-American Foundation, Council of 1000
Member, National Italian-American Bar Association
Member, Geriatrics and Gerontology Advisory Committee, Dept. of Veterans Affairs
Board of Directors, Bowie Cable TV, 1992-1994
Member, Bowie Cable TV City Council Advisory Committee, 1989-1991
Co-host, *Veteran's Forum*, Bowie Cable TV, 1991-1994

MATTHEW L. PUGLISI
ASSISTANT DIRECTOR FOR GULF WAR VETERANS
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
VETERANS' AFFAIRS SUBCOMMITTEE ON BENEFITS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
PROCESSING OF PERSIAN GULF WAR VETERANS' CLAIMS

MAY 14, 1997

Mr. Chairman and distinguished members of the Subcommittee:

The American Legion appreciates the opportunity to offer testimony regarding the processing of Persian Gulf War claims by the Department of Veterans Affairs. We commend the Chairman for convening this hearing. The topic of Persian Gulf claims has received little media attention, but is an important issue that lies at the heart of how the federal government aids disabled veterans of the Gulf War. This hearing comes in the midst of a massive review of Gulf War undiagnosed illness claims by VA because of earlier widespread processing errors and the recent extension of the presumptive period. This review and the extension of the presumptive period, although welcomed by The American Legion, both exacerbate the inherent flaw of the Gulf War Environmental Hazards processing system, of which undiagnosed illness claims are a major subset. The centralized processing of Gulf War Environmental Hazards claims has created a backlog of over 14,000 cases awaiting adjudication. Mr. Chairman, that's 14,000 disabled Gulf War veterans, many with families, forced to wait longer for their claim to be adjudicated. When VA initiated their plan to centralize Persian Gulf claims The American Legion adamantly opposed this effort because of the possibility it would create a massive backlog. The American Legion has consistently encouraged VA to immediately end the practice of processing Gulf War Environmental Hazards claims at four Area Processing Offices (APOs).

Background

In 1991, many returning Gulf War veterans reported chronic symptoms of fatigue, skin rash, memory loss, joint and muscle pain, and other symptoms that have come to be known as Gulf War Illness (GWI). GWI is a complex of ill defined and often poorly characterized symptoms that have evaded a case definition by the medical community, and therefore, go undiagnosed by medical doctors.

In November 1994, Congress passed and the President signed Public Law 103-446, the "Veterans' Benefits Improvement Act of 1994." This legislation was a bold, unprecedented approach to the payment of compensation for a service-connected disability. It allowed VA to pay compensation to Gulf War veterans who suffered from undiagnosed illnesses possibly related to their service in the Southwest Asia theater of operations. The legislation gave Gulf War veterans the benefit of the doubt concerning their current disabilities, keeping with the nation's long and proud tradition of caring for its disabled war veterans.

In February 1995, VA published the regulation titled " Compensation for Certain Disabilities Due to Undiagnosed Illnesses" (38 CFR, section 3.317). The regulation required some nexus between symptoms and service in the Persian Gulf.

To qualify for disability compensation under this regulation a veteran must prove or provide evidence of the following:

- Service in the Southwest Asia theater of operations during the Gulf War (August 2, 1990 to an as yet undetermined date);
- Suffers from a chronic, undiagnosed illness;
- Documentation of the undiagnosed signs and symptoms by a medical doctor or by statements from friends or family members;
- The signs and symptoms of illness which revealed themselves during service in the theater of operations during the Gulf War; or,
- The signs and symptoms of illness which revealed themselves not later than two years after the date on which the veteran last served in the theater of operations and the symptoms were severe enough to warrant at least a ten percent VA disability evaluation within those two years.

In March of this year, the Secretary of Veterans Affairs announced that the aforementioned two year presumptive period would be extended to 10 years. A Gulf War veteran must now exhibit undiagnosed signs and symptoms of illness before January 1, 2002. The new regulations concerning the extension of the presumptive period have not been published to date.

According to VA, the signs and symptoms that may be manifestations of undiagnosed illnesses include, but are not limited to:

- Fatigue
- Signs and symptoms involving skin (including hair loss)
- Headaches
- Joint and/or muscle pain
- Neurologic signs and symptoms
- Signs and symptoms involving the upper or lower respiratory system
- Sleep disturbances
- Gastrointestinal signs or symptoms (including diarrhea and constipation)
- Cardiovascular signs or symptoms
- Abnormal weight loss
- Menstrual disorders

How VA Currently Processes Gulf War Environmental Hazards Claims

An Environmental Hazard claim is one where the veteran's current disability may have been caused by exposure to an environmental hazard in the Southwest Asia theater of operations. An undiagnosed illness claim is one where the signs and symptoms of illness reported by the veteran go undiagnosed by a VA medical doctor. Undiagnosed illness claims are a subset of Environmental Hazard cases, and approximately 90 percent of Environmental Hazard cases involve an undiagnosed illness.

As of March 1997, the vast majority (83 percent) of Gulf War disability claims have not involved an environmental hazard as a possible cause of the veteran's disability. Most of the claims filed by Gulf War veterans, therefore, are adjudicated at the VA Regional Office that has jurisdiction for specified geographic area in the U.S. or overseas.

VA initially centralized the adjudication of Gulf War Environmental Hazards claims at the Louisville, Kentucky Regional Office. The influx of claims soon caused VA to add three more Area Processing Offices with a specific geographical area of responsibility. This system exists today. The Philadelphia VA Regional Office serves as the Area Processing Office (APO) for Gulf War Environmental Hazards claims filed in the Eastern area of the United States and foreign countries; the Louisville VA Regional Office serves as the APO for the Central U.S.; the Nashville VA Regional Office serves as the APO for the Southern U.S.; and Phoenix serves as the APO for the Western U.S. VA intended the APOs to develop the expertise necessary to properly adjudicate Gulf War environmental hazards claims in a few locations, rather than in every VA Regional Office in the United States. The APO

concept also enables VA Central Office to oversee this claims process more effectively than if these claims were adjudicated all over the U.S.

In 1995, investigations conducted by the Department of Veterans Affairs, the United States General Accounting Office and The American Legion's Gulf War Task Force found widespread errors in the processing of Gulf War undiagnosed illness claims. VA undertook a review of the over 11,000 claims that had been adjudicated as of July 1996 in response to the findings and recommendations of those investigations. VA is currently seeking evidence from the veterans who filed these claims and will reconsider them, if necessary. The American Legion commends VA for initiating this massive review.

The recent extension of the presumptive period automatically added over 5,000 undiagnosed illness claims initially denied service connection because the symptoms reported by the veterans who filed those claims fell outside the original two year presumptive period. Although welcomed by The American Legion, this has increased the backlog of Environmental Hazards claims to over 14,000 cases. The American Legion believes the remedy to the backlog lies in ending the centralized processing of these claims.

The APO System versus the ROs

The Claims Backlog

The backlog created by the APO system is one of the most severe problems faced by Gulf War veterans. During recent town hall meetings conducted by the Department of Defense's Special Assistant for Gulf War Illnesses, Gulf War veterans' chief complaint was slow service from VA. These complaints included the length of time VA takes to adjudicate Environmental Hazards claims. Many have suffered financially because of their disability, and the claims backlog has prevented VA from effectively assisting these veterans. Consequently, The American Legion has given over $600,000 in grants to Gulf War veterans in financial emergencies, many of whom have claims pending with VA. These grants are meant to provide temporary assistance and are not intended to replace the disability compensation system that exists today.

Special Training Unnecessary

The initial claims review that VA began last summer created such a logjam that VA was forced to ship 1,000 claims to the Muskogee, Oklahoma office and another 1,000 claims to the Cleveland, Ohio Regional Office. Neither station had specially trained staff, nor had they ever adjudicated Environmental Hazard claims. These stations are adjudicating these claims nevertheless, and this begs the question as to whether special training for Environmental Hazards claims is a necessity.

Distribute the Claims Among All the ROs

The Regional Offices (RO) throughout the country can handle the workload if the APO system were abolished. 17 percent of Gulf War claims is not a lot when spread around the nation.

ROs Will Not Have to Reinvent the Wheel

The APOs can pass lessons learned to ROs, and ROs can establish an effective Environmental Hazard claim processing system modeled on the best APOs.

Veterans' Right to Effective Representation

Veterans have the right to be represented by their VSO advocates in the states they live in. Under this APO system, their advocate in their home state does not have ready access to their claims folder. This does not allow the veteran to receive fair and adequate representation.

Unfair to VA Employees

Gulf War veterans are not the only victims of the APO system. The VA employees at the APOs are confronted with a crushing backlog of high profile claims. They are unfairly burdened after a long period of cutbacks at the Compensation and Pension Service.

Conclusion

VA should immediately end the practice of adjudicating Gulf War Environmental Hazards claims at four APOs. These claims should be adjudicated at the Regional Office of jurisdiction. This action would accomplish the following: it would quickly eliminate the current 14,000 case backlog; it would allow veterans and their advocates more ready access to the veterans claims folder; and it would alleviate an unnecessary burden on the VA employees who process and adjudicate these claims at the APOs.

The American Legion appreciates the cooperation of the Compensation and Pension Service in addressing problems associated with Gulf War Environmental Hazards claims over the last year. The last remaining hurdle is the APO system. By eliminating it, the C&P Service will vastly improve its service to Gulf War veterans, in our opinion.

Mr. Chairman, with regard to your letter of May 6, The American Legion is not fully aware of the details of any legislation which VA may be proposing to limit the liability for compensation and medical treatment for veterans with smoking related disabilities.

That concludes my testimony, Mr. Chairman I will now be happy to answer any questions.

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700
Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881
World Wide Web: http://www.vva.org • *E-mail 71154.702@compuserve.com*

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Presented By

WILLIAM F. RUSSO
DIRECTOR, VETERANS BENEFITS PROGRAM

Before The

House Veterans' Affairs Subcommittee on Benefits

Regarding

Compensation & Pension Service Performance
Persian Gulf War (PGW) Claims
VA Compensation for Smoking Related Diseases

May 14, 1997

Introduction

Mr. Chairman and members of the subcommittee, Vietnam Veterans of America (VVA) is pleased to have an opportunity to share our perspectives on the performance of the Compensation and Pension Service, processing of Persian Gulf illnesses claims, as well as Secretary Brown's recent proposal regarding smoking-related disabilities. We compliment you for holding this oversight hearing, as these issues are very complex and pose significant challenges for the veterans community, the VA and Congress.

I would like to note that VVA has strongly supports legislation to allow judicial review by the U.S. Court of Veterans Appeals of prior VA decisions involving clear and unmistakable error, and we praise the House Veterans' Affairs Committee for passing H.R. 1090. This bill would allow retroactive payments to veterans whose claims were unfairly denied by VA prior to passage of judicial review. We are hopeful that the Senate will support the bill as well.

Compensation & Pension Service Performance

Because be have not had an opportunity to review VA's preliminary plans for compliance and implementation of the Government Performance and Results Act (GPRA), VVA submits the following general comments about the Compensation & Pension Service's performance for your consideration. Following this hearing, VVA will be pleased to analyze VA's plans and make additional comments for the record.

The Veterans Benefits Administration (VBA) has not been innovative enough in changing its inefficient procedures for processing compensation and pension claims. Excessive delays and backlogs continue to plague the system, frequently forcing veterans to wait years for a final decision. Part of this situation stems from a general problem of the performance quality at the initial decision-maker level -- the rating specialists. As we have emphasized before, the first and most important goal is to find methods of improving the Regional Offices' performance on initial decisions, so they will "get it right the first time."

To address this, VVA believes that Congress should require VBA to review decisional data from Hearing Officers, Board of Veterans' Appeals, and Compensation & Pension Service (administrative reviews) to determine which rating specialists repeatedly make the same types of errors. This data should be used for retraining, as well as performance evaluations and appropriate personnel actions.

Another identified deficiency relates to coordination between VBA and VHA regarding the quality and appropriateness of compensation and pension exams. Often the VHA exams are significantly delayed, inappropriate to the specific nature of the claim, or incomplete -- sometimes causing not only delays but added inconvenience for the veteran who must be subjected to an additional examination. VVA is pleased that VA's budget proposal includes plans for contracting these physical evaluations to private doctors which in many cases will be more accessible and timely for the veteran claimant. We are hopeful that this program may, at least in part, address this problem.

VVA also recommends that VBA computerization/automation programs be closely monitored and held to task. There are opportunities to improve efficiency and quality of claims adjudications through these innovations. But, as GAO and this committee have already learned, we cannot depend upon technology alone for short-term efficiencies because these programs have been ill-planned and have shown little results.

Persian Gulf War (PGW) Claims

VVA strongly supports Secretary Brown's recent decision to extend the presumptive period for Persian Gulf claims from 2 years to 10 years. The testimony of several U.S. Marine Corps veterans to the Presidential Advisory Commission on Gulf War Illnesses last week -- indicating yet another previously unpublicized chemical exposure to our troops in the Gulf -- shows that we are still far from learning the cause(s) of Persian Gulf illnesses.

VVA supports the VA proposal to move PGW claims from the Area processing Offices (APO) back into the VA Regional Offices (VARO). The current system of utilizing APOs has been very problematic for a number of reasons. This plan of regionalizing veterans claims for these special circumstances has been a failure, and VVA remains opposed to any further expansion of such plans.

One year ago, VVA discovered a VA form letter, sent by the Philadelphia APO, informing a Persian Gulf veteran that his claim was denied. That letter seriously misstated the regulatory requirements for undiagnosed illness claims, telling the veteran he must prove that his symptoms "existed for at least 6 months in service and continued during a 2-year period following service." A primary purpose of developing the APO system was to train VA adjudication staff as specialists in PGW claims. The existence of this form letter, and the fact that it was actually used to improperly deny a claim, is strong evidence that the APO system has failed.

Fortunately, VA was informed of the above-cited mistake, and the failure of its staff to develop necessary evidence in PGW claims, it launched a massive re-review of all PGW claims last year. VVA applauds the Department's ongoing action. However, we also believe that the re-review and the adjudication would be much more effective if conducted in the VAROs. Even after the re-review has been largely completed, VVA is troubled by a disturbing inequality between the rates at which PGW claims are granted at different APOs.

According to the VA's most recent statistics (current through March 1997), the Western APO has granted 30% of the environmental hazard claims it reviewed, while approval rates for the other APOs are much lower -- Eastern was 12%; Central approved 13%; and the Southern APO showed 10% approval. For undiagnosed illness claims (a subset of environmental hazard claims), there is a similar inequality -- Eastern approved 7%; Central and Southern granted 5%. While the reasons for these inequities are unclear, their existence indicates that the APOs are not meeting their stated goal of providing more uniform adjudication than VAROs could provide.

Advocacy by Service Officers/Service Representatives serves as a system of checks-and-balances on the decision makers. VA's deciding claims in APOs, thousands of miles from the veteran and his/her representative, greatly limits the advocacy that could be effectively accomplished in these claims. Without access to the VA claim folder, representatives cannot analyze the evidence on which the claim is to be decided, they cannot speak personally with VA staff working the claim, and they cannot ask VA to obtain relevant evidence. Lastly, veteran claimants and/or their advocates have difficulty arranging a hearing (often crucial in compensation cases) under the APO system.

VA Compensation for Smoking Related Diseases

VVA appreciates this committee's rapid response to Secretary Brown's recent proposal to severely limit veterans' claims based on tobacco use while in service. We are strongly opposed to passage of such legislation, because it would be an unfair limitation on the rights of one particular group of service-disabled veterans -- those suffering smoking related ailments. Our reasons for this position are essentially as follows:

1. The military encouraged cigarette smoking -- As VVA officials stated in an April 25, 1997 article in The Wall Street Journal entitled "Battle Over Federal Aid for Tobacco Heats Up as Lawmakers Debate Issue," the military gave free cigarettes to service members for decades and also subsidized G.I.'s purchase of tobacco at greatly reduced cost. There were often no health warning labels on these cigarettes, in contrast to commercially available packs. (There were certainly no warning labels before the U.S. Surgeon General required them in 1964.) Moreover, the military often set aside a time and place specifically for smoking, thus encouraging a culture of "Smoke em' if ya got em'," and aboard Navy ships, "Now hear this, the smoking lamp is lit." The military's encouragement of smoking was noted by the VA's own General Counsel in O.G.C. Precedent Opinion 2-93.

2. The Clinton Administration has consistently asserted that cigarette smoking is addictive -- several officials including Vice President Al Gore and FDA Commissioner David Kessler have characterized cigarettes as a highly addictive product. VVA believes these statements are accurate and conflict with Secretary Brown's letter to Speaker Gingrich (quoted in the April

24, 1997 Washington Post), stating that smoking ailments are "resulting from veterans' personal choice to engage in conduct damaging to our health." The fact is that the military encouraged many service members to start smoking, and thus caused many to become addicted to cigarettes.

3. Under current law, very few veterans will likely be granted service connection, since they must produce a physician's statement that their current disease is the result of cigarette smoking (or the addiction thereto) in service, in order to meet the threshold requirement of a well-grounded claim. Experience shows that most VA claimants are unable or unwilling to obtain such evidence. Moreover, if a veteran is shown to have known about the medical dangers of smoking before he began smoking in service, which would be "willful misconduct," he would be barred under current law from receiving benefits.

Conclusion

As Congress considers various proposals from the Veterans' Claims Adjudication Commission and others, we would be very pleased to serve as a resource to you and your staff. VVA's network of service representatives has a great deal of experience at all levels of the original claims filing and appeal processes. VVA looks forward to working with this subcommittee to address the very complex issues facing veterans with in navigating the current VA adjudication system.

We are also particularly pleased, Mr. Chairman, that the subcommittee is taking a close look at the unique problems of Persian Gulf veterans. As detailed above, VVA has serious concerns about the difficulties these veterans have had to surmount to get appropriate benefits. VVA is very proud of our tradition and commitment to advocate for and assist all generations of veterans. And in the spirit of our founding principle, "Never again will one generation of veterans abandon another," VVA has established a working relationship with our colleague organization -- the National Gulf War Resource Center (NGWRC). The NGWRC can be reached at VVA address and phone numbers or by calling Executive Director Jeff Ford in Kansas City, Missouri at 816-960-0991. Please feel free to call upon either organization for insights into these issues.

Thank you for the opportunity to present VVA's views. This concludes our statement. We would be pleased to respond to any questions.

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700
Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881
World Wide Web: http://www.vva.org • *E-mail 71154.702@compuserve.com*

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

WILLIAM F. RUSSO
Director, Veterans Benefits Program

William (Bill) Russo joined VVA in 1994, when VVA's benefits/service representative program was brought in-house from a contract provider. Russo manages more than 300 VVA-accredited Service Representatives from across the country and supervises VVA's attorney representatives in Washington, DC at the Board of Veterans Appeals (BVA) and the U.S. Court of Veterans Appeals (COVA). He is also responsible for VVA's training and benefits publications programs.

During and immediately after law school, Bill worked for VVA, advising Service Representatives and representing veterans at the BVA. For more than a year, Bill then worked as a staff attorney with the U.S. Court of Veterans Appeals, analyzing veterans' cases for the Court's judges. From 1991 to 1994, Bill worked for a law firm and spent his spare time representing a number of veterans pro bono.

Bill received his law degree from George Washington University and his B.A. from the University of Maryland. He has been admitted to the bar in Maryland, Pennsylvania, and the District of Columbia. He resides in Great Falls, Virginia with his wife Beth Kelly, who is a attorney with the Department of Energy. They have one daughter, Isabel.

FUNDING STATEMENT
May 14, 1997

The national organization Vietnam Veterans of America, Inc. (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director of Government Relations
Vietnam Veterans of America, Inc.
(202) 628-2700, extension 127

STATEMENT OF

JAMES N. MAGILL
DIRECTOR, NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

Before the

SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

PROCESSING OF PERSIAN GULF WAR CLAIMS

WASHINGTON, D.C. MAY 14, 1997

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars of the United States, I wish to commend you for holding this hearing on the processing of Persian Gulf War claims. The VFW appreciates your continued concern for those who have worn the uniform of the United States Armed Forces.

Mr. Chairman, I believe it is generally accepted within the veteran community that Persian Gulf veterans are having some problems with the adjudication of their claims as they pertain to the Persian Gulf illnesses. Veterans of the Persian Gulf War, in general, are not satisfied with the manner in which their disability claims are being processed.

Over 10,000 veterans have filed claims for conditions they feel are associated with their service in the Persian Gulf, which have eluded a medical diagnosis. Over 13,000 veterans of the Persian Gulf War consider themselves to be in poor health (VA Fact Sheet 1-96). Furthermore, the primary complaint of the ill veterans who have taken part in the VA's Persian Gulf Registry exams list fatigue, joint pain, and headaches as those most frequently cited.

