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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2005

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

FEBRUARY 4, 2004

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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2005

WEDNESDAY, FEBRUARY 4, 2004

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

The committee met, pursuant to notice, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Christopher Smith (chairman of the committee) presiding.

Present: Representatives Smith, Evans, Buyer, Snyder, Stearns, Rodriguez, Moran, Michaud, Hooley, Simmons, Strickland, Miller, Berkley, Boozman, Udall, Bradley, Davis, Beauprez, Ryan, Renzi, and Murphy.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The hearing will come to order, and I'd like to wish everybody a good morning.

This committee has always taken, as all of the members know, a very serious approach to its responsibility to recommend necessary funding levels for veterans' benefits and services. However, controversy over matters having nothing to do with veterans funding resulted in unfortunate delays in the normal funding process. Fiscal year 2004 began more than 4 months ago, but the Department of Veterans Affairs is only now able to move forward and provide the services which we have provided funding for last October.

In January, the President signed into law an appropriation measure that increased funding for veterans' medical care by $2.5 billion over the previous year, a 10 percent increase. A year earlier, he also signed a measure which belatedly increased funding by $2.6 billion for fiscal year 2003. While all of us regret the delay in providing these funds, the bottom line is that more veterans will have access to vital health care services as a direct result of that budget.

An estimated 74 percent of living veterans have used one or more of the programs which a grateful nation has provided for them. Some think that it's time to rein in spending on veterans programs, that we've already done enough for veterans. I strongly disagree with those people, because I understand how much these programs have done to make our country what it is today. Let's look at what this country might be like if some current veterans programs had not been authorized and adequately funded.

The coffers of this country would be substantially leaner because veterans would not have achieved the level of income that the GI Bill enabled them to earn.

The middle class in America would be much smaller, and the number of persons enrolled in colleges and universities would be less than half of what it is today.

The housing stock in this country would be older, and several million houses would not exist.

Many veterans would have died prematurely or would be experiencing debilitating illness.

Our medical profession would be less skilled, and life-saving inventions and medicines would not be available.

The cost of Medicare and other government-sponsored health programs would be tens of billions dollars higher than they are today.

This Nation has a long history of taking care of veterans when they return from serving their country. Laws providing benefits for veterans were some of the first laws enacted by the first Congress. We continue that tradition today, not only because veterans deserve the gratitude of the Nation they served, but because it makes our Nation stronger and because it makes our Nation safer.

It is evident that this Congress and this administration have embraced the cause of veterans. Just look at the legislation signed into law in the last 3 years:

We increased the GI Bill education program by 46 percent.

We authorized more generous health care and pension benefits for surviving spouses of those who die of a service-related cause.

We've enacted a comprehensive array of authorities designed to end chronic homelessness among our veterans.

We've authorized concurrent receipt of VA disability compensation and military retirement for almost 250,000 veterans. We've set in motion the largest national cemetery expansion since this program was established during the Civil War. Thanks to the 30 percent funding increase signed into law by President Bush during the last 3 years, over one million more veterans are using the VA health care system.

In addition to these major legislative initiatives, which could not have been accomplished unless we worked in a bipartisan manner, we've seen services to veterans become more accessible and timely. This is a good record to build on.

Mr. Secretary, I have heard you quote Oliver Wendell Holmes, so let me refer to you one of his best-known quotations: "The great thing in this world is not so much where you stand as in what direction you are moving."

The budget for veterans' benefits and services unveiled on Monday is moving in the right direction. This budget requests almost $64.9 billion in appropriations for veterans' benefits and services. And while it certainly doesn't contain all the funding needed, it does request about 96 or 97 percent of what is required to get the job done.

In addition to these are laudable proposals to reduce the financial burden of VA health care for former prisoners of war, terminally ill and low-income veterans. We welcome these proposals and the request for funds to pay for them.

As in the past years, this budget doesn't cover the full cost of all health care which veterans are seeking from the VA, nor does it account for any growth in that demand. Thus, Congress will have

to add funds in the budget process, something we have done in 4 of the past 5 years. Our work begins today. In addition to the Secretary, we have the Veterans Independent Budget to help guide us, and as in the past years, it sets an ambitious goal for Congress, and we do take that budget very, very seriously.

I look forward to hearing from the Secretary and all of our very distinguished witnesses. I'd like to yield to Mr. Evans. And I would just point out to my colleagues, we will hear from the Secretary and then go to 5-minute questions. As you know, this committee cannot sit when there's a joint session of Congress. That's why we moved this back a half-hour. Then everyone will be recognized for their 5 minutes to make any comments or questions that they would like to make.

I would like to yield to our Ranking Member, Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. This year's Bush administration budget proposal for the Department of Veterans Affairs is a result of seriously misplaced priorities. I hope you will agree with me that a significant portion of the rehashed recommendations proposed should be soundly and quickly rejected.

I don't think anyone on this committee will celebrate an increase in the veterans' medical care budget of less than 2 percent. Plus, we've seen before—and rejected on a bipartisan basis—the administration's proposals that would increase pharmacy and primary care co-payments and establish user fees for veterans.

The administration requested about a $500 million increase for veterans's medical care, for a total of $27.4 billion, which does not include money collected from veterans and their insurers. In sharp contrast, without the projected savings from legislative initiatives or management efficiencies, the VA would require more than $2 billion in additional appropriations. The President said that this was a "tough" budget, and he wasn't wrong about that in terms of its impact on our veterans.

In my view, this disappointing budget proposal is another profound example of the need to take the VA's spending out of the political arena. Nine veterans' service organizations have made mandatory funding of veterans' health care their top legislative priority this year.

Mr. Chairman, thank you for holding this timely hearing. I look forward to working with you and the veterans' service organizations and the VA where we can.

Thank you.

[The prepared statement of Congressman Evans appears on p. 91.]

The CHAIRMAN. I thank my good friend. I'd like to welcome our first witness today, our good friend, the Honorable Anthony J. Principi, Secretary of Veterans Affairs. I'm sure most people in this room know the Secretary's background. However, for those who don't, here are some highlights of his very distinguished career.

Prior to his nomination, Mr. Principi was secretary of QTC—president, I should say—Medical Services, Inc., a group of profes-

sional service companies providing independent medical and administrative services and examinations. Before this, he was a senior vice president at Lockheed Martin, and a partner in the San Diego law firm of Luce, Forward, Hamilton & Scripps.

Secretary Principi has worked on national policy issues and has held several executive-level positions in Federal Government. He chaired the Federal Quality Institute in 1991 and was chairman of the Commission on Servicemembers and Veterans transition Assistance established by Congress in 1996. He also has no trouble getting around Capitol Hill, having served as chief counsel and staff director of both the Senate Armed Services Committee and the Veterans' Affairs Committee.

A graduate of the U.S. Naval Academy in Annapolis and a combat-decorated Vietnam veteran, Secretary Principi first saw active duty aboard the destroyer USS Joseph P. Kennedy. He also commanded a river patrol unit in Vietnam's Mekong Delta.

Secretary Principi, you have served our Nation proudly and well, and this committee welcomes you. Please proceed as you like.

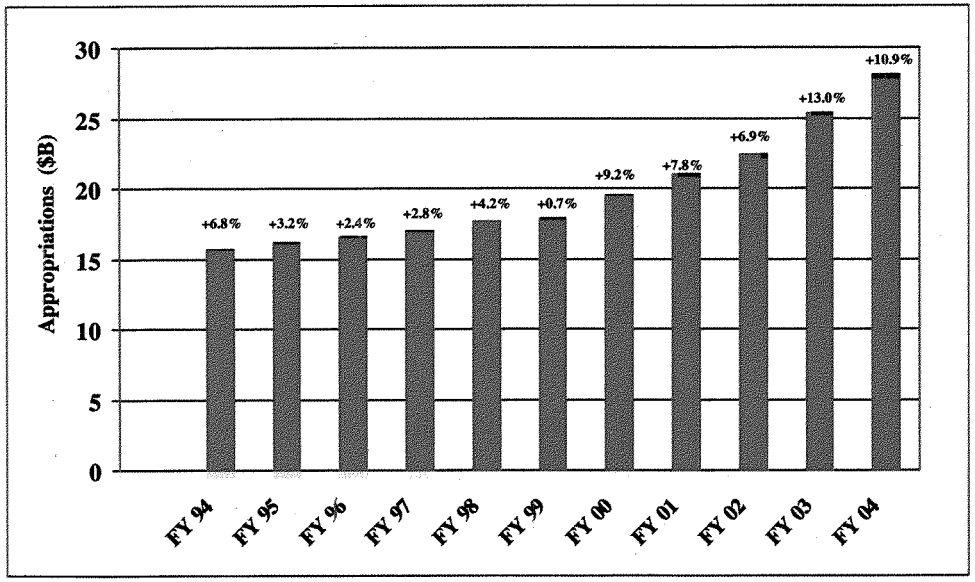
STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; VICE ADMIRAL DANIEL L. COOPER, U.S. NAVY (RET.), UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS; JOHN W. NICHOLSON, UNDER SECRETARY FOR MEMORIAL AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS; WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND MARK CATLETT, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Secretary PRINCIPI. Thank you, Mr. Chairman, and good morning to you and to Mr. Evans and to the members of the committee. It's always a pleasure to appear before you.

This year and next year, if this budget is approved, 800,000 more veterans will receive VA medical care than in 2001, the year I became Secretary of Veterans Affairs. And these veterans are the human dividend of a series of increased budgets requested by the President, combined with active and successful advocacy in the Congress, especially the members of this committee.

This first chart shows the unprecedented growth in VA's medical care budget, more than 40 percent in health care alone over the past 3 years. And on behalf of America's veterans, I thank the members of this committee for your contribution to this significant achievement.

Medical Care
Enacted Appropriations
Includes Collections

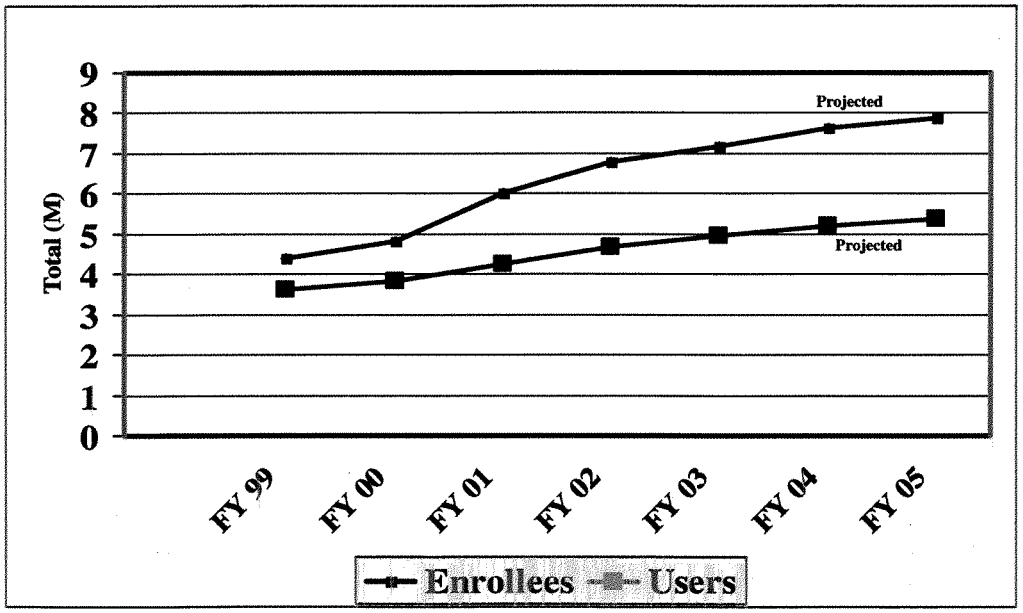


Percent change from prior year enacted levels. Starting in 1998, collections are available for VA

Secretary PRINCIPI. In my view, this is the Golden Age of VA health care. Never has quality of care been so good. Never has access been this broad, with close to 700 community-based outpatient clinics I'm proud to have built on the successful legacy of my predecessors who moved the VA from a hospital-centric system to a patient-focused system, and we will continue to open more community-based outpatient clinics in the future so that more veterans have greater access to our health care system.

And never before have we treated so many veterans at so many locations. This second chart shows the growth in our workload and the growth in our workload and the growth in our enrollees over a period of time, and certainly since I came into office in 2001, we have increased our enrollees by the end of fiscal year 2005 by 2 million, and over 800,000 veterans, as I have indicated, are now the recipients of health care. This could not have been done without the President and without your support.

Health Care Workload

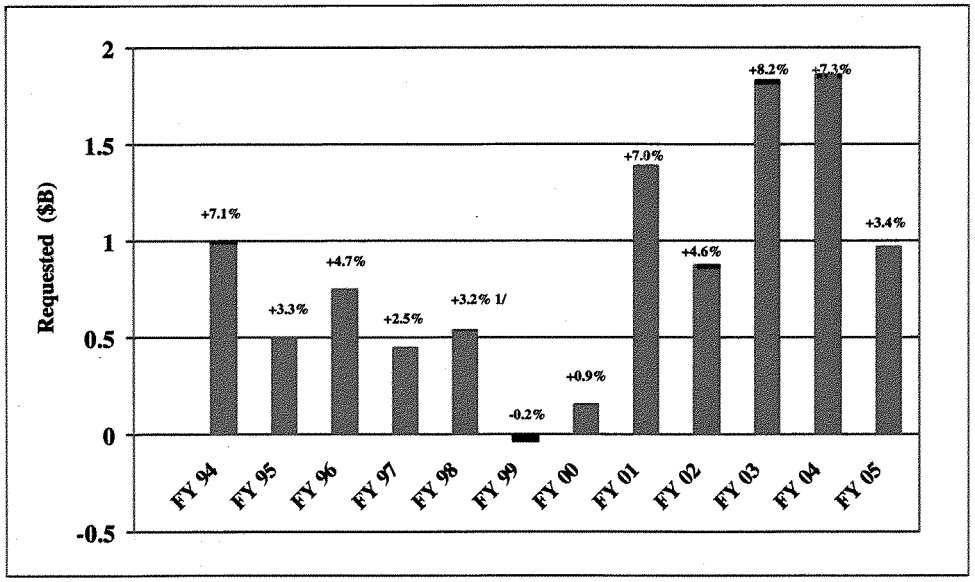


Secretary PRINCIPI. For 2005, our total health care budget authority would increase 3.4 percent under the old structure or 4.1 percent under the new structure, and that does include medical care costs recovery collections, either first party co-payments or from insurance. That process began in 1998 when the Congress authorized collections to stay with the VA as new resources. And since that time, they have been included in our collections.

I believe that this budget, combined with what we have been able to accomplish over the past 3 years in our growth, will allow us to sustain the gains we achieved over the last 3 years.

This next chart shows the medical care request change over prior years, and I'm very, very proud that the President has increased through his request VA medical care dollars by 27 percent.

Medical Care Request Change Over Prior Year



1/ Starting in 1998, open enrollment began and collections were made available to VA

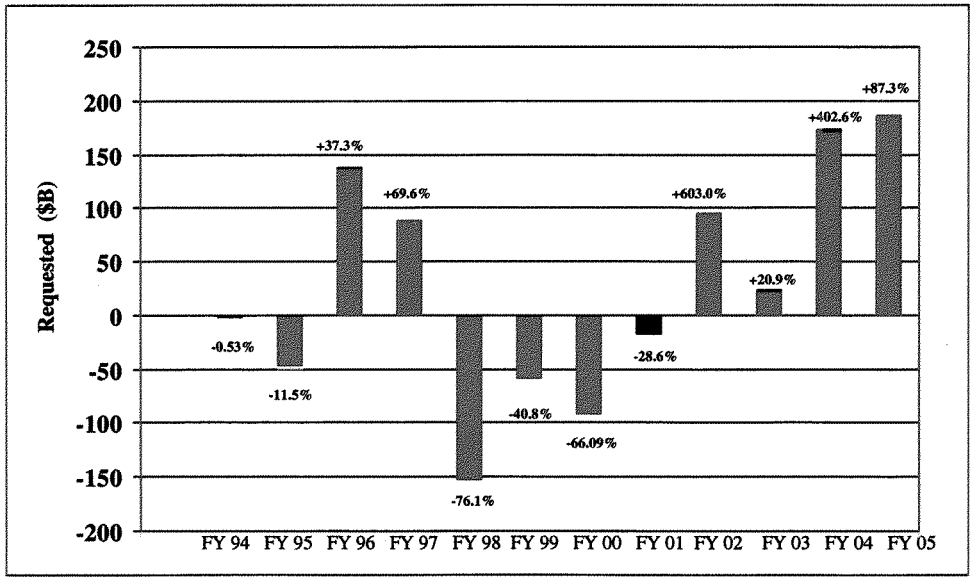
Secretary PRINCIPI. If the President's request is approved by Congress, I believe we will have the resources we need to maintain our status as the gold standard of quality care and meet our goal of scheduling nonurgent primary care appointments for 93 percent of the veterans within 30 days, and 99 percent within 90 days.

My goal, Dr. Roswell's goal, our Under Secretary of Health, is to eliminate our waiting list in 90 days with a very, very significant budget that we received in 2004, albeit late, but I understand and appreciate t he difficulties of the appropriation process in Congress, but we will use those dollars as best we can in the 7 or 8 months remaining in this fiscal year to work down that waiting list and get veterans in in a timely manner.

We will continue to focus on the medical needs of veterans identified by Congress as the highest priority, the service-connected disabled, the lower income who have few other options for health care in this country, and those veterans who need our specialized services.

I know that Congress has been very, very concerned about our construction budget over the years, and this next chart will show that our budget request for 2005 almost more than doubles the construction request from the previous fiscal year. This will allow us to improve our facilities, to modernize our facilities, soon to be identified through the CARES process.

VHA Major Projects Request Change Over Prior Year



Secretary PRINCIPI. In addition, it is my intent to use the authority granted by you and apply up to $400 million of the 2004 medical care appropriation to the CARES projects. We will see how things go this spring in terms of waiting lists, in terms of meeting our staffing needs and looking at our spend rate to determine how much of that $400 million we can use for new construction, modernization of our health care facilities.

What that means is a total of almost a billion dollars in 2004 and 2005 to transform VA's medical facilities into a 21st century health care system.

Perhaps most importantly, the budget will fund high quality care for veterans returning to our shores from overseas conflicts. Of the approximately 90,000 active duty servicemembers who served in Iraq and have been discharged, we have seen about 12 percent of them in our VA medical centers, about 9,700. Of the 15,000 who served in Afghanistan in Enduring Freedom and have been discharged, approximately 1,400 have come to the VA.

We are engaged in a major outreach activity to contact them, to make sure that they know of their benefits. I will be sending a letter to just about all 90,000 of those young men and women to let them know about this program. And we've started putting out a brochure, Operation Iraqi Freedom, which explains in detail the benefits they've earned by their service to America in this time of war.

There is no question, however, that we still have great challenges in the VA, and we are responding to those challenges in many different ways, and certainly policy initiatives are one way.

First, we emphasize our commitment to the highest priority veterans by asking Congress to raise the income threshold to $16,500 from $9,800 for exempting low income veterans from pharmacy co-payments. This would impact about 500,000, almost 500,000 low income veterans who currently have to make pharmacy co-payments, and lift that burden from their shoulders. We're talking about the poorest of the poor.

We also ask that you eliminate all co-payments for former POWs. Propose to eliminate co-payments for hospice care. When veterans are in a contract hospice program and are paying co-payments, we want to stop that process. And in those cases where our patients must make co-payments to their health insurers for non-VA emergent care in emergency rooms in the private sector, we want the authority to reimburse those veterans the co-payments that they must make to their insurers.

At the same time, we also ask Congress to approve both an increase in pharmacy co-payments and a very modest annual fee totaling less than $21 a month, a very small proportion of the cost of care for higher income nondisabled veterans using our system. This is not an enrollment fee. It would be an annual fee collected only from veterans actually receiving care in our system and could be paid on a monthly or an annual basis, depending on the needs of the veterans.

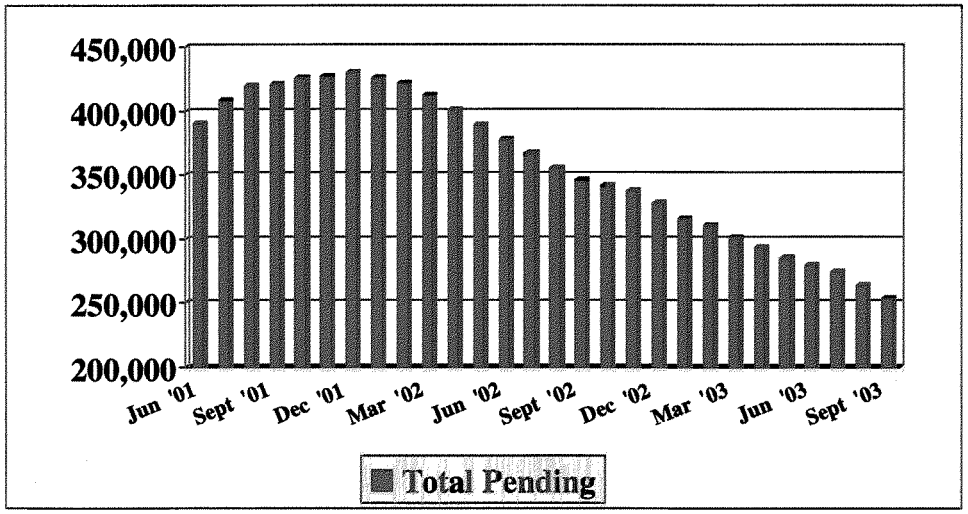
I would just like to point out that for many, many years, the Congress has required enlisted personnel—petty officers, staff sergeants, tech sergeants, who served 20 years or more on active duty, probably in one war, maybe two wars—when they retire, with a

very, very low retirement income, they must pay $254 a year to be enrolled in the TRICARE program, TRICARE Prime program. And when they reach 65, they must make $600 in payments to Medicare to HHS. I don't think it's unreasonable to ask someone who may have served only one hitch, has no disabilities from military service, and has an income higher than these retired enlisted persons, to make a very small monthly payment once they use it. And it's not to enroll in a program, but rather when they use it.

I believe that we can meet some of our challenges on our own. For example, I approved the recommendation from my Under Secretary, Dr. Roswell, to address regional funding imbalances by including all veterans—Category 7 veterans, Category 8 veterans—using our system and our resource allocation model. This will ensure those networks, those areas of the country that have a disproportionate share of higher income veterans, are counted in the allocation process so that they can meet the needs of those veterans.

In addition to improving access to health care, the President directed me to bring the benefits processing system under control. And with your help, we have made substantial progress. This next chart shows that by the end of this past fiscal year, we brought the backlog of disability claims down from 432,000 to 253,000. It has gone back up since then because of a court case that made us hold onto claims for up to a year to give the veteran the opportunity to add additional evidence. Congress has fixed that problem for us. We believe the court misinterpreted the law you passed, and I believe that we're going to be able to get that workload back down to my goal of 250,000.

Status of Disability and Pension Benefits Claims



Secretary PRINCIPI. I'm also proud that the number of veterans receiving service-connected disability compensation is projected to increase to 2.6 million, up from 2.3 million in 2001. That's 300,000 addition, notwithstanding the fact that unfortunately many of our veterans, World War II and Korea, Vietnam, are passing on, men and women with service-connected disabilities, and we are proposing a $2.8 billion increase, almost a $2.8 billion increase to fund this improvement in the disability comp program.

I think that's come about because we're bringing down the backlog, we're making decision, and we're serving service-connected veterans who have been exposed to herbicides and contract diabetes or other forms, other diseases.

VA is not only health care and benefits, but as the chairman indicated, the President's budget request will continue the greatest expansion of the National Cemetery system since the Civil War. We have opened one new cemetery. We have five close to completion. We will open up another six by the year 2009. That will expand our gravesite capacity by 85 percent, almost double our National Cemetery system's gravesite capacity over the next 5 or 6 years. And I thank you for your support in that area.

That concludes my statement. I'm sorry for running over, Mr. Chairman. I'd be more than happy to answer any questions you might have.

[The prepared statement of Secretary Principi appears on p. 111.]

The CHAIRMAN. Thank you very much, Mr. Secretary. If you wouldn't mind just briefly introducing your distinguished panel.

Secretary PRINCIPI. I'm sorry, sir?

The CHAIRMAN. If you wouldn't mind introducing your distinguished panel.

Secretary PRINCIPI. I'd be happy to. To my far left is General Jack Nicholson, our Under Secretary of Memorial Affairs. Admiral Dan Cooper, our Under Secretary of Benefits. Mark Catlett, our Principal Deputy Assistant Secretary for Management. Dr. Bob Roswell, our Under Secretary of Health, and William Campbell, our Assistant Secretary for Management.

The CHAIRMAN. Thank you very much, Mr. Secretary. Let me just say to Mr. Nicholson, I understand your brother, Jim Nicholson, who is our U.S. Ambassador to the Vatican, with whom I was with recently and has worked very effectively on the human trafficking issue and other human rights issues, it's his birthday today, so if you could convey to him my and many of our congratulations.

Mr. NICHOLSON. Can I tell him you mentioned that?

The CHAIRMAN. Please do. He's doing an extraordinarily good job, and especially in the area of human trafficking, sex trafficking, which the Vatican and our government and other interested countries have made a major difference in, and I've worked that issue for years, so I want to thank him for that.

Mr. Secretary, let me just say, it has been my privilege to serve on this committee for 24 years, and I would note and remind my colleagues that every year from President Reagan, President Bush, the previous Bush, Bill Clinton for 8 years and now President Bush again, we've received a budget that never quite got to where we wanted it to be as members of Congress, and I say that in a bipartisan way.

We've received that budget as a starting point. We're working with the administration, a work in progress, working with the appropriators. We have thankfully been able to ratchet up that budget, particularly in the medical care area, in a calm and deliberative way. And then at the end of the day, as we saw with the signing of the most recent appropriations omnibus bill, we get to at least within the ballpark of where we want to be. And I will predict that this year, this will be a starting point, as I said in my opening, this is 96, 97 percent of where we want to be, but it's not there.

So we will work, I give you and my colleagues the assurance, we will try to increase it in the area of medical care, because there are some veterans who will not get the kind of care that they need if we don't make those efforts. So I would just throw that out for just a historical perspective. Every budget, with no exception over the last 24 years, has been at the opening stages where we want to be, and we look forward to working with you to get hopefully where veterans will be well served in total.

I just wanted to ask you, 2 weeks ago when the President signed the omnibus bill increasing by $1.2 billion approximately than was requested from Congress just a year ago, this came, as you know, after a very vigorous debate. There were strong convictions. It was bipartisan, and thankfully we were able to prevail.

I noticed in the budget, though, that $800 million of those funds may be carried over to the following year. Could you explain that for us?

Secretary PRINCIPI. Certainly, Mr. Chairman. This is the second year, unfortunately, that we received our appropriation some 4 months late. And there's no directive, I can assure you, to hold back on spending appropriated dollars and carrying them over for the next fiscal year. I want our people to use the dollars, of course to use them widely and no year-end binge spending. These are taxpayer dollars.

But last year, because we received the appropriation late, in February again, we carried over some $770 million to this year. And our appropriation that year wasn't as high as this year. So I anticipate that we will carry over $800 million, maybe even more than that, into the next fiscal year. But that's just an assumption based upon getting the appropriation in February and not October. If it's all spent this year, and spent wisely and making sure that veterans get health care, that's absolutely fine, and modernizing equipment, that's fine. But I think that's a safe assumption.

The CHAIRMAN. It appears to me that the $250 enrollment fee or whatever else we might want to call it, and the pharmacy co-payment hike as proposed in the budget for 7 and 8's, would discourage its use. Can you explain that? I mean, last year when we looked at this, and the VA's own forecasting model suggested a number of veterans would decide or opt to go elsewhere. That concerns many of us. You know, there are already co-payments for acute care beds, and there are already co-payments, modest as they are, for outpatient services. This additional fee—you broke it up month by month, which obviously makes it appear to be less, but——

Secretary PRINCIPI. It may discourage some use, Mr. Chairman, for veterans in 7 and 8 who have other options. I don't believe it's

going to discourage anybody from using the VA health care system who has no other options.

I remember not too long ago seeing a memo from some health administrator at one of America's largest corporations urging the corporation to send a memo around to all of the employees, 50,000 employees who were veterans, urging them to abandon the corporation's health care system and go over to VA and get their pharmaceuticals. Maybe they wouldn't abandon their corporation's health care system.

So, yes, you might have a little bit of that. But I sincerely believe that it's so modest that those with the higher income—I'm not saying they're wealthy by any stretch of the imagination—would still get a wonderful health care benefit at a very, very small, small cost.

The CHAIRMAN. I see my time is up. Mr. Evans.

Mr. EVANS. Mr. Secretary, we appreciate your joining us this morning. We applaud you for your work that you do. But how would you characterize the fiscal year 2005 budget request? Is it a good budget request for the VA?

Secretary PRINCIPI. I would characterize the 2004 request as a very, very good request, and I applaud the Congress for their assistance in this committee with the appropriation process. So I think it was a very, very good request. I'm very proud of it.

You know, sure, I've never come before this committee and misrepresented the truth. I've always said that, you know, we need additional resources to meet this surging demand for health care brought on by open enrollment and a great benefit and quality and more and more outpatient clinics.

But I feel that we have done extremely well. Not me, I mean, both the executive branch and this committee and the Congress working together. It's not ideal, but we've come a long way, as I've indicated with these charts. And a million veterans getting more care since 2001 I think is an extraordinary accomplishment, and it would not have happened without the dedicated people in VHA and the work of the President and this committee and the Congress.

Mr. EVANS. When we look at the resources that are available to fund the VA's obligations for fiscal year 2005, it appears that you will be approximately $2 billion short if your proposed legislation is not enacted. Is this correct?

Secretary PRINCIPI. Well, if the proposals are not enacted, as I indicated last year, we would fall short, and it would entail, you know, longer waiting lines or, you know, maybe a more difficult enrollment decision or additional resources. Those are the options that would be before us. But, you know, I'm counting on those policy proposals to help us generate some revenues so that we can expand the reach of health care. And the beauty is that you let us keep those resources and use them to benefit veterans.

Mr. EVANS. I want to make sure you're very clear about my feelings and concerns that you raised. And I appreciate it. We've worked together in the past. But just one more question here, and that is, did your request to OMB include full funding of the VA for that $2 billion? Did you talk to OMB about that?

Secretary PRINCIPI. I asked OMB for $1.2 billion more than I received.

Mr. EVANS. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Chairman Buyer.

OPENING STATEMENT OF HON. STEVE BUYER, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. BUYER. Thank you, Mr. Secretary. I support your firm commitment to continue a focus on veterans in the highest statutory priority groups. I believe that providing the timely, high quality health care to VA's core constituency, the veterans with service-connected disabilities, those with lower incomes as you spoke of, and veterans with special health care needs, such as those with spinal cord injuries, loss of vision, I think you've got the right focus.

Congress chose, back when we did eligibility reform back in 1996, to ignore the warnings of the surge by GAO and CBO. We ignored those warnings and we sided with the testimony of the veterans service organizations. This committee and the VSOs had it wrong. The surge came.

