

VA ADJUDICATION OF HEPATITIS C CLAIMS,
AND H.R. 1020, H.R. 3816, H.R. 3998, AND
H.R. 4131

HEARING
BEFORE THE
SUBCOMMITTEE ON BENEFITS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
SECOND SESSION

APRIL 13, 2000

Printed for the use of the Committee on Veterans' Affairs

Serial No. 106-37



U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 2000

COMMITTEE ON VETERANS' AFFAIRS

BOB STUMP, Arizona, *Chairman*

CHRISTOPHER H. SMITH, New Jersey	LANE EVANS, Illinois
MICHAEL BILIRAKIS, Florida	BOB FILNER, California
FLOYD SPENCE, South Carolina	LUIS V. GUTIERREZ, Illinois
TERRY EVERETT, Alabama	CORRINE BROWN, Florida
STEVE BUYER, Indiana	MICHAEL F. DOYLE, Pennsylvania
JACK QUINN, New York	COLLIN C. PETERSON, Minnesota
CLIFF STEARNS, Florida	JULIA CARSON, Indiana
JERRY MORAN, Kansas	SILVESTRE REYES, Texas
J.D. HAYWORTH, Arizona	VIC SNYDER, Arkansas
HELEN CHENOWETH-HAGE, Idaho	CIRO D. RODRIGUEZ, Texas
RAY LAHOOD, Illinois	RONNIE SHOWS, Mississippi
JAMES V. HANSEN, Utah	SHELLEY BERKLEY, Nevada
HOWARD P. (BUCK) McKEON, California	BARON HILL, Indiana
JIM GIBBONS, Nevada	TOM UDALL, New Mexico
MICHAEL K. SIMPSON, Idaho	
RICHARD H. BAKER, Louisiana	

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

SUBCOMMITTEE ON BENEFITS

JACK QUINN, New York, *Chairman*

J.D. HAYWORTH, Arizona	BOB FILNER, California
RAY LAHOOD, Illinois	SILVESTRE REYES, Texas
JAMES V. HANSEN, Utah	SHELLEY BERKLEY, Nevada
JIM GIBBONS, Nevada	LANE EVANS, Illinois

CONTENTS

April 13, 2000

OPENING STATEMENTS

	Page
Chairman Quinn	1
Hon. Bob Filner	2
Hon. Lane Evans	7
Prepared statement of Congressman Evans	59
Hon. Silvestre Reyes, prepared statement of	53
Hon. Shelley Berkley, prepared statement of	56

WITNESSES

Daniels, Sidney, Deputy Director, National Legislative Service, Veterans of Foreign Wars	28
Prepared statement of Mr. Daniels	155
Egan, Nora, Deputy Under Secretary for Management, Veterans Benefits Administration; accompanied by John H. Thompson, Deputy General Counsel, Department of Veterans Affairs, and John McCourt, Deputy Director, Compensation and Pension Service, Veterans Benefits Administration	33
Prepared statement of Ms. Egan	161
Gaytan, Peter, National Legislative Director, AMVETS	20
Prepared statement of Mr. Gaytan	139
Ilem, Joy J., Associate National Legislative Director, Disabled American Veterans	21
Prepared statement of Ms. Ilem	143
Roselle, Gary A., M.D., Program Director for Infectious Diseases, VA Medical Center, Cincinnati, OH	9
Prepared statement of Dr. Roselle	98
Schneider, Richard C., Director, State/Veterans Affairs, Non Commissioned Officers Association	26
Prepared statement of Mr. Schneider	150
Schwartz, Linda Spoonster, Associate Research Scientist, Yale University School of Nursing and Chair, VA Advisory Committee on Women Veterans .	19
Prepared statement of Ms. Schwartz	133
Shallow, Michael, veteran	11
Prepared statement of Mr. Shallow, with attachment	107
Snyder, Keith D., Attorney at Law	13
Prepared statement of Mr. Keith Snyder	119
Snyder, Hon. Vic, a Representative in Congress from the State of Arkansas	3
Stupak, Hon. Bart, a Representative in Congress from the State of Michigan .	6
Thomas, Harley, Associate Legislative Director, Paralyzed Veterans of America	18
Prepared statement of Mr. Thomas	129
Wilkerson, Philip R., Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion	28
Prepared statement of Mr. Wilkerson	158

IV

MATERIAL SUBMITTED FOR THE RECORD

Page

Bills:	
H.R. 1020	43
H.R. 3816	46
H.R. 3998	48
H.R. 4131	50
Correspondence:	
Letter of January 28, 2000 from Congressman Evans to Department of Veterans Affairs from Congressman Evans re regional office decisions on requirements of a "well-grounded" claim in the case of Hepatitis C claims	92
Letter from Department of Veterans Affairs to Congressman Evans re VA's response to inquiry concerning a sampling of claims for disability compensation, March 9, 2000	66
Letter from Department of Veterans Affairs to Congressman Evans re additional information in response to questions raised in letter of January 28, 2000	202
Statements:	
National Military and Veterans Alliance	64
Mr. Brian D. Klein, Hepatitis C Action & Advocacy Coalition (HAAC) San Francisco, CA, submitted March 14, 2000	176
<i>Written committee questions and their responses:</i>	
Congressman Evans to Ms. Nora Egan, Deputy Under Secretary for Management, Veterans Benefits Administration	177
Congressman Evans to Dr. Gary A. Roselle, Program Director for Infectious Diseases, Veterans Health Administration	210

**VA ADJUDICATION OF HEPATITIS C CLAIMS,
AND H.R. 1020, H.R. 3816, H.R. 3998, AND H.R.
4131**

THURSDAY, APRIL 13, 2000

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

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 334, Cannon House Office Building, Hon. Jack Quinn (chairman of the subcommittee) presiding.

Present: Representatives Quinn, Gibbons, Filner, Reyes, Berkley, and Evans.

OPENING STATEMENT OF CHAIRMAN QUINN

Mr. QUINN. Good morning, everybody. I'd like to begin and convene our subcommittee hearing today and apologize and thank everybody for their patience. We were to begin at 10 o'clock, but the House had a recorded vote on the journal from yesterday's proceedings, so we're getting a little bit of a late start. I also want to point out to everybody that we have a big agenda today with a number of panels and members of Congress to hear from, at least five panels, so we are going to ask all of our witnesses to try to stay to the 5-minute rule if they can.

We begin every hearing by saying that we have all of the comments and all of the testimony for the record. It is received. Our first two witnesses—I should say before we begin that we're receiving testimony on VA's adjudication of Hepatitis C claims as well as H.R. 1020, the Veterans' Hepatitis C Benefits Act of 1999. In addition, we'll be receiving testimony on H.R. 3816, a bill to provide that a stroke or a heart attack suffered by a member of a Reserve component while performing inactive duty for training shall be considered service-connected. Also H.R. 3998, the Veterans' Special Monthly Compensation Gender Equity Act. And finally, H.R. 4131, the Veterans' Compensation Cost-of-Living Act for the year 2000.

We appreciate all of you being here today, and we'll talk with others on the panels as they come forward. But I especially want to thank Congressman Vic Snyder, who is at the witness table first this morning, a member of the full committee, and an active, thoughtful, helpful member on the full committee, I might add. We are going to be joined by Representative Bart Stupak in a few minutes to talk about his respective bill. In the interest of time, Vic,

if it's okay with you, we're going to begin after Bob has the podium for a minute, and start while Bart Stupak is on his way over.

At this time I'd like to yield to Mr. Filner for any opening remarks he has to make.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. I thank you, Mr. Chairman, and thank you for the hearing. We are considering a number of bills, all of which I am an original co-sponsor of and support. And I want to thank our first panelist, Mr. Stupak, for bringing to our attention the serious impact on veterans and their families by failing to provide service connection to members of the Guard and Reserve when they suffer heart attack or stroke while on inactive duty training. This clearly is a wrong that should be righted.

And I thank, as you have, Dr. Snyder, for keeping our focus on the emerging issue of Hepatitis C, whose bill H.R. 1020 provides a presumption of service connection, recognizing the impossibility of proving the etiology of infection with the Hepatitis C virus. Veterans would, of course, still be required to establish that they were exposed to one of the listed risks during military service. While that's a formidable task, since military records are often silent as to risk factors, I think the bill is a strong step forward, Dr. Snyder, and I thank you for it.

I think you also recognize the impossibility of determining the source of an infection once an individual has developed Hepatitis C and can identify at least one recognized risk factor. The impossibility of determining which of multiple risk factors is responsible was clearly stated by Dr. Thomas Holohan, the VA's Chief Patient Care Officer, during a June 1999 subcommittee hearing of the Committee on Government Reform and Oversight. He said, "A patient may have one, two, or many risk factors, and to determine which was in fact the proximate cause of the disease is in my opinion impossible."

But despite VHA's recognition of the impossibility of making a medical determination, veterans are currently required to obtain just such a medical opinion. When it is not possible for medical science to provide an answer concerning whether a service-connected event is the cause of a veteran's disability, the evidence should be considered equal, and the benefit of the doubt should be given to the veteran.

So I thank you for H.R. 1020. It presumes service connection when certain risk factors are recognized, and it would provide that veterans are in fact given the benefit of the doubt.

We will hear VBA—testimony from VBA, and I'm troubled by the suggestion that the criteria used by VBA should not be the Veteran's Health Administration criteria but epidemiological? No.

Mr. QUINN. He's the doctor.

Mr. FILNER. Would you give me that pronunciation?

Mr. Vic SNYDER. Epidemiologic.

Mr. FILNER. Epidemiological—thank you—data from Centers for Disease Control. Since VHA criteria focuses on the specific characterizations of Hepatitis C in veterans rather than the population in general, I believe it is more appropriate to use one set of criteria.

They keep telling us we're One VA, let's use one set of criteria based upon the factors that the veterans confront.

I think VBA now seems to be rejecting evidence of abnormal liver tests during military service as evidence of infection in service. Since the onset of this disease is so insidious, abnormal liver tests may be the only evidence available to a veteran in trying to establish a claim for a service connection. And we continue, Mr. Chairman, to hear from veterans who appear to warrant the service connection but are facing serious bureaucratic barriers in receiving it.

I also welcome testimony recognizing the importance of special monthly compensation for veterans who have undergone a radical or modified radical mastectomy. As more and more women enter military service, they should understand that a disease which impacts them disproportionately will be compensated commensurate with those paid for conditions which impact male veterans.

And I firmly believe that we cannot allow the costs of inflation to eat away at the benefits earned by our disabled veterans and their survivors. The last bill we're considering, H.R. 4131, will at least assure that compensation and dependency and indemnity compensation benefits will keep pace with the cost of living.

So I thank the chairman for these bills. I thank Dr. Snyder for being with us and look forward to your testimony.

Mr. QUINN. Thank you, Bob. Ms. Berkley, any opening statements?

Ms. BERKLEY. No. I'd like to associate myself with all of Mr. Filner's remarks, except for the epidemiology statement—

(Laughter.)

Ms. BERKLEY (continuing). And say that I—well, I'm a doctor's wife, so that excuses—

Mr. QUINN. And then Mr. Filner wants to associate his remarks with your comments.

Ms. BERKLEY (continuing). And just say I am also a very proud co-sponsor of this legislation.

Mr. QUINN. Thank you, Shelley. Thank you, Bob. Thank both of you.

Vic, before you begin, I want to publicly thank you for your interest in this whole issue to keep it on our agenda. You and I have been talking about this for quite some time, didn't quite get to it when we wanted to last year, but committed ourselves in this session to address it. And then also publicly thank you for your interest and involvement in the panels here today to get enough testimony, as well as outside the panels, for us to make a decision on this issue. So thank you from all of us on the full committee and the subcommittee for your work of this. And, of course, you may begin. Thanks.

STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. Vic SNYDER. Thank you, Mr. Chairman and Mr. Filner. And Mr. Chairman, I appreciate your not only holding the hearing today but also being a co-sponsor of the bill. Let me say, first of all, that, you know, my overriding goal, as is every member of this committee, is to ensure that veterans who contract Hepatitis C

while serving their country get the treatment and compensation they need and deserve.

Let me give a little background on the disease. It's a relatively new disease, Hepatitis C is. It was not identified until 1989, and as a family practitioner, there was just not a reliable test until the early 1990s, until 1992. If left untreated, Hepatitis C can lead to cirrhosis, liver cancer, liver failure and death. And for many, it is a disease that requires a liver transplantation, many of which are done in our VA hospitals.

Equally as problematic is its long latency period. After contracting HCV perhaps asymptotically, symptoms may not appear for as many as 30 years. This is a problem for our veterans who have a current HCV diagnosis and apply for service connection. Often the claim is denied as not well grounded because of the veteran's inability to provide evidence of the existence of a disease that the medical community did not know existed.

Because of these factors, I introduced H.R. 1020, the Veterans Hepatitis C Benefits Act of 1999. It will provide a presumption of service connection for veterans with Hepatitis C who during service were exposed to one or more of the bill's 10 enumerated risk factors. Establishing presumptive service connection relieves veterans, many already sick from the disease, from this burden of proof. In other words, if the veteran was exposed during service to something that is believed to cause Hepatitis C virus and the veteran is diagnosed with the disease after military service, my bill would presume that it is at least as likely as not that the illness is due to the in-service risk factor, and thus by law is service connected.

I think we need to approach this whole topic of Hepatitis C with a certain level of humility—a heft level of humility, I might add. We still have a lot of information that we need to learn about Hepatitis C virus. We are learning more as our investigators within the VA and other government agencies and private entities conduct research to help us better understand the disease and its effects on the veterans population. My office has been contacted by a lot of veterans around the country since I filed the bill. They have shared with me and my staff the problems they encounter in receiving medical treatment from the VA for their current Hepatitis C diagnosis in obtaining service connection or in getting their current rating reevaluated in order to account for their current disability status.

But I really am not at all here today to criticize the VA. To the contrary, the department deserves a lot of praise for developing and implementing its five-pronged program, which includes patient education, provider education, epidemiological assessment, treatment, and research. And we also have the creation of our two Hepatitis C centers of excellence in Miami and San Francisco to help develop national, coordinated patient and provider programs, among other activities.

Given these activities, the VA should be commended for leading, and in many ways advancing, the national discussion and research on Hepatitis C virus. And again, my goal is to ensure that veterans who risk their lives and contract this disease while risking their lives for their country receive the care and consideration they de-

serve. In my opinion, this bill may be a more efficient tool than what we're currently doing to resolve these claims.

And once again, Mr. Chairman, I thank you for holding this hearing today on this bill. I have said before that this bill may not be the best way to get at this problem, but we've had this thing floating around out there for a year, and I have heard of no better way to get at this problem, because of the unique nature of Hepatitis C virus.

I also look forward to hearing the discussions from our witnesses and from the members of the committee today. Thank you, Mr. Chairman.

Mr. QUINN. Thanks very much, Vic. Bob?

Mr. FILNER. Just a quick question, Congressman, and I thank you for, again, your own expertise. It gives us a lot of confidence. Are you aware of the testimony that's going to come about the use of the epidemiological data. The VA's use of that data from the Centers for Disease Control?

Mr. Vic SNYDER. Yeah. I'm looking forward to that discussion, too. I mean, I read some of the CDC reports, and I think that there are some—I understand your perspective, that we seem to have one set of discussion that deals with one set of risk factors, and then when we're doing disability ratings, we have a different set of risk factors. But even if we do that, for example, the CDC report we talk about, I think the testimony that we were given from the VA today says that there's no studies from the United States that show that tattooing and body piercing is a risk factor in Hepatitis C virus. Well, I pulled up that CDC report, and the preceding line says—it enumerates like eight studies from overseas. Well, I think that's a—you know, we actually have men and women in the military that go overseas. I know that some of us may find this shocking, but they do. And so I think that, again, you know, we enter this with a certain level of humility. And I think it is difficult to come up with this perfect list, regardless of who's doing it, whether it's a legislator or an administrator. But, yeah, there is a conflict it would seem to me, Mr. Filner.

Mr. FILNER. Thank you. And I, too, I want to welcome Congressman Stupak and thank him for focusing our attention on this obvious injustice that's occurring that we ought to remedy. Thank you for being here.

Mr. QUINN. Thank you, Vic. Thank you, Bob. Bart, welcome. We had some opening remarks on your way over here. I hope you don't mind if we started without you.

Mr. STUPAK. No problem.

Mr. QUINN. I know you were here earlier, and then we headed over for the vote. But I want to thank you on behalf of the subcommittee and the full committee for your hard work on H.R. 3816, a bill to provide that a stroke or a heart attack suffered by a member of a Reserve component while performing inactive duty for training shall be considered as service connected. And Bob and I had some opening remarks, and Shelley did, too.

So thanks for coming over not only to work on the bill but for appearing here this morning. Your entire statement, of course, is received, but please take some time now to discuss the bill. Welcome.

**STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF MICHIGAN**

Mr. STUPAK. Thank you, Mr. Chairman, and thank you for the opportunity to be here, because it is a very important issue, not just for veterans but also their families. I want to let the reflect that although there was a drafting error with this bill, my intent was and always has been to ensure that heart attacks—myocardial infarctions—and strokes—cerebral vascular accidents—receive coverage. I understand that a little bit of drafting in the—explaining those two, and that will be taken care of at the mark-up level.

As you point out, Mr. Chairman, the issue is somewhat a simple one. National Guard and Reservists are required to undergo inactive duty for training, or IDT, periodically. IDT can encompass a number of things, just depending on the full range of training that the unit may be doing. Depending on what the unit's mission is, IDT can be like fitness tests, weapons training, or other stressful activities that can, you know, trigger an acute medical event such as a heart attack or a stroke.

If the Guard member or Reservist happens to suffer a stroke or heart attack while undergoing IDT, they are not eligible for benefits. This is patently unfair, especially as IDT activities are mandatory, they are not optional. Under current law, if a Guard member or Reservist on IDT suffers a heart attack or a stroke, the disability as characterized as due to illness and not to service-connected for purpose of benefits from the VA.

If a Guard member or Reservist was on active duty or active duty for training and became severely disabled or died, regardless of the cause, the Guard member or Reservist or his dependents, his or her dependents, would receive benefits from the VA.

H.R. 3816 just addresses this discrepancy. This inequitable treatment of Guard members and Reservists on "inactive duty for training" should be eliminated.

Unfortunately, the issue was brought to my attention when Ron Pearce was performing his mandatory Army Physical Fitness Test. He had been suffering from a heart condition for some time, a condition that was known to his superiors, and in the course of performing his Fitness Test, Master Sergeant Pearce had a massive heart attack and died. And everything, you know, applied for the benefits. The benefits were received. A few months later upon review, benefits were denied, and Mrs. Pearce was then—had to go out and find a job to support her family.

Upon doing further research, we discovered that this has—it's not just Master Sergeant Pearce but a number of others it has occurred to. 3816, Inactive Duty for Training Fairness Act, will correct this inequity. Members of Guard and Reserve, while they're serving their country while on inactive duty for training, should be covered. And while on inactive duty for training, if they suffer a heart attack or a stroke, those medical conditions should be considered by law to be service-connected for the purpose of VA benefits.

Finally, I'd just like to mention that the intent of the bill applies to a very restrictive category of injuries. Although the CBO has not yet released its final estimate, initial evidence and review seems to indicate that the benefits would be to a very small number of cases annually. Members of the Guard and Reserve and their families de-

serve no less, and I want to thank the committee for having this hearing. Hopefully we'll have a quick markup, but also the personal interests of the members of the committee and their staff, and hopefully this is one we can remedy without much delay.

Thank you very much.

Mr. QUINN. Thank you very much, Mr. Stupak. I just said to Bob Filner, that correction—it almost sounds like a technical correction more than anything.

Mr. STUPAK. It really is. It really is.

Mr. QUINN. Unbelievable that that kind of thing isn't covered. And I think you bring by your work on this more clarity to the whole question of what is and isn't service connected. It seems to me it would help everybody, both the reviewers as well as the public and the veterans and their families, as you correctly point out.

May I ask both of you, are we far enough along that we have any counterpart on the Senate side for your activity?

Mr. STUPAK. No. I know Senator Levin's been taking a look at it. He's on the DOD on the—Armed Services, I should say, on the Senate side. He's very interested. He said he would carry it on that side.

Mr. QUINN. Beautiful. If we can help with anybody that we come in contact with, let me know.

Vic, anything on yours?

Mr. Vic SNYDER. Senator Snowe has a version of this. Some slight differences, I believe. I'm not sure what the status of it is today, but it was filed some time ago.

Mr. QUINN. Great. Good job. Thank you. Bob, anything?

Mr. FILNER. No, thank you.

Mr. QUINN. Shelley, any questions? Mr. Evans, anything for you now?

Mr. EVANS. I'd like to make an opening statement when there's time.

Mr. QUINN. Absolutely. Please do. Right now.

OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. First, I want to thank my colleagues for introducing their important bills. I believe they're very necessary, and I think they represent your advocacy for them, Bart, a classic case of serving your constituents as an ombudsman in terms of helping them out with their problems. So we salute you both for taking the step to go further and advance this legislation.

Let me request a letter I received from the National Military and Veterans Alliance in support of H.R. 3816 be included in the hearing record.

Mr. QUINN. Without objection, so ordered.

[The statement of National Military and Veterans Alliance appears on p. 64.]

Mr. EVANS. Hepatitis C is a serious problem affecting our Nation's veterans. On January 28, 2000, I wrote to Under Secretary Joe Thompson to express my concerns about regional office decisions on requirements of a "well-grounded" claim, particularly in the case of Hepatitis C claims. I request that a copy of my letter and Mr. Thompson's response also be included in the record, Mr. Chairman.

Mr. QUINN. Without objection, so ordered.

[The attachments appear on pp. 66 and 92.]

Mr. EVANS. I want to thank Vic for his leadership on this issue. His legislation, H.R. 1020, is needed for the fair and accurate processing of claims.

Under current law, the following claims for Hepatitis C have been rejected:

A recently discharged veteran diagnoses in-service with Hepatitis C;

A Vietnam Purple Heart recipient who had lung surgery in Vietnam due to a combat wound; and

A Korean Veteran who received a blood transfusion in 1955 at a VA hospital during surgery for service-connected TB.

If these claims are being rejected at the VA's "well-grounded doorstep," consider how much more difficult it is for veterans who have other recognized risk factors to obtain benefits for Hepatitis C.

This disease Hepatitis C's claims adjudication problems are not limited to this issue of service-connection. Guidelines for performing medical examinations are rarely used. Veterans with severe symptoms and severe liver damage verified by liver biopsies have their claims rated at 10 percent or less.

I support enacting this legislation, new regulations which will accurately describe chronic Hepatitis C impairments, and determining the incidence of Hepatitis C in family members of infected veterans to determine if additional legislation for family members is required.

And I'm very pleased Congresswoman Berkley has joined us in helping us in these battles. We appreciate it very much.

I am pleased that Dr. Linda Schwartz, the chair of the VA's Advisory Committee on Women Veterans, will testify concerning H.R. 3998 and the committee's recommendations for this legislation.

And I want to note my strong support for H.R. 4131, which provides a cost-of-living increase in compensation benefits to our disabled veterans. We cannot afford to allow these benefits to erode due to increases in the cost of living.

Thank you, Mr. Chairman, for recognizing me and holding this important hearing.

[The prepared statement of Congressman Evans appears on p. 59.]

Mr. QUINN. Thank you, Mr. Evans. We always appreciate your input and activity on and off the committee. It's very helpful to us.

If there are no further questions for the first two witnesses, we thank you both and would call our second panel.

Mr. STUPAK. Thank you.

Mr. QUINN. Thank you, Bart, and thank you, Vic.

Dr. Gary Roselle, Mr. Keith Snyder, and Mr. Michael Shallow, please come to the witness table now.

Good morning, gentlemen, and thanks for joining us this morning. I mentioned, and I know you were in the audience when we began this morning, we have five panels with us today. An ambitious schedule. We're expecting a vote probably about 11:30 a.m. this morning, so we're going to try to get as much of this in as we can before we're called away for that vote or two.

Mr. Roselle—Dr. Roselle, excuse me—I'm going to ask you to begin. I said earlier that we'd like to keep your remarks to about 5 minutes. Mr. Shallow and Mr. Snyder, we will hear from you before we entertain any questions for the panel, so we'll get everyone's testimony on the record first.

Dr. Roselle, would you please begin?

STATEMENTS OF GARY A. ROSELLE, M.D., PROGRAM DIRECTOR FOR INFECTIOUS DISEASES, VA MEDICAL CENTER, CINCINNATI, OH; MICHAEL SHALLOW, VETERAN; AND KEITH D. SNYDER, ATTORNEY AT LAW

STATEMENT OF GARY A. ROSELLE, M.D.

Dr. ROSELLE. Thank you for the opportunity to provide data regarding Hepatitis C in the VHA. In order to reasonably interpret the data that I would present, it's necessary to briefly describe how the data were collected with a comment about the meaning of the test data.

The data were collected from the Emerging Pathogens Initiative, an automated electronic surveillance system that is in place throughout the VA nationally. Once a positive Hepatitis C virus antibody laboratory test is found by the local computer system, a variety of other data are automatically extracted, particularly demographic data such as age, gender, and era of service. Demographic data for all persons served by the VHA during fiscal years 1998 and 1999 were extracted from the VHA data set located at the Austin Automation Center in Texas.

The information provided today will include data on persons who are Hepatitis C virus antibody positive at time of testing during fiscal years 1998 and 1999, and data on the total patient population served by the VHA over the same time interval.

The Hepatitis C virus antibody test as used is designed to screen patient serum for the presence of antibody to Hepatitis C virus. A positive test result does not mean that an individual patient has active hepatitis. But, as with all antibody tests, it defines the response of the individual person to infection with the virus. As with all tests, false positive and false negative results can occur. The likelihood that a positive test for Hepatitis C virus antibody is truly positive is directly related to the number of people in the population who have the disease.

When testing for cause—meaning there is evidence of possible liver disease—in the VHA population served, it is very likely that the majority of the positive Hepatitis C virus antibody tests are true positives. However, some patients are tested for a variety of reasons, including at their own request, despite lack of identifiable risk factors. It should also be noted that Hepatitis C virus antibody tests can be intermittently positive, particularly in persons who have relatively low levels of antibody.

Now I will provide some data that covers the 2-year period. For this 24-month period, there's an opportunity for each reporting site to provide data 24 times since it is transmitted monthly. For FY98 and FY99, 92.12 percent of these total possible months were actually in the data set. This is remarkable provision of data for any surveillance system.

For the 24 months, 54,682 unique persons in the VHA had a positive test for Hepatitis C virus antibody. I use the words "unique persons" to define actual individuals with a positive antibody test, and not just number of individuals having a positive test, since a single person could have been tested more than once.

In Graph 1, the age distribution revealed an average of slightly greater than 49 years old, with a rather narrow standard deviation of approximately 9.4 years. This indicates that for the most part, the age group of persons with Hepatitis C virus antibody were clustered closely around the mean age of 49. As seen in Graph 2, when looking at gender in these persons with a positive Hepatitis C virus antibody test and reporting gender, 96.4 percent were male and 3.6 percent were female.

Era of service is illustrated in Graph 3. Of the total number of persons who were Hepatitis C antibody positive and reported an era of service, 62.7 percent were noted to be from the Vietnam era. The second most frequent group is listed as post-Vietnam, at 18.2 percent. The percentage of other eras served drops fairly dramatically after these two, with 4.8 percent Korean conflict, 4.3 percent post-Korean conflict, 4.2 percent from World War II, and Persian Gulf era veterans representing 2.7 percent.

For comparison, it is worthwhile to look at the demographic data for all the unique persons served by the VHA during fiscal years 1998 and 1999, since this describes the population from which the persons with Hepatitis C virus antibody were a subgroup.

There was a total of 4,186,667 unique persons in this data set. Graph 4 depicts the age distribution and shows the expected two peaks, one at approximately 50 years old, and the other at approximately 75 years old. These would account for the groups of Vietnam and World War II era veterans. For comparison, the average age of the persons with Hepatitis C virus antibody was slightly greater than 49 years.

With regard to gender in Graph 5, for the same 2-year period there were approximately 89 percent male and about 11 percent female in the total population served. In persons with test positive for Hepatitis C virus antibody, 96 percent were male.

For era served over the 2-year period seen in Graph 6, 27.7 percent were Vietnam era veterans, with 22.9 percent being World War II era veterans. This is consistent with the age distribution that was seen previously in Graph 4. Each of the remaining eras provided small percentages of the total patient population seen.

Lastly, using the Student's t-test for age and chi-square test for gender and era, statistical comparisons can be made between the persons who were found to be Hepatitis C virus antibody positive and the overall population served by the VHA over the same time period. Persons who were Hepatitis C virus antibody positive were statistically more likely to be younger, at age 49.4, compared to age 56.6 in the overall population served. The Hepatitis C virus antibody positive group was also significantly more likely to be male, at 96.4 percent compared to 89.1 percent in the population served. The Hepatitis C virus antibody positive group was also significantly more likely to be from the Vietnam era of service, at 62.7 percent, compared to the 27.7 percent found in the overall population served during the 2 years of the review.

Again, thank you for the opportunity to provide these data, and I will be glad to respond to any questions.

[The prepared statement of Dr. Roselle appears on p. 98.]

Mr. QUINN. Thank you, Doctor. Thank you very much. Mr. Shallow, you have the podium. Thanks for coming.

STATEMENT OF MICHAEL SHALLOW

Mr. SHALLOW. Thank you, Mr. Chairman. My name is Michael Shallow. I served in the waters of Southeast Asia on the U.S.S. Midway during 1977 and 1978. In 1978 I returned stateside. Later that year I had surgery on my shoulder at Camp Lejeune Naval Hospital and was 20 percent service-connected for the resulting disability. I believe this surgery to be the source of my infection with Hepatitis C.

I wish I could tell my story and it would have a happy ending, but I can only tell you that my fatigue, joint pain, and ability to concentrate and remember things has gotten worse. And despite efforts by the Speaker of the House and others, I have not yet gotten a determination on my HCV-related disability claim from the VA, nor have I received treatment for my Hepatitis C.

My story begins exactly one year ago today. My family was living the American Dream. Our household income was over \$100,000. Our four daughters were healthy, intelligent, and doing well in school. We lived in a new home, and my wife and I had plans to retire early. I was experiencing HCV symptoms, but I attributed them to the aging process, previous surgeries and job stress. The only thing we lacked, I thought, was insurance to cover the possibility that my wife or I would die before reaching retirement.

In late April of 1999, we applied for term life insurance. In May I received a letter from the insurance company declining coverage due to Hepatitis C infection.

In July 1999, blood tests and a liver biopsy confirmed that I have active, chronic Hepatitis C with Stage 2 (moderate) fibrosis. My doctors felt that I had contracted the virus at least 20 years ago, and based on my military service, it most likely came from blood products received during the surgery at Camp Lejeune. They agreed I should begin treatment as soon as possible.

I spent the rest of the summer in denial, which led to depression, for which I am still receiving treatment. I began to read everything available on Hepatitis C, paying particular attention to the statistics of the virus in veterans. I read about H.R. 1020 and S. 72, the two bills that would provide a presumption of service connection. The bills seemed to be stalled in committee. I contacted my congressman, who happens to be Speaker Hastert, and also Senator Durbin, asking for their support for this legislation. One of Speaker Hastert's aides suggested I contact Dr. Lennox Jeffers at the HCV Center for Excellence at the VA Center in Miami.

I was able to see Dr. Jeffers with only 2 weeks' notice, and I beg you to ask me follow-up questions about my difficulty in getting treatment in VISN 12 afterwards. He reviewed my test results and history and wrote a letter to the VA which stated in part, and I quote, "It is my medical opinion that it is as likely as not that Mr. Shallow was infected with HCV during his military service." End

quote. We discussed treatment. The threatened side effects of the treatment scared the hell out of me.

I decided to delay treatment as long as possible. However, 2 days later, my boss pointed out that I had used 47 sick days in 1999 and that the company could no longer afford to employ me. I had just lost my job of 8 years where I had worked selling medical management software to hospital systems.

Termination on the last day of the year also put a dent in my treatment and financial plans. I immediately applied for 100 percent VA disability compensation due to unemployability. I was told the VA was taking on average 24 weeks—that's 6 months—to determine claims. And a look at our family budget showed we would fail to meet financial obligations long before this determination was made.

It is that 6-month backlog and the impact that the waiting time has on my family, my financial situation and my health that has led me here today. Given a 6.6 percent infection rate among veterans, the figure currently being used by the VA, there are at least a quarter million enrolled veterans with Hepatitis C. I am just the tip of the iceberg, and yet the wait for a determination is 6 months. Without a presumptive service connection for HCV, I do not believe the VA adjudicators can reach a correct determination in HCV claims in anything resembling a reasonable timeframe. Let me explain.

I have a definitive diagnosis of HCV by five different doctors. Confirmatory tests have been done at Hines and during my C&P exam at Westside VA. Most well-grounded claims will have a definitive diagnosis.

I have a letter by one of the VA's top hepatologists to establish a nexus between my military service and my HCV, specifically stating, again I quote, "It is as likely as not that Mr. Shallow was infected with HCV during his military service." Unquote. Most vets will not have this critical piece of evidence in their claim.

I've brought along two visual images. One shows a radio operator, not necessarily a high-risk MOS, but note the deep scratches on his right hand. If this brother were called away from the radio to assist in loading bodies onto a chopper or to pull a wounded man to safety, he would have risked contracting HCV. It might be difficult to get a doctor to write a letter in support of his claim that he contracted HCV while working as a radio operator.

The next image is of two grunts. One is shaving the other. The razor being used was part of a platoon's special rations packet—intended for the entire unit. I think it would be very difficult to get a physician's opinion linking HCV to military service if sharing razors was your only risk while in service.

I realize this picture makes it pretty clear that these guys were in the thick of things—on the ground in Vietnam. However, without a Purple Heart, good medical service records, the corroboration of a buddy and mountains of other paperwork, this grunt if infected with HCV may progress to end-stage liver disease before he can become service-connected through the VA.

Veterans need to hear it from you, Congress, that it is your intent that we be presumptively service-connected for this silent epidemic.

A former member of Congress from the great state of Illinois once faced the same dilemma this committee faces today—how to provide for the everlasting wounds of battle. In his second inaugural address, Abraham Lincoln called on Congress to support a high standard. I quote, “to strive to finish the work we are in, to bind up the nation’s wounds, to care for him who shall have borne the battle, and for his widow and his orphan.”

Thank you.

[The prepared statement of Mr. Shallow, with attachment, appears on p. 107.]

Mr. QUINN. Thank you, Mr. Shallow. Thanks very much. Mr. Snyder.

STATEMENT OF KEITH D. SNYDER

Mr. Keith SNYDER. Thank you. My testimony is based on my experience for the past I guess 20, 21 years, as an advocate for veterans, and the past 10 years as an attorney in private practice. I have currently I guess four clients who have Hepatitis C virus.

I see, and must share with Mr. Shallow’s testimony, a significant need for service connection being available on a presumptive basis.

Mr. QUINN. Excuse me, Mr. Snyder. Where do you practice? Where’s your home town?

Mr. Keith SNYDER. Olney, MD, about 16 miles north of here.

Mr. QUINN. Thank you.

Mr. Keith SNYDER. My practice, however, is nationwide.

Mr. QUINN. Excuse me. Go ahead.

Mr. Keith SNYDER. The VA needs a presumption of service connection to follow to guide it, because it is taking so much longer and longer to process claims. Vets with Hepatitis C have less and less time left. They’re running out of time at the same time VA is taking longer to process claims.

Establishing service connection was difficult in the normal process, all aside from the most recent difficulties that veterans have, given the Court of Appeals for Veterans Claims decision in Morton with regard to what the duty to assist is for veterans. Even aside from that additional burden, that the veterans need to come with a well-grounded claim, these claims are very, very difficult. There are extra difficulties involved.

There’s a lack of diagnosis, specifically in service medical records. There’s a very long latency period. There are missing records that would corroborate some of these issues. And getting a supporting document—a supporting medical opinion from doctors—is not an easy matter in my experience. It takes quite a bit of time to try to do that, and the VA doesn’t explain to veterans that that’s what’s needed. The VA may say to veterans, you need a nexus, but what’s a nexus? They don’t say. You need to have an opinion from your treating physician that will link your present disease with some specific incident in service. That’s not explained. That needs to be. In the absence of that, these are very difficult cases to process.

And of course even with a presumption of service connection being available, that’s no guarantee of service connection being granted. VA still gets to assess the credibility of the presence of risk factors, the VA still gets to develop and evaluate whether

there was an intercurrent risk factor that might have been a cause of the Hepatitis C, and the VA gets to rebut the presumption. That's all built in still, even if presumption is granted as a result of this bill.

And still, if service connection is granted, that doesn't open the coffers of the Treasury to all the veterans that might in fact have a service connection for hepatitis. You have to go through a very elaborate and detailed and lengthy, again, process for establishing what percentage of disability is appropriate.

But to the extent that presumption can be granted through this legislation now, it's certainly going to save time for veterans, and veterans need to save time. VA also needs to save time. This will process these cases much more quickly. There will be fewer stumbling blocks for VA to try to get over. So I think there's a value both to veterans and to the VA in having service connection on a presumptive basis made available.

And clearly, you have several precedents for doing this. I mean, I'm a little chagrined that I sit here at only age 50, but I look back on my 20 years of working for veterans, and I've seen this legislative history for atomic veterans. I've seen it for Agent Orange veterans. I've seen it for Persian Gulf War veterans. I don't want to see it again. I don't want to see the time that's been involved and still goes on for Agent Orange veterans, for atomic vets, trying to add conditions here or there, down the road, 40, 50 years after the fact.

This group of veterans doesn't have that kind of time. And I really would urge you to push forward with this legislation.

There are also parallels to note with each of those conditions. Atomic vets' radiation claims, the Agent Orange claims, and the Persian Gulf War claims, in that VA did some work reluctantly initially, but not enough. We had numbers that said VA was granting very few of those claims initially. Congress stepped in and established a presumption. Those numbers then have gone up considerably. You need to do that now, and I'd urge you to do that quickly.

There's also some I think extra disturbing evidence as to why you need to act now and establish a presumption. Clearly, VA's testimony and VA's medical testing has revealed there's a high rate of infection in veterans. VA has tried repeatedly, however, as you'll see in its testimony, to educate its ratings specialists as to how to process these cases, but they have to re-educate, and they want to re-educate some more. Their last fast letter that went out to ratings specialists pointed out continual problems with handling these cases. And I don't think it's a matter of educating the ratings specialists. I think what Congress has to do is provide the guidance that VA then will simply implement.

And despite not wanting to denigrate VA's efforts with regard to Hepatitis C, I think there's a stonewalling going on, as I see in certainly VA's testimony today, with regard to these compensation claims. You don't have from the VA the numbers. The VA is not telling you how many folks have applied for this, what are the risk factors that they faced, and how many have been granted. What percentage of disability was granted on these claims? Where is that data? Is the VA collecting that? If they're collecting it, why aren't they giving it to you? My sense is that you need some more num-

bers, but you clearly have the numbers of persons infected. You clearly have the epidemiological evidence that suggests this is a significant problem. I think there's enough for you to act on now in establishing a presumption.

And something that I must say as a veteran, I find disturbing in VA's testimony at page 10. VA appears to suggest and wants to in a sense I think denigrate veterans' service by suggesting in its testimony that the research establishes that the highest incidence of hepatitis infections occurs in persons who would not be eligible for VA compensation. Injecting drug use accounts for about 60 percent of HCV cases. Now, this is not clear to me whether it's epidemiological research involving the entire citizens of the United States or purely veterans. But to suggest and emphasize that drug abuse is the cause of so much Hepatitis C I think does a disservice to our veterans who served honorably and need your assistance. And I would urge you to enact this H.R. 1020. Thank you.

[The prepared statement of Mr. K. Snyder appears on p. 119.]

Mr. QUINN. Thank you, Mr. Snyder. First, let me thank everybody on the panel. As far as the latency issue you bring up, Mr. Snyder, that's probably more of a medical question, but you bring it up. You also talk about better explanations for the vets and better education I think for the ratings specialists, which is just a communications problem. That's not medical, necessarily. It's just making sure they have the tools they need.

I'm going to save my questions. I'm going to rely on Dr. Snyder here this morning because of his work on this. But I wanted to thank you all for being here, Mr. Shailow, particularly, for your service to our country, and Mr. Snyder for your service to our veterans on behalf of the country.

Bob Filner, do you have anything?

Mr. FILNER. I'd like to just join you in yielding to Congressman Snyder as the author of legislation.

Mr. QUINN. Vic?

Mr. Vic SNYDER. Thank you, Mr. Chairman. Thank you, Mr. Filner. I guess we ought to point out, Mr. Snyder, to your and my knowledge, we're not related.

Mr. Keith SNYDER. Not to my knowledge, no, sir.

Mr. Vic SNYDER. Well, that's good.

Mr. Keith SNYDER. We were speculating.

Mr. Vic SNYDER. That's good for you. I wanted to ask Dr. Roselle, the whole issue of risk factors, and I have sat and talked with some of the doctors before they make these decisions, and they're not easy decisions to make. But when we have this problem of the latency period, 80 percent or so, according to VA testimony, we think were asymptomatic, even if they were symptomatic at the time, anyone in Vietnam or any kind of war zone that had, you know, diarrhea and vomiting and fatigue for a period of time, I mean, that was a common occurrence. You didn't go to the corpsman, or if you did you got some Maalox or something. So even the symptomatic ones in most cases wouldn't be suspicious of the disease.

But the issue is, how do you look back over a period of time and make a decision? For example, let's suppose I'm a corpsman and sustain a minor injury of some kind, maybe not from shrapnel, but tear a foot open running or a leg open on a tent stake or some-

thing, trying to treat some folks. In the course of treating people I get blood on me. And later in life, after getting out of the service, go into health care, become an emergency room orderly. Later in life I have a blood transfusion in the private world, and then I look back 25 or 30 years after I have contracted Hepatitis C at someplace. Is it a fair statement to say that we will never know what was the source of a person's infection in that kind of a situation?

Dr. ROSELLE. I think that's a fair statement. The only way you generally can define where a point source is if you have a single-source outbreak where, say, one person is contaminating 10 people, and then you can do the epidemiologic and genetic evidence. But in the broader sense that you're describing, I don't think you can pinpoint the cause.

Mr. Vic SNYDER. So then if we want to add on the complication I think that some of our veterans have, if the person making the decision, in addition to those other factors I threw in there in a life history of a Vietnam veteran, if they have incidents of IV drug use, it has seemed to me there is going to be an inclination to disregard all the other potential risk factors. But that's the one that if you're the adjudicator, you may clearly say, well, that may be more likely than not. But the reality is, you do not know what that point of the viral contact is. Is that correct?

Dr. ROSELLE. Then it becomes a statistical evaluation of what's likely and what's not, which in large populations may be valid but may have no validity for an individual case.

Mr. Vic SNYDER. I think that's about the most eloquent description of the problem that I've heard over the last year, and I feel for the VA. They look at the numbers and they say, look, a hefty number of these are going to be IV drug use, but when you consider an individual, you do not know and you will never know what the source of their infection was.

Would you talk a little bit, please—it relates to Mr. Snyder's comments about disability ratings—in terms of, if people get treated, this issue of what percentage disability rating they should have, describe would you please a course of treatment. What, for somebody like Mr. Shallow—I don't know his specific situation, but—will there be periods when a person may well be unemployable for prolonged periods of time, maybe have periods of being employable? But just describe potential alternatives there.

Dr. ROSELLE. In general, since most of these cases are genotype one, people will get 48 weeks of treatment, assuming response. Six months, even if there's no response. That is a regimen of medication orally twice a day and a subcutaneous shot three times a week.

In the early phases, side effects are quite common and can be significant. Up to 2, 3, 5, 8 percent will have significant side effects, and slightly fewer than that may actually come off therapy based on adverse events associated with the treatment. Up to 15 percent will probably have some significant side effects that will require dosage adjustments. The major side effects are from the ribavirin are anemia, and that many people get anemic from ribavirin. It is a pretty standard event with the drug. Some will have a greater drop in their blood counts.

For the Interferon is flu-like illness and malaise and headaches and those sorts of things, as well as difficulties with concentration and depression.

So when you ask will people be unable to work on therapy, I think that I'm fairly confident some will have difficulties working on therapy. The number in the VA is not known. We may have a particularly vulnerable population with the association of post-traumatic stress, et cetera. So I think those data are not entirely clear at the moment. The study that's under way based in San Francisco should shed some light on that next year.

Mr. Vic SNYDER. I see my time's about up. One last question. As a physician in the VA system, do you think that establishing service connection for a veteran, using Mr. Shallow's example, does that help, hinder, or have no effect on the veteran seeking treatment and getting the appropriate treatment?

Dr. ROSELLE. I can't really go into policy. In terms of a patient I would see, it would have very little effect.

Mr. Vic SNYDER. Because you're already seeing the patient?

Dr. ROSELLE. Because we see patients. So I think that I really can't answer that in a broader sense.

Mr. Vic SNYDER. Thank you, Mr. Chairman.

Mr. QUINN. Vic, I'm prepared to yield my time if you have some more questions, and so is Mr. Filner. We don't want to cut you off, but—

Mr. Vic SNYDER. I think I'm all right for now.

Mr. QUINN. Okay. Good. Thanks.

Mr. FILNER. I just want to thank all of you, Mr. Shallow especially, for coming. You have—it's not often that we can say that these hearings always advance the cause of the legislation. You know, there's a lot of stuff going on. But you really have helped us understand this, and you have advanced the legislation, and I'm looking forward to passing it, and with your eloquent testimony here to help us.

Mr. QUINN. Mr. Shallow, I'd also just finish up. We all obviously interact with all the Members of the House, whether they're on the committee or the subcommittee or the Speaker of the House, for that matter. So I take it under advisement where you live, and your Member of Congress, we'll be sharing with his office your testimony this morning and also try to work with him to see if we can assist in any way that Vic hasn't already started. Thank you all.

Mr. SHALLOW. Thank you.

Mr. QUINN. We'd ask our third panel to come forward now. We're pleased to have with us Mr. Harley Thomas, who will begin for us this morning as we work our way across the table. Harley, good to see you again.

Mr. THOMAS. Good morning, sir.

Mr. QUINN. Ms. Linda Schwartz, who's on the VA Advisory Committee on Women Veterans. Mr. Peter Gaytan, and finally, Ms. Joy Ilem. It's good to see you again this morning.

Ms. ILEM. Thank you.

Mr. QUINN. And as I said earlier, we're in the middle of our five panels, so we'll give you an opportunity—we've received your testimony, give you an opportunity to summarize for a couple of minutes, and we'll save any questions that we have, yielding again to

Dr. Snyder until all four of you have testified. Harley, would you like to begin?