One of the more significant problems can be demonstrated when a veteran reports to a VA medical facility with many of these same symptoms and walks out with varying diagnosis such as migraines, muscle strain, and arthritis. Because the veteran now has a diagnosed condition, he or she may not be considered for compensation for an "undiagnosed illness." If these diagnosed conditions are not annotated in the veteran's service medical records, service connection will likely be denied. This problem can be solved by requiring the examining physicians to look at the symptoms collectively and then render a diagnosis. Additionally, the examiner should render an opinion as to whether or not the symptoms were incurred as a result of the veteran's service in the Persian Gulf. If this is done on a consistent basis, it will go a long way in ensuring that Gulf War veterans will receive proper care.

The distribution of Persian Gulf War claims to the area processing offices (APOs) has proven to be less than effective. The VFW fully supports the decentralization of Persian Gulf War claims back to the originating regional office. The use of APOs places an unnecessary burden on the service officer and precludes him or her from intimately tracking the progress of a particular case. Additionally, it places a tremendous burden on a select few service officers whose case loads in other matters remain the same.

In the past, VA has objected to changing the policy of centralized Persian Gulf claims by stating that our service officers should be contacting one another on the progress of the claims. This is true and it does happen. However, VA wrongly assumes that simply because a Veteran Service Officer is listed as the veteran's representative that the named organization was the one to submit the claim for that veteran. When this occurs and the claim originated in one part of the country and was decided in another part of the country, a service officer cannot conduct the necessary follow-up to ensure that every aspect of the claim was fully explored and properly considered. The

centralization of these claims increases the likelihood that such a veteran's claim will go under represented. Reinstating the face-to-face encounters between the veteran and his/her service officer will help ensure every aspect of the claim is fully explored and will help to protect the rights of the veteran. We are pleased VA is working towards correcting this policy.

We are encouraged by the extension of the presumptive period until December 31, 2001. The VFW has been relentless in its pursuit of extending the previous two year period which placed an arbitrary burden in the way of Persian Gulf War veterans disability claims. We understand that the VA is planning to review the claims of those veterans denied because their symptoms did not manifest within the two year period. We applaud this effort but are concerned that it may not go far enough.

The latest statistics from VA's Compensation and Pension Service indicate approximately 4,600 veterans have had their claims denied specifically because they did not manifest symptoms within the previous two-year period. A category of denials that indicates the illness was not shown by evidence of record, which includes approximately 2,700 claims, may also be affected. Still, there may be other claims who have had one symptom service connected and other symptoms denied because they did not manifest within the previously allotted time frame; the VA considers such cases as granted claims. As you can see, there may be a need for a complete review of all "Undiagnosed Illness" claims as a result of this change.

The new presumptive period will allow Gulf War veterans to report symptoms for a total of about ten years after having left the region. This time period is certainly more liberal than the previous period and we support its extension. However, we must remember that the law (P.L. 103-446) requires that the time period be based in part on the available evidence from the scientific and medical communities. Science has not made a determination that all symptoms will manifest within ten years. Hopefully, by 2001, we will have such a conclusion. If we do not, rest assured the VFW will continue this fight for our Gulf War veterans.

The VA has made some great strides over the years in ways it reaches out to the veteran population. However, it is a fact that cannot be overlooked that less than one tenth (65,000) of all Persian Gulf veterans have taken the Registry exam. Only about 190,000 have called in to register. Information on submitting a claim to the VA is available; however, Persian Gulf veterans do not know where to look for this information. We are still contacted by far too many ill veterans who have little or no information on how to get help. VA must expand its outreach efforts to reach these veterans.

In our letter of invitation to this hearing, we were also asked to address the issue of compensating veterans on the ill effects of tobacco use.

A letter from VA Central Office to the Regional Offices dated February 14, 1997, provided instruction on the adjudication of these claims. Subsequently, the Secretary disagreed with these instructions and recommended that legislation be advanced that would prohibit such compensation.

This recommendation gives some veterans the perception that VA is waiting for them to die off before pursuing action in this matter. VA could end this perception by adjudicating claims under the same guidance mentioned in the February letter. Current regulations allow the adjudication of these claims. The VA's General Counsel's opinion supports this position. Decisions should be made, as provided in the CFR, giving the benefit of the doubt to veterans.

This concludes my testimony and I will be happy to respond to any questions you may have.

SERVING
WITH
PRIDE

STATEMENT OF

CHUCK BURNS
AMVETS National Service Director

Before the
Subcommittee on Benefits

Of the
Committee on Veterans' Affairs

U.S. House of Representatives

Wednesday, May 14, 1997
Room 334
Cannon House Office Building

AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE (301)459-9600
FAX: (301)459-7924
FTS: (700)344-3552

Mr. Chairman, my name is Chuck Burns. I am the National Service Director for AMVETS, the American Veterans of WW II, Korea and Vietnam. We appreciate the opportunity to present our views on Persian Gulf claims processing and the proposed legislation on limiting the Department of Veterans Affairs liability for compensating and treating veterans with smoking-related diseases. Neither AMVETS, nor myself, have received any federal grants or contracts during FY 97 or in the previous two fiscal years.

I. PERSIAN GULF CLAIMS PROCESSING

Chairman Quinn, much has been written and said criticizing VA's handling of Persian Gulf Illness claims, some justified, some not. Widely circulated rumors emanating from VA concerning additional administrative changes in the processing of Persian Gulf claims only throw more sand in the gears of the claims adjudication process.

We see the major areas of difficulty as follows:

1. Proper development of the claimed issues at the VA Regional Office;
2. Providing adequate VA staff to develop, rate and adjudicate the Persian Gulf veterans' claims at the Area Processing Offices (APO's);
3. Lack of diagnosis.

Much of the burden for improper claim development can be laid directly at the feet of VA. Since VA began processing Persian Gulf Illness claims, they have sent out three change of procedure letters, causing innumerable delays in claims processing. There are cases out there that are four and five years old, now in the process of a third development. It is my understanding that a fourth development letter may soon be forthcoming.

Looking at the Phoenix, Arizona APO, there are six VA personnel assigned to develop, rate and adjudicate nearly 1,400 pending claims and they are receiving, on average, 100 new claims per month. With new development letters constantly coming over the transom from VA Central Office, this backlog will only get worse. If VA would supply additional trained personnel to the four APO's, rather than sending the cases back to the regional office for processing, they would save not only money and time, but also the expertise that has been developed at the APO's which is not readily available at the Regional Offices.

Persian Gulf Illness or Syndrome is a catch-all term that does not have an assignable diagnostic code under current regulations. Lack of such a code can also be blamed for causing some of the delays in processing these Persian Gulf Illness claims. We would suggest that an already existing code could be utilized to expedite the processing of these claims -- 8881-8100 (Undiagnosed illness manifested by fatigue and headaches).

In sum, AMVETS strongly urges VA to make every effort to keep centralized processing at the APO's because the expertise lies there to properly process these claims. Returning the claim to the various Regional Offices, while it may put the paperwork closer to the claimant, deprives that claimant of the knowledge base in the Area Processing Office, knowledge which has accumulated over the past several years and which cannot be transferred to the Regional Office in a one day training session. VA should properly staff the APO's to speed up the claims process and give the Persian Gulf veteran the best adjudication of his claim possible.

II. PROPOSED LEGISLATION TO LIMIT THE VETERANS ADMINISTRATION'S LIABILITY FOR COMPENSATING AND TREATING VETERANS WITH SMOKING-RELATED DISEASES.

Mr. Chairman, while AMVETS does not currently have a governing resolution on this matter, and has not seen a copy of the proposed legislation, we would like to offer some views on the issue.

When VA's General Counsel issued her opinion on VA liability, we, like everyone else, were stunned at the potential dollar cost to VA should these claims be adjudicated. If one considers that there are some 27 million veterans in this country and that even if only one-half to one-quarter of that number successfully filed a smoking-related illness claim, the potential cost to VA over the next twenty to thirty years could well reach into the billions of dollars. This is unacceptable.

Much has been said about VA's and the Department of Defense's culpability in smoking by service men and women -- everything from free cigarettes in C-rations to "smoking circles" in boot camp to free cigarettes for patients in VA hospitals following WW II and Korea. It has been further mentioned that because cigarette packaging prior to January 1, 1966 did not contain "Warning Labels" that the veterans have a right to file a claim. While we believe that is common sense turned upside down, we would like to offer an opinion as to how VA and DoD could work together to mitigate the potential monetary damage to each of these agencies.

Since the major tobacco companies in this country are presently in negotiations with several states to indemnify them for the dollar losses they have suffered while caring for citizens with smoking-related illnesses, DoD and VA could jointly appeal to the tobacco companies, using whatever legal means necessary, to set up a trust fund to pay the veterans claims for smoking-related illnesses as well as any hospitalization resulting from these illnesses. The trust would be administered by a third party and would be established for thirty years. Only those veterans who served on active duty prior to the date that warning labels were put on cigarette packaging would be eligible to file claims. Claims of second-hand smoking related illnesses would be disallowed.

DoD and VA would have to be partners in this effort because DoD was the "agent" for the tobacco companies in distributing the product by whatever means it did and VA is the agency charged with caring for the veterans who became sick from ingesting this product.

Obviously, we would like to see other remedies to this problem, namely a reversal of the General Counsel's opinion, but that notwithstanding, we would urge VA to explore the option presented here.

Mr. Chairman, thank you and the Committee for the opportunity to present AMVETS' views on these two topics. This concludes my testimony and I would look forward to answering any questions you or the Members of the Committee might have.

BIO OF CHUCK BURNS, AMVETS NATIONAL SERVICE DIRECTOR

Chuck Burns assumed the duties of AMVETS National Service Director in April of this year. Prior to joining AMVETS, Mr. Burns served as Assistant Legislative Director for The American Legion National Headquarters here in Washington. He is a decorated Marine Corps, Vietnam veteran, having served his country as a helicopter machine gunner/crew chief during one tour in Vietnam.

Mr. Burns brings more than twenty years' public affairs experience to the National Service Director's position. He founded his own public affairs firm in New Orleans in the early 1980's, representing the Charity Hospital system, among other clients, before the State Legislature. On moving to Washington some ten years ago, he joined the public affairs/public relations firm of Burson-Marsteller where he represented several of the country's largest health care companies as well as a veterans service organization.

He is a graduate of the University of Notre Dame with a B.A. in Government and International Relations.

Non Commissioned Officers Association of the United States of America

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

BEFORE THE

SUBCOMMITTEE ON BENEFITS

COMMITTEE ON VETERANS AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ON THE

PROCESSING OF PERSIAN GULF WAR CLAIMS

AND

VA LIABILITY RE SMOKING-RELATED DISEASES

MAY 14, 1997

Chartered by the United States Congress

The Non Commissioned Officers Association of the USA (NCOA) thanks the distinguished Chairman for your invitation to appear and present testimony on the processing of Persian Gulf War Claims and to comment on what appears to be DVA's intention to limit liability regarding smoking-related diseases. Your interest, Mr. Chairman, in both of these issues, as evidenced by this hearing, is appreciated. The Association also looks forward to commenting on VA's strategies to implement the Government Performance and Results Act (GPRA).

PROCESSING OF PERSIAN GULF WAR CLAIMS

NCOA's volume of activity in assisting veterans process their claims for Persian Gulf War illnesses has not been dramatic. The modest level of activity the Association has experienced is attributable to the fact that many of NCOA's members are still serving in the Armed Forces. The Association is aware, and therefore advises this Subcommittee, that many Armed Forces members still on active duty are reporting and receiving treatment for conditions and symptoms identical to those which other veterans have reported to VA under the general classification of Persian Gulf Syndrome. Therefore, NCOA's concern regarding processing of Persian Gulf claims is two fold. The Association is concerned not only with those veterans who are currently in the system but also for those future veterans who will rely on VA to fairly and expeditiously adjudicate their claims.

NCOA has experienced many of the widely reproted impediments in processing Persian Gulf claims. The Area Processing Office's are a prime example of good intentions gone awry. While VA's intent was to give priority to Persian Gulf claims and simultaneously develop expertise on these issues along with standardization, none of this has occurred. Evidence of this is revealed in the approval rates for the same conditions and symptoms which vary significantly between the APO's. The problem was not necessarily the APO concept but rather the way it was implemented and managed.

Apparently, VA now intends to re-direct Persian Gulf Claims to the appropriate Regional Office with future Persian Gulf claims to be processed by the RO's also. It is immaterial to NCOA where these claims are processed because arguments can be made for and against both the APO's and RO's.

The important factor to remember is that APO's were not properly staffed and trained to handle the increased claims workload they were expected to process. VA Headquarters did not, in NCOA's view, exercise their responsibility to ensure standardization in adjudication between the APO's. Shifting responsibility to the RO's will not solve this situation and may, in all likelihood, complicate it even further.

Another major impediment in the processing of Persian Gulf claims has been the burden for claims development. Few people, and least of all the individual veteran, can keep apace with the VA changes in procedures. VA has changed the claims development procedures three times in five years and NCOA has been led to believe a fourth change is being finalized. In this Association's view, there is plenty of confusion among veterans and their service organizations and VA has done a good job in keeping it that way.

Several questions beg for an answer at this point and NCOA is hopeful that this Subcommittee will elicit straight forward answers from VA officials that brings accountability to these problems. Among these are:

> If VA could not properly resource and train APO staff, what assurances do we have that they will do so at 57 RO's? What are VA's plans to shift resources to those RO's that will bear a disproportionate burden for these claims?

> What measures will be put into effect, at either the APO's or RO's, that will ensure standardization in the Persian Gulf claims adjudication process?

> What measures will VA put into effect that fulfills the spirit and intent of "duty to assist" the veteran claimant?

> After more than five years into this issue, why can't VA come to a conclusion on the evidence needed to support a Persian Gulf Claim? What measures will VA employ to notify individual veterans, who have claims in the pipeline, that the rules have changed?

> What measures will VA headquarters put into effect, at either the APO's or RO's, that brings accountability to this process? VA has readily admitted that Persian Gulf claims have been "mishandled", yet no one is ever held accountable.

In NCOA's opinion, Mr. Chairman, accountability must be brought to the Persian Gulf claims process and the entire claims process as well. Much of what we are experiencing with Persian Gulf claims is a systemic VA problem that has existed for many years. The only difference is that the public spotlight is now shining brightly on these veterans. It is unfortunate that it took a group of sick Gulf War veterans to elevate public attention to the problem. It is even more unfortunate that their rightful claim to benefits is being delayed or denied as a consequence of a bureaucratic, almost uncaring, system.

VA LIABILITY REGARDING SMOKING RELATED DISEASES

Apparently, Mr. Chairman, legislation has been drafted that would limit VA's liability for smoking related diseases. That legislation, for whatever reason, has not been shared by VA with this Association. Therefore, our comments are based on press reports and quotes attributed to the Secretary of Veterans Affairs.

As the members of this Subcommittee know, smoking and the use of tobacco products, up until recently, was widely accepted, encouraged and practiced in the military services. The Subcommittee members also know that Congress subsidized its availability, not only for those provided in rations, but for cigarette and tobacco sales at military outlets ashore, at sea and in foreign countries. The military often set aside time and a place that created and encouraged a culture of smoking in the military. This Subcommittee knows these things and VA's General Counsel also knows and recognizes them (Precedent Opinion 2-93).

In NCOA's view, the above is sufficient for this Association to oppose VA's effort to limit their liability on this issue. The Association considers it unfortunate that the Secretary of Veterans Affairs chose the words "life style choice" in announcing his intention. If life style choice is a determining factor in establishing liability, VA long ago should have limited their liability for drug and alcohol abuse. Yet, in 1995, VA estimated that it spent $2 billion of its health care budget to treat veterans with substance abuse disorders, of whom 74% had no service-connected conditions whatsoever. If life style choice is to become a determining factor in liability questions, what does this mean for the thousands of veterans whom today VA provides some of the most expensive health care for the treatment of AIDS?

In NCOA's view, there is more than just "limited or suggestive evidence" to suggest that VA has a liability on this question. The Association is also fearful that this rush to "political correctness" will become the convenient reason for any respiratory disorder or cancer when the etiology is uncertain. The implications are many Mr. Chairman and NCOA would urge this Subcommittee to be thorough and methodical in your examination of any legislative proposal on this issue.

Thank you.

POST-HEARING QUESTIONS
CONCERNING THE MAY 14, 1997 HEARING ON
COMPENSATION AND PENSION SERVICE OPERATIONS
USING GPRA PRINCIPLES, PROCESSING OF PERSIAN GULF WAR CLAIMS,
AND PROPOSED LEGISLATION ON SMOKING-RELATED DISABILITIES

FOR THE DEPARTMENT OF VETERANS AFFAIRS

FROM THE HONORABLE JACK QUINN
CHAIRMAN, SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

Question 1: Please give us a brief history of VA's actions regarding compensation of smoking-related illnesses and explain the VA's position on this issue.

Answer: On January 13, 1993, the General Counsel issued VAOPGCPREC 2-93, which concerned entitlement to benefits for disabilities resulting from tobacco use while in service. The essential holdings of that opinion were that tobacco use does not constitute drug abuse and that direct service connection of disability or death may be established if the evidence shows that injury or disease resulted from tobacco use during active military, naval, or air service.

After the General Counsel precedent opinion was released, the Compensation and Pension Service (C&P) began to develop guidelines for adjudicating tobacco use claims. Pending issuance of these guidelines, regional offices were instructed to defer action on these claims and to maintain a log of all such claims until the guidelines could be issued. Upon review of the proposed guidelines, the General Counsel suggested that we address the adjudication of tobacco-related claims by regulation. Several regulatory approaches were drafted and discussed within VA, but the Secretary ultimately determined that a regulatory approach was not the most appropriate way of dealing with the issue and directed that claims for smoking-related disabilities be adjudicated under existing statutes, regulations, and case law. It was then that the C&P Service developed the guidelines contained in a letter sent to all regional offices on January 28, 1997. (A copy of this letter is attached.)

Concurrently with our issuance of the guidance letter, we asked the Veterans Health Administration to advise their physicians about tobacco claims and of the necessity for medical opinions with respect to the etiology of the particular disability suffered by a veteran. On February 14, 1997, the Under Secretary for Health sent Information Letter 10-97-008 to all field facilities informing them of new guidance for compensation and pension examinations when claims are based on tobacco use. (A copy of this letter is attached.)

Due to concerns involving claims alleging nicotine dependence as a result of in-service smoking, the C&P Service requested an opinion from the General Counsel on that issue. Before ruling on that subject, the General Counsel asked the Under Secretary for Health to provide a medical opinion on whether nicotine dependence could be considered a disease or injury for compensation purposes. In a May 5, 1997, memorandum, the Under Secretary for Health, stated that nicotine dependence may be considered a disease for compensation purposes. After consideration of that memorandum, the General Counsel issued VAOPGCPREC 19-97, Secondary Service Connection Based on Nicotine Dependence, on May 13, 1997. The General Counsel held that a determination as to service connection depends upon whether nicotine dependence may be considered a disease for purposes of the laws governing veterans' benefits, whether a veteran acquired a dependence on nicotine in service, and whether that dependence may be considered the proximate cause of disability or death resulting from the use of tobacco products.

The President's budget for fiscal year 1998 includes a request for legislation that would preclude service connection for most smoking-related disabilities. The provision would amend title 38, United States Code, to prohibit service connection of disabilities or deaths based solely on their being attributable, in whole or in part, to the use of tobacco products during service. The proposal would not preclude establishing service connection for disabilities which were manifested during active duty service or within applicable presumptive periods. If enacted, such a prohibition would be effective prospectively, so regardless of the proposed legislation, we still must deal with the currently pending claims. If this legislation is not enacted, we will process claims under existing regulations and statutes, and under any additional regulations which may be promulgated in order to insure that these claims are adjudicated properly.

Question 2: VA is currently readjudicating over 11,000 Gulf War claims. Please describe what the department is finding during this process and what data is being kept to further Persian Gulf Illness research?

Answer: A total of 10,736 claims were developed for readjudication in July and August 1996. As of May 1997, 5,606 or 52% of these claims have been readjudicated. The readjudication has resulted in 853 new environmental hazard grants for a grant rate on review of 15%. Of this number, 601 new grants (10.7% of the total reviewed) are for conditions with a recognized medical diagnosis and 252 new grants (5% of the total reviewed) are for undiagnosed illnesses. The readjudication was undertaken to assure that all evidence submitted is fully considered and that proper weight is accorded to lay statements. As our rating specialists become more familiar with the new concept of disability resulting from illness that has no known medical diagnosis, we anticipate that this review will result in additional grants of service connection. The data maintained from this review pertains only to claims adjudication. It is not intended or suitable for use in Persian Gulf illness research.

Question 3: Goal number 1 shows significant reductions in processing time. With the equally significant reductions in FTEE that are proposed in the budget, how do you propose to achieve those improvements in timeliness?

Answer: The elements of the BPR vision are intertwined and dependent on one another and designed to function as a system to bring about radical change. We cannot achieve the dramatic performance improvements proposed in the budget without implementing a comprehensive and coordinated package of reengineering initiatives.