And now what's happening is even some of the testimony that was provided by CBO, they warned us in the future Congresses you would see this type of politics that we're seeing today of you coming and people then bashing and measuring compassion by the dollar; oh, you're not giving us enough, when in fact we here in Congress have created this problem which you are having to manage. So we here are at fault for this.

And I just want you to know, Mr. Secretary, I intend to explore those testimonies by the VSOs and also bring them to account. We can't have people just come and testify and then we have this problem later on, and to think that this creation of a system for veterans that is now without shame, whereby veterans of whom are non-service-connected can just push our service-connected disabled veterans out of the way and leap ahead of them, I think this is wrong. So I want to applaud you, Mr. Secretary, for focusing on the core competencies here.

Secondly, I also recognize that you inherited a large backlog in claims. I applaud you for the 40 percent reduction in claims over the last 3-year time period. I also recognize your modified budget account structure. I like it. Keep it up. I think it's helpful to us as we examine the budget, and I suppose all the years I did with DOD budgeting, I like that. And transparency and seamlessness, and it permits us to examine. I think it also permits some more precise accountability of where the money is going. So I just wanted to share that with you.

I also thank you for establishing the benefits delivery discharge program. When you set that up at the 136 military bases around the country, I believe it was to ensure a more seamless and timely transition of our active duty and reserve component men and women when they separate from active duty. It's been long overdue, and it's a great program. We've been watching what you're doing, and we're getting feedback. And I just want to applaud you for that.

You also finally have brought about measurable performance outcomes in the department's what I would classify as the undisciplined billion dollar information technology programs. And I hope

your newly confirmed CIO continues to provide strong oversight of your IT programs and not let the decade-old project, VETSNETs and the CoreFLS project to continue to be funded without requiring a measurement of improvement. So I solicit your comments on your IT.

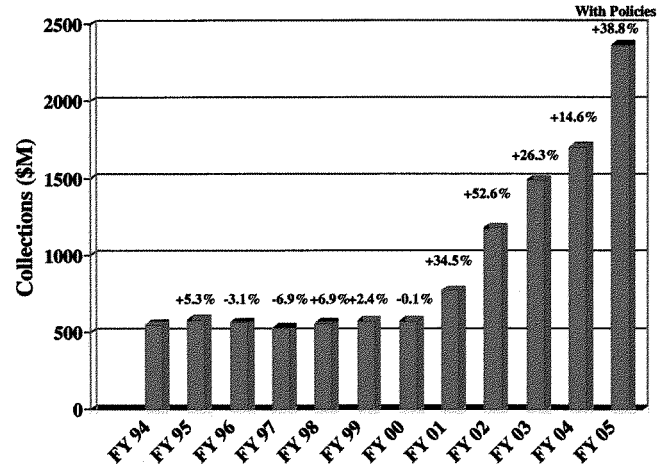
Also with regard to the significant dent in your third-party claims processing, you have some great expectations that you've laid out in this budget, and I would welcome your comment as to whether or not you can realistically meet them.

And last, I'd like your comment on whether you are pleased with the progress or lack of progress in the DOD-VA sharing initiatives, and will continue to monitor both of the departments' commitment to the President's mandate. I do recognize, Dr. Roswell, that you have an ongoing discussion with General Webb out at Tripler, and Mr. Secretary, it's dumbfounding that we can have state of the art equipment at Tripler and you can throw a paper airplane from Tripler to the VA, yet in radiology where we run filmless x ray, that those two systems can't talk and communicate to each other.

So the more we get ahead and get on with it with DOD sharing, even in the purchasing of equipment, let's be smart about our business. I'd welcome your comment.

Secretary PRINCIPI. Well, I have a chart on medical care cost recovery, if you could please just bring that one up. Again, of course, we have increased collections, because we have more veterans being treated, and then we had an increase several years ago from $2 to $7 in pharmacy co-payments, but I think we've done a much, much better job over the past few years increasing the collections. Again, those dollars stay with the VA, which is the beauty of the whole thing, and there's a real incentive to do well in this area.

Medical Care Collection Fund



Secretary PRINCIPI. So I believe that with the new systems coming on line, like patient financial services system and some of the electronic software applications and insurance verification and identification and accounts receivable, we'll be able to continue to improve our collections from insurance companies. But, of course, as you know, Medicare is the biggest insurer in the Nation, and they're off bounds to the VA, as well as many of the HMOs, that we have much difficulty collecting from them because they refuse to do so. And your support in that area, especially with the HMOs and the IPOs, whatever they're called, would be very, very helpful. I'll ask Dr. Roswell to talk about the radiology issue.

Dr. ROSWELL. Thank you, Mr. Buyer, Mr. Chairman. We are very pleased with the level of sharing between the VA and DOD. As the Secretary mentioned in his opening comments, we now have an exchange of information including the receipt of lists of persons who have been discharged following service in Operation Enduring Freedom and Operation Iraqi Freedom. That has allowed us to do the needed directed outreach to make sure that those men and women have seamless health care, and we're very pleased to be able to do that.

With regard to the situation at Tripler, certainly the commitment that both the Department of Defense and the Department of Veterans Affairs have made to go to a data repository architecture to mount electronic medical records by the end of fiscal year 2005 will allow the sharing of digital imaging, including digital radiographs, at that location, and we're very pleased with the progress that we've made within VA towards the data repository architecture with the electronic medical record, and certainly hope that similar progress is being made within DOD.

The CHAIRMAN. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman. Welcome, Mr. Secretary and gentlemen. Mr. Secretary, I think that medical inflation is running around 8 percent now, something in that range, nationally, and I know it's hard to compare your system. Your medical care budget is a 4.1 percent increase. You've talked about the problems with surging demand, but it's not just the surging demand of increased numbers, it's also the problem of increased costs.

I appreciate your candor in telling us that your request to OMB was $1.2 billion more than this budget, which means in my view that this budget is $1.2 billion short perhaps. But if I add on the $1.2 billion, that gets me to 8.39 percent right at medical inflation. And all those charts are great about showing increased bar graphs, but they don't take into account the problems of medical inflation. I don't think that's a very fair comparison for the American public to make. But I appreciate your candor in telling us that you are aiming to get to that percent increase.

A specific item—any comments you want to make about it are fine—but a specific item I would like you to spend some time on, and I don't know what happened if you made your request, you were told you were going to be $1.2 billion short, and then you had to go back to your budget and look for ways to find that, but your research budget is a $50 million cut, your research, medical re-

search budget, is a $50 million cut. And that is—and fortunately, we see that in other places in the budget, not in your budget, the DOT, the basic research budget is a cut, an actual cut in dollars. This is not keeping up with inflation. This is a cut in dollars, and that's real money. And would you tell us what your thinking was on the cut in the——

Secretary PRINCIPI. Yes, sir. If I can just address very quickly the medical inflation issue. We're not subjected, although obviously we do have medical inflation, we're not subjected to the same medical inflation that the private sector. Of course, 60 percent of our budget is payroll, and we're capped.

Of course, we have a physician recruitment and retention problem which we hope that the Congress will work with us on this year, as well as our pharmacy. We've done a great job, as you know, in keeping our pharmacy costs under control.

On the research, yes, we've seen a slight cut in the research budget. However, I believe that's more than offset by much more aggressive effort to attract research dollars from NIH. And I believe that the number of grants we're getting—perhaps Dr. Roswell can comment on it—will more than offset the appropriation reduction but will increase the dollars actually coming to the VA in grants from NIH.

Dr. ROSWELL. Thank you, Mr. Secretary and Dr. Snyder. The fiscal year 2005 budget request does combine the indirect research support with research support. And you're correct about the reduction.

It was our hope that we would offset that by being able to capture NIH indirect funding for over $600 million in NIH-funded research that's taking place within the Department of Veterans Affairs, and yet we're one of a very small number of agencies who aren't able to capture the indirect cost of research.

Were we able to capture that NIH indirect cost for NIH funds, funding research in VA medical centers by VA investigators, serving the needs of veterans, then the offset in our appropriation would be more than made up, and we would certainly welcome your support to that end.

Dr. SNYDER. Well, the problem is, is that the NIH budget has its own pressures. It surely is subject to the medical inflation rate, because most of their business is with institutions out there that are nongovernmental. The Department of Defense basic research budget is cut.

I mean, I don't think this is the best way to do government is to say we're counting on another agency getting a robust increase to give us money to make up for the fact that we cut the research line by $50 million. I think one of the folks made some comments about your budget being budgetary gimmicks and smoke and mirrors, and I think it kind of laid it out for you. But I consider this last comment a bit of budgetary gimmickry and smoke and mirrors.

The bottom line is, you all are cutting back on medical research and you're counting on getting money from another federal agency that may well not happen. And I think it's like the canary in the mine, you know. This is like the seed corn for the future. We've got a lot of veterans out there that are dealing with a lot of ailments. They want the ailment to go away. They don't want to come to the

VA hospital. They want to be able to see this stuff go away and be prevented and get the kind of treatments 10 and 15 and 20 and 25 and 30 years from now that—you know what I'm talking about.

Secretary PRINCIPI. Absolutely.

Dr. SNYDER. And the VA has always been one of the most significant players in research in this country, and on certain illnesses, is the number one leader in the world on research in certain areas. Hepatitis C, prosthetics. And we're cutting that.

And I think that, Mr. Chairman, I would encourage us to pay very close attention to this research number, because I think it's got some ominous—it's not as sexy as a lot of this other stuff, but it's got some ominous consequences for our long-term commitment—long-term commitment—to veterans' health care.

Secretary PRINCIPI. Dr. Snyder, I just want you to know that I feel very much like you do. We fought very, very hard for the research dollars. OMB, of course, they have pressures and it doesn't make any difference who is in office, but we fought very hard.

The CHAIRMAN. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. Mr. Secretary, good to see you. I understand the budget constraints that you must be under, I suppose every agency is under.

If you could in the few minutes we've got explore with me some of the efficiencies that you might have seen in drafting this budget, some of your expectations. I recall last year a lengthy discussion about your—about pharmaceuticals and savings that you hoped to realize there. Are there any significant efficiencies that maybe you see coming this year?

Secretary PRINCIPI. Well, we're proposing an efficiency rate of 1.5 percent, which I think is very, very small compared to the private sector, what we're seeing in productivity improvements in this country of ours because of technology, and so we're probably less than half of what's happening.

And indeed, I think the vast investment that you have made in us in information technology is allowing us to do things smarter and better.

You know, I just previewed a new software application that we brought online. We call it our capital asset management system, that allows us to track every lease we have, and believe me, we have thousands of leases. And by tying into the GSA databank, we know which leases we're paying more than market value and which ones are less. So we can now go out and renegotiate leases and make those kinds of efficiencies improvements.

Our medical care cost recovery has become much more efficient as we've consolidated some of that and brought on new technologies to help us collect money from insurance companies.

DOD sharing. I can't say enough about DOD sharing. In some areas, it doesn't always work where we have a great population growth. But we need to do more together. We need to purchase together, procure equipment, procure pharmaceuticals, medical/surgical supplies.

Standardization. I've preached to my people to go national contracting and standardization to drive down the costs. We don't need to buy 15 different types of certain pieces of equipment. We can standardize that and discount it 10 or 20 percent. And when you

procure $7 billion worth of goods and services, you know, you can cut off 5 percent or maybe a little bit more, you can save a lot of dollars. And we need to do more of that, and we are. But it's a struggle to change cultures and the habits of how people have done things in the past.

Mr. BEAUPREZ. Well, I bring it up probably because of a conversation at breakfast this morning with a manufacturer, a machine tool company in my own district, who's got a contract with DOD, Navy specifically, and he said through their design and efficiency process, begin a very small business, what used to cost $100 now costs $55. It basically cut the cost in half.

And I don't want to make work for you all, but I would suggest that it might be beneficial for members of this committee to understand more fully some of the efficiencies that you can achieve as you go forward.

Let me pursue another line, if I might, and just throw in a comment as well. The cost recovery issue you all know is important to me. I've sponsored some legislation to assist in that. I hope we can find a solution in it. I would also second Dr. Snyder's concern about research wherever it comes from, I hope we're continuing our research.

But long-term care. I notice a comment in one of the briefs that we have that you are continuing to look at closing some beds, and that of course raises alarms, but I also see comments about the changing nature of long-term care, more in-home hospice. Could you comment a little bit on where the VA sees that going?

Secretary PRINCIPI. Yes. We are in fact trying to do more in noninstitutional care, by instituting programs and making sure we have uniformity across the country to allow veterans to reside in their homes for as long as possible.

We believe that technology and better care management allows veterans to stay home, combined with respite care, adult day care, home-based primary care, you know, adult day care. So we believe that we can reach and help many more veterans if we can shift some of our focus into the noninstitutional care setting.

But at the same, I know of the interest of this committee in maintaining a level of VA nursing home beds. And we are doing that. But we would like to see the community nursing home beds that we contract for, that allows veterans to reside in nursing home beds closer to their home, as well as the state homes that we have funded at an increased level, we are proposing that those be included in the definition of nursing home beds, and we think it's more adequate and more balanced.

Mr. BEAUPREZ. Thank you, Mr. Chairman.

The CHAIRMAN. If the gentleman would yield just briefly before going to Mr. Rodriguez, just to amplify or to underscore how important this committee does see the nursing home, long-term nursing home issue, we had a hearing just a few days ago on that. Dr. Roswell knows it well. And there is strong bipartisan support for not decreasing but actually increasing the whole mix, including those beds that are provided on the federal level. So I just wanted to make that point. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. And by the way, Mr. Chairman, I did listen to your comments regarding the need to continue to work on this budget. And, Mr. Secretary, I also listened to you, the fact that you had requested that additional $1.2 billion that was needed.

The bottom line is the President's budget raises health care costs for over 500,000 veterans, imposes new co-payments and enrollment fees that will cost veterans approximately $2 billion over a 5-year period, according to the data. And in fact, over 5 years, the budget for the veterans health care program is $13.5 billion below the amount needed to maintain services for current levels.

Mr. Chairman, I know that last year we worked together on increasing I know with yourself and Mr. Evans and others are making sure we would increase the budget, and I would hope that we do the same this time around. I just cannot believe that the administration would do this and continue to do that, and we've had difficulties in increasing that. And I saw the charts. But the reality is, even with the increased number—even with the increased number, Mr. Secretary, and you've done a tremendous job on a variety of areas, including the backlog, as well as the numbers, the fact is that we have 25 million veterans out there.

And, yes, we've known, both during the Clinton administration and during the Bush administration, both Republicans and Democrats, we have failed to basically respond to the needs of our veterans, and we've known those numbers, both Democrats and Republicans. And there's a real need for us to come forward.

We're in war right now, and this is shameful for us—it should be shameful for both Republicans and for Democrats, that we cannot come up with the resources that are needed for our veterans. And the reality is, the fact is that we are addressing less than 4.7 percent of our veterans that are out there in need.

And so we have a situation where almost 81 percent of our veterans are not even being serviced by the administration, Veterans Administration. And so based on the figures, if there's over 25 million, we've got less than 4.7 of them, you know, there's a large number out there. And we know the demographics, and we've known them in previous administrations also.

And so, Mr. Chairman, I would hope that as we look at these numbers that we battle away together as we did the last time and try to come back. But I cannot believe that the administration would come back forward once again and begin to dialogue about some of the same issues that we had some concerns last year, and that was on the co-payments that we agreed that, you know, we were against and that we were not wanting to touch on those issues and that we needed some additional resources.

Right now as far as I know, we still have some young people coming back from Iraq, from Afghanistan, that are coming back, some with serious illnesses. We went to Walter Reed. We see these young people coming back.

I'm told also that it appears that the VA has added some 500 million for medical care, an increase of less than 2 percent; an increase of less than 2 percent. That 4 percent that's being talked about, I presume is the co-payments that are being added to that

over the next—so it's less than 2 percent increase. And I know Dr. Roswell has talked about the need for 13 to 14 percent overall in terms of just to keep up with existing programs, just to keep up with existing services.

And as we get the reports from the President's advisory task force on care, we know the disparity that exists between regions in areas in states throughout this country. The fact that we have certain areas in South Texas that to this day do not get the services that they should be getting because of the fact that they're not there. And I know we're working hard to try to meet those needs. But, you know, if nothing else, both Democrats and Republicans ought to look at this.

This is an election year, and this budget, in all honesty, is embarrassing. And I'm glad to hear, Mr. Secretary, that you asked at least for an additional $1.2 billion, and I'm glad to hear the chairman say that this is not satisfactory, at least that's what I gather that you were saying, that we need to do more. And I'm hoping that we buckle down and get some resources in this area, because this is something that we should not tolerate.

And I've said this under Democratic administrations and I continue to say it under the Republican administration. The fact is that we've got to come to grips with this. This is unacceptable, and we've got to make some changes. And we can show all kinds of figures about increasing numbers. But the demographics show we're probably still disproportionately responding to the need because of the need that's out there.

And so we can say, yes, we've made some inroads, but we're not there yet, Mr. Secretary.

The CHAIRMAN. Thank you. Mr. Renzi.

OPENING STATEMENT OF HON. RICK RENZI

Mr. RENZI. Thank you, Mr. Chairman. Mr. Secretary, thank you. It's good to see you this morning. I don't know always that you get the commendation that you deserve for your leadership and your service. I'm grateful for it. I think you speak with humility today in your stewardship role as you describe to a lot of the colleagues here the economies of scale that you've been able to find.

I think you put together a great team. I commend you for it. I want to look into the budget and ask you, as I go through and looked, and I know last year when we got together, we spoke about a little bit of a judicial activism that we saw with the courts as it relates to the case involving *Allen* v. *Principi* with the alcohol, not the treatment of the alcohol or drug abuse, but the compensation of alcohol and drug abuse.

I had a chance to go out to Prescott, where you have at the new Bob Stump Veterans Hospital out there, one of the finest detox centers in America, compared to anything. Arizona has a lot of detox centers. In talking with some of the addicts out there, and the addictions that they are struggling with, they don't want the compensation. You talk to these guys and these gals coming out of addiction, and they're not looking for another subsidy, another handout. They're looking to pull themselves up by their own bootstraps.

I wanted to give you a chance to expand upon if we're able to get some sense into the courts, if we're able to pull back from this,

not the obligation we have to treat, certainly not to treat, but to compensate, the kind of savings and efficiencies you would see there, please.

Secretary PRINCIPI. Well, it's my understanding in the past we have proposed legislation that would prohibit payment of disability compensation to those who use alcohol or drugs. I think that was turned down.

I believe the focus should be on rehabilitation. The veterans who, for whatever reason, have a substance abuse problem, the VA should have its doors open to address that issue, as well as other behavioral conditions that would lead to homelessness. I think that's the most compassionate way to address this problem.

So, you know, I'm just maybe a little too traditional. I've never believed that a disability compensation program was intended to compensate people for substance abuse problems. We have a responsibility to help cure them so that they don't become homeless, and devote our resources there.

I know veterans do have PTSD and they may turn to alcohol and substance abuse, and we should compensate for them for the PTSD. But I don't believe they should be compensated for the substance abuse. That's just a personal philosophy of mine. But I want to help them.

Mr. RENZI. I'm with you.

Secretary PRINCIPI. And we have added so much money to our homeless program. We're going to have 10,000 beds, the grant and per diem program. We're increasing funding from 175 million to 188 million in 2005. I think the VA is the leading integrated provider of homeless services in this Nation. And we still have too many homeless veterans, but I think we're making great progress, and it's because of the dedicated employees in VA.

Mr. RENZI. Sure. I wanted to give you a chance to expand on maybe the numbers that you think we could save, the efficiencies that could be found if we were able to roll it back.

Secretary PRINCIPI. $2.8 billion that we compensate for substance abuse.

Mr. RENZI. $2.8 billion.

Secretary PRINCIPI. Sorry. Over 10 years.

Mr. RENZI. I'm with you. But when we talk about shifting monies this year and we get down to arguing together and debating, we do have an ability within the system to find major amounts of monies that we can shift over into medical and true care.

Lastly, I want to talk to you about, within the budget, the line item that you have for education, reaching out to our veterans, educating them on some of the programs that are available to them, I want to put a commercial in for a piece of legislation that we passed on a bipartisan basis that affects our disabled American veterans, allowing them to use their Montgomery GI Bill, not only to go to school and take entrepreneurship classes, but to develop small businesses. If it wasn't for Mr. Rockefeller on the Senate side, we would have had a much limited piece of legislation that allows sole-source only to veterans, disabled American veterans within the business that they're conducting with Veterans' Affairs. We now have expanded that to include DOD, Homeland Security. I would ask your vision of educating the disabled American veteran

so that they now know that they have this program available, that they can go out and develop a small business and do sole-source contracting with the government.

Thanks, Mr. Secretary.

Secretary PRINCIPI. Yes. I couldn't agree more. I think the legislation that was enacted into law that now allows us to do more with disabled veterans in small business ownership is a long overdue step in the right direction.

I think everything we can do to outreach to disabled veterans who are interested in pursuing their own business, help them get started, set aside some contracts for them, some small business contracts, I think it's a very, very important step.

The CHAIRMAN. Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you, Mr. Chairman. Good morning, Mr. Secretary. I appreciate your candor this morning and honesty, but I must say that I am very disappointed that we ask our military personnel to risk their lives around the world and the administration has presented us with a budget which fails to adequately provide the benefits and services earned by the men and women who wear the uniform as well as the budget does not even include the cost of the war in Iraq as it relates to veterans' services.

[The prepared statement of Congressman Michaud appears on p. 95.]

Mr. MICHAUD. I have four questions. The first one is can you explain why the administration is proposing to cut benefits for approximately 50,000 veterans per year who uses VA's home loan program at a cost of $91 million over the 10-year period?

Second question is, I understand you're pleased with what the DOD is doing as far as sharing information. Are they sharing enough information with you, and do you feel that you are able to effectively plan to provide care for our military personnel as they return from Iraq and Afghanistan?

The third question is, like you, I do believe that improving management efficiencies is extremely important. This budget, like previous budgets, has used management efficiencies to cover costs for the sake of improving management efficiencies of the management. Do you have itemized data to show where the VA actually has saved money in previous fiscal years?

And my last question is, there is a severe threat concerning VA state homes, and we had a hearing just last week. States are being compelled to seek VA's per diem payments as a veterans third-party liability and offset them against Medicaid payments to the homes. We were told last week by the National Association of State Veteran Homes that this approach may have a profound effect on their future operations and even cause some of these homes actually to close their doors. Does the VA have a position on this?

Secretary PRINCIPI. I'd just start out, I think we may disagree on the budget. I appreciate your position and am certainly not trying to be argumentative.

I'm very proud of our track record over the past 4 years, and I think—and our work with Congress to have a 40 percent increase in health care alone, which perhaps maybe after World War II,

there was a big plus-up in the VA, but I think in modern history, the VA health care system has never seen such an increase that I know of. And I could be wrong, but I think we should be very, very proud of that, and I'm very proud of the President. That 40 percent breaks down to 27 percent based upon the President's request and the Congress added 13 percent to the President's request over the past 3 years.

Mr. MICHAUD. But, Mr. Secretary, may I interrupt? I appreciate those numbers. I've been in the legislature in Maine for 22 years, and I can appreciate how you can manipulate numbers. The bottom line is, veterans are not being taken care of today. And you can use these increases.

The budget has been inadequately funded over a number of years, number one. Number two, with the cost of inflation, it definitely has caused a huge burden on the effect.

Number three, when you look at the economics in this country, in the State of Maine, we've had labor market areas with over 38 percent unemployment. And there are a lot of these veterans who lost their health care because of the private industry who had been subsidizing the VA, taking care of benefits for the veterans, and they need their help now.

So there is a huge need out there. When I look at whether or not we're taking care of our veterans, I look at are they receiving the services.

I can appreciate using these numbers to try to justify it, and I appreciate all that you've done for the VA, and I know that you have to, you know, work for this administration, and I appreciate your additional money. Hopefully we'll be able to get that increase in there. But don't try to say that they're being take care of, because they're not because the real dollar figure is definitely not up there.

Secretary PRINCIPI. I understand. I'd like to—certainly you raised a very important issue about the home loan program. There's economic assumptions when that proposal came up that showed a cost savings. It now shows a cost over 10 years of $91 million, and I think that really needs to be looked at, and I'm sure the committee will look at it very, very carefully.

I was very insistent that if there was going to be any change that active duty military personnel be exempt, because they move around all the time and can't built up equity in their homes. So that active duty military personnel should be able to use that benefit as many times as they need to while they're on active duty, but that after you become a veteran, to take advantage of it one time to build up equity, so that you can buy your home and put the 20 percent down. But again, the economic assumptions have changed.

And then there was another question. I think we're making great progress. We're not there yet, Congressman, on DOD-VA sharing, to make sure that we have seamless transition for our active duty personnel coming back from war, and to go into the VA health care system. But as Dr. Roswell said, by the end of 2005, we should have this bi-directional data sharing in place, but I do think we really made this a very high priority and am proud of the steps we've taken so far.

The CHAIRMAN. Ms. Hooley.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chair. Thank you, Mr. Principi, for being here and for the job you do. Thank you for coming to Oregon. Our veterans have made personal sacrifices, and one of the things we said to them, they won't have to worry about health care. I don't think when they come back from battle they should have to worry about health care.

The President's budget falls about $2 billion short of what is needed to provide adequate health care to our Nation's veterans. In fact, over the next 5 years, it will be over $13 billion below the amount needed to maintain services at the current level.

The needs of our veterans are not being met. Funding for medical care per veteran has steadily declined in constant dollars over the last decade, while the number of veterans seeking health care has increased.

In Portland VA, we have a waiting list of about a thousand veterans who want to see a primary care physician. We have something like 700 to 800 veterans each month trying to get into the health care system. It takes them over a year to get to see a primary care physician. Health care costs are going up.

I mean, when you talk about a 2 percent increase, a 3 percent increase, the fact is under Medicare health costs are going up 8 percent. I've talked to people who run hospitals, insurance programs, they're talking 8—15, 14, 15 percent increases, and this budget doesn't keep up with the increase in health care costs.

One woman recently wrote me and she said, we got to the hospital about 3:00 p.m. and we were in the emergency room. I don't know why they were in the emergency room. They got there at three o'clock in the afternoon. They waited until almost 12:30 a.m., 9 hours, and there were still people ahead of them, and so they finally left.

So my question is, what are we going to do about people—and this isn't the only story I've heard about people waiting that long in emergency care. In fact, a woman who works for VA just this weekend told me that somebody had broken their toe and they were in the—they were waiting for, I don't know, again, 9 or 10 hours, and she was a mental health worker, and the person was fairly agitated, and she spent a lot of time trying to calm the person down.

So how are we going to fix that?

Secretary PRINCIPI. It's a real challenge. You know, I think we need to keep in perspective that prior to 1998, only about 2.9 million veterans had eligibility for the full continuum of VA health care. And Congress made the decision to open the door to all 25 million veterans, and it dramatically changed the face of the VA, to go from 3 million one year, and the next day you have 25 million who can go to outpatient clinics.

And, you know, I wasn't here then, but Congress must have envisioned that not all veterans would be able to get care, because they established—you established a priority scheme with seven, now eight different priority levels, and then you put in the law that the Secretary had to make an annual enrollment decision, quote, "based upon the extent resources are made available to you in appropriation acts."

If it was intended that all 25 million would come, there would be no need for priority levels. There would be no need for enrollment decisions. I think there was an understanding that we may not be able to do that.

And obviously when I came here, demand and budgets were just totally out of sync. And we were just growing, and veterans were being placed on waiting lists. Like, you know, you can enroll, but you're not going to see a doctor for 6 months or a year. I mean, what kind of health care system is that?

So we started to struggle to bring down the waiting list, and it's been difficult, but we're getting there. We're doing that through increased resources that the President and you have given us. We're doing it through advanced health access by incorporating new initiatives, building more outpatient clinics, hiring more doctors. So now we're down to 30,000, but it's still too many. And we're still enrolling veterans at an unprecedented rate.

So it is a challenge.

Ms. HOOLEY. And yet we said to veterans——

Secretary PRINCIPI. I can't disagree with you.

Ms. HOOLEY. Right. But we said to veterans, if you're going to serve in the military, if you're going to put your life on the line, then we're going to serve you and we're going to provide health care, and we've got to figure out a way to do this. And again, we're not going to do it with an increase of 2 percent or 3 percent or 5 percent when you talk about health care costs going up and you talk about enrollment going up.

Secretary PRINCIPI. I'd agree with you.

Ms. HOOLEY. And it's huge.

Secretary PRINCIPI. You know, there is no higher priority for me than the kids—the kids—the young men and women in Iraq and Afghanistan. I mean, I've had two sons there at the same time. I feel deeply about this. This is very personal to me, and we have to be there. We have care coordinators now in every hospital. We have full time staff up at Walter Reed and Bethesda Naval Hospital to make sure none of these young heroes fall through the cracks.

And I can assure you—I can assure you that we will do everything in our power to make sure that if they need health care, if they need prosthetics for lost limbs, we're going to give them the best. And that's just the way it has to be. There should be no higher priority than the disabled men and women who serve this country in uniform. And to the extent we can take care of many more people, wonderful. But we've got to remember who, you know, to care for him who shall have borne the battle were Lincoln's words that are on the cornerstone of my building, who have borne the battle. They're our highest priority in my view.

The CHAIRMAN. The chair recognizes Mr. Boozman.

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. Yes. First of all, I really do want to thank you and your staff, Mr. Secretary. I know that nobody—you've got a tremendously difficult job in dealing with this, but I believe with all my heart that you and your staff care about veterans as much as any-

body in this committee or anyplace. So we really do appreciate your hard work.

A couple of things. You mentioned earlier about the co-pay with the HMOs, you know, and different entities and trying to get that money. Is the problem—do we have the legislation in place to get that done, or is it a matter of enforcement, or is it a matter of coding, or what do we need to do different to help you out in that respect?

Secretary PRINCIPI. Maybe Dr. Roswell can answer more technically. We just have been very, very unsuccessful in collecting from HMOs the cost of the care. Private insurers, you know, employer insurance we do pretty well, but HMOs, and I think we need legislative help to require HMOs to reimburse us a reasonable level for the cost of the care that we provide to those who have paid premiums for health care in an HMO.

Mr. BOOZMAN. Right.

Secretary PRINCIPI. And those dollars could stay with the VA so that we can do as Congresswoman Hooley and Michaud asked us to do is to provide more health care, and I think that's a component of the authority you've given us, but we're struggling.

But it's also coding. We have internal problems. You know, getting our doctors to document what they do and then code properly and then send out that bill. I think we're doing better in those areas, but we could use help.

Mr. BOOZMAN. Well, I know you're working on that. But you do then feel like legislation is needed to beef the thing up where we've got some penalties or whatever, some enforcement mechanism to actually to get them to come through.

The other thing is, we mentioned, you know, about the seamless transition as far as from the DOD to VA. How about as far—you know, we, as a committee as a Congress, we've tried to encourage the DOD to cooperate better with us as far as facilities, you know, health care facilities and just some equipment sharing, you know, in that area. How is that coming?