STATEMENTS OF HARLEY THOMAS, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; LINDA SPOONSTER SCHWARTZ, ASSOCIATE RESEARCH SCIENTIST, YALE UNIVERSITY SCHOOL OF NURSING AND CHAIR, VA ADVISORY COMMITTEE ON WOMEN VETERANS; PETER GAYTAN, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND JOY J. ILEM, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF HARLEY THOMAS

Mr. THOMAS. Good morning, Mr. Chairman, Mr. Filner, Dr. Snyder. On behalf of the Paralyzed Veterans of America, it's a pleasure to be here this morning and give our views on the pending legislation.

H.R. 1020, Veterans Hepatitis C Benefits Act of 1999, will permit veterans who contracted Hepatitis C to receive benefits and services they deserve by adding a presumption of service connection when the veteran was exposed to any of the conditions outlined in the bill.

Hepatitis C is the most common chronic bloodborne infection known in the United States. Studies conducted by the VA show veterans to be at much greater risk for the infection with Hepatitis C than the general population. It has been our experience that the VA appears to reject service connection because the veteran cannot produce evidence that the current diagnosis of Hepatitis C is related directly to his military service and exposure under conditions most veterans experienced on a day-to-day basis.

It is our opinion that the VA currently has the authority to make the connection between many experiences and exposures related to military service and subsequent disabilities such as Hepatitis C encountered later in life. The question arises as to whether the VA is currently giving veterans with Hepatitis C the benefit of the doubt. It is clear in many cases they are not. This appears to be based on many reasons, including renegeing on the veterans—excuse me, on the VA's duty to assist veterans in bringing their claims forward.

This new legislation would attempt to correct this problem by providing a list of potential in-service exposures which could be presumed to be the cause of Hepatitis C. PVA applauds the intent of this legislation by giving VA concrete direction in adjudicating veterans' claims relating to Hepatitis C, and we'd like to thank Dr. Snyder for the introduction of 1020.

PVA fully supports the enactment of H.R. 3816. We feel it is not only reasonable but also logical that should a member of a Reserve component suffer a cardiovascular accident or acute myocardial infarction during the period covered by performance of inactive duty training, the condition should be presumed to be service connected. Typically when an individual undergoes excessive physical and/or mental stress preceding either of these conditions, it may be hours or even days before the condition manifests itself.

H.R. 3998, Veterans' Special Monthly Compensation Gender Equity Act, PVA supports H.R. 3998 and believes it will deliver equity without regard to gender.

Any member of the United States armed forces subject to the loss of one or more breasts due to radical mastectomy should be compensated for the service-connection condition. Women constitute the fastest-growing population of veterans eligible for VA health care and benefits. Today women account for 15 percent of the active force and about 20 percent, except for the Marine Corps, of new recruits. By 2010, women will account for more than 10 percent of the veteran population. That's 150 percent increase over the current numbers.

PVA believes this legislation is both timely and proper and we'd like to thank Mr. Evans for the introduction of it. I would like to point out, however, Mr. Chairman, that although the bill references gender equity, it must be remembered, even though the numbers are quite small, men are also at risk for this condition. Therefore, we believe gender should not be an issue.

The Veterans' Compensation Cost-of-Living Adjustment Act of 2000, H.R. 4131. Many disabled veterans have limited earning power due to their service-connected disability. In some cases, they have completely lost their earning power and must rely on compensation for the basic necessities of life. Similarly, surviving spouses of veterans who died as a result of a service-connected disability must also rely on Dependency and Indemnity Compensation, DIC.

Disability compensation and DIC rates are quite modest. And due to inflation, recipients with fixed incomes must rely on cost-of-living adjustments in their struggle just to keep pace with day-to-day cost of living.

Mr. Chairman, PVA has always supported annual compensation and adjustments and will continue to do so. As in the past, we believe that all adjustments to compensation should be rounded up to the nearest dollar instead of down.

Mr. Chairman, this concludes my testimony, and I'll be happy to answer any questions.

[The prepared statement of Mr. Thomas appears on p. 129.]

Mr. QUINN. Thanks very much, Harley. I'm going to—Dr. Snyder, would it be okay with you? We've got 15 minutes to get over there—if I suggested that we try to give the other three panelists about 3 minutes or so instead of—excuse me, instead of a full five, and then that way at least we'd get the testimony out of the way until we go vote?

So, Linda, could I ask you now to summarize even further what you've boiled down to 5 minutes into about 3 minutes?

Ms. SCHWARTZ. All right.

Mr. QUINN. The questions will be fabulous from Dr. Snyder, I promise.

Ms. SCHWARTZ. I hope so.

Mr. QUINN. Go ahead.

STATEMENT OF LINDA SPOONSTER SCHWARTZ

Ms. SCHWARTZ. I just want to state for the record that I am Dr. Linda Schwartz, an associate research scientist at the Yale School

of Nursing. I am medically retired from the United States Air Force, and I have the honor to chair the VA Advisory Committee on Women Veterans.

I will be very succinct in my remarks today. I want you to know that obviously you know that the reason the whole question of the special K-award came up was because of the Women Advisory Committee's report to the Congress. And I think it's really important at this juncture for me to explain to you why we made that recommendation.

At that point, we felt that because men and women received the same compensation for mastectomies, we did not feel that we were looking for a strategy in which to add another consideration to the magnitude of the loss that a woman suffers when she suffers a mastectomy, the radical and the simple radical mastectomy. So that's why we made this recommendation as the K-award.

And obviously, the question on everybody's mind this morning to me is, do we support this legislation because of the special K-award? I think the most important thing is for people to understand that \$76, no one would really want to be against anybody receiving \$76 in addition to the pain and sorrow they have with mastectomy, be they man or woman. However, if someone would ask me, do I think it is the same for a man or a woman to have a mastectomy, I would say no. And obviously if you—I refer you to my testimony and I enumerated the number of reasons why I believe that women do suffer a great deal when they have mastectomies.

One of the things that I would like to point out is that if a woman were service-connected for a mastectomy, she would be leaving the service because of cancer, most probably. And that is somewhat of a problem for women in a childbearing age, between 30 and, you know, 40, or 50 even some people can have children. This robs them of a very important part of the creative reproductive process, which is breast feeding and the ability to nurture their newborn.

Additionally, this is also a part of their body image. It is something that reflects them. It's a physical part that is easily discernible. And so for those many reasons, that is why my committee brought this forth to the Congress.

My last point is that we brought this forth to the Congress because we are required by law to give you a report. However, I would like to tell you that this is—the 1998 report is our last report to you. The legislation has sunsetted the requirement for the Secretary of Veterans' Affairs to convey our report to the Congress, and I am hoping that as you go through your deliberations in the next year that you will consider the value of the input of this committee and the need for that kind of a report to come forth.

Thank you.

[The prepared statement of Ms. Schwartz appears on p. 133.]

Mr. QUINN. Thank you very much, Linda. Mr. Gaytan.

STATEMENT OF PETER GAYTAN

Mr. GAYTAN. Mr. Chairman, members of the subcommittee, I appreciate the opportunity to provide testimony this morning on behalf of the more than 250,000 members of AMVETS. And in the in-

terest of time, Mr. Chairman, if you don't mind, I would like to summarize very briefly.

We—AMVETS does support each of the bills that we're discussing here this morning, and I would like to yield the remaining time to the doctor to ask more questions. There's nothing that I can say in my prepared testimony that has not already been said this morning or will not be said later, and I think it's in the best interest of advancing this legislation if I stop here.

[The prepared statement of Mr. Gaytan appears on p. 139.]

Mr. QUINN. Thank you, Peter. We'll invite you back again. We like this. (Laughter.)

Thank you very much, sir. In fact, next time we need only one panelist, I think.

Mr. GAYTAN. I am available.

Mr. QUINN. Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman, and members of the subcommittee. I, too, appreciate the opportunity to provide testimony here today.

As an organization dedicated to the welfare of our Nation's disabled veterans, DAV is very concerned about Hepatitis C and its effect on the veteran population. The American Liver Foundation reported last year that one in 10 United States veterans are infected with HCV, a rate five times greater than the 1.8 percent infection rate realized among the general population.

Increased numbers of veterans are being diagnosed with Hepatitis C and seeking treatment and disability compensation for the disease. Unfortunately, we've had numerous reports from our DAV field representatives from around the country indicating that VA is inappropriately denying many of these claims on the basis that they're not well-grounded.

In a VA November 1998 letter, it informed rating specialists that when there was evidence that a veteran was exposed to certain risk factors for Hepatitis C in service, such as a blood transfusion, hemodialysis or employment in a health care occupation, a claim for Hepatitis C resulting from one of these risk factors in service would be a plausible nexus for the purpose of well-groundedness. They noted that these certain risk factors are both plausible and a cause of Hepatitis C infection and capable of substantiation by documentation in the service records.

In written testimony submitted for the record, I provided a synopsis of a couple of cases providing those obstacles veterans face in meeting the well-grounded requirement. In each case, the veteran had a current diagnosis of Hepatitis C, reported a risk factor in service, such as in the first case a blood transfusion before 1992, and in the second case, he reported that he worked in a health care occupation and had experienced an accidental needle stick. Each of these cases noted were denied based on not well-grounded for a lack of evidence of showing an in-service occurrence of the disease. Reported risk factors were not confirmed or addressed by the rating specialist in the rating decisions of those claims.

The slow progression of this disease over a 20 to 40-year period in most cases prevents you from seeing the in-service occurrence of

the disease. The incurrence in service generally will be lacking. We feel that VA is obligated to monitor these cases closely and to provide equitable and uniform decisions for these claims.

We recommend that VA amend 38 C.F.R. subsection 3.303(d) to expressly include Hepatitis C under its provisions and authorize service connection in the absence of direct proof where a cause-and-effect relationship is shown between the in-service related factors and the disease diagnosed after service.

With regard to H.R. 1020, the Veterans' Hepatitis C Benefits Act of 1999, providing a presumption of service connection in certain veterans, we appreciate the introduction of that bill and we support its goals.

We do not have a mandate regarding H.R. 3816 to provide that a stroke or heart attack incurred by a member of a Reserve component performing inactive duty for training shall be considered service connected. However, its purpose is a beneficial one, and we certainly support its favorable consideration.

Regarding H.R. 3998, we support this bill to authorize special monthly compensation payments for veterans who have established service connection for residuals of radical mastectomy. Traditionally, service connection is provided for medical conditions incurred during military service based on a loss of earning capacity. However, as mentioned by Congressman Lane Evans, these also provide recognition of noneconomic losses such as loss of physical integrity. So certainly we feel that would be appropriate under that statute.

The DAV also supports H.R. 4131, and we're appreciative of the annual increases Congress provides for the rates of disability compensation, DIC and clothing allowance. I'll be happy to answer any questions that you have. Thank you.

[The prepared statement of Ms. Ilem appears on p. 143.]

Mr. QUINN. Thank you very much, Joy. For the purposes of the record now I want to make certain we understand that Ms. Berkley has a statement that we'll accept for the record this morning, even though she had to leave. Without objection, that is ordered.

[The statement of Hon. Shelley Berkely appears on p. 56.]

Mr. QUINN. Secondly, make sure we understand that we do have some questions for this panel, so when Vic and I leave in a minute, you'll be back at the table when we come back. And then we have two more panels to go when we do return. Peter?

Mr. GAYTAN. Mr. Chairman, I just wanted to make it clear that I wanted my testimony that was submitted to be added to the record.

Mr. QUINN. Oh, absolutely. Absolutely.

Mr. GAYTAN. Thank you, sir.

Mr. QUINN. We began with—

Mr. GAYTAN. Didn't want to be too brief. I still have to do my job.

Mr. QUINN. That's right. Before you know it, you'd just be sending it in, and then you we won't get a chance to talk to you. (Laughter.)

Mr. GAYTAN. Thank you, sir.

Mr. QUINN. Nobody wants that to happen. So I'm going to—Vic, we'll recess here for enough time to get us over. It's one vote. So we'll be back in about 5 minutes or so. Thank you.

[Recess.]

Mr. QUINN. Let's get back to work, if we may. Thanks for your patience and indulgence again. To show how bipartisan we are, Vic and I are both voting yes on all these things over there today. (Laughter.)

Whether they like it or not, we're going to vote the same way. Seriously, though, thanks for understanding. I think we've got over an hour and that can get us through both panels with some questions. I'm going to yield to Dr. Snyder now to begin some of the questioning. I had one sort of in there that I've talked to Vic about, and he's going to get a question for me. I am going to step out for a bit, and Congressman Gibbons will take over in the chair for maybe the rest of the morning and afternoon. Thank you.

Vic, the time is yielded to you.

Mr. Vic SNYDER. Thank you, Mr. Chairman. Ms. Ilem—is it Ilem or Ilem?

Ms. ILEM. Ilem.

Mr. Vic SNYDER. Ilem. Ms. Ilem. I wanted to ask—and I just got a written copy of your testimony this morning—but as I heard your comments and quickly glanced at your testimony, you all have concerns about H.R. 1020 because of its cost. Is that correct?

Ms. ILEM. The—not specifically. It would be the PAYGO, you know, effects, that there may be some PAYGO effects there. But, I mean, we don't have an objection to it. We would hope that it could be corrected within VA, but we recognize that in the past with other presumptive disabilities for atomic vets, Agent Orange, et cetera, have not. They haven't been able to do it appropriately. So that this may be the necessary, you know, way to go. And we certainly don't have an objection to the bill.

Mr. Vic SNYDER. Mr. Quinn and I were talking on the way over, because that's always a concern if you create something new that it takes money from the proven programs you have. It's just that it seems—this is clearly a group of veterans that are sick, and I'm not sure—I'm not sure if we should—it seems to me that we ought to move ahead with trying to take care of those that are ill and then scream and shout to be sure that all our veterans—

Ms. ILEM. I think that may be the only way. It may be the only way to do it based on historically what's happened with some of these other—

Mr. Vic SNYDER. I think the cost estimate is a little over like \$33 million a year, which it didn't seem unreasonable to me. I wanted to ask, you did suggest, however, another alternative, did you not, in your testimony? Would you describe that in more detail?

Ms. ILEM. Yes. That would be to, under 3.303(d) of the 38 C.F.R., to include that specifically to include Hepatitis C under that provision, so that it's specifically spelled out that that would be, you know, for that specific disability.

Mr. Vic SNYDER. But you think that that alternative would not result in the same cost problems? Do you see H.R. 1020 as being more expansive in terms of veterans that would be covered? Is that what you're saying.

Ms. ILEM. No. I mean, it would just be an alternative. I mean, by doing it under 38 C.F.R. 3.303(d), you know, without having that same, you know, offset I guess with H.R. 1020. I mean, I see

what you're saying that, you know, it should be equivalent, but I guess that's just another way to take care of it. Either way. But we certainly don't have an objection to implementation of H.R. 1020 and as it involves the different disabilities, risk factors, excuse me, that VA wouldn't consider. It seems that they haven't been considering, taking into consideration as plausible risk factors. And you list the additional ones in H.R. 1020 that certainly warrant consideration, I think.

Mr. Vic SNYDER. I want to ask, for anyone who has a comment on this, the issue of the IV drug use as an obviously a known source. It seems that I guess the issue for me comes down is where do you make the error? Do you make the err—under the bill I have I think it would be very clear that there would be additional people who would be service-connected with Hepatitis C and treated for their illness that, if the truth were known, probably got it from IV drug use.

My concern, though, is under the current system, that we are excluding people that did not get it from IV drug use because of the way the lines are being drawn. And so from your all's perspective, I mean, what do you think about a system that, you know, one of the criticisms is, under H.R. 1020, we probably would end up with people that acquired it by IV drug use, but they had another risk factor, but we'll never know what the true source was. Do you all have any comments on that?

Mr. THOMAS. Mr. Chairman—or excuse me, Dr. Snyder—as you stated, there's such a long gestation period for this disease to appear, I don't believe that anyone can probably sit here and say that we can definitively say that a veteran did or did not contract Hepatitis C while they were in the service based upon various lifestyles.

However, I think that we have a duty to give the veteran the benefit of the doubt. That if they were exposed to any of these conditions during their military service, regardless of what they did after they got out of the service, we have to give them the benefit of the doubt.

Ms. SCHWARTZ. Dr. Snyder, I served in the Air Force as a nurse in a battle casualty staging area in Japan during the Vietnam War. I also served in Europe. At that time, the military had a program called the Limited Privileged Communication Program, where if someone had a drug problem they were given amnesty of a sort, a general discharge, and promised treatment. I don't know if that adds anything to your knowledge of the subject, but from my perspective, I think at that time it was an intrinsic difficulty that people encountered while they were serving in the military, and through that Limited Privileged Communication Program, the offer of care I think would continue on to care as a veteran.

Mr. GAYTAN. Sir, with AMVETS, it's our main concern that any veterans who were exposed during service to Hepatitis C and contract it in later years do receive the care that they need. And I think it's been said this morning that you cannot actually distinguish cause exactly when you're dealing with two different exposures. So I think by including those veterans who were exposed initially during service, that will accomplish our goals of making sure those veterans are treated.

Ms. ILEM. I would have to agree both with Mr. Gaytan and Mr. Thomas on that issue as well. You know, if we have two risk factors and we're unable to determine, I think it has to go to the benefit of the doubt of the veteran.

Mr. Vic SNYDER. Thank you, Mr. Chairman.

Mr. GIBBONS. [presiding] No more questions, Mr. Snyder? Because if you do, I would be happy to yield you a few extra minutes. I have no questions of this panel at this time.

Mr. Vic SNYDER. I asked Dr. Roselle the issue of do we think that, because you all have contact, direct contact with veterans trying to get benefits, what do we think or what is your all's opinion about what kind of delay results in the veterans seeking treatment are able to obtain treatment because of inability to establish service connection?

Ms. ILEM. Well, I think in my testimony I pointed out we asked our field representatives to send us several, you know, any cases where there had been a problem. We wanted to take a look at them and see what sort of problems veterans are facing. And I think that even though the VA had clearly spelled out in their directives into the field, you know, what would be—what should be considered and could be substantiated by their service records, you know, just hasn't been taken into consideration with regard to this.

You know, they've got—they're providing evidence that they've, you know, they have the disease, they're being treated for it. Now I don't know in certain areas of the country that I haven't had complaints that I haven't been able to be treated for it because I'm not service connected yet. I think when they've gone in initially to be tested, that they're doing that. But, you know, it may—I mean, once they're denied, I don't know what their situation may be based on their financial need or whatever of being able to continue treatment.

But certainly, I think VA needs to do a better job in looking at these types of claims and making sure that their people who are making determinations are looking at all the factors and at least getting past the well-grounded issue to look to make sure, you know, that the service connection can be established when it's appropriate. Even, you know, they're aware of this long-term 10 to 40 years incubation period or period until it usually manifests to a point where they recognize that they have some sort of, you know, disease.

But certainly as the testimony provided earlier from the physicians about the severity of the symptoms and, you know, the inability to work a lot of times based on their treatment regime and medications, et cetera, and the devastating effects, I mean, if it's related to service, it needs to be service connected so they can be adequately compensated as well as receive treatment.

Mr. Vic SNYDER. Thank you, Mr. Chairman.

Mr. GIBBONS. Thank you, Mr. Snyder. With that, we'd like to thank this panel for their enlightened and informative testimony. It's very helpful to us to hear your thoughts on this issue. We would excuse you at this point and like to call up our fourth panel this morning.

The fourth panel will consist of Mr. Richard Schneider, Director of State/Veterans Affairs, Non Commissioned Officers Association;

Mr. Sidney Daniels, Deputy Director, National Legislative Service, Veterans of Foreign Wars of the United States; and Mr. Philip R. Wilkerson, Deputy Director, National Veterans Affairs and Rehabilitation Commission for The American Legion. Gentlemen.

Again, your full testimony, your written testimony, will be submitted to the record without objection if you would care just to summarize and perhaps keep your testimony to somewhere around 5 minutes would be appreciated.

With that, we'd start with Mr. Schneider. Welcome. Good morning, and the floor is yours.

STATEMENTS OF RICHARD C. SCHNEIDER, DIRECTOR, STATE/ VETERANS AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA; SIDNEY DANIELS, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND PHILIP R. WILKERSON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF RICHARD C. SCHNEIDER

Mr. SCHNEIDER. Thank you very much, Mr. Gibbons, and thank you, committee, for holding this hearing. And thank you for looking at the reality of these particular four pieces of legislation.

I'm just going to provide specific comments on Hepatitis C and on the mastectomy issue, and then I'd like to dwell a little bit longer on the Reserve/Guard component personnel and also the COLA recommendation that is contained in one piece of legislation.

Hepatitis C we support unconditionally, equivocally that it should be an automatic presumption of service connection. There is no doubt that it has to be that way or veterans will not get through the front door of the Veterans Benefits Administration and will not receive the care that they should receive through VHA. They need to get it. They need to get it, and they need to get it quickly.

It was impressed upon us this morning, and I impress it again upon you, time is of the essence for these people, even though 24 years have elapsed, the next years are critical. And now that we know the problem, we need to identify the care. The thing that's interesting, too, is VA has gone out through VHA and identified everything that's in the proposed legislation and said if you have these, you ought to be tested for Hepatitis C. VA has been on line very strongly right now to do the screening process. We need to move over to the benefits side and say presumptive finding. Start the process rolling.

On mastectomy—mastectomy, excuse me for that—we fully support that particular issue as being an equitable issue for women, and we support fully the K, and we think it's ridiculous to even debate the amount of money involved with the K award. We support everything that was addressed at the earlier panel.

Regarding the Reserve and Guard components, and here I'd like to say, we strongly, strongly support the intent of the regulation, but we will be the first to tell you, it does not go far enough for the members of the Guard and Reserve. The Guard and Reserve

are no longer the hometown boys serving in their backyard communities and being viable members of the Nation's armed forces.

The people in the Guard and Reserve carry a tremendous deployment ratio and balance. They're going to be used in every scenario to complement and to augment the active duty troops. And I'll tell you, the Guard and Reserve of today are a great force to be reckoned with. We need them. But as much as I say we need them, we also need to take care of them. And this nonsense about duty status going to and from an inactive duty training assignment, what happens enroute, what happens while they're at the UTA, what happens between successive periods of the UTA; that is, what happens on Saturday night between the drill period on Saturday and the drill period on Sunday. We have to take care of our people.

Mr. Stupak this morning indicated the word "disease," and I jumped right up. I could have applauded from the back of the room. That's not what he really wanted to say, and I'll be the first to admit that. But coronary disease is a problem, because it's listed as a pre-existing condition. It's listed as something that immediately disqualifies the Guard and Reserve member from consideration of a service-connected problem if during the UTA or the ITA, if during that assembly period they extend, they exert, they aggravate the conditions they have, and have a coronary event, that they in all likelihood are excluded from continued Reserve service.

You're not going to deal with that today. But our association wants to put it on the record. We want to put it before you, and we hope that you will talk with your contemporaries in Armed Services and recognize that we have got to do a better job of taking care of our Guard and Reserve people. We bring them out and when they come they don't know that they have a congestive heart problem, disease, or anything else. I will tell you that they are not informed by their Reserve medical care unit that they get in the Guard and Reserve component. As a matter of fact, I would tell you that I think their medical care such as coronary screening stinks in both active and Reserve components. Stinks! It doesn't identify such medical problems, doesn't tell the people they have a problem. So they really are working, they're performing their duty and they're deploying without ever knowing that they have potential heart problems.

Fortunately, if they deploy and have a coronary event, they're covered because they're on active duty and they're taken care of. And I say to you, that two people that fall down, one active duty, one Guard or Reserve, ought to be treated the same. They ought to be treated the same.

I'll move to the COLA. I made the point. I'll move to the COLA. We fully support COLAs for veterans, but we don't support the legislation that you have before us today. And I'll tell you why we don't support it. Because it creates a linkage of veteran benefits with Social Security and integrates the two, and we want to see the two remain separate. We want to see them remain distinct. We don't give a flip whether or not the amount is the same or not. That's up to deliberation and that's up to the approval process. But we want them separate and distinct. And when you hear of funding problems envisioned in the future, questions as to whether Social Security will be here, will they have the money, will there be a So-

cial Security cap, we don't want veterans to be an integrated part of COLA decisions with SSA. NCOA wants that process de-linked. Thank you.

[The prepared statement of Mr. Schneider appears on p. 150.]

Mr. GIBBONS. Thank you very much, Mr. Schneider. Mr. Daniels, welcome. Good morning. The floor is yours.

STATEMENT OF SIDNEY DANIELS

Mr. DANIELS. Thank you, Mr. Chairman. To begin with, the VFW supports each of the bills under consideration this morning.

With respect to H.R. 1020, we believe this legislation is an appropriate response to what is recognized as one of the biggest medical challenges facing us today. Hepatitis is a disease that has historically been associated with military service. Field bleeding, surgery and transfusions, and exposure to blood by military medics and surgeons all constitute high risk.

Veterans infected with Hepatitis C during military service are generally unable to establish a service connection. The lack of knowledge of Hepatitis C and until recently the lack of a reliable test, not to mention the long latency period of this disease, makes it difficult to prove that the infection was acquired during military service.

Even today when there are reliable tests for Hepatitis C, the military does not conduct HCV tests as part of its discharge physical examination. Without a presumption of service connection, most veterans who contracted Hepatitis C in the military will not be eligible for treatment in VA facilities. In fact, in a review of nearly 1,600 cases of chronic hepatitis brought before the Board of Veterans Appeals between the years 1994 and 1996, only 37 cases resulted in approval of a service-related disability rating for Hepatitis C.

Accordingly, we would urge quick passage of this measure, Mr. Chairman.

With respect to H.R. 3998, we have concern that the language as currently written would create an inequity. In general, the rating schedule is gender neutral in the evaluation of disabilities. For example, a male veteran should be considered the same in this legislation because the disfigurement of breast removal procedure would most likely be the result of a comparative disease that attacks either gender. Therefore, all veterans should be entitled to the same consideration for the surgical procedure of breast removal under the rating schedule.

And on that note, Mr. Chairman, I conclude my statement, and I'd be happy to answer any questions. Thank you, sir.

[The prepared statement of Mr. Daniels appears on p. 155.]

Mr. GIBBONS. Thank you very much, Mr. Daniels. Your testimony is very helpful.

Mr. Wilkerson, welcome. Good morning. The floor is yours.

STATEMENT OF PHILIP R. WILKERSON

Mr. WILKERSON. Thank you very much, Mr. Chairman. The American Legion appreciates the opportunity to express our views on several legislative initiatives being considered this morning.

H.R. 1020 proposes that, if a veteran in service was exposed to one or more enumerated risk factors, then service connection on a presumptive basis could be established for Hepatitis C. Hepatitis C is now recognized as a transmittable bloodborne virus, which can have potentially long-term health consequences. Current data indicates that approximately 2 percent of the general population have been exposed. However, what is truly alarming is the finding of the prevalence in the veteran population, with Vietnam veterans seemingly most directly affected.

Such findings would be consistent with the inherent risks associated with military service both here and abroad where training, combat and other activities can frequently involve exposure to potentially infected blood or blood products and other health risks. Many veterans who currently have Hepatitis C-related problems unknowingly contracted the disease 25 or 30 years ago.

Now, when veterans file a claim for service connection, they must prove they were exposed or treated for Hepatitis C in service, just as with any other type of disability claim. However, if they cannot produce such medical evidence of this condition in service, the claim is generally denied as being not well-grounded. This can be an insurmountable legal hurdle for most veterans. The American Legion believes there is sufficient and compelling scientific evidence of a link between the various risk factors associated with military service, such as those enumerated in H.R.1020, and the current diagnosis of Hepatitis C as to warrant either a regulatory or statutory presumption of service connection.

The establishment of a presumptive service connection for Hepatitis C will, in our opinion, enable veterans disabled by this disease to receive benefits and assistance as well as appropriate VA medical care and treatment.

With regards to H.R. 3816, the American Legion believes it will be beneficial and appropriate to revise the statute so that veterans who suffer a heart attack or a stroke while on inactive duty for training can receive service-connected disability benefits.

This longstanding provision of the law has always distinguished between disability due to physical injury and disability arising during this period which is considered due to a pre-existing disease process. Claims for service connection for heart attacks or strokes have generally been denied, unless it can be shown that it was precipitated by some type of physical injury or trauma. This bill will overcome this problem and recognize that there are added risk factors for those who continue to serve this Nation in our ready Reserves and National Guard.

The American Legion is supportive of H.R. 3998 to provide additional compensation to veterans who have been disabled as a result of mastectomy surgery. We believe this change in law will make the compensation for all disabled veterans more fair and equitable.

The American Legion is strongly supportive of the cost-of-living adjustment as proposed by H.R. 4131. Annual congressional hearings to consider the adequacy of these benefits is important in ensuring the continued welfare and well being of this Nation's disabled veterans and their families. This type of hearing is also an important opportunity to discuss this and other issues affecting veterans and their benefits.

That concludes our testimony, Mr. Chairman. We would certainly be glad to respond to any questions you may have.

[The prepared statement of Mr. Wilkerson appears on p. 158.]

Mr. GIBBONS. Thank you very much, Mr. Wilkerson. Perhaps I can lead off with just a general question for each of you based on your prior military service and knowledge of conduct within each military. This bill, H.R. 1020, does create a presumption that would compensate veterans for body piercings and tattoos while on active duty service. Is there an issue involved in this which would deal with the obtaining of body piercing or tattoos that might be an issue of willful misconduct or personal responsibility with this bill? Can any of you address that issue?

Mr. DANIELS. I'd be happy to. Historically, when you serve in the military, it's often said that they own you, lock, stock, and barrel, 24 hours a day, so ownership does not get a break. For those soldiers who choose—soldiers, airmen, Marines—who choose to get a tattoo, I would presume that that's a morale booster for them and they're quite welcome to do that. But the fact of the matter is, it's the same as if you're in an automobile traveling from one base to the other, and you should have an accident, the military is still responsible for you. So, no, I don't give any credence to tattoos being willful misconduct. I still believe it's in the course of your regular duty, and that the government is responsible for it.

Mr. WILKERSON. I'd like to comment, if you wouldn't mind. At least tattoos seem to be historically associated with people in the military service, and it's a form of military culture, if you will. Not everybody acquires one while they were in service. However, I think what is important in considering the legislative relief that's being proposed here deals with events that took place years ago during a person's military service, and we should not try to substitute current judgment or any decision of that nature upon past behavior, since it's clearly not within the category of willful misconduct, as some other activities of our servicemen clearly are.

So I think it would be wrong to impose such a restriction at this particular juncture. Possibly in the future, assuming that this legislation would be enacted into law, it might be amended to place such a restriction on tattooing, if there was sufficient informed consent by an individual when he enters into military service. Something like, "I know the risks of obtaining a tattoo or body piercing, and if I do so, then it's my own responsibility" that sort of thing.

Mr. SCHNEIDER. Yes, I'd also like to add a comment. And the comment I would add is that there's never been a military prohibition against tattoos. There has been a prohibition recently on tattoos that show above the collar where some of the people were coming up their neck and around the side of their face. These were considered to be unattractive and inappropriate. People were cautioned not to do that or be separated. But even today there is still no absolute prohibition. I don't propose that we should limit such activity, or that we should characterize these people as involved in willful misconduct, because they are not.

And, if you were to have a person in service for 3 months who gets caught shooting drugs or using needles or what have you, then that person is normally separated for misconduct. You have a different situation entirely. If you had somebody go 18 years and they

served in Vietnam in their first 4 years, and 18 years later they had some kind of a problem, you'd have to weigh in favor of the individual with regard to the care, not necessarily compensation, but in regard to the care.

I think of how many women get pierced ears, all the way up and down the side, and body piercing of this type for women has never been prohibited. So I would strongly support that we leave that alone and that not make it an issue. If the military wants to deal with that, make it an issue, or make it a prohibition, than at that point we need to address it as an issue. Thank you.

Mr. GIBBONS. Thank you, gentlemen. One of my concerns is that any time you start to actually enumerate reasons for obtaining a disease or for incurring or contracting a disease, that by inadvertent exclusion of any other possibility, you have then eliminated that opportunity to be compensated for it, which seems to me that we've got a bill with an actual enumeration of reasons that you could be exposed to Hepatitis C, and I'm just wondering, have we left anything out that could be a potential source of Hepatitis C not covered in this bill that should be addressed and should be included?

Mr. SCHNEIDER. What you have covers really almost, you know, anything that a person could have done or a gal could have done in military service. I don't know how to expand the list further. I think the presumptive finding is sufficient for these people.

Mr. GIBBONS. Well, Mr. Schneider, let me ask you this question while you're addressing that issue. If there's a presumption that Hepatitis C should be covered, can we not just say that if there is a diagnosis of Hepatitis C, there's a presumption that there is compensation liability on behalf of the armed services, rather than listing out all of the incidences in which you would have to have had been exposed in order to be covered by this bill?

Mr. SCHNEIDER. Absolutely right.

Mr. WILKERSON. I think we would agree with that approach. For the most part, we're still at the same point. You're not going to be able to prove that you helped move an injured comrade and, got blood on your skin. Anything of this type of exposure, short of some sort of medical treatment where there may have been findings of some abnormalities, it's just not going to exist and may not ultimately benefit the individual.

I think the idea, the intent, clearly, of this legislation is to have sufficiently broad and appropriate presumptions that would apply. And if there's concerns that an enumeration of certain risk factors and those only, might prevent certain individuals from ultimately getting benefits, we would be supportive of an amendment to that effect. Well, let me just leave it there.

Mr. DANIELS. That's good enough. I would agree with that approach, Mr. Chairman.

Mr. GIBBONS. Let me ask one question of Mr. Schneider real quick-like. I notice he testified very articulately when he began about the Guard and Reserve forces being inadequately covered in this bill.

Mr. SCHNEIDER. Yes, sir.

Mr. GIBBONS. Do you have any suggestions for language that you would make that would amend this bill so that it did cover Guard

and Reserve forces during UTAs, ITAs, or other training periods when they should be covered by this bill?

Mr. SCHNEIDER. I think we can come up with something to submit back to you for inclusion in the proposal.

The issue comes back to people with pre-existing conditions with regard to the heart, pre-existing conditions that are aggravated in the course of military service on an ITA. And again, the difference is the ITA. If we realize that if we deploy that person anyplace in the world as an active duty asset, the person is fully protected and would be service connected and would have the benefits in turn because it would be aggravation of a pre-existing condition. The Guard and Reservist does not have that luxury. We can probably come up with some language, for your consideration.

Mr. GIBBONS. Certainly. I would welcome your support on that issue. Mr. Snyder, questions?

Mr. Vic SNYDER. We've got Snyders everywhere here today.

Mr. SCHNEIDER. Yes. We missed them on one panel. That was noted.

Mr. Vic SNYDER. That's right. I appreciate your all's comments about the legal activity of tattoos. You know, I was in Marine boot camp in 1967, and I mean, our officers, our NCOs, our drill instructors, I mean, a tattoo was just as you said, a rite of passage. And even when we were in Vietnam, there was never anything posted, no tattooing in Vietnam while you're there. And I think it would be changing the rules in the game.

The business about—I was struck by the chairman's comments, too, about this actual enumeration. Of course, you know, I've been criticized on the bill because the list is so expansive. There are some people that see some things on the list they'd like to take off of it. But the list is not an exclusive one. I mean, if there is a—Mr. Gibbons asked is there something on the list that—or something else out there that ought to be on the list, my own feeling is that as time goes by, we'll find, particularly as we have more and more women veterans, that we'll find more and more people acquire Hepatitis C through sexual transmission I think. Household contact with known, or you know, married to somebody who acquires Hepatitis C. My guess is we'll see some cases that are acquired that way through household contacts. Does that mean that if that person was in the service at the time under this bill they could not prove service connection? No. They would just have to make the case the way they do now.

But we're trying to deal with these situations in the past where there's a proof problem of how do you approve that you acquired this thing, and we tried to take things that, I guess really looking at the Vietnam War experience, as the testimony showed earlier, you know, what things occurred during the Vietnam War experience that seemed to have some epidemiologic connection with acquiring Hepatitis C.

So I appreciate your concerns about the list, but that's how we came up with that list. I don't think I have any specific questions. I appreciate your all's support. Feel free to comment.

Mr. SCHNEIDER. Could I make a comment? And I think I'd like to come back to your comment regarding sexual transmission and what have you. The number of people that are infected with Hepa-

titis C right now, the VA alluded this morning that we need more research to talk about families. And I think we need to encourage that research. We have a concern that it might have been the other way. It might have been the GI infecting their spouse, as opposed to the spouse infecting the GI. And for 25, 30 years, veterans have been running around not aware that they were even contaminated—quote, “contaminated.”

The issue of children, the issue of spouses, the issue of Hepatitis C, I think we're going to learn an awful lot more about it in the coming years. And I agree with you that there may be other legislative changes necessary. And we may again at some point, like we did with spina bifida, have to look at other language, other legislation, other programs to include the dependents of Hepatitis C-infected personnel. Thank you.

Mr. WILKERSON. Mr. Snyder, I'd like to comment, too, that even though there is a list and as I say, I understand the intent of it, it will be up to the VA to develop appropriate regulations that clearly reflect the extent of this legislation; what committees' or what Congress' intent fully was in establishing a list and not to make it exclusive, and to show where reasonable judgment needs to be exercised by those adjudicating the claims.

Mr. DANIELS. No comment.

Mr. GIBBONS. Well, gentlemen, before you leave, I want to assure you that all of us who were in the military appreciate your testimony here today. I went on active duty, just as my colleague, Mr. Snyder, did, in 1967 during Vietnam, but I do recall over the 28 years that I served in the military that each and every time we were deployed overseas, there was a very specific warning about the hazards of tattoos, about needles, about hepatitis, about what you could incur overseas, at least in the Air Force. I'm not familiar with the Marines, but—

(Laughter.)

Mr. GIBBONS. You may have a different set of medical standards from the Air Force. (Laughter.)

But I just wanted to say that not all of us ran out and got tattoos as a rite of passage.

Gentlemen, thank you very much for your testimony here today. With that, we'll excuse you as a panel and call up our fifth panel.

Our fifth panel will consist of Ms. Nora Egan, Deputy Under Secretary for Management, Veterans Benefits Administration. She'll be accompanied by Mr. John Thompson, VA Deputy General Counsel, and Mr. John McCourt, Deputy Director, Compensation and Pension Service, Veterans Benefits Administration.

Ms. Egan and gentlemen, welcome. We look forward to your testimony here today. I presume, Ms. Egan, that since you're at the top of the list, you should go first.

STATEMENT OF NORA EGAN, DEPUTY UNDER SECRETARY FOR MANAGEMENT, VETERANS BENEFITS ADMINISTRATION; ACCOMPANIED BY JOHN H. THOMPSON, DEPUTY GENERAL COUNSEL, DEPARTMENT OF VETERANS' AFFAIRS, AND JOHN McCOURT, DEPUTY DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION

Ms. EGAN. Yes, Mr. Chairman. Thank you. Good afternoon.

Mr. GIBBONS. Yeah, it is good afternoon. I've been telling everybody good morning, if you'll just excuse my inability to read the clock. That's what they taught me in the Air Force, though.

Ms. EGAN. I thought what I would do this afternoon, is make my oral comments even briefer than we originally intended, because I know the hour is late and I assume that there are some questions that, Mr. Chairman, you might want to ask or I assume, Dr. Snyder would like to ask. I will go through the issues as quickly as I can.

I would also like to acknowledge, as you did, that Mr. McCourt is the Deputy Director of Compensation and Pension Service, which has the responsibility for overseeing the rules and regulations by which we adjudicate claims in VA. And, of course, Mr. Thompson is the Deputy General Counsel and plays a key advisory role in developing legislation, regulations, and the legal opinions regarding the nonmedical benefits program.

First, I would like to comment on H.R. 4131, the bill that authorizes the compensation cost-of-living adjustment. We absolutely support this bill and believe that it's necessary and appropriate. There is one thing that I would like to add to that. On February 15, the Secretary of Veterans' Affairs, Mr. West, sent a proposed legislative package to this committee. It did address the compensation COLA adjustment, but it also had another provision that I would like you to consider.

As a result of the Balanced Budget Act of 1997, payments that would normally be made to the 3.2 million veterans and their beneficiaries on September 29, 2000, will be delayed until October 2nd of 2000. Title 38 provides that when the actual date of the benefit increase falls on a Saturday or a Sunday that the effective date of the benefit would be the preceding Friday. The Balanced Budget Act of 1997 overrode that provision. So, in fact, if it is not changed this year, we will not be making those payments until October 2. For some of our beneficiaries and veterans, this could cause financial difficulties, especially to those who live from check to check. In addition to which, given the number, 3.2 million, who are used to receiving their checks on this date, we are concerned that their checks not being there, either by direct deposit or in the mail, will cause a fair amount of consternation which I believe, will probably generate a fair amount of telephone traffic to us by people who are concerned about the delivery date of their benefits. So I would ask that the committee take under advisement the proposal submitted by the department.

I also briefly want to touch on H.R. 3816, the service connection for stroke and heart attack. We have three primary issues with this bill. First of all, we do support it. But secondly, we do believe that there are some additions or some refinements to the bill that would help to strengthen it. The first one, I think you already touched on, cardiovascular versus the cerebral vascular, and we're going to take care of that.

The second issue is that the way the statute or the language of the legislation is constructed is that it would consider a heart attack or a stroke to be an injury. We have some concerns about that. Both by legal and judicial precedent, injuries in VA for purposes of VA compensation are considered and do not include nontraumatic

incurance or aggravation of diseases. We believe that this distinction is valid and should be retained. But we believe you could address the situation by saying that in addition to injury in line of duty, a cerebral vascular accident or acute myocardial infarction incurred as a result of duty to be considered qualifying for an individual for veteran status. We would urge you to make that change, which would retain the distinction of injury being those things which are more traumatic in nature, versus disease, but permit heart attack and stroke to be covered under this legislation by saying "in addition to injury."

Finally a third minor modification that we would recommend be made, would be to make sure that travel to and from these periods of inactive duty would be covered, much as they are for an injury.

With regard to H.R. 3998, the special monthly compensation, VA also supports this legislation. As mentioned in earlier testimony, this issue was initially raised by the Secretary's Advisory Committee on Women Veterans, and in fact was the subject of some discussion.

We did consult with the General Counsel, and as a result of a recent legal opinion, their recommendation or their determination was that we could not amend, we could not through rulemaking or through regulation provide coverage for mastectomy; that it, in fact would require legislation in order to extend the special monthly compensation K authority to mastectomy. At the same time we were discussing what we should do about developing legislation, this legislation was introduced, and VA is very happy to support that.

With regard to H.R. 1020, the presumptive service connection for Hepatitis C, VA is unable to support this legislation, at this time primarily because it's overly broad. VA does not take issue with the intent of the legislation. In fact, we applaud it. We understand and take our responsibilities very seriously with regard to our veterans and the incidence of Hepatitis C being so much more prevalent in the veteran population. We absolutely believe that this issue needs to be addressed.

But while we do support the intent of the legislation, because it does help to associate the Hepatitis C diagnosis with past events, including those which may have occurred in service, I believe the difference that we have with the legislation is the inclusion of certain risk factors as opposed to the intent of the legislation.

Based on the medical evidence, primarily that from the CDC, we do not believe that a presumption of service connection is warranted for some of the risk factors described in the legislation. Just as a brief example, health care personnel. While we absolutely believe consideration needs to be given to those individuals in the health care occupations who were in areas of combat, with obviously no universal precautions taken at that time, given the exposure, not just episodic but on a continuous basis, to a situation in which they could contract Hepatitis C would certainly be a valid consideration. The way it is currently defined, though, it would cover pharmacists, optometrists, or other occupations in health care, we just believe that this is an overly broad approach to it.

Given our concern about it, though, we want to advise the committee that we do have a regulation under development which

would stipulate certain presumptions for Hepatitis C. When we develop a rule in the DVA, as you know, we work with our VHA counterparts as well as the Office of the General Counsel, and coordinate through the Office of Management of Budget. But we do have an expectation that we would have a regulation out sometime within the next 6 months.

It will not address, Dr. Snyder, all the risk factors that you've covered in your legislation, but we believe it addresses a sufficient number of them where the presumption of service connection is supported by the science/research. I think what's important to remember is that even if something is not a presumptive risk factor for service connection, that does not mean that a veteran's claim would not be adjudicated in the favor of that veteran if the evidence showed the hepatitis was incurred during service. For those risk factors, we would entertain and certain evaluate all medical evidence.

Under the provisions used to service connect on a direct basis, there seems to be some concern that we would create a situation in which we would weigh whether or not drug usage or multiple risk factors if one outweighed the other. That has not been our past practice. We do have a statutory requirement that, if there are no other factors and if the individual was an intravenous drug user, requires us to look at the situation.

However, if there are multiple risk factors, and if it is determined medically that there is no way to determine which of those factors was the causal origination of the Hepatitis C, that decision would be made in the favor of the veteran. There is no way that the people who rate these claims are going to get into a moral adjudication of which is more likely if the medical evidence is not there to support that. I just wanted to address that point since it did come up.

When Mr. Evans was here, he made reference to a letter that he sent to us with regard to the adjudication of Hepatitis C cases. I looked at that letter in preparation for this hearing, and I agree that we were not as responsive to the issues raised as we could have been, and that you will get a more specific response within a week.

Lastly, we were asked to touch on the bases we use to adjudicate claims. And as you have heard from the preceding panels, there are some difficulties in adjudicating these claims. I think, as we have learned from Agent Orange and Gulf War, that issues involving diseases are far more complex and difficult to adjudicate than traumatic injuries.

Hepatitis C presents us with some unique circumstances in that the period of time between the exposure to the agent which may have caused the Hepatitis C and the manifestations of the symptoms can be considerable, and that the medical records are not always going to be there. Some of the evidence concerning exposure to the risk factor will be lacking. We are very acutely aware that this requires us to be very careful in the development of the evidence.

We have, over the last year and a half, put out guidance and information on developing and evaluating claims for Hepatitis C. There is some specific information in the testimony. I'd be happy

to answer specific questions about that. But this is an ongoing process of trying to ensure that the people who are evaluating these claims have the right information or are making consistent and correct decisions.

As of today, a regulation to change the rating schedule to provide specifically for diseases of the liver, which will differentiate between Hepatitis A, Hepatitis B, and Hepatitis C, is at the Office of Management and Budget. Subsequent to their review, it will go through the Administrative Procedures Act, and I'm hoping, depending on the number of comments we receive during the comment period, that we would have the change to the rating schedule out by the end of the summer.

That concludes my oral testimony, and my colleagues and I will be happy to answer any questions that you might have.

[The prepared statement of Ms. Egan appears on p. 161.]

Mr. GIBBONS. Thank you, Ms. Egan. Does either Mr. Thompson or Mr. McCourt have a statement for the record, or are they just here in support?

Ms. EGAN. They're here in support.

Mr. GIBBONS. Thank you. Mr. Snyder?

Mr. Vic SNYDER. Thank you all for the long wait. We apologize for having had two votes that delayed things.