Our approach to reengineering the claims process involves fundamental changes that include:

- strengthening of partnerships with veterans and their representatives,
- core process modifications, and
- infrastructure adjustments.

We will reorient our processes to direct participation by veterans through expanded outreach and veteran service representatives, who will work with veterans one-on-one to focus issues and resolve concerns. The redesigned process stresses streamlining by greatly reducing the number of people in the process and the number of hand-offs. Our ability to implement and maximize the streamlined processes depends heavily on investments in information technology. Enhanced information systems will enable veterans to file claims quickly, monitor claims status, and discuss the merits of cases with personnel who are responsible for deciding claims and accountable for their decisions. Supporting information systems leverage human resources, allowing claims processors to focus on customer contact, analysis, and decision-making. Time spent waiting for evidence is greatly reduced with electronic links with other Federal agencies. Because we will work with veterans and VSOs throughout the claims process, claim resolution will be faster, more accurate, and more responsive to each veteran's needs.

It is the reengineering of the claims process and supporting information technology that make staff reductions possible. Without the resources needed to implement the comprehensive package of reengineering initiatives, we will not achieve the dramatic performance improvements proposed in the budget and will not be able to significantly reduce the C&P staffing.

Question 4: Would you please describe how the Department intends to achieve goal number 4 - to reduce overall operating costs? I am especially curious about the methodology described on page 2-50 in the budget submission in which several unit costs go up.

Answer: The unit cost analysis in the FY 1998 budget submission focused on direct labor costs only. As part of BPR implementation planning, teams identified the ways that the various initiatives will improve the claims process and made assumptions on how these changes will occur in the reengineered vision. In the vision, many non-value added steps, such as authorization and award preparation, are eliminated. These assumptions were applied to the Extend simulation model built for *A Case for Change*.

The Extend simulation model provides estimates of how many hours each type of employee spends on certain types of claims for both the current process and the reengineered process. A GS level was assigned to each modeled position. The salaries used to compute the costs were the Washington DC area with an added 20.15% load for benefits. An hourly payroll rate was computed and the resulting unit cost was calculated for the various types of claims.

For a number of the different types of claims, the projected direct labor unit cost associated with the vision exceed the comparable baseline unit cost figures. This counter-intuitive result is due, in part, to the fact that the reengineered claims process involves fewer, but more highly skilled and highly trained field staff. Because of these higher skills, the salary grades of the field staff will be higher.

In addition, under the reengineered process, due to automation, inter- and intra-agency interfaces, or changes in laws/regulations, the number of easier actions/claims will be significantly reduced. Those that remain will be the more complex and time consuming actions/claims. The staff will be concentrating their efforts on the more difficult tasks, thus driving up the average unit cost.

The results shown for the individual units reflect incremental changes to the AS-IS process and assume the current staff structure. The costs in general go down because the salary levels and positions remain the same, but workload decreases.

The unit cost for Appeals and Hearings for the AS-IS process reflects the average cost of processing four end products (EPs 070, 172, 173 and 174). A single appeal can generate multiple numbers of these end products. In the vision, each appeal action will constitute one end product. This occurs because the decision review process is designed to focus the issue and to quickly reach a conclusion. Because fewer end products will be generated per appeal, the average cost per appeal end product will increase significantly.

Question 5: GAO points out that VBA has not addressed the primary outcomes of the program - to measure whether the program is compensating veterans for the average decrease in earnings capacity. How would address that observation?

Answer: On November 8, 1996, we responded to GAO on this issue in reply to their draft report VA DISABILITY COMPENSATION: Disability Ratings May Not Reflect Veterans' Economic Losses (GAO/HEHS-97-9). A copy of GAO's final report, including our letter of November 8 (page 35 of GAO report) is attached.

6. Would you please describe your vision of goal 7 - training and certifying employees?

Answer: This question is in reference to goal 5 on training and certification of employees. The fundamental changes that are envisioned with BPR demand the development and incorporation of dynamic training programs. Likewise, stakeholders have expressed concern with the lack of consistency in rating decisions and the absence of formal credentials possessed by those employees making rating decisions. It is, therefore, imperative that we develop and implement an objective and consistent process for training and certifying employees.

Today, VBA is in the early stages of developing a standard training methodology or formal method of certifying proficiency of employees; the primary focus at this time is the rating specialist. To ensure consistency of rating decisions and other claims actions, a certification process will be established as part of a comprehensive training, support and credentialing systems (TPSCS), which will ultimately be linked to how employees progress and are paid. Job competency certification will be the new formal, standardized process by which employees will demonstrate that they have acquired the skills and knowledge to perform in their positions. As with the implementation of the BPR environment, there is still much work to be done and changes to be made in this area. This we expect to accomplish through BPR with our employees, stakeholders and partners.

Question 7: Should VSO service officers working at the ROs, BVA, and the Court go through some certification process?

Answer: VBA's ability to provide world class service, as articulated by the Secretary and as envisioned in the BPR environment, is dependent upon a partnership with the Veterans Service Organizations and County Service Officers. VBA will continue to serve in its role as the decision maker, but will rely as well on VSOs for the upfront part of the business process which includes initial veteran or family member contact, claims development, and liaison between the veteran and VBA staff; and thus, collaboratively produce a better and more timely product for the veteran customer. To achieve this end, VBA will be including and involving the VSOs in the training needed for this new process. Whether or not the certification part of this process will be used with the VSO's in future years is not known at this time. Under current statute and regulations, however, VA is charged with the accreditation of representatives to assure that claimants for VA benefits have qualified representation. Certification of VSOs will be considered as the training is developed, perfected and validated.

Attachment 1
(Rep. Quinn's Q&A #1)

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Washington DC 20420

January 28, 1997

Director (00/21)
VA Regional Office

In Reply Refer To: 213C (97-09)

SUBJ: Claims Involving Disabilities or Death Based on Tobacco Use During Active Service

1. This letter provides guidance for the adjudication of claims involving the use of tobacco products while on active duty. Sections 1110, 1131, and 1310 of title 38, United States Code, authorize VA to pay compensation to a veteran for disability resulting from personal injury suffered or disease contracted in line of duty in the active military, naval, or air service, or to a surviving spouse, child or parent of a veteran for the service-connected death of the veteran.

2. In VAOPGCPREC 2-93 dated January 13, 1993, the General Counsel (GC) addressed the issue of service connection for disabilities or death resulting from the use of tobacco products in service. The essential holdings of that lengthy opinion, for purposes of this discussion, were that tobacco use does not constitute drug abuse, (see Omnibus Budget Reconciliation Act (OBRA) of 1990, (38 CFR § 3.301(d)), and that direct service connection of disability or death may be established if the evidence shows that injury or disease resulted from tobacco use during active military, naval, or air service.

3. Medical research has identified many diseases that may be potentially caused by the use of tobacco products such as cigarettes, cigars, pipe tobacco, snuff, and chewing tobacco. Disabilities that may be caused by cigarette smoking include, but are not limited to, cancer of the lung, larynx and esophagus, coronary artery disease, atherosclerotic peripheral vascular disease, emphysema, chronic bronchitis, and chronic obstructive pulmonary disease (COPD). Cancers of the cheek and gum have been potentially linked to snuff and chewing tobacco. Medical literature has also indicated a possible link between cigar and pipe smoking and cancers of the lip, tongue, larynx and esophagus. Additionally, there may be other disabilities related to the use of tobacco products.

4. As in all claims for VA benefits, the first determination to be made is whether or not the claim has met the well-grounded threshold. Section 5107(a) of title 38, United States Code, provides that: "[A] person who submits a claim for benefits under a law administered by the Secretary shall have the burden of submitting evidence sufficient to justify a belief by a fair and impartial individual that the claim is well grounded." The United States Court of Veterans Appeals (the Court), in *Murphy v. Derwinski*, 1 Vet. App. 78 (1990), defined a well-grounded claim as one which is meritorious on its own or capable of substantiation. Such a claim need not be conclusive but only possible to satisfy the initial burden of section 5107(a). The Court held in *Tirpak v. Derwinski*, 2 Vet. App. 609 (1992), that, to be well grounded, a claim must be accompanied by supportive evidence and that such evidence must justify a belief by a fair and impartial individual that the claim is plausible. It is important to note that "evidence" can consist of many diverse items such as VA or private medical records, service records, lay

statements, or the veteran's own testimony. If it is determined that a claimant has not submitted a well-grounded claim, the claim should be denied on that basis, and a decision on the merits would be inappropriate. *Grottveit v. Brown*, 5 Vet. App. 91 (1993).

5. There have been several Court decisions which bear directly upon the issue of the establishment of service connection for a disability or death. The Court has stated that, in order for a claim of service connection to be well grounded, the veteran must present competent evidence of the following: (1) a current disability (a medical diagnosis); (2) incurrence or aggravation of the claimed disease or injury in service (lay or medical evidence); and, (3) a nexus between the in-service injury or disease and the current disability (medical evidence). *Watai v. Brown*, 9 Vet. App. 441 (1996); *Caluza v. Brown*, 7 Vet. App. 498 (1995), aff'd, 78 F.3d 604 (Fed. Cir. 1996) (per curiam). For additional guidance, *see Combee v. Brown*, 34 F.3d 1039, 1042 (Fed. Cir. 1994), ("[p]roof of direct service connection . . . entails proof that exposure during service caused the malady that appears many years later"); *Cosman v. Principi*, 3 Vet. App. 503, 505 (1992), ("even though a veteran may not have had a particular condition diagnosed in service, or for many years afterwards, service connection can still be established"); and 38 CFR § 3.303(d). The nexus requirement may also be satisfied by a presumption that certain diseases manifesting themselves within certain prescribed periods are related to service. See 38 U.S.C. § 1112(a); 38 CFR §§ 3.303(b), 3.307 and 3.309; *Caluza v. Brown*.

6. In *Ramey v. Brown*, 9 Vet. App. 40 (1996), the Court applied the same three requirements for a well-grounded claim for service connection of a disability to a claim for service connection for a death, *i.e.* medical evidence of a current disability, evidence of incurrence or aggravation of a disease in service, and a nexus between the current disability and in-service disease. The Court held that in claims for service connection for the cause of death of a veteran, the requirement for evidence of a current disability will always have been met because that was the condition that caused the veteran to die. However, the last two requirements, an in-service event and a nexus, must be supported by evidence of record. Therefore, the guidelines provided in this letter are also applicable in claims for death benefits based upon the veteran's tobacco use while on active military, naval, or air service.

7. Once a well-grounded claim has been received, VA must execute its duty to assist. That duty includes, in appropriate circumstances, gathering VA and private records, conducting a thorough and contemporaneous medical examination, and liberally reading the claimant's documents and oral testimony so as to identify all claims that are reasonably raised by the record. See M21-1, Part III, paragraph 2.01a and Part VI, paragraphs 2.08 and 2.10 for additional information on well-grounded claims and VA's duty to assist.

8. Duty-to-assist obligations generally involve development of all relevant facts from all identified sources, both government and private (including lay evidence such as the veteran's tobacco-use history). In service-connected disability and death claims, VA must request all relevant prior medical records and Social Security Administration (SSA) records of which it is put on notice. *Suttmann v. Brown*, 5 Vet. App. 127 (1993); *Lind v. Principi*, 3 Vet. App. 493 (1992). A request for a thorough and contemporaneous examination may be necessary, for example, when a review of prior medical treatment records may resolve diagnostic questions pertinent to service connection, or an opinion concerning possible medical relationships between past and present disorders may be relevant to a finding of service connection. *See Suttmann v. Brown*, 5 Vet. App. 127 (1993) and *Green v. Derwinski*, 1 Vet. App. 121 (1991). The duty to assist ends when all relevant evidence is obtained, or cannot be obtained despite reasonable efforts, or benefits are granted.

9. After the duty-to-assist obligations are met, the evidence will be assessed as to its credibility and weight. The decision maker must then apply the law to the facts. The law includes all statutes, court cases, regulations, and GC opinions that are applicable. As stated in paragraph 1, VA is authorized to provide compensation for a service-connected disability or death under the provisions of 38 U.S.C. sections 1110, 1131, and 1310. Regulations pertaining to direct service connection are found at 38 CFR sections 3.303, 3.304, 3.305, 3.306, and 3.312. In addition, the provisions of 38 CFR section 3.102 (the reasonable-doubt rule) are applicable. If it is determined that the evidence does not establish service connection for a disability or death due to tobacco use during service, then the claim must be denied. The "Reasons and Bases" section of the rating decision must clearly explain why the claim for the disability or death alleged to have been due to the in-service use of tobacco products is not supported by the evidence. If, on the other hand, the evidence establishes service connection, the claim must be granted.

10. Given the above background, the claimant must provide a history of the use of tobacco product(s) in service; medical evidence of a current disability; and medical evidence of a relationship between the current disability and tobacco use during active service in order to establish a well-grounded claim. If the claim is not well-grounded on initial review, advise the claimant what evidence is necessary to make his or her claim well-grounded (steps b-d). It is the responsibility of VA to obtain the veteran's service medical records (SMRs) if available. Because of the time involved in obtaining SMRs from the military, requests for those records should be concurrent with the notification to the claimant of the evidence necessary to make the claim well grounded. Once it is determined that a well-grounded claim has been submitted, execute VA's duty to assist and adjudicate the claim. Where indicated, request submission of post-service treatment records for the claimed disability and a complete tobacco product use history. Adjudication of claims based on the use of tobacco products will normally follow the steps outlined below (steps b-d are required if evidence is not submitted with the claim):

a. Develop service medical records.
b. Ask the claimant for a history of the use of tobacco products.

c. Ask the claimant for medical evidence of current disability.
d. Ask the claimant for medical nexus evidence.
e. Where indicated, ask the claimant for post-service treatment records.
f. In well-grounded claims, request an opinion from a VA examiner, if necessary, concerning any etiological relationship between in-service tobacco use and the claimed disability. In such cases, the claims folder will be made available for review by the physician.
g. Weigh the evidence and decide the claim.

11. During the March 4, 1993, Judicial Review Conference Call, regional offices were advised to defer action on claims involving the use of tobacco products during active service and to maintain a log for control of the cases. Effective immediately, regional offices should pull and adjudicate all cases on that log. For end product control purposes, the date of claim for all claims received on or before the date of this letter, will be the date of this letter. For all claims received after the date of this letter, the date of claim will be the actual date of receipt of the claim. If service connection for a claim based upon the use of tobacco products during service is granted, the effective date will be based on the actual date of receipt of the claim.

12. In the near future, regional offices will be required to provide statistical information about each tobacco-related claim. See Attachment A for the budgetary information that needs to be captured. Please complete a sheet for each completed claim and hold for future instructions.

Kristine A. Moffitt

TOBACCO-USE CLAIMS

Station Number _____ Claim Number _____

Name of Veteran _____

Name of Claimant _____

Power of Attorney Code _____

PVA	71	AL	74	AMVETS	77
DAV	83	MOPH	89	VFW	97
Atty	99	None	00	Other	01

Service Dates EOD _____ RAD _____

EOD _____ RAD _____

Date of Claim _____

Type of Tobacco Product _____

Cigarettes	1	Pipe Tobacco	2
Cigars	3	Chewing Tobacco	4
Snuff	5	Multiple Tobacco Products	6

Disposition of Claim(s) for Tobacco-related Disorder(s) Granted _____ Denied _____

If Granted:

Diagnostic Code(s) _____ _____ _____
(For tobacco-related disorders only)

Percent(s) of Evaluation _____ _____ _____

Effective Date(s) _____ _____ _____

Combined Percent Without Tobacco-related Disorders _____

Combined Percent With Tobacco-related Disorders _____

Prior Combined Percent in Non-original claims that are granted: _____

Amount of retroactive pay only for disability(ies) due to tobacco-use $_____
Do not include amounts paid for non-tobacco-use disorders.
(Total amount of retroactive payment less amount of retroactive payment for non-tobacco-use products.)

Was an opinion requested from a VA examiner? Yes _____ No _____

(Attachment A)

Attachment 2
(Rep. Quinn's Q&A #1)

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-97-008
In reply refer to: 112

February 14, 1997

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

CLAIMS INVOLVING DISABILITIES OR DEATH BASED ON TOBACCO USE DURING ACTIVE SERVICE

1. This Information Letter provides new guidance for compensation and pension (C&P) examiners on claims involving the use of tobacco products while on active duty. On January 28, 1997, Veterans Benefits Administration (VBA) sent their regional offices guidance on the adjudication of claims on this subject.

2. In Department of Veterans Affairs Opinion of General Counsel Precedent (VAOPGCPREC) 2-93 dated January 13, 1993, the General Counsel (GC) addressed the issue of service connection for disabilities or death resulting from the use of tobacco products in service. The essential holdings of that lengthy opinion, for purposes of this discussion, were that tobacco use does not constitute drug abuse, for purposes of statutes barring service connection of disability or death resulting from drug abuse, and that direct service connection of disability or death may be established if the evidence shows that injury or disease resulted from tobacco use in line of duty during military, naval, or air service. During the March 4, 1993, Judicial Review Conference Call, VBA regional offices were advised to defer action on claims involving the use of tobacco products during active service and to maintain a log for control of the cases. Effective immediately, VBA regional offices have been told to pull and adjudicate all cases on that log. The Veterans Health Administration (VHA) C&P examiners should be aware that they will be receiving an increase in their workload for this reason.

2. Medical research has identified many diseases that may be potentially caused by the use of tobacco products such as cigarettes, cigars, pipe tobacco, snuff, and chewing tobacco. Disabilities that may be caused by cigarette smoking include, but are not limited to, cancer of the lung, larynx and esophagus, coronary artery disease, atherosclerotic peripheral vascular disease, emphysema, chronic bronchitis, and chronic obstructive pulmonary disease (COPD). Cancers of the cheek and gum have been potentially linked with snuff and chewing tobacco. Medical literature has also indicated a possible link between cigar and pipe smoking and cancers of the lip, tongue, larynx, and esophagus. There may be other disabilities related to the use of tobacco products.

3. **VHA C&P examiners need to be aware that they will be requested to express an opinion on the relationship of tobacco use in service and current disability.** Review of the claims folder will be necessary. Such an opinion must be supported by factual information about, and

IL 10-97-008
February 14, 1997

assessment of, all pertinent issues, including the following: the relationship of tobacco use to the specific disability claimed; the extent of tobacco use during service, as well as before and after service; the presence of other risk factors for the claimed disability and their relative importance as causal factors; the time of onset of the claimed disability; and, if applicable, the effect of cessation of smoking.

4. It is hoped that this information will be helpful to VA medical center staff, especially C&P examiners and their administrative staff, since the claims for these disabilities are now being processed. This information needs to be shared with all C&P examiners in order to make them aware of this new guidance and to prepare them to handle the influx of new claims.

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 2/18/97
FLD: VISN, MA, DO, OC, OCRO and 200-FAX 2/18/97
EX: Boxes 104, 88, 63, 60, 54, 52, 47 and 44 - FAX 2/18/97

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Compensation, Pension, Insurance and Memorial Affairs, Committee on Veterans' Affairs, House of Representatives

January 1997

VA DISABILITY COMPENSATION

Disability Ratings May Not Reflect Veterans' Economic Losses

GAO/HEHS-97-9

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-274058

January 7, 1997

The Honorable Terry Everett
Chairman, Subcommittee on Compensation,
Pension, Insurance and Memorial Affairs
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs' (VA) disability program is required by law to compensate veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during military service. These injuries or conditions are referred to as "service-connected" disabilities. Veterans with such disabilities are entitled to monthly cash benefits under this program even if they are working and regardless of the amount they earn.

In fiscal year 1995, VA paid about $11.3 billion to approximately 2.2 million veterans who were on VA's disability rolls at that time. Over the past 50 years, the number of veterans on the disability rolls has remained fairly constant. During this period, the disability rolls were at their lowest level in fiscal year 1946 with a total of about 1.9 million veterans and at their highest during fiscal years 1978 through 1984 with a total of about 2.3 million veterans each year.

The amount of compensation veterans with service-connected conditions receive is based on the "percentage evaluation," commonly called the disability rating, that VA assigns to these conditions. VA uses its "Schedule for Rating Disabilities" to determine which rating to assign to a veteran's particular condition. VA is required by law to readjust the schedule periodically on the basis of "experience." Since the 1945 version of the schedule was developed, questions have been raised on a number of occasions about the basis for these disability ratings and whether they reflect veterans' current loss in earning capacity.

This report responds to your request for information that would enable the Subcommittee to assess the need for a comprehensive study of the economic validity of VA's rating schedule. It describes (1) the basis for the disability ratings assigned to conditions in the current schedule; (2) socioeconomic changes that have occurred since the original version of the schedule was developed that may have influenced the earning

capacity of disabled veterans; (3) the results of a previous study that examined the validity of ratings in the schedule; (4) VA's efforts to help ensure that the ratings do reflect disabled veterans' average impairment in earning capacity; and (5) the advantage of basing ratings in the schedule on actual loss in earnings, and approaches that could be used to estimate this loss.