Secretary PRINCIPI. I think it's much better today. Bob, you may want to answer. We have a joint economic council. We have a joint strategic plan, and we're committed to it, but there are a lot of cultural and institutional barriers to really breaking down the walls completely. But I do think we're light years ahead of where we were after Vietnam, maybe even after Persian Gulf I.

My predecessor has made some great strides. I think we're continuing to make strides, but there's just more that needs to be done.

Dr. ROSWELL. I would point out that in the Capital Asset Realignment to Enhance Services process, the CARES process, DOD was an active participant. Over 80 joint ventures were considered in the formulation of the regional and national CARES plan. A number of those were identified as priorities in the draft national plan, and we certainly hope that they will be in the recommendations that the CARES Commission presents to the Secretary in the next week or two.

Mr. BOOZMAN. Okay. Thank you.

The CHAIRMAN. The chair recognizes Ms. Davis.

OPENING STATEMENT OF HON. SUSAN A. DAVIS

Mrs. DAVIS. Thank you, Mr. Chairman. Welcome, Mr. Secretary, good to see you, and thank you for your commitment in San Diego as well.

I wonder if I could ask a few questions about our help for our veterans who either have post-traumatic stress from other situations or certainly from the war in Iraq and Afghanistan. How much of this budget—we talked about long-term care last week and the questions that we all have, not just in the general population, but of course for our vets in trying to have the research available and to treat really our problems with mental illness today—how much of this budget is directed at that out of the medical dollars, if that number is available?

I'm looking for the increases. What do we expect to see as a result of particularly Iraq and Afghanistan, and does this budget really reflect that? What would be our best guess on that?

Secretary PRINCIPI. Well, we have proposed to increase our budget for PTSD alone from $167 million to $181 million, and the number of patients will grow from 59,000 to almost 64,000 2004 to 2005, so there is an increase in the level of care for PTSD.

But you know, it seems to me, and I should let Dr. Roswell comment, all of these conditions are intertwined. You know, they have PTSD, they may have substance abuse problems. They're probably homeless in many cases, and they have mental health issues that need to be addressed. So I think it's a matter of trying to address all of those underlying concerns.

Dr. ROSWELL. I appreciate the question. It's more than just dollars. It's a cultural workforce sensitivity towards the needs. We have been fortunate that we haven't yet seen a huge number of cases of PTSD in the men and women who've served in OIF and OEF.

But I think that some of the world class research this committee alluded to earlier shows that as support systems weaken, as readjustment issues are encountered, as some of the fanfare dies down and people face going back to work, dealing with a spouse or a child who is not doing well in the school after the servicemember's absence, that's when PTSD becomes a problem.

So we're taking this hiatus, if you will, to focus our educational efforts, making sure that there's heightened staff awareness, making sure that we're using new clinical practice guidelines developed in concert with DOD, making sure that our staff are aware. We're working with our readjustment counseling service as well as our mental health services to make sure that we have the sensitivity and the preparation to recognize PTSD at its earliest manifestation so that we can treat it definitively.

Mrs. DAVIS. I appreciate the new interest in trying to track and alert people to the services that are available, but I would like you to think about, you know, realistically, are those gains enough? Should we putting more of our efforts up front?

I've been to just far too many stand downs in San Diego, and, you know, it really is based largely on the kinds of care, the services that were not available to these people when they really needed them. And so if we can take a realistic look at that, that may

be an area that we need to shift some resources as those needs become available and obvious. I appreciate that.

I know that we have dealt with the long-term care issue, the fact that there would be fewer beds available. We're making some assumptions I think that a lot of the veterans can be served at home perhaps with additional supplementary care. That may be an assumption that doesn't work for this population, and we probably need to be taking another look at that as well.

Mr. Secretary, I wonder if you could respond. Of the issues that you have tried to address of the $1.2 billion that you would have liked to have seen in this budget, would you share with us, what part of this budget gives you the greatest amount of concern?

Secretary PRINCIPI. Well, there are a lot of things I'd like to do, Congresswoman Davis, to address the needs of veterans, to take care of more veterans if possible, you know. I grapple with the issue of the Category 8 veterans and should that door be opened again? If so, when? We still have a waiting list.

So, you know, again, I'm very proud of what's been done by people of the VA with your support, the President's support, but I, you know, I—veterans live in—veterans are not as kind of a segmented group of people. We're Americans. And, you know, terrorism is an issue for us and our families and the war and the economy and jobs, and, you know, taxes. All of these things impact the veteran community, because we are ordinary Americans. Some have done better than others. They scaled the walls of Normandy, came home and built modern America. And they faced the same challenges that all of us, that all Americans face.

And so I want to be mindful to do everything I possibly can to advocate for veterans programs but also to remember that education for our children is important, et cetera, et cetera. And so there are priorities that you, the Members of the Congress and the President, have to determine how do we divide all of this up. And it's a very difficult process. But I think that we have got it—we have done very, very well over the past 3 years.

The CHAIRMAN. Chairman Rob Simmons.

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. SIMMONS. Thank you, Mr. Chairman. Thank you, Secretary Principi. Let me just say for the record that you and I both served together in Vietnam, albeit you were in the Navy. I'll forgive you for that, I suppose. But we also served together on the Senate side as Senate staffers back in the eighties, and it's been a great pleasure for me over the last year or so to serve as chairman of the Health Subcommittee and to work with you and your fine staff to try to come up with better solutions for the health care of our veterans, better solutions.

Now there are some good things in this proposal, and I have been through the proposal and I'm happy to see some of the good stuff. I'm happy to see that former prisoners of war will no longer have to do co-payments if they're in a hospice program. I mean, gosh, almighty. It's a small thing, but it sends a powerful message.

And I'm glad that we're increasing support for our homeless assistance programs because my experience—you said veterans are

Americans. They are. I'm a veteran. I'm an American. If I'm sick and if I can get treatment at home, that's what I'd prefer, to going to an institutionalized setting. And so I think that's good and I think that's worked very well around the country.

Waiting lists for access. You know, we have heard all the horror stories. When the new VA principal for Connecticut was installed 9 months ago, I said I want you to bring the waiting list down. Our waiting lists in Connecticut are under 30 days. That wasn't done with passing a law. That wasn't done with more money. That was done by setting a challenge out to the people that administer the programs and say 90 days plus is too much. Let's see what you can do. And they brought it down to under 30 days, which is about what it takes me to get into my private care physician, which is kind of amazing.

CARES process. I think the fact that we're going forward with funding certain projects now because we see the need is really important. And I think that's a real plus.

Third-party claims. Huge. I want to expand it. I want to do more there.

That being said, the chairman and I did go to the administration to OMB over the break, and we did lobby heavily for more dollars for veterans, and we I suspect were not successful. But then, that's the beauty of our process and that's the beauty of our system. The President has proposed it. It's for us to dispose of it, and that means we conduct hearings, which we will, we make changes. That's the way the system works, and that's the way I think we should work.

[The prepared statement of Congressman Simmons appears on p. 93.]

Mr. SIMMONS. And with that in mind, Mr. Secretary, my first question goes to the issue of the $1.2 billion. In anticipation of committee or subcommittee hearings on this budget, will you provide us with what was requested and denied in that $1.2 billion and in a timely fashion so we can take a look at it before we go into our hearing process this spring?

Secretary PRINCIPI. We'll provide that information.

Mr. SIMMONS. I appreciate that. Secondly, the chart is pretty clear. Cumulative increases since FY 1996, 61 percent in funding. That's your medical care appropriation. In most circumstances, that's an awesome figure. I mean, it's an awesome figure, except the unique VA patient load has gone up almost 76 percent.

And, you know, that's the ugly reality. As Mr. Buyer has pointed out very clearly, 1996, the Congress changed the rules of the game. Unfortunately, when we changed the rules of the game, we didn't fund it. We failed to fund it. That's not your fault. That's our fault. That's what we have to address.

So my second question goes to the issue of pharmacy benefits. I feel that pharmacy benefits are a huge issue for many veterans who would like to access pharmacy, would like to capture the savings of VA pharmacy, but for one reason or another are not able to access the system, and that includes priority 7 and 8's. Could you explain to me what you are proposing in the pharmacy area, and would you also explain for the record how your pilot program on pharmacy has worked? I believe you announced it last summer.

Secretary PRINCIPI. The pilot program I thought went very, very well. We provided pharmaceuticals to I believe it was about almost 8,000 veterans who had private sector physicians and only wanted the pharmaceutical benefit, in an effort to help those who are waiting a long time to see doctors just to get prescriptions filled, we did the pilot. I thought it worked very well.

I'm hesitant to expand it right now. You know, I believe that what we need to do is get veterans in, get them seen in a timely manner, provide them with their pharmaceuticals. But a prescription only benefit program would have serious implications for the VA if we just became a—filled prescriptions. And I would imagine the costs would skyrocket because of that segment of the population who would just come to the VA just for script only.

But it's something that we continually explore, Mr. Simmons, and will continue to do so with you.

Mr. SIMMONS. I appreciate that. I know my time has run out. My guess is that if we could provide veterans with a pharmacy benefit in a timely fashion, we would not see them waiting for 12 hours in the emergency room, because the prescription drugs would regulate their chronic condition, which would enhance their health.

But I appreciate your testimony. We look forward to working with you and your staff and the VSOs in the spring to dispose of this budget that has been proposed to us. Thank you.

The CHAIRMAN. Thank you, Chairman Simmons. Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you, Mr. Chairman, and happy birthday, Mr. Nicholson. It's a pleasure to have you here on such a special day of your life.

Mr. Principi, Secretary Principi, and Dr. Roswell, it's always a pleasure to see you. I can't tell you how much I appreciate all your efforts on behalf of the community that I represent trying to help me in my efforts to provide the veterans that live in the Las Vegas Valley with a full scale medical complex.

By your own estimates, as you are well aware, the prediction is that the number of annual visits by veterans in the Las Vegas Valley to their primary care clinic will rise from the 200,000 that currently exist to a half a million in 2010. That is a mere 6 years from now. And as you are well aware, right now the veteran population in Las Vegas is continuing to explode, and the VA officials in southern Nevada are diligently trying to meet their health care needs with no clinics, no hospital and no long-term care facility. It is quite a chore for them to do that.

I met with Mr. Hemple this past week, and as you know, he'll be retiring in March, and I will have a new VA district director in March. This will be the third one in the 5 years that I've been serving, and I'm hoping that this one will last a little longer. I suspect there's a little burnout, because the chore that they've been tasked with in the Las Vegas Valley is probably more than anybody can actually handle and do successfully.

Veterans in southern Nevada and across the country are counting on the CARES plan to provide the necessary VA facilities. The President has requested $524 million to begin implementing recommendations associated with the CARES plan, which includes of

course a full service VA medical complex in Las Vegas. My concern is when the CARES Commission submits a final plan, the concern is that the proposed resources for the VA construction programs will not be enough to begin this process.

As the CARES blueprint is finalized, I am looking forward to working with you to deliver on our mutual promises made to the 200,000 veterans in southern Nevada. Can you give me some idea—and again, let me very quickly share with everybody the fact that our clinic closed because of structural defects. I've got 80-year-old veterans standing in front of the ten VA facilities that are now scattered across the Las Vegas Valley waiting for a shuttle to pick them up in 110 degrees. That can't go on very long.

I also would like you to comment on where we are with the Department of Defense in this cockamamie proposal to share facilities, which simply does not work, and I think the Michael O'Callahan Hospital in Las Vegas is evidence that it doesn't work, and the veterans get shortchanged when that happens.

One other—or two other things, if I could. Long-term nursing home care. Since we have none, some would be great. And while I think home care is important and day care and respite care, all of that is wonderful for the mix, but I've got a unique type of veteran. Most of them moved to Las Vegas in their retirement years, and they are alone. They've lost their spouse. Home care, respite care, day care is not what they need. They need long-term nursing facilities to care for them when there is nobody—nobody else there to care for them. And so I'd like you to concentrate on those issues.

But one other thing, before my time runs out: There's been a continuing—my office is being barraged by concerns that the VA is allowing non-physicians to perform eye surgery in the VA hospitals. I would appreciate you enlightening me on that, because it's becoming a drumbeat back home, and I'm wondering what is that drumbeat all about, Mr. Secretary?

Secretary PRINCIPI. Okay. All right.

Ms. BERKLEY. And you have about 30 seconds to answer all those questions. (Laughter.)

Secretary PRINCIPI. Let me say, we should have $1.3 billion in this year, in 2005, for CARES, $1.3 billion, not really $524 million. That's truly what the President requested, which is more than double from last year. But you gave me the authority to use $400 million of the medical care appropriation. We have carryover—not carryover, we just have—yeah, we have carryover. So the total amount available for CARES today should be $1.3 billion.

Obviously, Las Vegas is a very high priority. You know of my commitment that we need to replace the clinic there. Dr. Roswell is in full agreement on the need for a 120-bed nursing home in Las Vegas, and we both agree that the capacity at O'Callahan—while I am a strong supporter of sharing, I believe it's the way to go—they may not have the complete capacity to take care so that we have to send veterans to San Diego and to Los Angeles to get their care. That's unacceptable. We need to do better. I'm hopeful that when we get CARES done, a strategic plan will be offset.

Ophthalmologists are very upset that optometrists are doing laser surgery. They have launched a major, major campaign to stop optometrists from doing laser surgery. We did permit one or two

optometrists who were licensed to do laser surgery to do it. The ophthalmologists felt that this was inappropriate.

Dr. Roswell, do you have any——

Dr. ROSWELL. At present, no optometrists are performing laser surgery in the VA. We have asked for a suspension of that practice pending our ongoing negotiations with a variety of stakeholders, including ophthalmologists and others, to make sure that we allow a full expression of scope of practice within the Department of Veterans Affairs but don't in any way endanger veterans. That simply will not be tolerated.

Having said that, though, I don't believe that the scope of practice of clinicians should be legislated by the Congress nor regulated by the executive branch of the Federal Government. I believe that's a states rights issue, and we're trying to develop and articulate and promulgate policy that honors that relationship but still safeguards veterans.

Ms. BERKLEY. But you've suspended the practice of——

Dr. ROSWELL. It has been suspended.

Ms. BERKLEY. Okay. And, Mr. Chairman, can I ask one more very quick question? Very quick, very quick. Thank you. Could you—when do you think the CARES Commission is going to finish their work? And then we can get some more space.

Secretary PRINCIPI. They are finished. They're going to submit the report to me on February 12 or 11.

Ms. BERKLEY. Oh, that's great.

Secretary PRINCIPI. I will then take the balance of the month, probably, to review the recommendations, come up with a decision package, and get it to Congress.

The CHAIRMAN. The chair recognizes Dr. Murphy.

Ms. BERKLEY. Thank you very much.

Dr. MURPHY. Thank you, Mr. Chairman. Thank you, Secretary. Because I'm anticipating press releases and critiques that may come out of this, I just thought I'd ask this straight-up question. Based upon the veterans budget, will there be any closing of beds, loss of care, reduction, whether it's nursing home, hospital beds or anything else?

Secretary PRINCIPI. Not because of the budget.

Dr. MURPHY. Not because of the budget. Absolutely not, sir. So even any percentage reduction because of an increase in the number of veterans who may be asking for those? I just want to make sure I have it on the record.

Secretary PRINCIPI. I can assure you there is going to be no cutback, no closures. We have the CARES process ongoing, as you know, and that involves some consolidations and closures and openings and new hospitals. But as a result of this budget, sir, I do not anticipate any cutback in service.

Dr. MURPHY. Because I know last year we ended up seeing some criticisms of that, and I just want to make sure we avoid any cutbacks along those lines.

Jumping to another issue here, I wanted to ask about funding that deals with state veterans homes in Pennsylvania, we have veterans homes where it costs about $200 per day for care per veteran, and the VA I think kicks in about $56 or so per diem for "VA-recognized" veterans. And yet Pennsylvania has the largest Army

guard in the Nation, the fourth largest air guard, several major reserve components, including just in my district alone, they've got an Army reserve regional command headquarters, a Marine and Navy reserve command headquarters, the 28th Infantry Division of the Pennsylvania National Guard, et cetera. And most of all who may have also served in the war on terror in some way or another.

But I understand now what currently happens is there is a distinction made between who may qualify for getting some federal assistance or per diems if they're in a veterans home for care versus a distinction between those who may have been active duty versus those who are reservists?

Secretary PRINCIPI. I don't believe so, Congressman Murphy. I'm not—I may not understand the question. I may have to follow up with you personally. Why don't we look at that?

Dr. MURPHY. That's fine. I'd appreciate it.

Dr. ROSWELL. The states do have some authority to establish priorities for access to the state veterans homes. That's not a federally regulated issue. Our policies address the per diem reimbursement, the certification of those, the delivery of services, but not specifically what criteria the states choose concerning access.

Dr. MURPHY. Well, I just bring that up because I'd like to pass it on to you and get some feedback.

And one other area I wanted to ask about, I know a lot of comments were made last year about waste, fraud and abuse within the VA system. One area that I particularly tried to pursue had to do with finding other ways of purchasing medical equipment and supplies such as reverse online auctions or other elements like that. I left it with Mr. McKay. I guess he's now gone to another job.

And I'd appreciate a follow-up on that to see what other kinds of moves are being made within the Veterans Administration to improve purchasing because I know where you can save money, that's money that can go on to other care, and I was impressed with some of the efforts that the VA had before with identifying waste, fraud and abuse and improving efficiency, so I'd love to hear some updates on that.

Mr. CAMPBELL. Yes, sir. We have, at the urging of the Secretary, we had a procurement reform task force that is giving us savings of over $250 million annually on buying medical and surgical equipment and supplies.

We also have been using, to some limited extent, reverse auctions. We started off using the U.S. Navy's reverse auction software, and we have tried it on a limited amount.

We're also doing things like going back and making sure that we're not paying people twice. We have audit recovery programs. We have a post-award audit recovery program which over the past 2 years has recovered $63 million. We've gotten about $8 million in eliminating duplicate payments at our financial services center in Austin, Texas over the last 2 years, and we are doing things like better bill paying so that we reduce the late interest penalties that we've paid. We've cut that back down to below I believe this past year we went down below a million dollars for the first time, $906,000, and we are increasing our discounts that we're taking from vendors.

So in the past year, we have gotten about $4 million in improved bill paying where we're reducing our late interest penalties and we're improving our discounts.

We're also getting larger amounts of rebates on using our micro purchase cards. Last year we got $17.5 million in rebates. We've subsequently renegotiated our contract for the next 5 years, and we anticipate even without an increase in the volume, we should get at least $25 to $27 million a year.

So we're looking at every efficiency we can.

Dr. MURPHY. Thank you. I appreciate that. Thank you, Mr. Secretary.

The CHAIRMAN. The chair recognizes the gentleman from Ohio, Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Secretary, I'd like to begin my remarks by thanking you for your service to our country. And on two occasions when I've been with you, you've mentioned your two sons. And I know you're very proud of them, and I want to thank you for their service to our country as well.

I think you are a good and decent man. My only wish is that the folks at OMB were as concerned about veterans as I believe in my heart that you are, sir.

I have a question regarding the *Allen* decision, and——

Secretary PRINCIPI. Which decision, sir?

Mr. STRICKLAND. The *Allen* decision, regarding the compensation for alcohol and substance abuse. My understanding is that compensation for those reasons is always secondary to a service-connected condition. Is that correct?

Secretary PRINCIPI. That is correct. I have general counsel here, but I want to make sure. I believe that is correct.

Mr. STRICKLAND. Okay. And you had mentioned that if we ceased providing this particular compensation that there was a savings perhaps over 10 years of $2.8 billion. And I'm wondering, are you able to track that? I mean, do you have actual data that would support that 2.8 number that you shared with us?

Secretary PRINCIPI. I believe we do, Mr. Strickland. I would want to follow up with you, sir, to make sure I gave you all the data. But I believe that in our compensation, disability compensation rolls, we can track that amount and, you know, extrapolate what the savings would be over 10 years.

Mr. STRICKLAND. Okay. Thank you for that. What we're talking about here is a budget, and a budget is a reflection of our Nation's values. And it is all about establishing priorities. I mean, I think that's the most significant thing that any legislative body does or members of a legislative body is establish priorities.

Lots of things, good things, need to be done. We can't do them all. And so as a government, we decide which things are more important than other things. Now I believe that we all understand that the proposals in this budget regarding the co-payment for medicines, the—I won't call it the enrollment fee, but the use fee of $250 year. The Congress rejected those proposals in the past, and I think that most of us who are realistic understand that they're likely, most likely to be rejected this time.

You said if those proposals are not enacted, earlier you mentioned three results. There could be longer waiting lines. You would

have to make perhaps more difficult enrollment decisions, or additional resources. And it seems to me that we all understand that additional resources are needed. And we are making decisions here with this budget.

Now, Mr. Secretary, you and I have talked, and I'm going to bring out an issue here in the committee that I think all of my colleagues need to understand, and I'm talking about the memo. I'm talking about the memo regarding the proactive dissemination or marketing of VA services. And I'm going to read from that memo, and I'd like for my colleagues just to listen to these words. It was dated July the 18th, 2002, from Mrs. Laura Miller. And some of the things she says in that memo are this:

"VHA has achieved significant advances in quality and coordination of patient care. However, the current situation put those advances at risk. In this environment, the marketing of VA services, such activities as health fairs, veteran open houses to invite new veterans to the facilities, or enrollment displays at VSO meetings, are inappropriate. Therefore, I am directing each network director to ensure that no marketing activities to enroll new veterans occurs within your networks, even though some sites might have local capacity. As a national system, all facilities are expected to abide by this policy. Marketing activities could include those mentioned above, as well as generalized mailings to veterans, local newspaper articles encouraging veterans to enroll, or similar public service announcements."

This memo is proof positive that we need more resources in this system. And, Mr. Secretary, my time is up and I don't know if the chairman will give you an opportunity to explain or not or to comment. I hope he does. But——

Secretary PRINCIPI. I'd be pleased, Mr. Strickland, and I appreciate your concerns. I just want to assure you that we have not stopped outreach. I would never stop education and providing our veterans with all the information they need. I felt at the time when we had a waiting list of some 318,000 veterans, you know, engaging in marketing activities so to speak like I mentioned that corporation going out there to make sure we take them from the corporation and enroll them in the VA health care system, I didn't think it was appropriate until we got the waiting lists down.

But I've always wanted, and it was a clarification to that memo, to make sure that health fairs stand downs, TAP programs, outreach, pamphlets like this go out. So I do want to clarify that. I understand the point you're making, and I respect your position. But I think there is a difference between outreach and marketing. And as soon as we get this waiting list taken care of and there's room at the VA, then we should do everything we can to get veterans into the system.

So I think there may be a little bit of misunderstanding with regard to what I intended and how I'm trying to approach it, but I feel strongly about making sure veterans understand what they've earned, and if they choose to use the VA system, we're there for them.

The CHAIRMAN. Mr. Ryan.

OPENING STATEMENT OF HON. TIM RYAN

Mr. RYAN. Thank you, Mr. Chairman. I also, as Mr. Strickland said, would like to thank you. You're in a very difficult position. And I know just witnessing over the last year what a tremendous job you've done in trying to negotiate the rapids in the system.

But I think there is something that needs to be talked about that I think, as I sat here for the last hour and a half, has not been talked about, and it's like the big elephant sitting in the middle of the room that nobody wants to talk about, and it's the tax cuts.

And I know, or I believe that we can't have a specific discussion on this issue without having a general discussion the budget. And I know that this isn't the budget committee, and I know you're not, you know, working at OMB, so it's difficult. But Mr. Strickland made the point. It's about priorities, and that's what we have to do here is decide what our priorities are. And I think for the President to say that we should have another trillion dollars in tax cuts over the next 10 years, which is $100 billion a year, for primarily folks who make a lot of money and have a lot of money, and to take the resources away from—and puts you in a predicament and us in a predicament to make these very, very difficult decisions I think really is a tragedy. And I wanted to be on record saying that, that when we talk about priorities and we use some general language, I believe it comes down to the tax cuts. And I wanted to be on record for saying that.

Now Dr. Snyder talked a little bit about the prosthetic research cuts, $50 million that would no longer be available. Can you explain or just talk a little bit about as we're losing men and women daily in Iraq, most of them in my visit to Walter Reed, most of them are amputees, is the VA doing anything as far as projections to figure out when these soldiers return if it continues at the current pace, is the VA keeping the proper statistics to say in the next year—because we're projected to be over there for at least the next 5 years—is this system going to be ready to handle the influx of these soldiers?

Secretary PRINCIPI. I believe so. You know, one loss of American life, one wounded soldier up at Walter Reed is certainly one too many for me. But as I look at the current situation, I'm grateful that relative to, you know, Vietnam where we lost 58,000 killed and hundreds of thousands severely wounded and, you know, Korea, World War II, 400,000 killed, millions wounded, the numbers today are very small. But still, we need to be there for them.

I will tell you that one area that I really think that the VA needs to spend more of its resources, and I think the current war highlights it, is building a center of excellence in amputee research and rehabilitation. Again, I go back to our core mission, to care for people who have been wounded and disabled in combat or in training. And today, because of body armor and battlefield medicine, we're keeping these young soldiers and marines alive, but they're coming back with amputation. And we need to do everything in our power to develop the most modern prostheses available for them and to have a rehabilitation program that's second to none in this country.

And I think we've lost the edge. We spend a lot of money on research at the VA, $1.4 billion, between VA appropriations that you give us and NIH funding, DOD funding, and I don't think we spend

enough on this area. So I just—timing is perfect, because we just had a meeting on this subject yesterday, and I called in a number of amputees from Vietnam, guys I served with who lost their legs and arms in Vietnam. And they agreed. We're not doing enough. And so it's a serious issue in my view.

Mr. RYAN. Well, thank you for your comments. My concern is that the President and the administration maybe doesn't share your own personal vision as I started this out.

Secretary PRINCIPI. I know it's a $50 million reduction, but it's a very, very large base, and like I said and Dr. Roswell said, we need to go after that indirect funding from NIH and go for more grants from NIH. And that's very important. I think we can offset that $50 million by getting more money from NIH. They send the grants out. There's no reason why it shouldn't come to the VA.

Mr. RYAN. Thank you. Mr. Chairman, can I have 30 seconds just to? My last question was the projections of—do you have any numbers as far as how many of these young soldiers are going to be coming back as amputees? Are we projecting down the road? I'm just——

Secretary PRINCIPI. I think to date we have 120 amputees. I would like to provide it for the record. Maybe you can come up and see it. But I think it's 120. I don't know if we have a projection of the total number. But right now it's in the hundreds who have been disabled by virtue of having lost an arm or a leg.

Mr. RYAN. Thank you very much.

The CHAIRMAN. Thank you. Mr. Udall.

OPENING STATEMENT OF HON. TOM UDALL

Mr. UDALL. Thank you, Mr. Chairman. And, Mr. Secretary, thank you for being here with us today. Let me first of all say that I sense, and you don't need to answer this part of it, I don't think you like these cuts that have been presented in your budget, cuts in research, cuts in benefits, cuts in dollars to veterans, and clearly these were decisions that were made above your pay grade in terms of priorities for the Nation.

And you can hear members talking, and you've heard it throughout the day that we don't think the priorities are right, and we think we ought to dedicate additional resources to veterans. And I think you're going to see a bipartisan group of representatives move to try to give you additional money. And I hope that you will continue the fight within the administration to make sure that when that movement happens that it's accepted, and you don't need to answer that part of it. You're a good soldier and you have to come up here and do what's been assigned you.

But Secretary Principi, I want to get back to this whole issue of the research, and Dr. Roswell talked about it. And this is this indirect cost issue. You've got a cutback of $50 million in the budget on research. In the last 15 months, the Oversight Committee of this Veterans Committee has taken testimony, and we've shown in our testimony that NIH once paid for indirect costs of third-party research conducted on VA property. So they once did it.

We showed in the testimony that NIH pays indirect costs to other organizations for indirect costs associated with research grants, and we have also shown that NIH pays foreign organiza-

tions indirect costs. They don't pay the VA, but they pay foreign organizations indirect costs. The funds to pay for those indirect costs now come out of veterans health care. And if you look at the budget of NIH since 1998, it's doubled to $28.8 billion.

Now I think, you know, you asked us to help. I think we have helped a lot. I wrote to Health and Human Services Secretary Thompson asking him to pay the rent, to pay the VA. Ranking Member Evans wrote you on March 12 and asked you also to pursue this reimbursement. If we could recover the full amount of this reimbursement, it would take care not only of the $50 million but a lot more, as you know.

[The prepared statement of Congressman Udall appears on p. 99.]

Mr. UDALL. So my question is, what is happening in the administration to pull the parties together? I think you're pushing for this. I think somebody at a higher level needs to pull you in and pull Secretary Thompson in, get the decision made and get this thing rolling. Because this is a significant amount of money that could come in. It could help veterans now, and we just need to do it.

And so could you elucidate a little bit on that and let us know what your position is on it?

Secretary PRINCIPI. Well, I'd like to—let me defer to the Under Secretary, who has really been tracking this very, very closely and working closely with HHS and the Hill to try to resolve this. There are just some strong views I guess at NIH and other places against providing this indirect funding to VA. But perhaps Dr. Roswell can——

Dr. ROSWELL. Thank you, Mr. Secretary. And Mr. Udall, you're absolutely correct in your assertion. Based on the current level of NIH funding provided already to VA investigators, if we were reimbursed at our actual cost of supporting those grants, at approximately 23 percent of the cost, which is modest by comparison to most major academic institutions, if we were reimbursed at that level, it would bring over $117 million of additional funding in to VA research support which would more than offset the $50 million reduction that's in the proposed budget.

We sought that with our negotiations with OMB, quite frankly. We were told that other agencies were impacted. We've not been able to identify other federal agencies outside the Department of Veterans Affairs that have anywhere near our level of NIH funding. So we don't believe that this is precedent-setting and would create a tremendous burden on NIH.

We have worked with NIH to negotiate this. We continue to dialogue with NIH and are continuing to pursue options that would allow the reimbursement for unfunded administrative support within the Department of Veterans Affairs, and we certainly thank you for your support to that end.

Mr. UDALL. Thank you. And thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Udall. Let me just ask one final question, Mr. Secretary. As you know, one of the passions that I have, and I have many on this committee on veterans affairs, is for the homeless. It was after a tremendous amount of work. It was bipartisan. Mr. Evans and I authored a very sweeping $1 billion

Homeless Veterans Assistance Act that was signed into law in 2001 in December.

And one of the many aspects of that mutually reinforcing law, and our hope was, and I would just remind everyone, was to end homelessness within a decade, and the numbers then were 275,000 homeless on any given night, which is an outrage. You know, 18 divisions worth of our men and women on the streets at any given night. That should be something that all of us roll up our sleeves, not just to mitigate but to end completely.

We authorized in that legislation, as you know, ten new domiciliaries. As a matter of fact, while we were going through the process of hearings and field visits, this committee learned clearly that domiciliaries work. They are one of the most effective means of matriculating someone who is out on the streets and changing their lives. And the VA has a tremendous track record in rehabilitating a life that otherwise would be lost through the doms.