Ms. Egan, I wanted to ask if I heard what you were saying, let me give you a case scenario when you talked about you don't make moral judgments or however you described that. But let's take the case of a man in the Vietnam era that had one blood transfusion that's documented in 1970.

Ms. EGAN. Alright.

Mr. Vic SNYDER. Gets out of the service in 1971 and becomes an IV drug user, acknowledge IV drug user for the next 30 years. Are you telling me here today that if he walked in with a 30-year history of multiple arrests and one blood transfusion in 1970 in his military record that we would service connect that veteran?

Ms. EGAN. If—

Mr. Vic SNYDER. Because I—that's not what I'm hearing from folks.

Ms. EGAN. If the medical evidence—again, if the medical evidence in the evaluation of the physician stated that there is no way to determine which event caused the Hepatitis C, that it could just as likely have been caused by that transfusion as the intravenous drug use, we would make the decision to service connect that veteran.

Mr. Vic SNYDER. All right. But that's a little bit different, I think, as I heard what you were saying earlier. Because I think that the physician—I've sat and talked to some of the adjudicators, some of the doctors who make these decisions, and I think the doctor would look at that and say, well, it's more likely than not that the person got it from the IV drug use in that situation.

Ms. EGAN. Right.

Mr. Vic SNYDER. And that's—but it's like Dr. Roselle, I don't know if you heard Dr. Roselle, who very eloquently said, you know, epidemiologic studies are great for herds but not so great for individuals. And so you may have an individual—you do not know that

that person got it from IV drug use or from that one transfusion. We're just playing the odds.

Ms. EGAN. Yes. But again, the decision on the service connection would not be made on the basis of the CDC statistics. I mean, there is a likelihood of that. But if the examining physician who is providing the evaluation or the report to VA as a part of making that decision said it is just as likely that it came from that blood transfusion as from intravenous drug use, I believe we would make the decision in favor of the veteran, and maybe I would ask Mr. McCourt—

Mr. Vic SNYDER. Let me—but I think that is—I think that's a different tone than what you said in your opening statement, in my view, because that's the problem that we have. It becomes a proof problem when there's no way to prove one way or the other. It's just—and I talked to one of the doctors that made the decision. I said, I'd hate to be in your—making those decisions, because it's just a throw of the dice about, well, yeah, how many times do you think you shot up, you know? I mean, I don't know how you make those kind of determinations.

I thought what I heard you say if someone had a known risk factor that was not willful misconduct, in your opening statement I thought you said that they would be approved. But that's not what you're telling me.

Ms. EGAN. I'm sorry. What I meant to say is if there were multiple risk factors, which I believe is the situation that you were addressing with the panel, and that based on medical evidence, it could not be determined which of those risk factors, even if one did include intravenous drug use, could have been the precipitating factor for Hep C, we would make the decision in favor of the veteran.

The issue that you've described where the physician cannot say or the physician were to say it's more than likely that it came from drug use, puts us in a quandary. It's not that there's an effort on our part to be moral or judgmental, but we have a statutory requirement that says if the diseases, for which an individual would be applying for benefits, are as a result of intravenous drug use, we are prohibited from making that service connected. I will grant you that that makes the adjudication of these claims difficult because we do have that willful misconduct consideration.

Mr. Vic SNYDER. But you're not going to be able to solve that problem with a regulation. I mean, that's going to have to be solved by statute, it seems to me.

Let me ask you, would you respond to Mr. Filner's point that he brought up in his opening statement about why the discrepancy between what seems to be the health side and the benefits side seems to have a different view of risk factors.

Ms. EGAN. Okay. I think if I understood his statement, and I didn't make a note on that, that he is concerned that there are two ways of looking at this. Institutionally from VA, we need to look at it two different ways. We are first and foremost concerned about the health of the veteran. No matter how he or she may have contracted Hepatitis C, we have a responsibility to test that individual. We have a public health concern that needs to be addressed. The information that went out listing all the risk factors says if

you have these risk factors, you should be tested, because you may in fact have a health issue which either we will address or we'll help you address.

That's a different than when you're taking those same factors and applying them to determine whether or not there should be service connection and compensation paid to a veteran. If that's what I understood him to say, I would like to give an example. While it will probably be the worst case scenario, whether or not a veteran contracted Hepatitis C through intravenous drug use from a pure standpoint of the health of that veteran, VHA would want to test them and either treat them or, if they could not treat them, make sure that they were pointed in the right direction for the appropriate treatment. That is a clear case where we would be concerned about the health of the veteran but we would not make a determination of service connection for purposes of compensation.

Mr. Vic SNYDER. Maybe since Mr. Gibbons and I like talking about tattoos, I had a state senator friend in Arkansas. He had to judge a tattoo contest one time, so this does come up in politics some, but the—

(Laughter.)

Mr. Vic SNYDER. On page—I think it was page 5—

Mr. GIBBONS. I just want to know, did you win?

Mr. Vic SNYDER. No, I did not, sir. I was not—I was ineligible to enter. (Laughter.)

The comment about in your written statement where you talk about, and you quote the CDC as saying, "According to the CDC, there are no studies in the United States demonstrating that persons with a history of tattooing or body piercing are at increased risk for HCV infection based on these exposures alone." But then the—let's see if I've got my—but then there is a line here that talks about overseas in the CDC study. I mean, I've got the—I guess it's from the MWR, that there are overseas studies that show that there is association with tattooing.

Now, that seemed to me to be a bit of selective sharing of information, because some of the concern that some of us have had has been the nature of tattoo parlors overseas, where there's just no paying much attention at all to cleanliness, et cetera.

Ms. EGAN. I picked up on that in the earlier testimony, that we have cited the CDC studies to say there is no evidence, and I think one of the previous witnesses testified that there were other studies. Certainly after consulting with VHA to determine their relevance, we would consider them. There's no attempt here to exclude any evidence or information that might be helpful. I think as we evolve and develop a greater body of medical knowledge on Hepatitis C, certainly we would want to do what we could to revise either our benefits program or medical services to make sure that we were meeting the needs of veterans.

Mr. Vic SNYDER. I think it's kind of interesting, your written testimony puts a lot of credence in the CDC information, and I think CDC puts out good information, but it is I think studies between 1978 and 1986, and one of their conclusions is, quote, "these studies reported no association with military service." Well, part of your testimony here today is clearly there is an increased incidence of this disease amongst our veteran population, so, you know, we real-

ly need to be careful when we start pulling out these epidemiologic studies and then make policy decisions based on information that even you don't agree with.

Regarding the issue of—and I would say the same thing about health care workers. The CDC quotes studies done of general surgeons, orthopedic surgeons, and I forget another class of specialty surgeon. That is a whole different kind of health care worker than what we have in the military, as you know. I mean, I don't have to make that point. I mean, we haven't done studies like this on medics in Vietnam, because we didn't know there was a Hepatitis C. I would even—you brought up the point of pharmacists of being overly broad, and I'd certainly be willing to look at any kind of narrowing we need to do, but we even have, I mean, it's I think some states, I think Arkansas is among them, pharmacists can now give injections. You know, they have—people can show up at some pharmacies around the country and get their flu vaccine.

I mean, there are—and in the military, my experience overseas is paraprofessionals get involved in a whole lot of activities. So I think that's the reason that we selected health care workers.

Would you comment if you would on the issue of abnormal liver tests? The reason we put that in the bill is because a person could go—could pull out a medical record from 20 years ago and show, before we had an ability at all to know there was even a Hepatitis C and we'd just talk in terms of non-A, non-B, and they could show at some point an elevated liver function test of some kind, and the point of having that in the bill was that is some indication that during military service, there was a liver problem. Now, they may not have known they were sick, because more than 80 percent of the time, by your testimony, these are asymptomatic.

Ms. EGAN. Yes.

Mr. Vic SNYDER. But it is at least some evidence on a military record that they were having liver problems in service. And I recognize what you said in there in your written testimony there was other causes of abnormal liver enzymes. No one's doubting that. But again, we're trying to help the veteran sort through when did he come down with this disease that we know he has today that's rotting his liver and may lead to his death or a liver transplantation. And my staff member and I were talking this morning. Well, maybe if we had put abnormal liver function tests before 1992 or something, that would have been more acceptable.

It seemed to me you were addressing an issue of if someone had abnormal liver tests today. Well, today we can test for Hepatitis C. But we're talking about trying to help the veteran find evidence from the past of hepatitis. And at a time when it's mostly asymptomatic. Would you comment on that abnormal liver test?

Ms. EGAN. Yes. One of the things that I again want to stipulate that this does not mean that we would not, on an individual basis, have a finding of a service connection for an individual veteran. This testimony is specifically related to the inclusion of them as presumptives.

I'm not a medical specialist. We work very closely with the medical health care professionals, and part of their advice to us is reliant on different epidemiological studies that have been done.

If someone were to have a medical record that showed that they had some liver dysfunction while they were in the service before the test for Hepatitis C was in place, we would certainly consider that. And if there are possible refinements to this, we would be happy to work with you. But in terms of the medical application of this, I'm a little out of my league since I'm not a medical specialist on how we would differentiate between that. And I don't know, John, if you would want to add anything.

Mr. MCCOURT. Yes. What I'd like to say is, the harder case would not be if a veteran may have had an elevated liver test, because we'd have it in the service medical records and that, quite frankly, would be one of the easier cases. Now there are tests available, as you know, today to determine whether what type of hepatitis, if it was hepatitis. There are antibodies in the bloodstream that they can test for. The harder cases would still be the risk factors in terms of if there isn't any evidence of an infection in service with any elevated liver test. There are still a lot of these veterans that didn't have symptoms, and it's really a question of the risk factors more than it is the people who actually did have some symptoms while they were in the service.

Mr. Vic SNYDER. Thank you, Mr. Chairman, for your patience. I would just say, I don't know what your regulations are going to look like. But I think this is a real challenge out there. And I think this more-likely-than-not standard is artificial. I don't see how anyone can sit there—this is like the game of Clue, where you don't have the candlestick and you don't have Miss Scarlett. I mean, you're trying to figure these things out, and the bottom line is, these folks must go to bed at night and say to themselves, there is no way I will ever know whether that patient did or did not acquire that disease in service. There's just no way to do it.

And I think what we're trying to do is to find a way of sorting that out so that we don't have to make comments like, well, is it more likely than not, which is really an epidemiologic statement, as Dr. Roselle pointed out, and not an individual statement. I think that's where this has gotten blended together.

Ms. EGAN. I appreciate your concern. There is a great deal of discussion on how to properly construct this regulation, which in part is what has delayed us from already having completed it.

As part of this VA, the Veterans Health Administration, and I would like Dr. Roselle or any of the other health care professionals who are experts in this arena to help us craft that regulation so that we can do the best job given the statutory limitations.

And I also would welcome the opportunity to work with you and your staff for any insight or guidance that you would want to provide us for developing those regulations.

Mr. Vic SNYDER. Thank you, Mr. Chairman.

Mr. GIBBONS. Thank you, Mr. Snyder. Ms. Egan, thank you for your patience this morning. We've covered a lot of issues. You've been patient. You've waited until your time at bat, and we certainly appreciate that greatly, and your comments and those of your colleagues have all been helpful, and we've appreciated your sharing those views with us today. There may be other questions which the committee may have that would be submitted to you in

writing. We would ask your indulgence for you to respond to those questions in writing as is normally the case here today.

Ms. MCCARTHY. Mr. Chairman—excuse me, could we add one additional matter to the record, Mr. Chairman?

Mr. GIBBONS. We have a statement submitted by Mr. Brian D. Klein from the Hepatitis C Action and Advocacy Coalition of San Francisco dated March 14, 2000, that will be submitted for the record.

[The statement of Brian D. Klein appears on p. 176.]

Mr. GIBBONS. With that—

Ms. EGAN. Mr. Chairman, excuse me—

Mr. GIBBONS. Yes, Ms. Egan?

Ms. EGAN. If there are two comments that I would be permitted to make. Number one, I appreciate the fact that you appreciate the fact that we waited some time to get up here and testify. But I also want to say I think it's important. In the past, often the executive agencies testify, and then the other panels come in. Not everyone always stays to hear them. I think it's important for myself personally; for my colleagues; here and others, to hear the concerns of our stakeholders are so that we may address those either directly in questions or for comments for the record.

The only other comment I would like to make is on the draft of the proposed bill for Hepatitis C, as I read the language of the bill, on the reference it makes to Title 38, we talk about people who served during a period of war. Since there is a fair amount of time that elapsed between the end of the Vietnam era and when the test was available for Hepatitis C, you may want to rethink that language so that we don't end up excluding a large number of peacetime veterans who may in fact have been exposed to Hepatitis C.

I appreciate the opportunity to appear before the committee.

Mr. Vic SNYDER. And if I might comment, Mr. Chairman.

Mr. GIBBONS. Certainly.

Mr. Vic SNYDER. I appreciate that. We had actually floated that draft throughout the VA almost a year ago, and reading your testimony last night was the first I'd heard of that draft, but I think you're correct. I think that's a drafting error. Thank you.

Mr. GIBBONS. Well, with that, if there's no other comments or questions or submissions for the record, again, thank you for your patience and your presence here today, and this meeting is adjourned.

[Whereupon, at 12:46 p.m., the subcommittee was adjourned.]

APPENDIX

I

106TH CONGRESS
1ST SESSION

H. R. 1020

To amend title 38, United States Code, to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 4, 1999

Mr. SNYDER (for himself, Mr. EVANS, Mr. FILNER, Ms. CARSON, Mr. MINGE, Ms. BROWN of Florida, Mr. ABERCROMBIE, Mr. SHOWS, Mr. DICKEY, Mr. SMITH of New Jersey, Mrs. MCCARTHY of New York, and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Veterans' Hepatitis
5 C Benefits Act of 1999".

1 **SEC. 2. PRESUMPTION OF SERVICE CONNECTION FOR HEP-**
2 **ATITIS C FOR VETERANS.**

3 (a) **IN GENERAL.**—Subchapter II of chapter 11 of
4 title 38, United States Code, is amended by adding at the
5 end the following new section:

6 **“§ 1119. Presumption of service connection for hepa-**
7 **titis C**

8 “For purposes of section 1110 of this title, and sub-
9 ject to section 1113 of this title, hepatitis C becoming
10 manifest in a veteran shall be considered to have been in-
11 curred in or aggravated by active military, naval, or air
12 service, notwithstanding that there is no record of evidence
13 of such illness during the period of such service if it is
14 shown that during such service the veteran experienced
15 one or more of the following:

16 “(1) Transfusion of blood or blood products be-
17 fore December 31, 1992.

18 “(2) Blood exposure on or through skin or mu-
19 cous membrane.

20 “(3) Hemodialysis.

21 “(4) Tattoo or body piercing or acupuncture.

22 “(5) Unexplained liver disease.

23 “(6) Unexplained abnormal liver function tests.

24 “(7) Working in a health care occupation.”.

25 (b) **CLERICAL AMENDMENT.**—The table of sections
26 at the beginning of such chapter is amended by inserting

1 after the item relating to section 1118 the following new

2 item:

“1119. Presumption of service connection for hepatitis C.”.

○

106TH CONGRESS
2D SESSION

H. R. 3816

To amend title 38, United States Code, to provide that a stroke or heart attack that is incurred or aggravated by a member of a reserve component in the performance of duty while performing inactive duty training shall be considered to be service-connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs.

IN THE HOUSE OF REPRESENTATIVES

MARCH 1, 2000

Mr. STUPAK (for himself, Mr. SANDERS, Mr. COYNE, Ms. CARSON, Mr. EVANS, Mr. FILNER, Ms. MCKINNEY, Mr. GUTIERREZ, Mr. LIPINSKI, Mr. REYES, Mr. FROST, Ms. BROWN of Florida, Mr. RODRIGUEZ, Ms. BERKLEY, and Mr. QUINN) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to provide that a stroke or heart attack that is incurred or aggravated by a member of a reserve component in the performance of duty while performing inactive duty training shall be considered to be service-connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. STROKES AND HEART ATTACKS INCURRED OR
2 AGGRAVATED BY MEMBERS OF RESERVE
3 COMPONENTS IN THE PERFORMANCE OF
4 DUTY WHILE PERFORMING INACTIVE DUTY
5 TRAINING TO BE CONSIDERED TO BE SERV-
6 ICE-CONNECTED FOR PURPOSES OF BENE-
7 FITS UNDER LAWS ADMINISTERED BY THE
8 SECRETARY OF VETERANS AFFAIRS.

9 Section 101(24) of title 38, United States Code, is
10 amended by adding at the end the following new sentence:
11 "For purposes of this paragraph, a cardiovascular acci-
12 dent or an acute myocardial infarction incurred in per-
13 formance of duty during a period of inactive duty training
14 shall be considered to be an injury incurred or aggravated
15 in line of duty."

○

106TH CONGRESS
2D SESSION

H. R. 3998

To amend title 38, United States Code, to provide that the rate of compensation paid by the Department of Veterans Affairs for the service-connected loss of one or both breasts due to a radical mastectomy shall be the same as the rate for the service-connected loss or loss of use of one or more creative organs.

IN THE HOUSE OF REPRESENTATIVES

MARCH 16, 2000

Mr. EVANS (for himself, Ms. BERKLEY, Ms. DELAURO, Mr. FILNER, Mr. GUTIERREZ, Ms. BROWN of Florida, Ms. CARSON, Mr. REYES, Mr. RODRIGUEZ, Mr. SHOWS, Mrs. MORELLA, Ms. BALDWIN, Ms. KAPTUR, Ms. LOFGREN, Mrs. MINK of Hawaii, Ms. WATERS, Mr. ABERCROMBIE, Mr. BROWN of Ohio, Mr. COSTELLO, Mr. FROST, Mr. KENNEDY of Rhode Island, Mr. MCHUGH, and Mrs. THURMAN) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to provide that the rate of compensation paid by the Department of Veterans Affairs for the service-connected loss of one or both breasts due to a radical mastectomy shall be the same as the rate for the service-connected loss or loss of use of one or more creative organs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Veterans’ Special
3 Monthly Compensation Gender Equity Act”.

4 **SEC. 2. COMPENSATION TO BE PAID BY DEPARTMENT OF**
5 **VETERANS AFFAIRS AT SO-CALLED “K” RATE**
6 **FOR SERVICE-CONNECTED LOSS OF ONE OR**
7 **BOTH BREASTS DUE TO RADICAL MASTEC-**
8 **TOMY.**

9 Section 1114(k) of title 38, United States Code, is
10 amended by inserting “or one or both breasts due to a
11 radical mastectomy or modified radical mastectomy,” after
12 “loss or loss of use of one or more creative organs,”.

○

106TH CONGRESS
2D SESSION

H. R. 4131

To increase, effective December 1, 2000, the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain disabled veterans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 30, 2000

Mr. STUMP (for himself, Mr. EVANS, Mr. QUINN, and Mr. FILNER) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To increase, effective December 1, 2000, the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain disabled veterans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Veterans' Compensa-
5 tion Cost-of-Living Adjustment Act of 2000".

1 **SEC. 2. INCREASE IN RATES OF DISABILITY COMPENSA-**
2 **TION AND DEPENDENCY AND INDEMNITY**
3 **COMPENSATION.**

4 (a) **RATE ADJUSTMENT.**—The Secretary of Veterans
5 Affairs shall, effective on December 1, 2000, increase the
6 dollar amounts in effect for the payment of disability com-
7 pensation and dependency and indemnity compensation by
8 the Secretary, as specified in subsection (b).

9 (b) **AMOUNTS TO BE INCREASED.**—The dollar
10 amounts to be increased pursuant to subsection (a) are
11 the following:

12 (1) **COMPENSATION.**—Each of the dollar
13 amounts in effect under section 1114 of title 38,
14 United States Code.

15 (2) **ADDITIONAL COMPENSATION FOR DEPEND-**
16 **ENTS.**—Each of the dollar amounts in effect under
17 sections 1115(1) of such title.

18 (3) **CLOTHING ALLOWANCE.**—The dollar
19 amount in effect under section 1162 of such title.

20 (4) **NEW DIC RATES.**—The dollar amounts in
21 effect under paragraphs (1) and (2) of section
22 1311(a) of such title.

23 (5) **OLD DIC RATES.**—Each of the dollar
24 amounts in effect under section 1311(a)(3) of such
25 title.

1 (6) ADDITIONAL DIC FOR SURVIVING SPOUSES
2 WITH MINOR CHILDREN.—The dollar amount in ef-
3 fect under section 1311(b) of such title.

4 (7) ADDITIONAL DIC FOR DISABILITY.—The
5 dollar amounts in effect under sections 1311(c) and
6 1311(d) of such title.

7 (8) DIC FOR DEPENDENT CHILDREN.—The
8 dollar amounts in effect under sections 1313(a) and
9 1314 of such title.

10 (c) DETERMINATION OF INCREASE.—(1) The in-
11 crease under subsection (a) shall be made in the dollar
12 amounts specified in subsection (b) as in effect on Novem-
13 ber 30, 2000. Each such amount shall be increased by the
14 same percentage as the percentage by which benefit
15 amounts payable under title II of the Social Security Act
16 (42 U.S.C. 401 et seq.) are increased effective December
17 1, 2000, as a result of a determination under section
18 215(i) of such Act (42 U.S.C. 415(i)).

19 (2) In the computation of increased dollar amounts
20 pursuant to paragraph (1), any amount which as so com-
21 puted is not a whole dollar amount shall be rounded down
22 to the next lower whole dollar amount.

23 (d) SPECIAL RULE.—The Secretary may adjust ad-
24 ministratively, consistent with the increases made under
25 subsection (a), the rates of disability compensation pay-

VETERANS' AFFAIRS BENEFITS SUBCOMMITTEE HEARING

April 13, 2000

10:00 A.M.

334 Cannon H.O.B.

INTRODUCTORY REMARKS FOR HEARING ON

H.R. 1020, H.R. 3816, H.R. 3998, H.R. 4131.

CONGRESSMAN SILVESTRE REYES

Mr. Chairman, I want to thank you for scheduling this hearing. Today, we will address several issues of vital importance to our nation's veterans and the benefits for which they are entitled.

These bills go a long way to assuring that our women veterans, our members of the reserve, those suffering from Hepatitis C, and all veterans are properly remembered and provided for under the VA's mission to serve our veterans.

As President Lincoln, so aptly stated in his second inaugural address, our nation must "bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan."

His words resonate today, and I think we should always bear them in mind and we work to serve today's veterans, and the unique issues that arise with this generation of America's defenders.

With this in mind, I am extremely pleased that we are considering H.R. 1020. This bill will establish a presumption of service connection for the occurrence of Hepatitis C in our nation's veterans. I want to express my support for Congressman Snyder in introducing this bill, as it truly addresses the growing problem of Hepatitis C in our veteran population. Hepatitis C has a long incubation period without symptoms, and until recently there was

no verifiable test to detect its presence. Veterans exposed to blood transfusions and other means of incubation while in service, have a difficult time establishing a claim without the presumption that Mr. Snyder's bill would provide. With the damaging effects of Hepatitis C, we should acknowledge the difficulty Veterans have in currently establishing a claim, and give them the benefit of the doubt through this legislation. Moreover, I want to take this opportunity to urge VA to expedite the process of updating the VA rating schedule to properly reflect the complications of Hepatitis C in light of the current rating schedule which focuses on Hepatitis A.

Moreover, with the new reality that our reserve forces are increasingly being called upon to defend our nation, it is incumbent upon us to properly address the needs of these veterans. I am therefore appreciative of Congressman Stupak in his effort to address a gap in the current qualifications for benefits for reserve forces through H.R. 3816. His bill's provision of service-connection for a reservist who in the performance of duty while on inactive training suffers or aggravates a stroke or heart attack, is commendable and long overdue.

Furthermore, with the integration of women into our armed forces, we must recognize that their service connected ailments and disabilities are no different than those of their male counterparts for purposes of compensation. I am therefore pleased that we are considering today, H.R. 3998. This bill recognizes the equally devastating effect of a radical mastectomy on the lives of our veterans, and ensures that the loss of a breast is compensated comparably to other losses of organs which are currently compensated. As breast cancer is one of the leading causes of death for women, we should not shortchange the benefits for which these veterans are entitled. This bill addresses this situation, and I am therefore proud to have co-sponsored this legislation with our Ranking Member, Mr. Evans, who provides leadership on so many veterans issues.

Finally, I am pleased that we are taking up H.R. 4131 - the Veterans' Compensation Cost-of-Living Adjustment Act. It is our responsibility to make sure that compensation and pension benefits for our veterans reflect annual raises in the cost of living. Our veterans and their families rely on these benefits and the erosion of their value is something that we can not allow. I am therefore pleased that we are considering this bill to adjust benefit rates effective December 1, 2000, to reflect the rise in the cost of living, as part of the annual increases Congress provides.

In conclusion, I commend you for bringing these bills up for consideration. These bills will improve and enhance benefits for our veteran population, honor their service, and adequately provide for their needs. I therefore look forward to today's testimony to hear the perspective of our witnesses on these important proposals.

Thank you, Mr. Chairman,

Congresswoman Shelley Berkley
Veterans Benefits Subcommittee Hearing on
adjudication of Hepatitis C claims, and H.R. 1020, H.R. 3816 and H.R.
3998
Opening Statement
Thursday, April 13, 2000

- **THANK YOU, MR. CHAIRMAN**
- **I'D LIKE TO TAKE THIS OPPORTUNITY TO THANK THE BENEFITS SUBCOMMITTEE FOR HOLDING THIS IMPORTANT HEARING TODAY.**
- **THE ISSUES WE ARE DISCUSSING AFFECT A GREAT MANY VETERANS IN MY DISTRICT OF SOUTHERN NEVADA AND THROUGHOUT THE COUNTRY.**
- **I WOULD ESPECIALLY LIKE TO THANK THE COMMITTEE. . .**
- **FOR CONSIDERING H.R. 3998, *THE Veterans' Special Monthly Compensation Gender Equity Act*, WHICH I HAVE INTRODUCED ALONG WITH MY COLLEAGUE, CONGRESSMAN EVANS.**

- **THIS BILL WOULD PROVIDE AN ADDITIONAL “SPECIAL MONTHLY COMPENSATION” PAYMENT OF \$76.00 PER MONTH TO VETERANS WHO ARE SERVICE-CONNECTED FOR A RADICAL OR MODIFIED RADICAL MASTECTOMY.**
- **THIS BILL WOULD PROVIDE FOR GENDER EQUITY IN RECOGNITION OF THE SERVICE-CONNECTED LOSSES SUFFERED.**
- **WITH INCREASING NUMBERS OF WOMEN ENTERING THE MILITARY IT IS SIMPLY TIME FOR THIS SECTION OF THE FEDERAL LAW TO BE BROUGHT UP TO DATE.**

→ INS I

- **ONCE AGAIN, MR. CHAIRMAN, I THANK YOU FOR HOLDING THIS IMPORTANT HEARING. . .**
- **AND I LOOK FORWARD TO HEARING THE TESTIMONY TODAY.**

~~—H.R. 3998—Veteran's Special Monthly Compensation Gender Equity Act~~

~~You have introduced this bill with Lane Evans. The Veterans Benefits Subcommittee will consider the legislation on Thursday.~~

What the bill does....

- ~~• Would provide an additional "special monthly compensation" payment of \$76.00 per month to veterans who are service-connected for a radical or modified radical mastectomy.~~
- ~~• (In order to be considered "service connected," the disability must have been incurred or aggravated *during* military service—but not necessarily *caused by* military service.)~~
- ~~• These payments are made as additional compensation for the anatomical loss or loss of use of various body parts, including hands, feet and "creative organs." VA does not include breasts under the definition of "creative organs."~~
- ~~• This legislation codifies a recommendation made in the 1998 Annual Report of the Department of Veterans Affairs Advisory Committee on Women Veterans.~~
- ~~• The VA is presently verifying how many recipients would benefit from this bill—right now, the estimate is 300-400 veterans.~~
- ~~• Although cases of male mastectomies are very rare, men would also be available for the extra benefit under this bill.~~

Why this legislation is necessary....

- The loss of a breast is a traumatic event in the lives of those affected. This bill recognizes that loss of a breast is comparable to other losses which are currently compensated.
- Congress has provided service-connected disability compensation for various medical conditions, cancer for example, incurred or aggravated during military service. However, there has long been recognition that certain disabilities have an impact on veterans in non-economic ways, such as physical integrity. The special monthly compensation payment for conditions listed in law include recognition of such non-economic losses.
- This bill would provide for gender equity in recognition of the service-connected losses suffered. With increasing numbers of women entering the military, it is simply time for this section of the federal law to be brought up to date.

OPENING STATEMENT OF
HONORABLE LANE EVANS
RANKING DEMOCRATIC MEMBER
HOUSE COMMITTEE ON VETERANS AFFAIRS
APRIL 13, 2000 – 10:00 AM – 334 CHOB

Mr. Chairman, thank you for holding this hearing. The bills we are considering today would improve the lives of men and women who became disabled while serving our Nation. I strongly support each measure.

I commend Bart Stupak for introducing HR 3816 and his leadership on this issue. This bill provides compensation for heart attacks and strokes for veterans who become disabled during inactive duty for training. This measure does contain a drafting error as noted by some witnesses. As this bill advances, the correct medical term for stroke will be substituted.

I request that a letter I received from the National Military and Veterans Alliance in support of H.R. 3816 be included in the hearing record. Hepatitis C is a serious problem affecting our Nation's veterans. On January 28, 2000, I wrote to Under Secretary Joe Thompson to express my concerns about regional office decisions on requirements for a "well-grounded" claim, particularly Hepatitis C claims.

I request that a copy of my letter and Mr. Thompson's response also be included in the record of this hearing.

I thank Vic Snyder for his leadership on Hepatitis C. His legislation, HR 1020, is needed for the fair and accurate processing of claims.

Under current law the following claims for Hepatitis C have been rejected:

- a recently discharged veteran diagnosed in-service with Hepatitis C;

- a Vietnam Purple Heart recipient who had lung surgery in Vietnam due to a combat wound; and
- a Korean veteran who received a blood transfusion in 1955 at a VA hospital during surgery for service-connected TB.

If these claims are being rejected at VA's "well-grounded doorstep", consider how much more difficult is it for veterans with other recognized risk factors to obtain benefits for Hepatitis C.

Hepatitis C claims adjudication problems are not limited to the issue of service-connection.

- Guidelines for performing medical examinations are rarely used.
- Veterans with severe symptoms and severe liver damage verified by liver biopsy and have their claims rated at 10% or less.

I support:

1. Enacting HR 1020;
2. New regulations which accurately describe chronic Hepatitis C impairments; and
3. Determining the incidence of Hepatitis C in family members of infected veterans to determine if additional legislation for family members is needed.

I am pleased HR 3998, which Shelley Berkley and I introduced, is also being considered. HR 3998 authorizes veterans' service-connected for a radical or modified radical mastectomy to receive the same monthly compensation provided for loss of other body parts and functions.

I am pleased Dr. Linda Schwartz, the Chair of VA's Advisory Committee on Women Veterans, will testify concerning the Committee's recommendation for this legislation.

I strongly support HR 4131, which provides a cost-of-living increase in compensation benefits to our disabled veterans. We can not afford to allow these benefits to erode due to increases in the cost of living.

I urge all members to support the bills we are discussing today.

NATIONAL MILITARY AND VETERANS ALLIANCE

Telephone: (703) 750-2568

Fax: (301) 899-8136

April 3, 2000

The Honorable Lane Evans
Ranking Member, House Committee on Veterans Affairs
333 CHOB
Washington, DC 20510

Dear Mr. Evans;

On March 1, 2000 H. R. 3816, the "Inactive Duty for Training Fairness Act" was introduced in the House.

We, the undersigned, representing the National Military/Veterans Alliance (NMVA) – a group of 20 military and Veterans organizations with over 3 million members and their 6 million supporters and family members – would like to express our strong support for this legislation that would benefit and support our reserve forces.

Members of the National Guard and reserve units are required to participate in training, like weekend drills, related to their Guard and reserve service. Much of this training is classified as "inactive duty for training" because these Guard members and reservists are not on full time active duty during training. Nevertheless, "inactive duty for training" can result in serious injury or death.

Under current law, if a Guard member or reservist on "inactive duty for training" suffers a heart attack or stroke the disability is characterized as a "disease" and is *not* service-connected for purposes of benefits from the Department of Veterans Affairs (VA). If a Guard member or reservist was on "active duty" or "active duty for training" and became severely disabled or died, regardless of the cause, the Guard member or reservist or his dependents would be eligible for benefits from the VA. Reserves and Guardsmen deserve parity in VA benefits in a Total Force Military.

"Inactive duty for training" can involve stressful activities which can trigger an acute medical event such as a heart attack or stroke. Members of the Guard and reserve should be eligible for VA benefits for these acute conditions. This inequitable treatment of Guard members and reservists on "inactive duty for training" should be eliminated.

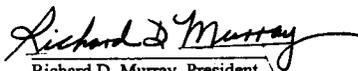
Members of the Guard and reserve serve their country while on "inactive duty for training". While training they test their physical capabilities in preparation for combat/crisis, if they suffer a heart attack or stroke, those medical conditions should be considered by law to be service-connected for the purpose of VA benefits. The members of the Guard and reserve deserve no less.

We recognize and appreciate your longstanding personal commitment on behalf of the men and women who have defended this great country. Your efforts, as always, are greatly appreciated.

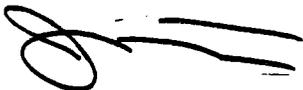
Please see attached signature sheet



Arthur C. Monson
National President



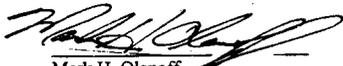
Richard D. Murray, President
National Association for
Uniformed Services



James Staton, Executive Director
Air Force Sergeants Association



Bonnie Carroll, President
Tragedy Assistance Program
For Survivors



Mark H. Olanoff
Legislative Director
The Retired Enlisted Association



Richard Johnson, Executive Director
Non Commissioned Officer Assoc.



Bob Manhan
Veterans of Foreign Wars



DEPARTMENT OF VETERANS AFFAIRS
 Veterans Benefits Administration
 Washington DC 20420

MAD 9 2000

In Reply Refer To: 211B

Honorable Lane Evans
 U.S. House of Representatives
 Committee on Veterans' Affairs
 Washington, DC 20515

Dear Mr. Evans:

I am replying to your inquiry concerning a sampling of claims for disability compensation reviewed during the past year by Ms. Mary Ellen McCarthy.

The major focus of Ms. McCarthy's review centers around claims for service connection for hepatitis C, where that disease is diagnosed at some point following a veteran's separation from active military service. The United States Court of Appeals for Veterans Claims (CAVC or the Court) has held that all claims for benefits under title 38 United States Code must be well grounded. The Court has further held that a well-grounded claim is a plausible claim, 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 on a claimant imposed by 38 U.S.C. § 5107(a). In order for a claim to be well grounded, there must be (1) competent medical evidence of current disability; (2) medical, or in certain circumstances, lay evidence of incurrence or aggravation of a disease or injury in service; and (3) medical evidence of a nexus between an in-service injury or disease and the current disability. The nexus requirement may be satisfied by a presumption that certain chronic diseases are related to service, or, where there is no medical evidence of a causal nexus, by continuity of symptomatology, in the form of medical evidence or lay testimony.

For a claim for service connection for hepatitis C infection, with or without liver disease due to hepatitis C, to be well-grounded, there must be a current diagnosis of hepatitis C infection, based on serologic studies. This will satisfy the first requirement of a well-grounded claim, that there must be medical evidence of current disability.

Second, in order to fulfill the requirement that there must be lay or medical evidence of incurrence or aggravation of a disease or injury in service, there must be evidence of an acute hepatitis C infection in service or of the presence of a risk factor for hepatitis C in service to which the veteran was exposed. Under the provisions of 38 C.F.R. § 3.304(d), lay or other evidence may be used to establish the occurrence of a risk factor in service where such risk factor was related to combat. The provisions of this regulation, however, do not presume the first and third requirements of a well-grounded claim, i.e., medical evidence of current disability and medical evidence of a relationship between the inservice event and a subsequently developing hepatitis.

Page 2
Honorable Lane Evans

The major risk factors for hepatitis C infection are:

1. Intravenous drug use;
2. Blood transfusions before 1990;
3. Accidental exposure in healthcare workers;
4. Hemodialysis;
5. Intranasal cocaine;
6. High-risk sexual activity;
7. Other direct percutaneous exposure, such as tattoos, body piercing, or, acupuncture with nonsterile needles, shared toothbrushes or razor blades.

Certain of these risk factors are both plausible as a cause of hepatitis C infection and capable of substantiation by documentation in the service records. These include blood transfusions, hemodialysis, and working in a healthcare occupation. A claim that hepatitis C infection resulted from one of these in service, supported by competent medical evidence, would fulfill the third or nexus requirement for purposes of well-groundedness. In claims involving other risk factors, the veteran would need to provide evidence showing that the risk factor occurred in service and a medical opinion that the hepatitis C infection resulted from that risk factor.

We are aware of the inconsistencies that exist in our decision making and are striving to, if not eliminate them, substantially improve our performance in that area. In that regard, we are proposing regulations to provide for the consistent processing of claims based on chronic hepatitis C infection. Until final regulations are published, our decision makers will continue to be guided by instructions contained in letters issued to our field stations by the Compensation and Pension Service on November 30, 1998, and September 28, 1999. The C&P Service has a conference call scheduled with our field stations in early April of this year, and the results of Ms. McCarthy's review will be discussed with them. They will be reminded of the importance of adjudicating these claims in accordance with the instructions provided. Copies of these letters are enclosed for your reference.

With respect to the adequacy of our decision notifications, we very strongly believe that in order to provide fundamental due process to our claimants, the reasons and bases for the decision must be clearly stated. This includes, in a claim denied as not well grounded, a statement as to why the claim is not well grounded. The requirements for providing an adequate statement of the reasons and bases for the decision in a particular claim are well established in existing regulations and caselaw of the U.S. Court of Appeals for Veterans Claims. Failure to do so will be held as erroneous in reviewing completed claims under the C&P Service's STAR (Statistical Technical Accuracy Review) program.

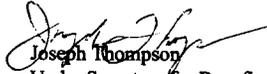
Page 3

Honorable Lane Evans

In evaluating disability resulting from hepatitis C, the Schedule for Rating Disabilities includes criteria other than demonstrable liver damage for the assignment of 60 and 100% evaluations. In order to determine if an evaluation assigned is proper in a particular case, that case would need to be reviewed.

Ms. McCarthy also points out certain deficiencies with respect to the application of "the well-grounded claim criteria" in cases involving certain presumptions. As stated above, we realize that there are inconsistencies in claims processing and we are working hard to rectify them. We are working on a final regulation concerning well-grounded claims, and it is our intent to make this area of claims processing as easy to understand and to consistently apply as is possible. The citation to the claim denied as not well grounded where an ex-POW's service medical records did not show evidence of a trauma appears, on its face, to be questionable, however, it is a situation that we would need to review on a factual basis. If you could provide me with the veteran's name and claim number, we would be happy to do so.

I appreciate the opportunity to write and your continued concern for the welfare of our nation's veterans.


Joseph Thompson
Under Secretary for Benefits

Enclosure

In Reply Refer To: 211C
Fast Letter (99-94)

September 28, 1999

Director (00/21)
All VBA Regional Offices and Centers

SUBJECT: RATING HEPATITIS

INTRODUCTION

During a recent Central Office review of claims where service connection for hepatitis was an issue, it became apparent that additional training is necessary for rating hepatitis. The purpose of this letter is to emphasize that **understanding the different types of hepatitis is the key to properly rating hepatitis**. To assist you in this, an attachment concerning the interpretation of hepatitis B panel, the diagnosis of hepatitis C, the normal values of liver function tests (LFTs), and the names of some of the medications currently used to treat hepatitis C is provided. The attachment will also contain several examples from our review of hepatitis cases.

GENERAL CONSIDERATIONS

Hepatitis is a result of damage to the liver by infection (virus); systemic diseases (lupus); drugs (Isoniazid, Acetaminophen, Phenytoin); and toxic substances (alcohol). This discussion is limited to viral hepatitis caused by the A, B, and C viruses.

Hepatitis A Virus (HAV) causes **acute hepatitis only**.

- transmitted by fecal-oral route (old name "infectious hepatitis");
- is seldom severe and does not leave residuals;
- **anti-HAV** (antibodies to hepatitis A virus) are present in the blood one month after the acute illness and persist for life. Serologic blood tests show the presence of anti-HAV, indicating that the veteran had hepatitis A in the past.

Hepatitis B Virus (HBV) causes **acute disease** in 90-95% of cases. 5-10% have **chronic disease**. The virus has two antigens: a surface antigen-**HBsAg** (hepatitis B surface antigen) and a core antigen-**HBcAg** (hepatitis B core antigen). As a result, two types of antibodies appear in the blood: antibodies to the surface antigen, called **anti-HBs**, and antibodies to the core antigen called **anti-HBc**.

- transmitted by blood products or sexual contact (old name "serum hepatitis");
- acute disease can be severe and death may occur;
- cirrhosis and liver cancer may develop;
- **HBsAg** is present in the blood during the acute phase. The antibodies, anti-HBs and anti-HBc appear in the blood after a few months and persist for life giving **immunity**.

- Positive anti-HBs by serology blood tests indicates a history of hepatitis B. If HBsAg persists more than 3 to 6 months, it is probable that the chronic disease or carrier status has developed.

Hepatitis C Virus-HCV (old name "non-A non-B) causes a clinically asymptomatic, acute disease which becomes **chronic** in about 80% of the cases. The diagnosis is made accidentally many years later, when positive antibodies to the hepatitis C virus, **anti-HCV**, and/or elevated LFTs are noted.

- transmitted by infected blood; in many cases the cause is unknown;
- individuals with hepatitis C may have also type B and/or A hepatitis;
- high rate of cirrhosis and liver cancer;
- **DIAGNOSIS: the presence of anti-HCV is not sufficient for a diagnosis** of chronic hepatitis C, because it can be present in other diseases. The **EIA** (enzyme immunoassay) is the first **confirmatory test**. If EIA is **positive**, **RIBA** (recombinant immunoblot assay) should be performed because EIA gives many false-positives. If the RIBA is positive, the diagnosis is chronic hepatitis C. If the C-file contains these tests, no additional serology testing is necessary to identify the type.

RATING HEPATITIS

SERVICE CONNECTION FOR HEPATITIS SHOULD NOT BE GRANTED WITHOUT IDENTIFYING THE TYPE OF HEPATITIS. BLOOD SEROLOGY TESTS ESTABLISH A DIAGNOSIS OF HEPATITIS AND ITS TYPE-A, B or C. LFTs are necessary to assess the severity of the disease along with other clinical and laboratory findings.

It is imperative to establish, if possible, the type of hepatitis in all claims for service connection. A clinical diagnosis of hepatitis on the VAE, without serologic testing to establish the type (if unknown), is inadequate for rating purposes. This examination should be returned with a request for serology to identify the type of hepatitis, along with LFTs (if not available). The results should accompany the examination. The rating should always **specify the type of hepatitis for which service connection is granted.**

If we know that a veteran had hepatitis in service, and many years later he is claiming service connection, serology and LFTs must be performed. All treatment records and the claims folder should be made available for review. The examiner should review the SMRs and current medical records to assess the type (or types) of hepatitis.

An opinion should be provided whether a relationship exists between the episode of hepatitis in service and the current type of hepatitis.

If you have any questions concerning the contents of this letter, please contact Brad Flohr at 202-273-7241 or by e-mail.

Robert J. Epley, Director
Compensation and Pension Service

Enclosure

Interpretation of Hepatitis B Panel

TEST	RESULTS	INTERPRETATION
EXAMPLE# 1		
HBsAg	negative	
anti-HBc	negative	susceptible to infection
anti-HBs	negative	(no history of hepatitis B)
EXAMPLE # 2		
HBsAg	negative	
anti-HBc	negative or positive	immune
anti-HBs	positive	
EXAMPLE # 3		
HBsAg	positive	
anti-HBc	positive	
IgM anti-HBc	positive	acute infection
anti-HBs	negative	
EXAMPLE # 4		
HBsAg	positive	
anti-HBc	positive	
IgM anti-HBc	negative	chronic infection
anti-HBs	negative	
DIAGNOSIS OF CHRONIC HEPATITIS C*		
*after 1992		
anti-HCV	positive (probable chronic hepatitis)	need to verify diagnosis
EIA	positive	supplemental test
RIBA	positive	diagnostic
HCVRNA	follow up of chronic hep.C	not needed for rating

HBsAg-hepatitis B surface antigen
anti-HBc- hepatitis B core antibodies
anti-HBs- hepatitis B surface antibodies
IgM- immunoglobulin M

anti-HCV-hepatitis C antibodies
EIA-enzyme immunoassay
RIBA-recombinant immunoblot assay
HCVRNA-measures viral load

LIVER FUNCTION TESTS Normal Values*

ALT - Alanine aminotransferase (formerly SGPT)-----0-35 units/L

AST - Aspartate aminotransferase (formerly SGOT)---0-35 units/L

Alkaline phosphatase - 41-120 units/L

Bilirubin (direct) - 0.1-1.0 mg/dL

Serum albumin - 3.5-5.5 g/dL

Total protein - 6.5-8.5 g/dL

***Values vary by laboratory** (normal values are given on the laboratory results in parentheses)

Medications for Treatment of Hep. C

- **Interferon** : Intron, Wellferon, Alfacon (Infergen), Betaseron or Roferon
- **Ribavarin**
- **Rebetron (Interferon+Ribavarin)**

ANTIGEN - substance capable to induce the body's immune response (examples of antigens-bacteria, pollen, viruses)

ANTIBODY - is the body's response to an antigen

EXAMPLE # 1

- Vet had hepatitis in service in 1973 (type unknown);
- No exposure to blood products; discharged in 1974;
- 1998-claims SC for hepatitis C with cirrhosis;
- SC granted for hepatitis C and 100% assigned. CUE :
 - Type of hepatitis in service not established (serologic tests not performed);
 - Claim was not well grounded as an opinion from the examiner on the relationship between the hepatitis in service and the current hepatitis C was not obtained.

EXAMPLE # 2

- SMRs-positive for anti-HCV found on blood donation;
- Repeat test of anti-HCV assessed previous test as false positive;
- On VAE anti-HCV, non-reactive; no diagnosis made;
- SC for hepatitis C granted: CUE because:
 - positive anti-HCV without confirmatory tests, do not indicate the presence of chronic hepatitis C
 - no diagnosis was made
 - not a well grounded claim

EXAMPLE# 3

- Vet had hepatitis in service in 1981, type unknown;
- On the VAE in 1998 he gives a history of hepatitis B in service; diagnosis of hepatitis B on VAE;
- SC granted for hepatitis B; premature grant because:
 - Inadequate exam; without serology to establish the presence of anti-HBs, it is not known whether the veteran had B hepatitis in service.