To develop this information, we analyzed legislation and reviewed documents on the history of the program and had discussions with current and former VA officials and representatives from veterans service organizations (VSO) familiar with the program's history. We also reviewed the results of the President's Commission on Veterans' Pensions (known as the Bradley Commission) study and the Economic Validation of the Rating Schedule (ECVARS). We discussed the ECVARS and its results with VA's Office of Inspector General and Compensation and Pension officials and former VA officials familiar with this study.

To identify possible approaches VA could use to evaluate and update its rating schedule to help ensure that ratings reflect the average reduction in veterans' earning capacity, we reviewed literature on research design and methods and reviewed the ECVARS methodology. We also obtained the views of Bureau of the Census, Social Security Administration, and Bureau of Labor Statistics officials, economists, statisticians, and research methodologists.

We did our work from April 1995 to December 1996 in accordance with generally accepted government auditing standards.

Results in Brief

The disability ratings in VA's current schedule are still primarily based on physicians' and lawyers' judgments made in 1945 about the effect service-connected conditions had on the average individual's ability to perform jobs requiring manual or physical labor. During fiscal year 1995, disabled veterans' basic monthly benefit ranged from $89 for conditions rated at 10 percent to $1,823 for conditions rated at 100 percent. Veterans rated at 100 percent who have special needs, however, could receive up to a total of $5,212 monthly.

Although the ratings in the schedule have not changed substantially since 1945, dramatic changes have occurred in the labor market and in society since then. The results of an economic validation of the schedule conducted in the late 1960s indicated that ratings for many conditions did

not reflect the actual average loss in earnings associated with them. Therefore, it is likely that some of the ratings in the schedule do not reflec the economic loss experienced by veterans today. Hence, the schedule may not equitably distribute compensation funds among disabled veterans

VA has done little since 1945 to help ensure that disability ratings correspond to disabled veterans' average loss in earning capacity. Despite the results of the economic validation study, VA's efforts to maintain the schedule have concentrated on improving the appropriateness, clarity, an accuracy of the descriptions of the conditions in the schedule rather than on attempting to ensure that the schedule's assessments of the economic loss associated with these conditions are accurate. For example, some of the criteria have been revised to describe more accurate measures of disease severity or to recognize the effects of medical and technological advances on particular disabilities.

Basing disability ratings at least in part on actual earnings loss rather thai solely on judgments of loss in functional capacity would help to ensure that veterans are compensated to an extent commensurate with their economic losses and that compensation funds are distributed equitably. For example, according to the schedule, loss of the use of a hand has a disability rating of 60 percent for the nonpredominant hand and 70 perce for the predominant hand because such a loss is expected to reduce veterans' earning capacity on average by 60 and 70 percent, respectively. However, VA's economic validation study in the late 1960s showed that th reduction in earning capacity that veterans who had lost the use of a han experienced was, on average, closer to 40 percent. In contrast, veterans who had a disability rating of 70 percent for pronounced psychotic conditions were found, on average, to have experienced a reduction in earnings closer to 80 percent.

Our work demonstrates that there are generally accepted and widely use approaches to statistically estimate the effect of specific service-connected conditions on veterans' average earnings. These estimates could be used to set disability ratings in the schedule that are appropriate in today's socioeconomic environment. It could cost betwee $5 million and $10 million to collect the data that produce these estimat a small fraction of the over $11 billion VA paid in disability compensatio to veterans in fiscal year 1995.

VA's Disability Compensation Program

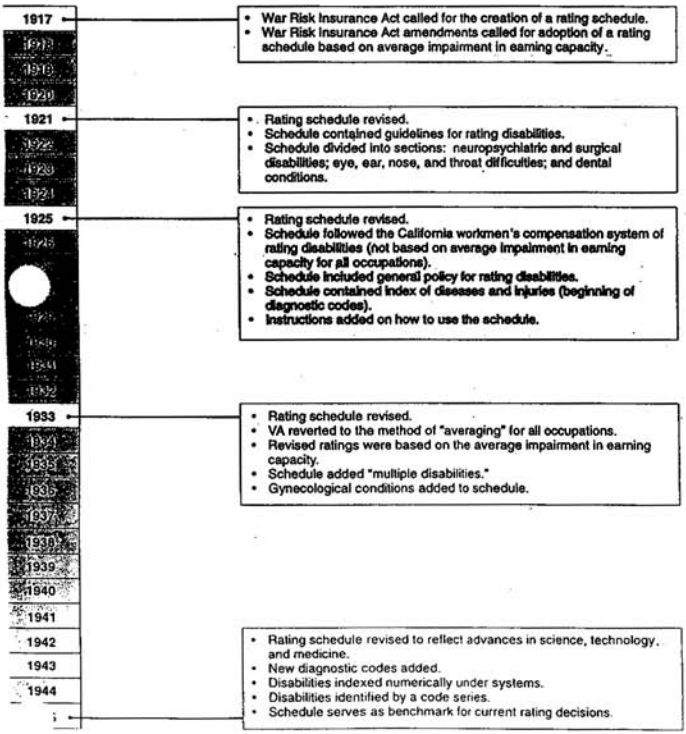
The law directs VA to compensate veterans for their service-connected physical or mental conditions according to a schedule of disability ratings, which represents the average impairment in earning capacity that results from these conditions. The first schedule was developed in 1919 and has undergone many changes since then. The Schedule for Rating Disabilities includes a list of physical and mental conditions with disability ratings assigned to each. These ratings are used to determine the amount of compensation that veterans are entitled to receive on the basis of their specific conditions.

VA's Schedule for Rating Disabilities

Federal law (38 U.S.C. 1110 and 1155) requires VA to "adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries" to determine the amount of compensation disabled veterans are entitled to receive. The ratings are to be based, "as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations." The law gives the chief administrator of VA the discretion to define "average impairments in earning capacity" and the authority to readjust the schedule to help ensure that disability ratings reflect VA's experience.

The War Risk Insurance Act of 1917 called for the creation of the first rating schedule. The schedule was developed in 1919 and provided an early framework for the basic design of the current compensation and pension programs for disabled veterans. It underwent major revisions in 1921, 1925, 1933, and 1945, becoming more comprehensive with each major revision (see fig. 1). The last major revision to the schedule was made in 1945.

Figure 1: History of VA's Schedule for Rating Disabilities



The Schedule for Rating Disabilities contains medical criteria and disability ratings. The medical criteria consist of a list of diagnoses organized by body system and a number of levels of medical severity specified for each diagnosis. The schedule assigns a percentage evaluation, commonly referred to as a disability rating, to each level of severity associated with a diagnosis. The disability rating conceptually reflects the average impairment in earning capacity associated with each level of severity. For example, VA presumes that the loss of a foot as a result of military service results in a 40-percent impairment in earning capacity, on average, among veterans with this injury. All veterans who lose a foot as a result of military service, therefore, are entitled to a 40-percent disability rating whether this injury actually reduces their earning capacity by more than 40 percent or not at all. Ratings for individual diagnoses in the schedule range from 10 percent to 100 percent in gradations of 10 (see table 1).[1]

Table 1: Number of Veterans Receiving Disability Compensation During FY 1995, by Degree of Disability

Degree of disability (percent)	Number of veterans
0	18,588*
10	886,279
20	365,241
30	308,377
40	183,679
50	106,583
60	106,798
70	60,770
80	37,488
90	16,592
100	143,280
Total	**2,235,675**

*While 0-percent ratings are normally noncompensable, some veterans may receive special monthly compensation for such things as the loss of a procreative organ.

Source: VA, Annual Report of the Secretary of Veterans Affairs—Fiscal Year 1995 (Washington, D.C.: VA, Mar. 1996).

[1]A veteran can also receive a 0-percent noncompensable rating that may be increased to a compensable rating of 10 percent or more if the veteran's condition worsens. A 0-percent rating generally means that VA has determined that a veteran has a condition that can be classified as service connected; however, it is not severe enough to qualify for monetary compensation on the basis of the medical criteria specified in the schedule. Some veterans with a 0-percent rating receive special monthly compensation under the VA disability program. On the basis of 1994 data, VA estimated there were about 1.2 million veterans who were rated at 0 percent and were not receiving disability compensation.

Disability Compensation Amounts

The amount of compensation veterans are awarded for their disabilities is based on (1) the disability rating the schedule assigns to a veteran's specific condition and (2) the specific benefit amount the Congress sets for each of these disability rating levels. To determine what basic compensation a veteran with a service-connected condition is due, first the veteran's condition is medically evaluated to determine its severity. Then VA compares the results of the evaluation with the medical criteria in the schedule to determine what disability rating is warranted given the severity of the veteran's condition. The veteran will receive the amount the Congress has set for that disability rating.

The Congress has adjusted the benefit amounts for each disability rating level annually. In fiscal year 1995, the basic monthly benefit amount ranged from $89 for conditions assigned a rating of 10 percent to $1,823 for conditions assigned a rating of 100 percent (see table 2).

Although the primary purpose of VA's disability compensation program is compensation for impairment in earning capacity, the program also provides for additional monthly compensation over and above the amount based on the schedule, for loss of "physical integrity." Loss of physical integrity is defined as tissue loss, loss of body parts, or any disease or injury that makes an individual less functionally whole. The law (38 U.S.C. 1114) provides for additional monthly compensation for such things as the loss of a hand, foot, eye, or procreative organ.

VA regulations also allow veterans to receive "extra-schedular" awards when VA determines that the severity of a veteran's condition is not adequately captured by the rating the schedule assigns to it. Extra-schedular awards allow veterans to receive compensation for a rating higher than the one specified in the schedule for their condition. In a case of unemployability, for example, if the criteria in the schedule indicate that a veteran's condition warrants at least a 60-percent disability rating but VA determines that, on the basis of that veteran's unusual circumstances, he or she is unable to obtain and sustain gainful employment, VA can raise the compensation for that veteran to the amount provided for a 100-percent rating.

VA regulations also allow veterans to be compensated for "social inadaptability" or "social impairment" to the extent it affects industrial adaptability. Social inadaptability contemplates those abnormalities of conduct, judgment, and emotional reactions that affect economic adjustment, that is, that impair earning capacity.

Table 2: VA Disability Compensation Rates During FY 1995, by Degree of Disability

Degree of disability (percent)	Monthly rate
10	$89
20	170
30	260
40	371
50	529
60	666
70	841
80	974
90	1,096
100	$1,823[a]

Note: Effective December 1, 1995, these rates were increased to the following: 10 percent—$91; 20 percent—$174; 30 percent—$266; 40 percent—$380; 50 percent—$542; 60 percent—$683; 70 percent—$862; 80 percent—$999; 90 percent—$1,124; and 100 percent—$1,870.

[a]When veterans suffer from conditions that result in additional needs, such as special assistance in the home, they can receive up to $5,212 a month in disability compensation, including the basic benefit.

Source: VA, Federal Benefits for Veterans and Dependents, 1995 ed., VA Pamphlet 80-95-1 (Washington, D.C.: VA, 1995).

In 1995, about 70 percent of the 2.2 million veterans on the rolls were being compensated for conditions with disability ratings of 30 percent or less for a total of nearly $2.8 billion, or about 25 percent of total benefits paid to veterans that year. Those rated 100 percent accounted for only 6 percent of those on the disability rolls that year and received $3.7 billion, or about 32 percent of the total amount of benefits paid (see table 3).

Table 3: Total Compensation Paid During FY 1995 to Disabled Veterans, by Degree of Disability

Degree of disability (percent)	Number of veterans	Percentage of all veterans	Total amount paid	Percentage of total amount paid
0	18,588	0.8	$ 14,917,200	0.1[a]
10	886,279	39.6	950,119,200	8.4
20	365,241	16.3	746,307,600	6.6
30	308,377	13.8	1,068,338,400	9.4
40	183,679	8.2	913,666,800	8.1
50	108,583	4.8	762,907,200	6.7
60	106,798	4.8	1,256,940,000	11.1
70	60,770	2.7	892,731,600	7.9
80	37,488	1.7	659,898,000	5.8
90	16,592	0.7	330,303,600	2.9
100	143,280	6.4	3,707,430,000	32.8
Total	**2,235,675**	**100.0[b]**	**$11,303,559,600**	**100.0[b]**

[a]While 0-percent ratings are normally noncompensable, some veterans may receive special monthly compensation for such things as the loss of a procreative organ.

[b]Totals may not add to 100 percent because of rounding.

Source: VA, Annual Report of the Secretary of Veterans Affairs—Fiscal Year 1995 (Washington, D.C.: VA, Mar. 1996).

Disability Ratings May Not Reflect Economic Loss

Disability ratings in the current schedule may not reflect the actual economic loss that disabled veterans, on average, now experience. While the law contains no definition of "impairments in earning capacity," ratings assigned to conditions in the schedule are based more on judgments of the loss in functional capacity, rather than in earning capacity, resulting from these conditions. Advances in medicine and technology and changes in the economy and public policy and in the field of rehabilitation since 1945 raise questions about whether ratings for specific conditions set 50 years ago reflect the average loss in earning capacity today among veterans with these conditions. In addition, studies conducted in the mid-1950s and the late 1960s concluded that the ratings in the schedule did not accurately reflect the reduction in earning capacity that disabled veterans experienced at those times and that the ratings needed to be updated.

Impairments in Earning Capacity Not Defined in the Law

The law gives the Secretary of Veterans Affairs the authority to determine what is meant by "average impairments in earning capacity" in civilian occupations. Although VA's Economic Validation of the Rating Schedule (ECVARS) in the late 1960s defined reduction in earning capacity as "the loss or lowering of average income from wages or employment," VA has not defined in regulations what is meant by average impairment in earning capacity other than to generally describe it as an economic or industrial handicap.

Beginning at least as early as 1923, when assigning a rating to a condition, VA used the loss in physical or overall functional capacity resulting from that condition (or some other proxy, such as the average veteran's ability to compete for employment in the job market) as an indicator of average impairment in earning capacity. According to an official in VA's Office of General Counsel, the average impairment in earning capacity in civilian occupations means the impairment of an individual's ability to engage in any type of work available in the economy.

Functional Capacity Used as an Indicator of Earning Capacity

The actual loss in earnings associated with a service-connected condition has not been considered when determining the degree to which that condition impairs earning capacity. Nor has it been considered when determining the rating that condition should be assigned in the schedule. In 1945, when the framework for the current schedule was developed, the job market was oriented toward physical labor, and physical capacity was expected to have a major influence on earning capacity. At that time, a Disability Policy Board, consisting of doctors and lawyers, set the disability ratings for the conditions contained in the schedule. According to a former Director of VA's Compensation and Pension Service, VA's Department of Medicine and Surgery, now the Veterans Health Administration, provided the Board with a medical monograph—a detailed description of etiology and manifestations—for each of the conditions included in the schedule at that time. The Board used these monographs to estimate the relative effects different levels of severity of a condition have on the average veteran's ability to compete for employment in the job market. It set disability ratings on this basis. Thus, ratings for conditions that limited physical ability, such as the loss of the use of an arm or leg, were expected to greatly impair veterans' average earning capacity and were given a relatively high rating.

Since 1945, VA has made many revisions to the schedule. The revisions have included modifications to medical criteria associated with the

ratings, changes in the maximum convalescence period allowed before requiring reevaluation of the condition, and addition of more levels of evaluations or ratings. The revisions, however, have not been based on empirical data on the effects certain conditions have on veterans' earnings.

According to VA Compensation and Pension officials, the basic procedure used to determine what disability rating to assign to a condition has not changed since 1945. This determination has been and continues to be based on the judgment of individuals with knowledge and expertise in this area. When adjusting ratings for conditions already in the schedule or assigning ratings to new conditions added to the schedule, VA's goal has been to maintain the internal consistency of the schedule over time. In doing so, VA tries to ensure that new or adjusted ratings are consistent with the ratings of analogous conditions and reasonable relative to all other conditions. As a result, the ratings in the 1945 schedule have been, in effect, the benchmark for all the ratings adjusted and added since then, and VA officials acknowledge that the ratings in the current schedule are consistent with the ratings developed in 1945.

Changes in the Economy and Society Since 1945 Indicate That Ratings May Need Updating

Even if functional capacity accurately approximated disabled veterans' reduction in earning capacity in 1945, changes have occurred since then that have implications for how accurately those ratings reflect disabled veterans' reduction in earning capacity today. Numerous technological and medical advances have taken place, as well as economic changes, that have created more potential for people to work with some conditions and less potential for people to work with other conditions. There have also been changes in the labor market and social attitudes toward the disabled that may affect disabled veterans' ability to work.

Since 1945, medical and technological advances have enabled individuals with some types of disabilities to obtain and sustain employment. Advances in the management of disabilities, like medication to control mental illness or computer-aided prosthetic devices that return some functioning to the physically impaired, have helped reduce the severity of the functional loss caused by both mental and physical disabilities. Electronic communications and assistive technologies, such as synthetic voice systems, standing wheelchairs, and modified automobiles and vans, have given people with certain types of disabilities more independence and potential to work.

There has also been a shift in the U.S. economy since 1945 from predominantly labor and manufacturing to skill- and service-based jobs. In the 1960s, earning capacity became more related to a worker's skills and training than to his or her ability to perform physical labor. Advancements in technology, including computers and automated equipment, following World War II and the Korean Conflict reduced the need for physical labor. The goods-producing sector's share of the economy—mining, construction, and manufacturing—declined from about 44 percent in 1945 to about 21 percent in 1994. The service-producing industry's share, on the other hand—such areas as wholesale and retail trade; transportation and public utilities; federal, state and local government; and finance, insurance, and real estate—increased from about 57 percent in 1945 to about 80 percent in 1994.

While the shift to a more service-oriented economy may have had a positive effect on job opportunities for veterans with physical disabilities, it may have had the opposite effect for those with some mental impairments. However, new treatments and medications have made it possible for individuals with some mental illnesses to function more fully today. About 20 percent of the veterans on the disability rolls as of September 30, 1995, were receiving compensation for psychiatric and neurological conditions, whereas 80 percent were being compensated for general medical or surgical conditions, or physical disabilities (see table 4).

Table 4: Distribution of Veterans on the Rolls in FY 1995, by Degree of Disability and Major Medical Category

Degree of disability (percent)	Total number of veterans	Psychiatric and neurological conditions		General medical and surgical conditions	
		Number of veterans	Percent	Number of veterans	Percent
0	18,588	*	*	18,588	100
10	886,279	111,002	13	775,277	87
20	365,241	23,852	7	341,389	93
30	308,377	70,225	23	238,152	77
40	183,679	27,147	15	156,532	85
50	108,583	39,774	37	68,809	63
60	106,798	19,487	18	87,311	82
70	60,770	22,430	37	38,340	63
80	37,488	11,061	30	26,427	70
90	16,592	4,873	29	11,719	71
100	143,280	97,203	68	46,077	32
Total	**2,235,675**	**427,054**	**19**	**1,808,621**	**81**

*Not applicable.

Source: VA, Annual Report of the Secretary of Veterans Affairs—Fiscal Year 1995 (Washington, D.C.: VA, Mar. 1996).

In addition, in recent decades there has been a trend toward greater inclusion of and participation by people with disabilities in the mainstream of society. Changes in public attitudes toward people with disabilities have resulted, over the past 2 decades, in public policy requiring the removal of environmental and social barriers that prevent the disabled from fully participating in the workforce as well as in their communities. The Americans With Disabilities Act of 1990 (ADA), which supports the full participation of people with disabilities in society, fosters the expectation that people with disabilities can work. The act prohibits employers from discriminating against qualified individuals with disabilities and requires employers to make reasonable work place accommodations for these individuals.

Studies Have Found That Ratings Need [illegible]ating

Two major studies have been conducted since the implementation of the 1945 version of the schedule to determine whether the schedule constitutes an adequate basis for compensating veterans with service-connected conditions. One was conducted by a presidential commission in the mid-1950s and a second by VA in the late 1960s. Both concluded, for various reasons, that at least some disability ratings in the

schedule did not accurately reflect the average impairment in earning capacity among disabled veterans and needed to be adjusted.

The President's Commission on Veterans' Pensions, commonly called the Bradley Commission, was created in 1955 "to carry out a comprehensive study of the laws and policies pertaining to pension, compensation, and related nonmedical benefits" for veterans. As part of this study, the Commission examined VA's Schedule for Rating Disabilities. To determine whether the schedule at that time constituted an adequate and equitable basis for compensating disabled veterans, the Commission examined (1) the medical criteria in the schedule and (2) the disability ratings associated with these medical criteria.

On the basis of the results of a survey designed to obtain the views of medical specialists nationwide, the Commission concluded that the medical criteria in the schedule did not reflect the advances that had been made in medicine since 1945. The Commission also asked 169 physicians whether they believed the ratings fairly represented the average impairment of earning capacity resulting from the various degrees of severity of physical impairment. Forty percent of the 153 physicians who responded believed that the ratings fairly represented average impairment in earning capacity, 40 percent believed the ratings did not, and 20 percent did not respond or gave vague responses. Many of those who believed the schedule's ratings in general fairly represented average impairment of earning capacity, however, believed that the ratings for the lower disability percentages (usually below 30 percent) did not.