We authorized ten new doms. To the best of my knowledge, not one of those have been authorized or appropriated for or opened by the VA. My request today would be for you—and we have worked in a bipartisan way to up significantly the amount of money available to the VA for veterans health care for all veterans' programs, including doms, that at least three, maybe more, in this fiscal year would be opened so that we can meet the needs of our—and it's something that I feel passionately about, I know other members of this committee feel passionately about, and it's something that's doable, and I would hope that you could give us a yes on that.

Secretary PRINCIPI. Well, I know of your commitment and I share that commitment for homeless veterans. I quite honestly was not aware of the ten domiciliaries. I know we've increased funding for long-term workloads in domiciliaries from three—what is that, three thousand, three million?

Dr. ROSWELL. Three thousand, seven hundred.

Secretary PRINCIPI. Three thousand seventy-two to 4,389. Mr. Chairman, let me look at this domiciliary issue to see what's been appropriated in that regard.

I think as you know, we're doing a great deal with the grant and per diem program. We're increasing the number of beds to 10,000. We have a joint initiative with HUD and HHS to establish some permanent housing, especially those with mental illness. And I'll continue to work with you, because I think it is a pressing problem. I think we're making great progress—I think we're making progress. I think the number of homeless is down to about 200,000 now, so it's going in the right direction but still far too high.

The CHAIRMAN. I do appreciate that, and I hope you'll work with us. I mean, one of the reasons why obviously the compelling need for more health care dollars is why members of this committee, including the chairman, fought so hard through a very arduous process, because we know the need is there. This, in addition to the other issues that everyone talks about, and I'm glad that the numbers are going down. But these doms work, and we did authorize ten with the full expectation that they would be funded. So I hope you will go back. And I would just say to my friends on the committee, we plan a series of oversight hearings on the homeless issue. The good news, as you just relayed, of the numbers going

down, but also what additional things we ought to be doing, again, to end homelessness of our veterans.

Pursuant to Rule 11(i), the committee stands in recess pending conclusion of the joint session of Congress, and then we will reconvene—my estimate is about 12 o'clock or so—with the next panel.

Thank you.

Secretary PRINCIPI. Thank you, Mr. Chairman, Mr. Evans.

[Recess.]

The CHAIRMAN. The committee will reconvene. And I would like to welcome our next panel, the Independent Budget, which consists of four veterans service organizations, the Disabled American Veterans, the Paralyzed Veterans of America, AMVETS and the Veterans of Foreign Wars.

Our first witness will be Mr. Joseph Violante, a disabled Vietnam veteran, who has been the National Legislative Director of the Disabled American Veterans since July of 1997. A New Jersey native, Mr. Violante served with the 2nd Battalion, 4th Marines in Vietnam and was discharged in 1972 with the rank of sergeant. Mr. Violante was a practicing attorney in Thousand Oaks, California, before moving to Washington, D.C. where he then worked as a staff attorney for the Department of Veterans Affairs' Board of Veterans Appeals in 1985.

Joe also chaired the Veterans Appeals Committee of the Federal Circuit Bar Association from 1992 to 1996.

We will then hear from Mr. Richard Fuller, who is the National Legislative Director for the Paralyzed Veterans of America, or PVA.

Mr. Fuller graduated with a Bachelor of Arts degree from Duke University in 1968. He served in the United States Air Force from 1968 to 1972, stationed 2½ years in Vietnam and Southeast Asia as an air crew Vietnamese linguist with the Air Force Security Service.

We will next hear from Mr. Rick Jones, who has been the National Legislative Director of AMVETS since January of 2001.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era.

Rick completed undergraduate work at Brown University prior to his Army service and earned a master's degree in public administration from East Carolina University in Greenville, North Carolina, following military service.

And finally, we'll hear from Mr. Dennis Cullinan, who has been the Director of the National Legislative Service for Veterans of Foreign Wars of the United States since 1997. He started with the VFW Washington office staff in 1983 as a service officer trainee with the National Veterans Service.

Prior to being honorably discharged from the U.S. Navy in 1970, Dennis served as an electronics technician aboard the USS Intrepid and completed three tours of duty in Vietnamese waters.

I'd like, Joe, if you could begin, we will go to each of our distinguished panelists.

STATEMENTS OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND DENNIS M. CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you, Mr. Chairman. As has been our custom in the past, each organization will testify on their section of the Independent Budget.

On behalf of the Disabled American Veterans and its auxiliary, I thank you for allowing us to present our assessment of the President's fiscal year 2005 budget and to provide our own alternative recommendations for resources and program improvements.

Mr. Chairman, after reviewing the President's budget submission, I have a better understanding of the famous quote uttered by Yankee great Yogi Berra when he said "it's deja vu all over again." The FY 2005 budget submission is last year's budget, only worse. In an election year, it sends a chilling message about what our Nation's veterans, especially those disabled in military service, can expect in the future.

Again this year, the President's budget submission contains few legislative recommendations to improve, expand or add new benefits for veterans. The budget recommends a cost of living adjustment for compensation based on the projected 1.3 percent increase in the cost of living, which will again be rounded down to the nearest whole dollar. We urge Congress to discontinue the practice of rounding down our COLA.

Again, the budget seeks legislation to deny compensation to disabled veterans who suffer greatly from their service-connected posttraumatic stress disorder and other mental disorders if they self-medicate to escape the agony and develop secondary disability as a result. We again urge you to send the administration another resounding no in response to this request for unjust action.

I would like to thank the members of the committee whose efforts successfully resulted in the passage of legislation to improve and expand benefits for disabled veterans, including removing the 2-year limitation on accrued benefits and increasing grants for specially adaptive housing and automobiles and burial benefits. However, to remain effective for their purposes, these benefits must be adjusted for increases in the cost of living and to address other needed improvements.

Therefore, the Independent Budget continues to include recommendations for legislation to increase the amount of the automobile grant and the grants for specially adaptive housing and to provide for an automatic annual adjustment for increased costs.

For substantive improvements to the insurance programs, the IB recommends legislation to authorize VA to use modern mortality tables instead of the 1941 mortality tables to determine life expectancy for purposes of commuting premiums for service-disabled veterans' insurance, and to increase the maximum protection available

under the base policy of service-disabled veterans insurance from $10,000 to $50,000.

We are extremely concerned about the inadequate resources requested for veterans' benefits administration (VBA) in the President's budget. The budget requests 829 fewer full-time employees (FTE) for fiscal year 2005 than authorized at the end of the last fiscal year, fiscal year 2003, and 540 FTE below the fiscal year 2004 level. We do not see how VBA can achieve enough productivity improvements to offset such a substantial loss of resources.

The budget also substantially scales back investments in ongoing programs to modernize VBA's essential information technology improvements. The IB recommends that C&P (Compensation and Pension) Service be authorized 7,757 FTE for fiscal year 2005. Although VA had initially projected that its workload would allow it to draw down its FTE, those projections did not take into account an additional 391,000 claims and an additional 52,000 appellate caseload over the next 5 years VA now expects incidental to judicial and legislative changes.

The President's budget proposes 7,270 FTE or 487 fewer direct program FTE for C&P services in fiscal year 2005 than in fiscal year 2003. To aid in the accuracy and uniformity in claims adjudication and to achieve the greater efficiencies of modern information technology, VA began its compensation and pension evaluation redesign initiative during 2001. VA needs approximately $3.5 million in fiscal year 2005 to continue development of this system, and the IB recommends that Congress provide this essential funding.

To sustain current levels of performance with its projected workload, vocational rehabilitation and employment services needs to retain the staffing strengths it had at the end of fiscal year 2003. In addition, the Secretary's VR&E task force team has made a number of recommendations to improve voc rehab and employment services for veterans and projected that approximately 200 additional FTE will be needed to implement those substantive changes. The IB therefore recommends that Congress authorize 1,131 direct program FTE for VR&E in fiscal year 2005.

Mr. Chairman, in closing, just let me say that we appreciate very much what this committee has done in enacting many of the recommendations found in the Independent Budget over the last several years, and we would hope that you will again find our recommendations meritorious and will shepherd legislation through this year to adopt more of them.

Thank you. That concludes my statement. I'd be happy to answer any questions.

[The prepared statement of Mr. Violante appears on p. 120.]

The CHAIRMAN. Thank you very much. Mr. Fuller.

STATEMENT OF RICHARD B. FULLER

Mr. FULLER. Mr. Chairman and members of the committee, as one of the four veterans service organizations publishing the Independent Budget, Paralyzed Veterans of America is pleased to present the views of the Independent Budget regarding the funding requirements of the VA health care system for 2005.

This is the 18th year PVA, along with AMVETS, Disabled American Veterans, and Veterans of Foreign Wars have presented the

Independent Budget, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs.

Mr. Chairman, we are becoming increasingly troubled by the delays in enacting VA appropriations. For the past 2 years alone, the VA health care system has had to struggle along at previous year's inadequate funding levels for nearly one-third of each year. These delays directly affect the health care received by veterans. This deplorable state further points to the importance of a mandatory funding mechanism for VA health care. But until that happens, we ask that this Congress move expeditiously to put necessary funding levels in place by the start of fiscal 2005.

The Administration's budget request for health care is a shocking one, providing once again woefully inadequate funding levels for sick and disabled veterans. The budget calls for only a $310 million increase in appropriate dollars for the medical care account, a mere 1.2 percent increase over fiscal year 2004. This is the smallest health care appropriation request of any Administration in nearly a decade. Indeed, the VA Under Secretary for Health himself testified in this room just last year that the VA requires a 12 to 14 percent increase just to keep its head above water.

In addition, once again we are faced by a request that relies too heavily on budget gimmicks and accounting sleight of hand, rather than on real dollars that veterans need. The Administration is again resurrecting its user fee and increased co-payment schemes, proposals soundly rejected by the House and Senate last year.

And once again, we see unrealistic management efficiencies utilized to mask how truly inadequate this budget is. The VA must be accorded real dollars in order to care for real veterans.

For fiscal year 2005, the Independent Budget recommends a medical care amount of $29.791 billion. This amount represents an increase of $3.2 billion over the amount provided in fiscal year 2004. The Independent Budget recommendation is a conservative one. The VA health care system, in order to fully meet all of its demands and to ameliorate the effects of chronic underfunding, could use many more dollars.

The Independent Budget recommendation provides for the impact of inflation on the provision of health care and mandatory salary increases of health personnel. It provides resources to begin funding the VA's critical fourth mission, to back up the Department of Defense health care system. It provides increased prosthetics funding and long-term care funding, and provides enough resources we believe to enroll all Priority 8 veterans.

For medical and prosthetic research, the Independent Budget is recommending $460 million. This represents a $54 million increase over the fiscal 2004 amount, which was the committee's recommendation last year as well in its views and estimates.

Sadly, the Administration has proposed cutting research, according to our estimates and calculations, by $21 million. Accepting this level of $385 million would set the research grant program back 6 years to fiscal year 1999 levels.

I would like to add, based on the testimony earlier this morning, that there seems to be some thought that by increasing indirect costs that we could offset this particular cut. In actuality, indirect costs don't cover what this cut cuts. According to what we under-

stand from VA sources, this reduction equates to eliminating approximately 500 clinical researchers. These are not only doctors who are conducting research. They are also clinicians providing care for veterans. This has a real impact in human terms.

In closing, the VA health care system faces two chronic problems. The first is underfunding, which I have already outlined. The second is a lack of consistent funding. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not knowing how much money it is going to get, but equally important, when it's going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them.

The only solution we can see for this is for this committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it. We look forward to working with this committee in order to begin the process of moving a bill calling for mandatory funding through the House and Senate as soon as possible.

This concludes my testimony, Mr. Chairman. I'll be happy to answer any questions you may have.

[The prepared statement of Mr. Fuller appears on p. 128.]

The CHAIRMAN. Mr. Fuller, thank you very much. Mr. Jones.

STATEMENT OF RICHARD JONES

Mr. JONES. Mr. Chairman, Mr. Strickland, it's an honor to represent AMVETS before you in this magnificent hearing room. As co-author of the IB, AMVETS is pleased to provide you with our recommendations on the resources necessary to carry out a responsible National Cemetery Administration budget for fiscal year 2005.

We note and appreciate your strong leadership and continuing support. As they say on the campaign trail, you get it. You understand. And as congressional champions, you help lead the country on issues important to veterans and their families.

The National Cemetery Administration maintains more than 2.6 million gravesites on approximately 14,000 acres of cemetery land while providing more than 100,000 interments annually. The VA is scheduled to open new cemeteries in Atlanta, Oklahoma, Pittsburgh, Detroit, Miami and Sacramento. Also under legislation passed last year, VA is directed to design and construct cemeteries at six new locations in Philadelphia, Birmingham, Jacksonville, Bakersfield, Greenville, and Sarasota, Florida.

Without the strong commitment of Congress and its authorizing and appropriations committees, the VA would likely fall short of burial space for millions of veterans and their eligible dependents. It should be recognized that not only is the interment rate increasing and the construction of new facilities accelerating, there are repair and upgrades needed.

The Study on Improvements to Veterans Cemeteries, a comprehensive report submitted in 2002 by VA to Congress on the conditions at each cemetery, identified nearly $300 million in more than 900 projects for gravesite renovation and repair.

The Independent Budget veterans service organizations recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems. Volume 3 of the study describes veterans cemeteries as national shrines, saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who serve in the Armed Forces.

More than 30 years ago, Congress formally recognized veterans cemeteries as national shrines. They stated: "All national other veterans cemeteries...shall be considered national shrines as a tribute to our gallant dead." Moreover, many of the individual cemeteries within the system are steeped in history. The monuments and markers represent the very foundation of these United States. These grounds represent a national treasure that deserves to be protected and nurtured.

Unfortunately, the system has been and continues to be seriously challenged. The National Cemetery Administration operation requires continued adequate funding to ensure that NCA remains a world class quality operation to honor veterans and recognize their contribution and service to the Nation.

And the members of The Independent Budget recommend that Congress provide, because the challenge ahead is so clear, $175 million in fiscal year 2005 for the operational requirements of the National Cemetery Administration, for the national Shrine initiative, and for the backlog of repairs. We recommend your support for a budget consistent with the National Cemetery Administration's growing demands and in concert with the respect due every man and woman who wears the uniform. This is an increase of nearly $30 million over current year requests—over next year's request.

Regarding the State Cemetery Grants Program, the funding for the State Cemetery Grants Program, the members of the IB recommend $37 million in the new fiscal year. The State Cemetery Grants Program has helped increase burial service for veterans, especially those living in less densely populated areas.

For example, this year the Independent Budget service organizations, as we all do, we expect fast track operations to open in Boise and Kansas and Massachusetts and in the Tidewater area of Virginia. The Tidewater area, I might note, serves over 200,000 veterans.

To augment support for veterans who desire burial in state cemeteries or in their local communities or churches, the members of the Independent Budget recommend a series of additions in the current provisions of statute for burial. Among these is the plot allowance. We would like to see the plot allowance lifted to $725 from the current level of $300. The plot allowance now covers less than 6 percent of funeral costs. A series of other provisions are in the Independent Budget.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views and I'd be pleased to answer any questions you might have.

[The prepared statement of Mr. Jones appears on p. 135.]

The CHAIRMAN. Thank you very much, Mr. Jones. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Chairman Smith, Mr. Strickland and Mr. Michaud. On behalf of the men and women of the Veterans of Foreign Wars, I express our deep appreciation for including us in today's most important hearing. As has already been mentioned, the VFW is responsible for the construction portion of the VA budget, so I will limit my testimony today to that area.

A historical overview of VA major and minor construction clearly shows that since 1993, VA's construction budget and annual appropriations for both major and minor projects continue to drop sharply to current low levels.

Most unfortunately, VA construction funding has been in steady decline. In FY 1993, the combined total was approximately $600 million. However, by FY 2003, the total had decreased to only about $300 million, and the budget we're looking at today, the total would only be about $200 million, excluding the money put in for CARES.

VA's history low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets. It also files in the face of a moral as well as statutory mandate to provide for the short and long-term care needs of our most seriously service-connected veterans.

The administration is once again proposing counting state nursing home beds as part of the long-term care capacity. We view this as being a disgraceful attempt to circumvent both the letter and intent of the law with a number of our most deserving and vulnerable veterans suffering as a consequence.

We are all aware of the Price Waterhouse study that concluded that VHA has significantly underfunded its construction spending and continues to do so. The VFW and the other IB VSOs are concerned that if the CARES implementation costs are factored into the appropriation process, Congress will not or will not be able to fully fund the VA system, further exacerbating the current obstacles impeding veterans's access to quality health care in a timely manner.

It is our opinion that VA should not proceed with CARES mission changes and consolidations until sufficient funding is appropriated for the construction of the new facilities and renovation of existing hospitals to take their place.

We acknowledge the administration's proposal to provide CARES with $524 million in FY 2005. But as was testified earlier today, in fact $1.3 billion is needed for this to properly expedite this process in 2005.

We view the administration's proposal to provide only $3.7 billion over the next 7 fiscal years to be totally inadequate.

We are dismayed at the administration proposal to provide a totally inadequate $97 million and $69 million for major and minor construction respectively in FY 2005.

We and the other IB VSOs recommend that Congress appropriate $571 million to the major construction account for 2005. This amount is needed for seismic correction, clinical and environmental improvements, National Cemetery Administration, construction, land acquisition and claims.

We also call upon the Congress to appropriate $545 million to the minor construction account for 2005. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in FA research facilities, a staff office account and an emergency fund account. Increases provide for inpatient and outpatient care and support infrastructure, physical plant and historic preservation projects.

The Independent Budget in fiscal year 2004, we cited the recommendations of the President's Task Force to improve health care delivery for our Nation's veterans, the PTF. That report was made final in 2003. To underscore the importance of this issue, we will again cite the recommendations of the PTF.

In short, the PTF asserts that the VA must accomplish three key objectives:

(1) Invest adequately in the necessary infrastructure to ensure safe, functional environments for health care delivery;

(2) Right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care.

And finally, the third: (3) Create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts. Clearly, the administration's proposed budget for fiscal year 2005 is inadequate to this task.

It has been suggested that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical care services. Due to a number of factors, including age, location, lack of ability to properly configure these properties, this proposal simply is not viable.

VA should perform a comprehensive analysis of its own excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved and protected. Some space may be appropriate for enhanced use, others may not.

Mr. Chairman, I'll simply conclude by expressing the fact that we are once again mystified that this budget would preclude the expenditure of any funds for four emergency preparedness centers that were authorized last Congress. We simply can't understand it. And with that, I'll conclude.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Cullinan appears on p. 144.]

The CHAIRMAN. Thank you very much, Mr. Cullinan. And thank you all. I think the Independent Budget has been a very valuable source of documentation, gives us a blueprint from very knowledgeable sources—yourselves. I actually read and study the Independent Budget.

I think the 113 pages that make it up this year really provide us a reliable database that rivals the VA itself in terms of their forecasting capabilities. So I want to thank you for the many recommendations that you make in it.

You know, there are some organizations in other areas of jurisdiction on this Hill that say we want this or we want that, but very often, there's a threadbareness to it in terms of the justification. You tell us things very often that make us scratch our heads and say, we should have known that. And the VA very often also is enlightened about what may be going on under their own jurisdiction that they were not aware of.

So the Independent Budget is a very, very valuable source, and I want to thank you for spending the time and the effort and the expertise to give us the wisdom that it provides. Like I said, it's a blueprint. Last year we used it, the VA's forecasting model and other sources, and our own independent analysis as well. We came out with recommendations that were in the end very close to what you were recommending, and that became our marching orders, if you will, as a committee in a bipartisan way to make our case to the rest of the Congress as to why VA health care spending in particular needed to be ratcheted up significantly.

I would also encourage you, and I know you do this, but I would encourage my colleagues as well, as I will do throughout the next few months, to take the time to read this document or at least read portions of it. You know, we do rely on the division of labor that Congress affords through the committee system, but there are many people in very important gatekeeper positions who need to take the time to read this and to become aware of its comments. Because you're not crying wolf. You're not suggesting the impossible. You are I think right on the money in terms of what is needed for our veterans.

You know, I was very happy to hear our Secretary, Secretary Principi, earlier in the hearing talk about the needs of veterans. He related to us that he had asked for an additional $1.2 billion, which did not make its way into the final product. That's for real veterans' services, health care services that will go unrecognized and unprovided for if we do not provide that.

And then if you factor in some of the other items, like the $250 enrollment fee, the increases in co-pays for pharmaceuticals, which we did not enact last year, and for good reason. That too has a price tag that I think needs to be put over on the appropriated dollars side. So we will make our best case, I can assure you, using the very valuable information you have provided.

Mr. Violante, you mentioned deja vu all over again, the Yogi Berra statement. Well, I would use another one of his statements when he said it ain't over till it's over. This committee, again, I think plays a very valuable, sometimes not appreciated role in advising our colleagues, admonishing our colleagues, taking actions on the floor and everywhere else in between to say this is a real number. These are real men and women who if we don't provide these resources, they will not get the care that they are entitled to and deserve.

You know, you haven't asked for the moon. You've asked for what's needed. And I can assure you, I and my colleagues will try our level best to do just that.

I just don't really have any questions. I mean, one of the nice things about your presentations, both your oral and your written, and then the Independent Budget itself, is that it's comprehensive. It has much girth to it, and, you know, I'm very appreciative for that.

One of the things that I was concerned about in the testimony today was the $800 million carryover. You know, the Senate was a little slow, as we all know, in getting their final product, voting on the appropriations bill. We weren't as slow but we weren't as fast as we would all like. But that shouldn't be, I don't think, a pretext for taking those appropriated dollars and punting and putting them into 2005. They're for 2004, and they ought to be used for 2004 to meet the gap that exists. So I can assure you that we will be looking to make sure that that's not used as a filler as we move forward into 2005.

And I thank you, Mr. Cullinan, for mentioning the emergency preparedness centers. I am baffled in the extreme how a bill that passed in a bipartisan way, I was the prime sponsor I'm happy to say, but it was a bipartisan bill that established these emergency preparedness centers, centers of excellence, to look at the radiological, biological and chemical weapons that very possibly could be used against our men and women in uniform, and by extension, civilian populations.

And I can tell you without any fear of contradiction, after we had our hearing, at which we saw that there was an overwhelming need for those kinds of centers, that when anthrax hit my own district in Hamilton Township, we were woefully unprepared, and I'm not convinced that we are any better prepared today.

Yes, we've moved the ball a little bit, but we need every level of government, and the VA has been sterling in its centers of excellence, whether it be for battlefield injuries or spinal cord injury. We need to allow the good people at the VA working in concert with NIH and others to take the lead on this, because we're not as prepared as we might think we are. And to say that bioshield or some other piece of legislation automatically covers it just isn't true.

And I would also remind my colleagues, we had a floor vote on this. There was a bar in the appropriations bill when the VA-HUD bill was on the floor that said none of these funds shall be used to implement this legislation and this law. I offered the amendment, and it got well in excess of 300 votes in favor of stripping out that bar. And I think this is the second year in row, and like I said, I'm baffled in the extreme. We have asked the VA to weigh in on this, and I would hope that the appropriators would not seek to do that again next year.

Because if this does hit, if there is a problem relating to radiological, biological or chemical and we didn't do all that we could possibly do, there's an accountability issue here for those who said we shouldn't have these centers of excellence. Nobody can say to me with a credible face, with a straight face, that we're doing too much in the area of research into what those terrible agents can

do and will do if they're ever used against our men and women in uniform or the civilian population.

We've only done the tip of the iceberg, and this wasn't the panacea or the fix. This was part of a concerted effort to lessen our vulnerability on this score. So we're going to push hard on that, and I plan on having a hearing as well in this committee to look at bioshield and other laws to see what gaps remain. Because this is a modest amount of money. We authorized $20 million each year over 5 years.

We know for a fact that the VA was ready to go out and roll that out. They had a number of VA hospitals, research, including one in my state, Florida, all over, who were ready to go to put in their submissions and try to procure some of this money or to obtain some of this money to get down to the basic research. So again, I'm very discouraged but will not give up in trying to get those additional dollars.

But again, I thank you, the Independent Budget and all of you with your expertise give us a tremendous opportunity to do good for our veterans with facts, figures, and it's an excellent product. And I wish that every member of Congress and every member of the United States Senate would read it.

I yield to Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. And, Mr. Chairman, I would like unanimous consent that all members would have 5 legislative days to revise and extend their remarks.

The CHAIRMAN. Without objection.

Mr. STRICKLAND. Thank you, sir. Thank you, gentlemen, for being here. Before I ask a question related to your specific testimonies, I'm going to go back to something that happened a little earlier this morning when I was asking Secretary Principi regarding the gag order.

And after that meeting, Laura Miller, who had issued the memo, came in, and I don't want to be critical of Mrs. Miller. I've known her for a long time. She served in Ohio before coming to Washington, and I have a great deal of respect for her capabilities. But she indicated to me that there is a difference between marketing and outreach. And I indicated to her that I was going to go back and get a dictionary and try to, you know, distinguish the difference in the meanings.

But the bottom line is, the policy of the VA is for one purpose, and that is to limit the number of veterans who are coming in for services. That's the only reason for such a policy. And I simply said to her, why don't you just rescind the memo then if you're doing all of these things—health fairs, meetings, news releases, other publications and so on—just rescind the meeting?

Now I've joined with the Vietnam Veterans of America, and we have instituted legal action against the VA. It was a last resort. It occurred after I had written the President, I had written the Secretary, I had met with the Secretary. We had discussed in detail. This policy is offensive to me. It is offensive that we would have a policy for the specific purpose of limiting the number of veterans who become aware of VA services and consequently come in to receive services they are legally entitled to receive.

Having said that, I'll move on to this question. The VA has expressed a desire to transfer some $400 million from VA medical care to the CARES investment fund in this fiscal year as was authorized in the omnibus appropriations bill. And I would just like for each of you to tell me how you respond to that, if it's something you agree with, disagree with, or have concerns about.

Mr. FULLER. Congressman Strickland, let me respond to that by saying that we were rather concerned about that, to say the least, last year when the appropriation was going through. I think you all are aware and were very much involved in the long, hard battle that we got starting just a year ago when the Administration came in with its request. We had to go to the budget committees and the budget process and the allocations and the appropriations process in the House and the Senate as we do every year. That was a long, hard fight to try to get that budget for this year bumped up, and particularly in the medical care side.

Then, all of a sudden, to see $400 million of that long, hard-fought for money now going to subsidize another program that was already underfunded, the VA construction program, we became quite concerned about that. Our concern about CARES has always been that the "E" in CARES stands for enhancements. If CARES is designed to improve services for veterans, there's going to be a price tag on that. The CARES report itself says this price tag is somewhere in the neighborhood of $4 or $5 billion to be spent over some unknown period of time in the future.

If that's to be the case, then we want to see the real dollars put into the VA construction budgets on a yearly basis to plan, build, construct and design these new and better facilities. We should not try to rob Peter to pay Paul by siphoning this cost out of already short medical care dollars.

Mr. CULLINAN. Mr. Strickland, I would just add to that that certainly this situation certainly illustrates the problem with the current funding methodology or when it doesn't work right. The reason that that money is there is the appropriation was made, I think it was almost 5 months late, and that's a travesty.

As was said earlier, money for a given fiscal year should be spent within that fiscal year, but if you get it 5 months late, that's not going to work out. And that's a real problem.

Mr. VIOLANTE. And DAV also has concerns about that transfer of those funds. I mean, they're there for a specific purpose, and they're not being used for that purpose.

Mr. JONES. Mr. Strickland, regarding the $400 million transfer, put it in context. You have a projected $800 million carryover. If you took the $400 million out of medical care, replaced it with what you project to be carryover, you then have $400 million remaining, if I'm correct, $800 million minus 400 is $400 million.

If you then took the average cost of serving a priority veteran at $2,500, which the VA says is about right, and divided that into the $400 million remaining, you could do two things. You could shift the funds, take care of CARES. You could replace the funds out of the 800 carryover, and you could open VA to Priority 8 veterans. You could serve 167,000 veterans with the remaining $400 million. So we're concerned about $400 million, but we're more concerned about the carryover. If you're going to transfer $400 million out of

medical care into CARES, what are you talking about with the carryover?

Mr. STRICKLAND. I want to thank each of you. I'm sorry we don't have more time, but we have additional questions, and maybe we can either submit them to you or have an additional round of questioning. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Bradley.

Mr. BRADLEY. Thank you very much, Mr. Chairman. I have nothing at this time.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman. I want to thank the VSOs for all that you've been doing for our veterans, and especially I want to thank you for this Independent Budget. It definitely is a document I definitely read, and it is very helpful and it really puts things in perspective, and that's part of the problem I had earlier today with the Secretary's remarks when you talk about percentage.

And, yes, we have increased the budget by a certain percentage. But when it's inadequately funded in the first place, number one, but when you actually look at the real dollars and the effect that it's having, I think that tells another whole story. So I do appreciate all that you've been doing to help keep this committee informed of what's happening.

And when you look at the carryover issues, the dollars and because of the lateness of the budget when it passed, it leads me to believe that the only way we're going to ever solve this problem is for mandatory funding. And I think it's an area that hopefully the committee will continue to work in a bipartisan manner to try to put forward that guaranteed funding so that we'll not have to deal with this issue year after year, which we definitely should not be having.

So I don't have any questions at this time, Mr. Chairman, but I do want to thank the VSOs for everything that you have done as it relates to veterans.

Mr. FULLER. If I might say, Mr. Michaud, we have provided a copy of the Independent Budget, a pre-release copy for all members of the committee. The published document with the Administration's numbers will be back from the printer next week. In the meantime, it is online and it has its own web site, which is www.independentbudget.org. Independentbudget is one word.

Mr. JONES. Is that dot org?

Mr. FULLER. Dot org, yes. That's my commercial for the day.

Mr. MICHAUD. Thank you.

The CHAIRMAN. Mr. Bradley.

Mr. BRADLEY. Yes, and I apologize to the members for not thanking them for being here and looking forward to working with you to make sure that we take care of America's veterans. I didn't have any questions at this point in time. Got a lot of reading to do and look forward to working with you, as I said. Thank you.

The CHAIRMAN. Thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. And I apologize. I got kind of confused on the schedule, Mr. Chairman. I had to run to another meeting and went back to my office. It was getting close to eleven, and you all just kept going right on through the session.

And so I thought, well, I'll—anyway. You actually, the Spanish, our Spanish leader and friend finished before this hearing finished. So I got confused.

And I've got to go the Armed Services at one, but I was—and so you've all probably talked about this some, but really I think Secretary Principi is a fine man. I think we're lucky to have him. And of course one of his qualities is his candor, and so somebody asked him, well what did you ask for from OMB? And we've gone years here without having anyone tell us what they asked from OMB, and he said I wanted $1.2 billion more. Well, there it was right there. So we're going through all these gyrations. What's the bottom line? Secretary Principi, who I—he doesn't strike me as a budget padder. He doesn't strike me as somebody who would build in stuff in that budget that they can cut away and have OMB cut out fluff or something. He looks to me like he's a straight shooter. I suspect he shoots straight with OMB. And he said he wanted $1.2 billion more. And the reason I don't think he's padding his budget is when I look at that research number. They cut $50 million. I mean, that's real money. That means there's somebody out there that's doing research right now that's not going to get funded in another year.