Page 2

EXAMPLE# 4

- Vet had “infectious hepatitis” in service in 1975; discharged in 1976;
- 1998-claim for pension, did not claim hepatitis;
- VAE-normal LFTs; no serology drawn (type of hepatitis in service not known);
- Diagnosis-“apparently hepatitis C”-inadequate exam;
- SC granted for hepatitis C-CUE: hepatitis C not shown

EXAMPLE # 5

- Vet had a transfusion in service;
- Chronic hepatitis C diagnosed before discharge;
- SMRs-cirrhosis with esophageal varices, severe anemia and thrombocytopenia, thrombosis of splenic vein on CT scan, confusion and somnolence due to hepatic encephalopathy; the vet was also S/P gastrectomy;
- A 10% evaluation was assigned based on SMR's;
- CUE-the evidence was sufficient to assign a 60% evaluation.
- NOD was received and a VAE requested (not necessary);

November 30, 1998

Director (00/21)
All VBA Offices and Centers

211B (98-110)

SUBJ: Infectious Hepatitis

The purpose of this letter is to provide further information about viral hepatitis with specific emphasis on hepatitis C. In addition to general background information, the letter discusses VA exams for liver disorders, and rating decisions involving viral hepatitis and its complications. (Also see: All Station Letter 98-35 "Hepatitis C," dated April 8, 1998.)

1. General

The liver is a complex organ composed of thousands of individual microscopic functional units that perform vital metabolic, excretory and defense tasks. The liver helps purify the blood by filtering harmful chemicals and breaking them down into substances that can be excreted from the body in urine or stool. The liver produces proteins that are essential for health, including albumin, which is the building block protein of the body, and other proteins that help blood clot properly. The liver stores sugars, fats and vitamins needed by the body, and functions to metabolize or change other substances into compounds the body requires. Primary among these is control of cholesterol metabolism.

Any inflammation of the liver inhibits its vital functions and can result in liver damage. One specific inflammation of the liver is hepatitis. Hepatitis is usually caused by a viral infection, but can also be caused by toxic agents such as alcohol, carbon tetrachloride or other chemicals, and by drugs such as acetaminophen, INH, Thorazine, Aldomet and Ilosone. The most common hepatitis viruses in the United States are viruses for hepatitis A, B, and C. The alphabetical list of hepatitis viruses continues to grow, and includes viruses D, E, F, and G. In addition, other less common viruses such as infectious mononucleosis, cytomegalovirus, and yellow fever can cause hepatitis, but these do not primarily attack the liver.

For rating purposes, it is important to distinguish between acute hepatitis and chronic hepatitis.

2. Acute Hepatitis

Many people infected with the hepatitis virus, primarily those with hepatitis C, have few symptoms or no symptoms at all. Others may be so ill as to require hospitalization. In the early or acute stages, hepatitis mimics a variety of flu-like illnesses and may be difficult to diagnose. Initial laboratory tests to confirm a suspected diagnosis of hepatitis infection include blood tests that indicate the presence of liver inflammation and show abnormalities of liver function. However, diagnosis of a specific hepatitis A, B, or C infection requires serologic studies (blood tests).

Acute hepatitis usually resolves in 4-6 weeks, often without specific treatment. Individuals with acute hepatitis A infection will not develop chronic hepatitis. However, some individuals with acute hepatitis B and C infections will go on to develop chronic hepatitis. A chronic infection can last for many years and will often result in liver damage. Individuals with chronic hepatitis infection are at increased risk of developing liver cirrhosis and/or liver cancer.

3. Specific types of viral hepatitis

Hepatitis A Infection

Hepatitis A infection, formerly known as "infectious hepatitis," is caused by the hepatitis A virus (HAV) and is spread by oral or fecal contamination of food or water, usually because of poor sanitation.

The incubation period between exposure to the virus and onset of the illness ranges from 45 to 180 days.

Hepatitis A is a self-limited, acute disease. It heals without residual disability and does not result in chronic hepatitis infection or liver damage. The acute infection produces lifelong immunity to re-infection.

Hepatitis B Infection

Hepatitis B infection, caused by the hepatitis B virus (HBV), was once referred to as "serum hepatitis" because it was thought that the only way it could be spread was through blood or serum contamination. Now it is known that it can also be spread through close personal contact with a person who is infected. Persons most at risk for HBV infection are intravenous drug users, hemophiliacs, hemodialysis patients, healthcare and dental care workers, blood product workers, babies born to infected mothers, people who received blood products or transfusions before 1975, and people who engage in high-risk sexual practices. HBV infection can also be spread by tattooing, body piercing, or sharing razors and toothbrushes.

The incubation period ranges from 45 to 180 days. A vaccine is available to prevent HBV infection for people known to be in high risk groups. In addition, Hepatitis B Immune Globulin is available to administer to individuals exposed to HBV.

Chronic HBV infection develops in 2% to 10% of cases. Individuals with chronic hepatitis B can infect other individuals. Chronic HBV infection can result in liver damage, including cirrhosis and primary hepatocellular carcinoma.

Hepatitis C Infection

Hepatitis C infection, caused by the hepatitis C virus (HCV), was formerly referred to as "non-A, non-B hepatitis" because the specific virus causing the infection had not been identified, although it was known to be neither type A nor type B.

Major risk factors for HCV infection include receipt of blood or blood products before 1992; intravenous drug use; occupational exposure to contaminated blood or fluids via employment in patient care or clinical laboratory work; high risk sexual practices; intranasal cocaine; hemodialysis; organ transplants; body piercing or tattooing. Although a potential risk factor can be identified for approximately 90% of persons with HCV infection, in some patients no recognized source of infection can be identified.

Blood donor screening for HCV was not possible until 1989, when the specific virus was identified. In 1992, a reliable second generation test for the C virus became available and more effective screening of blood became possible. Up to 90% of transfusion-associated hepatitis is related to HCV.

HCV infection is the most common chronic bloodborne infection in the United States and is now recognized as a major public health threat. During the 1980's, it is estimated that an average of 230,000 new infections occurred each year. With improved blood donor screening, the annual number of new infections declined to 36,000 in 1996. However, nearly 4 million Americans are believed to be currently infected. Approximately 85% of people with acute HCV infection will develop chronic HCV. Most will experience no symptoms, or only minor symptoms of illness, such as mild, intermittent fatigue. The diagnosis of HCV is often an incidental finding on blood tests done for some other reason, sometimes years after the acute infection.

Active liver disease develops in a high number of chronically infected HCV patients. The progression of chronic liver disease is usually slow, without symptoms or physical signs for the first two or more decades after infection. Up to 20% of all chronic HCV patients develop chronic, progressive liver damage leading to cirrhosis within 20 years. From 1% to 5% of chronic patients develop hepatocellular carcinoma within 20 years. Chronic HCV patients who use alcohol regularly, even in small amounts, are known to develop cirrhosis and liver cancer more rapidly. HCV infection is now the leading reason for liver transplantation in the United States.

The incubation period for infection following exposure to the virus ranges from 2 to 26 weeks. However, remember that:

- (1) the onset of infection may be unrecognized since symptoms may not be severe enough to require medical attention; and
- (2) chronic liver damage will not manifest for many years.

There is no vaccine to prevent HCV infection. Treatment of chronic HCV at present is with interferons. There are low rates of sustained response with treatment. Recently, the Food and Drug Administration (FDA) approved combination therapy with interferon and ribavirin, although the effectiveness of this combination therapy is still unknown.

4. Diagnostic Tests for the Specific Virus Causing Hepatitis (i.e., HAV, HBV, HCV)

Serologic tests determine the presence of antigens and antibodies to the specific virus. The presence of antibodies to the specific virus (anti-HAV, anti-HBV or anti HVC) indicates the infection is present.

For VA compensation purposes, the diagnosis of HCV infection requires two specific tests. The initial test is the enzyme immunoassay (EIA). If the EIA is positive, the recombinant immunoblot assay (RIBA-2) is used as a supplemental test to confirm the presence of the virus. (Another test directly measures the viral gene, HCV RNA, but this test is not required for compensation purposes.)

Other tests you should be aware of for compensation purposes include:

- HBsAg is a hepatitis B surface antigen. If positive, it is a marker for acute or chronic hepatitis B infection.
- Anti-HBc indicates antibodies to the hepatitis B virus core antigen. If positive, it is a marker for hepatitis B infection.
- Ferritin is the iron storage protein. It is increased in hemochromatosis.
- Apha-fetoprotein (AFP) is a tumor marker used in screening for hepatocellular carcinoma.

Note: See Attachment 2, the Under Secretary for Health's information letter on testing and evaluation for hepatitis C.

5. Liver Function Tests

1. Indicators of overall liver function

- Serum albumin (measures the serum protein produced by the liver; may be decreased in liver disease)
 - Prothombin time (assesses blood clotting; may be prolonged in liver disease)
2. Markers of liver disease or inflammation (liver enzyme tests)
- ALT (or alanine transaminase, formerly SGPT; may be elevated in inflammation)
 - AST (or aspartate transaminase, formerly SGOT; may be elevated in inflammation)
 - Alkaline phosphatase (may be elevated in liver disease or indicate bile disorders)
 - Serum bilirubin (may be elevated in liver or biliary tract disease)

6. Rating Issues Involving Hepatitis

A. Rating Schedule Provisions

How do we address hepatitis in claims for service connection? The Rating Schedule contains criteria that allow us to evaluate liver disorders. (See Diagnostic codes 7311 and 7301 for liver injuries, 7312 for cirrhosis, 7345 for hepatitis, and 7343 for carcinoma.)

To allow accurate tracking of hepatitis-related complications, the rating must show a hyphenated diagnostic code with the hepatitis code placed first to indicate that cirrhosis, carcinoma, etc. is related to hepatitis. For example, cirrhosis due to hepatitis C would be shown as 7345-7312.

A change to Part 4 of the regulations is currently under development that will update evaluation criteria for disabilities of the liver and specifically address hepatitis C and its sequelae.

B. Well-Founded Claims.

For hepatitis, as for any claimed condition, the issue of well-foundedness must be addressed before a claim is developed and referred for rating. The Court of Veterans' Appeals has held that a well-founded claim is a plausible claim, one which is meritorious on its own or capable of substantiation. This does not mean that the claim itself is conclusive, but only that it is possible.

According to the Court of Veterans Appeals, in order for a claim to be well-founded, there must be:

- Competent medical evidence of current disability;
- Medical or, in certain circumstances, lay evidence that the disease or injury was incurred or aggravated in service; and

- Medical evidence of a nexus or link between the in-service injury or disease and the current disability.

In order for a claim for service connection for hepatitis C infection to be well-grounded, there must first be evidence of a current diagnosis of hepatitis C infection.

In order to fulfill the requirement that there must be lay or medical evidence that a disease or injury was incurred or aggravated in service, there must be evidence of an acute hepatitis infection in service, or evidence that the veteran was exposed to a known risk factor for hepatitis in service.

We know that the risk factors for hepatitis B and C are similar:

- Intravenous drug use
- Blood transfusions
 - before 1975 for HBV
 - before 1992 for HCV
- Accidental exposure in healthcare workers
- Hemodialysis
- Intranasal cocaine
- High-risk sexual activity
- Other direct percutaneous exposure such as tattoos, body piercing, acupuncture with non-sterile needles, shared toothbrushes or razor blades

There are certain risk factors that are plausible as a cause of hepatitis B or C. These include blood transfusions, hemodialysis, and employment in a health care occupation. A claim that hepatitis B or C infection resulted from one of these in service would be plausible nexus information for the purpose of well-groundedness.

Situation: Service connection is claimed for cause of death due to cirrhosis and liver cancer. The veteran never filed a claim during his lifetime, and cirrhosis was diagnosed 20 years after service. The veteran also had a diagnosis of hepatitis C and a long history of problems with alcohol. During service, the veteran was a medical corpsman.

Is this sufficient to make the claim well-grounded? Yes.

The fact that the veteran was a health care worker during service establishes that the veteran was exposed to a risk factor during service that could be the cause of HCV infection and subsequent complications. The diagnosis of HCV was submitted with the claim. This is sufficient to make the claim plausible.

Although the claim is well-grounded, the rating activity will need to develop and evaluate all pertinent evidence, including evidence of treatment after service and presence of other possible risk factors. Once all evidence is developed, a medical

determination will be required as to the most likely cause of the veteran's cirrhosis and liver cancer.

A claim for service connection for hepatitis due to IV drug use or nasal cocaine cannot be service-connected by law. (See 38 United States Code §§ 105, 1110). Such a claim should be denied under Code 8 on the basis of no statutory entitlement.

C. Medical Examinations

A new AMIE worksheet has been prepared for Liver, Gall Bladder and Pancreas examinations. The new worksheet is more detailed and comprehensive and will help examiners provide more specific information to help rating specialists evaluate claims involving hepatitis and its sequelae. (See Attachment 1)

It is important that rating personnel become familiar with the new worksheet so that they can ensure all necessary tests have been accomplished, all risk factors have been considered, and necessary medical opinions have been provided.

D. Risk Factors and Medical Opinions

A common rating problem will be that service records show hepatitis infection but do not define the type of hepatitis present. If a veteran claims service connection for hepatitis B or C infection or one of the known complications many years after service, complete development will be needed to evaluate intervening causes, and explore other possible risk factors. Situations where multiple risk factors exist will present particularly difficult problems.

The question as to the most likely cause of a particular disease or complication is a medical determination. Claims for hepatitis B or C will frequently require the opinion of a medical professional as to the most likely cause of hepatitis B or C.

Following are some typical situations you may encounter and the questions that must be answered for each situation to reach a decision. **All of these situations require an opinion by a medical professional to answer the question posed.** For all of these medical questions, the examiner will need to review the claims file and elicit a complete history from the veteran in order to furnish an opinion. The rating activity has a responsibility to develop all available evidence prior to the exam.

Situation: A veteran had a transfusion in service in 1969, and another transfusion after service in 1979. He now claims service connection for hepatitis C infection.

Question: Which risk factor is the most likely cause of the current hepatitis C?

(Note: If the physician cannot determine if one risk factor is more likely than another to be the cause, the exam report should so state, and should explain. See the revised AMIE worksheet.)

Situation: A veteran had a transfusion in service in 1975. In 1971, prior to service, he was an IV drug user for 6 weeks. He now claims service connection for hepatitis B.

Question: What is the most likely cause of the currently diagnosed hepatitis?

Situation: A veteran had a transfusion in service in 1975 and has been using IV drugs for the past 5 years. He claims service connection for hepatitis C, stating that it is due to the in-service transfusion.

Question: What is the most likely cause of the currently diagnosed hepatitis C?

Situation: A veteran had acute viral hepatitis in service, but the type of hepatitis is not known. He now claims service connection for hepatitis C.

Question: Is the in-service acute viral hepatitis the forerunner of the currently diagnosed chronic hepatitis?

Situation: A veteran claims service connection for cirrhosis and is an alcoholic.

Question: What is the most likely cause of the veteran's current disability?

(Note: Cirrhosis is a possible outcome of chronic hepatitis infection, but can, of course, have other causes. Assuming this claim is well grounded, a medical opinion would be required to resolve the etiology of the cirrhosis)

E. Miscellaneous Rating Problems

Situation: Hepatitis C is claimed and diagnosed, but no risk factors are present.

In a situation like this, your action depends upon several factors. When was the hepatitis C diagnosed? If diagnosed in service, you have a possibility for service connection. If diagnosed after service, you would need to determine if you have a well-grounded claim before you proceed.

Situation: The veteran was diagnosed after service with non-A non-B hepatitis.

Again, your action depends upon several factors. What is the current diagnosis? Is there evidence showing in-service exposure to risk factors? Is the claim well-grounded?

Situation: Hepatitis C is claimed and was shown as an acute infection in service. The veteran currently has no liver damage, and the only evidence of hepatitis C is the presence of anti-HCV on blood test.

If it is determined that service connection is in order, the rating schedule provides a zero-percent evaluation under DC 7345 for healed, nonsymptomatic infectious hepatitis. The diagnosis of HCV confirmed by anti-HCV on blood serum warrants service connection under this code, unless prohibited as due to drug abuse.

F. Making a Decision

Once you have a well-grounded claim, complete development, a good medical examination and a medical opinion, it is up to you as a rating specialist to make a sound decision. To do this, you must carefully weigh all of the evidence presented. You are not free to disregard evidence; your duty is to assess and evaluate the evidence. You must remember that your personal opinion is not evidence. However, if, in your opinion, the evidence is inadequate, you are not only free to obtain more evidence, you are obligated to do so.

If you have conflicting evidence, or conflicting medical opinions, you may need to request clarification of a statement previously furnished or an opinion already rendered. You must decide if the preponderance of evidence is in favor of the claim, against the claim, or evenly balanced. Remember that under the law, if the evidence is evenly balanced, a favorable decision is required. As in any decision, you must fully discuss all evidence considered and furnish complete reasons and bases for your decision.

7. A copy of Under Secretary for Health's Information Letter, IL 10-98-012, "Hepatitis C: Standards for Provider Evaluation and Testing," dated June 11, 1998, is enclosed as Attachment 2 for additional information.

8. If you have questions about the contents of this letter, please contact the Policy and Regulations Staff at (202) 273-7210.

/s/

Robert J. Epley, Director
Compensation and Pension Service

Enclosure

Attachment 1

Compensation and Pension Examination

LIVER, GALL BLADDER, AND PANCREAS

Name: _____ SSN: _____

Date of Exam: _____ C-number: _____

Place of Exam: _____

A. Review of Medical Records: This may be of particular importance when hepatitis C or chronic liver disease is claimed as related to service.

B. Medical History (Subjective Complaints):

Comment on:

1. Vomiting, hematemesis, or melena.
2. Current treatment - type (medication, diet, enzymes, etc.), duration, response, side effects.
3. Episodes of colic or other abdominal pain, distention, nausea, vomiting duration, frequency, severity, treatment, and response to treatment.
4. Fatigue, weakness, depression, or anxiety.
5. When chronic liver disease is claimed, record history of any risk factors for liver disease, including transfusions, hepatitis (and what type), intravenous drug use, occupational blood exposure, high-risk sexual activity, etc. When did they take place? Describe current symptoms of liver disease and onset of symptoms.
6. Provide history of alcohol use/abuse, both current and past.

C. Physical Examination (Objective Findings):

Address each of the following as appropriate, and fully describe current findings:

1. Ascites.
2. Weight gain or loss, steatorrhea, malabsorption, malnutrition.
3. Hematemesis or melena (describe any episodes).
4. Pain or tenderness - location, type, precipitating factors.
5. Liver size, superficial abdominal veins.
6. Muscle strength and wasting.
7. Any other signs of liver disease, e.g., palmar erythema, spider angiomas, etc.

D. Diagnostic and Clinical Tests:

1. For esophageal varices, X-ray, endoscopy, etc.
2. For adhesions, X-ray to show partial obstruction, delayed motility.
3. For gall bladder disease, X-ray or other objective confirmation.

Page 2

Compensation and Pension Examination

4. For liver disease: liver function tests (albumin, prothrombin time, bilirubin, AST, ALT, WBC, platelets); serologic tests for hepatitis (HBsAg, anti-HCV, anti-HBc, ferritin, alpha-fetoprotein); and liver imaging (ultrasound or abdominal CT scan), as appropriate. If hepatitis C is the diagnosis, a positive EIA (enzyme immunoassay) test for hepatitis C should be confirmed by a RIBA (recombinant immunoblot assay) test.
 - a. With a diagnosis of hepatitis, name the specific type (A, B, C, or other), and for hepatitis B and C, provide an opinion as to which risk factor is the most likely cause. Support the opinion by discussing all risk factors in the individual and the rationale for your opinion. If you can not determine which risk factor is the likely cause, state that there is no risk factor that is more likely than another to be the cause, and explain.
 - b. With a diagnosis of cirrhosis, chronic hepatitis, liver malignancy, or other chronic liver disease, state the most likely etiology. Address the relationship of the disease to active service, including any hepatitis that occurred in service. If you cannot determine the most likely etiology, cannot determine whether it is more likely than not that one of multiple risk factors is the cause, or cannot determine whether it is at least as likely as not that the liver disease is related to service, so state and explain.
5. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

Signature:

Date:

Attachment 2**DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420****IL 10-98-012**

In Reply Refer To: 11

June 11, 1998

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER**HEPATITIS C: STANDARDS FOR PROVIDER EVALUATION AND TESTING**

1. **Background:** Hepatitis C virus (HCV) infection was first recognized in the 1970's, when the majority of transfusion-associated infections were found to be unrelated to hepatitis A and B, the two hepatitis viruses recognized at the time. This transmissible disease was then simply called "non-A, non-B" hepatitis. Sequencing of the HCV genome was accomplished in 1989, and the term hepatitis C was subsequently applied to infection with this single strand ribonucleic acid (RNA) virus. The genome of HCV is highly heterogeneous and, thus, the virus has the capacity to escape the immune surveillance of the host; this circumstance leads to a high rate of chronic infection and lack of immunity to reinfection. Reliable and accurate (second generation) tests to detect antibody to HCV were not available until 1992, at which time an effective screening of donated blood for HCV antibody was initiated.

2. HCV infection is now recognized as a serious national problem. Nearly 4 million Americans are believed to be infected, and approximately 30,000 new infections occur annually. Only about 25 to 30 percent of these infections will be diagnosed. HCV is now known to be responsible for 8,000 to 10,000 deaths annually, and this number is expected to triple in the next 10 to 20 years.

3. Hepatitis C has particular import for the Department of Veterans Affairs (VA) because of its prevalence in VA's service population. For example, a 6-week inpatient survey at the VA Medical Center, Washington, DC, revealed a prevalence of 20 percent antibody positivity. A similar investigation at the VA Medical Center San Francisco, CA, found 10 percent of inpatients to be antibody positive. Veterans Health Administration (VHA) Transplant Program data reveal that 52 percent of all VA liver transplant patients have hepatitis C. An electronic survey of 125 VA medical centers conducted by the Infectious Disease Program Office from February through December of 1997, identified 14,958 VA patients who tested positive for hepatitis C antibody. Clearly, HCV infection is becoming a leading cause of cirrhosis, liver failure, and hepatocellular carcinoma. The incidence and prevalence rates are higher among nonwhite racial and ethnic groups.

4. HCV is transmitted primarily by the parenteral route. Sources of infection include transfusion of blood or blood products prior to 1992, injection drug use, nasal cocaine, needlestick accidents,

Page 2

Under Secretary for Health's Information Letter

and, possibly, tattooing. Sexual transmission is possible, and while the risk is low in a mutually monogamous relationship, persons having multiple sexual partners are at higher risk of infection.

5. After infection, 90 percent of HCV infected patients will develop viral antibodies within 3 months. The disease becomes chronic in 85 percent of those infected, although one-third will have normal aminotransferase levels. The rate of progression is variable, and chronic HCV infection leads to cirrhosis in at least 20 percent of infected persons within 20 years; 1 to 5 percent of those infected will develop hepatocellular carcinoma.

6. At present, treatment for HCV infection is limited, consisting primarily of administration of interferon alpha, with or without the addition of ribavirin. The treatment benefits some patients and appears to alter the natural progression of the disease, although evidence is lacking that it will translate into improvements in quality of life or reduction in the risk of hepatic failure. Current regimens include the use of 6 or 12-month courses of interferon alpha, with or without ribavirin. The recent National Institutes of Health Consensus Statement on Hepatitis C concluded that liver biopsy should be performed prior to initiating treatment. If little liver damage is apparent, therapy need not be initiated; treatment is probably appropriate for those with significant histologic abnormalities. However, data presented at this Consensus Conference indicated that significant uncertainty remains regarding indications for treatment. Treatment options and a listing of VA protocols will be the subject of a separate Information Letter.

7. A number of serologic tests are available for diagnosis and evaluation of HCV infection. Enzyme immunoassays (EIA) are "first line" tests, and are relatively inexpensive. They contain HCV antigens and detect the presence of antibodies to those antigens. Recombinant immunoblot assays (RIBA) contain antigens in an immunoblot format, and are used as supplemental or confirmatory tests. Viral RNA can be detected by reverse-transcription polymerase chain reaction (PCR) testing. Quantitative HCV RNA testing uses target amplification PCR or signal amplification (branched deoxyribonucleic acid (DNA)) techniques.

8. The EIA tests have sensitivities in the range of 92 to 95 percent. Specificities depend on the risk stratification pre-testing. That is, in blood donors with no risk factors, 25 to 60 percent of positive EIA are also positive by PCR for viral RNA. About 75 percent of low risk donors with positive EIA and RIBA will be positive by PCR. Positive EIA tests should be confirmed by RIBA. If that is also positive the patient has, or has had, HCV infection. In high-risk patients who are EIA positive, particularly if there is evidence of liver disease, supplemental testing with RIBA or HCV RNA analysis is probably unnecessary. Quantitative RNA tests may be useful in the selection and monitoring of patients undergoing treatment.

9. All patients will be evaluated with respect to risk factors for hepatitis C, and this assessment documented in the patient's chart. Based upon those risk factors, antibody testing should be utilized as elaborated on in the algorithm found in Attachment A.

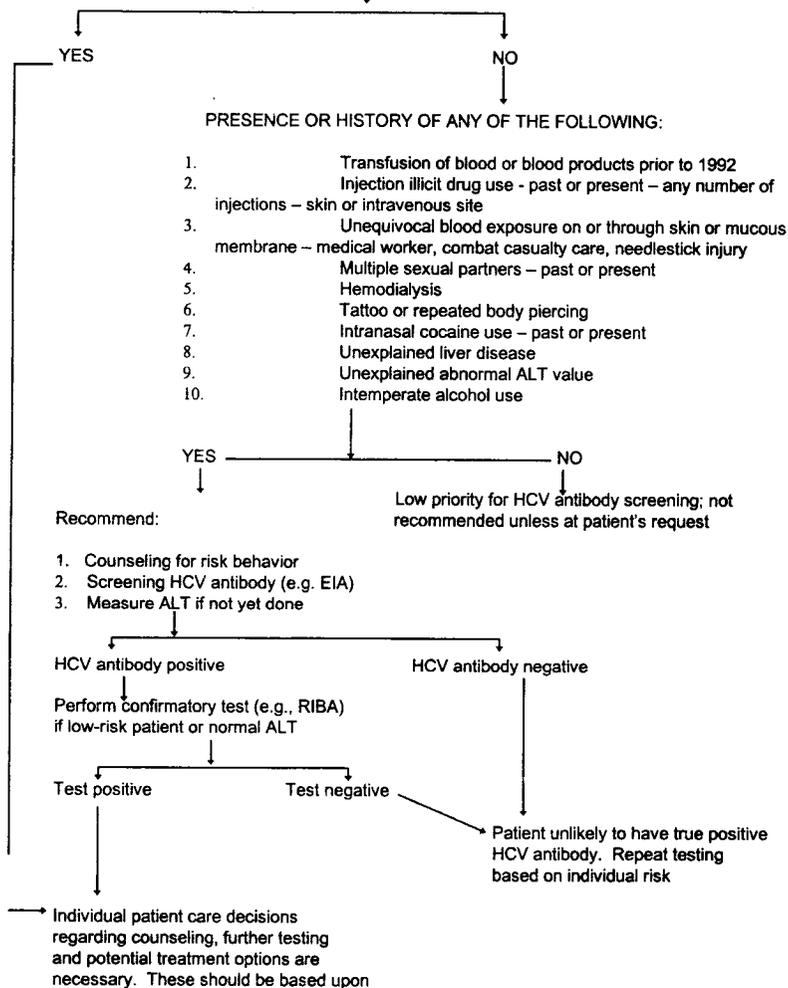
S/Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 6/11/98
FLD: VISN, MA, DO, OC, OCRO, and 200 – FAX 6/11/98
EX: Boxes 104,88,63,60,54,52,47,and 44 – FAX 6/11/98

ATTACHMENT A

**HEPATITIS C VIRUS ANTIBODY SCREENING
FOR THE VETERAN POPULATION
HISTORY OF POSITIVE TEST FOR
HEPATITIS C VIRUS ANTIBODY**



current literature or performed within
approved research protocols

REPUBLICANS

BOB STUMP, ARIZONA, CHAIRMAN
 CHRISTOPHER H. SMITH, NEW JERSEY
 MICHAEL BLURBAKE, FLORIDA
 FLOYD SPENCE, SOUTH CAROLINA
 TERRY EVERETT, ALABAMA
 STEPHEN E. BUYER, INDIANA
 JACK CLARK, NEW YORK
 CLIFF STEARNS, FLORIDA
 JERRY MORAN, KANSAS
 J.D. HAYWORTH, ARIZONA
 HELEN CHENOWETH, IDAHO
 RAY LAMODE, ILLINOIS
 JAMES V. HANSEN, UTAH
 HOWARD P. BUCK, MICHIGAN, CALIFORNIA
 JIM GRIGGINS, NEVADA
 MICHAEL E. SIMPSON, IDAHO
 RICHARD H. BAKER, LOUISIANA

CARL D. KOMENATOR
 CHIEF COUNSEL AND STAFF DIRECTOR

DEMOCRATS

LANE EVANS, ILLINOIS
 BOB FLENER, CALIFORNIA
 LUE V. SUTHERS, ILLINOIS
 CORRINE BROWN, FLORIDA
 MICHAEL F. DOYLE, PENNSYLVANIA
 COLLIN C. PETERSON, MINNESOTA
 JULIA CARSON, INDIANA
 SILVESTRE REYES, TEXAS
 VIC SHYDER, ARKANSAS
 CRO D. RODRIGUEZ, TEXAS
 RONNE SHOWS, MISSISSIPPI
 SHELLEY BERKLEY, NEVADA
 BARRY P. HILL, INDIANA
 TOM UDALL, NEW MEXICO

U.S. House of Representatives

COMMITTEE ON VETERANS' AFFAIRS

BOB STUMP

CHAIRMAN

ONE HUNDRED SIXTH CONGRESS

335 CANNON HOUSE OFFICE BUILDING

WASHINGTON, DC 20515

<http://veterans.house.gov>

January 28, 2000

Honorable Joseph Thompson
 Under Secretary for Benefits
 Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Mr. Secretary:

During the past year, Mary Ellen Mc Carthy has reviewed a number of claim files and cases to provide oversight of the application of current Veterans Benefits Administration (VBA) policies in the adjudication of claims. In the course of those reviews a number of issues of concern have arisen. To better understand current VBA policies and practices, I would appreciate and request receiving your response to the following observations.

I. *Hepatitis C Cases*

There is confusion concerning the application of the "well-grounded claim" criteria to cases involving Hepatitis C.

- Claims have been denied as not being well grounded with veterans being advised that in order to well-ground a Hepatitis C compensation claim the veteran must demonstrate that Hepatitis "was first diagnosed in service". Information concerning current Compensation and Pension (C&P) policy which allows for a claim

Honorable Joseph Thompson
January 28, 2000
Page 2

to be well-grounded if the veteran was exposed to certain risk factors for Hepatitis (such as exposure to blood or a blood transfusion during military service) are not mentioned in the decisions.

- Claims of veterans who engaged in combat with the enemy are judged as not well-grounded due to lack of military medical records showing that the hepatitis was due to a combat injury without regard to the requirements of 38 C.F.R. §3.304 concerning acceptance of lay testimony. This is compounded by the almost insurmountable difficulty encountered by veterans in obtaining medical records, such as transfusions during surgery in a field hospital after being wounded in combat.
- Although the evidence produced by the veteran should be presumed credible for purposes of a well-grounded determination, claims are denied as not well-grounded if documentation supplied by the veteran, such as a copy of a certificate for bronze star with valor describing the veteran's exposure to severely wounded comrades during combat activity, is not a verified copy. (No request for verification of the military records was made.)
- Veterans are allowed 30 days to provide information to well-ground their claims. Given the amount of time it currently requires to obtain military medical records, claims are denied as not well-grounded when the military records would provide the evidence necessary to establish a well-grounded claim, e.g. a veteran who served in a health care occupation during military service.

Honorable Joseph Thompson
January 28, 2000
Page 3

There appears to be a belief that "all potential alternate sources of hepatitis" be identified and "ruled out" before a claim can be allowed.

- For example, a diabetic veteran with no history of IV drug use who received a blood transfusion during surgery for a service-connected condition was informed that VA is required to explore whether or not the use of prescribed insulin could be the source of the Hepatitis infection. This is particularly problematic, since VHA specialists have stated that while a number of risk factors can be identified and rated for potential risk, it is not possible to attribute or "rule out" a specific exposure to the infection where multiple exposure routes are possible in an individual case. Where there is no evidence or indication of any other risk factor than the one alleged by the veteran, veterans are given the impression that they must prove a negative, that is the lack of any other explanation for the disease.

There is confusion concerning the application of the rating schedule for infectious hepatitis to chronic hepatitis cases.

- For example, a veteran who had been service-connected for Hepatitis C requested an increased rating after liver biopsy showed "mild to moderate" liver damage. The veteran had received a medical leave of absence from his employment in order to undergo intensive therapy for Hepatitis C. Despite objective evidence of "mild to moderate liver damage", a rating at 10% was maintained which requires only "demonstrable liver damage."

The lack of information in military medical records concerning risk factors for Hepatitis C

- In reviewing records of veterans who were diagnosed with hepatitis during military service, two-thirds of the records contained no reference to risk factors. For example, of 18 records reviewed of

Honorable Joseph Thompson

January 28, 2000

Page 4

veterans who had a diagnosis of hepatitis in their military service records, no indication of the risk factor was recorded in 12 medical records.

Specific Issues To Be Addressed

- Lack of evidence in medical records concerning blood transfusion. Should "lay evidence" concerning the administration of blood observed by the veteran or another be accepted as evidence of a blood transfusion if the testimony is otherwise consistent with the evidence of record?
- Is it appropriate to deny a claim as not well-grounded when there is a current diagnosis of Hepatitis C and the veteran alleges combat exposure to blood or blood products as a victim, rescuer or health care professional?
- How should the presumptions related to combat veterans be applied in determining whether or not a claim for Hepatitis C is not well-grounded?
- Does a decision which denies a claim for Hepatitis C as not being well-grounded, but fails to specify the element or elements of the requirements for a well-grounded claim which are not satisfied, meet the requirements for fundamental due process?
- In evaluating a claim for Hepatitis C pending the revision of the rating schedule, what is the reason evidence of a liver biopsy showing moderate or marked liver damage should not result in a rating of 60% for moderate liver damage and 100% for marked liver damage? Has any guidance been provided to rating specialists for evaluation of severity of hepatitis based upon liver biopsy results?

Honorable Joseph Thompson
January 28, 2000
Page 5

II. Well-Grounded Claim Issues

There appears to be some confusion concerning the application of the "well-grounded claim" criteria to cases involving certain presumptions.

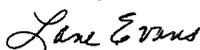
- A veteran-filed claim at time of separation from service after being discharged pursuant to a medical board decision with a 20% rating. Claim denied by VA as not well-grounded.
- An Ex-POW claimed disability due to arthritis as related to injuries sustained when he bailed out of a plane which had been shot down over enemy territory. The claim was denied as not well-grounded because the military medical records did not show evidence of the trauma. No reference was made to 38 C.F.R. §§3.304 (e) or 3.309 (c).

Specific Issues To Be Addressed

- There appears to be a need to clarify the relationship between presumptions related to combat veterans and POW's concerning the acceptance of testimony not withstanding the absence of official service medical records.

I would appreciate it if the appropriate personnel on your staff would review these observations and provide me a response by February 29, 2000 describing the Department's action to address the concerns raised.

Sincerely,



LANE EVANS

Ranking Democratic Member

cc: Deputy Under Secretary Nora Egan
Deputy Under Secretary Rick Nappi

Testimony of Rep. Bart Stupak
Benefits Subcommittee of Veterans Affairs
April 13, 2000

Mr. Chairman, thank you for the opportunity to testify on behalf of my bill, H.R. 3816. I appreciate your willingness to allow me to discuss this very important issue, which affects veterans and their families all across the country.

The issue my bill addresses is a simple one. National Guard and Reservists are required to undergo Inactive Duty for Training, or IDT, periodically. IDT encompasses a huge range of activities – in essence, the full range of training. Depending on what the unit's mission is geared towards, IDT can be a fitness test, weapons training, or other potentially stressful activities which can trigger an acute medical event such as a heart attack or stroke.

If a Guard member or Reservist happens to suffer a stroke or a heart attack while undergoing IDT, they are *not* eligible for benefits. This is patently unfair, especially as IDT activities are mandatory, not optional. Under current law, if a Guard member or Reservist on IDT suffers a heart attack or stroke the disability is characterized as due to a "disease" and is *not* service-connected for purposes of benefits from the Department of Veterans Affairs (VA). If a Guard member or Reservist was on "active duty" or "active duty for training" and became severely disabled or died, regardless of the cause, the Guard member or Reservist or his dependents would be eligible for benefits from the VA.

My bill, H.R. 3816, would address this discrepancy. This inequitable treatment of Guard members and Reservists on "inactive duty for training" should be eliminated.

This issue was first brought to my attention by a case in my district. Master Sergeant Ron Pearce, father of six and husband to Carol, was performing the mandatory Army Physical Fitness Test. He had been suffering from a heart condition for some time, a condition that was well known to his superiors. In the course of performing his fitness test, Master Sergeant Pearce had a massive heart attack and died. His widow, a stay-at-home mother who homeschooled her children, initially received benefits from the Department Veterans Affairs. However, upon VA review, these benefits were denied her a few months later, forcing her to find a part time job to support herself and her family. Upon further research, I discovered several very disturbing cases along similar lines.

H.R. 3816, "The Inactive Duty for Training Fairness Act," will correct this inequity. Members of the Guard and Reserve serve their country while on "inactive duty for training." While on "inactive duty for training," if they suffer a heart attack or stroke, those medical conditions should be considered by law to be service-connected for the purpose of VA benefits.

Finally, I would like to mention the intent of this bill applies to very restrictive categories of injuries. Although the Congressional Budget Office has not yet released its final estimate, initial evidence seems to indicate this would give benefits to a low number of cases annually.

The members of the Guard and Reserve and their families deserve no less than the enactment of this bill.

I thank the Committee again for having this hearing, and I urge markup of my bill as soon as possible.

**Statement of
Gary A. Roselle, M.D.
Program Director for Infectious Diseases
Veterans Health Administration
Department of Veterans Affairs
Before the
Subcommittee on Benefits
Committee on Veterans' Affairs
U.S. House of Representatives**

April 13, 2000

Thank you for the opportunity to provide data regarding veterans testing positive for hepatitis C in the VHA. In order to reasonably interpret the data that I will present it is necessary to very briefly describe how the data were collected with a comment about the meaning of the test data.

The data were collected from the Emerging Pathogens Initiative, an automated electronic surveillance system that is in place throughout the VA nationally. Once a positive hepatitis C virus antibody laboratory test is found by the local computer system, a variety of other data are automatically extracted, particularly demographic data such as age, gender, and era of service. Demographic data for all persons served by the VHA during fiscal years 1998 and 1999 were extracted from the VHA data set located at the Austin Automation Center in Texas. The information provided today will include data on persons who are hepatitis C virus antibody positive at time of testing during fiscal years 1998 and 1999, and data on the total patient population served by the VHA over the same time interval.

The hepatitis C virus antibody test used is designed to screen patient serum for the presence of antibody to hepatitis C virus. A positive test result does not mean that an individual patient has active hepatitis, but, as with all antibody tests, it defines the response of the individual person to infection with the virus. As with all tests, false positive and false negative results can occur. The likelihood that a positive test for hepatitis C virus antibody is truly positive is directly related to the number of people in the population who have the disease. When testing for cause, meaning there is evidence of possible liver disease, in the VHA population served, it is very likely that the majority of the positive hepatitis C virus antibody tests are true positives. However, some patients are tested for a variety of reasons, including at their own request, despite lack of identifiable risk factors. It should also be noted that hepatitis C virus antibody tests can be intermittently positive, particularly in persons who have relatively low levels of antibody.

Now I will provide some data that covers the two year period. For this 24 month period, there is an opportunity for each reporting site to provide data 24 times since it is transmitted monthly. For FY 98 and FY 99, 92.12% of these total possible months were actually in the data set. This is remarkable provision of data for any surveillance system.

For the 24 months, 54,682 unique persons in the VHA had a positive test for hepatitis C virus antibody. I use the words "unique persons" to define actual individuals with a positive antibody test and not just number of individuals having a positive test, since a single person could have been tested more than once.

In graph 1, the age distribution revealed an average age of slightly greater than 49 years old with a rather narrow standard deviation of approximately 9.4 years. This indicates that, for the most part, the age group of persons with hepatitis C virus antibodies were clustered closely around the mean age of 49. As seen in Graph 2, when looking at gender of these persons with a positive hepatitis C virus antibody test and reporting gender, 96.4%, were male, and 3.6%, were female.

Era of service is illustrated in graph 3. Of the total number of persons who were hepatitis C antibody positive and reported an era of service, 62.7% were noted to be from the Vietnam era. The second most frequent group is listed as post-Vietnam at 18.2%. The percentage of other eras served drops fairly dramatically after these two with 4.8% Korean conflict, 4.3% post-Korean conflict, 4.2% from WWII, and Persian Gulf era veterans representing 2.7%.

For comparison, it is worthwhile to look at the demographic data for all the unique persons served by the VHA during fiscal years 1998 and 1999, since this describes the population from which the persons with hepatitis C virus antibody were a subgroup.

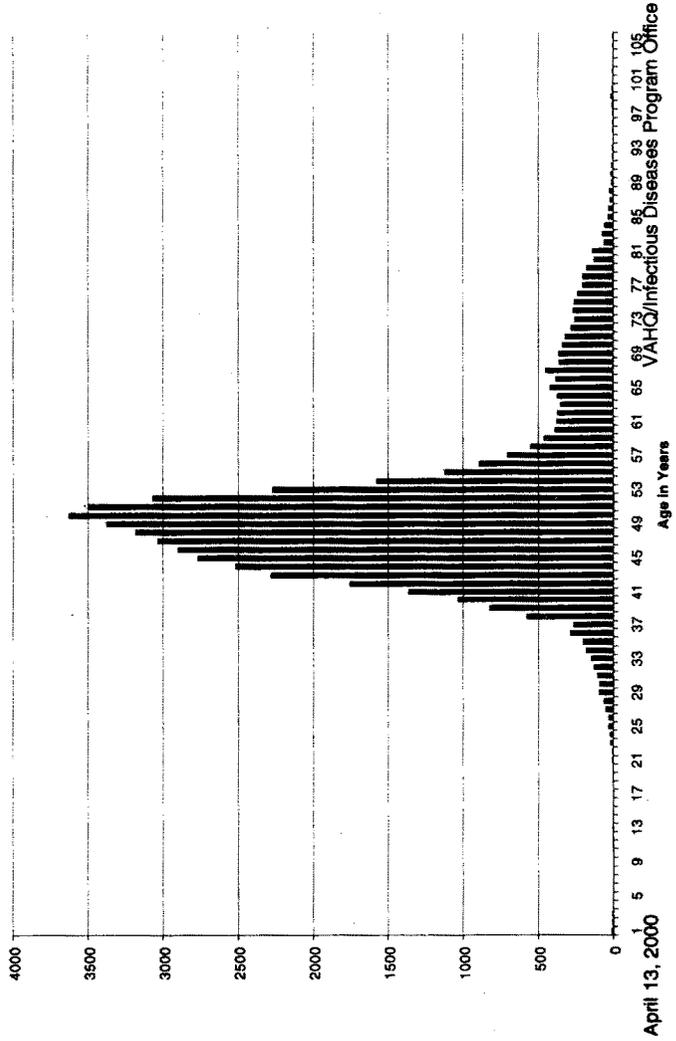
There was a total of 4,186,667 unique persons in this data set. Graph 4 depicts the age distribution and shows the expected two peaks, one at approximately 50 years old and the other at approximately 75 years old. These would account for the groups of Vietnam and WWII era veterans. For comparison, the average age of the persons with hepatitis C virus antibody was slightly greater than 49 years.

With regard to gender in graph 5, for the same two year period there were approximately 89% male and about 11% female in the total population served. In persons with tests positive for hepatitis C virus antibody, 96% were male.

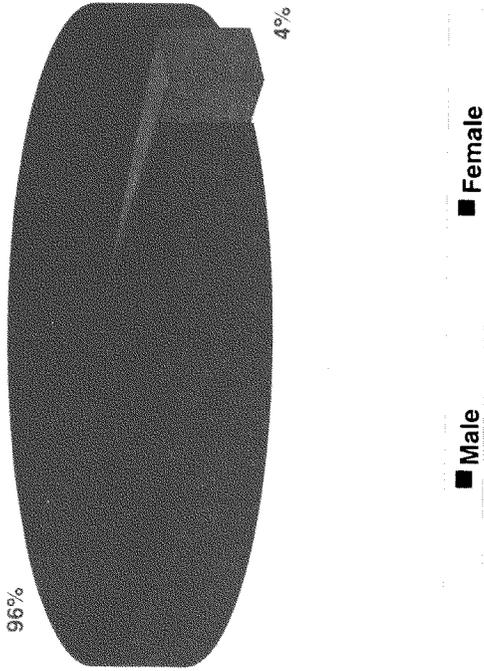
For era served over the two year period seen in graph 6, 27.7% were Vietnam era veterans with 22.9% being WWII era veterans. This is consistent with the age distribution that was seen previously in Graph 4. Each of the remaining eras provided small percentages of the total patient population seen.