The Commission's comparison of the earnings and income of disabled veterans with the earnings and income of nondisabled veterans and others indicated that, with the exception of totally disabled veterans and elderly disabled veterans, there was little difference in combined median annual earned income of these groups. The Commission concluded that the amount of disability compensation seemed to make up for the difference in overall income between the two groups. But this compensation was not based on the average impairment in earnings capacity. The Commission observed that no studies had been conducted to measure the actual impairment in earnings capacity among the disabled, and the standard used to set disability ratings in the schedule was geared to the impairment of the individual who performs manual labor. Thus, because "functional physical capacity" has a major effect on a laborer's ability to work, the Committee concluded that physical impairment has been VA's predominant standard for setting disability ratings.

In addition to presenting the results of its study, the Commission pointed out that advances have been made in surgery, prosthetics, medical treatment, and rehabilitation since the schedule was revised in 1945 and that these advances could change the extent to which physical impairment affects earning capacity. The Commission also noted that the job market has shifted from predominantly manual labor jobs to more clerical and service-oriented jobs. Thus, the Commission concluded that the rating schedule tended to be less representative of the average impairment in earning capacity of veterans who performed nonmanual labor jobs.

The Commission's overall recommendation with regard to the schedule was that it should be revised thoroughly on the basis of factual data to ensure that it reflects veterans' average reduction in earning capacity, as required by law. The Commission stated that the basic purpose of the program is economic maintenance and, therefore, it is appropriate to compare periodically the average earnings of the working population and the earnings of disabled veterans, and update the schedule accordingly to help ensure that veterans are adequately compensated for the average reduction in earnings they experience as a result of their service-connected conditions.

In the late 1960s, VA conducted the ECVARS in response to the Bradley Commission recommendations and recurring criticisms that ratings in the schedule were not accurate. This study was designed to estimate the average loss in earning capacity among disabled veterans by calculating the difference between the earnings of disabled veterans, by condition, and the earnings of nondisabled veterans, controlling for age, education, and region of residence.[2] The ECVARS is the most comprehensive assessment of the validity of the ratings ever done. On the basis of the results, VA concluded that of the approximately 700 diagnostic codes reviewed, the ratings for 330 overestimated veterans' average loss in earnings due to their conditions, and about 75 underestimated the average loss among veterans. For example, for the disarticulation of an arm (amputation through the joint where the shoulder and arm join), VA estimated a 60-percent rating more closely approximated veterans' average reduction in earning capacity than the 90-percent rating listed in the schedule. VA also estimated that a 40-percent rating was more representative of veterans' average reduction in earning capacity for the disarticulation of the thigh (with the loss of extrinsic pelvic girdle muscles) than the 90 percent that was listed in the schedule. Some of the ratings that underestimated veterans' reduction in earning capacity were

[2]See app. I for a description of the scope and methodology of the ECVARS

assigned to mental conditions. For example, VA estimated that pronounced neurotic symptoms so severe that they would impair a veteran's ability to obtain or retain employment would result in an 80-percent reduction in earning capacity as opposed to the 70 percent listed in the schedule.

VA Has Not Taken Adequate Steps to Help Ensure That Ratings Reflect Loss in Earnings

VA has not systematically reviewed and adjusted the disability ratings in the schedule to reflect the current average impairment in earning capacity. Although the ECVARS found that many of the ratings in the schedule did not correspond to the actual earnings loss experienced by veterans, no changes were made to the schedule on the basis of these findings. Current revisions VA is making to the schedule focus on updating medical criteria, not on ensuring that disability ratings accurately represent the effect that service-connected conditions have on the average earning capacity of disabled veterans, and few adjustments are being made to ratings in conjunction with these revisions. When making adjustments to the ratings or adding conditions to the schedule, VA relies on its experience implementing the schedule and the responses it receives from the proposed rule-making process to help ensure that ratings are appropriate.

Ratings Were Not Changed on the Basis of the Results of ECVARS

On the basis of the results of the ECVARS, VA proposed adjustments to the disability ratings and produced a revised schedule that included ratings it believed more accurately represented the reduction in earning capacity that veterans experience as a result of their service-connected conditions. However, VA did not adopt this revised schedule. According to VA and VSO officials, the schedule was not adopted because VA believed that the Congress did not support it. Since the ECVARS was conducted, VA has not done another comprehensive study to systematically measure the effect of service-connected conditions on earnings.

Current Update Does Not Assess the Extent to Which Ratings Reflect Economic Loss

In a 1988 report,[3] we reviewed the medical criteria in VA's rating schedule to determine whether they were sufficiently current to ensure veterans were being given accurate and uniform percentage ratings. We found that VA could not ensure that veterans were given accurate and uniform ratings because the schedule had not been adjusted to incorporate recent medical advances at that time. We recommended that VA update the medical criteria in the schedule and keep them current. In response to these recommendations, VA is in the process of systematically updating the

[3]Need to Update Medical Criteria Used in VA's Disability Rating Schedule (GAO/HRD-89-28, Dec. 29, 1988)

medical criteria in the rating schedule. VA is reviewing each major body system in the schedule to ensure that the medical criteria for each diagnosis are up to date. The objectives of the current update are to make the criteria for assigning the disability ratings clearer, more objective, and accurate.

To date, VA has revised the medical criteria for 8 of the 16 body systems contained in the schedule. Revisions generally consist of such things as (1) wording changes for clarification or reflection of current medical terminology, (2) addition of alternative criteria, (3) addition of medical conditions not in the schedule, (4) deletion of conditions that through advances in treatment are no longer considered disabling, and (5) reductions in the time period for reevaluating unstable conditions.[4]

Few revisions involved the disability ratings themselves. Of about 68 diagnostic codes subject to revision in the first 4 body systems VA reviewed, the ratings for 12 were modified in some way. Of these 12 modifications, 3 resulted in obvious reductions in ratings, while none resulted in obvious increases.[5] None of these reductions in ratings, however, will result in lower ratings for veterans currently on the disability rolls. Federal law (38 U.S.C. 1155) specifies that changes in the rating schedule will, in no event, reduce a veteran's rating in effect when a change occurs, unless the veteran's condition has improved.

When a revision in the medical criteria or the addition of a new condition to the schedule requires VA to adjust or set ratings for conditions, these adjustments are generally based on the judgments of VA's Compensation and Pension staff. VA's goal is to maintain the internal consistency of the schedule over time by trying to ensure that new or adjusted ratings are consistent with the ratings of analogous conditions and reasonable relative to all others. For example, when VA added endometriosis to the schedule, it tried to find a condition already listed in the schedule that was analogous or comparable in terms of the physical impairment. On the basis of the Veterans Health Administration's medical monograph for this condition, VA determined that the most severe outcome of having endometriosis would be a hysterectomy, which was already in the schedule under another diagnosis and has a disability rating of 50 percent. VA, therefore, set the maximum evaluation for endometriosis at 50 percent.

[4]See app. II for examples of the types of changes made as a result of the current update of the rating schedule.

[5]See app. III for a summary of the types of changes made to the rating schedule as a result of updating 4 of the 16 body systems.

VA then set disability ratings for the less severe symptoms associated with endometriosis. In setting the rates for the less severe symptoms, VA Compensation and Pension personnel told us that they used their best judgment or experience, or both, to estimate the amount of time an individual might lose from work as a result of this condition. VA set the rating at 30 percent for moderate symptoms and 10 percent for milder symptoms (see table 5).

Table 5: Disability Ratings for Endometriosis

Symptoms	Disability rating (percent)
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy bleeding not controlled by treatment, and bowel or bladder symptoms	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control	10

VA's Process for Setting and Adjusting Ratings Does Not Factor in Loss in Earnings

When it proposes changes to the schedule, VA relies on its experience in implementing the schedule, on feedback from veterans and VSOs, and on the comments it receives from the public. According to VA officials, the feedback they have received from veterans and VSOs over time about the schedule and VA's experience implementing it indicate that veterans appear to be generally satisfied with the ratings in the schedule. The VSO officials we contacted believe that VA's disability rating schedule is a well-constructed document that has withstood the test of time. They also believe that ratings in the schedule generally represent the average loss in earning capacity among disabled veterans.

Under the proposed rule-making process, proposed changes to the schedule are published in the Federal Register, and veterans and others are given the opportunity to comment on these changes before they are adopted. According to VA officials, veterans have made relatively few comments on changes currently proposed, which they believe suggests that current changes are acceptable.

Because the schedule appears to be widely accepted, VA officials believe that the process they use is adequate to ensure that ratings fairly accurately represent veterans' average impairment in earning capacity, and therefore there is no need to further assess their appropriateness.

Using Data on Earnings Has Advantages in Determining Impairment in Earning Capacity

Although VA has chosen not to do so, using an estimate of actual loss in earnings to approximate loss in earning capacity would help VA make certain that veterans are compensated to an extent commensurate with the economic losses attributable to service-connected conditions. This would also help to ensure that disability compensation funds are equitably distributed among disabled veterans given today's work environment. Unlike judgments about loss in functional capacity, estimates of actual loss in earnings are objective and economic indicators of loss in earning capacity.

When the 1945 schedule was developed, no study was done to determine whether ratings based on loss in functional capacity correlated with disabled veterans' loss in earnings. Even if ratings did correlate with loss in earnings at that time, in 1956 the Bradley Commission found that they did not. The Commission recognized that the basic purpose of the program was economic maintenance and that it was appropriate to compensate disabled veterans on the basis of the average reduction in earnings they experience as a result of their service-connected conditions. It recommended updating the schedule periodically, primarily by using estimates of the average loss in earnings experienced by disabled veterans. The results of the ECVARS again illustrated that functional loss, even if it had correlated with economic loss in 1945, did not accurately approximate the economic loss associated with service-connected conditions in the late 1960s. When ratings based on functional capacity were compared with the estimated loss in earnings experienced by disabled veterans, they often did not coincide.

There are several advantages to using empirical data, as opposed to judgments, to determine impairment in earning capacity. Estimates of the loss in earnings resulting from service-connected conditions based on empirical data are objective and more reliable than individuals' judgments about the effect these conditions may have. Such judgments can vary greatly, as the results of the Bradley Commission's survey of physicians illustrate. Half of the physicians who responded to the survey believed the ratings in the schedule fairly represented the average loss in earning capacity resulting from the various degrees of severity of physical impairment. The other half disagreed.

Judgments about the effect certain conditions may have on the ability to function, work, or earn money do not allow VA to determine whether the program is compensating disabled veterans to an extent commensurate with their economic loss. If VA compared estimates of loss in earnings,

based on empirical data, for specific conditions with the ratings for these conditions, it could objectively determine whether the program was achieving this goal and was distributing disability compensation equitably.

It Is Feasible to Base Estimates of Impairment in Earning Capacity on Earnings Loss

The average impairment in earning capacity associated with specific service-connected conditions can be estimated by calculating the difference between what veterans with those conditions earn, on average, and what they would have earned if they did not have those conditions. The average loss in earnings associated with specific service-connected conditions can be determined by using widely applied research designs for estimating the effect of one variable on another. A number of decisions would have to be made, however, with respect to an overall methodology for a study that would produce these estimates, and a number of options are related to each. Each option has implications for the cost of such a study and the validity of its results. Our work suggests that it could cost between $5 million and $10 million to conduct a study like this.

Widely Applied Approaches Can Be Used to Quantify the Effect of Service-Connected Conditions on Earnings

Some generally accepted research designs for estimating the effect of one variable on another can be used to estimate the average loss in earnings associated with specific service-connected conditions. These designs are widely applied. While no study that measures the effect of service-connected conditions on earnings loss will give absolutely definitive results, many studies have demonstrated that it is possible to produce acceptable estimates of the impact of one variable on another. These designs have been used in policy analyses to examine the factors affecting the growth of Social Security Administration disability programs,[6] the role vocational rehabilitation plays in the tendency of disabled persons to return to work,[7] and the impact of job training on employment among ex-offenders.[8]

[6]K. Rupp and D. Stapleton, "Determinants of the Growth in the Social Security Administration's Disability Programs—An Overview," Social Security Bulletin, 58:4 (Winter 1995), pp. 43-70

[7]J.C. Hennessey and L. S. Muller, "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled Worker Beneficiary Back to Work," Social Security Bulletin, 58:1 (Spring 1995), pp. 15-28.

[8]M.A. Finn and K.G. Willoughby, "Employment Outcomes of Ex-Offender Job Training Partnership Act (JTPA) Trainees," Evaluation Review, 20:1 (Feb. 1996), pp. 67-83

Such designs have also been used in many studies that specifically measured the impact of such things as military service,[9] functional impairments,[10] and medical conditions such as epilepsy[11] and arthritis[12] on wages and earnings. VA's ECVARS is an example of one of these. It relied on a design that is often used in policy analysis and program evaluation to estimate the effect of service-connected conditions on the average earnings of veterans on the VA disability rolls at that time. Given that other studies have successfully employed methods for quantifying the effect functional impairment and specific disabilities have on earnings, these methods can also be applied to the question of how service-connected conditions affect disabled veterans' earning capacity.

Options for a Design and Methodology for Estimating Loss in Earnings

In deciding how to conduct a study to estimate the effect of disability on earning capacity, questions related to such things as scope and study design, data collection, and analysis would need to be addressed. The feasibility and cost of a study designed to estimate the effect of service-connected conditions on earnings would depend on the options chosen relative to each of these. Following are some options we identified during our review of the literature and discussions with experts.

Study Scope

The study's scope—how comprehensive and specific it should be—would need to be determined. Decisions about the scope will affect the overall cost and feasibility of the study and the validity of the results. The study could attempt to measure every condition's effect on earnings at each disability rating level or could select only certain conditions, depending on (1) the extent to which a condition is thought to represent or be represented by other conditions in the schedule or (2) the number of veterans on the rolls with that condition. The more conditions examined individually, the more costly and complicated the study is likely to be. However, estimates for individual conditions are more valid if those conditions are examined individually.

[9] R.R. Bryant, V.A. Samaranayake, and A. Wilhite, "The Effect of Military Service on the Subsequent Civilian Wage of the Post-Vietnam Veteran," The Quarterly Review of Economics and Finance, 33:1 (Spring 1993), pp. 15-31.

[10] M.L. Baldwin, L.A. Zeager, and P.R. Flacco, "Gender Differences in Wage Losses From Impairments: Estimates From the Survey of Income and Program Participation," The Journal of Human Resources, 29:3 (Summer 1994), pp. 865-87.

[11] M. Famulari, "The Effects of a Disability on Labor Market Performance: The Case of Epilepsy," Southern Economic Journal, 58:4 (Apr. 1992), pp. 1072-87.

[12] T. Pincus, J.M. Mitchell, and R.V. Burkhauser, "Substantial Work Disability and Earnings Losses in Individuals Less Than Age 65 With Osteoarthritis: Comparisons With Rheumatoid Arthritis," Journal of Clinical Epidemiology, 42:5 (1989), pp. 449-57.

Study Design

It is possible to quantify the effect of service-connected conditions on earnings by estimating the difference between the actual earnings of veterans on the disability rolls and what their earnings would have been if they did not have their service-connected conditions. The actual earnings of disabled veterans can be measured directly. If it were possible to control which veterans would incur service-connected conditions, veterans could be randomly assigned to groups with or without a disability, and the difference between the earnings of these two groups would constitute the effect of disability on earnings. Since this is not possible, what disabled veterans would have earned if they were not disabled has to be approximated.

The earnings of the disabled prior to the onset of their disabilities, or the earnings of a group of individuals who were not disabled, could be used for this approximation. Given the data requirements associated with estimating loss in earnings by comparing the earnings of veterans before and after the onset of disability, it may be more feasible to estimate this by comparing the earnings of disabled veterans with those of a comparison group of nondisabled individuals.

When using the difference between the earnings of the disabled and nondisabled to estimate the effect of a service-connected condition on earnings, the goal would be to use a nondisabled group that is similar in as many ways as possible to the disabled group. The more equivalent the two groups are, the more able we are to assume that the difference in earnings is the result of the condition and not some other factor. Veterans who are not on the disability rolls, therefore, would seem to be an appropriate comparison group. However, veterans not on the disability rolls may differ from disabled veterans in other characteristics that could explain earnings differences, including gender, age, and whether the veteran has been out of the workforce for reasons such as institutionalization. Some of these factors could be considered when selecting the final comparison group for the study or conducting the statistical analysis of the data (see next section).

ontrolling for Other Variables hat Affect Earnings

If the study design chosen compared the earnings of the disabled with those of the nondisabled, the simple difference between the two would not necessarily represent the effect of the condition on earnings. To isolate the condition's effect on earnings, other variables that may differ between the disabled and nondisabled group and also influence earnings would have to be controlled for. The more variables influencing earnings that are

controlled for simultaneously, the more valid the estimates of the effect of service-connected conditions on earnings.

Which variables to control for is another issue that the study's methodology would need to address. Some of the characteristics of both disabled and nondisabled veterans that are believed to have an impact on earnings are age, education, gender, race, and region of residence. The number of variables controlled for could influence the cost and complexity of the study.

Cross-tabulation and multiple regression are two statistical approaches that can be used to control for the differences in the characteristics of disabled and nondisabled veterans, other than disability status, that may account for the difference in earnings. Cross-tabulation would involve making comparisons of disabled with nondisabled veterans within potentially many different subgroups of the control variables (for example, age, gender, and education). Multiple regression allows the analyst to more efficiently analyze a larger number of variables simultaneously than does a series of cross-tabulations. Recent studies have used multiple regression to estimate the influence of different variables on wages and earnings.

ta Sources

Where and how to obtain data on earnings and the characteristics of veterans that may influence earnings is another decision to be made when developing an overall approach for this type of study. Existing administrative databases, such as Social Security Administration earnings records and Internal Revenue Service tax records, as well as data from national surveys, including the Survey of Income and Program Participation and the Current Population Survey conducted by the Bureau of the Census, contain information on earnings and, in some cases, other characteristics of the general population. These databases could be used in conjunction with information in VA administrative files to identify the effect service-connected conditions have on disabled veterans' earnings. If data from these sources do not meet the requirements of this study or it is not feasible to use these sources, original data need to be collected. If this approach is necessary, sampling and data collection strategies for surveys of veterans on and off the disability rolls would need to be developed.

Estimating Average ...nent in Earning ...acity

As a result of their experience with similar studies, officials at the Bureau of the Census estimated that it would cost between $5 million and $10 million to conduct a study to determine the average impairment in

earning capacity resulting from all, or nearly all, the conditions in the schedule. The precise cost would depend on the study's design and methodology.

Observations

VA's disability rating schedule has served as a basis for distributing compensation among disabled veterans relative to their level of impairment in earning capacity since 1945. The schedule's ratings do not, however, reflect the many changes that medical and socioeconomic conditions may have had on veterans' earning capacity over the last 51 years. Thus, the ratings may not accurately reflect the levels of economic loss that veterans currently experience as a result of their disabilities.

Estimates of disabled veterans' average loss in earnings attributable to specific service-connected conditions could be (1) compared with the ratings for these conditions to determine whether the ratings correspond to economic loss and (2) used to adjust ratings that do not reasonably reflect this loss. There are pros and cons, however, to developing earnings-based disability ratings.

It is uncertain what overall effect earnings-based ratings would have on total program outlays in the short term. Estimates of loss in earnings might show that ratings are appropriate and accurately represent the average loss in the earnings veterans experience. On the other hand, they might show that ratings assigned to some conditions are not appropriate and either overestimate or underestimate veterans' average loss in earnings. Even if a significant number of ratings in the schedule are reduced on the basis of these estimates, it would not result in any short-term reduction in program outlays. Veterans on the rolls are protected by law from being adversely affected if the disability ratings assigned to their conditions are reduced. If estimates indicate that some ratings should be increased, the Secretary of VA has the discretion to increase these ratings for veterans on the rolls at that time. If the Secretary decides to do so, in the short term, total program outlays would increase.

The long-term effect of an earnings-based schedule on total program outlays is also uncertain. Depending on (1) the number of ratings increased and reduced, (2) which rating levels change, (3) how much the levels change, and (4) the number of people that are affected by these changes over time, total program outlays might increase, decrease, or remain about the same over the long term.

It could cost between $5 million and $10 million to develop estimates of the average loss in earnings veterans experience as a result of specific service-connected conditions. The cost, however, represents a small fraction of the approximately $11.5 billion in disability compensation benefits paid to veterans in fiscal year 1995.

In our opinion, there is a distinct benefit to be derived from developing these estimates and using them to adjust disability ratings in the schedule. We recognize the uncertainty surrounding the effect that basing ratings on loss in earnings might have on long-term program outlays. However, we believe this uncertainty does not outweigh the benefit of ensuring that disabled veterans receive appropriate and equitable compensation. In addition, the cost of developing these estimates is not substantial relative to the program benefits paid annually.