So I think that's a problem. During the break, I went—and I also heard Secretary Principi gave very eloquent testimony while I was in my office watching this, talking about research. He talked about having met with Vietnam veterans with prosthetics. I'm sure you all heard that, were in the room when you heard that testimony. I mean, he clearly gave a very strong case. I think he talked about a center for excellence and prosthetics and a need for additional money in research on prosthetics. And a number—he said in the hundreds of amputees we have from the current war.

So he just made a very strong argument for wanting to have a good research number. But it tells me that by him having to cut that $50 million in the research budget, he was not padding that budget that went to OMB. So I think $1.2 billion—we may just want to make a motion, Mr. Chairman, we add $1.2 billion and all go home and just trust Secretary Principi.

But one of the things they were talking about was, well, we can get this money from NIH, which I think is just really strange. We've fought this fight before. It's not going to work. And frankly, that doesn't have anything to do with VA's responsibility to properly funding research.

But during the break, I found out NIH's budget went up 2.6 percent. So my guess is, they don't feel like they're rolling in tall cotton this year with a lot of extra money, you know, just keeping pace with inflation, and because it's medical research, you can't take the normal inflation rate, because a lot of it does get caught up in this 8 percent or so of medical research.

And the DOD, the basic research budget is down 4 percent. Now basic research is your basic sciences, not medical. But my point is, we've got a problem in our—I think throughout the budget, and have had for a while, except for NIH, of research being cut. But this was really brought home in this budget today I thought. That the Secretary didn't get $1.2 billion. He had to find things to cut. And when you start cutting research dollars when we've got, you

know, some real challenges out there for our veterans in their health care and the special needs that they have. This is down to the bone now on some of those line items. So that was just my comment I wanted to make. If you all have any comments about that.

Mr. JONES. May I just give a quick comment? If you take the Secretary's request, $1.2 billion, add to that the $1.2 billion he said he asked OMB for but did not get. And then remember there's an $800 million carryover. Adding those together, you come up exactly to what the IB is recommending for the next—for fiscal year 2005—$3.2 billion increase.

Mr. FULLER. Dr. Snyder, we are also very concerned about this research cut. We've never seen anything like this being proposed in recent history, if I recall, at all. At the magnitude of a $50 million cut, we went back and looked at the record. That amount would bring VA research back to about the 1999 level.

There was a lot of discussion this morning with the Secretary and others on the fact that if we were only able to get this indirect cost from NIH, this could offset the cut here. That's not the case at all, because the indirect costs are totally apart from cutting $50 million out of the direct grant program of the VA. We understand that reduction equates to losing about 500 clinician researchers lost to the system not only performing research, but also providing clinical care for veterans at the same time.

I find it difficult to believe, and it's very admirable that we want to set up a center of excellence in prosthetics. I think that's a marvelous thing for the VA to do. VA has been in the past a leader in prosthetic research. But how do you start these new initiatives if you're cutting the research budget by $50 million in one particular year? I think they don't quite match the intent and the reality of their budget proposal.

Dr. SNYDER. My understanding is that, Mr. Chairman, that somebody had asked and the Secretary said that he would provide us with his—what he had asked for specifically in that $1.2 billion. It will be interesting to see what his number, what his requested number is. I suspect it's more than $50 million. I suspect it's just an inflationary increase. But I think probably it's more than just $50 million that got cut out of his budget request. I'll bet it's closer to 65 or so.

But I appreciate you all for being here and appreciate the work you put in on this. And I think we ought to keep talking about this research issue, because this has got ramifications throughout our budget, not just for health care on the DOD side in terms of how we fight future wars and how we take care of our men and women in uniform before they become veterans. And if we keep cutting research all across the budget or don't fund it properly or don't take advantage of the opportunities out there in science and technology for research, we do a disservice to the American people.

Thank you.

The CHAIRMAN. Thank you very much, Dr. Snyder. Just to amplify a little bit from the budget submission, that 499 FTE that would be lost if that budget cut were to go through, when you really start breaking it out, you see what damage that potentially could do in the biomedical laboratory science research, we would lose 85

people; health services research, 17; rehab research, 21; clinical science research, 26 people; and in medical care support, 350.

So it's a very significant number to drop or decline. So I thank you for your questions along that line. Yes, Doctor?

Dr. SNYDER. Just a final comment. And I appreciate your interest in this issue. It's something, you know, I had my own health problems this year with surgery and all, but.

The CHAIRMAN. You're looking great.

Dr. SNYDER. Yeah, thank you very much. But, you know, every family has somebody that has medical things. So we all—we spend a lot of time talking about access to care and paying for medicines and transportation to doctors and all that.

The bottom line is, you know, we're all still young enough. Think what health care is going to be like 30—I'm planning to be here 40 years from now. But we've got some real opportunities to prolong life and the quality of life, but it doesn't come for free. And I think the American people somehow think it's not just enough that we have a good looking VA building like we do in Little Rock and we have it staffed. What we want is as years go by that what happens in there gets better and better and better.

And so, you know, paralysis. I mean, who knows where we'll be 30 or 40 years from now with regard to quadriplegia. Maybe it will be a curable disease. It won't be if we don't put the money into it.

Thank you.

The CHAIRMAN. I agree. You know, speaking for myself, I think this cut is totally unwarranted and counterproductive because every dollar we spend in research is needed, and we've seen this with the NIH and other monies that we expend. You almost can't—there's no overload capacity in cancer research, and especially in medical care for our veterans. There are horizons that have not, or challenges that have not been met. So hopefully we can restore every dollar of that. Let me just ask a couple of follow-up questions or just make points. Mr. Jones, you had commented on older VA cemeteries. As you probably know, our staff visited the TOGUS main cemetery a year ago. It was closed in 1954. The conditions were unacceptable. I wrote to the Secretary, and he immediately moved to try to rectify the situation. And what should the VA be doing to restore those older VA sites, if you could respond to that?

And I would just also, to Mr. Cullinan, as you know, we passed Public Law 108–170, which was the first in a number of years, VA construction budgets as part of the health care initiative or health budget, that provides $276 million for eight named projects, $86 million for five advanced planning projects, which will carry additional dollars if the planning goes as we anticipate, and authorizes studies in four additional areas, including in the State of New Jersey.

The third time's the charm. We had passed previous bills that died in the Senate. I remember H.R. 811, which provided $550 million over 2 years. We thought that, you know, was warranted. CARES was used as a pretext to say wait until they do their work on CARES before we do this seismic and other construction advancements, and it never went through.

Mr. Moran had a bill that we did as well, passed the House, unfortunately died in the Senate. So this one finally was passed. You

may just want to comment further. Because I'm afraid that if CARES gets delayed or perhaps if anything goes forward, some of these very important projects will again be put on the back burner, you know, delay is denial.

Mr. CULLINAN. Mr. Chairman, our observation has been that CARES is being used as a justification, as an excuse to bring construction basically to a halt in VA, period. And it's certainly manifest in the President's budget submission, what they would provide for actual, you know, major or minor construction projects.

CARES has become a block, a barricade to proper construction projects, proper renovations, our concerns about seismic deficiencies, all of these things have been brought to a halt by CARES. And one has to question how long it's going to take for CARES to go forward to any extent.

There's not enough money being provided or being offered by the President to really pull it off in the upcoming fiscal year. There seems to be an ongoing delay in the presentation of the study. The Secretary indicated earlier he expects to get the CARES study February 12, I believe he said, and then they're going to look at it for another month, and then maybe it's going to come to light. And one might suppose that, you know, election year politics could provide another barrier.

We're very, very concerned.

The CHAIRMAN. Mr. Jones?

Mr. JONES. Yes, sir. Critical projects have been identified and associated with the National Shrine Commitment initiative. These projects include gravesite renovations, headstone alignment, repair of roofs, drives, parking lots, walks, buildings, statues, memorials and all related projects.

This is the answer to care for older cemeteries, those cemeteries that are no longer open. If we are to have a commitment to the National Shrine initiative, we need to ensure that it's a priority. To get the job done, we need to have priority funding for the National Shrine initiative. I think that's essential, to answer your question, and the question of others who visit these shrines and recognize what service has been given to this country and the debt we owe so many people who have gone before us.

The CHAIRMAN. Ms. Davis?

Mrs. DAVIS. Thank you, Mr. Chairman. I know in your testimony you talk about the loss of budget dollars, and I'm just wondering, and you probably have addressed this, one is the real consequences, and I think, Mr. Fuller, you speak to the consequences in the budget to our military families. I wonder if you wanted to just elaborate on what you think those consequences would be.

And Mr. Violante, I just wonder, thinking—you mentioned the trend, that the trend is in your estimation is gong the wrong way, what we would anticipate 5 years from now. Where do you see the real impact to be, judging on the gaps in this particular budget? Either one, Mr. Cullinan or——

Mr. CULLINAN. Could I? I could speak to that in budgetary terms, and it's a thought that kind of clarified in my mind when I was listening to Mr. Buyer speak earlier. A number of years ago, we all fought to get to allow VA to collect and retain third-party collections, the idea being, at least among ourselves and our friends here

in Congress, that these dollars would be used to augment the system, to supplement appropriations. Of course, we all understood that there'd be some shifting. Obviously there would be some shifting.

But for 2005, we're presented with a budget, depending on whether you use the traditional methodology or the new methodology, where collections represent five to six times as much as the appropriation support. That's not augmenting appropriations, that's supplanting them. And if that trend continues, we're in a horrible situation, both ethically and in practical terms. The money is not going to be there to sustain the system.

There is language in the President's 2005 budget which basically mandates that dollars be spent on Categories 1 through 6 before 7's may be addressed, as long as 1 through 6's needs are properly attended to, whatever that means exactly. Once again, that's a dangerous situation. Sevens, which should be designated as 5's in our mind anyway—they don't really make all that much money—could suddenly be pushed out of the system.

There is the tendency again. We could have a system in a number of years that would be hard put to properly provide for the veterans that it does serve, and those veterans that it would be allowed to serve would be drastically diminished. I guess that's my gravest concern.

Mr. FULLER. I'd just like to reiterate one point. It appears that every time OMB or an Administration is facing a budget deficit or problems or doesn't want to spend the money on veterans' health care, then they recommend another increase in a user fee or a co-payment or raise this charge or that charge, which gathers in a lot of money, but it's also very, very painful for veterans.

Last year when we saw these same co-payments and user fees raised, we brought in an example of a PVA member who relies on the VA health care system for his specialized services and requires a lot of stuff, a lot of supplies, a lot of equipment, a lot of health care. We gauged what he was paying now and what he would be paying under the new system, and it just about tripled it. It went into the thousands of dollars. These are people who are not necessarily affluent, but who, when they rely on the VA health care system, have to make a choice of whether they're going to spend that money or go without the health care itself. That's the real concern.

Mrs. DAVIS. What we think about as the benefits couldn't be cut in half or even greater than that in the future, and that might be a picture that we don't want to paint.

Mr. FULLER. Well, I think we also have to face the fact that we have a chronic problem in VA health care system now—waiting times. The reason people have to wait a long time is because there isn't enough staff to be able to actually staff the clinics to push people through on a timely basis. And where do you get staff? You get staff from adequate budgeting. Not only the amount of budget you get, but also when the VA gets that particular appropriation. That has become a problem as well.

Mrs. DAVIS. Thank you. Is there anything else in particular? I know always in a hearing there's that feeling when you leave, oh, I wish I would have. Is there anything that wasn't in your testi-

mony that you haven't had an opportunity to answer and you really would like us to leave here focused on that particular issue?

Mr. FULLER. If I could just raise a topic which I didn't dwell very much on in my testimony but which was also raised here I believe briefly is the really serious reductions and cuts in the number of nursing home beds that are in this particular document.

I mean, this is really shocking.

Mrs. DAVIS. It's about 5,000. Is that the number you have?

Mr. FULLER. Yes. One of the historic functions of the VA going way back was long-term care and domiciliaries and housing. It's very clear to us that the VA just wants to abdicate this mission and then push people off into either Medicaid or state homes or other state programs.

From PVA's standpoint, home and community-based services are the most humane way to deal with a long-term situation if the home is adequate and the help is adequate at home. The level of care is appropriate for the patient. But, home and community based care cannot really be a substitute for all types of long-term care services. You need nursing homes. You need the ability that the VA has.

Historically, VA nursing homes have been better staffed, better equipped, with higher skills than what you could possibly find in the private sector. They are able to take extraordinarily complex patients, such as ventilator-dependent patients and people with very high levels of chronic dementia. We would just hate to see the VA lose this expertise in caring for the aging veteran.

Mrs. DAVIS. I appreciate that. Thank you. I know I raised that issue earlier today as well.

Mr. VIOLANTE. Congresswoman Davis, one thing that really sent the message home to me when the VA briefed us on the budget was dealing with the COLAs. And for their employees in 2004, they projected a 2 percent COLA. They wound up with a 4 percent COLA, and that meant that on the health care side, it cost VA hundreds of millions of dollars to make up that difference in the COLA. That came out of our health care. On the benefits side, it was about $30 million. This year they're projecting a 1.5 percent increase for their COLA. So if you're going to give them more, you might want to factor in some additional money to do that so it doesn't have to come out of the program funds.

Ms. SNYDER. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Davis. And if I could, Mr. Fuller, and I'm sure you've seen the VA's numbers. I agree with you. As a matter of fact, we had a hearing last week focusing on the long-term health care crisis and the fact that we're not meeting our needs, that the Millennium Health Care Act passed just a few years ago was designed to put in a floor, not a ceiling, and certainly a floor now that has been breached if this proposal were to go through.

While we're happy that the VA suggests that the state home nursing will rise 30 percent from 14,674 to 19,010, I agree with you that the VA itself should not see a 37 percent decrease, which is in their data, from 13,391 to 8,500. Yes, there's a big push towards noninstitutional care. An 84 percent increase year over year is what they're suggesting here. But as you pointed out, that's not ap-

plicable in all cases, and there are so many cases, as we all know from our own personal experience—from our grandparents and others—that works, but only in a limited set of circumstances.

Last year we fought very hard to ensure that the proposed 5,000 decrease in VA nursing home beds would not happen. I can assure you we will do the same thing this year. Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, I don't have any questions, but I'm just sitting here, you know, the more this budget becomes exposed, the more bizarre this becomes. I mean, we are in the middle of a war. We're talking about going to Mars. And we're talking about cutting 5,000 beds out of long-term care for veterans. And this budget is unrealistic. It's not going to happen. We're not going to impose those co-payment increases. I don't think—I don't think Republicans or Democrats either one in this House is going to accept that. And I don't think they're going to accept the $250 user fee or whatever it's now being called.

And this budget is based upon the assumption that that's going to happen. So not only are we short to begin with, based upon most of what I think all of us in here believe, you know, if these proposals don't take place, we're going to be even shorter.

And if I can just say one thing about the research. I got a call from a colleague this summer during the August recess. This colleague said to me, you know, I've been thinking about this VA system. You know, why don't we just get rid of the VA health care system? And why don't we just let people, you know, go to the Cleveland Clinic or wherever they want to go get their health care? I think we could save a lot of money.

He said, you know, I think I'll as the GAO to do an investigation of this to just tell us how much money we could save. And I'm thinking, go right ahead. In fact, I said to him, go right ahead. Why don't you do that? Because I think what he'll find out is we wouldn't save money. The VA is efficient in providing the kind of services it provides.

And one of the things that I am most proud of when I talk to people about the VA system and why it should be preserved is the research that goes on. Christopher Reeves has made whatever progress that he's made in significant part because of research that took place at the VA facility in Cleveland, Ohio. Breast cancer research that's gone on in the VA. I mean, this is a jewel. We should be so proud of this research effort, and we should just commit ourselves to protecting it.

So I just wanted to say that. Mr. Chairman, I know where you are on all of these things, and so, you know, because sometimes I feel like I'm kind of preaching to the choir so to speak, especially when we talk to each other in this room. But these are important things. And I just want to—I want to thank you. Keep up the fight. I think the fact that you are unified and this is a unified effort put forth by the various VSOs gives it great power.

Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. I want to thank our very distinguished panel again for the great work you've done past, present and I know in the future going forward. Your presentations today were very enlightening and very helpful.

Thank you. I'd like to ask our final panelists, group of panelists, panel number three, to be seated, and beginning with Mr. Peter Gaytan, who is the Principal Deputy Director of the Veterans' Affairs and Rehab Division for the American Legion.

He attended Wesley College in Dover, Delaware where, Mr. Gaytan earned a B.A. in political science. He also is a graduate of the Defense Information School of Fort Meade, Maryland.

Mr. Gaytan entered the U.S. Air Force, and after completing initial training, served as Military Protocol Liaison with the 435th Airlift Wing at Dover Air Force Base in Delaware. In addition to his active duty service, Peter served 6 years with the 5412th Airlift Wing, U.S. Air Force Reserve, as a public affairs specialist.

Next we'll hear from Mr. Richard Schneider, who is the National Director of the State/Veterans' Affairs Non Commissioned Officers Association.

Mr. Schneider has a Bachelor of Science degree from the University of Southern Colorado and a master of arts from the University of Northern Colorado.

Mr. Schneider served in the United States Air Force from August 1957 to September of 1990. He retired at the grade of chief master sergeant.

Next we'll hear from Colonel Robert F. Norton, U.S. Army (Retired), who is co-chair of the Veterans Committee for The Military Coalition. When he wears his other hat, he is the Deputy Director of Government Relations for the Military Officers Association of America.

After earning his undergraduate degree, he enlisted in the U.S. Army as a private and was commissioned as a second lieutenant of infantry after completing officer candidate school. After a tour of duty in Vietnam as a civil affairs platoon leader with the 196th Infantry Brigade in I Corps, he transferred to the Army Reserve and taught school at the secondary level.

Colonel Norton served in various staff positions with the 356th Civil Affairs Brigade, U.S. Army Reserve, until he volunteered to return to active duty in 1978. He served two tours in the Office of the Secretary of Defense. He finished his career as Special Assistant to the Principal Deputy Assistant Secretary for Defense, Special Operations/Low Density Conflict, and retired in 1995.

Next we will hear from Master Sergeant (Retired) Morgan D. Brown, who is also a Co-Chair of the Veterans Committee for The Military Coalition. Mr. Brown also serves as the Legislative Assistant for the Air Force Sergeants Association. He entered the United States Air Force and completed Basic Military Training, Law Enforcement Specialist Training, the Military Working Dog Patrol Dog Course, all at Lackland Air Force Base in Texas.

He held various positions during his time in the military, including Law Enforcement Patrolman, Narcotic Detector Dog Handler, Explosive Detector Dog Handler and Kennelmaster.

We will then hear from Mr. Richard Weidman, who serves as Director of Government Relations on the National Staff of the Vietnam Veterans of America. He served as a medic with Company C, 23rd Med, Americal Division, located in I Corps of Vietnam in 1969.

Rick has served as a consultant on legislative affairs to the National Coalition for Homeless Veterans, and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment and Training, the President's Committee on Employment of Persons with Disabilities, on Disabled Veterans, and numerous other advocacy posts in veterans affairs.

So, Mr. Gaytan, if you could begin.

STATEMENTS OF PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS' AFFAIRS AND REHABILITATION, THE AMERICAN LEGION; RICHARD C. SCHNEIDER, NATIONAL DIRECTOR, VETERANS AND STATE AFFAIRS, NON-COMMISSIONED OFFICER ASSOCIATION; COLONEL ROBERT F. NORTON, U.S. ARMY (Ret.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA AND CO-CHAIR, VETERANS COMMITTEE, THE MILITARY COALITION; MASTER SERGEANT MORGAN BROWN, U.S. AIR FORCE (Ret.), LEGISLATIVE ASSISTANT, AIR FORCE SERGEANTS ASSOCIATION AND CO-CHAIR, THE MILITARY COALITION; AND RICHARD F. WEIDMAN, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

STATEMENT OF PETER S. GAYTAN

Mr. GAYTAN. Thank you, Mr. Chairman, for the opportunity to express the views of the 2.8 million members of the American Legion regarding the Department of Veterans Affairs 2005 budget request.

The American Legion continues a proud tradition of advocating for proper funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. As American servicemembers continue to fight for our freedom in more than 130 countries worldwide, it is the responsibility of this committee, as well as the entire Congress, to provide a budget that will allow VA to fulfill its mission.

In the FY 2005 budget request, there is a continued emphasis on the treatment of the core mission veteran population. Term "core mission veteran population" does not appear in Title 38. In 1998, eligibility reform ensured all eligible veterans could seek health care through VA, not simply those designated as the core mission veteran population.

Since then, we have seen VA shut its door on Priority Group 8 veterans. Tailoring the patient population to meet the budget was not the intent of Congress when VA eligibility was reformed. The American Legion urges this committee to fund VA at a level that will ensure all veterans have access to the VA health care system. The VA budget must reflect the true demand for care.

Today veterans continue to suffer as the result of a system that has been routinely unfunded and is now ill equipped to handle the large influx of veterans waiting to use their services. Despite recent progress, veterans continue to experience long waiting times for medical appointments as well as long waiting times for claims adjudication. The American Legion applauds Secretary Principi for his efforts to reduce the extreme backlog of patients waiting to re-

ceive care at VA facilities, and we urge VA to continue to implement practices that will eliminate the backlog systemwide.

Last year the American Legion initiated an effort to learn firsthand the concerns of VA facility directors. Under the "System Worth Saving" initiative, Past National Commander Ron Conley visited 60 Veterans' Affairs medical centers, and so far this year, a team of Legionnaires has visited more than 25 facilities.

We are learning one of the main issues of concern for facility directors is the increase in medical care collection fund targets. The VA medical centers are concerned over the significant increases in their MCCF goals and what impact the restriction on enrolling any Priority Group 8 veterans will have on their ability to meet these goals.

The American Legion shares their concerns, and we are also concerned about the impact of certain proposals included in the FY 2005 budget request that seek to generate increased revenue for VA from the pockets of veterans instead of through allocation of federal funds.

The American Legion opposes the continuation of the suspension of enrollment of new Priority Group 8 veterans. Denying veterans access to VA health care, particularly while the Nation is at war, is the wrong message to send, not only to the members of the all volunteer force, but also to the young men and women who may be considering a life of service in the U.S. Armed Forces.

The American Legion also opposes the implementation of a $250 annual enrollment fee for non-service-connected Prior Group 7 veterans and all Priority Group 8 veterans. The American Legion would urge Congress to once again reject this proposal just as it did last year.

While the American Legion applauds the initiatives to exempt any hospice care from co-payments, and to exempt former POWs from co-payments for extended care services, we do not support increasing the pharmacy co-pay from $7 to $15 for Priority Group 7 and 8 veterans.

Additionally, the American Legion opposes the proposed regulatory change that would increase outpatient primary co-pays from $15 to $20 for all Priority 7 and 8 veterans. The American Legion would rather VA seek reimbursements for CMS for all enrolled Medicare-eligible veterans being treated for non-service connected medical conditions before trying to balance the budget on the backs of Priority Group 7 and 8 veterans.

The American Legion is very concerned with the proposed reduction in long-term care beds. We did submit testimony for the record at the hearing last week, and the American Legion is very concerned about this issue, and VA must meet the mandates of the Millennium Health Care Bill, and eliminating long-term care beds is not the answer.

The American Legion recommends $30 billion for VA medical care in FY 2005, without inclusion of MCCF collections.

The American Legion advocates for all MCCF collections to be added to the budget numbers and not be treated as an offset to the budget.

Regarding the Veterans Benefits Administration, the American Legion is committed to ensuring VA will adjudicate veterans'

claims fairly and impartially within a reasonable amount of time. We commend Secretary Principi for the dramatic reduction in the claims backlog in the past 2 years. At the end of August 2003, VBA reported the number of pending claims had been reduced to 265,000, and the average processing time was now about 160 days.

While these improvements are very much needed, we must keep in mind that faster is not always better. The drive to achieve the mandated production quotas must not compromise VBA's quality improvement efforts. The lack of appropriate action on thousands of claims has resulted in over 134,000 pending appeals. Even though there is an effort to resolve appeals at the regional office through the decision review officer program, most cases will eventually go to the Board of Veterans Appeals for final decision.

The American Legion is pleased with the FY 2005 budget request proposal to address the influx of claims resulting from returning servicemembers from Operation Enduring Freedom and Operation Iraqi Freedom. These deserving veterans should not be told to wait in line when turning to VBA.

Given the many and varied issues that VBA is faced with, it is imperative that Congress critically evaluate the level of discretionary funding requested and whether this will enable the regional offices to operate efficiently and provide timely quality service that this Nation's veterans expect and deserve.

In closing, the American Legion would like to join with our colleagues who earlier expressed support for mandatory funding. We fully support designating funding for VA medical care as a mandatory funding item within the federal budget.

Mr. Chairman, the American Legion is fully committed to working with this committee to ensure that America's veterans receive the entitlements they have earned.

Thank you again for this opportunity.

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

The CHAIRMAN. Thank you very much for your testimony. Mr. Schneider.

STATEMENT OF RICHARD C. SCHNEIDER

Mr. SCHNEIDER. Thank you very much, Mr. Chairman Smith and members of the committee. It's a pleasure to be here and to represent the Non Commissioned Officers Association and its global membership today.

And today it's especially meaningful, because so many of our members are deployed as members of the active duty military. They're in Afghanistan. They're in Iraq, and they are looking for support from the home front for many of the things they do. But one of the things that they don't need to hear on the other side of the pond is that there is a question in the care that may be available for them through the Department of Veterans Affairs.

The Non Commissioned Officers Association recognizes that the Secretary of VA has done a marvelous job, but he has also done it year after year after year with an underfunded budget. This committee has been instrumental in ensuring the funds to provide for the care of America's veterans. This year is no different.

I was floored and almost fell off my chair this morning when the Secretary said he was $1.2 billion short in his budget. I listened

to the numbers a day ago at VA, and I read yesterday in the paper, the federal page, the report of a reporter who said VA was about 2 percent funded for the current year and 2005, and that 1.8 percent was for medical health care. And I thought that is a tragedy. It's a tragedy that must be stopped. We must fund the program right.

Three areas that I'm going to hit very quickly is benefits. There's savings in the VA budget by eliminating employees, full-time employees who work in the federal benefits side of the Department of Veterans Affairs. And the wonderful news is, we have technology. We can expedite. We can create productivity. We can have efficiency. And if you look at the numbers of the past year, yes, the numbers have changed, the cases have come down, yes they have come down, but there's still a backlog.

And if you look at the numbers, you see a number that just makes me kind of grit my teeth, and that number is 88 percent accuracy rate acceptable. Well, I'll agree, that's a damn sight better than 65 or 70 percent years ago, but 88 percent accuracy rate is unacceptable. It should never be tolerated. Twelve out of every hundred people not having their claim filed right, that is wrong.

The veterans health side. We've heard about the projection of the co-pay for pharmaceutical benefits, an increase from 7 to the magical teen numbers. Sevens and eights. No, we don't agree with that. Leave it alone.

A user fee of $250. Wrong. These people paid their dues. They are entitled to their benefits. You might say they're non-service-connected veterans, and they may well be, but they served America. They stood in the breach. Their lives never got on, and now they need a support system, and that support system is the institution that we have promised them over the past 5 years.

And I want to comment one thought. One thought. VA asked us to work with them to ensure that we would open the Department of Veterans Affairs to non-service-connected veterans. Part of that concept of opening up VA was all the money they were going to bring in from their insurance parties, all the money they were going to bring in that was going to expand at the local facility within the local network services for those veterans. Well, you know as well as I do, that has not necessarily happened. The money now is an offset. It's included into the budget number and it adds to this record budget that we're getting, and adding cost this year doesn't do anything more than make available more dollars so that, quote, the appearance of a record budget next year will also be available. That's flat wrong. Long-term care, we need more facilities.

Mr. Chairman, you said it right earlier today. Years ago we said we needed domiciliaries for homeless veterans and other issues. VA has gone through a transformation, and the transformation was inpatient to outpatient. You cannot take care of all America's veterans as an outpatient. We need those domiciliaries. We need mental health beds in our facilities for those who are homeless, for those who have substance abuse, for those who have alcohol abuse programs. We need to move VA back in line to taking care of those people.

I would also submit to you, long-term care, veterans are the worst liars in the world. As a matter of fact, they're not the worst. They're the best liars in the world. Doctor has to approve a veteran for long-term care and he says, how are you feeling, sarge? And the veteran says, gee, I never felt better in my life. Damn lie. He doesn't have a wife at home. He doesn't have children at home. He doesn't have a support structure around him, and yet he's telling this doctor how well he's doing, and the doctor is saying, God, this guy is independent. He doesn't need to be in a facility. We'll send him back home and look at him against next year. Wrong, wrong, wrong. Need to take care of him.

Other points that I would make are in the statement that I have submitted for the record, and I commend that statement to you. Two areas that I would ask you to look at, and I'll not comment long on them. One is we fixed in part DIC benefits for spouses who remarry, and we wanted age 55. We got age 57. Again, wrong. It ought to be 55 consistent with other programs.

Educational benefits, the VEAP enrollments. That will be addressed later. We support reopening those who have never had the opportunity to sign up for the Montgomery GI Bill to have that opportunity.

For our guard, people who received an incentive to join the National Guard because they would have a Montgomery GI Bill entitlement but the time, the clock started running the day they signed the paper, and they had X number of years to complete the program, many of those people in Iraq today, the clock ran out on their GI Bill benefits years ago. I think we ought to extend, and NCOA recommends that we extend the MGIB entitlement to those who still have remaining entitlement on their Montgomery GI Bill.

The rest of the statement we could talk about for hours, and I'll tell you what, it would be fun. The red light has been on. You've been gracious, and I'll stop. Thank you so much.

[The prepared statement of Mr. Schneider appears on p. 169.]

The CHAIRMAN. Mr. Schneider, thank you very much for your testimony. And as you know, we are working with you and with others on the Montgomery GI Bill extensions, and we have right now at the CBO a request for a cost estimate on what it would cost to reopen that eligibility. Because I agree with you, and I think we all agree with you that it's a wrong that has to be fixed. So thank you for those recommendations.

Colonel Norton.

STATEMENT OF COLONEL ROBERT F. NORTON

Col. NORTON. Thank you, Mr. Chairman and members of the committee for this opportunity to present testimony today on behalf of The Military Coalition.

The Coalition represents the collective interests of 35 military and veterans organizations, including a number of organizations that have testified at this hearing today, and we have a combined membership of over five-and-a-half million members.

First, Mr. Chairman, I want to thank the individual members of the committee and Congress at large for enacting last year historic legislation on concurrent receipt for severely disabled retired veterans. This was landmark legislation. We greatly appreciate that

the Congress took this step. More needs to be done, but this was a tremendously historic piece of legislation, and we are grateful for the continued progress on that issue.

Let me talk for a moment, Mr. Chairman, about mandatory funding for VA health care. We're very disappointed that last year a presidential task force's major recommendations on VA health care have not been acted on. Across the board, we had representatives from business, health care experts from across the country, veterans and military representatives—a bipartisan commission appointed by the President.