Lastly, using the Student's t-test for age and chi-square test for gender and era statistical comparisons can be made between the persons who were found to be hepatitis C virus antibody positive and the overall population served by the VHA over the same time period. Persons who were hepatitis C virus antibody positive were

**VHA Unique Persons Positive for Hepatitis C Antibody
Age Distribution
FY 1998 - 1999**

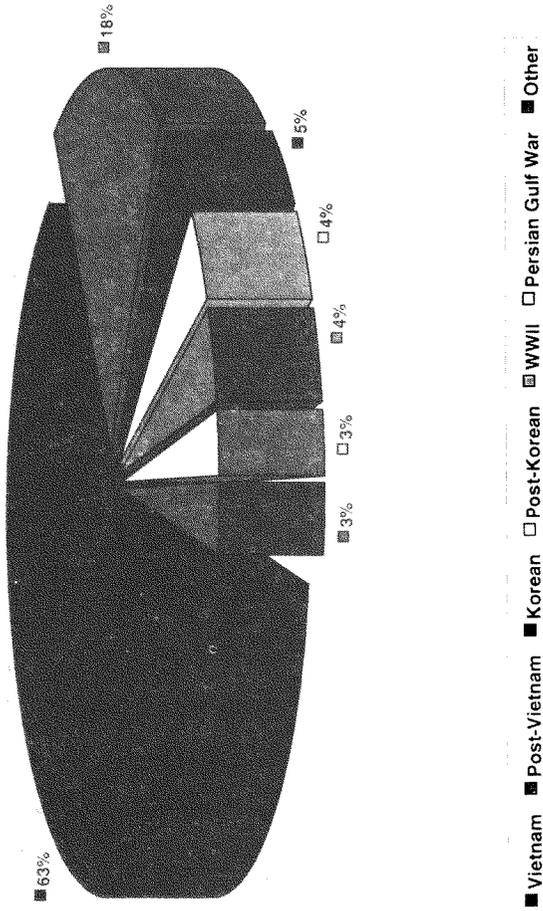


**VHA Unique Persons Positive for Hepatitis C Antibody
Percent by Gender
FY 1998 - 1999**

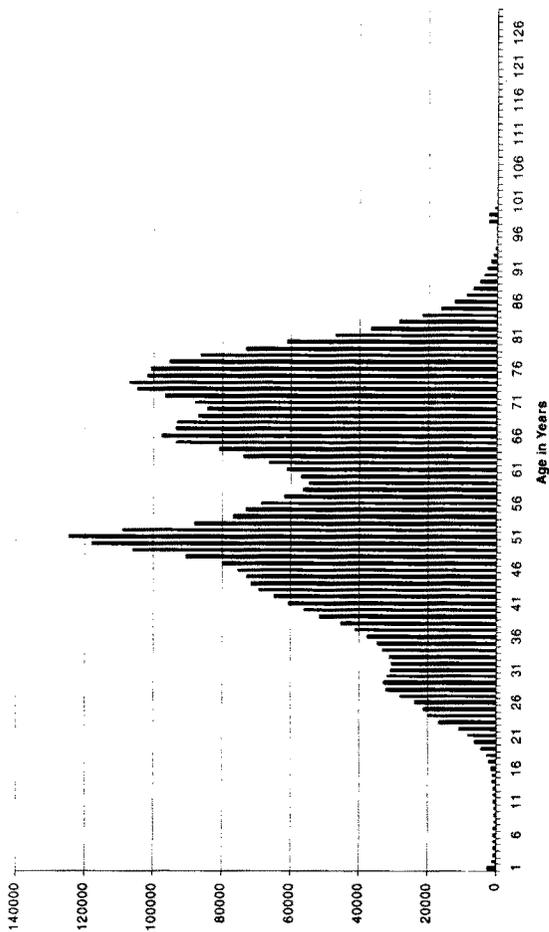


**VHA Unique Persons Positive for Hepatitis C Antibody
Percent by Era of Service
FY 1998 - 1999**

Graph #3



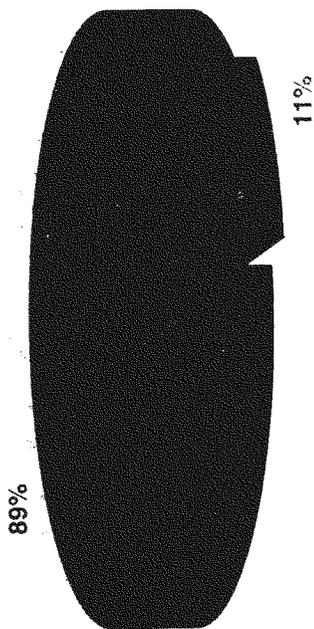
**Total VHA Unique Persons Served
Age Distribution
FY 1998 - 1999**



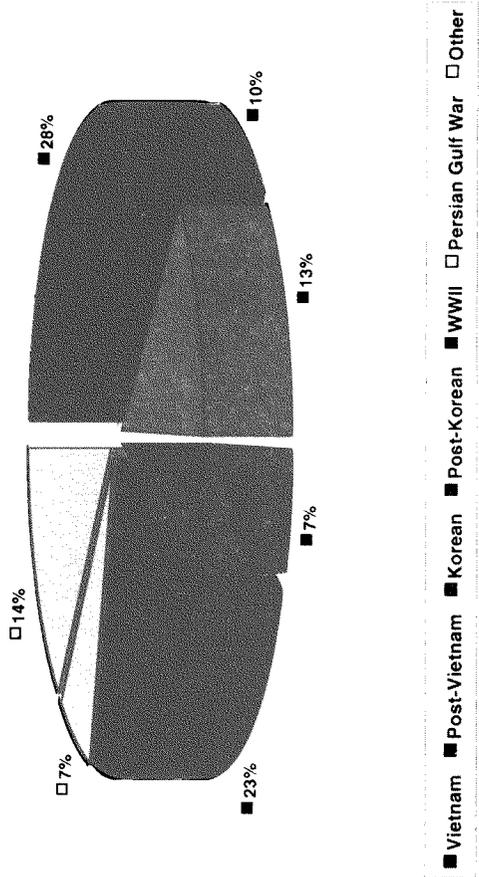
VAHQ/Infectious Diseases Program Office

April 13, 2000

**Total VHA Unique Persons Served
Percent by Gender
FY 1998 - 1999**



**Total VHA Unique Persons
Percent by Era of Service
FY 1998 - 1999**



**STATEMENT OF
MICHAEL SHALLOW,
VETERAN
COMMITTEE ON VETERAN'S AFFAIRS
SUBCOMMITTEE ON BENEFITS
VETERANS AND HEPATITIS C
APRIL 13, 2000**

My name is Michael Shallow. I served in the waters of Southeast Asia on the USS Midway during 1977– 1978. In 1978 I returned stateside. Later that year I had surgery on my shoulder at Camp Lejeune Naval Hospital and was 10% service connected for the resulting disability. I believe this surgery to be the source of my infection with hepatitis C.

I wish I could tell my story and it would have a happy ending. But, I can only tell you that my fatigue, joint pain, and ability to concentrate and remember things has gotten worse, and despite efforts by the Speaker of the House and others I have not yet gotten a determination on my HCV-related disability claim from the VA, nor have I received treatment for my Hepatitis C.

My story began exactly one year ago today. My family was living the American Dream. Our household income was over \$100,000, our four daughters were healthy, intelligent and doing well in school, we lived in a new home, and my wife and I had plans to retire early. I was experiencing HCV symptoms, but I attributed them to the aging process, previous surgeries and job stress. The only thing we lacked, I thought, was insurance to cover the possibility that my wife or I would die before reaching retirement.

In late April of 1999, we applied for term life insurance. In May, I received a letter from the insurance company declining coverage due to hepatitis C infection.

In July 1999 blood tests and a liver biopsy confirmed that I have active chronic Hepatitis C with Stage 2 (moderate) fibrosis. My doctors felt that I had contracted the virus at least twenty years ago, and based on my military service, it most likely came from blood products received during the surgery at Camp Lejeune. They agreed I should begin treatment as soon as possible.

I spent the summer in denial, which led to depression, for which I am still receiving treatment. I began to read everything available on Hepatitis C, paying particular attention to the statistics of the virus in veterans. I read about HR 1020 and S71, the two bills that would provide a presumption of service connection. The bills seemed to be stalled in committee. I contacted my Congressman who happens to be Speaker Hastert and also Senator Durbin asking for their support for this legislation. One of Speaker Hastert's aides suggested I contact Dr. Lennox Jeffers at the HCV Center for Excellence at the VA Medical Center in Miami.

I was able to see Dr. Jeffers with only two weeks notice. (I beg you to ask me follow up questions about my difficulty in getting treatment in VISN 12.) He reviewed my test results and history, and wrote a letter to the VA, which stated, in part, (and I quote) "It is my medical opinion that it is as likely as not, that Mr. Shallow was infected with HCV during his military service." (end quote) We discussed treatment; the threatened side effects scared the hell out of me.

I decided to delay treatment as long as possible. However, two days later my boss pointed out that I had used 47 sick days during 1999 and that the company could no longer afford to employ me. I had just lost my job of 8 years where I had worked selling medical management software to hospital systems.

Termination on the last day of the year put a dent in my treatment and financial plans. I immediately applied for 100% VA disability compensation due to unemployability. I was told the VA was taking, on average, 24 weeks—THAT'S

SIX MONTHS--to determine claims, and a look at our family budget showed we would fail to meet financial obligations long before this determination was made.

It is that six month backlog and the impact that the waiting time has on my family, my financial situation and my health that has led me here today. Given a 6.6% infection rate among veterans, the figure currently being used by the VA, there are at least quarter million enrolled veterans with hepatitis C. I am just the tip of the iceberg and yet the wait for a determination is six months. Without a presumptive service connection for HCV I do not believe that VA adjudicators can reach a correct determination in HCV claims in anything resembling a reasonable timeframe. Let me explain.

I have a definitive diagnosis of HCV by five different doctors. Confirmatory tests had been done by Hines and during my C&P exam at Westside. Most well grounded claims will have a definitive diagnosis.

I have a letter by one of the VA's top hepatologists to establish a nexus between my military service and my HCV, specifically stating "It is as likely as not, that Mr. Shallow was infected with HCV during his military service." Most Vets will not have this critical piece of evidence in their claim. I have brought along two visual images. One shows a radio operator--not a high risk MOS--but note the deep scratches on his right hand. If this brother were called away from the radio to assist in loading bodies onto a chopper or to pull a wounded man to safety he would have risked contracting HCV. It might be difficult to get a doctor to write a letter in support of his claim that he contracted HCV while working as a radio operator.

The next image is of two grunts. One is shaving the other. The razor being used was part of a platoon's special rations packet--intended for the entire unit. I think it would be very difficult to get a physician's opinion linking HCV to military

service if sharing razors was your only risk while in service. I realize that this picture makes it pretty clear that these guys were in the thick of things—on the ground in Vietnam. However, without a Purple Heart, good medical service records, the corroboration of a buddy and mountains of other paperwork, this grunt—if infected with HCV—may progress to end stage liver disease before he can become service connected through the VA. Furthermore, veterans needs to hear it from you—Congress—that it is your intent that we be presumptively service connected for this silent epidemic.

A former member of Congress from the Great State of Illinois once faced the same dilemma this committee faces today—how to provide for the everlasting wounds of battle. In his second inaugural address Abraham Lincoln called on Congress to support a high standard (I quote) " to strive to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan."

Thank you.



DEPARTMENT OF VETERANS AFFAIRS
Medical Center
1201 Northwest 16th Street
Miami FL 33125-1693

December 29, 1999

In Reply Refer To:

Shallow (3156)

Department of Veterans Affairs
 Att: Veterans Service Officer
 536 S. Clark Street
 Chicago, IL

Dear Sir/Madam:

I have reviewed the medical history on Mr. Michael Shallow, who was diagnosed with hepatitis C in May 1999. On December 29th, 1999, I examined Mr. Shallow at the Miami VA Medical Center, to determine his appropriateness for HCV therapy. This letter is to provide my medical opinion as to the source of Mr. Shallow's HCV infection in the hopes that his current VA disability rating of 10% can be increased to account for his needs during, and perhaps following, the period for which he will undergo treatment for this disease.

Mr. Shallow was hospitalized three times during active duty in the 1970's for conditions that required surgery. Although I have not yet reviewed his medical records for this period, at least one of the surgeries, a left shoulder surgery, was an orthopedic surgery, which may have required the administration of blood or blood products. Mr. Shallow does not recall being given such products, however, his recollection of these surgeries and recuperation periods is poor. Mr. Shallow was also tattooed with a military insignia during his active duty, and was exposed to blood while trying to stop a fight at a Marine Corps sponsored event. He also served in Viet Nam, which indeed was a risk factor for HCV.

Following his separation from service, Mr. Shallow did have significant fatigue, but he did not follow up with a physician for this symptom when he returned home. He was reviewed for a service connection due to his shoulder injury; however, HCV was not a recognized illness at that time and because of this his HCV status was not discovered.

It is my medical opinion that it is as likely as not, that Mr. Shallow was infected with HCV during his military service. Although there are several risk factors in his case, multiple surgeries along with his service in Viet Nam are the most outstanding. I therefore would suggest that Mr. Shallow be granted an increase in his disability benefits based on his military exposure to hepatitis C. His disability is of paramount importance while he is on interferon and Ribavirin therapy for one year.

Should you have any questions concerning this patient please contact me at 305 324 3172.

Sincerely,

A handwritten signature in cursive script, appearing to read "Lennox J. Jeffers".

Lennox J. Jeffers, M.D., F.A.C.P.
 Chief, Hepatology

SENT VIA EMAIL 1/25/00
SENT VIA FAX (202/225-0697) ON 1/28/00

1/25/00

Dear Mr. Speaker:

I wrote to you about a month ago asking for your support for HR1020, regarding service connection for veterans afflicted with HCV. I write now in the hope that your personal intervention on my behalf might hasten the bureaucratic process at the VA and expedite my claim for increased disability.

On 12/29/99, I was examined by Dr. Lennox Jeffers at the Center of Excellence at the VA Medical Center in Miami. He wrote a letter to the Department of Veterans Affairs, which stated in part, "It is my medical opinion that it is as likely as not, that Mr. Shallow was infected with HCV during his military service." (A Copy of this letter is available on request). I have since been laid off from my job (12/31/99) and applied to the VA for increased disability compensation so that I can begin treatment. The Viet Nam Veterans of America (Ms. Dorothy LeClear - PH 312/353-2613) has been given power of attorney to represent me in my claim.

Unfortunately, I have been told that the VA is taking, on average, 24 weeks to make determinations on disability claims. Right now, we estimate that severance, savings and my wife's income will allow us to meet our financial obligations through the end of March, maybe mid-April. If the VA takes anywhere near 24 weeks to make a determination, we will most likely lose our house and vehicles, or have to declare bankruptcy, a choice I don't wish to make.

My only other option is to seek new employment, although I have serious doubts over my ability to get or keep a job, given the increasing bouts of severe joint pain, fatigue, depression, etc. that come with HCV. My increasing inability to work a full week (or a full day) was the major reason for being laid off from my previous job. Going to work will also undermine my claim of "unemployability" with the VA and/or Social Security.

I feel stuck between a rock and a hard place, and that is why I'm hesitant to begin treatment (which I know will make it completely impossible to work) without a determination on my claim. On the other hand, every doctor I've spoken with, including Dr. Jeffers at VAMC Miami, has stressed the importance of beginning treatment as soon as possible.

I would sincerely appreciate anything you could do to expedite my claim. My family's future depends on it. Thank you in advance for any assistance you can render.

Sincerely,



Michael Shallow
401 Badger Lane
Oswego, IL 60543
630/554-7027



DEPARTMENT OF VETERANS AFFAIRS
 Chicago VA Regional Office
 536 South Clark Street
 Chicago, Illinois 60605

February 9, 2000

In Reply Refer To **328/TEAM F5/ML**
C 29 591 583
SHALLOW, M T

MICHAEL T SHALLOW
401 BADGER LN
OSWEGO IL 60543

Dear Mr. Shallow:

We have received your claim that your service connected left shoulder condition has increased in severity as well as your claim for service connection for hepatitis C.

WHAT WE HAVE DONE

We have asked the VA Medical Center Westside to schedule an examination for you. They will send you a letter telling you when to report. It is very important that you report at the scheduled date and time.

When entitlement or continued entitlement to a VA (Department of Veterans Affairs) benefit cannot be established or confirmed without a current VA examination or reexamination, it is necessary for you to appear for the scheduled examination. If you fail to appear for such an examination without good cause, the claim will be rated based on the evidence we currently have if the claim is an original compensation claim. If the examination was scheduled for any other original claim, a reopened claim for a benefit which was previously denied or a claim for increase, regulations require that the claim be denied. Some examples of good cause include, but are not limited to, illness or hospitalization of yourself or the death of an immediate family member.

WHAT WE NEED FROM YOU

Dependency evidence needed:

- Completed VA Form 21-686C

Please have your last employer complete and return the enclosed VA Form 21-4192, Request for Employment Information in Connection with Claim for Disability Benefits.

2

C 29 591 583
Shallow, M T

IF YOU NEED TO CONTACT US

If the information contained in this letter or any future letter is unclear, or you have not received notification of our final decision on your claim within four months of this letter, PLEASE CALL OUR TOLL FREE NUMBER: 1-800-827-1000. If you are in the local dialing area of a VA regional office, check your local telephone directory for the regional office's telephone number.

If you are hearing impaired and must communicate through a Telecommunication Device for the Deaf (TDD), our number is 1-800-829-4833. One of our benefit counselors will provide the assistance you require.

TIME LIMITS TO SUBMIT REQUESTED EVIDENCE

If you have been asked to submit evidence, the evidence should be submitted as soon as possible, preferably within 60 days from the date of this letter. In any case, the evidence must be received in the Department of Veterans Affairs within one year from the date it was requested, otherwise, if entitlement is established, benefits may not be paid for any period prior to the date the evidence is received.

If your address should change while your claim is pending, be sure to notify the Department of Veterans Affairs immediately by writing to the address at the top of this letter or calling our toll free number. Whenever you contact the VA always furnish your VA claim number and your full name.

HOW LONG IT WILL TAKE

Because of the amount of evidence we must gather and review, compensation claims are taking about 23 weeks to process. We know this is a long time to wait for an answer. We will make every effort to complete your claim sooner.

Sincerely yours,

Carolyn F. Hunt

CAROLYN F. HUNT
Service Center Manager

Enclosure(s): VA Form 21-686C

VA Form 21-4192 --

cc:Vietnam Veterans of America



DEPARTMENT OF VETERANS AFFAIRS

Chicago VA Regional Office
536 South Clark Street
Chicago, Illinois 60605

FEB 25 2000

HONORABLE J DENNIS HASTERT
SPEAKER
UNITED STATES HOUSE OF REPRESENTATIVES
27 NORTH RIVER STREET
BATAVIA IL 60510

In Reply Refer To: 328/f5
C 29-591-583
SHALLOW, M

Dear Mr. Hastert:

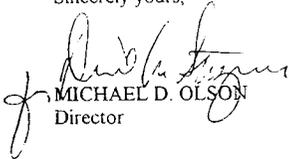
In reply to your letter dated February 9, 2000, on behalf of Mr. Michael Shallow.

A review of our records shows on January 18, 2000, we received a claim from the veteran requesting an increase in his service connected left shoulder condition, service connection for hepatitis c and a request for an increased compensation based on unemployability. We scheduled the veteran for an examination at the Westside VA Medical Center. We are currently waiting on the results of that examination.

A claim for increased compensation is currently averaging 24 weeks. We will make every effort to honor the request made by the veteran to expedite his claim.

We appreciate your interest and assistance in Mr. Shallow's case.

Sincerely yours,


MICHAEL D. OLSON
Director

J. DENNIS HASTERT
14TH DISTRICT, ILLINOIS

THE SPEAKER

2263 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-1314
(202) 225-2976

dhastert@mail.house.gov
www.dennishastert.house.gov

27 NORTH RIVER STREET
BATAVIA, IL 60510
(630) 406-1114



Congress of the United States
House of Representatives
Washington, DC 20515-1314

March 2, 2000

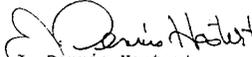
Mr. Michael Shallow
401 Badger Lane
Oswego, IL 60543

Dear Mr. Shallow:

I have enclosed a copy of an interim letter received by my office from the Department of Veterans Affairs regarding your claim. I will be in touch with you as soon as I have something further to report.

Please be assured of my interest in this matter. If you have any questions or concerns, please contact Ruth Richardson in my Batavia office at 630-406-1114.

Sincerely,


J. Dennis Hastert
Speaker

JDH:rr

MICHAEL T. SHALLOW
401 BADGER LANE
OSWEGO, IL 60543
(630) 554-7027

March 7, 2000

Department of Veterans Affairs
Attn: Michael D. Olson, Director
Chicago VA Regional Office
536 South Clark Street
Chicago, IL 60605

RE: C29-591-583 SHALLOW, M

Dear Mr. Olson:

I am in receipt of your 2/25 letter to Speaker Hastert regarding my claim, and while I appreciate the efforts on my behalf, which you speak of, I find your 24-week average on claims to be absolutely incredible. Let me explain why.

By now, the blood taken at VA West Side has no doubt confirmed the diagnosis of Drs. Bell, Zepeda, and Layden, whose own test results were included with my claim. Further, blood taken at VA Hines subsequent to my examination at West Side have already confirmed that I have a "very high viral load".

One of the VA's top hepatologists, Dr. Lennox Jeffers, has written a letter that was included in my claim that states in part, "it is as likely as not, that Mr. Shallow was infected with HCV during his military service."

As to unemployability, if my condition before treatment made me "unemployable" with an employer of eight years, how employable would I be with a new employer? Finally, I have enclosed herein a copy of a consent form that I signed at VA Hines on 3/6/00. Please take particular note of the risks and side effects of either treatment regimen and tell me how my employability will be enhanced during treatment. It should not take anywhere near 24 weeks to reach a conclusion on my claim.

This disease has taken its toll on my physical and emotional state, as well as the emotional state of my family. Now I must gather my resources to handle a treatment regimen that will make me sicker and weaker than I am now. For the VA to add financial uncertainty to this situation makes it more difficult than it has to be.

I would sincerely appreciate the opportunity to meet with you before I begin treatment to discuss this further, so that I can fully understand this 24 week backlog, and pass this understanding along to my family and creditors. Please call me at your earliest convenience at 630/554-7027. Thank you in advance for your prompt attention to my plight.

Sincerely,

Michael T. Shallow

Enclosure

Cc: Speaker J. Dennis Hastert
Carolyn Hunt, DVA Chicago
Dorothy LeClear, VVA

facsimile transmittal

To: Dr. Bernard Nemchausky Fax: 708/202-7960

From: Michael Shallow – DOB 09/06/55 Date: 3/27/00

Re: Study Participation Pages: 1

Urgent For Review Please Comment Please Reply Please Recycle

This fax constitutes my formal withdrawal from your study titled "Randomized Comparison Of Daily Interferon And Ribavirin For 24 Weeks Versus Standard Interferon And Ribavirin For 48 Weeks In Untreated Patients With Chronic Hepatitis C".

It has been 3 weeks since my initial appointment and I have yet to receive any indication when this study was going to commence. And while I appreciate your observation that my enzyme levels are not dangerously high, the fatigue and joint pain I am experiencing has worsened over the past year, along with the increase in my viral load.

Further, given the long wait times to get an appointment at Hines, due in part I believe, by the inadequate clinic time devoted to HCV, I have decided to seek standard treatment at the Milwaukee VAMC.

I wish you every success with your study and sincerely regret the fact that I will not be participating, but I feel I must ultimately act in my own (and my family's) best interest.

Sincerely,

Michael T. Shallow
VA File #C29-591-583

Statement of

KEITH D. SNYDER
Attorney at Law

before the

Committee on Veterans' Affairs
Subcommittee on Benefits
United States House of Representatives

April 13, 2000

on

**H.R. 1020, The Veterans' Hepatitis C Benefits Act of
1999**

Keith D. Snyder, PC
PO Box 5
Olney MD 20830
301-774-1525

Mr. Chairman, thank you for the invitation to present my views on H.R. 1020, a bill to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans. This statement is offered to the committee in my individual capacity as a private attorney with extensive experience litigating VA claims at the U.S. Court of Appeals for Veterans Claims and representing veterans, their survivors and family members before the U.S. Department of Veterans Affairs. My current clients include veterans with Hepatitis C. I am also the immediate past president and a founding member of the National Organization of Veterans' Advocates, an association whose membership is open to those persons admitted to practice before the Court of Appeals for Veterans Claims.

My statement addresses three areas that I believe warrant discussion regarding Hepatitis C claims: (1) the need for a presumptive basis for service connection, (2) the need for revisions to the VA Schedule for Rating Disabilities, and (3) the unique need for services to family members of veterans affected.

Presumptive Service Connection

Establishing entitlement to service connected disability compensation is not easy—not for the veteran and not for the VA. Nor is the process quick. By outlining the risk factors associated with Hepatitis C and permitting the establishment of service connection on a presumptive basis, H.R. 1020 will lighten the burden and speed the process for both veterans and the VA.

The current administrative process is mindboggling in its complexity and in the time it takes for the process to run its course. Given the current limits on hiring attorneys, I generally retained by veterans after they have

been denied by the Board of Veterans' Appeals and are on their way to the U.S. Court of Appeals for Veterans Claims. It is not unusual for my clients to have spent five to eight years getting through the administrative process. Then they face at least one year in litigation and, typically, one or two more years back on remand to the Department.

Congress has grappled most recently with the increasing delays faced by applicants by appropriating additional funds to hire more adjudication personnel. However, in my opinion, there are basic, systemic problems with the process that cannot be fixed simply with the addition of VA personnel.

From my clients' perspective, consider these problems:

1. They are not provided an application form that tells them what information is needed in order to have a chance at providing the relevant information.
2. They receive letters from the VA asking for names and addresses of healthcare providers so that VA can obtain medical records but they are not told they must provide an opinion letter from a doctor that addresses the relationship between their current disability and certain in-service events.
3. They are not told that they need to obtain a photocopy of their VA claims file (and that it is available free of charge under the Privacy Act, 5 U.S.C. § 552a) so that they can present that to their doctors to permit the doctors to provide opinions based on all the records. Failure of the veterans' doctors to refer to these records enables the VA to discredit the opinions and give greater weight to its in-house examinations.
4. They are provided form letter denials accompanied by multi-page rating decisions that recite the text of largely irrelevant VA regulations. Even after wading through 12-15 page initial denial letters, Hepatitis C claimants may not understand that they need to establish that they had been exposed to certain risk factors.
5. They are provided form letters that are accompanied by a statement of appellate rights printed in a tiny typeface and written in incomprehensible bureaucratic legalese.
6. They are warned they face deadlines to pursue their claims but they are not given a date-certain by which time they must have their appeals post-marked. Instead, veterans are left to calculate when their one-year deadline to file a Notice of Disagreement expires; whether they really have 60 days from the date on the cover letter accompanying an undated Statement of the Case to file their VA Form 9, Appeal to the Board of Veterans' Appeals, or whether, by a close reading of the instructions on the VAF9 they might not have more than 60 days (depending on the date of the initial denial letter from the VA). They are left to determine whether they have to file another VAF9 given the information in a Supplemental Statement of the Case (which might refer to issues previously addressed in an earlier Statement of the Case but which are not itemized in the present SSOC).

7. They are not told that there is a marked advantage to having a personal appearance hearing at the VA regional office. Although statistics vary by regional office and year-to-year, historically, the rates at which hearing officers have overturned initial rating board decisions range between 15 and 50%.
8. They are not told that there is a marked advantage to having a personal appearance hearing before a member of the Board of Veterans' Appeals. In Fiscal Year 1999, hearings conducted in Washington resulted in a 28% allowance rate.

The above problems are not unique to Hepatitis C claimants. Hepatitis C claimants do face unique burdens beyond those outlined above. First of all, they are likely struggling with the VA application process while suffering with symptoms such as extreme fatigue and depression; maybe they are suffering from near-complete liver failure or are awaiting a liver transplant. Nonetheless, it is necessary for them to obtain old service medical records and 20-30-year-old civilian medical records to demonstrate, for example, that they had a blood transfusion or to document "unexplained liver disease" or "unexplained abnormal liver function tests." The VA offers no guidance for veterans to obtain old service medical records and, while VA can obtain medical records from civilian facilities free of charge, there are state-by-state charges applicable to veterans requesting copies of medical records.

Demonstrating exposure to blood on or through skin as a result of handling wounded colleagues or engaging in combat is difficult. The burden should be lessened, under 38 U.S.C. § 1154, for those who are accepted as having engaged in combat with the enemy, but this does not encompass the personnel who helped unload the wounded in a rear area or those who may have been exposed in other non-combat settings.

There was a time when the VA would routinely obtain military records; would routinely obtain civilian medical records; would routinely schedule medical examinations. Not any more. Since the decision last year by the U.S. Court of Appeals for Veterans Claims in *Morton v. West*, 12 Vet.App. 477, the VA has assumed a markedly adversarial position: it now routinely denies claims because the veterans have not established that their claims are "well grounded." In the absence of meeting this high burden, VA does not feel it has a duty to assist veterans in obtaining benefits. No veterans I have worked with who have received the VA's form letters denying their claims because they are not well grounded can be convinced that the VA is user-friendly or pro-claimant.

It is true that the VA's form letters denying claims as not well grounded do recite the applicable law regarding a well-grounded claim of service connection. To quote a recent letter one my clients received:

A well-grounded claim for service connection requires evidence of a current disability, evidence of incurrence or aggravation of a disease or injury in service, and evidence of a nexus, or link, between the in-service injury or disease and the current disability.

However, what is missing is the claim-specific advice for the individual veteran. Also missing is the truth about the "nexus, or link." Veterans who call me for help have no clue what the work "nexus" means but once I explain it, they tell me over and over that the "link" is obvious, anybody can see it. What they have a problem with is getting their doctors

to put the same thing in writing. Civilian physicians are oriented toward providing treatment, not opinion letters in support of their patients' claims for disability benefits. Even if the civilian physician can be persuaded to write a letter, and even if the VA accepts that as sufficient to find the claim is well grounded, the veteran's struggle is far from over.

In my experience from reviewing hundreds of VA claims files, once the VA decides to schedule the veteran for a Compensation and Pension Examination (or C&P exam), at the nearest VA medical facility a whole new set of problems arise. The VA regional office sends a message to the C&P Unit at the VAMC asking it to schedule an exam. The VAMC schedules the exam, conducts it and transmits a report to the VA regional office which uses it to make a decision on the merits. But there is a major problem with this process: the VA regional office does not routinely ask the VA examiner to offer an opinion regarding the etiology of the condition or the nexus. And in the absence of an opinion regarding the etiology or nexus, the regional office and the Board of Veterans' Appeals routinely deny the claim, often citing the failure of the civilian examiner's opinion to be based on a review of the VA claims file and that the VA examiner's report does not support the veteran's claim. This process appears intentional and designed to give the regional office adjudicator the unbridled discretion to deny the claim for lack of evidence.

The failure of the VA regional offices to ensure that medical examinations are truly adequate for rating purposes under 38 C.F.R. § 4.2 is widespread; it is one of the primary deficiencies that leads to time-consuming remands from the Board of Veterans' Appeals and, from my own practice of law, leads to remands from the Court of Appeals for Veterans Claims.

The problem of remands is not isolated. In FY 1999, the BVA remanded 36% of the appeals brought to it. The Court of Appeals for Veterans Claims routinely disposes of appeals brought to it via remands. But having remanded a case and issued specific instructions of what is to happen next, does not insure compliance by the VA regional offices.

In 1998, the Court of Appeals for Veterans Claims issued a decision in *Stegall v. West*, 11 Vet.App. 268, that scolded the Secretary of Veterans Affairs for failing to ensure compliance with a prior remand order by the Court. In turn, the Board of Veterans' Appeals had remanded the case with instructions to the regional office to have specific questions answered during a medical examination. The exam was again not adequate, but the Board relied on it to again deny the claim. The Court was left to once again remand the appeal for compliance with its orders. The Court noted that "the protracted circumstances of this case and others which have come all too frequently before this Court demonstrate the compelling need to hold, as we do, that a remand by this Court or the Board confers on the veteran ..., as a matter of law, the right to compliance with the remand orders." 11 Vet.App. at 271.

The Court's decision in *Stegall* has had some impact on the Board of Veterans' Appeals, if not the regional offices. In my recent review of decisions regarding Hepatitis C rendered by the Board of Veterans' Appeals in 1999, the Board addressed the claim for service connection for chronic Hepatitis C that was on appeal from a 1992 rating decision of the St. Petersburg VA Regional Office. The Board considered and remanded the case in 1997. The Board again considered and remanded the case in 1998. In May 1999, the obviously irked Board member noted that "the

Board posed two clear questions to a medical professional. The examiner did not comply. There is no indication that the examiner is willing to cooperate. Despite a phenomenal Stegall violation, the Board shall proceed." BVA Docket No. 96-50 489 at page 2 (redacted decisions of the Board are available for review on the VA's website or on a CD-ROM offered for sale through the Government Printing Office). Fortunately, the Board granted service connection; unfortunately, this veteran will still have to contend with the same VARO to establish the level of disability.

The problems faced by veterans applying for benefits are daunting and frequently overwhelming. The drop-out rate of persons denied benefits who do not follow through to appeal is drastic—compared to the millions of rating actions taken by regional offices, the Board of Veterans' Appeals in FY 1999 only issued 37,373 decisions. Of course, if veterans don't follow through on an appeal, they can always reapply. However, the VA does not provide an application form that explains what constitutes "new and material evidence" needed to successfully reopen their claims. Nor does the VA explain that veterans seeking to reopen their claims had better get a photocopy of their VA claims file to assess what evidence was previously considered by the VA and then be able to determine what evidence might now be considered new and material.

Extending service connection on a presumptive basis could eliminate many of the current hurdles facing veterans and drastically shorten the application process for both veterans and the VA. If H.R. 1020 were enacted into law, it would still be necessary for VA to not only prepare clear implementing regulations but also to provide an application form that would explain what risk factors are accepted by the VA, what evidence is needed to demonstrate the veterans experienced one of those risk factors, and how to obtain that evidence.

The VA apparently is working on Hepatitis C regulations, despite the lack of specific legislative guidance. I urge this Committee to provide specific guidance via legislation. To the extent that the VA exercises its general rulemaking authority to develop rules, they are more likely subject to successful challenge in the U.S. Court of Appeals for the Federal Circuit. The absence of clear legislative history, and worse, the negative implications that could be drawn from considering but not passing legislation, could result in challenges that would tie up all Hepatitis C claims. I urge the Committee to act favorably on H.R. 1020.

VA Schedule for Rating Disabilities

Once service connection is established, veterans still face the task of establishing the level of their disability. Many of the same procedural difficulties noted above regarding the adequacy of VA form letters and the deficiencies in C&P examinations lead to lengthy delays in a final resolution of claims.

The current rating schedule, 38 C.F.R., Part 4, provides for rating Hepatitis C claims under the general heading of "Hepatitis, infectious" with a Diagnostic Code of 7345. 38 C.F.R. § 4.114. It was last revised in March 1976. The rating schedule needs to be revised to ensure that the symptoms characteristic of chronic Hepatitis C are adequately considered in establishing a percentage of disability.

In particular, given the experience of one of my clients recently, it is important that the debilitating side-effects of treatment be considered. For certain conditions, the rating schedule provides:

The 100 percent rating shall continue beyond the cessation of any surgical, radiation, antineoplastic chemotherapy or other therapeutic procedures. Six months after the discontinuance of such treatment the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no recurrence, rate on residuals.

See note at DC 7703, Leukemia (38 C.F.R. § 4.117), and at DC 7914, Neoplasm, malignant, any specified part of the endocrine system (38 C.F.R. § 4.119). A similar provision should be applicable to Hepatitis C ratings.

Further, if required treatment leads to a liver transplant, the schedule should be revised to reflect the provision currently applicable in the case of veterans who have kidney transplants:

The 100 percent evaluation shall be assigned as of the date of hospital admission for transplant surgery and shall continue with a mandatory VA examination one year following hospital discharge. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of § 3.105(e) of this chapter.

See note at DC 7531, Kidney transplant (38 C.F.R. § 4.115b). A similar provision should be applicable to Hepatitis C ratings.

Given the increasing need for liver transplants, this Committee may wish to consider whether it may be able to encourage or facilitate the broader understanding within the community of veterans of the need for organ donations.

Considerations for Family Members

The spouse of one of my clients who has a pending claim for Hepatitis C has not been tested. She clearly is at risk and she wants to be tested but because the family has no health insurance and cannot afford the testing, she does not know her status. If the spread of Hepatitis C is to be slowed, it is vital that testing be extended to family. Not only are spouses at risk but their children may also be at risk. For example, one of the methods of exposure is through shared toothbrushes.

The Committee should consider whether medical care can be extended to family that tests positive. Currently, only after veterans are service connected and evaluated as permanently and totally disabled are their family members eligible for CHAMPVA healthcare benefits. Extending treatment options to family of veterans not yet rated P&T should be considered.

Finally, there is a recent precedent for providing compensation to family. The children of Vietnam veterans exposed to Agent Orange who suffer from spina bifida are paid compensation based on the severity of their condition. 38 U.S.C. § 1805; 38 C.F.R. § 3.814. Given the prevalence

today of two wage-earners per family, this Committee is urged to consider whether compensation may be appropriate for the non-veteran spouse who is infected and whose ability to work is impaired.

**CURRICULUM VITAE OF
KEITH D. SNYDER PC**

Attorney at Law
PO Box 5
Olney MD 20830
301-774-1525
FAX 301-774-1551
keithsnydr@aol.com

EDUCATION

Washington College of Law (J.D. 1983)
George Washington University (Paralegal Certificate 1976)
The American University (B.S. 1976)

EMPLOYMENT

PRIVATE PRACTICE (1989—present)

Practice focuses primarily on appeals for veterans' disability benefits before U.S. Court of Veterans Appeals and U.S. Department of Veterans Affairs.

Director, VETERANS EDUCATION PROJECT, Washington DC (1977—present).

The Project is a nonprofit, tax-exempt organization that publishes and distributes a series of "self-help guides" (on military discharge upgrading, veterans' appeals) for use by individual veterans. Formerly edited the *Veterans' Law Reporter*, a comprehensive legal reporting service for advocates and attorneys, the *Veterans Rights Newsletter* and *Discharge Upgrading Newsletter*. Currently provide, under contract with the Vietnam Veterans of America, a series of self-help guides, bi-monthly newsletter, and training for its service representatives.

Program Director, NATIONAL VETERANS LEGAL SERVICES PROJECT, Washington DC (1987—June 1989).

The Project is a Legal Services Corporation-funded back up center specializing in veterans benefits law. Responsibilities included supervising staff, preparing and monitoring a budget, complying with detailed reporting requirements; also included researching inquiries received from Legal Services staff; identifying trends from these inquiries and developing appropriate written materials; preparing training manuals and conducting training programs for Legal Services staff.

Staff Attorney, NATIONAL VETERANS LEGAL SERVICES PROJECT, Washington DC (1984—1987).

Staff Attorney, VIETNAM VETERANS OF AMERICA LEGAL SERVICES, Washington DC (1984—June 1989).

The Legal Services was the in-house law firm for the Vietnam Veterans of America, a Congressionally-chartered veterans service organization. Responsibilities included tracking regulatory and legislative developments involving the Veterans Administration and Department of Defense; preparing training manuals and conducting training programs for lay advocates; advising veterans advocates on procedures for

persons seeking to upgrade military discharges and appeal denials of veterans benefits.

Paralegal, NATIONAL VETERANS LAW CENTER, Washington College of Law, Washington DC (1979—1983).

Hospital Corpsman, U.S. NAVY (1969—1972).

PUBLICATIONS

- *VVA Veterans Benefits News* (1995—2000), editor of bi-monthly newsletter (Vietnam Veterans of America, Washington, DC).
- *VVA's Guide on PTSD* (1998), author (Vietnam Veterans of America, Washington, DC).
- *VVA's Guide on VA Claims and Appeals* (1995), author (Vietnam Veterans of America, Washington, DC).
- *VVA's Guide on PTSD* (1995), author (Vietnam Veterans of America, Washington, DC).
- *VVA's Guide on Agent Orange* (1995), author (Vietnam Veterans of America, Washington, DC).
- *Veterans Benefits* (1994), co-author (HarperCollins, New York).
- *Veterans' Law Reporter* (1987—1991), editor.
- *Veterans Rights Newsletter* (1981—April 1987), editor.
- *Discharge Upgrading Newsletter* (1979—1980), editor.
- *Self-Help Guide to U.S. Court of Veterans Appeals* (1991), author (Veterans Education Project, Washington, DC).
- "Advising the Veteran Facing Debt Collection by the VA," *The Practical Lawyer* (December 1990).
- "Introduction to Practice Before the U.S. Department of Veterans Affairs," *The Practical Lawyer* (December 1989).
- *Self-Help Guide to Discharge Upgrading* (1979 and rev. ed. 1983, 1990), author (Veterans Education Project, Washington, DC).
- "Paralegal's Guide to Veterans' Administration Advocacy," *Clearinghouse Review* (July 1989).
- "Ask The Lawyer," weekly column carried by Army, Navy and Air Force Times (1986-1988), contributing author (Times Journal Co., Springfield, Virginia).
- *VVA on Agent Orange* (1984, and rev. ed. 1988, 1989), author (Vietnam Veterans of America, Washington DC).
- *Self-Help Guide to VA Claims* (1988), author (Vietnam Veterans of America, Washington DC).
- *Agent Orange* (1986), author (Vietnam Veterans of America, Washington DC).
- *LITTLE MAX: CREATING MAXIMUM BENEFITS FOR CHILDREN, ELDERLY, POOR, AND "DISABLED" PEOPLE* (1986 and 1987), contributing editor (Massachusetts Law Reform Institute, Boston, Massachusetts).
- *OVERPAYMENTS OF VETERANS ADMINISTRATION BENEFITS: LEGAL SERVICES PRACTICE MANUAL* (1985), author (National Clearinghouse for Legal Services, Chicago, Illinois).
- *VIET VET SURVIVAL GUIDE* (1985), co-author (Ballantine Books, New York).
- *GUIDE TO VETERANS BENEFITS: VVA SERVICE REPRESENTATIVES MANUAL* (1983 and rev. ed. 1985), co-author (Vietnam Veterans of America Foundation, Washington, DC).
- *Self-Help Guide to Stress Disorder* (1985 ed.), editor (Veterans Education Project, Washington DC).

- Self-Help Guide to Agent Orange (1983 ed.), editor (Veterans Education Project, Washington DC).
- "PTSD: The War Is Over, The Battles Go On," TRIAL Magazine (January 1983), co-author.
- Self-Help Guide to Radiation (1982), editor (Veterans Education Project, Washington DC).
- Self-Help Guide to Stress Disorder (1982 ed.), editor (Veterans Education Project, Washington DC).
- MILITARY DISCHARGE UPGRADING AND INTRODUCTION TO VETERANS ADMINISTRATION LAW (1982), co-author (Veterans Education Project, Washington, DC).
- "Effect of Public Law 95-126 on the Special Discharge Review Program and the Discharge Review Boards," 6 MIL. L. REP. 6001 (Jan.-Feb. 1978), co-author.
- COMPILATION OF STATE AND FEDERAL PRIVACY LAW (1975), co-author (Privacy Journal, Washington DC).

MEMBERSHIPS

- Founding member, past president, National Organization of Veterans' Advocates.
- Admitted to practice before U.S. Court of Appeals for Veterans Claims.
- Admitted to practice before U.S. Court of Appeals for the Federal Circuit.
- Member, Rules Advisory Committee, U.S. Court of Veterans Appeals (1992-99).
- Montgomery County Bar Association.
- Maryland State Bar Association.
- District of Columbia Bar Association.
- Member, Veterans Administration Advisory Committee on Health-Related Effects of Phenoxy Herbicides (1986-87).

TRAINING PROGRAM PRESENTATIONS

- Veterans Benefits Basic Training, sponsored by the Vietnam Veterans of America, Washington, DC (June 1999).
- Veterans Benefits Basic Training, sponsored by the Vietnam Veterans of America, Washington, DC (June 1998).
- Veterans Law Seminar: Practice and Procedures Before the U.S. Court of Veterans Appeals, sponsored by the National Organization of Veterans' Advocates, Washington, DC (September 1996).
- Veterans Benefits Basic Training, sponsored by the Vietnam Veterans of America, Washington, DC (June 1996).
- Veterans Law Seminar, sponsored by the National Organization of Veterans' Advocates, Seattle, Washington (March 1996).
- Veterans Benefits Basic Training, sponsored by the Vietnam Veterans of America, Boston, Massachusetts (February 1996).
- Veterans Benefits Basic Training, sponsored by the Vietnam Veterans of America, Washington, DC (June 1996).
- Veterans Law Seminar, sponsored by the National Organization of Veterans' Advocates, Kansas City, Missouri (October 1994).
- Third Judicial Conference of the U.S. Court of Veterans Appeals, Arlington, VA (October 1994).
- Veterans Law Seminar, sponsored by the National Organization of Veterans' Advocates, Kansas City, Missouri (May 1994).
- Second Judicial Conference of the U.S. Court of Veterans Appeals, Arlington, VA (October 1993).
- Veterans Law Seminar, sponsored by the National Organization of Veterans' Advocates, Washington, DC (October 1993).

- Veterans Law Seminar, Washington, DC (March 1993).
- Veterans Law Seminar, Los Angeles, CA (November 1992).
- Veterans Law Seminar, Washington, DC (September 1992).
- Veterans Law Seminar, Washington, DC (May 1992).
- Jacksonville Area Legal Aid, Jacksonville, Florida (April 1991).
- Ohio State Legal Services Association, Columbus, Ohio (December 1990).
- Vermont Legal Aid & Department of Rehabilitation and Aging, Randolph, Vermont (April 1990).
- V.A. Disability Law Seminar, Washington, DC (June 1989).
- District of Columbia Bar and Georgetown University Law Center's Continuing Legal Education Division, Washington, DC (May 1989).
- Vermont Legal Aid & New Hampshire Legal Assistance, White River Junction, Vermont (May 1989).
- Coalition of Colorado Legal Services Programs, Denver, Colorado (February 1989).
- Community Legal Services, Philadelphia, Pennsylvania (January 1989).
- Volunteer Lawyers Program, Milwaukee, Wisconsin (October 1988).
- Puerto Rico Legal Services Program, San Juan, Puerto Rico (February 1988).
- Volunteer Lawyers Program, Phoenix, Arizona (October 1987).
- Kentucky Legal Services Program, Lexington, Kentucky (August 1987).
- Vietnam Veterans of America Service Representatives, Washington, DC (June 1983—89, 5-day programs).
- Georgia Legal Services Programs, Atlanta, Georgia (May 1987)

MISCELLANEOUS

- Presented testimony before Senate Veterans Affairs Committee on funding for Pro Bono Consortium (May 23, 1996).
- Qualified as Expert Witness for Plaintiff in *Day v. Department of Veterans Affairs*, No. C-90-38 (S.D. Tex. trial March 1993) (testified as to the complexity of VA regulations, policies, procedures and need for counsel).
- Qualified as Expert Witness for Plaintiffs' in *National Association of Radiation Survivors v. Walters*, No. 83-1861 (N.D. Cal. trial September 1987) (testified as to the complexity of VA regulations, policies, procedures).
- Elected to Town Council, Kensington, Maryland (1984—86).

DISCLOSURE STATEMENT REQUIRED BY HOUSE OF REPRESENTATIVES RULES

I have received no Federal grant or contract relative to the subject matter of the testimony presented during the current or previous two fiscal years.

STATEMENT OF
HARLEY THOMAS, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON BENEFITS
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
"VETERANS' HEPATITIS C BENEFITS ACT OF 1999" - H.R. 1020,
"H.R. 3816",
"VETERANS' SPECIAL MONTHLY COMPENSATION GENDER EQUITY
ACT" - H.R. 3998,
"VETERANS' COMPENSATION COST-OF-LIVING ACT OF 2000" - H.R. 4131,
APRIL 13, 2000

Chairman Quinn, Ranking Democratic Member Filner, Members of the Subcommittee, on behalf of the Paralyzed Veterans of America (PVA), I appreciate this opportunity to testify regarding the pending legislation before this subcommittee today.