Matter for Congressional Consideration

VA's disability ratings do not reflect the effect economic, medical, and other changes since 1945 may have had on disabled veterans' earning capacity. Therefore, the Congress may wish to consider directing VA to determine whether the ratings for conditions in the schedule correspond to veterans' average loss in earnings due to these conditions and adjust disability ratings accordingly.

Agency Comments

In commenting on a draft of our report, VA said that the "schedule as it is currently structured represents a consensus among Congress, VA and the veteran community" and that the "ratings derived from the schedule generally represent the average loss in earning capacity among disabled veterans." VA considers total disability to be "a purely medical determination," and it contends that changing the basis for the ratings in the schedule would serve no useful purpose. In addition, VA believes that "economic factors converge with" disability ratings primarily when the Congress establishes the amount of compensation payable for each disability rating level, and the Congress may adjust these amounts whenever it determines they are not appropriate.

VA also expressed concern that basing ratings in the schedule on average loss in earnings would (1) result in disparate awards based on such things as rank or education, (2) preclude the use of extra-schedular evaluations for exceptional disabilities, (3) not allow for meaningful input from VSOs, and (4) require annual revisions to the schedule to keep up with changing economic and vocational conditions.

Although the schedule may represent a consensus among the program's key stakeholders, there is no assurance that this consensus produces ratings for conditions in the schedule that accurately represent the average impairment in earning capacity currently associated with these conditions. Furthermore, while total, or 100 percent, disability may be a reasonable reference point from which to establish ratings for partial disability, we do not agree with VA's contention that disability is or should be solely a medical determination. Other programs define disability as loss in the ability to earn wages or work as a result of an impairment. An impairment is defined as a medical diagnosis of a specific abnormality, such as "paralysis of upper and lower limbs—one side."[13] Studies have shown that medical conditions are poor predictors of incapacity to work, that is, disability.[14]

We agree with VA that the Congress can adjust the rate—that is, the amount of compensation—it establishes for each rating level (10 through 100 percent) in the schedule when it believes that these benefit amounts are not appropriate. However, the primary responsibility to ensure that veterans are compensated commensurate with the average impairment in earning capacity they experience because of these conditions rests with the VA. This can be done by establishing ratings for conditions contained in the schedule that reflect veterans' average economic losses attributable to these conditions.

Basing ratings on estimates of the average earnings loss among veterans would not necessarily result in disparate treatment of veterans. Service-connected conditions that result in a high-percentage loss in earnings, on average, among veterans with these conditions would be assigned a rating higher than conditions that result in a low-percentage loss in earnings. As with the current schedule, veterans who have conditions that are assigned the same disability rating would receive the same basic monthly compensation regardless of such circumstances as their military rank or education.

We believe disability ratings in the schedule should be based primarily but not solely on estimates of veterans' average loss in earnings. Therefore,

[13]World Health Organization, International Classification of Impairments, Disabilities, and Handicaps (Geneva: World Health Organization, 1980).

[14]For example, see S.O. Okpaku and others, "Disability Determinations for Adults With Mental Disorders: Social Security Administration vs. Independent Judgments," American Journal of Public Health, Vol. 84, No. 11 (Nov. 1994), pp. 1791-95, and H.P. Brehm and T.V. Rosh, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

earnings-based ratings would not preclude extra-schedular evaluations. Nor would an earnings-based schedule prevent VA from obtaining and taking into account comments from VSOs and others when it revises the schedule just as it does today. Finally, the economists we consulted agreed that ratings based on earnings loss would need to be validated only once every 10 to 20 years to keep pace with changes in the economy and advances in medicine and technology that might influence the earning capacity of veterans with service-connected conditions.

We have modified the report where appropriate in response to VA's technical comments on the draft report. The complete text of VA's comments appears in appendix IV.

We are sending copies of this report to the Chairman and Ranking Minority Member of the Senate Committee on Veterans' Affairs; the Ranking Minority Member, Subcommittee on Compensation, Pension, Insurance, and Memorial Affairs, House Committee on Veterans' Affairs; other appropriate congressional committees; the Secretary of Veterans Affairs; and other interested parties. We will also make copies available to others on request.

If you have any questions about this report, please call Clarita Mrena, Assistant Director, at (202) 512-6812, or Sheila Drake, Evaluator-in-Charge, at (202) 512-7172. Other major contributors to this report are listed in appendix V.

Sincerely yours,

David P. Baine

David P. Baine
Director, Veterans' Affairs and
Military Health Care Issues

Contents

Letter	1
Appendix I Design and Methodology for the Economic Validation of the Rating Schedule	30
Appendix II Examples of Changes Made to the Rating Schedule During the Current Update	33
Appendix III Results of VA's Current Review and Update of the Disability Rating Schedule—Number and Types of Diagnoses Changed, by Type of Change	34
Appendix IV Comments From the Department of Veterans Affairs	35

Appendix V GAO Contacts and Staff Acknowledgments 38

Tables

Table 1: Number of Veterans Receiving Disability Compensation During FY 1995, by Degree of Disability 6
Table 2: VA Disability Compensation Rates During FY 1995, by Degree of Disability 8
Table 3: Total Compensation Paid During FY 1995 to Disabled Veterans, by Degree of Disability 9
Table 4: Distribution of Veterans on the Rolls in FY 1995, by Degree of Disability and Major Medical Category 13
Table 5: Disability Ratings for Endometriosis 18
Table III.1: Number of Diagnoses Added to and Deleted From the Schedule, by Body System 34
Table III.2: Changes in Medical Criteria—Number of Diagnoses Changed in Each Body System, by Type of Change 34
Table III.3: Changes in Disability Ratings—Number of Diagnoses Changed in Each Body System, by Type of Change 34

Figure

Figure 1: History of VA's Schedule for Rating Disabilities 5

Abbreviations

ADA	Americans With Disabilities Act of 1990
ECVARS	Economic Validation of the Rating Schedule
VA	Department of Veterans Affairs
VSO	veterans service organization

Design and Methodology for the Economic Validation of the Rating Schedule

Study Objectives

The Economic Validation of the Rating Schedule (ECVARS) was designed to provide information that could be used to

- estimate the average economic loss attributable to individual service-connected disabilities,
- recognize trends toward increases or decreases in the rate of economic loss that can be expected with the passage of time and aging of the veteran population,
- recognize and evaluate the basic differences between the disability evaluation policy of VA and that of other federal agencies for comparable disabilities, and
- formulate proposals for the refinement of the schedule on the basis of these estimates and evaluations.

Study Design

To determine the average impairment in earning capacity resulting from specific service-connected conditions on the rating schedule, the ECVARS calculated the difference between the median earnings of veterans on the VA disability rolls, grouped by their disability's diagnosis, and the median earnings of veterans not on the rolls. The earnings of nondisabled veterans were used to approximate what the earnings of disabled veterans would have been if they did not have their disability.

Sample Design

To estimate the average loss in earnings experienced by disabled veterans as a result of their specific service-connected condition, all disabled veterans on the disability rolls at that time were stratified into groups by the diagnosis assigned to their disability. While all disabled veterans in strata that contained 500 or fewer veterans were selected for this study, samples of disabled veterans were drawn from strata that contained more than 500. Sample sizes for each stratum ranged from about 200 to about 1,900 veterans.

In total, 485,000 of the approximately 2 million veterans who were receiving disability compensation when this study was done were chosen to participate. Not included were female veterans on the disability rolls, veterans with multiple disabilities, and veterans whose VA disability compensation was based on the 1925 schedule.

The ECVARS' estimates of the median earnings of nondisabled veterans were based on the earnings of a sample of noninstitutionalized, nondisabled veterans selected from lists of individuals in the general

population that the Bureau of the Census was using at that time to draw samples for its ongoing Current Population Survey. In total, approximately 14,000 nondisabled veterans were chosen for this survey.

Study Scope

The ECVARS did not validate all diagnoses on the schedule, nor did it validate each individually. Diagnoses that accounted for very small numbers of veterans on the VA disability rolls at that time were excluded from the study. Diagnoses with fewer than 200 veterans and similar symptoms were combined and validated as a single diagnosis. Diagnoses accounting for at least 200 veterans were validated individually unless they were what VA referred to as "adequately represented" by another diagnosis or group of diagnoses, in which case they were not validated. The ECVARS validated about 400 diagnosis strata, each containing at least one diagnosis from the schedule.

vey Methods

The ECVARS used a mail survey to collect data on earnings from disabled and nondisabled veterans. The Bureau of the Census administered this survey for VA. Census mailed out a total of approximately 500,000 questionnaires in February 1968, which asked the veterans for data on earnings and other characteristics during the prior year. Census mailed out two additional follow-up questionnaires to nonrespondents and conducted telephone and face-to-face interviews to obtain data from those who did not respond to the mail questionnaire. Data collection was completed in the first quarter of fiscal year 1969.

Method for Estimating Loss in Earnings

In addition to data on earnings, the ECVARS collected data on the age, education, and geographic residence of veterans. The age variable was split into four categories—under age 30; ages 30 to 49; ages 50 to 64; and age 65 and over. Education was classified as less than a high school graduate, high school graduate, and 1 or more years above high school graduate. There were two categories for the regional variable—the South and all other geographical regions.

When calculating the difference between the earnings of the disabled and nondisabled, each diagnosis stratum was paired with a unique "control" group that contained nondisabled veterans who were equivalent with respect to age, education, and region of residence to the disabled veterans in that diagnosis stratum. By controlling for the influence of these other

variables, the study attempted to isolate the effect that the service-connected condition alone had on earnings.

The ECVARS calculated a separate estimate of loss in earnings for each rating level associated with a specific diagnosis stratum. Study results were presented in terms of disabled veterans' annual dollar loss in earnings, disabled veterans' median percentage loss in earnings relative to the median earnings of nondisabled veterans, and disabled veterans' median loss in earnings relative to the median earnings of production workers.

Examples of Changes Made to the Rating Schedule During the Current Update

Diagnostic code	Old rating schedule	Revised rating schedule	Type of change	Rationale
7501	Kidney, abscess of: rate for residuals	Kidney, abscess of: rate as urinary tract infection	Change in criteria	New system of three general areas of dysfunction
7505	Kidney, tuberculosis of, active or inactive: active - 100; inactive - see 4.88b and 4.89[a]	Kidney, tuberculosis of: rate in accordance with 4.88b or 4.89,[a] whichever is appropriate	Change in wording	Editorial changes only
7619	Ovaries, removal of both: with complete extirpation and artificial menopause, for 6 months after excision - 100; thereafter, 30; removal of one with or without partial removal of the other - 10	Ovary, removal of: for 3 months after removal - 100; thereafter, complete removal of both ovaries - 30; removal of one with or without partial removal of the other - 0 (review for entitlement to special monthly compensation under 3.350 of this chapter)[a]	Change in convalescent period; change in heading; and change in evaluation criteria	To account for improved surgical techniques, to make this diagnostic code explicitly applicable to the removal of one and two ovaries, and to make removal of one ovary noncompensable because it does not ordinarily impair earning capacity

[a]Reference is to 38 C.F.R. parts 0-17 (1995).

Source: VA, Rating Schedule Amendments Training Package, Vol. II (Washington, D.C.: VA, 1995).

Results of VA's Current Review and Update of the Disability Rating Schedule—Number and Types of Diagnoses Changed, by Type c Change

Table III.1: Number of Diagnoses Added to and Deleted From the Schedule, by Body System

	Body system			
	Genitourinary	Oral/ dental	Gynecological	Hen lympha
Diagnoses before review/update	31	14	17	
Diagnoses eliminated	4	1	0	
Diagnoses remaining	27	13	17	
Diagnoses added	11	3	2	
Diagnoses after review/update	38	16	19	

Table III.2: Changes in Medical Criteria—Number of Diagnoses Changed in Each Body System, by Type of Change

	Body system				
Type of change in medical criteria	Genitourinary (out of 27 diagnoses)	Oral/dental (out of 13 diagnoses)	Gynecological (out of 17 diagnoses)	Hemic/lymphatic (out of 11 diagnoses)	(o diag
Wording change	8	3	11	5	
Criteria changed	17	0	10	7	
Alternative criteria added	2	1	0	2	
Reduction in minimum convalescence period before medical reevaluation	2	0	3	1	
Increase in minimum convalescence period before medical reevaluation	0	0	0	0	

Table III.3: Changes in Disability Ratings—Number of Diagnoses Changed in Each Body System, by Type of Change

	Body system				
Type of change in rating	Genitourinary (out of 27 diagnoses)	Oral/dental (out of 13 diagnoses)	Gynecological (out of 17 diagnoses)	Hemic/ lymphatic (out of 11 diagnoses)	(ou diag
Reduction in existing rating	1	0	1	1	
Increase in existing rating	0	0	0	0	
Addition of new evaluation levels or combination of evaluation levels	1	1	0	5	
Elimination of minimum percentage evaluation	1	0	1	0	

Appendix IV

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Washington DC 20420

NOV 08 1996

In Reply Refer To: 213A

Mr. David P. Baine
Director, Veterans' Affairs
and Military Health Care Issues
United States General Accounting Office
Washington, DC 20548

Dear Mr. Baine:

Thank you for the opportunity to respond to your draft report entitled VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses (GAO/HEHS-97-9). The major conclusion of the report is that it is likely that some of the ratings in the current rating schedule do not reflect the economic loss experienced by veterans today and that Congress may wish to consider directing VA to conduct a study to determine whether current disability ratings correspond to average loss in earnings and to adjust the schedule accordingly.

Compensation is a critical cost of our nation's capacity to maintain a strong national defense. Until a rating schedule was adopted after the War Risk Insurance Act of 1917, officers received a higher level of compensation than enlisted men for the same disability. Maintaining the rating schedule is one way of precluding disparate awards based on rank, education, social status, or any other arbitrary factor. The rating schedule as currently structured represents a consensus among Congress, VA, and the veteran community about an equitable way to determine compensation for America's disabled veterans. As your draft report points out, veterans service organization officials believe that the rating schedule is a well-constructed document that has withstood the test of time and that the ratings derived from the schedule generally represent the average loss in earning capacity among disabled veterans. We concur with this basic assessment. We don't believe change in the basis of a rating schedule that has served so well and so long should be undertaken, or would serve any useful purpose.

We have enclosed a paper stating in more detail some specific concerns we have about the draft report. In addition, we noted a few factual errors and have pointed them out in another enclosed paper.

Thank you again for the opportunity to offer our comments on the draft of your report.

Sincerely yours,

Stephen R. Lemons
Deputy Under Secretary for Benefits

Enclosures

AREAS OF CONCERN REGARDING THE DRAFT REPORT

CURRENT RATING SCHEDULE REVIEW

In response to recommendations contained in a previous GAO report, (VETERANS' BENEFITS: Need to Update Medical Criteria Used in VA's Disability Rating Schedule (GAO/HRD-89-28)), VA has completed approximately half of the first comprehensive review of the medical criteria in the schedule since 1945. The review process has been a deliberative one. We solicited recommendations from non-VA medical specialists as well as the Veterans Health Administration. We also made sure that the veterans service organizations had the opportunity to be involved at several stages in the process by publishing advance notices of proposed rulemaking for each body system to solicit input before we began drafting changes, as well as publishing proposed changes for public review and comment before adopting final revisions. The rating schedule as it is currently structured therefore represents a consensus among Congress, VA and the veteran community. As the draft report clearly indicates, veterans service organization officials believe that the rating schedule is a well-constructed document that has withstood the test of time and that the ratings derived from the schedule generally represent the average loss in earning capacity among disabled veterans.

MEDICAL-BASED CRITERIA FOR RATING SCHEDULE

VA's rating schedule is based on medical criteria that establish higher evaluations for more severe medical conditions, an approach that is consistent with those adopted by other disability programs. Workers' Compensation claims, for example, are generally assessed under the American Medical Association Guides to the Evaluation of Permanent Impairment. The Guides were established to bring greater objectivity to estimating the degree of permanent impairments by evaluating how they affect a patient's daily activities and occupation. Medically-based ratings are no more theoretical and abstract than ratings based on average earnings impairment as measured by an economic study, which must take into account numerous variable factors.

CONCEPT OF TOTAL DISABILITY IS A MEDICAL DETERMINATION

The concept of total disability, the point where an individual's functional capacity is so diminished that the performance of work is infeasible for the average person, is a purely medical determination and, as indicated by the considerable agreement across different disability systems as to what constitutes total disability for different conditions, is a sound reference point for evaluation. For example, certain pulmonary function test values are considered to be indicative of total disability by VA, by the AMA Guides, and by the American Thoracic Society. Partial disability is some smaller percentage of total disability, and the best way to quantify it is by comparison of the partial loss of function to total disability.

NEED FOR EXTRA-SCHEDULAR EVALUATIONS FOR EXCEPTIONAL DISABILITIES

In some cases, where there is extreme facial disfigurement, for example, or other catastrophic condition, the adverse impact on the quality of life, above and beyond the direct economic impact, must be taken into consideration to assure adequate compensation. Extra-schedular compensation helps to assure an equitable evaluation in such conditions.

FAIR, EQUITABLE, AND CONSENSUS-BASED SCHEDULE NEEDED

The current schedule establishes a method for evaluating the disabilities of veterans that is fair and equitable and that treats disparate disabilities with roughly equivalent disabling effects in a consistent manner. In our judgment, this consistency of approach helps reassure the veteran

community that the rating schedule is a valid document for evaluating disabilities, and we would argue against an approach that does not allow for meaningful input from the veterans service organizations. The study recommended by your draft report is just such an approach. Revising the schedule on a purely statistical basis would leave little, if any, leeway for addressing valid concerns that the veteran community might raise. Since it is essential that we maintain the consensus that has been built up over the years if the disability compensation program is to continue to work, all concerned parties must be involved in any attempt to revise the basis of the schedule. Prior to the development of the first rating schedule in 1919, compensation for service-connected disability was based on both rank and degree of disability, with officers receiving a higher amount. The maintenance of the rating schedule is important in preventing a return to disparate treatment based on rank, education, etc.

ECONOMIC FACTORS AND DISABILITY EVALUATION

Economic factors converge with disability evaluation primarily at the point where Congress establishes the compensation rates for total and partial disability. Whenever Congress feels these rates are not appropriate, it may adjust them.

CURRENT SCHEDULE CONSISTENT WITH FISCAL RESTRAINT

The rating schedule is the cornerstone of a complex benefit system that is a responsible and reasonable means of addressing the needs of disabled veterans. Considering the amounts of some disability claims awarded by state courts presents a striking contrast to compensation awards for veterans. In a California case, for example, a 50 year old man who was struck by a bus and rendered quadriplegic received a nine million dollar settlement. That is a significantly larger amount than a veteran rendered quadriplegic by battle wounds at a much younger age would receive over the course of a lifetime from VA compensation. Veterans, however, are not on their own when it comes to health care, vocational rehabilitation, or providing for their survivors because the compensation determined from the ratings in the schedule is but one part of a comprehensive system designed to meet the obligations of a grateful nation to its disabled veterans at a reasonable cost to the government.

STABILITY OF MEDICALLY-BASED RATING SCHEDULE

Relying on economic considerations as the sole basis of disability evaluations would lead to instability of the rating schedule because frequent revisions would be needed to keep pace with changing economic, as well as vocational, conditions. On the other hand, relying on medically-based ratings allows a more stable rating schedule because medical change proceeds more slowly than economic change. Maintaining a rating schedule based on economic validity is likely to require an annual cost, rather than the projected one time cost, of $5 to $10 million, for economic studies.

CURRENT SCHEDULE WORKS WELL

Disabled veterans are being equitably compensated using a medically-based rating schedule with reliable and valid guidelines for measuring disability. The current schedule is efficient, it works, and we see no reason to validate the ratings solely from an economic perspective

Appendix V

GAO Contacts and Staff Acknowledgments

GAO Contacts

Clarita Mrena, Assistant Director, (202) 512-6812
Shelia Drake, Evaluator-in-Charge, (202) 512-7172

Staff Acknowledgments

The following individuals made important contributions to this report: Connie D. Wilson, Senior Evaluator, collected a major portion of the evidence presented; Timothy J. Carr, Senior Economist, reviewed the literature on the relationship between disability and earnings and provided advice on methodology; Steven Machlin, Statistician, provided guidance on research design and statistical methods; and Stefanie Weldon, Attorney, served as legal advisor.

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOSEPH A. VIOLANTE
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE JACK QUINN
CHAIRMAN
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON BENEFITS
MAY 14, 1997 HEARING

Question One: DAV states that Gulf War veterans appear to be sicker and more severely disabled than their predecessors. On what do you base that statement?

Answer:

This statement was based on both personal observations and the observations of DAV National Service Officers. It has now been more than six years since the fighting ceased in the Persian Gulf theater and the majority of U.S. veterans returned home, yet there has been no noticeable decrease in the number of new claims being filed by Gulf War veterans as a result of illness believed to be associated with their service in that theater.