They came forward and recommended to you, to the President, and frankly, they recommended to the Nation that it was now time to put the VA health care system on solid fiscal basis and provide mandatory funding or some other mechanism that would guarantee and ensure funding for America's veterans. And frankly, Mr. Chairman, the Military Coalition is dismayed and disappointed that that pivotal recommendation of the President's own task force has been ignored.

The VA budget submission fails to implement the full funding mandate, and we strongly recommend that this committee and Congress provide the additional resources needed to close the gap between growing demand and capacity.

The second funding issue I'd like to highlight, Mr. Chairman is that of seamless transition between active duty and veteran status. This has come up in a number of places this morning and this afternoon. And frankly, the VA and DOD have made significant progress in coordinating services, and we commend that progress.

The VA has posted staff at major military medical facilities like Walter Reed and Bethesda Naval Hospital to smooth the transition of severely wounded and ill servicemembers into the VA system. Benefits delivery at discharge has been a successful project at the start, some 136 separation transfer points are participating.

But I learned last week, Mr. Chairman, at the Worldwide TRICARE Conference that coordination activities for the less acutely disabled could be improved. Right now there are 250,000 troops being rotated in and out of Iraq—the single largest peacetime rotation since World War II. It's imperative that the VA and DOD build on their collaboration by improving outreach and transition services at all military hospitals, redeployment sites and separation activities. We recommend that the committee oversee this process and ensure that there are sufficient funds to support the needs of returning servicemembers, including the more than 350,000 members of the Guard and Reserve, our Nation's newest veterans, who have been mobilized since 9/11.

And related to that, Mr. Chairman, I want to emphasize on behalf of the Coalition that more needs to be done on seamless transferrable medical records for our servicemembers. This is not just about technology. We know, Mr. Chairman, that there are two robots on Mars. If we can put that technology on Mars, we can do better to ensure records from our servicemembers are transferred seamlessly between DOD and VA. This is not just about business. This is about those people who have raised their hands. They need to have the proper care throughout their service careers in active

duty and into veteran status until the day that they pass from this life.

Not only does this help veterans, but frankly this also saves the government billions of dollars in terms of initial claims, proper diagnosis on active duty, and when they get into the VA, medical care, and research. This needs to be done, and it's not being done. There was a hearing last November that indicated it would be until 2006 or 2007 till this project gets completed. But this needs to be done now.

As a number of members have indicated today, we are at war. We have thousands of young men and women who will be returning with PTSD problems and other health conditions. They need to have a smooth seamless transition from DOD into VA, and The Military Coalition asks your support for this activity.

Mr. Chairman, I would be happy to take your questions and those of the members of the committee, and I thank you again for this opportunity to testify today.

[The prepared statement of Colonel Norton appears on p. 178.]

The CHAIRMAN. Colonel Norton, thank you very much. Mr. Brown.

STATEMENT OF MASTER SERGEANT MORGAN BROWN

Sgt. BROWN. Mr. Chairman, distinguished members of the committee, good afternoon, and thank you for the opportunity to present testimony on behalf of The Military Coalition. I'd like to just touch briefly on a couple of education issues that the Coalition would appreciate you looking at this year.

The TMC appreciates your efforts in recent years to increase the value of the GI Bill. You have actually taken significant steps towards having the program actually pay the full cost of books, tuition and fees, and we hope that you will continue to work towards that end.

We also ask that you provide an enrollment opportunity in the Montgomery GI Bill for those who declined the old veterans educational assistance program. Currently, there are about 90,000 active duty members in this situation, and these individuals are the senior NCOs and officers leading the younger troops in the war on terrorism and in Iraq and Afghanistan.

In the past, you enacted legislation which allowed the participants the opportunity to enroll in the Montgomery GI Bill. However, the decliners have never had the opportunity. Consequently, they have no educational transition benefit. The TMC recommends that the committee authorize an enrollment opportunity for career servicemembers who turned down the Bill.

And finally, more than 350,000 Guard and Reserve members have been mobilized since September 11, 2001. Thousands more are preparing to deploy, and many of these individuals are part-time or full-time students. Due to the recent increases in the Montgomery GI Bill, the Selected Reserve GI Bill benefit has not kept pace with the active duty counterpart. In 1985, Congress set the Selected Reserve GI Bill benefit rate at 47 percent of the active duty benefit. With the recent increases in the Chapter 30 benefit, the value of the Selected Reserve benefit fell to 29 percent. The Se-

lected Reserve rate needs to be increased in order to reestablish proportional parity with the active duty Montgomery GI Bill.

And, Mr. Chairman, that's all I'll cover today. The TMC looks forward to working with you on behalf of all veterans. We thank you and the members of this committee for your leadership and commitment to the men and women of the Armed Forces who so valiantly serve and have served this Nation.

[The statement of Master Sergeant Brown appears on p. 178.]

The CHAIRMAN. Mr. Brown, thank you very much for your testimony. Mr. Weidman.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, on behalf of Tom Corey, our National President of Vietnam Veterans of America, I thank you, sir, and this distinguished panel for allowing us the opportunity to testify here today.

I also want to second the thanks about the extraordinary moral and political courage demonstrated by yourself and by many of your colleagues on this committee on both sides of the aisle last year to secure the budget that we did have in the end. It was a true test of why one is in public office and reminded us at VVA, although it was put in a slightly sexist way, Lyndon Johnson once said that boys run for office to be somebody; men run for office in order to do something. And there were a lot of men and women on this committee and in this Congress last session, and we look forward to winning the battle again this year.

VVA's recommendation for the medical care account of VA is $31.31 billion. We arrived at that, Mr. Chairman, by taking the $28.5 billion, which is what ultimately the Under Secretary for Health admitted was what was needed last year in hard cash appropriated funds in order to reopen the system to Category 8's. We took that and applied the 6 percent projected just pure medical inflation, not increased medical costs, just pure inflation by the Center for Medicare and Medicaid Services, utilizing the same methodology that we did in the whitepaper which was released last summer. And that took us to $30.31 billion.

It is our estimate that it will take approximately $1 billion to start to rebuild the organizational capacity, particularly in mental health, but also in the other specialized services, and in acute care, where we have a dangerously low patient-to-RN and patient-to-LPN ratio.

And last but by no means least, we have not even begun to address properly the whole issue of Hepatitis C across this country. Most of the clinics are underfunded. Most of the clinics are understaffed, and we are now looking at a train wreck in the making that will hit us by the year 2010 or 2011 unless we successfully deal with Hepatitis C here today. That would bring, with the main budget, bring all of veterans health administration to $31.42 billion.

VVA is proud to be an endorse of The Independent Budget for the Veterans Service Organizations and agree with their calculations, with that one exception of medical care account, on virtually every other category.

I want to express our thanks to our brother and sister organizations for the extraordinary effort that they put forward and their fine work which enhances all of our credibility, not just the VSOs, but our friends in the Congress.

I also want to talk a bit about triage. It was with a great deal of sadness and certainly no anger or elation that Vietnam Veterans of America joined with Representative Strickland. Usually we get into trouble all by ourselves, Mr. Chairman, but this time we had some guidance. But we have been deeply concerned and asking about outreach and pushing on outreach about restoration for some time.

Outreach, marketing. We went to the dictionary when this has been brought up to us, and we can find no difference between them. In fact, the best definition of how to reach a homeless veteran or a veteran who is reluctant to come to the VA, no one is more skeptical than homeless veterans. You have to go, and the definition of "marketing" in the dictionary is—that we consulted—is to sell the individual on the services so that the individual buys the service. There is no better description of what needs to be done on an individual basis in order to get an individual homeless veteran to come into the system to establish that kind of trust and get them the help that they need in order to come to full recovery and go on and lead a productive life.

We were deeply—we had backed in this hearing room last year the temporary suspension of Category 8's as a necessary triage decision. Less than 3 weeks—about 3 weeks later, we were in a meeting on CARES and discovered that the temporary suspension was slugged into the planning figures for VAs through the year 2023. That is one heck of a temporary suspension.

We were quite upset with that. We went to the chief of staff of VA and said, well, we're a little taken aback by this. What we believe happened because—and I wanted to mention, as I was starting to say, about the whole issue of outreach and joining in the suit to restore proper outreach, is it comes back to the question of lack of resources, and now VA is planning for the future not to have enough resources on a permanent basis, as a way of limiting who is eligible.

If in fact folks want to change who is eligible under Title 38, then let's do it through the front door. Let's do it openly. Let's do it honestly. And frankly, Vietnam Veterans of America and I'm sure all of us in this room will welcome that debate out in the sunshine. It is through the back door in the dark of night of by de facto underfunding the VA system and therefore denying Category 8's.

This is not a victimless crime, we would suggest. This outreach in education is key. Most Vietnam veterans go nowhere near the VA system. Most Vietnam veterans and those of us who served on the ground in country have no idea that our prostate cancer rate is many, many times that of our nonveteran cohort group. And therefore, we need to be checked much more often.

And if folks do get sick, and many have gotten sick and died from prostate cancer who served on the ground in Vietnam, they perish, never having a clue that they died for their country as a result of wounds and exposures that were received in Vietnam. That leaves the family in debt instead of with DIC. It is that kind of example

that we would use that excluding Category 8's as a matter of course is excluding people who should be Category 1 because ultimately they would be 50 percent or more service-connected before they perish.

In regard to the research dollars, we would second and feel very strongly that the refocus that Secretary Principi and commend the VA and the Secretary for refocusing VA research on the wounds of war. But to cut VA, the overall appropriation at this time is particularly bad.

I want to just finish up, Mr. Chairman, by saying, as usual, we were going to talk about the purpose of VA. The purpose of VA is to care for he who hath borne the battle. Currently, the VA has no idea who borne the battle. You don't even know by looking at the VA health care system who served in a combat theater of operations. They do not ask the questions on military history that they should be asking in order to do a complete diagnosis and lead to wellness, and that leads us to where we are today.

The gap between where we need to be and where we are will never be made up through the ordinary budget process. It will never be made up, no matter what heroic efforts, no matter how much moral and political courage you and your distinguished colleagues display. The only solution to this is moving to mandatory funding. We have to quote/unquote "go off budget." Whatever you want to call it. And that is the only way that we will achieve the money that we need now to start restoring the system to its organizational capacity in order to be ready for the young men and women coming home as well as taking care of the veterans who are already of previous generations in very much need of the care that VA only can provide when it's doing its job, focusing on being a veterans health care system as opposed to just general health care that happens to be for veterans.

Mr. Chairman, once again, I thank you, and I particularly thank you for your indulgence in allowing me to run slightly over time.

[The prepared statement of Mr. Weidman appears on p. 186.]

The CHAIRMAN. Thank you very much, Mr. Weidman. And like the previous panel, I want to thank all of you for the good work that you do, the very timely and extensive recommendations you make, not just at today's hearing and in anticipation of it, but throughout the entire year.

As you know, we take seriously those recommendations. We very often turn them into solid legislative proposals. You look at the bills that have been passed in the last several years, it is replete with insights and recommendations that have come right from you. So I do appreciate that. We all appreciate that very, very much.

As we went to our benefits bill, seven titles, 39 different district provisions in that bill. So many of them were recommendations that had come directly from you from the field.

When you talk about the GI Bill, Colonel Norton, I couldn't be more in agreement, and all of you who raised it. When we raised it a couple of years ago by 46 percent, that's not what we wanted. We wanted more than that. Just to keep pace with the rising cost of inflation at our colleges and universities and junior colleges, which have been growing almost exponentially in the last 10 years,

the GI Bill fell into disuse because it wasn't enough for a benefits package.

So again, your recommendations there were so helpful, and we have legislation we're preparing now that would meet some of those additional needs, and we will work it hard in this Congress.

I just would ask maybe a question, if I could. The recommendation in the administration's budget for $1.3 billion in management efficiencies. I'm not totally sure how after last year's billion, if it ever materializes, that we can squeeze that much out of productivity and synergistic work in the VA with DOD/VA sharing or however they define management efficiencies. Another 1.3 this year. Do you think that's a realistic figure, or do you think that's just something that was put in there to plug a hole? Mr. Weidman?

Mr. WEIDMAN. If it were management efficiencies, I think you would find not only Vietnam Veterans of America but my distinguished colleagues from all the other organizations would be all for it.

We have long since passed that. For the last 4 years, it has been a code word for reducing services. It's as simple as that, sir.

The CHAIRMAN. Yes, Colonel Norton?

Col. NORTON. Mr. Chairman, I'd just like to comment on the VA/DOD sharing process. It's a good process. There are opportunities out there, and DOD and VA have looked at opportunities to collaborate on equipment purchasing, facility sharing and so forth.

But what we're concerned about in the Coalition is that, again, when you look at the word "CARES" you don't see a metric that says how does this collaboration enhances services for eligible beneficiaries. Whether they're active duty, whether they're retired, whether they're returning servicemembers from Iraq, whether they're veterans.

So, collaboration is okay, and ultimately it may improve management efficiency, but we want to know, and we want to see what those efficiencies are going to produce in terms of access, quality of care, reducing waiting times. In other words, enhancing services. The "E" in CARES has to be a capital E if this thing is going to work between DOD and VA.

The CHAIRMAN. Yes?

Mr. GAYTAN. Mr. Chairman, I'd just like to add what Colonel Norton mentioned about the CARES initiative and the management efficiencies, the American Legion is very concerned about the CARES initiative and the proposals that are coming out of the draft national plan.

Our main concern is not that a more efficient run VA system—that's the goal of the American Legion as well as the CARES Commission. What we want to ensure is that any recommendations that come out of the CARES Commission do not suspend services while they're implementing any of the reconfiguring or realignment of facilities.

Not only can we not suspend those services, but we need to ensure that when the final recommendations are carried forth and funded and in place that none of the veterans in the local areas will be without care that they had prior to the CARES initiative.

Mr. SCHNEIDER. I think also on management efficiencies, the administration is very big on the score card and ranking performance

and the rest of it, and I think we need to start identifying the information to fill the score card in and setting a standard that is going to be acceptable and to just pursue on in directions to go into interagency dealings and what have you saying that this will result in better management, we need to define the process and what the result is going to be, as Bob said.

Mr. WEIDMAN. Real management efficiencies are achieved by getting people in and diagnosing them correctly at the early stages of maladies, such as whether that be Hepatitis C, whether that be prostate cancer, whether that be you name it.

And if we focus on asking the right questions and focus on being on the military history and asking questions that pertain to the individual's veteranness, if you will, we will save a heck of a lot of money down the line. But you can't do that when you bar the majority of veterans, and the majority of veterans in this Nation of the 24 million indeed are Category 8 veterans, when you bar them from even walking through the front door to do a preliminary physical based on when and where they served, what branch and what actually happened to them.

And they're barred from doing that now. And this makes no sense. We're going to wait until they get so sick they become indigent, and then we'll see them when they're terminally ill. And how expensive is that both in human terms, in economic opportunity costs, and in straight cash outlays, Mr. Chairman? It's going to be enormously expensive.

Mr. SCHNEIDER. I'd like to just add one other comment, and I touched on it lightly before, the transformation of VA from inpatient to outpatient. The next transformation, in my judgment, needs to be the reassessment of mental health professionals, practitioners working in veterans health administration.

All of the studies today and all of the reports that come up here from Congress from the different working groups in mental health, the homeless veterans group, the woman's advisory, all show documented decline in mental health, and all of them report surveys and other instruments that reveal that integrating mental health practitioners into the medical clinics will result in cost savings over the years.

A management efficiency that can give back millions of dollars by better utilizing resources at that level needs to be pursued. I'm delighted that Mr. Principi, Secretary Principi, has in fact appointed a working group to explore this, and I was shocked again and surprised, delightfully surprised, that the individual who was appointed to chair it was Dr. Fran Murphy.

And the reason I was so surprised, because she sat at this table years ago and said we don't need domiciliaries. We don't need mental health, that we can do this on an outpatient basis. I think that her current years of service and her research has showed that, hey, I may have made a mistake years ago, and she's pursuing this with a lot of vim and vigor. And that I believe is going to be the next transformation of VA, and it may give back the cost savings that will help the operating costs come down.

The CHAIRMAN. Thank you very much. I appreciate that. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Schneider, I was struck by your most recent comments. Before coming to the Congress, I had never served in a political office, but I did serve as a psychologist in a maximum security prison. And unfortunately, I worked in that prison with many veterans who suffered from PTSD and other kinds of mental health ailments that had never really been recognized or appropriately timely treated.

And they find themselves then, as veterans, people who had honorably served this Nation, but their lives on the line at great risk, being confined to a prison, I think in large part because they did not receive the kind of intervention they needed.

So I appreciate your concern. And I'm struck by the word games we're kind of playing with outreach versus marketing. It kind of reminds me of the definition whatever "is" is. The fact is that the issue is a life and death issue, as I understand your testimony, Mr. Weidman, because you shared with us that the data shows that if you were in Vietnam and you were exposed to Agent Orange or perhaps other toxic chemicals, that you are at increased risk of developing certain cancers, and in the case you mentioned, prostate cancer.

And are you telling us as a committee that there are Vietnam veterans out there who may have this illness or be at risk and need screening to see if they are developing this illness, and simply because they do not have the information that they may be at increased risk, and are entitled to services from the VA, may not be accessing those services? And if that's the case, this gag order that we've been talking about really has life and death implications. Is my description of the circumstances reasonable, logical, or is there something wrong with that reasoning from your point of view?

Mr. WEIDMAN. No, sir. You hit it right on the head. The example that I gave in the written testimony goes right to this. You have an individual, and we know that the prostate cancer rate—and Ms. McCarthy will probably correct me immediately after, but I believe it's roughly five times the incidence in our cohort group of those who did not serve in the military. So you're much more likely to get it. And that's one of the things that we believe is causing this bump where the incidence of prostate cancer in America is going up among men at an earlier and earlier age, but nobody's looking at the fact that there's a huge number of us who are getting it who are Vietnam in-country vets, in that cohort group.

So you may not get tested because you don't know you need to get tested more often. You may also, because you make $35,000 a year or in your district, $30,000 a year.

Mr. STRICKLAND. Or $24,000 I think in my district, certain parts of it.

Mr. WEIDMAN. Then $24,000 a year, you make $26,000, and you're not eligible. You're a Category 8. You're defined as a quote/unquote "higher income vet." Talk about newspeak.

Mr. STRICKLAND. May I interrupt just a moment to remind you that those of us who serve here in the House make somewhere in the vicinity of $150,000. It offends me that we would consider someone who makes such a modest income "higher income" for the purpose of being excluded. But please continue.

Mr. WEIDMAN. That is $10 or $12 more than most of the veterans service organizations, Mr. Strickland. But we don't have to maintain two residences. (Laughter.)

But the issue here is deadly serious, and it is, it's just that deadly serious. That individual, if they don't have medical insurance, and many of them don't, they're not going to be able to pay straight out for that, even if they have the knowledge that they need to get tested because they served in Vietnam.

Mr. STRICKLAND. Can I ask you this question, sir? Do you know—and I don't know this question, so I'm asking it in good faith—do you know if it is possible for the VA to identify those who have served, perhaps have been exposed, and to proactively reach out to them to inform them of their increased risk? Does the VA have that capacity, or are you aware of whether or not they do?

Mr. WEIDMAN. The VA only has that capacity if in fact the individual has used the VA sometime since they came out of the military, or recently. Many people—you came home from Vietnam and used the GI Bill for some period of time, but don't even live in the same state or part of the country.

If in fact they're service-connected disabled for any condition, then the VA knows where they are, and the VA can in fact do a mailing or try to reach people other ways.

If you ask the average—and incidentally, the majority of service-connected disabled veterans do not use the VA for any of their health care. I mean, we don't talk about that much, but they don't. And therefore, they're ignorant, as are most people ignorant, of what are the 15 conditions that are service-connected presumptive for exposure to herbicides, Agent Orange and other herbicides and toxins in Vietnam. Folks don't know.

And that's the whole point of doing a physical. But if you have a physical that is focusing on the veteranness, with Vietnam it's this stuff; with Gulf War I it's another thing; with Korea it's another, et cetera. Depending on when and where you served, what branches you served in.

But if you can't get access to the system at all, and there's no effort to work through the medical societies, through the AMA, the American Public Health—there is on the part of the veterans service organizations, but not of VA, to our knowledge, or it hasn't had an impact, where civilian doctors know to ask the question, did you serve on active duty in the U.S. military? And then they have a protocol available that will go into PC where they could actually do it there, one or the other.

At one point I asked—the Under Secretary and I got into a significant discussion on it between the two of us. And is someone whom I respect enormously. I think he's a fine man, a wonderful doctor, and a very good leader. But the issue was, he excoriated me for saying you're getting angry at a primary care physician for not knowing to ask the questions, as an example, once again, that I'm most familiar with, in Vietnam, about strongyloides or melioidosis. Strongyloides and melioidosis are tropical parasites. They can remain dormant, we know from American veterans who served in Burma, more than 50 years. When they reposit, it's sometimes, and actually manifest and develop, it is sometimes misdiagnosed as chronic fatigue syndrome, but nine times out of ten plus, it is diag-

nosed as chronic acute depression. Sound familiar? VA is treating 1.2 million people. And supposing it is only—and VA has known since 1980 that 6 to 9 percent of Vietnam veterans carry it in their body.

So supposing it is only 60,000 veterans that are receiving antidepressants, but what's really wrong with them is melioidosis or strongyloides? That's 60,000 people who ain't never gonna get well because we're not treating the right thing, number one. The economic opportunity cost and the impact on their family, and the expense of giving them medications. And I said to the Under Secretary that that's malpractice. He said you can't say that. I said, well, I just did. I would call it malpractice.

And he said you're holding that physician and getting angry at that physician, and that's not legitimate. And I said, you're right. That physician doesn't know. But that physician doesn't know because you didn't tell him. Because you made no effort to train him. Because you made no effort to cue him. And that is the same of it. Because at that point it becomes willful ignorance.

And the same thing is true on outreach. VA has always done a lousy outreach job on Agent Orange and on the toxic maladies. But it's done a much worse job in the last couple of years.

I just want to share one thing, Mr. Chairman, if you'll indulge me. I quoted at the last leadership board meeting, which was the day before, and it was only after this that we decided to move ahead with the suit on outreach. At that leadership board meeting, I asked the question of the VISN directors, and I think 20 out of the 21 were there. How many people here in your VISN are doing more outreach—and I used the word "outreach"—outreach today than you were one year ago? One person raised their hand.

I asked a second question. How many people in this room, how many VISN directors, are doing about the same? It was either five or six, I'm not sure exactly. But it was no more than six. So then I asked the question, how many people in this room are doing somewhat to significantly less than they were a year ago in regards to outreach? And all the rest of them raised their hand.

That—then I called Tom Corey, our national president, and we checked with Mr. Strickland and the attorneys, and we decided to go ahead and file suit the next morning. And that was the final decision. Because it was from them. It wasn't just our assessment. Our assessment already was from our people that we're going ahead. In the hallway outside the hearing room today, Ms. Miller came up and said to me, you know, I know about that. And I said, well, Laura, you were there. And she said, no I wasn't. I was out of the room. But afterwards, I approached each of the VISN directors individually, and they now all agree that they're doing the same or possibly even more outreach than they were a year ago when approached by their immediate supervisor. And I thought, wow. What a phenomenon that is. We can make all kinds of management efficiencies if we just approach it in the correct manner.

So I'm sorry to go on about that, Mr. Chairman, but I think it's important, because it cuts to the quick of the mission. The quick of the mission is not to save money. The quick of the mission is to take care of veterans, of men and women, American citizens, where they have been lessened by virtue of military service to

country. And it's a covenant, not a contract, between the individual who takes a step forward to defend the Constitution of the United States and the rest of the American people that where lessened spiritually, economically, physiologically or neuropsychiatrically, that the people of America will do what's necessary to make them whole.

That first one, spiritually, is not the business of government, but it is all of our business, and not just our churches and synagogues. But the other three are the province of government, and that is to help folks get a job, help get the training to get a job, and to take care of folks so they're physically well enough and so that they're neuropsychiatrically well enough to get past the terrible neuropsychiatric wounds of war.

And if people who've never been in combat think it doesn't change you, you're changed forever dramatically. Some deal with it and go through it better over a period of time, but some don't. But the point is, you've got to have focus on those wounds, and you've got to have the available service, and short of that, or accompanying that, you've got to have proper education and outreach through the medical societies, through the public media and PSAs, through outreach to places where veterans might be.

Mr. STRICKLAND. Thank you, sir, and thank you for your patience, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

I want to commend an excellent panel again this afternoon, for your testimony. I can't say that I disagree with anything that any of you said. I agree wholeheartedly with what you have said.

My biggest concern, actually, when I listened to the President's State of the Union Address, was when he had talked substantially about the war in Iraq, but did not talk about our veterans, and I was concerned that when he presented his budget, that there will not be adequate funding for our veterans, and I find that the budget that is presented to us is definitely inadequate when you talk about the veterans' health care issues, and that was pretty much stated, I think, by the Secretary this morning, where he did not even get his funding request that he had asked for, and I'm sure his funding request does not take care of the needs of the veterans.

I guess my question is, what I'm hearing a lot from our servicemen and the people who are in the Guard, particularly since the war in Iraq and Afghanistan had broken out and the rotation of our military, that there is a big strain on the Guard, as well.

Do you feel that everything that's happened with the rotation issue, but also, equally as important, the lack of funding and the constant battle that you have to go through here in Congress to get health care benefits that are earned by our veterans, that that is going to cause a problem as far as people enrolling in the military, as well as the Guard?

Mr. GAYTAN. Sir, you mentioned the constant battle that the VSOs wage every year for an adequate budget, or what's deemed an adequate budget. Specifically, that statement is why the majority of the VSOs are supporting mandatory funding for VA medical care.

If this were funded in the way Social Security and Medicare were, we wouldn't be waging these battles every year. Of course, it wouldn't be to the degree that we need to now.

You mentioned Guard rotation and the influx of returning veterans. I think Richard Fuller from PVA mentioned it earlier, that to enable VA to meet the requirements of these returning veterans in addition to the veterans who are already here and relying on VA for their care, there needs to be won under this process of appropriations an adequate budget at a level that will allow VA to provide the services that are needed.

In addition too, and specifically, is a budget that arrives on time, a budget that will allow the VA directors to hire the full-time employees and obtain the resources they need to meet the requirements of the veterans.

The backlog that the American Legion has experienced in the past year under our System Worth Saving and our I Am Not a Number campaigns, we went out and identified specifically those individual veterans—we didn't use numbers, we used faces, names, individuals who are waiting six, eight, 12 months to get the services they need—those backlogs are a result of inadequate funding.

Earlier today, we got into the discussion of eligibility reform. The American Legion long supported eligibility reform, and a lot of the backlog and the problems that VA is facing right now, some people are choosing to point fingers at 1998 and the eligibility reform as the major cause of that.

Well, eligibility reform as supported by the American Legion included revenue, new revenue streams which were Medicare reimbursement, DOD reimbursements, and premium-based coverage for veterans and their dependents.

The eligibility reform of 1996 that was finally implemented in 1998 would have allowed those revenue streams to reach VA.

That influx of revenue, of funding would have helped to leave the doors open to veterans who have earned their health care through the VA, and shutting the door to Priority Group 8 veterans right now under this form of appropriations is just the beginning.

That's why the American Legion fully supports mandatory funding for VA medical care.

Col. NORTON. Mr. Michaud, I thank you for your comment.

I would just offer the observation, looping back on the issue of outreach, that very often mobilized members of the National Guard and Reserve forces don't even know that once they complete their campaign tours in places like Bosnia, Afghanistan, and Iraq, that they are American veterans.

Now, there has been some progress made to identify and put out brochures and so forth, but the DOD and the VA have to do a lot more to educate these troops and to outreach to them, to market to them that they now are American veterans.

If you talk to a lot of Reservists and National Guardsmen, you will find out that when they come back, they just think they're back in the Guard and back in the Reserve, and they're not veterans, because they did not serve full 2, 3, or 4 or more years on active duty, but once they complete a campaign tour overseas, they are veterans, and the issue is getting that outreach to them to make sure that they know that they're eligible for VA health care,

they're eligible for applying for disability benefits, they're eligible for all the services that the VA provides.

In the spring, as you know, 40 percent of the forces on the ground in Iraq will be from the Guard and Reserve, and these rotations will continue on for the next few years.

We need to know for sure that both the Defense Department and the VA are planning for the kind of resources that will be needed to treat this large and growing population of returning veterans in all aspects of the care that they will need, including PTSD.

It's one thing to, you know, to take care of the severely disabled, because you can see them. I've seen them. I've met them at Walter Reed.

It's another thing for returning veterans from the Suni Triangle in Iraq to have silent, disabling disabilities, PTSD from the kind of 24/7 stress that they're under, unseen threats day and night as they go up and down the roads, as they fly, as they go about doing their missions.

I'd also like to point out, if I may, Mr. Chairman, many of these servicemembers today, unlike my generation, they're married, they have young children.

The issue that we have not addressed, and was not spoken to here today, is that for this growing problem of PTSD, many of them return home to families.

Those families themselves may need the kind of counseling that frankly is not available today in the VA system. This is a growing problem.

World War II, Korea, the Vietnam generation for the most part were single servicemembers, most of them drafted, but today, more than 60 percent of separating and retiring veterans are married and have families, and we must prepare for the kind of clinical support for PTSD and other mental services that these veterans are likely to see.

Frankly, the stories about suicide, that's a public issue out there right now, but below the surface of those who actually take their own lives, there are many, many more who are suffering disabling problems, and those disabling problems of PTSD will carry over into their family setting, and that's an issue, Mr. Chairman, I hope that you and the committee will look at, because frankly, we don't think that, in the Military Coalition, that this has been looked at properly.

The CHAIRMAN. Would my friend yield for a moment?

As you probably know, we have authorized that kind of inclusion of the family members, and whether or not the VA is actually implementing that is something we need to deal with by way of oversight.

Interestingly enough, I just completed a series of what I call one-to-one meetings throughout my district, and I heard from a wife whose husband is a Vietnam veteran, but suffers from very severe post-traumatic stress disorder, and she said that when he is at the VA—and this goes to what one of our witnesses said earlier—he is on his, quote, best behavior, and suggests that everything is fine, doesn't want in any way to show the stress that he truly is facing.

Then he comes home, and she said, you know, life is miserable, and her daughter is with her, as well, because he is suffering so

acutely, but she says, "The VA doesn't want to hear from us, doesn't include us in any way."

So I think your point about coming back to children and wife or husband is a very apt point, and we need to do, I think, some oversight to see what kind of inclusiveness the VA is doing to make sure those family members are heard, because they may see a whole different presentation of the affected person that they need to factor into their treatment protocol.

Yes, Mr. Weidman?

Mr. WEIDMAN. Just two things, Mr. Chairman.

I also have been up to Walter Reed quite a bit, both at Malone House and Ward 54, in addition to Ward 57, and there are quite a number of folks, where they're are just bursting at the seams.

They're trying to do groups with 25, 26 people, and that doesn't work. You can't do group therapy with that many people, hard-core combat vets, and that's who most of these folks are.

I think it will also come to light next week that there's a significant problem with PTSD with folks who haven't returned home, and large numbers.

VVA, we made a recommendation last year, we would strongly encourage you to do it this year, which is to include in the views and recommendations an additional $17.5 million to $18 million for the VA vet centers. They haven't had an increase in the VA vet centers in, I think it's over 12, 13 years.