H.R. 1020 - VETERANS' HEPATITIS C BENEFITS ACT OF 1999

H.R. 1020 will permit veterans who contract hepatitis C to receive benefits and services they deserve by adding a presumption of service connection when the veteran was exposed to any of the conditions outlined in the bill. Hepatitis C is the most common chronic bloodborne infection known in the United States. Studies conducted by the VA

show veterans to be at much greater risk for infection with Hepatitis C than the general population.

It has been our experience that the VA appears to reject service connection because the veteran cannot produce evidence that the current diagnosis of Hepatitis C is related to military service and exposure under conditions most veterans experienced on a daily basis.

It is our opinion that the VA currently has the authority to make the connection between many experiences and exposures related to military service and subsequent disabilities such as Hepatitis C encountered later in life. The question arises as to whether VA is currently giving veterans with Hepatitis C the benefit of the doubt. It is clear in many cases that they are not. This appears to be based on many reasons, including reneging on the VA's "duty to assist" veterans in bringing their claims forward. This new legislation would attempt to correct this problem by providing a list of potential in-service exposures, which could be presumed to be the cause of Hepatitis C.

PVA applauds the intent of this legislation by giving VA concrete direction in adjudicating veterans' claims relating to Hepatitis C. However, we urge caution to ensure that the real problems we are trying to address are not within VA adjudication procedures. If in fact, there are procedural impediments to establishing a presumption unilaterally on the part of VA, then legislation of this nature would be warranted.

H.R. 3816

PVA fully supports the enactment of H.R. 3816. We feel it is not only reasonable but also logical, that should a member of a reserve component suffer a cardiovascular accident or acute myocardial infarction during the period covering the performance of inactive duty training, the condition should be presumed to be service-connected.

Typically when an individual undergoes excessive physical and or mental stress preceding either of these conditions, it may be hours or even days before the condition manifests itself.

H.R. 3998 - VETERANS' SPECIAL MONTHLY COMPENSATION GENDER EQUITY ACT

PVA supports H.R. 3998 and believes it will deliver equity without regard to gender. Any member of the United States armed forces subjected to the loss of one or both breasts due to a radical mastectomy should be compensated for the service-connected condition. Women constitute the fastest growing population of veterans eligible for VA health care and benefits. Today, women account for 15% of the active force and about 20% (except for the U.S.M.C.) of new recruits. By 2010, women will account for more than 10% of the veteran population, a 150% increase over current numbers. PVA believes this legislation is both timely and proper and would like to thank Mr. Evans for introducing H.R. 3998.

I would like to point out Mr. Chairman, although the bill references gender equity, it must be remembered even though the numbers are small, men are also at risk for this condition. Therefore we believe gender should not be an issue.

H.R. 4131 - VETERANS' COMPENSATION COST-OF-LIVING ADJUSTMENT ACT OF 2000

Many disabled veterans have limited earning power due to their service-connected disability. In some cases, they have completely lost their earning power and must rely on compensation for the basic necessities of life. Similarly, surviving spouses of veterans who died as a result of service-connected disabilities must also rely on Dependency and Indemnity Compensation (DIC).

Compensation and DIC rates are quite modest, and due to inflation recipients with fixed incomes must rely on cost-of-living adjustments in their struggle just to keep pace with day-to-day living expenses.

Mr. Chairman, PVA has always supported annual compensation adjustments and will continue to do so. As in the past, we believe that all adjustments to compensation should be rounded up to the nearest dollar instead of down.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or members of the committee may have.

TESTIMONY PRESENTED

By

Linda Spoonster Schwartz RN, MSN, DrPH

Associate Research Scientist

Yale University School of Nursing

Chair VA Advisory Committee on Women Veterans

Before the

**House Veterans Affairs Committee
Subcommittee on Veterans Benefits**

Regarding

H.R. 3998

April 13, 2000

Linda Spoonster Schwartz RN, MSN, DrPH

**House Veterans Affairs
Subcommittee on Benefits
Regarding H.R. 3998
April 13, 2000**

Mr. Chairman I am Linda Spoonster Schwartz RN, MSN, DrPH, an Associate Research Scientist at the Yale University School of Nursing. I am medically retired from the United States Air Force and have the honor to Chair the VA Advisory Committee on Women Veterans. I would like to thank you for holding this hearing on HR 3998 and for asking me to testify this morning. I would also like to thank Congressman Lane Evans and Congresswoman Shelley Berkley for taking the initiative to introduce this legislation to amend Title 38 of the US Code Section (USC) 114 (k) and 38 Code of Federal Regulations (CFR) Section 3.350 (a) to include a Special Monthly Compensation K-award for veterans who have survived radical or modified radical mastectomy of one or more breasts.

As you know, the VA Advisory Committee on Women Veterans in our 1998 Report to Congress first recommended this change. The Advisory Committee was authorized by Congress in 1983 to assess the needs of women veterans with respect to compensation, health care, rehabilitation, outreach and other benefits and health care programs administered by the Department of Veterans Affairs. Additionally, the Committee was empowered to make recommendations for change and entrusted with the responsibility to evaluate these activities and report progress to the Congress in a biennial report. From that time to this, Committee members and advisors from all walks of life and all parts of this Nation have collaborated to improve the status of services and programs and assure that women veterans receive quality and gender specific care in a safe and secure environment.

The members of the Committee were unanimous in this recommendation because we felt the outcome of radical or modified radical mastectomy results in the loss equal to those enumerated under the "Special Monthly K award. Further the Committee felt this recommendation was in keeping with the spirit and intent of the existing law which also authorizes an additional compensation for, among other things, the loss of both buttocks, loss of sense of smell as well as the loss of use of one or more extremities. The tenor of the present language to the law is one of compassion and concern for a veteran who has sustained an anatomical loss or loss of one of the vital senses. Our discussion today raises a new challenge to the way in which the VA does business.

Let me be clear, this is not confrontational, it is in fact another juncture for VA to rethink its policies from the standpoint of America's 1.2 million women veterans.

This is not the first nor will it be the last time advocates for women veterans will encounter policies, regulations, or legal barriers, which constrain VA ability to respond to women veterans. We can appreciate the interpretation of these laws and regulations for compensation some that were codified long before women were an integral part of our Armed Forces. However DOD and VA sources now confirm that women constitute the fastest growing population of VA eligible veterans in America. There is no question that changes to the VA system will continue to evolve as the needs of veterans – man and women emerge in this new age of military

Linda Spoonster Schwartz RN, MSN, DrPH

**House Veterans Affairs
Subcommittee on Benefits
Regarding H.R. 3998
April 13, 2000**

technology and the toxic environments of today's warfare. In this case, the Veterans Benefits Administration of the VA did not concur with the recommendation on mastectomies. Congress now has the opportunity to rectify a small but important aspect of existing law.

It is the Committee's position that radical and modified radical mastectomies involve a loss comparable to those presently covered by Title 38 and should qualify for the "Special Monthly Compensation K Award". For women, the outcome of these procedures frequently results in sever physical disfigurement which necessitates major reconstructive surgery and/or the use of prosthetics. In the case of a modified radical mastectomy, the entire breast and some of the underarm lymph nodes are removed. With a radical mastectomy, there is an extensive removal of the entire breast, axillary lymph nodes and the chest wall muscles under the breast. The surgery was once very common but because of disfigurement and side effects it is now rarely performed.

Post-operatively, women may have temporary or permanent limitation of the use of the arm and shoulder. Numbness of the upper inner arm may also occur because the nerve controlling the sensation in that area travels through lymph nodes which may have been removed. Removal of lymph nodes carries a risk of lymphedema a swelling and inflammation of tissue which may extend to the entire upper extremity. In addition to the loss of physical integrity, the loss of a breast to a woman is the loss of an identifying feature, a secondary sex characteristic and a part of her persona as a female. Mastectomy and the post-operative treatment for cancer can also precipitate premature menopause and infertility. Because women have more breast cells than men do, breast cancer is more common in women. The American Cancer Society estimates that women have 100 times more breast cancer than men do. Especially striking is the ACS report that one out of 3,000 American women who are pregnant report a diagnosis of breast cancer. Breasts are also an important part of the maternal - child relationship. VA Reports note that there are an increased number of eligible women veterans of childbearing age using health care services. Thus, we see that these dynamics pose real questions about the role breasts have in the reproductive/creative process.

In addition to the question of breast-feeding and the ability to nurture a newborn, several factors may place a woman at higher risk for sexual problems following a mastectomy. There is the question of the loss of body image that comes with the loss of a breast and how that affects the ways in which a woman views herself and her body- her self-esteem, her hopes and fears and her place in society. There is the question of sexuality and how she will relate to her partner and express love physically and emotionally.

There can be no question the losses sustained by women who have radical and modified radical mastectomies is immense and has far reaching consequences for the veteran and her family. The proposed legislation signals a new challenge to the VA Women Veterans Advisory Committee and the Congress. In the past we have had to come to the Congress to assure privacy,

Linda Spoonster Schwartz RN, MSN, DrPH

**House Veterans Affairs
Subcommittee on Benefits
Regarding H.R. 3998
April 13, 2000**

adequate physical examinations and sexual trauma counseling for women veterans. Today, we deliberate on the question of mastectomies and challenge the status quo. We, which says the aftermath of radical and modified radical mastectomies is as devastating as the loss of an extremity, that the loss of a breast constitutes the loss of a vital part of the creative process and the loss of a breast is a major destruction of the physical integrity of the body of a veteran.

I have attempted to clarify the reasoning that went into the Advisory Committee's deliberations in making this recommendation. I, like several members of the Committee, am a Registered Nurse and have had the experience of caring for women who have had radical and modified radical mastectomies. The pain, sense of loss and great struggle that confronts a woman recovering from these surgeries does not have to be explained to us. I hope that I have been able to adequately convey the physical and emotional consequences experienced by women who survived these surgeries and that this information is sufficient for the Committee to act favorably on the proposed legislation.

As more women look to the military for careers, issues like the question of mastectomies will continue to arise. In this particular case, the VA did not concur with the thinking of the Advisory Committee. However through the process of our Report to Congress, we were able to bring the problem to another forum for consideration. This is indeed democracy in action. I believe it is the context in which the Congress meant the Advisory Committee to function.

Nevertheless, I would be remiss if I did not say that the 1998 VA Advisory Committee Report to Congress is our last. The authorizing legislation, which required the Secretary of Veterans Affairs to forward our reports to Congress, has been superceded by legislation, which requires us to report only to the Secretary.

The Federal Reports Elimination and Sunset Act of 1995 (PL 104-66) summarily eliminated the VA Women Veterans Advisory Committee, to send a report of our activities to the congress. The law takes effect this year. As you can see if that law had been in effect in 1998, there would not have been an official mechanism for us to forward this recommendation for your consideration. The importance of an open channel to convey our concerns and recommendations can not be underestimated. It is my hope that in the coming year, this Committee will restore the requirement for our committee to report to Congress.

LINDA SPOONSTER SCHWARTZ RN MSN DPH, MAJOR USAF, NC (RET)

Linda Schwartz received her diploma in Nursing from Saint Thomas Hospital School of Nursing in Akron, Ohio. She is a Cum Laude graduate of the University of Maryland and received a Masters in Psychiatric Nursing from Yale University School of Nursing. She completed her Doctoral Degree in Public Health from Yale University School of Medicine, Department of Epidemiology and Public Health in April 1998. Her dissertation "Physical Health Problems of Military Women Who Served During the Vietnam War" is the first major research investigation of the health of women veterans of the Vietnam Era. She presented her findings at the 18th International Symposium on Halogenated Environmental Organic Pollutants "Dioxin 98" in Stockholm Sweden later that year.

While in the Air Force she served both on Active Duty and in the Reserves. She earned her Senior Flight Nurse rating while on duty with the 69th and 58th Aeromedical Evacuation Squadron at McGuire Air Force Base, New Jersey and the 2nd Aeromedical Evacuation Group at Rhein Main Air Base Germany. She has the distinction of creating the position of Flight Clinical Coordinator for the European Command (USAFE) and was responsible for coordinating the airlift of over 1,000 patients a month within Europe and to the United States. She is a disabled veteran due to injuries she sustained in an aircraft accident while on duty with the United States Air Force.

She has a long history of involvement in nursing and veteran organizations. She has served as President of both the Connecticut Nurses Association, and the Connecticut Nurses Foundation. In 1987 she was elected to the Board of Directors of the American Nurses Association (ANA). She also served as Member of the Board and Treasurer of the ANA PAC (1987-1989). She has also served on the nursing faculty of Mohegan Community College, University of Connecticut and Central Connecticut State University.

She is an acknowledged veteran activist, who has earned the trust and respect of government officials and veterans groups alike. She has been invited by name to testify numerous times before both the US Senate and House of Representatives on issues related to veterans health care, women veterans, and the effects of Agent Orange. Connecticut Governor Wm. O'Neil appointed her to his Advisory Committee on Women Veterans and the Professional Advisory Committee to Evaluate the Effectiveness of the State's Health Care Prospective Payment System. Since 1989, she has served as Trustee of the State Veterans Home and Hospital which became the present Board of Trustees of the State Department of Veterans Affairs.

In 1989 she received a White House appointment to the VA Advisory Committee on the Readjustment of Vietnam Era Veterans. She made expansion of Post Traumatic Stress Disorder (PTSD) treatment to World War II and Korean Veterans, homeless veterans and women veterans her special interests. For many years, she championed the expansion of Vet Center services to all combat veterans. She currently serves as Vice-Chairman of the newly Congressionally

mandated Advisory Committee on the Readjustment of Combat Veterans. When VA Secretary Jesse Brown appointed her to the VA Advisory Committee on Women Veterans in 1994, she became one of the rare veterans selected to serve in more than one advisory capacity to the Department of Veterans Affairs. She was further honored by the Secretary in October 1997 by being appointed Chairman of the Women's Advisory Committee. At the present time, she also serves on the Consumer Council of the VA Committee on Care of Severely Chronically Mentally Ill Veterans and the VA Task Force on Homeless Veterans. On three separate occasions, the National Academy of Science has invited her to speak on the experiences and health problems of military women who served in Vietnam.

Her volunteer service includes five years working for the Vietnam Women's Memorial on the state and local level ultimately serving as Treasurer and Director of Legislative Affairs. She was a member of the Board of Directors of Vietnam Veterans of America from 1989-1995. She was one of the founders and served (1990-1996) as the President of the Vietnam Veterans Assistance Fund (VVAFF), a charitable organization certified for the Combined Federal Campaign, which focuses on the needs of the nation's 9.2 million Vietnam Era Veterans. During her Presidency, VVAFF raised over 1.8 million dollars to assist Vietnam Era and Gulf War veterans and their families with less than 6% administrative costs.

In 1996, she worked with the VA and the National Coalition on the Homeless to provide two national conferences on "Homeless in America". These conferences were the first time that federal, state and local providers of programs and services worked together to exchange ideas and develop plans to maximize the available resources to address the needs of nation's homeless population.

For seven years she has served in a volunteer capacity, as the Co-Director of "Project Partnership" which is a program in which VVAFF acquired and developed four homes for homeless and disabled veterans in conjunction with the West Haven VA Medical Center. Project Partnership became incorporated as a 501(c) (3) non-profit organization on November 22, 1997. This organization is dedicated to developing job opportunities for out of work veterans with plans on the drawing board for national employment projects.

In 1992, she was the first woman to receive VVA's highest honor the Commendation Award for "Justice, Integrity and Meaningful Achievement". On Veterans Day 1995, she received the prestigious State of Connecticut Veterans Commendation Medal, awarded "to those select few who have distinguished themselves through their service to Connecticut veterans and their families". In 1996, she further assisted VVA by serving for 6 months as the Acting Director of Legislative Affairs while the organization underwent a search for an Executive Director. She was also honored by the 1996 Olympic Committee to be one of 5,000 "Community Hero Torchbearers".

Linda Schwartz resides in Pawcatuck, Connecticut with her husband Stanley a restaurateur.

Statement of Peter Gaytan, National Legislative Director, AMVETS

Mr. Chairman, members of the Subcommittee, I appreciate this opportunity to provide testimony this morning on behalf of the more than 250,000 members of AMVETS. The issues before us today will help ensure that America's veterans receive the entitlements earned through service to their country. Neither AMVETS nor myself have been the recipient of any federal grants or contracts during FY2000 or the previous two years.

As a national Veterans Service Organization founded on the premise of veterans serving veterans, AMVETS prides itself on the service and assistance we provide to America's veterans in developing their disability claims to be considered by the Department of Veterans Affairs (VA). Through our nationwide cadre of national service officers (NSO's), AMVETS assisted in the filing of over 10,000 claims in 1999 alone. Those claims resulted in the recovery of over \$250 million in compensation to veterans for service-connected disabilities. With the increasing number of veterans being diagnosed with the Hepatitis-C virus NSO's are expecting to assist an even larger number of veterans in the future.

A study conducted by the Veterans Health Administration (VHA), involving 26,000 veterans indicates that up to 10 percent of all veterans in the VHA system tested positive for the Hepatitis-C virus, which is four to five times greater than the infection rate realized among the general population. It has also been reported that more than half of all liver transplant patients within the VHA are infected with Hepatitis-C.

In response to the growing evidence that U.S. veterans are at increased risk for Hepatitis-C, AMVETS, The American Legion, Disabled American

Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars, and the Vietnam Veterans of America along with the American Liver Foundation co-sponsored free hepatitis-C screenings for all U.S. veterans in eight cities across the country on March 31st and April 1st. It is important that those veterans who have contracted the virus are diagnosed as soon as possible to ensure that treatment is effective. AMVETS will continue to support outreach initiatives such as this in the future.

Although studies indicate a significant increase in the number of veterans being diagnosed with Hepatitis C, our NSO's are not reporting an increased number of Hepatitis C claims being processed. Since our NSO's have not processed many Hepatitis-C claims I do not feel qualified to comment on the VA adjudication of these claims. AMVETS does, however, feel that where Hepatitis-C is diagnosed after service and the veteran's service involved the risk of exposure with no other cause shown, service connection should be deemed proven by circumstantial evidence.

H.R.1020 Veterans Hepatitis-C Benefits Act

This bill, seeks to amend Title 38, United States Code, to establish a presumption of service connection for the occurrence of Hepatitis-C in certain veterans. The provisions of this bill reflect the opinion of AMVETS as outlined in the Independent Budget for fiscal year 2001. We feel that veterans diagnosed with Hepatitis-C after service, who were potentially exposed to the virus during service, should be deemed service-connected. AMVETS supports H.R. 1020 and we commend Congressman Snyder for his foresight in proposing this bill.

H.R. 3816

This bill, introduced by Congressman Stupak, seeks to amend Title 38, United States Code, to provide that a stroke or heart attack that is incurred or aggravated by a member of a reserve component in the performance of duty while performing inactive duty training shall be considered to be service connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs. As our active duty strengths continue to decrease and with service recruitment numbers consistently falling below mandated levels, our Reserve Forces have proven vital in ensuring that we as a nation meet our military commitments worldwide.

Since 1987, the military has seen a decrease of eight hundred thousand servicemen and women. Although the number of personnel in the military continues to drop, the number of deployments has risen. From 1998 to today, our military has supported thirty-two separate deployments. The unprecedented rate of downsizing and cutbacks experienced in the military in recent years has made the role of Reservists even greater. With the active duty being forced to “do more with less”, they are relying more and more on the Reserve forces for support. AMVETS recognizes the efforts of our Reservists and supports H.R. 3816.

H.R. 3998 Veterans' Special Monthly Compensation Gender Equity Act

Introduced by Ranking Minority Member Lane Evans, this bill would amend Title 38, United States Code, to provide that the rate of compensation paid by the Department of Veterans Affairs for the service-connected loss of one or both breasts due to a radical mastectomy shall be the same as the rate for

the service-connected loss or loss of use of one or more creative organs. Radical mastectomies require extensive surgery and often create lost movement in the arm and shoulder as well as swelling and numbness in the arm. According to the American Health Consultants scientific studies have shown that removing the chest muscles doesn't improve a woman's prognosis and isn't necessary if the cancer is found early. A modified radical mastectomy, which leaves both pectoral muscles intact, is now considered just as effective in stopping the cancer's spread. Also, modified radical mastectomies result in a decreased chance of nerve damage and therefore women suffer fewer complications. AMVETS applauds Mr. Evans inclusion of modified radical mastectomies within the text of this bill and we fully support H.R. 3998.

H.R. 4131 Veterans' Compensation Cost-of-Living Adjustment Act

This bill, introduced by Chairman Bob Stump, would increase the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain disabled veterans. AMVETS commends Chairman Stump for his leadership and his continued efforts to improve the lives of America's veterans. We support H.R. 4131.

Mr. Chairman, this concludes my testimony. Thank you again, for allowing me to present the views of our organization before this committee.

**STATEMENT OF
JOY J. ILEM
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON BENEFITS
April 13, 2000**

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I thank you for this opportunity to express the views of the DAV regarding the Department of Veterans Affairs (VA) management of hepatitis C claims and several bills on which the Subcommittee invited testimony.

Our discussion will encompass the provisions of the following legislation: H.R. 1020, to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans; H.R. 3816, to provide that a stroke or heart attack that is incurred or aggravated in the performance of duty while performing inactive duty for training by a member of a reserve component shall be considered to be service-connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs; H.R. 3998, to provide that the rate of compensation paid by the VA for the service-connected loss of one or both breasts due to radical mastectomy shall be the same as the rate for the service-connected loss or loss of use of one or more creative organs; and H.R. 4131, a bill to increase, effective December 1, 2000, the rates of disability compensation for veterans with service-connected disabilities, the rates of dependency and indemnity compensation (DIC) for survivors of certain disabled veterans, and the clothing allowance.

HEPATITIS C CLAIMS

Hepatitis C virus (HCV) is a potentially life-threatening disease that affects the liver and can lead to cirrhosis, liver cancer, and death. It is a slowly progressive disease advancing over a 10-40 year period. HCV, identified in 1989, is transmitted through blood contact and develops into a chronic infection in approximately 85 percent of the population infected. Currently, there is no cure or vaccine available to immunize individuals against the virus.

Those at risk include individuals who may come in contact with infected blood, instruments, or needles, such as health care workers or laboratory technicians, long-term hemodialysis patients, IV drug users, and persons who received a blood transfusion or organ transplant before July 1992. HCV may also be transmitted through unprotected sex with multiple partners, tattooing or body piercing in unsanitary conditions, or using the razor or toothbrush of an infected person.

The American Liver Foundation (ALF) reported 1 in 10 United States veterans are infected with HCV, a rate five times greater than the 1.8 percent infection rate realized among the general population. In June of 1999, Adrian M. Di Bisceglie, M.D., FACP, professor of internal medicine, Saint Louis University, and medical director of ALF, testified before the House Government Reform Subcommittee on National Security, Veterans' Affairs, and International Relations and stated, "...there is the likelihood that veterans have added risks related to exposure to infected blood on the battlefield or through blood transfusions received during combat casualty care." Unfortunately, many veterans who have hepatitis C are unaware that the disease affects them, because hepatitis C usually causes no symptoms until serious liver damage manifests.

The DAV commends the outreach effort undertaken by VA to identify and treat veterans infected with HCV. However, more needs to be done to ensure all the needs of this veteran population are adequately addressed, specifically in terms of adjudication of their claims for service connection for residuals of chronic hepatitis C infection. Increased numbers of veterans are being diagnosed with HCV and seeking treatment and disability compensation for the disease. Unfortunately, we have had numerous reports from DAV National Service Officers around the country indicating the VA is inappropriately denying many of these claims on the basis that they are not well grounded.

The United States Court of Appeals for Veterans Claims has held that all claims under title 38, United States Code, must be well grounded. Historically a well-grounded claim was a plausible claim, 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 on a claimant imposed by 38 U.S.C. § 5107(a). However, based on the Court's jurisprudence, in order for a claim to be well grounded, there must be (1) competent medical evidence of current disability; (2) medical, or in certain circumstances, lay evidence of incurrence or aggravation of a disease or injury in service; and (3) medical evidence of a nexus between an in-service injury or disease and the current disability.

The Veterans Benefit Administration (VBA), in a recent letter to House Veterans' Affairs Committee Ranking Member Lane Evans, indicated that once a veteran submits evidence confirming a diagnosis of HCV, the first requirement for a well-grounded claim is accomplished. For the second requirement to be fulfilled, VBA stated that a veteran must provide evidence of an acute hepatitis C infection in service *or* evidence of "the presence of a risk factor for hepatitis C in service to which the veteran was exposed." (Emphasis added.) Under the provisions of title 38, Code of Federal Regulations (C.F.R.) section 3.340(d), lay or other evidence may be used to establish the occurrence of a risk factor in service where such a risk factor is related to combat. The third requirement necessary is a medical statement from a physician indicating a link between the *in-service* disease and the current disability. (Emphasis added.)

VBA lists blood transfusions, hemodialysis, and working in a health care occupation as plausible risk factors in claims for service connection for hepatitis C. They note that these certain risk factors "...are both plausible as a cause of hepatitis C infection and capable of substantiation by documentation in the service records."

I have provided a synopsis of two recent cases sent from DAV field representatives demonstrating the obstacles veterans face in meeting the well-grounded requirement in claims for service connection for hepatitis C.

Case 1

The veteran filed a claim for service connection for residuals of hepatitis C and indicated he received a blood transfusion during active service. Outpatient treatment records reveal the veteran was diagnosed with hepatitis C, and liver disease (cirrhosis) and is receiving treatment for the condition. The VA notes the service medical records from the period February 4, 1981, to March 2, 1986 appear incomplete and are negative for treatment of hepatitis C. The claim is denied as not being well grounded. The veteran is notified he must provide (1) lay or medical evidence of incurrence or aggravation of the claimed condition *in service*; **and** (2) a nexus between the in-service injury or disease and the currently claimed condition. (Emphasis added.) There is no discussion in the reasons and bases portion of the rating decision about the veteran's statement in which he indicated that he received a blood transfusion during active service.

Case 2

The veteran filed a claim for hepatitis C and indicated he was a paramedic during active service and worked in an emergency room. He reported he was accidentally stuck by a needle and exposed to bodily fluids and that he was currently being treated for the claimed condition. The VA denied the claim as not well grounded stating there was no medical evidence showing hepatitis C began in service or was aggravated by service.

The rating decision included information related to another issue which noted the veteran had worked in an emergency room while in the Air Force and reported an incident where he had to collect body parts following a helicopter crash. However, the veteran's statement that he was a health care worker during active service was not confirmed or discussed in the reasons and bases portion of the rating decision. Nor did the VA indicate if the veteran had a current diagnosis of hepatitis C although this information is confirmed in outpatient medical records associated with the file.

It appears these claims for service connection for hepatitis C have been erroneously denied as not well grounded based on a lack of evidence showing an in-service occurrence of the disease. In each of the noted cases, known risk factors were not even addressed by the rating specialist in the rating decisions of those claims.

The nature of HCV—specifically its slow progression over a 10-40 year period—coupled with the absence of symptoms until serious liver damage is detected complicates the VA adjudication process concerning these claims for direct service connection. Veterans filing claims for hepatitis C have generally been discharged from the service for many years and have only recently been diagnosed with HCV. It is unlikely to see a diagnosis of chronic hepatitis C infection in the veteran's service medical records because the onset of infection goes unrecognized since symptoms are generally not severe enough to require medical attention. A good example of this would be veterans who received blood transfusions for combat related injuries in Vietnam and nurses and medics who cared for the sick and injured who have only just recently been diagnosed with liver disease due to HCV.

VBA stated in a recent letter to Representative Lane Evans concerning adjudication of HCV claims that two letters have been sent to the field to help guide decision makers in processing these types of claims. VA Letter 211B (98-110) clearly indicates that when there is evidence that a veteran was exposed to a known risk factor for hepatitis C in service such as a blood transfusion prior to 1992, hemodialysis, or employment in a health care occupation, a claim that hepatitis C resulted from one of these risk factors in service would be a plausible nexus for the purpose of a well-grounded claim. The following synopsis was provided in the letter as an example of a well-grounded claim.

“Situation: Service connection is claimed for cause of death due to cirrhosis and liver cancer. The veteran never filed a claim during his lifetime, and cirrhosis was diagnosed 20 years after service. The veteran also had a diagnosis of hepatitis C and a long history of problems with alcohol. During service, the veteran was a medical corpsman.”

VBA indicates the fact that the veteran was a health care worker during service establishes that the veteran was exposed to a risk factor during service that could be the cause of HCV infection and subsequent complications and that this is sufficient to make the claim plausible.

The VA admits there are inconsistencies in processing claims for service connection for chronic hepatitis C infection and indicates that they are striving to improve performance in that area. However, it is imperative that VA closely monitor these cases to ensure equitable and uniform decisions are made on claims for service connection for hepatitis C. We recommend that VA amend title 38 C.F.R. § 3.303(d) to expressly include hepatitis C under its provisions that authorize service connection in the absence of direct proof where a cause-and-effect relationship is shown between service-related factors and disease diagnosed after service.

The relatively recent identification of this disease as well as the silent nature of HCV in most cases prevented its detection during military service and for many years following; therefore, it is reasonable to expect direct evidence of service incurrence will be lacking. Nonetheless, where HCV is diagnosed after service, the veteran's service involved the risk factors for HCV, and no other cause is shown, service connection should be deemed proven by circumstantial evidence.

Additional concerns about adjudication of HCV claims include inappropriate evaluations being assigned in cases where service connection for residuals of hepatitis C has been established.

Case 3

The veteran had active service from March 1967 to April 1970. He served as a medical corpsman and had been awarded a Purple Heart and a Combat Medical Badge. The veteran was granted service connection for hepatitis C with a 30 percent evaluation assigned. Evidence of record showed the veteran suffered from cirrhosis of the liver stage 2 fibrosis indicative of significant scarring of the liver compatible with 20 to 30 years of infection. He complained of fatigue, malaise, depression, severe chronic gastrointestinal disturbance approximately 15-20 days per month, and weight fluctuation. The veteran appealed the rating decision for the percentage of disability assigned.

The veteran was granted an increased evaluation on appeal from 30 percent to 60 percent based on the medical evidence of record which indicated a rating more nearly comparable to 60 percent criteria under Diagnostic Code 7345 in the rating schedule for disabilities.

The physical effects of HCV are devastating and often require the veteran to undergo extensive medical treatment and drug therapy regimens. Some veterans are unable to work because of chronic symptoms such as fatigue, gastrointestinal problems and severe depression associated with the disease. The VA must ensure that evaluations assigned in these cases are consistent and that veterans are adequately compensated for residual effects of HCV. We are aware that VBA is awaiting final regulations to be published to provide for the consistent processing of claims based on chronic hepatitis C infection. However, until final regulations are published, VBA is obligated to make sure rating specialists clearly understand and carry out the instructions outlined in its letters issued to the field concerning the processing of their claims.

Unfortunately, we have heard a report of a case of a child suffering with the advanced residuals of HCV believed to be a result of a blood transfusion from her parent. The parent, who is a veteran, is suffering advanced stages of liver disease due to hepatitis C resulting from a blood transfusion received during active service. HCV is also known to be sexually transmitted and veterans' spouses may also be unwittingly exposed to the hepatitis C virus and experience the liver disease as well.

We recognize the far reaching and devastating effects of this incurable disease not only on former servicemembers but their spouses and children as well. We are sympathetic to the spouses and children of veterans who are service connected for HCV and who have contracted the virus themselves. The Government has an obligation to compensate them. This compensation would be paid to civilian dependents that contracted their diseases in civilian life rather than veterans suffering from service-connected disabilities, however. Consistent with our view on compensating dependent children with spina bifida, we believe such a program outside the scope of the VA's mission and should be authorized and administered under Social Security or some more appropriate Government agency.

H.R. 1020

Congressman Snyder introduced H.R. 1020 for himself and several cosponsors. The "Veterans Hepatitis C Benefits Act of 1999" would amend title 38, United States Code, to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans.

The DAV appreciates the introduction of H.R. 1020, and we support its goal. However, we are concerned that any pay-as-you-go offset will be taken from other veterans' programs. We believe legislation would be unnecessary if VA would make a more meaningful effort to improve adjudication of these claims. Additionally, under the circumstances of hepatitis C infection, direct service connection is more appropriate than presumptive service connection. Where evidence of service incurrence or exposure to a known cause exists, direct service connection is in order. Where disabilities manifest after service and a basis to assume service onset exists but proof is generally lacking, the law may allow the presumption of service connection.

For those reasons, the *Independent Budget* includes a recommendation that the Secretary of Veterans Affairs amend 38 C.F.R. § 3.303(d) to expressly include provisions that will assure service connection is granted where a veteran suffering from hepatitis C is shown to have been exposed to a risk factor during service. We certainly have no objection to enactment of H.R. 1020 if there is no offset against other veterans' benefits.

H.R. 3816

Congressman Stupak and several cosponsors introduced this bill to provide that a stroke or heart attack that is incurred or aggravated in the performance of duty while performing inactive duty for training by a member of a reserve component shall be considered to be service connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs.

Section 101(24) of title 38, United States Code, provides in part that any period of inactive duty training during which the individual concerned was disabled or died from an *injury* [shall be considered to be an injury] incurred or aggravated in line of duty. This bill seeks to clarify the term "injury" as specifically related to the above noted statute by adding the following new sentence: "For purposes of this paragraph, a cardiovascular accident or an acute myocardial infarction incurred in performance of duty during inactive duty training shall be considered to be an injury incurred or aggravated in line of duty." Based on the known strenuous physical rigors associated with military training, it is appropriate that a resulting stroke or heart attack due to such physical stresses should be service connected.

The DAV has no mandate from our membership on this measure. However, its purpose is a beneficial one and we do not object to its favorable consideration.

H.R. 3998

The DAV National Convention, assembled in Orlando, Florida, August 21-25, 1999, voted to support DAV Resolution No. 102, to amend section 1114(k) of title 38, United States Code, to add the anatomical loss of a female mammary gland.

Currently, service connection is available for the surgical removal of one or both breasts under 38 C.F.R. § 4.116, Diagnostic Code 7626. Section 1114(k) of title 38 United States Code, and section 3.350(a) of 38 C.F.R. grant special monthly compensation (SMC) to a veteran who, as a result of a service-connected disability, suffers the anatomical loss of use of one hand, one foot, both buttocks, one or more creative organs; blindness—one eye having light perception only, deafness—both ears having the absence of air and bone conduction; and complete organic aphonia with constant inability to communicate by speech.

Current VA regulations do not authorize SMC payments, which are payable in addition to the basic rate of compensation on the basis of degree of disability, for veterans who have lost a breast due to radical or modified mastectomy. Traditionally, Congress has provided service connection for medical conditions incurred or aggravated during military service based on the loss of earning capacity. However, as noted by Congressman Lane Evans in his March 9 "Dear Colleague" letter, "...there has long been recognition that certain disabilities impact the veteran in non-economic ways such as a loss of physical integrity. The special monthly compensation payment for conditions listed in 38 U.S.C. § 1114(k) include recognition of non-economic losses such as loss of physical integrity."

The breast is a distinctive characteristic and fundamental feature of female anatomy. The female mammary gland is an essential post partum accessory organ and an integral part of the female reproductive system. There is a significant hormonal interrelationship between the female mammary glands and the female reproductive system. Severe physical disfigurement and complete loss of use is a common result of the removal of the female mammary gland and generally requires reconstructive surgery or utilization of prosthesis to replace the amputated organ.

Women veterans who are entitled to service connection for residuals of a radical mastectomy are no less deserving of SMC payments under 38 U.S.C. § 1114(k) than other veterans who suffer the effects of disabilities authorized under this statute. The DAV agrees with the recommendation made by the VA Advisory Committee on Women Veterans in its 1998 Annual Report: "...a mastectomy involves a loss comparable to those covered in the law and should qualify for special monthly compensation k-award." We strongly believe veterans who have suffered severe physical disfigurement and complete loss of one or both breasts due to the effects of radical mastectomy have been unfairly denied this additional payment for these losses.

Mr. Chairman, we commend Representative Lane Evans, along with the 22 original cosponsors of H.R. 3998, for introduction of this legislation. We believe this bill will provide for gender equity in recognition of the service-connected losses suffered from the devastating surgical effects of radical mastectomy. We appreciate the Subcommittee's serious consideration of this bill.

H.R. 4131

House Veterans' Affairs Committee Chairman Bob Stump introduced H.R. 4131, with Congressmen Evans, Quinn, and Filner, cosponsoring this bill to increase the rates of disability compensation, dependency and indemnity compensation (DIC), and clothing allowance. This legislation would adjust these benefit rates effective December 1, 2000, to reflect the rise in the cost of living. To fulfill their purpose, veterans' benefits must be

adjusted periodically to keep pace with increases in the cost of living. The DAV supports H.R. 4131 and is appreciative of the annual increases Congress provides.

However, as recommended by the *Independent Budget*, ancillary benefits for severely disabled veterans and their dependents should also be included for annual raises. The value of these benefits erode to the extent they are not adjusted every year to offset inflation. Any erosion due to inflation has a direct detrimental impact on recipients, especially those on fixed incomes. To be effective—and accomplish the purpose for which they are intended—ancillary benefits such as educational assistance for survivors and dependents, automobile and adaptive equipment grants, housing grants and home adaptation grants for seriously disabled veterans need to be adjusted automatically each year to keep pace with the rise in the cost of living. For the same reasons that annual increases are warranted for compensation, DIC, and clothing allowance, they are warranted for these ancillary benefits.

We recommend Congress enact a cost-of-living adjustment (COLA) for all compensation benefits sufficient to offset the rise in cost of living. DAV is opposed to the rounding down of COLA's in veterans' benefits to the next lower dollar amount and request a repeal of the provision that authorizes such action. We also urge the Subcommittee to consider instituting a process to include all these benefits for service-connected veterans and their dependents or survivors in an annual cost-of-living bill.

CONCLUSION

We hope that our statement is helpful to you. These bills all have beneficial provisions that would improve benefits and services for disabled veterans and their eligible dependents and survivors. The DAV appreciates the Subcommittee's interest in these issues and its efforts to make these improvements to better serve our Nation's veterans.



Non Commissioned Officers Association of the United States of America

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

STATEMENT OF

**RICHARD C. SCHNEIDER
DIRECTOR OF STATE/VETERANS AFFAIRS**

BEFORE THE

SUBCOMMITTEE ON BENEFITS

**COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

ON

H.R. 1020, H.R. 3816, H.R. 3998 AND H.R. 4131

APRIL 13, 2000

Chartered by the United States Congress

DISCLOSURE OF FEDERAL GRANTS AND CONTRACTS

The Non Commissioned Officer Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

INTRODUCTION

Mr. Chairman and distinguished Members of the Subcommittee, the Non Commissioned Officers Association of the USA (NCOA) is most grateful for the opportunity to appear today. As an accredited veteran service organization, the Association is privileged to assist veterans in the preparation and submission of compensation and pension claims to the Department of Veterans Affairs (VA). NCOA recognizes that this hearing today is critically important to all men and women who serve or have served in the Uniformed Services of this Nation. Our discussion today focuses on a number of health issues that impact service members, veterans and relates to fairness in the disability arena in the manner in which they are treated.

Proposed Legislation and Recommendations

H.R. 1020

The Bill proposes to amend Title 38, United States Code, to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans that experience one or more of the following:

- "(1) Transfusion of blood or blood products before December 31, 1992.*
- "(2) Blood exposure on or through skin or mucous membrane.*
- "(3) Hemodialysis.*
- "(4) Tattoo or body piercing or acupuncture.*
- "(5) Unexplained liver disease.*
- "(6) Unexplained abnormal liver function tests.*
- "(7) Working in a health care occupation."*

NCOA notes that the Department of Veterans Affairs has already published an educational series of 10 topics on Hepatitis C or HCV for short. The first fact sheet entitled *Do I Need to Get Tested for Hepatitis C* contains a section to help veterans determine if they are at risk for HCV. In fact, it states that some people are at greater risk than others and proceeds to list every consideration contained in the proposed legislation. A significant recommendation on that fact sheet is the recommendation of testing if **"you are a Vietnam-era Veteran."**

NCOA recommends that Title 38, United States Code, be immediately amended as recommended by H.R. 1020. The Association recognizes that the advances in medical science, as evidenced by the VA fact sheets, are sufficient to recognize that all service members and veterans may be at risk for HCV.

H.R. 3816

The Bill proposes to amend Title 38, United States Code, to provide that a stroke or heart attack that is incurred or aggravated by a member of a reserve component in the performance of duty while performing inactive duty training shall be considered service connected for purposes of benefits. The specific wording of the amendment is of concern to NCOA. The wording follows:

"For purposes of this paragraph, a cardiovascular accident or an acute myocardial infarction incurred in performance of duty during a period of inactive duty training shall be considered to be an injury incurred or aggravated in line of duty."

The Association recommends two changes to clarify the intent of HR 3816.

First, NCOA is confused by the use of the word accident instead of the word incident. Frankly we are uncertain about what might be a cardiovascular accident. However, a cardiovascular "incident" or "event" might include tachycardia,

bradycardia, and dozens of other conditions. Accordingly, NCOA recommends that “event” or “incident” be substituted for the word accident in the bill.

Second, the Association fully supports the concept contained in H.R. 3816 that would service-connect members of reserve components who experience either a cardiovascular **incident** or acute myocardial infarction during any period of inactive duty training. Yet NCOA believes the language must also account for reasonable periods of travel to and from drill and for periods between multiple-drill sessions.

NCOA strongly believes the legislation must specifically address that period of time associated with reasonable travel to and from inactive duty training assignments. At issue is the fact that many members of the reserve components travel extensive distances to meet their inactive duty training obligations. The concept that these citizen-soldiers fulfill their reserve obligations in the local community is no longer valid. The reality is that reserve training facility closures and unit dis-establishments have forced increasing numbers of reservists to travel longer distances to continue participation, oftentimes on an involuntary basis. For career members, travel is the only option when no other assignment is available locally. These career citizen soldiers work full time jobs and then commence travel, oftentimes on Friday nights, to drive, or in some cases, fly to report for duty at their units of assignments. These travel requirements associated with their unit training assembly place them at increased risk for acute cardiac-related problems.

The Association also believes that H.R. 3816 must be modified to include that period of time between multiple-drill periods when the member may not be in a travel status. NCOA is specifically referring to that period of time after completion of travel on Friday and following the conclusion of training on a Saturday afternoon and the commencement of training on a Sunday morning. Reservists who travel long distances to attend training are authorized housing, either in a barracks or contracted quarters on Friday and Saturday nights. While the Association believes the intent of H.R. 3816 is to include these periods, the absence of language specifically stating coverage could be problematic.

NCOA strongly recommends that the language in H.R. 3816 be modified to include reasonable travel time to and from inactive duty training and specifically indicate coverage for the period of time between multiple-drill periods as stated in the preceding paragraph.

H.R. 3998

The Bill would provide that the rate of compensation paid by the Department of Veterans Affairs for the service-connected loss of one or both breasts due to radical mastectomy shall be the same as the rate for the service-connected loss or loss of use of one or more creative organs.

NCOA strongly supports H.R. 3998 and recommends compensation be authorized under the Department of Veterans Affairs K Rate.

H.R. 4131

THE VETERANS COMPENSATION COST-OF-LIVING ADJUSTMENT ACT OF 2000

H.R. 4131 would authorize, effective December 1, 2000, an increase in the rates of disability compensation for veterans with service connected disabilities and the rates of dependency and indemnity compensation for survivors of certain disabled veterans. The proposal would increase benefits by the same percentage as that payable under Title II of the Social Security Act as determined under Section 215(i) of the Social Security Act [42 U.S.C.415 (i)].

NCOA opposes the enactment of H.R. 4131. The Association does not believe it is proper or necessary to tie the fate of future compensation increases to the Social Security program. Additionally the need to provide an annual increase in compensation benefits by process of specific legislation assures an annual program review that is reassuring to veterans. Creating a link between Social Security benefits and veterans compensation increases could cloud future compensation increases as changes are made to assure solvency in the Social Security program.

The Association recommends instead of H.R. 4131 that the Committee seize this opportunity to enact legislation to repeal the provisions contained in sections 1104 and 1303 of Title 38 USC. Repealing these sections would sever the current ties between veterans and Social Security benefit increases and would also eliminate the rounding down provisions enacted as an economy measure several years ago. In this era of budget surpluses it is no longer necessary to penalize veterans and their survivors by reducing their compensation in this manner.

CONCLUSION

Mr. Chairman and distinguished members of the Committee, NCOA again thanks you for this opportunity to present its thoughts on these important legislative initiatives. Each bill under consideration deserves your expeditious consideration and approval.

Thank you.

STATEMENT OF

SIDNEY DANIELS
DEPUTY 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

H.R. 1020, H.R. 3816, H.R. 3998, and H.R. 4131

WASHINGTON, DC

APRIL 13, 2000

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you, Mr. Chairman, for the opportunity to testify today concerning the above-cited bills.

H.R. 1020

To amend title 38, United States Code, to establish a presumption of service connection for the occurrence of hepatitis C in certain veterans

This bill will establish a presumption of service connection for hepatitis C, notwithstanding, that there is no record of evidence of such illness during a veteran's military service, if the veteran meets certain criteria.

At our 100th National Convention this past August the delegates passed Resolution Number 699, *Establishing a Presumption of Service Connection for Veterans From Hepatitis "C."* This resolution urges the Secretary of Veterans Affairs to authorize an open-ended presumption of service connection for veterans suffering from hepatitis C.

The hepatitis C virus (HCV) is a chronic, blood-borne disease that infects between 4 and 5 million Americans or 1.8 percent of the population. It is a disease that was virtually unknown before the virus was isolated in 1989 and before effective screening tests were perfected in 1992. Since then, it has emerged as a major public health concern.

Hepatitis C is often a hidden disease after infection. Studies show that the virus usually develops over a period of 10 to 30 years, usually without symptoms, until it surfaces as chronic active hepatitis. (Only five percent of those currently infected with HCV are aware that they have the disease and fewer than two percent have ever been treated.) Transmission of hepatitis C generally occurs through blood-to-blood contact. Most people currently carrying the disease, however, were infected sometime within the last 30 years when blood transfusions and blood products were a significant source of infection. Prior to 1992, hepatitis C was prevalent in the nation's blood supply.

Hepatitis has historically been a disease associated with military service. Military training and combat offer many opportunities for transmission of blood-borne viral hepatitis through blood-to-blood contact. Field bleeding, surgery and transfusions, and exposure to blood by military medics and surgeons all constitute high risks.

Veterans of foreign combat are most at risk where prevalence of hepatitis C is particularly high. All major engagements of the last 50 years including World War II, Korea, and Vietnam have high rates of hepatitis. Viral hepatitis was viewed as a single disease in those years. Most treatments and documented cases were for acute forms of the disease.