Question Two: DAV notes that some Gulf War claims contain 30-40 issues. While a veteran should submit a claim for any legitimate disability or illness, doesn't such claims needlessly lengthen processing time for everyone?

Answer:

Certainly, claims containing 30-40 issues lengthen the processing time for claims; however, in many cases, the men and women being separated from service are encouraged to file claims for **all disabilities or illnesses** shown in their service medical records. In some cases, DAV National Service Officers are able to reduce the number of issues presented to only chronic disabilities or illnesses. Many veterans are concerned that their right to file a new claim in the future will be restricted, (a recommendation made by the Adjudication Commission) therefore, they want to present a claim containing all possible disabilities, notwithstanding the fact that it is not a chronic disability or presently manifested.

Question Three: You have voiced opposition to the VA's proposed restrictions on compensation for smoking-related illnesses citing things like a lack of warning labels, DOD's promotion of smoking and the addictive qualities of smoking. Could we not see DOD's attitude towards smoking as accommodating an existing socially acceptable personal behavior rather than promotion, and if smoking is addictive, doesn't that qualify as an abuse under section 1110 and therefore should not be compensable?

Answer:

Regardless of whether one considers DOD as merely "accommodating" rather than promoting an "existing socially acceptable personable behavior," the fact remains that veterans should not be treated as second class citizens. Should veterans be the only class of citizens to have their ability to receive compensation or medical treatment limited or prohibited because their disability is due in whole or in part to smoking?

Under some workers' compensation decisions, employees that have sustained injuries because of their consumption of employer-provided alcoholic beverages at employer-sponsored functions have been able to recover workers' compensation benefits, even though the drinking was voluntary and was done after hours. This seems even more egregious because the risks of alcohol are largely known, whereas public knowledge of the risks of smoking is relatively recent

It has not been until recently that the true extent of the addictive nature of smoking has been brought to light by the tobacco companies. Regardless, there is no basis to consider smoking to be the result of either willful misconduct or abuse of alcohol or drugs pursuant to 38 U.S.C. §1110.

Question Four: How would you limit compensation of smoking-related illnesses, if at all?

Answer:

The only limitation on compensation for disabilities resulting from smoking that we would consider would be to prospectively limit compensation to those men and women entering service after the enactment of such legislation. In this way, men and women entering military service will have adequate notice that potential disability compensation could be put in jeopardy because they choose to smoke.

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

May 23, 1997

The Honorable Jack Quinn, Chairman
Subcommittee on Benefits
Committee on Veterans' Affairs
United States House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Quinn:

In accordance with your [redacted] invitation, I write to provide you with the comments of the Disabled American Veterans (DAV) on the [redacted] of [redacted]

Veterans' claims for the benefits provided under the VA's compensation and pension program are processed at the VA's 58 regional offices, and most of the administrative functions associated with delivery of the benefits take place there as well. The program management and policy making functions are performed by C&P staff located at VA's Central Office here in Washington, D.C.

Of VA's various programs, none has perhaps been the source of more frustration and complaints in recent years than its compensation and pension program. The DAV attributes that to several factors. First, eligibility determinations for other VA benefits are much simpler in that they are governed primarily by such factors as the period, length, and character of service. Entitlement is essentially automatic where the veteran has the required service. Veterans expect good service from these programs, and they generally meet expectations. The complexity inherent in disability benefit determinations makes the compensation and pension program much more difficult to operate. The determination of entitlement goes far beyond basic eligibility requirements. Objective and subjective information must be weighed carefully with appreciation for the nuances and an understanding of the esoteric language of medicine and disability evaluation. Difficult questions of cause and effect are often confounded by concurrent or intervening factors. This necessitates extensive rules, some covering areas not susceptible to simple language. This area of law can be learned and effectively applied nonetheless; thus, the complexity does not excuse incorrect application or omission of the controlling rules.

Second, because of what has been referred to as VA's "splendid isolation" during the years before judicial oversight, VA adjudicators did not appreciate the supremacy of the law over personal beliefs about the merits of veterans' rights or even over administrative convenience. What may have started as conservative views about the treatment that should be accorded veterans' evidence or cases in certain regularly encountered situations probably grew into outright arbitrary practices and unwritten rules that either ignored the veteran's rights in law or even directly contravened the law. These unwritten rules were no secret and were sometimes discussed openly, even sometimes stated as reasons for denial of claims. The advent of judicial review brought enforcement of the letter and spirit of the law, and that exposed the widespread deficiencies in VA decisionmaking. The effect of judicial review shocked the VA system, and the adjustment to this new climate has been a challenge for VA because the old mindset is so deeply ingrained in its adjudicators.

In the early years of judicial review, there was some intransigence on VA's part. There was no effective effort to bring decisionmaking into conformance with the law and the Court's pronouncements on the law. Because the decisions of the Board of Veterans' Appeals were directly under the eye of the Court, the Board was forced to comply more closely with the law. Its allowance rates rose from the historic annual average of about 12% to around 20%. Its remand rates rose to close to 50% at times. This added work involving appeal cases in the regional offices was enough to clog an already saturated system. These effects were of course made worse by added claims from military downsizing and the Persian Gulf war. Claims backlogs grew, and delays became protracted.

With the results from VA's Business Process Reengineering (BPR) study, came a change in direction from VA's C&P service. VA acknowledged that poor quality was at the root of its claims backlog and timeliness problems. VA's BPR plan became its blueprint for fixing the system. Its BPR plan also became C&P's GPRA Business Line Plan for the fiscal year 1998 budget submission, and we assume that this and plans from the other VBA business lines will be integrated with the plans of the other administrations within VA to form the agency's strategic plan.

We believe that the BPR plan correctly identifies the major problems responsible for the backlog and timeliness problems in compensation and pension claims. We also believe that the plan includes the correct solutions. However, the success of the plan depends to two things: the details of implementation and the level of management's determination to bring adjudicators into compliance. Some of the most important details will be the standards and parameters for quality measurement. The level of determination will be reflected in the strength and effectiveness of the accountability mechanisms that are put in place and the level of enforcement.

As is required by GPRA, VA has been consulting with stakeholders in developing the details of the plan. Formulation of the implementation procedures has been assigned to various committees. Some of the members are from the regional office adjudication divisions.

The Honorable Jack Quinn
May 23, 1997
Page 3

Unfortunately, some of these individuals have attempted to use their position to insert recommendations for changing certain substantive or fundamental procedural elements of the programs. Some of these recommendations were not tied to any increased efficiency, but rather removed or altered some aspect of the program that the individual or individuals apparently had some personal disagreement with in principle. We have pointed out to C&P that such efforts pervert the BPR effort and tend to damage the cooperative spirit and effort between VA and stakeholders. Most of our concerns to date have been rapidly and satisfactorily addressed.

Accordingly, without getting into the details of C&P's GPRA plan, which we are sure VA will provide you, we must say that we are quite pleased and more encouraged about C&P's strategic direction and sincerity than we have been in recent memory. It is our belief that the soundness of the plan cannot be tested without moratorium on interference from outside, however. The veterans' community and Congress have properly been quite critical of C&P's past inaction. Now that C&P has a strong plan and gives all appearances of being serious about making improvements, we should give them a chance and necessary time and resources to do so. That does not mean we should not monitor and help them along the way or not advise them when they are getting off track. Congressional and stakeholder involvement is expected under GPRA. It does mean that we should hold off in imposing recommendations from the Veterans' Claims Adjudication Commission and others that do not harmonize with the BPR approach. Additionally, many of the Commission's recommendations would involve program changes detrimental to veterans that do not increase efficiency at all—they merely reduce VA's work by reducing veterans' access and entitlement to benefits. Moreover, if BPR is successful, such adverse actions may never become justifiable.

We therefore urge you to support C&P's BPR plan and to provide the investment in resources necessary initially to achieve the long-term efficiencies and cost-savings.

Sincerely,

RICK SURRATT
Assistant National Legislative Director

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOSEPH A. VIOLANTE
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE LANE EVANS
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON BENEFITS
MAY 14, 1997 HEARING

Question One: Do you believe that VBA has worked with you and taken your concerns seriously about inefficiencies and errors in the processing of Gulf War claims?

Answer:

Initially, VBA was slow to act on our concerns. However, for the most part, VBA is beginning to address many of our concerns regarding the handling of Gulf War claims. However, we are closely monitoring the situation to determine if VBA will properly handle our concerns regarding the scope of the VA's fourth review of Gulf War claims and our concern that many Gulf War veterans are underrated.

Question Two: The Committee has been concerned that the VBA has not adequately informed Gulf War veterans of the development needed to claim benefits for undiagnosed illnesses. In particular, VBA failed to inform veterans that "lay statements" could be used as evidence in claiming benefits. Could you please give us your recommendations of the type of outreach VBA should perform to inform veterans of the information they need to claim benefits?

Answer:

When a veteran files a claim for service connection, he or she should be provided a fact sheet outlining the type of evidence, i.e., service medical records, private medical records and lay statements, necessary to establish a claim for service connection. Each type of evidence should be briefly described so that the veteran can understand what is required and how each type of evidence can be used to support his or her claim. It is exactly this type of information, and more, that DAV National Service Officers solicit from veterans in order to best assist and represent them in their claims with the VA for disability and other benefits.

Question Three: How do you view centralization of claims processing in general? Do you see any lessons learned in your experience with the centralization of Gulf War claims?

Answer:

In general, the centralization of claims processing for insurance and education claims is working without any adverse impact on VA claimants. With respect to compensation claims, however, centralized claim processing is fraught with many problems. As evidenced by the fiasco of centralization of Gulf War claims, centralization of compensation claims processing does not appear to be working. We are beginning to also hear concerns with the centralization of POW claims processing.

As we saw with the processing of Gulf War claims in four area processing offices, the allowance rate for undiagnosed illnesses varied greatly from a high of 20% in the Western area to a low of almost 5% in the Southern area. A number of factors could account for this huge variance in the allowance rate, such as training, biases, workloads, or claim development, to name a few. It would be interesting to determine which factors were responsible for such a wide variance in the allowance rate. The handling of Gulf War claims has also further reinforced our belief that it is important that veterans and their representatives have access to the decision makers. Statistics demonstrate that veterans fare much better when they are able to meet face to face with the decision maker. The ability to observe the demeanor of a veteran claiming to be suffering from various illnesses assists an adjudicator in reaching a fair and equitable decision.

If there are any lessons to be learned as a result of the centralization of Persian Gulf claims, it is that, under the current structure and within current resources, the process does not work very well. Many veterans are frustrated because of the logistic hassles involved in having their claims adjudicated in another location -- they want to deal directly with the National Service Officer who will be handling their claim.

Question Four: How do you view the VA's goal of a 92 percent accuracy rate for claims?

Answer:

The VA's goal of 92 percent accuracy rate for claims is very admirable; however, it depends on what factors the VA is using to determine accuracy. For years, the VA has stated that they have had a 97 percent accuracy rate, yet two thirds of the cases appealed to the Board of Veterans' Appeals were either remanded or overturned on appeal and, of the cases appealed to the Court of Veterans Appeals, more than 50 percent of those appeals decided on the merits were reversed, vacated, or remanded, in whole or in part.

Question Five: In your view, are the criteria used to determine accuracy in the adjudication process useful in measuring the effectiveness of the claims adjudication process? How should effectiveness be measured? What should be measured to determine effectiveness?

Answer:

The bottom line in determining the effectiveness of the claims adjudication process should be whether the claim was properly decided the first time. To determine whether a claim was accurately decided, all that is necessary is to determine whether the case was properly developed and, if so, were the pertinent statutes, regulations, and case law properly applied to the correct facts, resulting in a legally sound conclusion.

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★ FAX (202) 861-2728 ★

June 6, 1997

Honorable Jack Quinn
Chairman
Subcommittee on Benefits
Committee on Veterans Affairs
U.S. House of Representatives
335 Cannon House Office Bldg.
Washington, DC 20515

Dear Congressman Quinn:

Attached please find The American Legion's answers to the questions posed in your letter of May 29, 1997 concerning compensation for smoking- related illness. I hope that the answers adequately respond to the questions, and if I can be of any further service, please do not hesitate to call.

Sincerely,

MATTHEW L. PUGLISI
Assistant Director
Gulf War Programs

1. You have voiced opposition to the VA's proposed restrictions on compensation for smoking-related illnesses citing things like a lack of warning labels, DoD's promotion of smoking and the addictive qualities of smoking. Could we not see DoD's attitude towards smoking as accommodating an existing socially acceptable personal behavior rather than promotion, and if smoking is addictive, doesn't that qualify as an abuse under section 1110 and therefore not be compensable?

2. How would you limit compensation of smoking related illnesses, if at all?

Regrettably, we cannot provide you with a response, as requested. Question 1 mistakenly indicates that "You have voiced opposition to the VA's proposed restrictions on compensation for smoking-related illnesses....." However, at the May 14th hearing, The American Legion did not testify either in support of or in opposition to the VA's proposal to restrict tobacco-related claims.

We are aware that VA included a statement in their FY 1998 budget proposal that legislation would be sought to restrict such claims. However, we have no specific information concerning the details of this change in policy. To our knowledge no legislation has been introduced.

The American Legion has no mandate to reevaluate or reassess its historical policy of representing veterans to the maximum extent possible in claims for any benefits to which they may be entitled under the law. We have kept our service officers informed of the new guidelines on the development and adjudication of smoking-related illness claims issued to the regional offices by the Compensation and Pension Service in January and February 1997, and the most recent VA General Counsel Precedent Opinion of May 13 (VAOGCPREC 19-97).

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

May 21, 1997

Honorable Jack Quinn
Chairman
Subcommittee on Benefits
Committee on Veterans Affairs
House of Representatives
335 Cannon House Office Bldg.
Washington, DC 20515

Dear Congressman Quinn:

This is in response to your letter of April 21, 1997 requesting the views of The American Legion on VA's implementation of the Government Performance and Results Act (GPRA).

The GPRA mandate has presented a major challenge for VA. We believe VA has made considerable progress in developing the framework of their strategic plan and a spectrum of initiatives and changes intended to achieve the requirements of GPRA and provide improved service in a more cost-effective manner. We are supportive of their efforts, but have some concerns.

VA's initial strategic planning efforts have not been without controversy and criticism. As an example, last year, as part of the Business Reengineering plans, a number of field restructuring initiatives were developed. With some, we thought there was adequate supporting data and justification for their implementation. There were several which would have involved the closure of several regional offices and major workload shifts. The plans for these initiatives lacked the necessary supporting documentation and justification as required by law. There was nothing, other than VA's promise that such changes would result in the projected service improvements and cost savings. Upon

further examination and consideration, the Secretary stopped action on these initiatives.

We are concerned that many other ongoing and planned initiatives, while well intentioned and provide conceptually appealing solutions, lack the necessary performance goals and measures. Similarly, the current system cannot provide the type of information and data needed for effective operational management, forecasting, and determining true resource needs.

Recently, we have noted the comments, conclusions and recommendations of the Veterans Claims Adjudication Commission regarding the shortcomings and deficiencies in its strategic management process and plans, including the question of Department leadership. The VCAC report also expressed the view that VA's effort to incrementally improve and fine tune the adjudication process were not going to be successful. The Chairman of the National Academy of Public Administration, Milton Socolar, in his testimony before the Senate Appropriations Committee expressed the opinion that the VA, as an institution, lacks the capacity for integrated strategic management. He recommended VA reexamine and improve the analysis, approach, and management of the BPR program along with a number of other fundamental management and programmatic changes. The May 14, 1997 Report by GAO on VBA's progress and challenges in implementing GPRA also noted that VA has made progress toward developing a strategic plan. Their criticism of current strategic plan is that it still remains process oriented rather than truly results oriented. It lacks the necessary integration of other programs within VA as well as those of other Federal agencies. Appropriate performance goals and measure needed to be developed.

The development of VA's strategic plan and its many components has been and will continue to be an evolutionary process. The task is enormously complex. VA is under tremendous pressure to make the transition to a more integrated, strategically managed system within a relatively short span of time in order to meet not only GPRA requirements but the balanced budget.

We believe it is important that VA reexamine and reevaluate its plans in light of the criticism and recommendations these various groups.

In addition, VA should also be trying to determine why claims processing timeliness has steadily worsened over the last 6 months and why productively has similarly declined. According to VA's data, VBA will not be able to meet its FY 1997 goals for the most part which will make it difficult if not impossible to meet the ambitious FY 1998 goals. VETSNET and BPR are major components of VA's strategic plans and hold great promise for dramatically improving claims processing by 2002. However, these initiatives have yet to demonstrate that can succeed. Given stakes involved, failure or even partial success will seriously jeopardize VA entire strategic plans.

Another issue which we discuss in our testimony for the May 21st hearing before the full Committee is the lack of accurate and reliable workload data. Unless and until this improves many key assumptions, decisions, and plans are open to serious question. We recommend VA give make correction of this situation one of its highest priorities.

We appreciate this opportunity to comment on these important issues.

Sincerely,

Philip R. Wilkerson
Dep. Dir. for Operations
National VA&R Commission

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★ FAX (202) 861-2728 ★

June 13, 1997

Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Congressman Evans:

Attached please find The American Legion's answers to the questions contained in your June 2, 1997 letter. The questions concerned the Subcommittee on Benefits Hearing of May 14, 1997 on the processing of Persian Gulf Claims and VA's proposed legislation to limit the liability for smoking-related illnesses.

I hope that the questions adequately address the questions. If I can ever be of further service, please do not hesitate to contact me.

Sincerely,

MATTHEW L. PUGLISI
Assistant Director
Gulf War Veterans

**ANSWERS TO FOLLOW-UP QUESTIONS
FROM THE HONORABLE LANE EVANS FROM THE
SUBCOMMITTEE ON BENEFITS HEARING OF MAY 14, 1997**

1. *DO YOU BELIEVE THAT VBA HAS WORKED WITH YOU AND TAKEN YOUR CONCERNS SERIOUSLY ABOUT INEFFICIENCIES AND ERRORS IN THE PROCESSING OF GULF WAR CLAIMS?*

Yes. The Director of the Compensation and Pension Service holds quarterly Veterans Service Organization (VSO) meetings to address questions and concerns of the VSOs. These meetings, combined with reports and congressional testimony prepared by The American Legion, have enabled VBA to understand what our concerns are regarding Gulf War claims. Although change has come slowly to VBA concerning the processing of these claims, VBA has eventually instituted all of The American Legion's recommended changes to the Gulf War claims system.

2. *THE COMMITTEE HAS BEEN CONCERNED THAT THE VBA HAS NOT ADEQUATELY INFORMED GULF WAR VETERANS OF THE DEVELOPMENT NEEDED TO CLAIM BENEFITS FOR UNDIAGNOSED ILLNESSES. IN PARTICULAR, VBA FAILED TO INFORM VETERANS THAT "LAY STATEMENTS" COULD BE USED AS EVIDENCE IN CLAIMING BENEFITS. COULD YOU PLEASE GIVE US YOUR RECOMMENDATIONS AS TO THE TYPE OF OUTREACH VBA SHOULD PERFORM TO INFORM VETERANS OF THE INFORMATION THEY NEED TO CLAIM BENEFITS?*

There are a number of ways that VBA can address this problem. First, VBA must keep veterans' advocates informed about all aspects of veterans' cases. The APO system usually prevented this from occurring, but the de-centralization of the claims process should facilitate VBA-VSO communication.

VBA should also work more closely with other organizations within VA, such as the Vet Centers and VAMCs. These organization have veterans seeking care and benefits, and VBA should assure that these groups are providing veterans with accurate and timely information regarding Gulf War claims.

3. *HOW DO YOU VIEW CENTRALIZATION OF CLAIMS PROCESSING IN GENERAL? DO YOU SEE ANY LESSONS LEARNED IN YOUR EXPERIENCE WITH THE CENTRALIZATION OF GULF WAR CLAIMS?*

Centralization of claims was a failure that The American Legion opposed from the beginning because of its inherent weaknesses. Removing the veterans' advocate from the claims process lead to inadequate development of these claims, and this in turn contributed to the low allowance rate. Training will be the key in making the de-centralization process a success, as was evident in the performance of the Phoenix Area Processing Office (APO). Its adjudicators received the most specialized training relative to the other APOs, and its allowance rate was the highest.

4. *HOW DO YOU VIEW THE VA'S GOAL OF A 92 PERCENT ACCURACY RATE FOR CLAIMS?*

VBA should have always had a "zero tolerance" error rate as a priority management goal. Veterans deserve nothing less. The fact that the system continues to tolerate poor quality decision making only adds to the already heavy workload burden and squanders resources which are increasingly in short supply.

VBA has reported that its quality assurance surveys showed that the national accuracy rate of claims adjudication has remained very high at about 95-96 percent, over the last several years. Information would be provided describing current performance to support their optimistic goals for better and faster service in the years to come. However, in the FY 1998 budget submission to Congress, VBA now states that "Data indicates that a significant number of decisions on original and reopened claims contain flaws from the customer's perspective." Based on various BPR initiatives, VBA projected the accuracy rate would improve from 90 percent in FY 1996 to a goal of 97 percent by FY 2002.