That would be for 250 additional counselors and for each of the 208 vet centers, that each of the 208 vet centers have a certified family counselor who is also certified in treatment of post-traumatic stress disorder to be able to deal with the whole family unit, because if you don't deal with the whole family unit, it's not going to work, and the whole purpose of the vet centers, when they're at their best, is not just to treat the veteran, but to keep the family together and help the veteran get and/or keep the job he or she already has.

So the family counselor is, you have folks out there who have been trying to do that for years, but they're not really trained in it. This would be a perfect opportunity and a perfect timing to go ahead and add those additional staff, sir.

The CHAIRMAN. Yes, Mr. Schneider.

Mr. SCHNEIDER. One last thought, also, is that our people coming back from this war is a cost of the war.

So often we hear statements on the news on the television that the cost of the war is going to require another $50 billion.

We can't let the administration or the public forget that taking care of these veterans, these war veterans is a 50-year progression, and it gets only worse for the families and for the individuals.

A comment regarding the troops coming back to Walter Reed and Bethesda and other locations is, they come back so quickly.

Medical care is great. You know, medics, the triage, getting them to Germany, getting them on other planes, bringing them in here is tremendous.

One of the things that they come back without is any personal possessions, and it's amazing that Walter Reed and Bethesda have shared the lack of personal possessions, the need for sneakers, the need for sweatsuits so that they can wind down and do their own

thing, and so many organizations raising money to provide it to Walter Reed and to Bethesda for these types of items.

I'm absolutely amazed that a nation doesn't recognize that it's got an obligation, and take care of these people when they come back, so it's not fund-raising in New Mexico or someplace else trying to send a pocket of money to the hospital.

It's great what the people of America are doing, but I don't know that we necessarily always fulfill our obligations as Americans to those who go into harm's way when we as a Nation send them to go.

The CHAIRMAN. Mr. Schneider, you may find it of interest to know, we recently wrote a letter to Secretary Rumsfeld asking that VSOs have greater access—in some cases they have no access at all—to our military hospitals like Walter Reed, where some of those amenities as well as other good support services could be provided.

So we have not heard back from him yet, but we fired that off several weeks ago.

Mr. WEIDMAN. We couldn't get official permission at VVA, either, Mr. Chairman, but like my fellow New York City kid, Colonel Norton, both 196th Division, we just said, "Okay. Well, listen, we're going up to visit so-and-so on Ward 57," and once you're in, you're in, just do what needs to be done in every way to try and support these young people, including materially, as Mr. Schneider pointed out, but it would be a heck of a lot easier if we got some cooperation from Secretary Rumsfeld, and once a signal comes down, it will happen.

The CHAIRMAN. Yes.

Mr. GAYTAN. Mr. Chairman, I would just like to add, with this discussion about the importance of mental health care within the VA, I think it's key to note that within the CARES draft national plan, all seven, each of the seven facilities that are targeted for closure, they each provide extensive mental health care in dementia, Alzheimer's, and those facilities and those services are going to be on the chopping block when this CARES recommendation is finalized.

The American Legion is very concerned about that. We are putting that in our testimony when we go around to each CARES Commission hearing, and we're letting them know of our concern over that.

The CHAIRMAN. I appreciate that, and you earlier point about holding harmless current services, I think, is very well taken.

This committee will do a very vigorous oversight when and if that list, if the Secretary accepts it, and I think February 12 is the day that he will get it.

What he does with it after that remains to be seen, but if that goes forward, we will do our due diligence to make sure that current services and those who are receiving services are held harmless.

As mentioned by one of our witnesses earlier, I think it was this panel, the "e" in enhanced needs to be emphasized as well, because, you know, realignment is one thing. We've seen this with previous BRACs.

Not only did we see MILCON grind to a halt at a number of military bases, including one in my own district at Lakehurst, because it was always, "Well, we might have a BRAC, we may end up losing this facility, so we went years without very important additions to that facility, which made it more vulnerable to a BRAC, as well, so it was two sides of the same sword. When we finally did it, it cost more money.

BRAC certainly has done, maybe some good, but it also leaves some things to be desired in terms of unanticipated costs to close those or radically realign many of those facilities.

And here, we're talking about a clientele that has to have absolutely uninterrupted service.

You don't say, "Well, go find it somewhere else." With BRAC, you could move the servicemembers to some other facility and hopefully there's no brain drain with people who refuse to go on the civilian side.

I know I'm on your borrowed time, Mr. Michaud, so I will yield back my time to you. I'm sorry about that.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

I always appreciate listening to you, because you definitely do feel strongly about veterans and veterans' issues.

I've learned a lot this past year that I've been a Member of Congress from your leadership, and I really appreciate it, and really appreciate the panel.

Mr. Weidman had mentioned earlier that hopefully we'll win this battle of the budget again this year.

I hope that we'll win the war and get mandatory funding, because one of the things that I've seen going on just this short time I've been a Member of Congress, Mr. Chairman, is the statistics that are being thrown around, you can make statistics say whatever you want to say, and usually it's to try to justify the budget that's before us, have the statistics justify the budget, and that's wrong. It's dead wrong.

When I look at adequately funding issues dealing with veterans, I look at what's happening out there in the real world, what is actually happening to our veterans. Are they homeless? Do they have to have a large waiting list?

Are they getting the services that they need? The answer is no, and that's how I look at budget issues, not on statistics, because you can manipulate those statistics anyway you want, to make it look like you're doing a good job, when in fact you are not doing a good job.

When you talk about the outreach program, one of the things as a Member of Congress that I'm doing in the State of Maine is, we are having an outreach program to outreach to our veterans' community to let them know what services and benefits they have, that they rightfully have earned.

I thought Maine was the only state that was not taking lists. Evidently, hearing the conversation today, there are other facilities around the country that are no longer even accepting Priority 8s, which is wrong, because that's not giving us an accurate figure of the need that is out there.

If we're going to provide the funding for the need, we have to know what that need is, and we're not getting that, because they're no longer allowed to even sign up, and that's wrong.

So I do want to thank the VSOs here for continuing to fight for issues.

I really want to thank Chairman Smith for your long and hard fighting efforts over the number of years that you've been in Congress fighting for veterans' issues. I hope that you continue that fight with us and the VSOs, and hopefully, we will ultimately win that battle—the war, rather—and get mandatory funding.

So thank you very much for all that you've done for us.

The CHAIRMAN. Thank you, Mr. Michaud, and thank you for your fine work as well, as the ranking member on our subcommittee, and I look forward to working with you and going forward in a bipartisan way.

Mr. Rodriguez, another ranking member.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I also want to thank you, because I know you've battled alongside in terms of making things happen for our veterans, and I also want to thank all the organizations.

Without your efforts, I know we would be lacking tremendously, even more so than what we're lacking now, so I want to personally thank each and every one of you and the organizations and everyone that you represent for being there for our veterans.

I just wanted to talk a little bit, and I was real pleased that the Vietnam Veterans of America came forward on that.

I know that no one likes to go to the courts, but I think that it was apparent that something needed to happen, and it's unfortunate, because I do have some concerns that if we have an atmosphere of not reaching out, an atmosphere of not educating our veterans about what exists out there, and then we have a CARES process going along where there are some recommendations of even some closures because of the fact that we don't have sufficient veterans there or attending, when we know full well that there are a lot in need, that that's not right, that's not appropriate, that we ought to do whatever we can.

I wanted to throw out, and maybe some of you might have more information than what we've been given, and that is that I was told that, because I was concerned after we did the SHAD piece of legislation, and we identified some five or seven thousand veterans that might have been exposed to the chemical and biological tests that we did on them, and I was informed that they were not part, that they were still going to solicit that, and I don't know if some of you have any information.

I've been told that they were still going to reach out to them. I don't know how that's going to happen or how that's going to occur, but if you could provide some feedback in that area.

Secondly, and Mr. Chairman, I would appeal to you, too, and maybe to the organizations out here, from a homeland defense perspective, as much as we're critical about the VA not being there for us, yet it's still the only system nationwide from a health care perspective that's there to respond in case of a serious emergency, serious problems that might occur, and we've done legislation already, language to identify some four sites throughout the country

as a first response team in case there's a major attack anywhere in the country or a major epidemic or whatever, or even from a natural disaster, you know, where the VA could play a role, because it's the only system we have nationwide, and we have passed the language, but we have not passed any monies for it.

So I wanted to get your feedback, because we really need to look at it also in terms of a homeland defense perspective, but also in terms of where we're at right now, and I wanted to throw that out to some of the members.

Mr. WEIDMAN. Let me take your second one first, if I could.

The VVA believes very strongly in that fourth mission, and appreciate very much, Mr. Chairman, your leadership on that for trying to move forward with the Centers of Excellence, and that VA has a very key role to play about the wounds of war, including toxins, if in fact we will only marshal it.

I think it was 10 days after 9/11 the Congress passed $24 billion for homeland security, and it was divvied up among the agencies.

VA ostensibly was going to get $77 million for that in order to deal with the fourth mission of VA, ultimately, according to Dr. Roswell, only got $2 million out of $24 billion.

Now, we have no idea how many millions went into bike paths that somehow is going to make us more secure against al Queda, but something is wrong with that picture, because VA, we get upset with VA not because VA is bad, because VA is good.

There was a time when VA wasn't all that good, and it has now changed dramatically. The problem is that there aren't the resources there to have enough people to hit critical mass to serve everyone well, and to serve folks safely, safely medically, because in many cases, we think it's medically dangerous.

In regard to SHAD, there's a good deal that's happening on that, Mr. Rodriguez. I'll be glad to brief you off-line, if you will, but suffice it to say that VVA is probably doing more outreach at this point than VA is.

They said they've sent a letter to everyone, but Commander Jack Alderson, who was commander of two of the major tests, including Big Tom and Command of the Tugs, still has yet to receive a letter, and we've given them his address.

I mean, that's just one example, and I don't mean to fault it. I think they've tried, but they've tried on their own terms, and have turned down all help from us as to how to better reach the people who were involved.

So it is problematic, where they're not doing outreach but they say they're doing outreach, so it's hard to figure out exactly what is going on there from the outside.

Mr. RODRIGUEZ. I was wondering, American Legion?

Mr. GAYTAN. Yes. Regarding the fourth mission of VA, the American Legion supports funding that is adequate for VA to meet their goal of the fourth mission.

I think it's easy for us to forget that mission of VA and their obligations to provide backup to DOD in case of emergency, especially when we're up here fighting for the essentials that VA operates under every day.

Because 9/11 was a while ago now, I think the importance of the fourth mission needs to be raised again.

The American Legion has a resolution, and we've put that in our full testimony, of the importance of the fourth mission, and we as the voice of veterans and veterans' organizations, we need to remind Congress and VA and the administration of the obligation to fulfill the funding needed for VA to meet any obligations placed in front of them, especially the fourth mission.

Mr. RODRIGUEZ. Have you heard any data on the SHAD effort?

Mr. Gaytan. Yes. Actually, we have a lot of information.

If you wanted specifics on SHAD, I could get our staff, we have a staff that handles exposures, and SHAD being one of them, they have a lot of information that we can share with you and let you know of our concerns over that.

Mr. RODRIGUEZ. Maybe, Mr. Chairman, I guess the Subcommittee on Health might be able to get a hearing just to get an update on SHAD.

The CHAIRMAN. Sure.

Mr. GAYTAN. We would welcome that.

The CHAIRMAN. I want to thank the gentleman for his work on Project SHAD and the ongoing efforts to identify and properly treat those who were mal-affected by it, so I appreciate your good work on that.

As you know, the legislation was included in our bill that went to the President and was signed into law.

Are there any other questions for our panel?

[No response.]

The CHAIRMAN. Then I want to thank our very distinguished panel for your insights. You've given us a boatload of ideas to work on.

This will not be the last time we ask for your counsel, and I'm sure we'll receive it, and thank you so much for testifying and for your patience for being here during this rather lengthy hearing.

I'd like to just point out for the record that Congresswoman Brown-Waite would have been here today, but she is recovering from recent surgery, will be with us again next week.

Without objection, regarding a statement by Congressman Baker, who is chairing his own subcommittee hearing on capital markets and insurance, I would ask that it be made a part of the record.

[The statement of Hon. Richard H. Baker appears on p. 102.]

The CHAIRMAN. And as was asked earlier, any member who would like to submit any comments for the record, may have 5 legislative days within which to do so.

[The statements of Hon. Bob Filner, Hon. Henry E. Brown, Jr., Hon. Corrine Brown, and Hon. Luis V. Gutierrez appear on pp. 104, 107, 108, and 110.]

The CHAIRMAN. Without further ado, the hearing is adjourned.

[Whereupon, at 2:30 p.m., the committee was adjourned.]

APPENDIX

STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS
HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 2005 BUDGET
FEBRUARY 4, 2004

Mr. Chairman, this year's Bush Administration budget proposal for the Department of Veterans Affairs (VA) is a result of seriously misplaced priorities. I hope you will agree with me that a significant portion of the re-hashed recommendations proposed should be quickly and soundly rejected.

I don't think anyone on this Committee will celebrate an increase in the veterans' medical care budget of less than 2 percent. Plus, we've seen before—and rejected on a bipartisan basis—the Administration's proposals that would increase pharmacy and primary care copayments and establish user fees for veterans.

The Bush Administration requested about a $500 million increase for veterans' medical care, for a total of $27.4 billion, which does not include money collected from veterans and their insurers. In sharp contrast, without the projected savings from legislative initiatives or management efficiencies, VA would require more than $2 billion in additional appropriations. The President said this was a 'tough' budget and he wasn't wrong about that in terms of its impact on America's veterans.

The VA health care system has costs that are not within its control—federal pay raises are mandated, for example, and the system must negotiate within the high-cost health care industry for everything from prices of its pharmaceutical drugs to contracts for physicians with highly specialized skills. Also, the Administration's budget calls for $340 million of vaguely defined management "efficiencies" in addition to the almost $1 billion of "efficiencies" it already has imposed on the system.

Other provisions in this year's budget submission that I call into question include:

- Cuts in VA's nursing home program that will bring its average daily census below the capacity mandated by federal law;
- Cuts in VA's research program that will take staff and resources away from already thin support services;
- Overly optimistic medical care cost recovery collection targets which are meant to substitute for appropriated resources; and,

- Insufficient resources in the VA construction program to make a significant start in the Department's major infrastructure restructuring process.

In my view, this disappointing budget proposal is another profound example of the need to take VA spending out of the political arena. As you know, Mr. Chairman, I introduced legislation, the "Assured Funding for Veterans Health Care Act of 2003," which has nearly 150 cosponsors in the House. Two bills with similar provisions have been introduced in the Senate. The bill would establish a formula based on the number of veterans enrolled for VA health care and the hospital inflation rate projected for each year and provide necessary funding directly from the U.S. Treasury to VA.

I want to salute four major veterans' service organizations—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States—for producing their 18th annual budget recommendation. The VSOs are requesting about $31.1 billion for all VA medical programs and construction. These organizations and five other major veterans' service organizations, including The American Legion and the Vietnam Veterans of America, have made passage of assured funding their top legislative priority this year. I want to commend all of you for your continued strong work in seeking adequate funding for veterans' programs.

In short, I believe this President must revisit his priorities. This budget is already certain to come under broad-based scrutiny because it lacks funding for the continued missions in Iraq and Afghanistan. We're in a time of war—veterans and defense should be high priorities, even if the wealthiest Americans have to wait a little longer for their tax relief.

Mr. Chairman, thank you for your timely convening of this critical hearing. I look forward to working closely with you in the days and weeks ahead.

Honorable Rob Simmons
Chairman, Subcommittee on Health
Committee on Veterans Affairs
February 4, 2004

Thank you Mr. Chairman.

Today, I would like to thank the Secretary, a fellow Vietnam veteran, for testifying before this Committee. I was in the Army and Secretary Principi served as a Navy officer on river patrol, but I do not hold that against him in any way. I also served with him 20 years ago as a staffer in the Senate, and I hope no one in the House will hold that against us. He is a good man, and has been a great advocate for veterans – sometimes a lonely job in this town.

There is an old adage, "the President proposes and Congress disposes." It is a good thing, that's how our system of government works. No one has all the answers, we work together for the benefit of the greater good. This is a tight budget but this budget has good things in it, and good policy, and I want to point out just a few so that this Committee can gain a balanced view of the request. I think a balanced view is the order of the day and serves all of our interests.

- I applaud the Secretary's proposals to relieve the former prisoners of war, and the dying in VA's palliative and hospice programs, from needing to pay further co-payments. It is a just and humane policy for exPOWs and those veterans at the end of their lives, and I am sure the Committee supports this good idea.

- This budget proposes another good increase in homeless assistance programs. Chairman Smith and Mr. Evans – this whole Committee -- authored a great bill in our first year under Chairman Smith's leadership, now Public Law 107-95, a comprehensive act to get homeless veterans back on their feet and back in society. Secretary Principi, in a very tight budget year, with endless competing priorities, is trying to keep faith with that mandate to give a hand up to homeless veterans. That is a very good thing.

- The waiting lists for access to VA care, and the time that veterans must wait between appointments, are coming down. My subcommittee held a very interesting hearing last September 30 on access to care. The Gentle Lady from Florida, Mrs. Brown-Waite, a highly effective member of the

Subcommittee, had introduced a bill to get VA more focused on improving access. It's a bill with some teeth, and VA was feeling the bite! We had a spirited hearing – one I am sure Dr. Roswell remembers so well. And VA does seem to be improving in it access programs, so I applaud that progress, because it is real and it means something to sick veterans.

- I am impressed with the Secretary's commitment to fully fund the CARES process. Let me report to you locally: The West Haven VA, built right after the Great War, the War to End All Wars, is one of those facilities in dire need of renovation and rehabilitation. Roger Johnson, the Connecticut VA director, assures me he is moving fast to get his project ready to go. I am sure the West Haven project is going to float right up there near the top of VA's priorities. I commend the Secretary for committing $401 million in this budget to CARES and for his willingness to spend up to $400 million in this fiscal year, 2004, to move some "old gray VA" facilities into the modern era. That means something to veterans and to the people who work at that medical center, and I thank the Secretary for that commitment. I also want to note that Secretary Principi made a determination to better utilize the under-used VA Medical Center in Newington as a site for the relocation of the Hartford VA Regional Office. It's a better use of federal property, and it means something to veterans to be able to deal with all these VA needs at one site, in Newington. Tony Principi listened carefully to my views on that situation, and he acted promptly, and he did the right thing.

So I see many good things here in this budget, but also I see challenges ahead. In 10 out of the last 11 years, I believe I am right that Congress added considerably to VA's budget, especially in the health care area. I expect us to do the same in this budget. We have done well by veterans and we will continue to do well by veterans.

So let's build on the good, solid record we have with this Secretary. Let's work in a bipartisan fashion as a Committee and a Congress to get the job done for veterans. I am a veteran, I am proud of my service; and Tony, you are a veteran and we're proud of your service. We can do this together for veterans, and we should do so.

Thank you, Mr. Chairman.

STATEMENT OF HON. MICHAEL H. MICHAUD
House Veterans Affairs Committee Hearing on the Department of Veterans' Affairs Budget Request for FY 2005
February 04, 2004

Thank you, Mr. Chairman.

I am very disappointed that as we ask our military personnel to risk their lives around the world, the Administration has presented us with a budget request that fails to adequately provide the benefits and services earned by the men and women who have served in uniform.

I am concerned that VA expects a smaller number of trainees to replace experienced Veterans Benefits Employees without loss of timeliness and quality.

I have worked in a paper mill.

I have worked in the Maine State Senate.

Now I am in Congress, and I have yet to see a work environment where a smaller number of trainees can produce higher quality work—and more quickly—than experienced workers.

I do not question the dedication of these employees, but I do not share the VA's view that the reduction in full time employees will improve services to veterans and their families.

During the past several years, decisions for the United Sates Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit have had a substantial impact on the processing of claims at regional offices and appeals at the Board of Veterans Appeals.

There is no reason to believe that the implementation of future court decisions will not require additional resources.

While I appreciate the efforts that have been made to improve the timeliness of decisions, I remain concerned that veterans applying for benefits do not always receive the high quality medical examinations needed to properly evaluate their claims.

Veterans in my district have experienced years of delays on their claims because examinations by appropriate specialists were not provided.

I am worried that the proposed reduction in VBA staff for fiscal year 2005 will increase the time veterans will wait for decisions and, more importantly, decrease the quality and accuracy of those decisions.

I recognize the difficult challenges facing the National Cemetery Administration, and I appreciate the entire NCA team for its efforts to meet ever-increasing demands for services with

limited resources.

We must honor our pledge to provide adequate and dignified burial settings for the Nation's brave heroes.

I would also like to note with some confusion that this budget seeks to cut 50,000 veterans annually out of the VA home-loan program at a cost to the VA of $91 million over ten years.

As our national debt grows and we face more budget shortfalls, I cannot support a proposition that would reduce funding for VA's home loan program and deprive veterans of a benefit they have earned as the result of their military service.

I am concerned that the purported increase for VA health care is grossly inadequate to meet the needs of those veterans who are currently being served, those veterans who are returning from combat around the world, and those veterans who are barred from VA health care because of their so-called "high incomes."

The cost of health care continues to rise.

When funding to pay for that care does not match the increases in costs, fewer veterans can be served.

We have to recognize, and I believe this budget does not, that caring for our veterans is a continuing cost of our national defense.

I thank the witnesses who are appearing before us and I look forward to your testimony.

Opening Statement
FY 05 HVAC Budget Hearing
Rep. Tom Udall

Thank you, Mr. Chairman.

I look forward to hearing the testimony today from Secretary Principi, the Under Secretaries, and the veterans organizations.

It is a good day when the Secretary is in this room because we know we will get answers to all of our questions. The buck stops with you, Mr. Secretary, and we're pleased to have you here today.

In talking with the veterans in my district in the past few days, I've found that many of their concerns with the Fiscal Year 2005 budget, are the same concerns we heard about the 2004 budget, and the 2003 budget.

Veterans health care funding remains the number one priority. Waiting months and months for their next

appointment, veterans do not want to be slapped with new co-payments and enrollment fees that break the promise of free healthcare to all our nation's veterans.

The veterans in my district in New Mexico want full concurrent receipt. Legislative Chairman of the Disabled American Veterans in New Mexico told a story about John Smokov (SMOKE-OV) of Chapter 33 in Bernalillo County, who is 85 years old. During their last DAV Department of New Mexico State Executive Meeting, some Chapter members asked why their chapter was fighting for Concurrent Receipt when some leaders in Congress presented their own version of it last year. Mark explained that this version will be gradually implemented in during the next 10 years. This will only be for 50% - 100% disabled veterans. He then turned to Mr. Smokov and asked his age. John has been fighting for Concurrent Receipt for 25 years, and Mr. Smokov will be 95 years old when he finally gets full Concurrent Receipt.

Veterans in my district are also concerned about funding and policies for the establishment of national cemeteries in the country and eventually in New Mexico. I look forward to hearing from the Secretary about his plan to ensure that veterans around the nation are laid to rest with the respect they deserve.

Thank you, Mr. Secretary, and thanks to the staff that are here today with him. I look forward to your testimony and to working with you on these crucial issues during the next session of the 108th Congress.

RICHARD HUGH BAKER
6TH DISTRICT, LOUISIANA

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COMMITTEE ON
VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

February 4, 2004

Chairman Christopher Smith
Committee On Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Smith:

As Subcommittee Chairman of Capital Markets, Insurance and Government Sponsored Enterprises, I regret that I will be unable to join my colleagues today due to a scheduled 10:00 am hearing that I must chair this morning. However, I would like to share a few thoughts.

Mr. Chairman, America's veterans have rightfully earned their benefits, fighting on the battlefields and serving their nation. As the guardians of our freedoms, these men and women are owed our respect and our support. Without a doubt, America has a special debt to her veterans, and we have sacred responsibility to fulfill the promises made to them.

Mr. Chairman, this past Monday, President Bush and his Administration submitted a Fiscal Year 2005 budgetary request. Specifically, the White House requested $64.9 billion in new appropriations for the Department of Veterans Affairs. This represents 2.8 percent of the total federal budget of $2.3 trillion. Of this $64.9 billion, $35.2 billion is for entitlement programs such as disability compensation and the Montgomery GI Bill payments. The other $29.7 billion is primarily for health care, medical research and administration of the benefits and cemetery system. All in all Mr. Chairman, the President's proposal represents a $5 billion increase or 8.3 percent boost, over the Fiscal Year 2004 Appropriations.

Mr. Chairman, while I realize there are many questions regarding the specifics of this budgetary proposal, particularly envolving the role of private insurance reimbursements as well as co-payments and or user fees charged to veterans, I am confident that the Members of this Committee will work closely together in crafting a final budgetary proposal that meets the needs of America's veterans.

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In closing Mr. Chairman, millions have died in service to our great country. Many have been wounded and sustained serious injuries in combat. Many entered harm's way to fight for and defend America's cherished freedoms. As a Member of this Committee, I am committed to fulfilling the promises made to each and every one of them. Mr. Chairman, I look forward to working with my colleagues on this endeavor.

Sincerely,

Richard H. Baker
Member of Congress

RHB\pje

STATEMENT OF CONGRESSMAN BOB FILNER

before the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

February 4, 2004

Mr. Chairman and colleagues, I was truly saddened when I saw the figures in the Administration's Budget Request for the Department of Veterans Affairs (VA) for the coming fiscal year.

Last year, in an effort that was actually just completed two weeks ago, the Members of this Committee, both Republicans and Democrats, and many other Members of Congress worked with the support of our nation's veterans service organizations to finally arrive at a budget, while not completely adequate, at least addressed many of the needs of our veterans.

So I am very disheartened to find ourselves in the same place as we were a year ago. We are faced with tired, old proposals to raise the co-pays on prescription drugs at the VA (a proposal that Congress has soundly defeated). We are faced with a proposal for a $250 annual fee for many veterans (which Congress has also defeated). We are faced with the VA policy of continuing to suspend enrollment for new so-called Priority 8 veterans. And this budget request from the Administration cuts the VA nursing home

program and cuts the funding for VA research.

Imagine how our veterans feel!

Actually, we know how they feel. The Paralyzed Veterans of America has issued a press release entitled "Another Year, Another Inadequate Budget Request for Veterans' Health Care". They go on to point out that this request includes the lowest appropriation request for VA health care made by any Administration for nearly a decade. Although the VA Undersecretary for Health has testified that an average yearly medical care increase of 12 to 14% is needed to meet the cost of inflation and mandated salary increases, there is less than 2% more than the fy2004 appropriation recommended in this budget request. Likewise, the leader of the Veterans of Foreign Wars and other veterans organizations have expressed dismay at the proposed VA medical care funding.

In fact, I feel like I should just pull out the old tapes and old speeches from last year and rerun them! Except it isn't last year. Since the last Budget Request from this Administration, the nation has sent our young men and women to a war in Iraq, and they will be coming home as veterans. Caring for our veterans is one of the costs of war, and the Budget Request does not take note of this fact!

I have enormous respect for Secretary Principi who, I believe, does a lot with inadequate budgets. But <u>even</u> this Secretary, or should I say – e<u>specially</u> this Secretary – needs a Congress that will pass a budget that is worthy of our veterans.

So I am signing up again! Whatever is needed, we will do to fill the budget holes for the coming fiscal year. Most of all, let us take note that this Budget Request points out the need for mandatory funding for VA health care – so we will not have to rerun the same tapes next year and the year after that.

Henry E. Brown, Jr.
Chairman
Subcommittee on Benefits

House Veterans Affairs Committee
Hearing on the VA's FY2005 Budget Request
334 Cannon HOB, February 4, 2004, 9:30 am

Opening Statement:

Mr. Chairman, we are definitely facing some serious budget challenges in the coming fiscal year. First, I want to thank Secretary Principi and all of the dedicated public servants within the VA system for all that they do for our deserving veterans. Too often we look to criticize them without taking into account all of their good deeds. Although I am certain that every member of this Committee has concerns with this budget proposal, I want to commend the President and the Administration for providing us with a budget blueprint that we can work with under our current fiscal constraints.

Let me spend a moment focusing on the Benefits side of the VA Budget proposal. It is very promising that the backlog of pending claims dropped to just over 250,000 by the end of 2003, a reduction in over 40%, with the 100-day average processing time in sight. However, this budget proposes staff losses of about 540 across the Veterans Benefits Administration. This is on top of similar losses of more than 300 employees in Fiscal Year 2004. I am concerned that we may lose the momentum in this area if we do not continue to commit the resources to claims processing. We must remember that justice delayed is too often justice denied—and the same can be said for the rightful benefits of our deserving veterans.

I look forward to working with Chairman Smith, and the Administration, as we make every effort to meet the budget needs of our veterans. With the Global War on Terrorism at home and abroad and operations continuing in Iraq and Afghanistan, we cannot forget to take care of this new generation of veterans, while remaining ever mindful of those who came before.

Congresswoman Corrine Brown, FL-03
Committee on Veterans Affairs
Full Committee Hearing on the FY05 Budget
February 4, 2004

Good Morning.

Our veterans continually get the shaft. The President's fiscal year 2005 budget is another example of how our nation's veterans are a low priority for the Bush administration. I question the commitment that this President has to America's veterans. He did not mention our veterans in his State of the Union and now he sends a less than adequate budget to Congress. This nation's veterans deserve better than a less than two percent increase in veterans health care.

The President's budget is $257 million below the amount that the Congressional Budget Office estimates is needed to maintain purchasing power at the 2004 level. How can the President's budget not even provide the most minimal amount to fund VA at the level it is funded at now? If we can afford massive tax cuts and Missions to Mars, then we should be able to afford to give VA the money it means to at least maintain its current buying power.

The Independent Budget, produced by four major veterans' service organizations, calls for a $31.1 billion budget for VA medical care and construction. The President's budget falls over $2 billion short of what the Independent Budget suggests is needed in order to provide veterans with the quality health care that they deserve. The amount appropriated to VA this year was unacceptable, and this President's fiscal year 2005 budget is unacceptable.

The President's budget requests legislative authority to implement a $250 annual use fee for Priority 7 and 8 veterans, and an increase

in pharmacy copayments for Priority 7 and 8 veterans from $7 to $15. Our veterans have already paid for their health care by their selfless service to our nation. Many veterans cannot afford these extra costs. And we cannot risk that veterans will decide to avoid treatment for illnesses because they cannot afford the enrollment fee and copayments. Further, we show potential and current members of the armed forces how America honors their sacrifice by how well we treat our veterans. And right now, we are not treating our veterans well.

This budget assumes a five-year savings of $1.5 billion from this enrollment fee. The budget also assumes five-year savings of $747 million from increasing pharmacy copayments. Both of these were proposed in last year's budget and rejected by Congress. The so-called savings from the collection of these user fees and the increase in pharmacy copayments is unrealistic.

I am very concerned with the portion of the President's proposal that would reduce the number of VA employees who process claims for compensation and pension, education and home loan benefits. In 2005, VA can expect to lose 540 full-time employees. This will be the second year in a row that there has been a significant staff reduction at VA. How are we to get veterans the quality service deserve, and still lack, with fewer employees?