Accordingly, veterans appear to have unusually high rates of hepatitis C. While the prevalence of hepatitis C in the nation as a whole is 1.8 percent, various special studies of veterans in VA facilities have shown rates of hepatitis C infection between 10 and 20 percent.

Vietnam veterans seem to be the group most directly affected by this problem today. Many veterans who contracted hepatitis C in Vietnam 25 to 30 years ago are now exhibiting symptoms of severe liver disease. When they were first infected, HCV had not been distinguished from other forms of hepatitis (in 85 percent of the cases, there would have been no acute symptoms at the time of infection).

Currently, there are 3.2 million surviving Vietnam veterans who were stationed in Southeast Asia during the Vietnam Conflict. A conservative estimate is that 10 percent (320,000) of these veterans are now infected with HCV. There are a number of likely risk factors related to the transmission of hepatitis C during the Vietnam War. These include:

Southeast Asia has high rates of hepatitis C infection. Currently, between five and eight percent of the Vietnamese population is infected with hepatitis C. Hepatitis C could have been transmitted to military personnel through tattoos, medical contact, sexual contact, and shared needles.

Approximately 300,000 Americans were wounded and 153,329 were hospitalized during the Vietnam War. Between March 1967 and June 1969, there were 364,900 transfusions given in Vietnam. It is estimated that a minimum of ten percent of those who were transfused received infected blood.

Surgeons, nurses, medics, helicopter crews, and others involved in evacuation and treatment of the wounded all were at risk for transmission of hepatitis C. Of an estimated 41.1 percent of all military personnel deployed to Vietnam, approximately 2.1 million were exposed to combat. Many assisted the more than 300,000 wounded. In addition, many medical personnel, not exposed to combat because of their assignment to hospital ships, also handled the wounded in the Vietnam theatre of operations.

Unclean needles that pierce the skin can transmit hepatitis C. While transmission of hepatitis C through tattoos has not been documented in the United States, it has been documented elsewhere. An estimated 34 percent of active duty military personnel have tattoos. Many of these were acquired in regions where sanitation was not optimal.

The Department of Veterans Affairs (VA) has been monitoring HCV cases and has noted a decided increase in the number of cases over the last few years. There were 6,600 HCV cases reported in the VA in 1991. By 1994, this number had increased to 18,854. Between 1995 and 1997, the annual number of newly identified persons rose from 20,203 to 24,850. In 1998, an additional 29,799 unique cases were recorded within the VA. VA officials expect this number to continue to rise substantially. Of all veterans in the VA system testing positive for hepatitis C, 64 percent were Vietnam-Era veterans. The mean age of HCV-infected veterans is 49 years.

Veterans infected with hepatitis C during their military service are generally unable to establish a service connection. The lack of knowledge of hepatitis C and, until recently, the lack of a reliable test not to mention the long latency period of this disease makes it difficult to prove that the infection was acquired during military service. (Even today, when there are reliable tests for hepatitis C, the military does not conduct HCV tests as part of the discharge physical examinations. Without a presumption of service connection, most veterans who contracted hepatitis C in the military will not be eligible for treatment in VA facilities. In fact, in a review of all 1,599 cases of chronic hepatitis brought before the Board of Veterans Appeals between 1994 and 1996, only 37 cases resulted in an approval of a service-related disability rating for hepatitis.

Accordingly, Mr. Chairman, the VFW strongly supports this bill.

H.R. 3816

To amend title 38, United States Code, to provide that a stroke or heart attack that is incurred or aggravated by a member of a reserve component in the performance of duty while performing

inactive duty training shall be considered to be service-connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs;

The Veterans of Foreign Wars supports this bill with no further comment.

H.R. 3998

To amend title 38, United States Code, to provide that the rate of compensation paid by the Department of Veterans Affairs for the service-connected loss of one or both breasts due to a radical mastectomy shall be the same as the rate for the service-connected loss or loss of use of one or more creative organs

With respect to H.R. 3998, we have a concern that the language, as currently written will create an inequity. In general, the rating schedule is gender neutral in the evaluation of disabilities, without the identification of a physiological impact. For example, a male veteran should be considered the same in this legislation because the disfigurement of a breast removal procedure (gynecomastia) would most likely be a result of a comparative disease that attacks either gender. Therefore, all veterans should be entitled to the same consideration for the surgical procedure of breast removal under the rating schedule contained in Part 4 "Schedule For Rating Disabilities," Title 38 of Code of Federal Regulations.

Accordingly, under the current version of the rating schedule, and to be inclusive in establishing equity (if that is the goal), the procedure known as mastectomy may result in the same disabling impact to the "average person." (The concept of the average person is the foundation principle found in 38 C.F.R. Part 4.) For instance, under Diagnostic Code 7626, "Breasts, surgery of;" (38 C.F.R. § 4.116), bilateral simple mastectomy is viewed as more disabling than an unilateral modified radical mastectomy (a 50% compensation rating versus a 40%). Under the proposed legislation, the veteran with the 40% rating as a result of a modified radical mastectomy involving one breast would receive a special monthly compensation under Title 38 United States Code § 1114(k) while the veteran rated at 50% does not although the 40 percent rating involves a more disabling condition (modified radical mastectomy).

Consequently, we recommend the proposed amended section 1114(k) instead be stated: "or one or both breast due to a mastectomy." The definition herein of "mastectomy" is meant to be either radical, modified radical, or simple. Making this change will guarantee true equality and gender equity in the rating schedule at 38 C.F.R. § 4.116.

H.R. 4131

To increase, effective December 1, 2000 the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain disabled veterans.

The Veterans of Foreign Wars also supports H.R. 4131 without further comment.

Once again, Mr. Chairman we thank you for the opportunity to lend our voice to today's most important testimony, and I will be happy to answer any questions you may have. Thank you.

**STATEMENT OF PHILIP R. WILKERSON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VARIOUS LEGISLATIVE INITIATIVES-
HR 1020, HR 3816, HR 3998 AND HR 4131**

APRIL 13, 2000

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to express our views on several legislative initiatives being considered today.

HR 1020

This bill is entitled the "Veterans' Hepatitis C Benefits Act of 1999." It would add new section 1119 to title 38, United States Code, to provide that, for the purposes of entitlement to service connection, hepatitis C shall be considered to have been incurred in or aggravated by military service, if the veterans experienced one or more enumerated risk factors during such service. These risk factors include: transfusion of blood or blood products before December 12, 1992; blood exposure on or through the skin or mucous membrane; hemodialysis; tattoo or body piercing or acupuncture; unexplained liver disease; unexplained abnormal liver function tests; or working in a health care occupation.

While hepatitis is not a new disease, the prevalence of hepatitis C and the long-term health consequences have only recently become recognized as a major public health problem. This is an easily transmitted blood-borne virus, which can have potentially fatal long-term health consequences. The circumstances of military training, combat, and other activities in locations around the world offer many opportunities for contact with infected blood or blood products. What is of particular concern is the epidemic proportion of this type of infection in our veteran population. VA estimates that ten to twenty percent of veterans have hepatitis C, as compared with a rate of under two-percent of the general population. Study data indicate that Vietnam veterans appear to be the group most directly affected. Many of these veterans, both men and women, unknowingly contracted the hepatitis C virus in Vietnam 25 or 30 years ago and may only now become symptomatic with possibly severe liver disease and other related problems. In addition to Vietnam, American armed forces have served in various countries where hepatitis C is endemic. Studies have also established that the virus can, in fact, remain dormant for a person's entire lifetime or, in others, it can become active at some point in time and attack various organs, particularly the liver. According to VA, fifty-two percent of VA's liver transplant recipients have hepatitis C.

We have been pleased by VA's pro-active response to what is clearly a national health policy and health care challenge. They have developed a five-point strategic initiative. It addresses veterans' need for information and education about the risks of hepatitis C and the need to be tested. Similarly, health care providers also need to be better informed about hepatitis C, in order to advise and assist veterans who may have been exposed to the virus at some point in the past. As a major part of its education and research efforts, VA has established Centers of Excellence in Miami and San Francisco. There are also screening and treatment programs underway to identify those who test positive for hepatitis C. If nonsymptomatic, they can be monitored and any problems treated early. For those with more serious medical problems, VA has available a course of drug treatment. The purpose of the screening, monitoring, and treatment programs is to try and avoid some the more tragic, costly, and risky consequences that can result from untreated hepatitis C, such as liver transplants

Mr. Chairman, we believe there is sufficient and compelling scientific evidence of a link between certain risk factors inherent in the training, combat, and other activities associated with

military service and veterans with a current diagnosis of hepatitis C. In light of this evidence, The American Legion wrote to Secretary West in August of 1999 recommending that regulations be developed and promulgated, in accordance with title 38, United States Code, establishing hepatitis C as a presumptive disease for the purposes of entitlement to service-connected disability compensation and VA medical care. It is now difficult for a veteran to get service connection for hepatitis C or a related medical problem, because of an inability to prove the virus was acquired during military service. Those hepatitis C veterans who may have been treated for acute hepatitis in service and who now claim service connection are also being turned down by VA, again, because they cannot prove the current condition is related to a prior exposure to hepatitis. The Board of Veterans Appeals often rejects a claim for service connection, because the service medical records do not show the presence of hepatitis C at time of separation or discharge from service.

We believe also that the nature and extent of this problem requires either administrative action by the Department of Veterans Affairs or the Congress to establish specific presumptions in claims for service connection for hepatitis C. Over the years, the presumptive provisions of the law and regulations have been amended to reflect advances in medical research on a variety of diseases. However, with regard to the risk factors enumerated in HR 1020, The American Legion does not have a formal position on these or the specifics of the presumptions that should apply. However, we do support efforts to establish an appropriate presumption for hepatitis C, in light of the prevalence of this disease, which can remain inactive for many years before it becomes manifested.

The provision for presumptive service connection for hepatitis C will be important for a number of reasons. The first is that it would remove an often-insurmountable legal hurdle and enable those veterans disabled by reason of hepatitis C and related problems to receive needed financial compensation. It would also entitle them to vocational rehabilitation benefits and assistance. Equally important, it would entitle them to the necessary VA medical treatment and care.

With regard to current treatment regimen for this disease, it is very similar to chemotherapy for cancer, in that there can be debilitating side effects. These often severely impact the individual's ability to work or return to work. This fact should be reflected in a separate diagnostic code for hepatitis C, to include a provision for an assignment of a 100% evaluation for a 6-month period while the individual is undergoing therapy. At the end of this period, the rating should be revised to reflect the current level of residual disability.

HR 3816

This bill would amend title 38, United States Codes, section 101(24) to expand the definition of a disability for which service connection can be granted to include a heart attack or stroke by a member of the reserve components of the armed forces performing inactive duty for training. Section 101(24), as currently interpreted, distinguishes between a disability which is due to a physical injury and that which is due to a disease process. A heart attack or stroke occurring during a period of inactive duty for training has been generally considered by VA as being due to a pre-existing disease process and, unless it was clearly shown to have been precipitated by an injury or trauma, service connection would be denied.

Veterans, in order to remain in a reserve program, must participate in often strenuous physical training activity during their periods of inactive duty for training. During such training, some of these veterans may suffer a heart attack or stroke and become disabled. The American Legion believes it would be beneficial and appropriate to revise the current statute to recognize this added risk factor associated with inactive duty for training and provide entitlement to compensation for any resulting disability.

HR 3998

This bill, entitled the "Veterans' Special Monthly Compensation Gender Equity Act," would amend title 38, United States Code, section 1114(k) to add the loss of one or both breasts due to a radical mastectomy or a modified radical mastectomy to the list of loss or loss of use disabilities.

Section 1114(k) authorizes an additional monthly statutory award where there is the anatomical loss or effective loss of use of one or more creative organs, a hand, a foot, or both

buttocks, blindness, deafness, or aphonia. This payment is over and above the basic rate of compensation payable for the particular condition.

Most patients having mastectomies are female. This procedure and its after effects can cause long-term serious physical and emotional problems. It appears this legislation is intended to entitle both men and women veterans to additional special monthly compensation at the (k) rate of \$76 currently, when one or both breasts have been surgically removed as a result of a radical or modified radical mastectomy due to some underlying disease process or injury. While The American Legion does not have a formal position on this proposal, we would offer no opposition, since we believe that with the enactment of this measure it will make the Department of Veterans Affairs compensation program more equitable and fair for all of our nation's disabled veterans.

HR 4131

The legislation, entitled the "Veterans' Compensation Cost of Living Adjustment Act of 2000," would increase the monthly rates of disability compensation and Dependency and Indemnity Compensation (DIC) by the same percentage as the increase authorized in Social Security benefits for 2000-2001. The increase in VA benefits shall be effective on December 1, 2000.

Mr. Chairman, VA has included a cost-of-living adjustment of 2.5% in disability compensation and DIC rates in the budget request for FY 2001. The American Legion supports an annual cost-of-living adjustment (COLA) in these benefits, in order to ensure they are providing an appropriate level of financial assistance. For the record, we too express our opposition to any proposal that would automatically index such COLAs to the annual adjustment in Social Security benefits. The American Legion believes it is important that Congress hold annual hearings on a proposed COLA, because such occasions provide an important forum in which to discuss the adequacy of these benefit programs and particular problems affecting the welfare and wellbeing of disabled veterans, their families, and survivors. If future COLAs were indexed, this valuable opportunity would be lost.

Mr. Chairman, that concludes our statement.

**Statement of
Nora E. Egan
Deputy Under Secretary for Management
Department of Veterans Affairs
Before the
House Committee on Veterans' Affairs
Subcommittee on Benefits
April 13, 2000**

Mr. Chairman and Members of the Subcommittee, I am pleased to be here this morning to provide the views of the Department of Veterans Affairs (VA) on several bills that affect important programs for veterans and their dependents and survivors. Today's agenda includes the following bills: H.R. 4131 (authorizing a compensation cost-of-living adjustment); H.R. 3816 (authorizing service connection for heart attack or stroke suffered by individuals performing inactive duty training); H.R. 3998 (authorizing payment of special monthly compensation for the service-connected loss of one or both breasts due to mastectomy); and H.R. 1020 (establishing a presumption of service connection for occurrence of hepatitis C in certain veterans). In addition, for purposes of oversight, you requested that we address separately the adjudication of hepatitis C claims. Accompanying me this morning are Mr. John H. Thompson, Deputy General Counsel, and Mr. John F. McCourt, Deputy Director, Compensation & Pension Service.

H.R. 4131 – COMPENSATION COST-OF-LIVING ADJUSTMENT

Mr. Chairman, one of the most important bills on today's agenda is H.R. 4131. This bill would direct the Secretary of Veterans Affairs to increase administratively the rates of compensation for service-disabled veterans and dependency and indemnity compensation (DIC) for the survivors of veterans whose deaths are service related, effective December 1, 2000. On February 15, 2000, the Secretary of Veterans Affairs transmitted to Congress draft legislation proposing a cost-of-living adjustment (COLA) for compensation and DIC recipients at the same rate of increase as the COLA that will be provided under current law to veterans' pension and Social Security recipients. We currently estimate that this year's Social Security adjustment will be 2.5 percent. We believe this proposed COLA is necessary and appropriate in order to protect the affected benefits from the eroding effects of inflation. Therefore, we strongly support this bill.

We estimate enactment of the COLA would cost \$345 million during fiscal year (FY) 2001 and \$6.3 billion over the period FYs 2001 – 2005. This increase is not subject to the pay-as-you-go (PAYGO) requirements of the Omnibus Budget Reconciliation Act of 1990 (OBRA).

I would also like to take this opportunity to urge your favorable consideration of another Administration proposal. Our draft legislative proposal of February 15 also included a provision to repeal a provision of the Balanced Budget Act of 1997 that would require VA to defer until October 2, 2000, making veterans-benefit payments which would otherwise be delivered by mail or transmitted for credit to the payee's account by Friday, September 29, 2000. We strongly believe that veterans should not be financially burdened by this provision and ask that you take action to correct this situation. This proposal is subject to the PAYGO requirements of the OBRA. The PAYGO effect will be an increase in outlays of \$1.8 billion in FY 2000, with a corresponding decrease in FY 2001.

H.R. 3816 – SERVICE CONNECTION FOR STROKE AND HEART ATTACK IN CASE OF INDIVIDUALS PERFORMING INACTIVE DUTY TRAINING

H.R. 3816 would amend current law "to provide that a stroke or heart attack that is incurred or aggravated by a member of a reserve component in the performance of duty while performing inactive duty training shall be considered to be service-connected for purposes of benefits under laws administered by the Secretary of Veterans Affairs." VA supports the principle embodied in H.R. 3816, although we believe that certain changes to the bill as drafted would be beneficial.

Specifically, H.R. 3816 would amend section 101(24) of title 38, United States Code, by adding at the end the following new sentence: "For purposes of this paragraph, a cardiovascular accident or an acute myocardial infarction incurred in performance of duty during a period of inactive duty training shall be considered to be an injury incurred or aggravated in line of duty." We note that the bill uses the term "cardiovascular accident," apparently referring to stroke. However, we believe the intended medical term is "cerebrovascular accident."

In general, the performance of inactive duty training does not qualify an individual as a "veteran" for VA purposes. Under 38 U.S.C. § 101(2), veteran status is conditioned on performance of "active military, naval, or air service." Currently, section 101(24) defines the term "active military, naval, or air service" to include active duty, any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty, and any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty. Thus, unless an individual suffers disability or death as the result of an injury incurred or aggravated during inactive duty training, the individual is not considered a veteran on the basis of participation in such training.

For purposes of laws administered by VA, the term "injury" has been interpreted as not including non-traumatic incurrence or aggravation of disease processes or manifestations thereof, including myocardial infarction (heart

attack). VAOPGCPREC 86-90. This interpretation was upheld by the U.S. Court of Veterans Appeals and affirmed by the U.S. Court of Appeals for the Federal Circuit in Brooks v. Brown, 5 Vet. App. 484 (1993), aff'd, 26 F.3d 141 (Fed. Cir. 1994) (table). Neither a heart attack nor a stroke results from an injury. In most cases, there is an underlying disease process at work. We believe the existing distinction Congress has made in this section between injury and disease is a valid and workable one and should not be disturbed.

Nonetheless, we recognize that certain non-traumatic physiological events or episodes during training, such as the strain of unaccustomed exertion, may result in disability or death through heart attack or stroke. Accordingly, we recommend that section 101(24) be amended to provide that any period of inactive duty training during which an individual was disabled or died from an injury incurred or aggravated in line of duty, or from a cerebrovascular accident or an acute myocardial infarction incurred as a result of duty, will be considered active military, naval, or air service.

Finally, the bill applies only to a heart attack or stroke incurred "in performance of duty." We note that this provision may be interpreted as barring service connection pursuant to 38 U.S.C. § 106(d) where an individual suffers a heart attack or stroke while proceeding to or coming home from inactive duty training. We do not believe eligibility should be so limited.

H.R. 3816 is subject to the PAYGO requirements of the OBRA, and, if enacted, it would increase direct spending. Our preliminary cost estimate for H.R. 3816 would result in benefit costs of \$111,000 in FY 2001 and a total benefit cost of \$1.1 million for FYs 2001-2005.

H.R. 3998 – SPECIAL MONTHLY COMPENSATION FOR SERVICE-CONNECTED LOSS OF ONE OR BOTH BREASTS DUE TO MASTECTOMY

H.R. 3998 would authorize special monthly compensation under 38 U.S.C. § 1114(k) for the service-connected loss of one or both breasts due to a radical mastectomy or modified radical mastectomy. VA supports this bill.

Section 1114(k) of title 38, United States Code, authorizes a special rate of compensation (the "k" rate) if a veteran, as the result of service-connected disability, has suffered the anatomical loss or loss of use of one or more creative organs, or one foot, or one hand, or both buttocks, or blindness of one eye, having only light perception, or has suffered complete organic aphonia with constant inability to communicate by speech, or deafness of both ears, having absence of air and bone conduction. Under current section 1114(k), a monthly award of \$76 is payable, generally, for each such loss or loss of use. This special monthly compensation is payable in addition to the compensation payable by reason of ratings assigned under the rating schedule.

Under the current schedule for rating disabilities, the disability suffered following surgical removal of one breast by radical mastectomy is assigned a 50% disability rating. (38 C.F.R. § 4.116). The resulting disability following removal of both breasts by radical mastectomy is currently assigned an 80% disability rating. The loss of one breast by modified radical mastectomy is rated 40% disabling, and the removal of both breasts by modified radical mastectomy is rated 60% disabling. A veteran is also compensated for at least six months at the total-disability level following the cessation of any surgical procedure to treat breast cancer.

Special monthly compensation is currently authorized for certain anatomical losses or losses of use for which the rating schedule, which is based solely on impairment of earning capacity, is considered inadequate for compensation purposes. The statute recognizes that the loss of a hand or foot, for example, or loss of a creative organ, involves loss of bodily integrity which may negatively affect self-image and precipitate considerable emotional distress.

The service-connected radical or modified-radical mastectomies covered by 38 C.F.R. 3998 involve loss of bodily integrity and associated emotional trauma to a degree that is at least comparable to the removal of a single testicle, for example, for which special monthly compensation is currently payable regardless of its effect on a veteran's procreative ability and regardless of whether the

veteran is still of procreative age. As a matter of simple equity, these mastectomies warrant equal compensation for the veterans who suffer them.

H.R. 3998 is subject to the PAYGO requirement of the OBRA and, if enacted, would increase direct spending. However, our preliminary estimate indicates that the bill would result in only insignificant costs in any fiscal year.

H.R. 1020 – PRESUMPTIVE SERVICE CONNECTION FOR HEPATITIS C

H.R. 1020 would establish a presumption of service connection for the occurrence of hepatitis C in certain veterans. VA opposes this bill.

H.R. 1020 would add a new section 1119 to title 38, United States Code, providing a presumption of service connection for certain veterans who served during a period of war and who suffer from hepatitis C, notwithstanding that there is no record of such disease during the period of active military, naval, or air service. The presumption would apply where a veteran experienced one of the following during service: 1) transfusion of blood or blood products before December 31, 1992; (2) blood exposure on or through skin or mucous membrane; (3) hemodialysis; (4) tattoo or body piercing or acupuncture; (5) unexplained liver disease; (6) unexplained abnormal liver function tests; or (7) working in a health care occupation.

Hepatitis C virus (HCV) infection was first recognized in the 1970s, when the majority of transfusion-associated infections were found to be unrelated to hepatitis A and B, the two hepatitis viruses recognized at the time. The infection now recognized as hepatitis C was often categorized as “non-A, non-B hepatitis,” a term used for any type of hepatitis that could not be identified as viral hepatitis A or B. In 1989, the identification of the distinct virus causing HCV infection was reported. A first-generation screening test to detect antibody to HCV in blood became available in 1990, and a more accurate, second-generation, test became available in 1992; during those years, effective screening of donated blood for HCV antibody was instituted. Nearly 4 million Americans have been infected with HCV; an estimated 3 million remain chronically infected, and approximately 36,000 new infections occur annually.

Most persons who become newly infected with HCV are unaware of their infection because more than 80% will have no discernable symptoms. HCV is now known to be responsible for 8,000 to 10,000 deaths annually, and this number could triple in the next 10 to 20 years. The mortality rate of HCV may be reduced by treatment; however, this is as yet unproven. HCV infection is becoming a leading cause of cirrhosis, liver failure, and hepatocellular carcinoma.

VA is very concerned about HCV because prevalence in the veteran population cared for by VA is likely higher than in the civilian population. On March 17, 1999, VA conducted the largest single HCV surveillance study in the United States, examining the blood of 26,000 veteran patients who agreed to be tested for HCV. Based on the results of this study and others, VA estimates that 6.6 percent of veterans receiving VA-provided health care are antibody positive, which is more than one and one-half times the national rate in adult men as reported by the Centers for Disease Control and Prevention (CDC).

With regard to H.R. 1020, we note initially that the bill provides, "[f]or purposes of section 1110 of this title," a presumption of service connection for hepatitis C would be established if a veteran experienced one of the enumerated risk factors during active military, naval, or air service. As a result of the reference to 38 U.S.C. § 1110, which governs entitlement to wartime disability compensation only, we believe that the presumption would only apply to veterans who served during a period of war, which may not have been intended.

We recognize that, because there is such a prolonged period between acute HCV infection, which is typically asymptomatic or results in mild illness, and the development of symptomatic liver disease, it is difficult, in the absence of a medical history, to determine the causative factor for HCV. However, current research establishes that the highest incidence of HCV infections occurs in persons who would not be eligible for VA compensation. Pursuant to 38 U.S.C. §§ 1110 and 1131, VA is prohibited from paying compensation if a disability is a result of a veteran's abuse of drugs. See also 38 U.S.C. § 105(a). A May 1999 CDC fact sheet, "Hepatitis C Virus and Disease," reports that injecting drug use

accounts for about 60 percent of HCV cases. According to an October 16, 1998, CDC report, "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HCV-Related Chronic Disease," 47 Morbidity and Mortality Weekly Report 5 (Oct. 16, 1998) (hereinafter "CDC Report"), injection of drugs currently accounts for a substantial number of HCV transmissions and may have accounted for a substantial proportion of HCV infections in the past. After 5 years of injecting drugs, as many as 90 percent of users are infected with HCV. (CDC Report at 6.) Based upon these data, we believe that many claimants would not be entitled to compensation based on the presumption of service connection to be established by new section 1119, because their HCV was caused by drug abuse.

VA is also opposed to enactment of H.R. 1020 because the CDC report indicates there is a very low risk of infection associated with several of the risk factors included in proposed new section 1119. New section 1119(2) would provide a presumption of service connection if a veteran who has HCV was exposed to blood "on or through skin or mucous membrane." New section 1119(7) would establish a presumption based on work in a health-care occupation. HCV is transmitted primarily through large or repeated direct percutaneous, *i.e.*, through the skin, exposures to blood. (CDC Report at 1.) The prevalence of HCV infection among health-care workers, including orthopedic, general, and oral surgeons, who are at risk for being infected as a result of exposure to blood, is no greater than that among the general population. (CDC Report at 6.) In addition, the CDC reports that there are no incidence studies documenting transmission associated with mucous membrane or nonintact skin exposures, although transmission of HCV from blood splashes to the conjunctiva (membrane lining the eyelid) have been described. (CDC Report at 7.) Thus, it appears likely that HCV infection would only occur if blood permeated a veteran's skin, such as through an open wound or skin puncture. Based upon these CDC data, we believe that the risk of HCV infection for veterans based upon exposure to blood on or through skin or mucous membrane is so small as to make a presumption on this basis unnecessary.

We also believe that a presumption is not warranted based upon occurrence of three of the other risk factors identified in the new section 1119. Section 1119(4) would provide a presumption of service connection for veterans infected with HCV who have experienced tattooing, body piercing, or acupuncture. According to the CDC, there are no studies in the United States demonstrating that persons with a history of tattooing or body piercing are at increased risk for HCV infection based on these exposures alone. (CDC Report at 7.) Further, of patients with acute hepatitis C identified in CDC's surveillance system during the past 15 years and who denied a history of injection drug use or other risk factors for infection, only 1% reported a history of tattooing or ear piercing, and none reported a history of acupuncture. (CDC Report at 7.) Thus, a presumption based upon a veteran's exposure to these risk factors is not warranted.

Section 1119(5) and (6) would provide a presumption of service connection for hepatitis C based on unexplained liver disease or unexplained abnormal liver function tests. Since testing became available for HCV, we are unaware of any evidence showing that unexplained liver disease diagnosed during service or unexplained abnormal liver function tests performed during service would indicate a veteran had an HCV infection which was not diagnosed while the veteran was on active service. We believe that serology testing is routinely performed when a service member is diagnosed with unexplained liver disease or has abnormal liver function tests and that that testing would reveal at the time whether the service member is infected with HCV. As a result, a presumption of service connection for unexplained liver disease or abnormal liver function tests would not be warranted.

In sum, advances in testing over the past ten years make clear that, for patients who have abnormal liver function tests, but whose serologic tests are negative for hepatitis A and hepatitis B, there are many causes for such abnormal tests other than HCV. These non-viral causes include liver toxins (e.g., alcohol, prescription and non-prescription drugs), non-viral infections (e.g., malaria, rickettsia), environmental factors (e.g., heatstroke), and malignancies.

By our preliminary estimates, enactment of this legislation would result in PAYGO costs of \$32.5 million in the first fiscal year and \$739 million over the five-year period.

ADJUDICATION OF CLAIMS FOR SERVICE CONNECTION OF HEPATITIS C

Mr. Chairman, you also requested that we address the issue of adjudication of claims for service-connected benefits for veterans diagnosed with hepatitis C. I wish to explain VA's procedures for adjudicating claims for service connection for hepatitis C and related conditions and to discuss the information we have given to our field personnel on this issue.

Instructions to field stations for rating claims for service connection for hepatitis C and related complications

To ensure that claims for service connection for hepatitis C were being appropriately addressed, we issued an instructional letter to our field stations in November 1998 on the subject of rating claims for hepatitis C. This letter explained the various known types of hepatitis, the symptoms and complications of each type, and the serologic tests used to diagnose them. We emphasized the fact that chronic hepatitis caused by the hepatitis B and C viruses (HBV and HCV) could persist in a latent form and return years later, having progressed slowly without symptoms or physical signs. The latent nature of the disease is the particular problem associated with rating such cases. We discussed the major risk factors for hepatitis C because it is those factors that our rating personnel would need to look for upon review of service medical records in each case. We also outlined the major related rating issues concerning claims for service connection for hepatitis C, including how such claims are determined to be well grounded and how to track the incidence of such claims for statistical purposes.

With respect to establishing a well-grounded or plausible claim for service connection for hepatitis C, we reminded our rating personnel of the courts' holding that there must be competent evidence of a current medical condition, in-

service incurrence, and a link between the two. For purposes of establishing a well-grounded claim for service connection for hepatitis C or a related liver disease, the medical evidence must show a current hepatitis C infection. There must also be medical evidence of a hepatitis infection in service, or, because an infection may go undetected, lay or medical evidence of exposure to a known risk factor for hepatitis in service. The known risk factors for hepatitis B and C infections were listed as these: intravenous drug use; blood transfusions; accidental exposure in healthcare workers; hemodialysis; intranasal cocaine use; high-risk sexual activity; direct percutaneous exposure such as through tattoos, body piercing, or acupuncture with non-sterile needles; and shared toothbrushes or razor blades. Because the quality and quantity of the evidence required to meet the statutory burden of a claimant to file a well-grounded claim will, by necessity, depend upon the circumstances, we consider a claim to be plausible or well grounded for service connection for hepatitis C if there is evidence of the veteran's exposure to one of the known risk factors which could later be substantiated, such as a blood transfusion, hemodialysis, or working in a healthcare profession, together with evidence of currently diagnosed hepatitis C. Service connection cannot be established for hepatitis C due to injecting drug use or intranasal cocaine use because, by statute, disabilities resulting from drug abuse are not considered to have been incurred in line of duty.

However, simply because the evidence shows that a claim for service connection for hepatitis C or a related condition is plausible does not mean that the evidence at that stage establishes entitlement to benefits. Rating personnel were instructed in the November 1998 letter that, after they determine that a claim is plausible, they are to develop and evaluate all pertinent evidence, including evidence of treatment after service and evidence of other possible risk factors. Once all this evidence is obtained, it is to be reviewed by a physician to determine the likelihood that the veteran's currently diagnosed hepatitis C or related liver condition is attributable to the hepatitis infection in service. We developed a new C&P examination worksheet to be used for medical examiners

to more easily elicit information which would be helpful to the rating specialists in adjudicating claims for service connection for hepatitis C and related conditions.

Problems inherent in adjudicating claims for service connection for hepatitis C and related conditions

There are potential complications inherent in rating these claims caused by the possible absence in veterans' service medical records of definitive diagnoses of hepatitis infections, or, where a diagnosis was made, the absence of a designation as to which type of hepatitis was involved. In addition, medical or service records could show evidence of multiple risk factors, or none at all. In cases where the veteran claims service connection for hepatitis C or related conditions many years after service, complete development is necessary to evaluate intervening causes and other possible risk factors unrelated to service.

Our letter to field personnel in November 1998 stressed that adjudication of these claims requires a medical review of the entire record, with the examiner giving careful consideration to the known risk exposures and providing us with a medical opinion as to whether any current hepatic condition is at least as likely as not related to those known factors or any identified hepatitis infection in service. Subsequently, as a further safeguard, the rating specialist carefully reviews the record, including the opinions rendered by any medical reviewers, and determines if the evidence has been fully and fairly developed. If further evidence is required to resolve conflicting or ambiguous medical evidence, then further evidence is sought. Any rating decision must fully explain how the evidence was weighed in arriving at a determination on whether the condition is service connected.

Review of claims decisions

In 1999 we reviewed claims in which service connection for hepatitis had been an issue. As a result, we issued further instruction on rating these cases in September 1999, reiterating the need to differentiate between the types of hepatitis, with an emphasis on understanding the serologic tests which confirm a

hepatitis infection. We also emphasized the need to obtain a medical opinion on whether a relationship exists between any confirmed episodes of hepatitis in service or any identified risk factors, and any currently diagnosed hepatitis.

Important Rating Considerations

In order to establish service connection for hepatitis C infection, there must be a definitive current diagnosis of HCV infection by serologic tests. The type of hepatitis must be specified by medical diagnosis and identified in the rating decision itself. Unless there is evidence of hepatitis C in service (which could not be reliably determined until 1992), there must be a medical opinion assessing the risk factors and giving an opinion as to the most likely risk factor in the veteran. The C&P examination worksheet developed for this purpose gives explicit instructions to the examiner related to diagnosing HCV and assessing its likely etiology. With service prior to 1992, any hepatitis or jaundice that occurred in service may be uncertain as to etiology. Neither hepatitis A, B, nor C had been identified at the start of the Vietnam War. Thus, we do not see these viruses identified specifically in service medical records from that period. However, the examiner does review the service medical records for evidence of occurrence of any risk factors in service and notes any general diagnoses of hepatitis, assesses any in-service illness, and correlates these with the current laboratory and clinical findings.

In cases where a veteran has established service connection for HCV, his or her condition is evaluated using the criteria currently contained in the Schedule for Rating Disabilities. These criteria are applied to assign an evaluation for symptoms manifested during active treatment for hepatitis C as well as for any related liver conditions that result from the infection. However, only criteria for evaluating hepatitis A are currently contained in the rating schedule. Hepatitis A is the first type of viral hepatitis that was identified and is an acute disease that almost never results in chronic infection. Therefore, hepatitis C claims are rated by using an analogous code as provided in 38 C.F.R. § 4.20. This permits the assignment of an evaluation under criteria for a closely related disease or injury where the functions affected as well as the

anatomy and symptoms are closely analogous to the condition diagnosed. In the case of complications of hepatitis C, for instance, an evaluation can be assigned under the diagnostic code for cirrhosis of the liver, or malignant new growths of the digestive system, as appropriate.

The evidence concerning the number of people who can continue to work while undergoing treatment for hepatitis C is currently incomplete; there are, however, ongoing clinical trials that should provide more information about effects of treatment on activities of daily living. Meanwhile, we assess each veteran individually and do not limit the evaluation assigned to an individual veteran based only on the current rating schedule criteria for infectious hepatitis. We separately evaluate diagnosed secondary conditions, such as major depression or seizures, that develop during treatment.

Conclusion

Mr. Chairman, because of the prevalence of hepatitis C in the veteran community, we are committed to thoroughly developing claims for service connection for hepatitis C and its complications. To facilitate the fair adjudication of these claims, we have undertaken education of our rating specialists on the different types of hepatitis and the keys to properly rating these claims. We are in the process of proposing revisions to our rating schedule that would provide a separate code for hepatitis C and new, more appropriate criteria for evaluating the condition. The revisions would also ensure that the rating schedule uses current medical terminology and unambiguous criteria and that it reflects current medical advances. We believe that proceeding proactively is the best way to ensure that veterans who contracted hepatitis in service are promptly and adequately compensated.

Mr. Chairman, this concludes my statement.



530 Divisadero Street, Box 162 San Francisco, CA 94117
E-mail: HAAC_SF@hotmail.com

March 14, 2000

BY EMAIL

Ralph Ibson
Staff Director, Subcommittee on Health
House Committee on Veterans' Affairs

Susan Edgerton
House Committee on Veterans' Affairs

Dear Mr. Ibson and Ms. Edgerton,

Recently some veterans with hepatitis C (HCV) have made us aware of a growing concern regarding the rating system for disability benefits from the VA for HCV. We hope you might be able to explore this issue.

According to these vets, the current disability benefit rating scheme is extremely vague. It only takes into account those symptoms associated with HCV such as cirrhosis and jaundice, but not the effects of HCV treatment, such as anemia, nausea, vomiting, diarrhea, weight loss, inability to perform ADL's (activities of daily living), which sometimes occur with Rebetron and other interferon-based therapy. Since the current rating scheme for HCV was written before 1998, it does not account for the new advances in treatment. This is comparable to rating cancer patients for cancer and subsequent symptoms of cancer without taking into account the side effects of chemotherapy or radiation therapy. The VA provides a temporary disability rating of 100% for cancer patients undergoing chemotherapy or radiation therapy. Yet it does not provide increased ratings for HCV patients undergoing their chemotherapy (interferon) treatments.

We ask you to please explore these concerns. If our understanding of the situation is correct, it would seem that the rating scheme for veterans with HCV needs to be amended to account for treatments that render people unemployable or otherwise unable to perform normal everyday activities. An updated ratings scheme might allow these vets some latitude when claims are submitted for review and would help to eliminate much of the vagueness and subjectivity of the ratings.

If it would be helpful, some of the vets we have been in contact with are willing to speak directly with you or to publicly testify if needed. Thank you for your continuing support and assistance to those living with hepatitis C. We look forward to hearing back from you regarding this matter at your earliest convenience.

Sincerely,

Brian D. Klein, MA, LMSW
Hepatitis C Action & Advocacy Coalition (HAAC), San Francisco

James Learned
Hepatitis C Action & Advocacy Coalition (HAAC), New York

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

**Post-Hearing Questions
Concerning the April 13, 2000, Hearing**

for

**Ms. Nora Egan, Deputy Under Secretary for Management
Veterans Benefits Administration, Department of Veterans Affairs**

from

**The Honorable Lane Evans
Ranking Democratic Member, Veterans Affairs' Committee
U.S. House of Representatives****1. Please explain VBA's rationale for recognizing different risk factors for Hepatitis C than those recognized by VHA?**

The Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) recognize essentially the same risk factors for Hepatitis C, but VHA employs some additional criteria in determining whether counseling and screening are called for in a particular case. Based upon a comparison of Fast Letter (FL) 98-110 (Nov. 30, 1998) (see Exhibit 1), which was issued by VBA, and Instruction Letter (IL) 10-98-013 (June 11, 1998) (see Exhibit 2), which was issued by VHA, it appears that, with three exceptions, VBA and VHA do in fact recognize essentially the same risk factors for Hepatitis C. Those factors are: injecting drug use; blood transfusions before 1992; health-care employment; hemodialysis; intranasal cocaine use; high-risk sexual activity, and other direct percutaneous exposure such as tattoos and body piercing.

Attachment A to IL 10-98-013 refers to three factors not referenced in FL 98-110, the presence or history of which requires HCV antibody screening by VHA: (1) unexplained liver disease; (2) unexplained abnormal ALT value; and (3) intemperate alcohol use. These three factors are not identified as "risk factors" for Hepatitis C in the Centers for Disease Control (CDC) report, "Recommendations for Prevention and Control of Hepatitis C Virus (HCV) Infection and HVC-Related Chronic Disease, 47 *Morbidity & Mortality Weekly Report* 3-7 (1998). We do not believe that unexplained liver disease and unexplained abnormal ALT value would constitute risk factors for HCV infection as they are not causative agents for the infection, although they may be indicative of the infection. We understand that there is a high prevalence of HCV among alcoholic patients, but 38 U.S.C. sections 105 (a), 1110, and 1131 prohibit the payment of compensation for a disability which is a result of abuse of alcohol.

2. VA physicians, Drs. Holohan and Roselle have testified before Congress that it is "impossible" or not "valid" to identify a specific risk factor as

the cause of a Hepatitis C infection when multiple risk factors are present. What is the rationale for asking VA examiners to identify, weigh or "rule out" risk factors in determining the likelihood of an in-service risk factor as the basis for a veteran's Hepatitis C infection?

Because VA does not yet have a presumptive scheme for adjudicating claims for Hepatitis C infection, we apply the same rating and evidentiary principles in rating these claims as we do most other claims. These principles require development of all the evidence relevant to the claim. Therefore, if the evidence shows that the veteran was exposed to multiple risk factors, we are required to develop evidence related to the other risk factors. Part of the evidence gathering function requires drawing upon the expertise of VA physicians. We agree that doctors cannot pinpoint the cause of a Hepatitis C infection, and we do not ask them to rule out any risk factor as the cause of a Hepatitis C infection. If a physician cannot state that one risk factor is more likely the cause of a current Hepatitis C infection than another, then reasonable doubt is resolved in the veteran's favor.

- 3. In your written testimony you objected to the use of elevated liver function tests during military service as evidence of a "risk factor" for Hepatitis C infection during military service." Since there was no reliable test for Hepatitis C prior to 1992, does VBA object to consideration of elevated liver function tests during military service prior to 1992 as an appropriate in-service risk factor?**

Yes, VBA objects to the inclusion of elevated liver function tests in service before 1992 as a basis for presumptive service connection. Our objection is based on the fact that these test results are an indicator of HCV infection, not a risk factor for the infection, according to the CDC. Moreover, the proposed use of elevated liver function tests is too broad. Although Hepatitis C was not recognized before that time, there are many non-viral causes that account for abnormal liver function tests. Examples of conditions which could result in abnormal liver function test results are alcohol liver disease, autoimmune Hepatitis, and altered liver function due to medications. Making an assumption that abnormal liver function tests were due to HCV infection would not be justified unless other potential causes of liver disease had been considered and excluded. However, we realize that elevated liver function tests may indicate Hepatitis C infection or other liver disease and would take that into consideration in determining direct service connection.

- 4. In your written testimony, you indicated that the rating schedule for Hepatitis is based upon the signs and symptoms of Hepatitis A. Have claims adjudicators been informed that the rating schedule does not reflect the characteristics of Hepatitis C and that Hepatitis C ratings need to be done by analogy? Please provide copies of any specific**

instructions for rating Hepatitis C claims by analogy which have been provided to claims adjudicators.

The criteria for infectious Hepatitis (type A Hepatitis) in our Rating Schedule are also generally appropriate for rating Hepatitis C infections because fatigue and liver damage, for example, two of the diagnostic criteria for Hepatitis C infections, are common in liver disease of many types. We instructed our rating personnel that all types of Hepatitis could be rated under the criteria for infectious Hepatitis. It is when the chronic effects of Hepatitis C cause other complications, that we use the criteria for evaluating other diseases to evaluate the new Hepatitis C complications. Cirrhosis is one such common complication of chronic Hepatitis C infections and it has its own rating criteria. So does liver cancer, another common complication of chronic Hepatitis C infections. In several training letters to our field stations, which are attached to this response, we discussed the fact that ratings need to accurately reflect the actual disease entity resulting from chronic Hepatitis C infection, such as cirrhosis or liver cancer. Generally, our case review has not shown that the evaluation of Hepatitis C infections or complications has been a problem.

5. Please describe any actions VBA plans to take to improve the accuracy of adjudication of claims for service connection due to Hepatitis C.

We realize that this is an area in which medical knowledge will continue to evolve, and we are committed to evolving our adjudication procedures with it. HCV infection is a matter of particular import for VA and we take our responsibility to properly evaluate these claims seriously. As part of our continuing efforts to ensure the consistency and quality of our rating decisions, we are revising our rating schedule so that we can better evaluate Hepatitis C conditions under more objective criteria. This regulatory revision is pending at the Office of Management and Budget. In addition, we have drafted a proposed regulation for presumptive service connection of Hepatitis C which is in the internal VA concurrence process. Also, we are using our quality assurance program, "STAR," to monitor the accuracy of rating decisions. Because our last case review of Hepatitis C claims was conducted prior to the *Morton v. West* decision and prior to our current policy on well-grounded claims, we will conduct another case review of Hepatitis C claims beginning in August 2000. In addition, we will also continue to emphasize the proper adjudication of Hepatitis C claims in future conference calls with our field stations and emphasize current policy on rating Hepatitis C claims to field stations. Finally, we conducted a general case review of claims that were denied as not well grounded in May 2000. The results of this review are currently being analyzed, and any general or specific findings related to Hepatitis C claims will be recorded and used to better focus our case review of Hepatitis C claims in August 2000. (**NOTE:** See Exhibit 3, a copy of a letter to the Honorable Lane Evans dated June 14, 2000 which provides additional information as requested at the hearing of April 13, 2000.)

6. During your oral testimony you made several recommendations for changes in the wording of H.R. 3816. How should the bill read to reflect your concerns?

H.R. 3816 would amend section 101(24) of title 38, United States Code, by adding at the end the following new sentence: "For purposes of this paragraph, a cardiovascular accident or an acute myocardial infarction incurred in performance of duty during a period of inactive duty training shall be considered to be an injury incurred or aggravated in line of duty." We note that the bill uses the term "cardiovascular accident," apparently referring to stroke. However, we believe the intended medical term is "cerebrovascular accident," and we recommend that the language of the bill be revised to substitute that term.

In general, the performance of inactive duty training does not qualify an individual as a "veteran" for VA purposes. Under 38 U.S.C. § 101(2), veteran status is conditioned on performance of "active military, naval, or air service." Currently, section 101(24) defines the term "active military, naval, or air service" to include active duty, any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty, and any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty. Thus, unless an individual suffers disability or death as the result of an injury incurred or aggravated during inactive duty training, the individual is not considered a veteran on the basis of participation in such training.

Because we recognize that certain non-traumatic physiological events or episodes during training, such as the strain of unaccustomed exertion, may result in disability or death through heart attack or stroke, we recommend that section 101(24) be amended to state that it includes "any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty, *or from an acute myocardial infarction or cerebrovascular accident occurring during such training.*"

Also, H.R. 3816 applies only to a heart attack or stroke incurred "in performance of duty." We note that this provision may be interpreted as barring service connection pursuant to 38 U.S.C. 106(d) where an individual suffers a heart attack or stroke while proceeding to or coming home from inactive duty training. We do not believe eligibility should be so limited and accordingly recommend that section 106(d) be amended by inserting ", acute myocardial infarction, or cerebrovascular accident" after "injury" each place it appears.

7. What is the VA's latest estimate for its HCV costs? The President's FY 2001 budget requests \$399.8 million (an increase of \$144.7 million over FY 2000 appropriation) for VA's initiatives?