In light of the continuing staffing, workload, and other problems which have a direct impact on the quality of adjudication decisions, it would not be unreasonable to conclude VBA's past statements concerning accuracy lack credibility. Is a 92 percent accuracy rate goal for 1998 any more credible than prior goals? Is an 8 percent error rate acceptable? How does this revision affect VBA's current performance measures and projected future resource needs? We cannot say, at this point in time.

5. IN YOUR VIEW, ARE THE CRITERIA USED TO DETERMINE ACCURACY IN THE ADJUDICATION PROCESS USEFUL IN MEASURING THE EFFECTIVENESS OF THE CLAIMS ADJUDICATION PROCESS? HOW SHOULD EFFECTIVENESS BE MEASURED? WHAT SHOULD BE MEASURED TO DETERMINE EFFECTIVENESS?

In terms of program management and oversight, we do not believe VBA's quality assurance data should be relied upon as the exclusive measure of the quality, accuracy, or effectiveness of the claims adjudication process. For FY 1998, VBA indicates that the methodology to implement a revised Quality Assurance Program is currently under development. To date, we do not have any information concerning the new criteria or the level of resources that will be devoted to this effort. It is hoped the revised guidelines will attempt to effectively and comprehensively correlate the assessment of technical errors and deficiencies with the more subjective element of whether or not a claim was effectively resolved from the claimant's perspective.

VBA acknowledges that the continuing high appeal and remand rate cause substantial workload problems, over and above an increasing volume of original and reopened claims. In addition to impacting processing time goals, this also has major short-term and long-term resource implications as VA's budget becomes increasingly constrained. It is, therefore, absolutely essential, in our opinion, that VBA demonstrate it has in place a viable and effective quality assurance program. This is necessary to not only ensure that veterans receive quality, timely service, but that management decisions concerning program activities and future resource needs are based on reliable and accurate data.

In the interim, an examination of the appeals process can provide some useful, albeit indirect, information on the claimant's perspective of the level of quality/accuracy of regional office decision making. VBA has repeatedly stated that each year there are some 3.5 million "claims actions" taken involving all types of benefits. Of these decisions, only a small percentage of claimants (2 percent or about 75,000 individuals) formally appeal to the BVA. This is cited as evidence of high quality adjudication and general "customer" satisfaction. We believe this is a false comparison of apples with oranges. We believe the overall error rate is probably much greater than VBA is willing to publicly admit.

The term "claims actions", as used by VBA, refers to the aggregate disposition of all benefit issues claimed which includes original and reopened claims of entitlement to service connection, DIC, or pension, burial benefits, education, and vocational rehabilitation. A single case may , in fact, involve a single or multiple benefit issues. Annually, in the last several years, adjudicative action has been taken on a total of about 3.5 million such "claim" issues. This does not mean there were 3.5 million individual claimants.

To illustrate the point, if a claimed benefit is denied the individual has the right of appeal. However, not everyone whose claim is denied files a Notice of Disagreement. An appeal, by its nature, involves the perception and allegation of error by the claimant, i.e. they were very dissatisfied for some reason with the decision made in their case.

According to BVA data for FY 1996, 74,757 veterans or their survivors filed appeals (Notices of Disagreement). Of those, approximately 87.9 percent or about 65,925 cases involved original and reopened claims for disability compensation and pension. According to VBA data for FY 1996, the number of adjudicated claims for compensation and pension totaled 668,819. If the total number of individual cases adjudicated involving the issue of compensation (668,819) is divided by the number of individuals filing appeals for compensation and pension (65,925), there would be, at a minimum, a "perceived" error rate of 9.5 percent. On average in its decisions, the BVA confirms the claimant's perception of error in whole by allowing about 20 percent of the appeals and in part by remanding about 46 percent of the appeals. On this basis, we believe the regional office's overall accuracy rate is probably much less than 90 percent which VBA is willing to publicly admit.

From the advocate's perspective, we would like to see more coordination between VBA and BVA in developing more specific data on claim outcomes which would identify problem issues/areas and problem stations. User survey data should also be developed on an on-going basis. In addition to the pending changes to the Quality Assurance Program, there is a similar need to ensure individuals and managers will be held accountable for poor quality work.

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700
Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881
World Wide Web: http://www.vva.org • *E-mail 71154.702@compuserve.com*

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

By Telefax

June 10, 1997

Rep. Jack Quinn
Chairman
Subcommittee on Benefits
HVAC
335 Cannon HOB
Washington, DC 20515

Re: Smoking Illnesses

Dear Rep. Quinn:

Enclosed please find my responses to your recent questions concerning VA compensation for smoking related illnesses. Thank you for your interest in this issue and please let me know if Vietnam Veterans of America can provide you with further information.

Sincerely,

Bill Russo

Bill Russo, Esq.
Director
Veterans Benefits Program

enclosure: response

1. You have voiced opposition to the VA's proposed restrictions on compensation for smoking-related illnesses citing things like a lack of warning labels, DoD's promotion of smoking and the addictive qualities of smoking. Could we not see DoD's attitude towards smoking as accommodating an existing socially acceptable personal behavior rather than promotion, and if smoking is addictive, doesn't that qualify as an abuse under section 1110 and therefore should not be compensable ?

VVA's Response: The Department of Defense went well beyond accommodation of cigarette smoking. Employers who merely set aside a time and place for employees to smoke might arguably be accommodating smoking, but an organization who does these things, and gives free cigarettes to service members with every meal, is promoting/encouraging smoking. The VA General Counsel himself stated in O.G.C. Precedent Opinion 21-93, at Par.16, "...the armed services have taken actions which could be viewed as encouraging the use of tobacco [such as] cigarettes... included in the K-rations and C-rations provided to service members, and cigarettes are sold in military commissaries at a price which is substantially less than in civilian stores."

In response to the second part of your question that "if smoking is addictive, doesn't that qualify as an abuse under section 1110 and therefore should not be compensable ?," VVA strongly disagrees. The VA General Counsel himself stated in O.G.C. Precedent Opinion 21-93, at Par.19-22, that cigarette smoking does not constitute drug abuse within the meaning of 38 U.S.C. Sec. 1110. This view is supported by a detailed analysis of the legislative history of that law.

One of the strongest points made by the General Counsel was that Congress could not have intended to make cigarette smoking considered drug abuse under Sec. 1110, while letting stand another statute that permits VA to furnish free cigarettes to its hospital and domiciliary patients. (See 38 U.S.C. Sec. 1715.)

And again, to assert that service members were wrongfully abusing cigarettes, while the military was dispensing them daily, would be an unfair result which we do not believe Congress intended.

2. How would you limit compensation of smoking - related illnesses, if at all ?

VVA's response: VVA is not currently aware of any circumstances in which it would be fair to limit compensation of smoking - related illnesses. VVA is willing to meet with members of Congress or their staff to discuss this issue further.

VETERANS OF FOREIGN WARS RESPONSE TO MAY 14, 1997 SUBCOMMITTEE ON BENEFITS QUESTIONS BY CONGRESSMAN JACK QUINN

1. You have voiced opposition to the VA's proposed restrictions on compensation for smoking-related illnesses citing things like a lack of warning labels, DoD's promotion of smoking and the addictive qualities of smoking. Could we not see DoD's attitude towards smoking as accommodating an existing socially acceptable personal behavior rather than promotion, and if smoking is addictive, doesn't that qualify as an abuse under section 1110 and therefore should not be compensable?

Certainly, we could presently consider DoD's attitude as accommodating. But that would signify a change in their thinking, and indeed, the government's. The VA's proposal to classify smoking as an ineligible disability extends a contemporary presumption of knowledge retroactively to our veterans. In other words, the Secretary of Veterans Affairs (and Congress) would be telling our veterans that "You should have known better!"

Smoking was, and still is, a legal activity. As it has often been stated lately, it was implicitly encouraged as part of relief from strenuous military duty -- "the smoking lamp is light" and "smoke 'em if you got 'em!" Cigarettes were provided in "K" and "C" rations. Our veterans from World War II, Korea, even Vietnam to a degree, did not have the available scientific and medical information on the health hazards of smoking in order to make conscientious decisions as to the addictive effects of nicotine.

A blanket "prohibition" against service-connection will put smoking in the same category as the current laws that deny service connection for substance abuse. One can certainly argue morally the differences between drug abuse and smoking, particularly when the former has never been remotely considered to be socially acceptable personal behavior.

For some veterans, eating is an addictive habit and can be a factor in many disabilities. But, we don't preclude compensation to a veteran who is service connected for hypertension but also happens to be slightly obese.

We believe there are adequate statutes right now in Chapter 11, 38 United States Code for the proper adjudication of smoking claims. It is not "automatic" that a disability, such as lung cancer, will be service-connected because the veteran smoked. There still must be a medical opinion that the disability was directly related to the veteran's smoking while on active military service. In other words, an examiner must find nicotine dependence, opine that dependence commenced during active military service, and comment as to whether it is the "link" to the claimed smoking-related disability. Achieving those requirements will be rather difficult for a veteran who is a life-time smoker and had only a few years of active military service.

2. VFW states its concern that a veteran filing a claim for undiagnosed illness may receive a diagnosis and therefore not be compensable. Doesn't the overall 70% (sic) allowance rate suggest that VA is using every avenue to grant service-connection?

The overall 78% allowance rate for all claims from Gulf War veterans suggests the VA is accomplishing its mission to ensure full consideration of direct service connection (under the provisions of Chapter 11, 38 United States Code) before applying Public Law 103-446 to a given case. However, such a commendable rate should not be confused with the high denial rate for specific "environmental hazard" claims, which is a sub-set of the overall claims. That denial rate is presently about 85% and it is the current focus of our concern. (This figure will change substantially and positively with the readjudication of claims under the new standard of a ten-year presumptive period.)

Accordingly, the disabilities included in the 78% allowance rate result from a diagnosis on a present disability and almost always involve a known event, e.g., a vehicle accident in the Persian Gulf theater of operations. The difference with environmental hazard claims is that they include either a diagnosed or undiagnosed condition and can involve known or unknown environmental hazard conditions. As stated, the total allowance rate for such claims is about 15%. This statistic is the one that now properly reflects the problems associated with Gulf War claims.

The current statute, 38 U.S.C. § 1117(c)(2), requires the VA to provide a description of the illnesses for which compensation may be paid. The implementing regulation, 38 Code of Federal Regulations § 3.317 has a list of, but not limited to, thirteen various symptoms. If a veteran displays symptoms consistent with those in the regulation, compensation should be granted. However, VA cannot provide compensation under 38 C.F.R. § 3.317 if a diagnosis also accompanies those consistent symptoms. Currently, this involves about 2,065 claims, or 21% of the denied undiagnosed illness claims.

VA physicians are now required to include a statement when a diagnosis cannot be reached. This is admirable; however, it also presents a dichotomy. Doctors are trained to find out what's wrong (a diagnosis) so they can treat us. They like definition in their work. Because of the current subjective nature of Gulf War symptoms, it is prophetic that many physicians may force themselves into providing "speculative" diagnoses. This situation can be mitigated by ensuring examining physicians render etiological opinions. Even if that is not possible, and there is no evidence of intervening or supervening conditions or events, the rating specialist should look at the symptoms collectively and rate the condition as being a result of Gulf War service.

3. How would you limit compensation of smoking-related illnesses, if at all?

Any limiting of compensation would require applying the standard of "willful misconduct" as stipulated in 38 U.S.C. § 1113 and, in this case, the implementing 38 C.F.R. § 3.301. In our opinion, this stigma cannot be considered until such time that the government officially declares smoking as unacceptable social behavior, specifically through public laws that apply to the entire population, and not just veterans.

We just don't see how a standard can be developed to support a proper definition of smoking. Will it be one cigarette in a life-time or a two-pack daily habit? That is critical because if smoking is classified as a prohibition for compensation, that will affect all compensation claims. For instance, it will be the intervening circumstance that will cause an automatic denial of a claim for service connection for lung cancer as a result of ionization/radiation exposure (38 C.F.R. § 3.311(b)(2)).

The thing to note is that it is going to be very difficult for any current active duty military member to eventually obtain service connection for smoking. That is because there is now so much available knowledge on the detriments of smoking that it will be virtually impossible for a claimant to rebut a medical determination from a VA medical examination that nicotine dependence occurred primarily because of the veteran's actions (and, accordingly, not the government's).

We must maintain the same standard on direct service connection in relation to smoking claims not unlike any other disability that may be incurred as a result of military service.

VETERANS OF FOREIGN WARS RESPONSE TO MAY 14, 1997 SUBCOMMITTEE ON BENEFITS QUESTIONS BY CONGRESSMAN BOB FILNER

1. **Do you believe that VBA has worked with you and taken your concerns seriously about inefficiencies and errors in the processing of Gulf War claims?**

The VFW has worked diligently with the Veterans Benefits Administration on this issue. They have been receptive to our comments and suggestions and, based just alone on the changes that have occurred, have taken our concerns seriously. (The obvious example is the presumptive period extension from two to ten years.) The one issue now in active discussion is the reason for the denial of 21 percent of the Public Law 103-446 claims as due to a "Diagnosed Illness".

2. **Could you please give us your recommendations of the type of outreach VBA should perform to inform veterans of the information they need to claim benefits?**

We believe the most critical aspect for outreach is to ensure that all Gulf War veterans enroll in the Persian Gulf registry and take advantage of the examination. The Department of Defense and Department of Veterans Affairs should continue to advertise the registry through various mediums. Concurrently, all Gulf War veterans should be given information when they enroll on how to file a claim for disability compensation. VA should coordinate with DoD's Veterans Data Management Team in the Office of the Special Assistant for Gulf War Illnesses to ensure the team has at their disposal the materials needed for VA claims filing and registry enrollment.

3 **How do you view centralization of claims processing in general? Do you see any lessons learned in your experience with the centralization of Gulf War claims?**

Centralization can have many advantages. For instance, it can lead to a more precise span of control that allows for comprehensive and dedicated training. It should be easier to obtain consistency in decision-making. It may facilitate responses to requests for assistance from claims processing personnel. Program changes can be implemented more quickly.

The question is why centralization has worked in the VBA for some situations but not others? POW claims is one example of a success. In our opinion, the difference between that program and, in comparison, the difficulties the VBA has encountered in the Education centralization has been the lack of an adequate mechanism that accommodates the rapid responding to inquiries on the status of claims.

That is precisely what happened with the Gulf War claims. The veterans did not like it that their "home" VA office no longer had control over their claims. There was now added a strong element of the faceless bureaucracy by being told that the case has "gone to Phoenix". Because of the great controversy and emotion associated with Gulf War undiagnosed illness issues, we agree that the intangible disadvantage of the lack of familiarity overwhelmed the advantages of decentralization.

The one lesson learned is that if the VBA is going to centralize the rating (or processing) of claims, there must be first in place an adequate communications system that allows direct and rapid responses to claim inquiries.

- PAGE 2 -
VETERANS OF FOREIGN WARS RESPONSE TO MAY 14, 1997 SUBCOMMITTEE ON BENEFITS QUESTIONS BY CONGRESSMAN BOB FILNER

4. How do you view the VA's goal of a 92 percent accuracy rate for claims?

We have never considered 92% to be satisfactory. That is, settling for an A-grade is not good enough, in our opinion, for our veterans.

However, we find it commendable that the VBA, under Business Process Reengineering, has the vision to raise the goal to 97% by Fiscal Year 2002. Just as important is the goal of a 25% BVA remand rate. Those are two of the reasons we support the VBA's Business Process Reengineering.

5. In your view, are the criteria used to determine accuracy in the adjudication process useful in measuring the effectiveness of the claims adjudication process? How should effectiveness be measured? What should be measured to determine effectiveness?

The criteria is useful and generally adequate, but it is not so much a question of usefulness as effectiveness, which involves the following two questions.

Beside the VBA's Quality Assurance program, other critical and important statistics are the BVA's grant and remand rate, the hearing officer's allowance rate and the percentages of adequate and complete Compensation and Pension examinations.

We have reviewed the draft report by the National Academy of Public Administration (NAPA) on their study, *Management of the Veterans' Compensation and Pension Benefits Claim Processes*. There is contained, in the proposed Chapter 8 of that report, an excellent discussion on the need for improvement in the VBA's Quality Assurance program. The proposed recommendation accompanying that discussion is worthy of serious consideration. (This should not be considered to be an endorsement of the entire NAPA report.)

Non Commissioned Officers Association of the United States of America

225 N. Washington Street · Alexandria, Virginia 22314 · Telephone (703) 549-0311

June 17, 1997

The Honorable Lane Evans
Ranking Member
Committee on Veterans Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Evans:

The enclosed responds to the questions for the record from Representative Bob Filner from the May 14, 1997, Subcommittee on Benefits hearing on the processing of Persian Gulf claims.

NCOA appreciates the opportunity to provide further comments relative to the hearing and trusts that our responses will be helpful to you and the Subcommittee members.

Sincerely,

Larry D. Rhea
Deputy Director
Of Legislative Affairs

Chartered by the United States Congress

Follow-Up Questions to VSOs
From Honorable Lane Evans from the
Subcommittee on Benefits Hearing of May 14, 1997

Question: Do you believe that VBA has worked with you and taken your concerns seriously about inefficiencies and errors in the processing of Gulf War claims?

NCOA Response: The short answer is no as amplified in the Association's responses to the below questions.

Question: The Committee has been concerned that the VBA has not adequately informed Gulf War veterans on the development needed to claim benefits for undiagnosed illnesses. In particular, VBA failed to inform veterans that "lay statements" could be used as evidence in claiming benefits. Could you please give us your recommendations of the type of outreach VBA should perform to inform veterans of the information they need to claim benefits?

NCOA Response: NCOA shares the Committee's concern in this area and it is a two-sided problem. The fact that veterans were not adequately informed on what was needed to ensure proper development of a claim was only half of the problem. VBA could not decide what was needed for claims development and this added additional confusion. VBA did not back brief VSO's on current evidence and criteria acceptable in the process. It has been difficult for this Association to keep apace with VBA changes in procedures. VBA has changed the claims development procedures for Gulf War veterans three times in five years and it is our understanding that a fourth change is being finalized. In this Association's view, there is plenty of confusion among veterans and their service organizations and VBA has done a good job in keeping it that way. In an area that has had intense public and congressional visibility, VBA communications with veterans and VSO's has not been good.

NCOA believes that the development and promulgation of a comprehensive fact sheet should be undertaken as a part of VBA's outreach. The fact sheet should include all undiagnosed illnesses that are allowed by presumptive funding. Further, it should include all the evidence needed to support a presumptive finding and be made available to veterans and VSO's.

Question: How do you view centralization of claims processing in general? Do you see any lessons learned in your experience with the centralization of Gulf War claims?

NCOA Response: As a general proposition, centralization of functions can be advantageous. There is nothing inherently wrong in centralization of claims processing as in the case of non-complex, easily understood issues (i.e., education claims). Persian Gulf claims were not such an issue – they were and are extremely complex in an altogether new area, undiagnosed illnesses. Expertise was never developed at the Regional Processing Centers – plain and simple, the experts weren't experts. There was no effective way to communicate with the RPC's. It is our impression that RO's weren't kept informed. Most importantly, there was no representation of the individual veteran at the RPC.

In our estimation, the important lesson learned in this experience is don't centralize when confusion and doubt exist. Develop the expertise at the RO level first where communication and interface with the veteran occurs more easily. Before centralization

is contemplated, the evidence needed to facilitate case development and adjudication must be fully understood by everyone. Finally, on questions of centralization, procedures must be put in place to keep RO's, veterans and their VSO's informed.

Question: How do you view the VA's goal of 92 percent accuracy rate for claims?

NCOA Response: Very favorably if you are among those fortunate enough to have a claim adjudicated properly; and, not so favorably if you are unfortunate enough to be among the 8 percent. If 92% accuracy is the goal, it does not speak well of where we are today nor does it speak well of where we're going in the future. An error rate of nearly one in every ten claims is unacceptable. The goal must be accuracy at every level, on every action, by every employee and to get it done right the first time. The path to achieve that goal is simple in NCOA's view – its called accountability.

Question: In your view, are the criteria used to determine accuracy in the adjudication process useful in measuring the effectiveness of the claims adjudication process? How should effectiveness be measured? What should be measured to determine effectiveness?

NCOA Response: The criteria are useful but limited in their ability to measure the overall effectiveness of the claims adjudication process. Measuring the effectiveness of the claims process must include other factors, such as the number of remands, appeals and the number of physical examinations required to support a case. Satisfaction of veterans is also a factor in measuring the effectiveness of the adjudication process. This includes promptness in the decision and an explanation of the decision in terms that the veteran can accept as fair and impartial regardless of whether the claim is approved or denied.

○

ISBN 0-16-055510-8

90000

9 780160 555107