The original estimates for Hepatitis C were based on a model developed in VA that included cost and workload assumptions on screenings, tests and treatments. With the availability of hard data (actual costs), a transition will be made from modeled baseline costs to actual baseline costs. At this time, some actual information is available for FY 2000, although somewhat limited. Using available information we have estimated costs for screenings, tests for patients including those who test negative, clinic and counseling staff for patients testing positive and education costs not available in actual cost reporting. Projecting actual and estimated costs for the full year results in a current Hepatitis C estimate of just under \$100 million for FY 2000. However, VA continues to analyze its data to ensure that it is capturing all Hepatitis C costs. As we refine the process and methodology, this projection may be revised upward. In addition, VA will spend approximately \$1.8 million to support the two Centers of Excellence for Hepatitis C and national training efforts in FY 2000. We are taking steps to capture more complete information on treatment of patients who are HCV positive and to improve our cost accounting for these patients. An automated Hepatitis C registry with a clinical reminder patch is currently being tested and is expected to be fully operational later this summer. This updated system will permit VA to better track its Hepatitis C efforts and their associated costs. Also, we are reviewing our program and its funding to ensure that our facilities and providers have the proper incentives to aggressively pursue the goals of this program.

8. How does VA plan to use these funds (i.e., what percentage will go to treatment, including medication; how much to diagnosis and screenings; how much to education)?

Based on second quarter actual (FY 2000) and attributed costs, 17% of total costs were for screening, 14% for testing, 5% for counseling, and 64% for treatment and pharmacy.

9. Does VA believe that it is best to provide presumption of service connection by regulation as opposed to by statute? Why?

VA believes that it can effectively establish by regulation the presumptions applicable to claims for service connection for Hepatitis C infection, and, in fact, it has already drafted a proposed regulation to do so. We are very familiar with the subtleties of the fact patterns presented by claimants with Hepatitis C infections, are aware of the nuances of the claims process which would be altered by new presumptions, and can craft a regulation more precisely to effectively and efficiently adjudicate these claims. There are no pay-go implications if we proceed by regulation.

However, if Congress decides it would rather proceed by statute to establish certain presumptions for Hepatitis C claims, VA stands ready to provide any technical assistance you may need in finalizing legislation that VBA can effectively administer.

Exhibit 1
VBA FL 98-110

November 30, 1998

Director (00/21)
All VBA Offices and Centers

211B (98-110)

SUBJ: Infectious Hepatitis

The purpose of this letter is to provide further information about viral hepatitis with specific emphasis on hepatitis C. In addition to general background information, the letter discusses VA exams for liver disorders, and rating decisions involving viral hepatitis and its complications. (Also see: All Station Letter 98-35 "Hepatitis C," dated April 8, 1998.)

1. General

The liver is a complex organ composed of thousands of individual microscopic functional units that perform vital metabolic, excretory and defense tasks. The liver helps purify the blood by filtering harmful chemicals and breaking them down into substances that can be excreted from the body in urine or stool. The liver produces proteins that are essential for health, including albumin, which is the building block protein of the body, and other proteins that help blood clot properly. The liver stores sugars, fats and vitamins needed by the body, and functions to metabolize or change other substances into compounds the body requires. Primary among these is control of cholesterol metabolism.

Any inflammation of the liver inhibits its vital functions and can result in liver damage. One specific inflammation of the liver is hepatitis. Hepatitis is usually caused by a viral infection, but can also be caused by toxic agents such as alcohol, carbon tetrachloride or other chemicals, and by drugs such as acetaminophen, INH, Thorazine, Aldomet and Ilosone. The most common hepatitis viruses in the United States are viruses for hepatitis A, B, and C. The alphabetical list of hepatitis viruses continues to grow, and includes viruses D, E, F, and G. In addition, other less common viruses such as infectious mononucleosis, cytomegalovirus, and yellow fever can cause hepatitis, but these do not primarily attack the liver.

For rating purposes, it is important to distinguish between acute hepatitis and chronic hepatitis.

2. Acute Hepatitis

Many people infected with the hepatitis virus, primarily those with hepatitis C, have few symptoms or no symptoms at all. Others may be so ill as to require hospitalization. In the early or acute stages, hepatitis mimics a variety of flu-like illnesses and may be difficult to diagnose. Initial laboratory tests to confirm a suspected diagnosis of hepatitis infection

include blood tests that indicate the presence of liver inflammation and show abnormalities of liver function. However, diagnosis of a specific hepatitis A, B, or C infection requires serologic studies (blood tests).

Acute hepatitis usually resolves in 4-6 weeks, often without specific treatment. Individuals with acute hepatitis A infection will not develop chronic hepatitis. However, some individuals with acute hepatitis B and C infections will go on to develop chronic hepatitis. A chronic infection can last for many years and will often result in liver damage. Individuals with chronic hepatitis infection are at increased risk of developing liver cirrhosis and/or liver cancer.

3. Specific types of viral hepatitis

Hepatitis A Infection

Hepatitis A infection, formerly known as "infectious hepatitis," is caused by the hepatitis A virus (HAV) and is spread by oral or fecal contamination of food or water, usually because of poor sanitation.

The incubation period between exposure to the virus and onset of the illness ranges from 45 to 180 days.

Hepatitis A is a self-limited, acute disease. It heals without residual disability and does not result in chronic hepatitis infection or liver damage. The acute infection produces lifelong immunity to re-infection.

Hepatitis B Infection

Hepatitis B infection, caused by the hepatitis B virus (HBV), was once referred to as "serum hepatitis" because it was thought that the only way it could be spread was through blood or serum contamination. Now it is known that it can also be spread through close personal contact with a person who is infected. Persons most at risk for HBV infection are intravenous drug users, hemophiliacs, hemodialysis patients, healthcare and dental care workers, blood product workers, babies born to infected mothers, people who received blood products or transfusions before 1975, and people who engage in high-risk sexual practices. HBV infection can also be spread by tattooing, body piercing, or sharing razors and toothbrushes.

The incubation period ranges from 45 to 180 days. A vaccine is available to prevent HBV infection for people known to be in high risk groups. In addition, Hepatitis B Immune Globulin is available to administer to individuals exposed to HBV.

Chronic HBV infection develops in 2% to 10% of cases. Individuals with chronic hepatitis B can infect other individuals. Chronic HBV infection can result in liver damage, including cirrhosis and primary hepatocellular carcinoma.

Hepatitis C Infection

Hepatitis C infection, caused by the hepatitis C virus (HCV), was formerly referred to as "non-A, non-B hepatitis" because the specific virus causing the infection had not been identified, although it was known to be neither type A nor type B.

Major risk factors for HCV infection include receipt of blood or blood products before 1992; intravenous drug use; occupational exposure to contaminated blood or fluids via employment in patient care or clinical laboratory work; high risk sexual practices; intranasal cocaine; hemodialysis; organ transplants; body piercing or tattooing. Although a potential risk factor can be identified for approximately 90% of persons with HCV infection, in some patients no recognized source of infection can be identified.

Blood donor screening for HCV was not possible until 1989, when the specific virus was identified. In 1992, a reliable second generation test for the C virus became available and more effective screening of blood became possible. Up to 90% of transfusion-associated hepatitis is related to HCV.

HCV infection is the most common chronic bloodborne infection in the United States and is now recognized as a major public health threat. During the 1980's, it is estimated that an average of 230,000 new infections occurred each year. With improved blood donor screening, the annual number of new infections declined to 36,000 in 1996. However, nearly 4 million Americans are believed to be currently infected. Approximately 85% of people with acute HCV infection will develop chronic HCV. Most will experience no symptoms, or only minor symptoms of illness, such as mild, intermittent fatigue. The diagnosis of HCV is often an incidental finding on blood tests done for some other reason, sometimes years after the acute infection.

Active liver disease develops in a high number of chronically infected HCV patients. The progression of chronic liver disease is usually slow, without symptoms or physical signs for the first two or more decades after infection. Up to 20% of all chronic HCV patients develop chronic, progressive liver damage leading to cirrhosis within 20 years. From 1% to 5% of chronic patients develop hepatocellular carcinoma within 20 years. Chronic HCV patients who use alcohol regularly, even in small amounts, are known to develop cirrhosis and liver cancer more rapidly. HCV infection is now the leading reason for liver transplantation in the United States.

The incubation period for infection following exposure to the virus ranges from 2 to 26 weeks. However, remember that:

- (1) the onset of infection may be unrecognized since symptoms may not be severe enough to require medical attention; and
- (2) chronic liver damage will not manifest for many years.

There is no vaccine to prevent HCV infection. Treatment of chronic HCV at present is with interferons. There are low rates of sustained response with treatment. Recently, the

Food and Drug Administration (FDA) approved combination therapy with interferon and ribavirin, although the effectiveness of this combination therapy is still unknown.

4. Diagnostic Tests for the Specific Virus Causing Hepatitis (i.e., HAV, HBV, HCV)

Serologic tests determine the presence of antigens and antibodies to the specific virus. The presence of antibodies to the specific virus (anti-HAV, anti-HBV or anti HVC) indicates the infection is present.

For VA compensation purposes, the diagnosis of HCV infection requires two specific tests. The initial test is the enzyme immunoassay (EIA). If the EIA is positive, the recombinant immunoblot assay (RIBA-2) is used as a supplemental test to confirm the presence of the virus. (Another test directly measures the viral gene, HCV RNA, but this test is not required for compensation purposes.)

Other tests you should be aware of for compensation purposes include:

- HBsAg is a hepatitis B surface antigen. If positive, it is a marker for acute or chronic hepatitis B infection.
- Anti-HBc indicates antibodies to the hepatitis B virus core antigen. If positive, it is a marker for hepatitis B infection.
- Ferritin is the iron storage protein. It is increased in hemochromatosis.
- Apha-fetoprotein (AFP) is a tumor marker used in screening for hepatocellular carcinoma.

Note: See Attachment 2, the Under Secretary for Health's information letter on testing and evaluation for hepatitis C.

5. Liver Function Tests

1. Indicators of overall liver function
 - Serum albumin (measures the serum protein produced by the liver; may be decreased in liver disease)
 - Prothombin time (assesses blood clotting; may be prolonged in liver disease)
2. Markers of liver disease or inflammation (liver enzyme tests)
 - ALT (or alanine transaminase, formerly SGPT; may be elevated in inflammation)
 - AST (or aspartate transaminase, formerly SGOT; may be elevated in inflammation)
 - Alkaline phosphatase (may be elevated in liver disease or indicate bile disorders)
 - Serum bilirubin (may be elevated in liver or biliary tract disease)

6. Rating Issues Involving Hepatitis

A. Rating Schedule Provisions

How do we address hepatitis in claims for service connection? The Rating Schedule contains criteria that allow us to evaluate liver disorders. (See Diagnostic codes 7311 and 7301 for liver injuries, 7312 for cirrhosis, 7345 for hepatitis, and 7343 for carcinoma.)

To allow accurate tracking of hepatitis-related complications, the rating must show a hyphenated diagnostic code with the hepatitis code placed first to indicate that cirrhosis, carcinoma, etc. is related to hepatitis. For example, cirrhosis due to hepatitis C would be shown as 7345-7312.

A change to Part 4 of the regulations is currently under development that will update evaluation criteria for disabilities of the liver and specifically address hepatitis C and its sequelae.

B. Well-Founded Claims.

For hepatitis, as for any claimed condition, the issue of well-foundedness must be addressed before a claim is developed and referred for rating. The Court of Veterans' Appeals has held that a well-founded claim is a plausible claim, one which is meritorious on its own or capable of substantiation. This does not mean that the claim itself is conclusive, but only that it is possible.

According to the Court of Veterans Appeals, in order for a claim to be well-founded, there must be:

- Competent medical evidence of current disability;
- Medical or, in certain circumstances, lay evidence that the disease or injury was incurred or aggravated in service; and
- Medical evidence of a nexus or link between the in-service injury or disease and the current disability.

In order for a claim for service connection for hepatitis C infection to be well-founded, there must first be evidence of a current diagnosis of hepatitis C infection.

In order to fulfill the requirement that there must be lay or medical evidence that a disease or injury was incurred or aggravated in service, there must be evidence of an acute hepatitis infection in service, or evidence that the veteran was exposed to a known risk factor for hepatitis in service.

We know that the risk factors for hepatitis B and C are similar:

- Intravenous drug use
- Blood transfusions
 - before 1975 for HBV
 - before 1992 for HCV
- Accidental exposure in healthcare workers

- Hemodialysis
- Intranasal cocaine
- High-risk sexual activity
- Other direct percutaneous exposure such as tattoos, body piercing, acupuncture with non-sterile needles, shared toothbrushes or razor blades

There are certain risk factors that are plausible as a cause of hepatitis B or C. These include blood transfusions, hemodialysis, and employment in a health care occupation. A claim that hepatitis B or C infection resulted from one of these in service would be plausible nexus information for the purpose of well-groundedness.

Situation: Service connection is claimed for cause of death due to cirrhosis and liver cancer. The veteran never filed a claim during his lifetime, and cirrhosis was diagnosed 20 years after service. The veteran also had a diagnosis of hepatitis C and a long history of problems with alcohol. During service, the veteran was a medical corpsman.

Is this sufficient to make the claim well-grounded? Yes.

The fact that the veteran was a health care worker during service establishes that the veteran was exposed to a risk factor during service that could be the cause of HCV infection and subsequent complications. The diagnosis of HCV was submitted with the claim. This is sufficient to make the claim plausible.

Although the claim is well-grounded, the rating activity will need to develop and evaluate all pertinent evidence, including evidence of treatment after service and presence of other possible risk factors. Once all evidence is developed, a medical determination will be required as to the most likely cause of the veteran's cirrhosis and liver cancer.

A claim for service connection for hepatitis due to IV drug use or nasal cocaine cannot be service-connected by law. (See 38 United States Code §§ 105, 1110). Such a claim should be denied under Code 8 on the basis of no statutory entitlement.

C. Medical Examinations

A new AMIE worksheet has been prepared for Liver, Gall Bladder and Pancreas examinations. The new worksheet is more detailed and comprehensive and will help examiners provide more specific information to help rating specialists evaluate claims involving hepatitis and its sequelae. (See Attachment 1)

It is important that rating personnel become familiar with the new worksheet so that they can ensure all necessary tests have been accomplished, all risk factors have been considered, and necessary medical opinions have been provided.

D. Risk Factors and Medical Opinions

A common rating problem will be that service records show hepatitis infection but do not define the type of hepatitis present. If a veteran claims service connection for hepatitis B or C infection or one of the known complications many years after service, complete development will be needed to evaluate intervening causes, and explore other possible risk factors. Situations where multiple risk factors exist will present particularly difficult problems.

The question as to the most likely cause of a particular disease or complication is a medical determination. Claims for hepatitis B or C will frequently require the opinion of a medical professional as to the most likely cause of hepatitis B or C.

Following are some typical situations you may encounter and the questions that must be answered for each situation to reach a decision. **All of these situations require an opinion by a medical professional to answer the question posed.** For all of these medical questions, the examiner will need to review the claims file and elicit a complete history from the veteran in order to furnish an opinion. The rating activity has a responsibility to develop all available evidence prior to the exam.

Situation: A veteran had a transfusion in service in 1969, and another transfusion after service in 1979. He now claims service connection for hepatitis C infection.

Question: Which risk factor is the most likely cause of the current hepatitis C?

(Note: If the physician cannot determine if one risk factor is more likely than another to be the cause, the exam report should so state, and should explain. See the revised AMIE worksheet.)

Situation: A veteran had a transfusion in service in 1975. In 1971, prior to service, he was an IV drug user for 6 weeks. He now claims service connection for hepatitis B.

Question: What is the most likely cause of the currently diagnosed hepatitis?

Situation: A veteran had a transfusion in service in 1975 and has been using IV drugs for the past 5 years. He claims service connection for hepatitis C, stating that it is due to the in-service transfusion.

Question: What is the most likely cause of the currently diagnosed hepatitis C?

Situation: A veteran had acute viral hepatitis in service, but the type of hepatitis is not known. He now claims service connection for hepatitis C.

Question: Is the in-service acute viral hepatitis the forerunner of the currently diagnosed chronic hepatitis?

Situation: A veteran claims service connection for cirrhosis and is an alcoholic.

Question: What is the most likely cause of the veteran's current disability?

(Note: Cirrhosis is a possible outcome of chronic hepatitis infection, but can, of course, have other causes. Assuming this claim is well grounded, a medical opinion would be required to resolve the etiology of the cirrhosis)

E. Miscellaneous Rating Problems

Situation: Hepatitis C is claimed and diagnosed, but no risk factors are present.

In a situation like this, your action depends upon several factors. When was the hepatitis C diagnosed? If diagnosed in service, you have a possibility for service connection. If diagnosed after service, you would need to determine if you have a well-grounded claim before you proceed.

Situation: The veteran was diagnosed after service with non-A non-B hepatitis.

Again, your action depends upon several factors. What is the current diagnosis? Is there evidence showing in-service exposure to risk factors? Is the claim well-grounded?

Situation: Hepatitis C is claimed and was shown as an acute infection in service. The veteran currently has no liver damage, and the only evidence of hepatitis C is the presence of anti-HCV on blood test.

If it is determined that service connection is in order, the rating schedule provides a zero-percent evaluation under DC 7345 for healed, nonsymptomatic infectious hepatitis. The diagnosis of HCV confirmed by anti-HCV on blood serum warrants service connection under this code, unless prohibited as due to drug abuse.

F. Making a Decision

Once you have a well-grounded claim, complete development, a good medical examination and a medical opinion, it is up to you as a rating specialist to make a sound decision. To do this, you must carefully weigh all of the evidence presented. You are not free to disregard evidence; your duty is to assess and evaluate the evidence. You must remember that your personal opinion is not evidence. However, if, in your opinion, the evidence is inadequate, you are not only free to obtain more evidence, you are obligated to do so.

If you have conflicting evidence, or conflicting medical opinions, you may need to request clarification of a statement previously furnished or an opinion already rendered. You must decide if the preponderance of evidence is in favor of the claim, against the claim, or evenly balanced. Remember that under the law, if the evidence is evenly balanced, a favorable decision is required. As in any decision, you must fully discuss all evidence considered and furnish complete reasons and bases for your decision.

7. A copy of Under Secretary for Health's Information Letter, IL 10-98-012 (*should be 013*), "Hepatitis C: Standards for Provider Evaluation and Testing," dated June 11, 1998, is enclosed as Attachment 2 for additional information.

8. If you have questions about the contents of this letter, please contact the Policy and Regulations Staff at (202) 273-7210.

/s/

Robert J. Epley, Director
Compensation and Pension Service

Enclosure

Attachment 1

Compensation and Pension Examination

LIVER, GALL BLADDER, AND PANCREAS

Name:

SSN:

Date of Exam:

C-number:

Place of Exam:

A. Review of Medical Records: This may be of particular importance when hepatitis C or chronic liver disease is claimed as related to service.

B. Medical History (Subjective Complaints):

Comment on:

1. Vomiting, hematemesis, or melena.
2. Current treatment - type (medication, diet, enzymes, etc.), duration, response, side effects.
3. Episodes of colic or other abdominal pain, distention, nausea, vomiting duration, frequency, severity, treatment, and response to treatment.
4. Fatigue, weakness, depression, or anxiety.
5. When chronic liver disease is claimed, record history of any risk factors for liver disease, including transfusions, hepatitis (and what type), intravenous drug use, occupational blood exposure, high-risk sexual activity, etc. When did they take place? Describe current symptoms of liver disease and onset of symptoms.
6. Provide history of alcohol use/abuse, both current and past.

C. Physical Examination (Objective Findings):

Address each of the following as appropriate, and fully describe current findings:

1. Ascites.
2. Weight gain or loss, steatorrhea, malabsorption, malnutrition.
3. Hematemesis or melena (describe any episodes).
4. Pain or tenderness - location, type, precipitating factors.
5. Liver size, superficial abdominal veins.
6. Muscle strength and wasting.
7. Any other signs of liver disease, e.g., palmar erythema, spider angiomas, etc.

D. Diagnostic and Clinical Tests:

1. For esophageal varices, X-ray, endoscopy, etc.
2. For adhesions, X-ray to show partial obstruction, delayed motility.
3. For gall bladder disease, X-ray or other objective confirmation.

Page 2

Compensation and Pension Examination

4. For liver disease: liver function tests (albumin, prothrombin time, bilirubin, AST, ALT, WBC, platelets); serologic tests for hepatitis (HBsAg, anti-HCV, anti-HBc, ferritin, alpha-fetoprotein); and liver imaging (ultrasound or abdominal CT scan), as appropriate. If hepatitis C is the diagnosis, a positive EIA (enzyme immunoassay) test for hepatitis C should be confirmed by a RIBA (recombinant immunoblot assay) test.
 - a. With a diagnosis of hepatitis, name the specific type (A, B, C, or other), and for hepatitis B and C, provide an opinion as to which risk factor is the most likely cause. Support the opinion by discussing all risk factors in the individual and the rationale for your opinion. If you can not determine which risk factor is the likely cause, state that there is no risk factor that is more likely than another to be the cause, and explain.
 - b. With a diagnosis of cirrhosis, chronic hepatitis, liver malignancy, or other chronic liver disease, state the most likely etiology. Address the relationship of the disease to active service, including any hepatitis that occurred in service. If you cannot determine the most likely etiology, cannot determine whether it is more likely than not that one of multiple risk factors is the cause, or cannot determine whether it is at least as likely as not that the liver disease is related to service, so state and explain.
5. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

Signature:

Date:

Exhibit 2
VHA IL 10-98-013

June 11, 1998

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

HEPATITIS C: STANDARDS FOR PROVIDER EVALUATION AND TESTING

1. **Background:** Hepatitis C virus (HCV) infection was first recognized in the 1970's, when the majority of transfusion-associated infections were found to be unrelated to hepatitis A and B, the two hepatitis viruses recognized at the time. This transmissible disease was then simply called "non-A, non-B" hepatitis. Sequencing of the HCV genome was accomplished in 1989, and the term hepatitis C was subsequently applied to infection with this single strand ribonucleic acid (RNA) virus. The genome of HCV is highly heterogeneous and, thus, the virus has the capacity to escape the immune surveillance of the host; this circumstance leads to a high rate of chronic infection and lack of immunity to reinfection. Reliable and accurate (second generation) tests to detect antibody to HCV were not available until 1992, at which time an effective screening of donated blood for HCV antibody was initiated.
2. HCV infection is now recognized as a serious national problem. Nearly 4 million Americans are believed to be infected, and approximately 30,000 new infections occur annually. Only about 25 to 30 percent of these infections will be diagnosed. HCV is now known to be responsible for 8,000 to 10,000 deaths annually, and this number is expected to triple in the next 10 to 20 years.
3. Hepatitis C has particular import for the Department of Veterans Affairs (VA) because of its prevalence in VA's service population. For example, a 6-week inpatient survey at the VA Medical Center, Washington, DC, revealed a prevalence of 20 percent antibody positivity. A similar investigation at the VA Medical Center San Francisco, CA, found 10 percent of inpatients to be antibody positive. Veterans Health Administration (VHA) Transplant Program data reveal that 52 percent of all VA liver transplant patients have hepatitis C. An electronic survey of 125 VA medical centers conducted by the Infectious Disease Program Office from February through December of 1997, identified 14,958 VA patients who tested positive for hepatitis C antibody. Clearly, HCV infection is becoming a leading cause of cirrhosis, liver failure, and hepatocellular carcinoma. The incidence and prevalence rates are higher among nonwhite racial and ethnic groups.
4. HCV is transmitted primarily by the parenteral route. Sources of infection include transfusion of blood or blood products prior to 1992, injection drug use, nasal cocaine, needlestick accidents, and, possibly, tattooing. Sexual transmission is possible, and while the risk is low in a mutually monogamous relationship, persons having multiple sexual partners are at higher risk of infection.

5. After infection, 90 percent of HCV infected patients will develop viral antibodies within 3 months. The disease becomes chronic in 85 percent of those infected, although one-third will have normal aminotransferase levels. The rate of progression is variable, and chronic HCV infection leads to cirrhosis in at least 20 percent of infected persons within 20 years; 1 to 5 percent of those infected will develop hepatocellular carcinoma.

6. At present, treatment for HCV infection is limited, consisting primarily of administration of interferon alpha, with or without the addition of ribavirin. The treatment benefits some patients and appears to alter the natural progression of the disease, although evidence is lacking that it will translate into improvements in quality of life or reduction in the risk of hepatic failure. Current regimens include the use of 6 or 12-month courses of interferon alpha, with or without ribavirin. The recent National Institutes of Health Consensus Statement on Hepatitis C concluded that liver biopsy should be performed prior to initiating treatment. If little liver damage is apparent, therapy need not be initiated; treatment is probably appropriate for those with significant histologic abnormalities. However, data presented at this Consensus Conference indicated that significant uncertainty remains regarding indications for treatment. Treatment options and a listing of VA protocols will be the subject of a separate Information Letter.

7. A number of serologic tests are available for diagnosis and evaluation of HCV infection. Enzyme immunoassays (EIA) are "first line" tests, and are relatively inexpensive. They contain HCV antigens and detect the presence of antibodies to those antigens. Recombinant immunoblot assays (RIBA) contain antigens in an immunoblot format, and are used as supplemental or confirmatory tests. Viral RNA can be detected by reverse-transcription polymerase chain reaction (PCR) testing. Quantitative HCV RNA testing uses target amplification PCR or signal amplification (branched deoxyribonucleic acid (DNA)) techniques.

8. The EIA tests have sensitivities in the range of 92 to 95 percent. Specificities depend on the risk stratification pre-testing. That is, in blood donors with no risk factors, 25 to 60 percent of positive EIA are also positive by PCR for viral RNA. About 75 percent of low risk donors with positive EIA and RIBA will be positive by PCR. Positive EIA tests should be confirmed by RIBA. If that is also positive the patient has, or has had, HCV infection. In high-risk patients who are EIA positive, particularly if there is evidence of liver disease, supplemental testing with RIBA or HCV RNA analysis is probably unnecessary. Quantitative RNA tests may be useful in the selection and monitoring of patients undergoing treatment.

9. All patients will be evaluated with respect to risk factors for hepatitis C, and this assessment documented in the patient's chart. Based upon those risk factors, antibody testing should be utilized as elaborated on in the algorithm found in Attachment A.

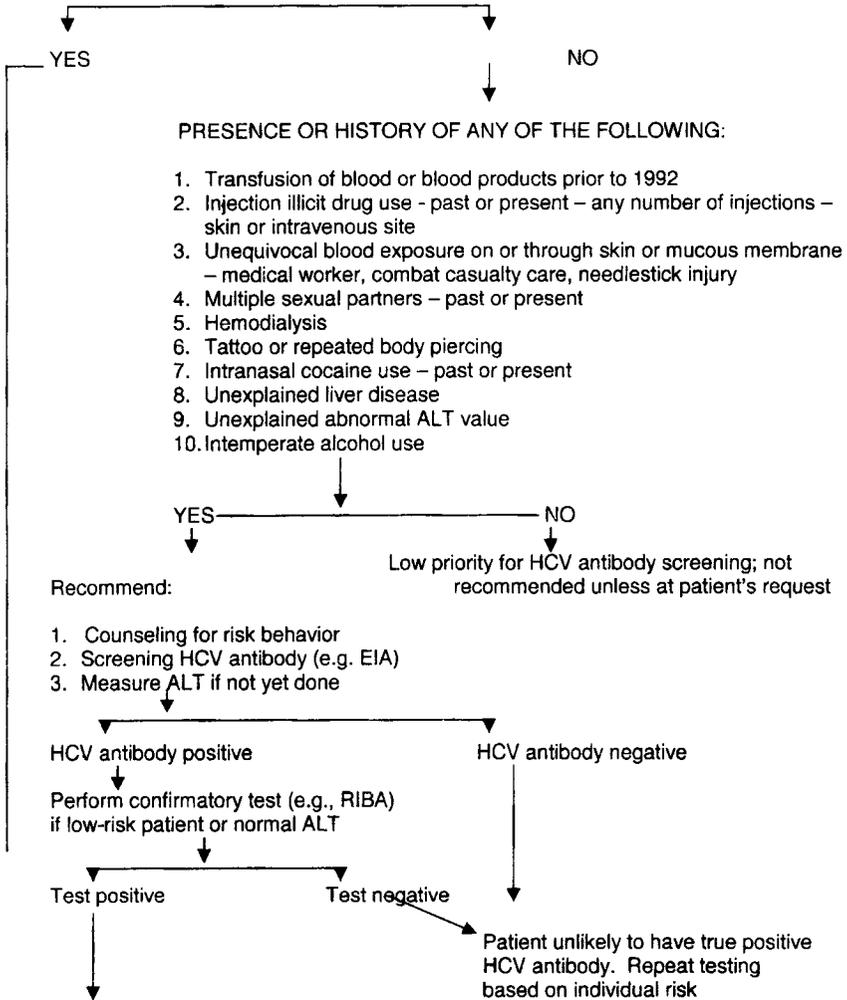
S/Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 6/11/98
FLD: VISN, MA, DO, OC, OCRO, and 200 – FAX 6/11/98
EX: Boxes 104,88,63,60,54,52,47,and 44 – FAX 6/11/98

ATTACHMENT A

**HEPATITIS C VIRUS ANTIBODY SCREENING
FOR THE VETERAN POPULATION
HISTORY OF POSITIVE TEST FOR
HEPATITIS C VIRUS ANTIBODY**



- Individual patient care decisions regarding counseling, further testing and potential treatment options are necessary. These should be based upon current literature or performed within approved research protocols

Exhibit 3
Letter to the Honorable Lane Evans



DEPARTMENT OF VETERANS AFFAIRS
Veterans Benefits Administration
Washington DC 20420

June 14, 2000
Honorable Lane Evans
U.S. House of Representatives
Committee on Veterans Affairs
Washington, DC 20515

In Reply Refer To: 211A

Dear Congressman Evans:

As discussed at the April 13, 2000 hearing concerning VA's processing of claims related to hepatitis C infections, enclosed is additional information in response to the specific questions raised in your letter of January 28, 2000.

As a preliminary matter, we know that there are several issues which cause confusion in rating claims involving hepatitis C. The virus, itself, was not identified until 1992 and often there is no evidence of the infection in military records. In addition, the *Morton v. West* decision on well grounded claims has created confusion between what evidence is required to well ground a hepatitis C claim versus deciding it on its merits. We are aware of these issues and are taking steps to issue clearer instructions to clarify the evidence needed to well ground hepatitis C claims.

We issued training letters to our regional offices on April 8, 1998, and November 30, 1998. These letters explained the types of viral hepatitis infections, risk factors associated with them, and rating criteria. They also provided specific information applying the well grounded claim criteria to claims for service connection for hepatitis C. We then reviewed a sample of hepatitis C claims to see if the instructions were being followed. We found that there was confusion as to the difference between the three forms of hepatitis, possible risk factors, and confirmation of a diagnosis. After this review, we issued another training letter on September 28, 1999 emphasizing the need to understand the different types of hepatitis in order to properly rate a claim. Most recently, in a conference call with our field stations on April 6, 2000, we again discussed the criteria for a well grounded claim for service connection for hepatitis C and risk factors for which no additional nexus evidence is needed. Finally, we released an additional training letter in May 2000 which gives our rating specialists additional guidelines for evaluating hepatitis along with information on current treatments and their side effects. Copies of these training letters and the text of the transcript of the conference call pertaining to hepatitis C claims are attached. Because our last case review was conducted prior to the *Morton v. West* decision and prior to our current policy on well-grounded claims, we will conduct another case review of hepatitis C claims beginning in August 2000. We will also continue to emphasize the proper adjudication of hepatitis C claims in future conference calls with our field stations.

Congressman Evans

Page 2

As you may know, we have also revised our rating schedule so that we can better evaluate hepatitis C conditions, and, in addition, have drafted a regulation to allow for certain presumptions of law for service connection of hepatitis C claims because of the difficulty of establishing certain facts in these cases. Finally, in May 2000 we will be conducting a general case review of claims that were denied as not well grounded. Any general or specific findings to hepatitis C claims will be recorded and used to better focus our case review of hepatitis C claims in June 2000.

I. Hepatitis C Cases

There is confusion concerning the application of the “well-grounded claim” criteria to cases involving hepatitis C.

- *Claims have been denied as not well grounded with veterans being advised that in order to well ground a hepatitis C compensation claim, the veteran must demonstrate that hepatitis “was first diagnosed in service.” Information concerning current Compensation and Pension (C&P) policy which allows for a claim to be well grounded if the veteran was exposed to certain risk factors for hepatitis (such as exposure to blood or a blood transfusion during military service) are not mentioned in the decisions.*

A decision that a claim for service connection for hepatitis C is not well grounded solely because hepatitis was not diagnosed in service is in error because it fails to address the issue of whether other evidence indicates exposure to a possible risk factor in service. We will address this issue in our case reviews to see how extensive this problem may be and will also use future conference calls on rating hepatitis C claims to give further instructions.

- *Claims of veterans who engaged in combat with the enemy are judged as not well grounded due to lack of military medical records showing that the hepatitis was due to a combat injury without regard to the requirements of 38 C.F.R. §3.304 concerning acceptance of lay testimony. This is compounded by the almost insurmountable difficulty encountered by veterans in obtaining medical records, such as transfusions during surgery in a field hospital after being wounded in combat.*

The statement of any veteran is enough to establish the occurrence of an event for purposes of well grounding a claim; the statement does not need to be verified by military records. 38 C.F.R. §3.304(d) requires us to accept a combat veteran’s statement as evidence of a risk factor in service. The veteran’s statement does not, however, serve as

Congressman Evans

Page 3

medical evidence of a link between the event and the current hepatitis C infection. We will reinforce this point during future conference calls with our field stations and in future directives.

- *Although the evidence produced by the veteran should be presumed credible for purposes of a well grounded determination, claims are denied as not well grounded if documentation supplied by the veteran, such as a copy of a certificate for bronze star with valor describing the veteran's exposure to severely wounded comrades during combat activity, is not a verified copy. (No request for verification of military records was made).*

Although this claim was characterized as a denial for not being well grounded, a veteran's statement, alone, is enough to establish an event's occurrence at the well grounded stage; verification in military records is not required. From the facts you presented, it appears that the rating activity was attempting to verify combat status for a merits decision. Because there seems to be some confusion here on the difference between well grounding a claim of a combat veteran and deciding it on its merits, we will clarify that issue in future directives and future conference calls, also emphasizing that there is no requirement that a veteran produce a verified copy of a combat citation at the merits stage.

- *Veterans are allowed 30 days to provide information to well ground their claims. Given the amount of time it requires to obtain military medical records, claims are being denied as not well grounded when the military records would provide the evidence necessary to establish a well grounded claim, e.g., a veteran who served in a health care occupation during military service.*

A veteran's statement that he or she served in a health care occupation in service is enough to establish the occurrence of an event in service for the purpose of well grounding the claim; the military records are relevant to deciding the claim on its merits. While claimants are gathering required evidence, we request their VA medical records and military records. If, after thirty days, the evidence of record does not establish a well grounded claim, it is true that we deny the claim. However, we review any evidence we receive in the subsequent year to determine if the claim has been well grounded.

We emphasized this procedure in several conference calls with field stations in the Fall of 1999. If a regional office is denying a claim for service connection for hepatitis C prematurely, we will learn this in the claims review to be conducted this quarter and determine how extensive this problem may be.

Congressman Evans

Page 4

There appears to be a belief that “all potential alternate sources of hepatitis” be identified and “ruled out” before a claim can be allowed.

- *For example, a diabetic veteran with no history of IV drug use who received a blood transfusion during surgery for a service-connected condition was informed that VA is required to explore whether or not the use of prescribed insulin could be the source of the hepatitis infection. This is particularly problematic, since VHA specialists have stated that while a number of risk factors can be identified and rated for potential risk, it is not possible to attribute or “rule out” a specific exposure to the infection where multiple exposure routes are possible in an individual case. Where there is no evidence or indication of any other risk factor than the one alleged by the veteran, veterans are given the impression that they must prove a negative, that is, the lack of any other explanation for the disease.*

If the evidence of record shows that there are exposures to multiple risk factors, we are obligated to develop this issue. We agree that doctors cannot pinpoint the cause of a hepatitis C infection, but they can assess the various risk exposures in an individual case and offer an opinion on the relative degree of risk presented by a risk factor. If a physician cannot state that one risk factor is more likely the cause of a current hepatitis C infection than another, then reasonable doubt is construed in the veteran’s favor.

There is confusion concerning the application of the rating schedule for infectious hepatitis to chronic hepatitis cases.

Although there may be individual errors using the rating schedule to rate hepatitis C cases, we are not aware of any pervasive problems evaluating these claims. However, we have drafted more objective criteria for evaluating liver disease with specific criteria applicable to evaluating hepatitis C, and increasing the number of possible evaluations for the condition. This proposed revision is currently being reviewed by the Office of Management and Budget.

- *For example, a veteran who had been service connected for hepatitis C requested an increased rating after liver biopsy showed “mild to moderate” liver damage. The veteran had received a medical leave of absence from his employment in order to undergo intensive therapy for hepatitis C. Despite objective evidence of “mild to moderate” liver damage,” a rating of 10% was maintained which requires only “demonstrable liver damage.”*

Congressman Evans

Page 5

The criteria in the rating schedule assign an evaluation based on laboratory findings of liver damage *and* disabling manifestations of the disease. Evaluations cannot be assigned based on liver biopsy tests alone.

The lack of information in military medical records concerning risk factors for hepatitis C.

- *In reviewing records of veterans who were diagnosed with hepatitis during military service, two-thirds of the records contained no reference to risk factors. For example, of 18 records reviewed of veterans who had a diagnosis of hepatitis in their military service records, no indication of the risk factor was recorded in 12 medical records.*

A claim for service connection for hepatitis C is well grounded if there is medical evidence that a veteran is currently diagnosed with hepatitis C and was first diagnosed with hepatitis in service. Evidence of an additional risk factor is not necessary to well ground the claim. We will emphasize this principle in future conference calls and instructional materials on this subject.

Specific Issues to be Addressed

- *Lack of evidence in medical records concerning blood transfusion. Should "lay evidence" concerning the administration of blood observed by the veteran or another be accepted as evidence of a blood transfusion if the testimony is otherwise consistent with the evidence of record?*

Yes, especially for the purposes of well grounding a claim. A decision on the merits, however, may require additional development and weighing of all pertinent evidence.

- *Is it appropriate to deny a claim as not well grounded when there is a current diagnosis of hepatitis C and the veteran alleges combat exposure to blood or blood products as a victim, rescuer, or health care professional.*

No, it is not appropriate to deny the claim as not well grounded.

- *How should the presumptions related to combat veterans be applied in determining whether or not a claim for hepatitis C is well grounded?*

Congressman Evans

Page 6

Lay testimony by any veteran is accepted as evidence of an in-service event to establish a well-grounded claim. As noted previously, the presumption in 38 U.S.C. 1154(b) applies to the merits of the claim and means that we do not have to verify the statement of a combat veteran that he or she was exposed to a hepatitis C risk factor in service.

- *Does a decision which denies a claim for hepatitis C as not being well grounded, but fails to specify the element or elements of the requirements for a well grounded claim which are not satisfied, meet the requirements of fundamental due process?*

Failure to give reasons why a claim is denied does not meet the statutory notice requirements of 38 U.S.C. 5104(b). Our procedure is not only to inform the veteran of the evidence needed to establish a well-grounded claim, but to notify the veteran of the reasons for any decision made in the rating decision, itself.

- *In evaluating a claim for hepatitis C pending the revision of the rating schedule, what is the reason evidence of a liver biopsy showing moderate or marked liver damage should not result in a rating of 60% for moderate liver damage and 100% for marked liver damage? Has any guidance been provided to rating specialists for evaluation of severity of hepatitis based upon liver biopsy results?*

Although valuable information may result from a liver biopsy, the rating schedule criteria for hepatitis require both clinical findings of liver disease *and* laboratory evidence of liver damage, because ratings are based on average impairment in earning capacity. For a 60-percent evaluation for hepatitis C under the current criteria, laboratory findings of moderate liver damage *and* disabling recurrent episodes of symptoms must be present.

Therefore, we do not evaluate based on laboratory findings alone but use them as additional evidence supporting the clinical manifestations. In addition, we do not require a liver biopsy for rating purposes, in part because it is an invasive procedure, which we avoid to the extent possible in rating criteria. In addition, liver function tests are the standard means of assessing liver function. The information gained from liver biopsy is generally more useful in defining structural damage and sometimes determining etiology. It may also be used to determine the need for treatment and to monitor response to treatment. For these reasons, we have not issued guidance to our rating specialists on rating based on liver biopsy results.

When the results of liver function tests or liver biopsy are unclear as to the severity of liver damage, the rater needs to consult the examiner, as in other rating situations where

Congressman Evans

Page 7

laboratory criteria are part of the criteria. In the proposed revision of the rating schedule criteria, evaluations are based on clinical findings alone, except that the diagnosis must be established by laboratory tests.

II. Well-Founded Claim Issues

There appears to be some confusion concerning the application of the "well-founded claim" criteria to cases involving certain presumptions.

- *A veteran-filed claim at time of separation from service after being discharged to a medical board decision with a 20% rating. Claim denied by VA as not well grounded.*

Based on the limited facts provided, the claim would be well grounded and the denial of the claim on that basis would have been in error.

- *An Ex-POW claimed disability due to arthritis as related to injuries sustained when he bailed out of a plane which had been shot down over enemy territory. The claim was denied as not well grounded because the military medical records do not show evidence of the trauma. No reference was made to 38 C.F.R. §§3.304(e) or 3.309(c).*

On the facts provided, a denial as not well grounded is in error because the veteran's statement, alone, is sufficient to establish the occurrence of the event described. Where the evidence shows the veteran served in combat conditions, then the presumption in 38 U.S.C. 1154(b) would apply and verification of the claimed in-service event would not be required in deciding the case on its merits.

- *There appears to be a need to clarify the relationship between presumptions related to combat veterans and POW's concerning the acceptance of testimony notwithstanding the absence of official service medical records.*

This is an issue which we will emphasize in future conference calls and training materials.

We realize that this is an area in which medical knowledge will continue to evolve, and we are committed to evolving our adjudication procedures with it. HCV infection is a matter of particular import for VA and we take our responsibility to

Congressman Evans

Page 8

properly evaluate these claims seriously. As part of our continuing efforts to ensure the consistency and quality of our rating decisions, we have drafted a regulation to establish presumptive service connection for hepatitis C under certain circumstances. We have established more objective rating criteria and are using our quality assurance program, "STAR," to monitor the accuracy of rating decisions. We have planned a case review of hepatitis claims for June 2000. In addition, we will continue to use conference calls and any other opportunity to clarify the issues and emphasize current policy on rating hepatitis C claims to field stations.

Because of the potential magnitude of the hepatitis C public health problem we are trying to develop a comprehensive and cogent policy that will treat veterans fairly but will also maintain program integrity and achieve consistency in our adjudication. We stand ready to work with you and other people in the process of developing this policy.

Sincerely,

/s/

Joseph Thompson

**Post-Hearing Questions
Concerning the April 13, 2000, Hearing**

**for
Dr. Gary A. Roselle, Program Director for Infectious Diseases
Veterans Health Administration, Department of Veterans Affairs**

**from
The Honorable Lane Evans
Ranking Democratic Member, Veterans Affairs' Committee
U.S. House of Representatives**

1. Question: Your data indicates that a large number of the hepatitis C patients seen in the VHA are Vietnam-age veterans. Are there any characteristics of service in the Republic of Vietnam, which would account for the prevalence of this disease in this group?

Response: The data acquisition model (Emerging Pathogens Initiative) does not retrieve characteristics of service in the Republic of Vietnam or elsewhere that may be related to hepatitis C virus infection because no such data are available at this time in the VHA computer system. Data are currently being gathered (a multi-center HCV Treatment Response Trial in U.S. Veterans [VA-HCV-001]) to collect information specifically related to hepatitis C virus risk factors including service in the Republic of Vietnam. We are adding specifics of service under the Veterans Health Initiative. We will also look for other databases that might have this information.

2. Question: Are you familiar with the risk factor screening criteria for Hepatitis C in veterans developed by the Veterans Health Administration?

How were those risk factors determined?

Response: Yes. Risk factors were determined by two methods. First was the use of the general risk factor definitions as defined by the National Institutes of Health in the Consensus Conference dated March 24-26, 1997. The second strategy was to expand the screening criteria for the VHA to include the special issues related to veterans (e.g., combat casualty care, tattooing).

3. Question: In your testimony you stated that a statistical evaluation of what's likely and what's not is valid for large populations, but may have no validity for an individual case. Could you explain why it is not scientifically appropriate to apply epidemiological data to determine which of multiple risk factors may be implicated in an individual case of Hepatitis C.

Response: Epidemiology is the study of the distribution and determinants of diseases and injuries in populations. Epidemiological data are gathered to address the frequencies and types of illnesses and injuries in groups of people

and with the factors that influence their distribution. This implies that disease is not randomly distributed throughout a population and that subgroups within the population may differ in the frequency of different diseases. Data presented in the testimony concerning hepatitis C virus were population based. As with many diseases, there may be multiple risk factors for disease transmission with any individual having from 0 identified risk factors to many opportunities for exposure. However, to determine what specific risk factors may be associated with infection in a given person, other data would be necessary. For example, these could include clear evidence of exposure to HCV, such as transfusion with infected blood, needlestick injury in an HCV-rich environment, etc. Lesser degrees of evidence, such as history of sexual promiscuity, cutaneous exposure to blood of unknown HCV status, etc., permit only broad and somewhat precarious estimates of probability of causation. Criteria for epidemiologic identification of specific organisms (thus providing higher degrees of evidence) can often be met in hospital clusters of disease, but they clearly cannot be met in the current veteran population with hepatitis C virus infection. Thus, while population characteristics can be defined regarding risk factors, for an individual patient it is not possible to absolutely determine which risk factor would be the one specifically related to that patient for transmission of hepatitis C virus.

4. Question: Under what circumstances, if any, is it possible to "rule out" a particular risk factor as the cause of an individual's Hepatitis C infection?

Response: It would be very difficult to absolutely "rule out" a particular risk factor as a cause of an individual's hepatitis C infection. The only way this could be done is if there was absolute assurance that an individual person did not have the risk factor at all. For instance, if it can be assured that an individual with hepatitis C has never had a transfusion then transfusion can be ruled out as a risk factor for that person. Otherwise it would be extraordinarily difficult.

5. Question: What are the Department of Veterans Affairs latest figures on prevalence rates for Hepatitis C?

Response: The only data regarding a case rate for hepatitis C virus infection on a nationwide scale was done on Hepatitis C Surveillance Day, March 17, 1999. While this surveillance did not represent true prevalence, the case rate found that day was 6.6%. This likely underestimated the true prevalence of infection, since blood was only obtained from those persons who were already scheduled for blood testing, and who agreed to the Surveillance Day activity. This methodology may well have excluded certain high risk populations such as those with addiction disorders, post-traumatic stress disorder, and many outpatients since they are less likely to have blood drawn on any given day compared to hospitalized patients. Therefore, we believe the prevalence may be greater than 6.6% in the population served by the VHA.