This shabby treatment of America's veterans has to end. We owe it to the soldiers, airmen, sailors and marines, who have served as a source of pride in our nation, to take care of them as they have taken care of our nation.

OPENING STATEMENT OF
LUIS V. GUTIERREZ
HOUSE COMMITTEE ON VETERANS' AFFAIRS
"Hearing on the President's Proposed FY 2005 Budget for the Department of Veterans Affairs"
WEDNESDAY, FEBRUARY 4, 2004 – 9:30A.M.

Mr. Chairman, I would first like to thank you for holding this hearing to examine the Veterans Affairs Budget Request for Fiscal Year 2005. I look forward to the testimony of our invited panelists and their answers to Member's questions.

Although the VA Budget proposal is still fresh off the presses, it's apparent that the Administration feels that taking care of our nation's veterans is not a price of national defense. I certainly disagree with the Administration. The President's budget does not adequately and fully provide for our veterans, and that is inexcusable and reprehensible.

I am particularly concerned with the Administration's decision to cut the VA Medical and Prosthetics Research Program. A decrease in the program would put research in priority areas, such as diabetes, substance abuse, mental health, Parkinson's disease, prostate cancer, spinal cord injury and heart disease, in jeopardy. Adequate and increased funding for the VA Medical and Prosthetics Research Program is vital to treating and finding the cures for the diseases that continue to devastate America's veterans. In fact it is vital in finding needed cures for the diseases that plague all Americans.

Unfortunately, this is not the first time the Administration has presented this committee with a budget that short changes our Veterans. This year we are again presented with increased co-payments and enrollment fees for Veterans.

The annual occurrences of under-funding, increased fees and disappointments are all the more reason to move forward with Ranking Member Evans' mandatory funding bill. It is encouraging that the number of major veterans' service organizations, many of them here today, are making mandatory funding one of their highest priorities. I hope that we can answer the call of these veterans much like they so honorably heeded the call to service when our country needed them most.

Mr. Chairman, I thank you for this hearing and hope that we move quickly towards fully acknowledging the blood sweat and tears our veterans have given this country. I thank the panelists for joining us today and I look forward to your testimony.

STATEMENT OF THE HONORABLE ANTHONY J. PRINCIPI

SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

February 4, 2004

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2005 budget proposal for the Department of Veterans Affairs (VA). The focal point of this budget is our firm commitment to continue to bring balance back to our health care system by focusing on veterans in the highest statutory priority groups.

The President's 2005 budget request totals $67.7 billion (an increase of $5.6 billion in budget authority)—$35.6 billion for entitlement programs and $32.1 billion for discretionary programs. Our request for discretionary funds represents an increase of $1.2 billion, or 3.8 percent, over the enacted level for 2004, and supports my three highest priorities:

- provide timely, high-quality health care to our core constituency—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;
- improve the timeliness and accuracy of claims processing;
- ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines.

The growth in discretionary resources will support a broad array of benefits and services that VA provides to our Nation's veterans. Including medical care collections, funding for the medical care program rises by $1.17 billion over the 2004 enacted level. As a principal component of our medical care budget, we are requesting $524 million to begin implementing recommendations stemming from studies associated with the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our budget request using a slightly modified new budget account structure that we proposed for the first time last year. This new structure more clearly presents the full funding for each of the benefits and services we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program. I am committed to providing Congress with the information and tools it needs to be comfortable with enacting the change.

Medical Care

The President's 2005 request includes total budgetary resources of $29.5 billion (including $2.4 billion in collections) for the medical care program, an increase of 4.1 percent over the enacted level for 2004, and more than 40 percent above the 2001 level. With these resources, VA will be able to provide timely, high-quality health care to nearly 5.2 million unique patients, a total 21 percent higher than the number of patients we treated in 2001.

I have taken several steps during the last year to refocus VA's health care system on our highest priority veterans, particularly service-connected disabled veterans who are the very reason this Department exists. For example, we recently issued a directive that ensures veterans seeking care for service-connected medical problems will receive priority access to our health care system. This new directive provides that all veterans requiring care for a service-connected disability, regardless of the extent of the injury or illness, must be scheduled for a primary care evaluation within 30 days of their request for care. If a VA facility is unable to schedule an appointment within 30 days, it must

arrange for care at another VA facility, at a contract facility, or through a sharing agreement.

By highlighting our emphasis on our core constituency (Priority Levels 1-6), we will increase our focus on the Congressionally-identified highest priority veterans. The number of patients within our core service population that we project will come to VA for health care in 2005 will be nearly 3.7 million, or 12 percent higher than in 2003. During 2005, 71 percent of those using VA's health care system will be veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs. The comparable share in 2003 was 66 percent. In addition, we devote 88 percent of our health care funding to meet the needs of these veterans.

While part of our strategy for ensuring timely, high-quality care for our highest priority veterans involves a request for additional resources, an equally important component of this approach includes a series of proposed regulatory and legislative changes that would require lower priority veterans to assume a small share of the cost of their health care. These legislative proposals are consistent with recent Medicare reform that addresses the difference in the ability to pay for health care. We are submitting these proposals for Congress' reconsideration because we strongly believe they represent the best opportunity for VA to secure the necessary budgetary resources to serve our core population. Among the most significant legislative changes presented in this budget are to:

- assess an annual use fee of $250 for Priority 7 and 8 veterans; and
- increase co-payments for pharmacy benefits for Priority 7 and 8 veterans from $7 to $15.

We will work with Congress to enact our legislative proposal to eliminate the pharmacy co-payment for Priority 2-5 veterans, who have fewer means by which to pay for these costs, by raising the income threshold from the pension level of $9,894 to the aid and attendance level of $16,509 (for a single veteran). This would allow about 394,000 veterans within our core constituency to receive outpatient medications without having to make a co-payment.

The 2005 budget includes several other legislative and regulatory proposals that are designed to expand health care benefits for the Nation's veterans. Among the most significant of these is a provision that would give the Department the authority to pay for insured veteran patients' out-of-pocket expenses for urgent care services if emergency/urgent care is obtained outside of the VA health care system. This proposal would ensure that veterans with life-threatening illnesses can seek and receive care at the closest possible medical facility. In addition, we are proposing to eliminate the co-payment requirement for all hospice care provided in a VA setting and all co-payments assessed to former prisoners of war. Currently, veterans are charged a co-payment if hospice care cannot be provided in a VA nursing home bed either because of clinical complexity or lack of availability of nursing home beds.

The President's 2005 budget for VA's medical care program also continues our effort to expand access to long-term care for veterans. This budget includes a legislative proposal to focus long-term care on non-institutional settings by expanding the 1998 average daily census nursing home capacity requirement to include the following categories of extended care services—nursing homes, community residential care programs, residential rehabilitation treatment programs, home care programs, non-institutional extended care services under VA's jurisdiction, and long-term care beds for which the Department pays a per diem to states for services in state homes. As part of this effort, we aim to significantly enhance access to non-institutional care programs that allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

We are continuing our work with the Department of Health and Human Services to implement the plan by which Priority 8 veterans aged 65 and older, who

cannot enroll in VA's health care system, can gain access to the new "VA Advantage" program. This would allow these veterans to use their Medicare benefits to obtain care from VA. In return, we would receive payments from a private health plan contracting with Medicare to cover the cost of the health care we provide.

In return for the resources we are requesting for the medical care program in 2005, we will continue to aggressively pursue my priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. During the last 3 years, we have significantly enhanced veterans' access to health care. We have opened 194 new community clinics, bringing the total to 676. Nearly 9 out of every 10 veterans now live within 30 minutes of a VA medical facility. This expanded level of access has resulted in an increase in the number of outpatient visits from 44 million in 2001 to 51 million in 2003, as well as a 26 percent rate of growth in the annual number of prescriptions filled to a total of 108 million last year. To further highlight the Department's emphasis on the delivery of timely, accessible health care, our standard of care for primary care is that 93 percent of appointments will be scheduled within 30 days of the desired date and 99 percent of all appointments will be scheduled within 90 days. For appointments with specialists, the comparable performance goal is 90 percent within 30 days of the desired date.

As I mentioned earlier Mr. Chairman, a key component of our overall access goals is the assurance that veterans seeking care for service-connected medical problems will receive priority access to health care. In addition, we have dramatically reduced the number of veterans on the waiting list for primary care. We will eliminate the 6-month waiting list no later than April 2004.

VA's health care system continues to be characterized by a coordinated continuum of care and achievement of performance outcomes that improve services to veterans. In fact, VA has exceeded the performance of private sector and Medicare providers for all 18 key health care indicators, from diabetes care to cancer screening and immunizations. The Institute of Medicine has recognized the Department's integrated health care system, including our framework for using performance measures to improve quality, as one of the best in the nation. Additionally, VA's quality score based on a survey conducted by the Joint Commission on Accreditation of Healthcare Organizations exceeds the national average quality score (93 versus 91).

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We expect to show improvements in both of our principal measures of health care quality. The clinical practice guidelines index will rise to 71 percent in 2005, while the prevention index will increase to 84 percent.

The 2005 budget includes additional management savings of $340 million that will partially offset the need for additional funds to handle the increasing utilization of health care resources, particularly among our highest priority veterans who require much more extensive care, on average, than lower priority veterans. We will achieve these management savings through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies such as consolidations.

Our projection of medical care collections for 2005 is $2.4 billion. This total is 38 percent above our estimated collections for 2004 and is more than three times the collections level from 2001. Approximately $407 million, or 61 percent, of the increase above 2004 is possible as a result of the proposed medical care policy initiatives. The Department continues to implement the series of aggressive steps identified in our revenue cycle improvement plan in order to maximize the health care resources available for the medical care program. We are establishing industry-based performance and operational metrics, developing

technological enhancements, and integrating industry-proven business approaches, including the establishment of centralized revenue operation centers. For example, during the last year we have lowered the share of reimbursable claims receivable greater than 90 days old from 84 percent to 39 percent, and we have decreased the average time to produce a bill from 117 days to 49 days. Further, the Department is implementing the Patient Financial Services System in Veterans Integrated Service Network 10 (Ohio). This will be a single billing system that we will use for both hospital costs as well as physician costs, and involves comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DoD) to enhance the coordination of the delivery of benefits and service to veterans. To address this Presidential initiative, our two Departments established a high-level Joint Executive Council to develop and implement significant collaborative efforts. We are focusing on three major system-wide issues: (1) facilitating electronic sharing of enrollment and eligibility information for services and benefits; (2) establishing an electronic patient health record system that will allow rapid exchange of patient information between the two organizations by the end of 2005; and (3) increasing the number of shared medical care facilities and staff. The sharing of DoD enrollment and eligibility data will reduce the burden on veterans to provide duplicative information when making the transition to VA for care or benefits. Shared medical information is extremely important to ensure that veterans receive safe and proper care. VA and DoD are working together to share facilities and staff in order to provide needed services to all patients in the most efficient and effective manner.

Capital Asset Realignment for Enhanced Services (CARES)

The 2005 budget includes $524 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative, a figure more than double the amount requested for CARES for 2004. This is a multi-year program to update VA's infrastructure to meet the needs of veterans in the 21st century and to keep our Department on the cutting edge of medicine. CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access. The resources we are requesting for this program will be used to implement the various recommendations within the National CARES plan by funding advance planning, design development, and construction costs for capital initiatives.

Mr. Chairman, the independent commission that is reviewing our draft CARES plan will be delivering their report to me soon. The commission had originally intended to complete their work by the end of November, but due to the intense interest in this project and the overwhelming volume of information they are faced with examining, their report has been delayed a few months. I look forward to reviewing the commission's analysis and recommendations. We will thoroughly evaluate their report and seriously consider their recommendations before making our final realignment decisions and preparing for the next phase of the CARES program.

Medical and Prosthetic Research

The President's 2005 budget includes total resources of $1.7 billion to support VA's medical and prosthetic research program. This request is comprised of $770 million in appropriated funds, $670 million in funding from other federal agencies such as DoD and the National Institutes of Health, as well as $230 million from universities and other private institutions. Our budget includes an initiative to assess pharmaceutical companies for the indirect administrative costs associated with the clinical drug trials we conduct for these organizations.

This $1.7 billion will support nearly 2,900 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, aging, diabetes, heart disease, mental illness, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

Veterans' Benefits

The Department's 2005 budget request includes $36 billion for the entitlement costs associated with benefits administered by the Veterans Benefits Administration (VBA). The budget includes another $1.19 billion for the management of these programs—disability compensation; pensions; education; vocational rehabilitation and employment; housing; and life insurance. This is an increase of $26 million, or 2.2 percent, over the enacted level for 2004.

We have made excellent progress in addressing the Presidential priority of improving the timeliness and accuracy of claims processing. Not only have we hired and trained more than 1,800 new employees in the last 3 years to directly address our claims processing backlog, but the productivity of our staff has increased dramatically as well. Between 2001 and 2003, the average number of claims we completed per month grew by 70 percent, from 40,000 to 68,000. Last year the inventory of rating-related compensation and pension claims peaked at 432,000. By the end of 2003, we had reduced this backlog of pending claims to just over 250,000, a drop of over 40 percent. We have experienced an increase in the backlog during the last few months, due in large part to the impact of the court decision (*PVA v Secretary of Veterans Affairs*) that interpreted the Veterans Claims Assistance Act of 2000 as requiring VA to wait a full year before denying a claim. However, this rise in the number of pending claims will be temporary, and we expect the backlog to be back down to about the 250,000 level by the end of 2004. We thank the Committee for the legislation that eliminated the mandatory 1-year waiting period.

In 2002 it took an average of 223 days to process a claim. Today, it takes about 150 days. We are on track to reach an average processing time of 100 days by the end of 2004 and expect to maintain this timeliness standard in 2005. One of the main reasons we will be able to meet and then sustain this improved timeliness level is that we have reduced the proportion of claims pending over 6 months from 48 percent to just 19 percent during the last 3 years.

To assist in achieving this ambitious goal, VA established benefits delivery at discharge programs at 136 military installations around the country. This initiative makes it more convenient for separating servicemembers to apply for and receive the benefits they have earned, and helps ensure claims are processed more rapidly. Also, the Department has assigned VA rating specialists and physicians to military bases where servicemembers can have their claims processed before they leave active duty military service.

We expect to see an increase in claims resulting from the return of our brave servicemen and women who fought to protect the principles of freedom in Operation Enduring Freedom and Operation Iraqi Freedom. We propose to use $72 million of the funds available from the war supplemental during 2004 to address the challenges resulting from an increasing claims processing workload in order to assist us in reaching our timeliness goal of 100 days by the end of 2004. We propose to use the remaining $28 million in 2005 to help sustain this timeliness standard.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2005 performance goal for the national accuracy rate for compensation claims is 88 percent, well above the 2001 accuracy level of 80 percent.

This budget request includes additional staff and resources for new and ongoing information technology projects to support improved claims processing. We are requesting $2 million for the Virtual VA project, the ultimate goal of which is to replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. The 2005 funding will maintain Virtual VA at the three Pension Maintenance Centers. We are seeking $3.4 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process. In addition, we are requesting $2.6 million in 2005 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

The Veterans Service Network (VETSNET) development is nearing completion and is scheduled to begin deployment in April 2004. This system offers numerous improvements over the legacy Benefits Delivery Network (BDN) that it is replacing (e.g., correction of material weaknesses and implementation of comprehensive claims processing within a modern corporate environment). Sufficient platform capacity is required to successfully deploy VETSNET and to ensure the continued and uninterrupted payment of approximately $24 billion annually in benefits to around 3.4 million deserving veterans and their beneficiaries. Therefore, $5 million in funding is requested to procure the capacity required. This platform capacity will ensure successful deployment and operation of VETSNET throughout VBA's Regional Offices and in a modern corporate environment that integrates all components of claims processing (e.g., establishing the claim, rating the claim, preparing the claim award, and paying the claim award). Without sufficient platform capacity, the Veterans Benefits Administration will be unable to operate this critical new system.

In support of the education program, the budget proposes $5.2 million for continuing the development of the Education Expert System. These resources will be used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment certification. This initiative will contribute toward achievement of our 2005 performance goals for the average time it takes to process claims for original and supplemental education benefits of 25 days and 13 days, respectively.

VA is requesting $9.6 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will allow us to answer calls at any place and at any time without complex call routing devices.

In order to make the delivery of VA benefits and services more convenient for veterans and more efficient for the Department, we are requesting $1.5 million for the collocation and relocation of some regional offices. Some of this will involve housing regional office operations in existing VA medical facilities. In addition, we are examining the possibility of collocations using enhanced-use authority, which entails an agreement with a private developer to construct a facility on Department-owned grounds and then leasing all or part of it back to VA. At the end of these long-term lease agreements, the land and all improvements revert to VA ownership.

In recognition of the fact that the home loan program is primarily a benefit that assists veterans in making the transition from active duty life to veteran status, the 2005 budget includes a legislative proposal to phase in an initiative to limit eligibility for this program to one-time use. Under our proposal, one-time use of the loan program would apply to any person who becomes a veteran after the date this proposed legislation becomes law. Those who are already veterans, or who will achieve veteran status prior to enactment of the proposed law, would

retain their eligibility to use the home loan benefit as many times as they need to for a period of 5 years after the law takes effect. Once that 5-year period has passed, they would no longer be able to use this benefit more than once. This legislative proposal does not change eligibility for active duty personnel who would retain the ability to use this benefit as many times as they need it. VA home loans are important for first-time buyers because they require no down payment—making them riskier than other loans. After the first use, home equity can be used to obtain more favorable terms from conventional loans, or through the Federal Housing Administration. Therefore, limiting this benefit to its original intent of one-time use after leaving the military will lower loan volume and risk, save money over the long-term, and coordinate federal programs.

Burial

The President's 2005 budget includes $455 million for the burial program, of which $181 million is for mandatory funding for VA burial benefits and payments and $274 million is for discretionary funding, including operating and capital costs for the National Cemetery Administration and the State Cemetery Grant program. The increase in discretionary funding is $9 million, or 3.4 percent, over the enacted level for 2004, and includes operating funds for the five new cemeteries opening in 2005.

This budget request includes $926 thousand to complete the activation of new national cemeteries in the areas of Detroit, MI and Sacramento, CA. These are the last two of the six locations identified in the May 2000 report to Congress as the areas most in need of a national cemetery. The other four cemeteries will serve veterans in the areas of Atlanta, GA, South Florida, Pittsburgh, PA, and Fort Sill, OK.

With the opening of new national cemeteries and state veterans cemeteries, the percentage of veterans served by a burial option within 75 miles of their residence will rise to 83 percent in 2005. The comparable share was less than 73 percent in 2001.

The $81 million in construction funding for the burial program in 2005 includes resources for Phase 1 development of the Sacramento National Cemetery (CA) as well as expansion and improvements at the Florida National Cemetery (Bushnell, FL) and Rock Island National Cemetery (IL). The request includes advanced planning funds for site selection and preliminary activities for six new national cemeteries to serve veterans in the following areas—Bakersfield, CA; Birmingham, AL; Columbia/Greenville, SC; Jacksonville, FL; Sarasota County, FL; and southeastern Pennsylvania. Completion of these new cemeteries will represent an 85 percent expansion of the number of gravesites available in the national cemetery system since 2001, almost doubling the number of gravesites during this time period. In addition, the budget includes $32 million for the State Cemetery Grant program.

In return for the resources we are requesting for the burial program, we expect to achieve extremely high levels of performance in 2005 and to continue our noble work to maintain the appearance of national cemeteries as shrines dedicated to honoring the service and sacrifice of veterans. Our performance goal for the percent of survey respondents who rate the quality of service provided by the national cemeteries as excellent is 96 percent, and our goal for the percent of survey respondents who rate national cemetery appearance as excellent is 98 percent. In addition, we will continue to place emphasis on the timeliness of marking graves. Our performance goal for the percent of graves in national cemeteries marked within 60 days of interment is 82 percent in 2005, a figure dramatically above the 2002 performance level of 49 percent.

Management Improvements

Mr. Chairman, we have made excellent progress during the last year in implementing the President's Management Agenda. Our progress in the financial, electronic government, budget and performance, and DoD/VA coordination areas is currently rated "green." Our human capital score is "yellow" due only to some very short-term delays. However, VA's competitive sourcing rating is "red" because existing legislation precludes us from using necessary resources to conduct cost comparisons of competing jobs such as laundry, food and sanitation service. The Administration will work with Congress to develop legislation to advance this effort that would free up additional resources to be used to provide direct medical services to veterans. We will continue to take the steps necessary to achieve the ultimate goals the President established for each of the focus areas.

We have several management improvement initiatives underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes. We are currently realigning our finance, acquisition, and capital asset management functions into business offices across the Department. There will be one business office in each of the 21 Veterans Integrated Service Networks and a single office for the National Cemetery Administration. For the Veterans Benefits Administration, the majority of the field functions will be centralized into product lines. In addition, we are establishing an Office of Business Oversight in our Office of Management that will provide much stronger oversight of these functions by our Chief Financial Officer, will improve operations through more specialization, and will achieve efficiencies in staffing. The realignment of these business functions will reduce and standardize field business activities into a more manageable size, limit the number of sites to be reviewed, provide for more consistent interpretation of policies and procedures, and promote implementation of performance metrics and data collection related to these business functions. As a result of the realignment, we will significantly strengthen compliance and consistency with finance, acquisition, and capital asset policies and procedures.

We continue to make excellent progress in implementing the recommendations of our Procurement Reform Task Force, as 43 of the 65 recommendations have been completed. By the end of 2004, we expect to implement all of the remaining recommendations. These procurement reforms will optimize the performance of VA's acquisition system and processes by improving efficiency and accountability. We expect to realize savings of about $250 million by the end of 2004 as a result of these improvement initiatives. This figure will rise after we have completed all 65 recommendations.

During 2005 VA will continue developing our enterprise architecture that will ensure that all new information technology (IT) projects are aligned with the President's E-government initiatives as well as the Department's strategic objectives. The enterprise architecture will help eliminate redundant systems throughout VA, improve IT accountability and cost containment, leverage secure and technologically sound solutions that have been implemented, and ensure that our IT assets are built upon widely accepted industry standards and best practices in order to improve delivery of benefits and services to veterans. One of our primary focus areas in IT will be cyber security. We will concentrate on securing the enterprise architecture and providing continuous protection to all VA systems and networks. This will require purchases of both hardware and software to address existing vulnerabilities.

We are continuing the development and implementation of our CoreFLS project to replace VA's existing core financial management and logistics systems with an integrated, commercial off-the-shelf package. CoreFLS will help us address and correct management and financial weaknesses in the areas of effective integration of financial transactions from Department systems, necessary financial support for credit reform initiatives, and improved automated analytical

and reconciliation tools. We have conducted initial tests at selected sites and are still on schedule for full implementation during 2006.

The Department has developed a comprehensive human capital management plan and has started implementing some of the strategies outlined in this plan. In addition, we are implementing a redesigned performance appraisal system to better ensure that all employees' performance plans are linked with VA's mission, goals, and objectives.

Closing

Mr. Chairman, VA has achieved numerous successes during the last 3 years that have significantly improved service to our country's veterans. We have enhanced veterans' access to our health care services that set the national standard with regard to quality; improved the timeliness of health care delivery; expanded programs for veterans with special health care needs; dramatically lowered the time it takes to process veterans' claims for benefits; and expanded access to our national cemetery system. The President's 2005 budget will provide VA with the resources necessary to continue to improve our delivery of benefits and services, particularly for veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

STATEMENT OF
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 4, 2004

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I appreciate the opportunity to appear before you on behalf of the 1.5 million members of the Disabled American Veterans (DAV) and its Auxiliary, and as one of the four partners of *The Independent Budget* (IB), to present our assessment of the President's fiscal year (FY) 2005 budget for veterans' programs and to provide our own alternative recommendations for resources and program improvements. Consistent with the division of responsibilities among the four IB coauthors, I will focus primarily on the benefit programs, the administrative expenses of the Veterans Benefits Administration (VBA), and the Court of Appeals for Veterans Claims.

Within the ultimate goal of providing the special assistance and services to veterans that our Nation has determined appropriate in return for their service and its impact upon them, are numerous goals to make beneficial adjustments and improvements. Because improvements are always possible, and always necessary, our work is inherently open-ended and ongoing. Unavoidably, most of what we can accomplish for veterans during the year depends upon the decisions you and your colleagues make on the budget for veterans' programs. In many ways, this hearing on the budget begins the process of laying the foundation for all else we do during the months ahead. However, what we do is not constrained or dictated by the Presidents' budget recommendations. Surely, there are substantial differences between the President's agenda and the common goals of this Committee and veterans' advocates. As is often observed, the President's budget is only the starting place, or reference document, from which to proceed on formulation of the real budget.

Consistent with recent years, the President's budget submission for FY 2005 contains few legislative recommendations to improve, expand, or add new benefits for veterans. The President's budget recommends a cost-of-living adjustment (COLA) for compensation based on a projected 1.3% increase in the cost of living. The IB also recommends a compensation COLA to keep its value even with increases in the cost of living. However, to maintain the value of compensation in relation to the cost of living, the IB urges Congress to discontinue the practice of rounding down the COLA to the nearest whole dollar. While the loss of value of compensation against rises in the cost of living may be insubstantial over the period of a year, rounding down for many years in succession will have a compounding effect and will substantially erode the value of the already modest rates of compensation.

Again this year, the President's budget seeks legislation to deny compensation to a group of disabled veterans who suffer greatly from their service-connected disabilities. These are veterans who are so distressed by symptoms of posttraumatic stress disorder (PTSD) and other mental disorders, for example, that they self-medicate with alcohol to escape the agony, and develop secondary disability as a result. With VA's unlawful prohibition of service connection for these secondary disabilities having been struck down by a Federal appellate court, VA now asks Congress to enact legislation for this purpose. We find this effort by the Federal agency established to assist veterans no less inappropriate and no less objectionable than we did last year, and we oppose it no less strenuously. We urge Congress to send VA and the Administration another resounding "no" in response to this request for unjust action.

The only thing worse than the Administration's repeated attempts to whittle away veterans' benefits is its outright attempt to take away big chunks of them. In the IB, we take a strong position against one such serious and immediate threat to disabled veterans, who depend on compensation to make up for the effects of service-connected disabilities. During last year's deliberations on the FY 2004 defense authorization bill, the Administration and House leadership devised a scheme to greatly reduce Government obligations to compensate disabled veterans for

service-incurred disabilities. Essentially, under their scheme, veterans who suffered injuries and contracted diseases in military service under circumstances other than during and in connection with the direct performance of functions of their particular military occupations would not be compensated. For example injuries occurring during mealtimes, or in a military barracks, would not qualify for service connection. A sevicemember who contracted a tropical disease while serving in a Third World country would not be eligible for service connection of the disability unless he or she could prove that the infection with the disease organism occurred while performing his or her regular military duties as opposed to mealtimes and off duty hours. VA projected that approximately two-thirds of the disabled veterans who now are entitled to disability compensation would not have been eligible under this new scheme. Current law does not base entitlement upon such unreasonable, problematic distinctions between disabilities due to direct performance of military duties and disabilities incurred during other activities incident to military service. It is self-evident that current standards governing service-connected status for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. We urge Congress to reject any revision of this standard for the purpose of permitting the Government to coldly and expediently avoid its responsibilities for the human costs of war and national defense.

To improve the compensation program, the IB makes three other recommendations for legislation:

- to exclude compensation as countable income for Federal programs
- to repeal the prohibition of service connection for disabilities related to tobacco use
- to repeal delayed effective dates for payment of increased compensation based on temporary total disability

For the pension program, the President's budget seeks legislation to make awards of death pension effective the first day of the month in which death occurred if the claim is filed within 1 year of the date of death. Prior amendments reduced this period from 1 year to 45 days. The IB has no recommendation on this issue, but it would liberalize the program for needy widows of wartime veterans, and in the process, restore uniformity to effective date provisions and thus restore uniformity to the administration of the compensation and pension programs.

In addition to compensation for the loss in earning potential and other effects of functional loss from disability, Congress has provided special assistance for veterans who suffer from service-connected disabilities that interfere with such things as mobility in the home and in other basic activities of daily living. These special benefits include grants for housing and automobiles with special adaptations. To remain effective for their purposes, these benefits must be adjusted for increases in the cost of living and to address other needed improvements. The IB therefore includes recommendations for legislation:

- to increase the amount of the grants for specially adapted housing and to provide for automatic annual adjustments for increased costs
- to provide a grant for adaptations to a home that replaces the first specially adapted home
- to increase the amount of the automobile grant and to provide for automatic annual adjustments for increased costs

The President's budget includes proposals for legislation to make three "technical amendments" to educational benefits programs. These amendments appear to have minimal budgetary impact and impact on beneficiaries. The IB has no position on them. To improve the education programs the IB recommends the following legislation:

- to expand Montgomery GI Bill eligibility to persons who, but for service on or before June 30, 1985, would be eligible for education benefits under this program
- to authorize refund of contributions to veterans who become ineligible for the Montgomery GI Bill by reason of discharges characterized as "general" or "under

honorable conditions"

In yet another unwarranted move to reduce the benefits Congress has made available to veterans, the President's budget proposes legislation to limit veterans to a one-time home loan guaranty. With the typical changes in family size and economic status, come changes in housing needs. In today's mobile society, families also move to new communities to follow greater opportunities. The ability of veterans, who are in good standing with VA's home loan guaranty program, to obtain loans for these replacement homes benefits them in the same way the first loan benefited them and is of no undue burden upon the Government. The IB urges you to reject this recommendation. For improvement in the home loan program for veterans, we recommend legislation:

- to increase the maximum VA home loan guaranty and provide for automatic annual indexing to 90% of the Federal Housing Administration-Federal Home Loan Mortgage Corporation loan ceiling

- to repeal funding fees imposed upon certain VA home loan guaranties

For the insurance programs, the President's budget proposes legislation for technical amendments "to clarify certain points such as defining an insurable dependent, terms of coverage and premiums." According to the budget, these changes require no additional funds. Without more specifics, we have no position at this time. For substantive improvements to the insurance programs, the IB recommends legislation:

- to exempt the dividends and proceeds from and cash value of VA life insurance policies from consideration in determining entitlement under other Federal programs

- to authorize VA to use modern mortality tables instead of 1941 mortality tables to determine life expectancy for purposes of computing premiums for Service-Disabled Veterans' Insurance

- to increase the maximum protection available under the base policy of Service-Disabled Veterans' Insurance from $10,000 to $50,000

- to increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000

Despite clear and emphatic language in the law to protect veterans' disability compensation and other benefits from diversion to third parties who have no right to such benefits, the courts have simply interpreted the law to permit what it unquestionably prohibits. As a result, veterans' benefits have become an easy target for former spouses seeking alimony. The courts show little reverence for the principle that veterans' benefits were created for veterans and little regard for congressional intent that a veteran, and not someone else, should be compensated for the effects of his or her disability. Courts seem to have no hesitation in ordering disabled veterans to pay part of their disability compensation to able-bodied former spouses. This situation is appalling. Existing law provides that veterans' benefits "shall not be liable to attachment, levy, or seizure by or under any legal or equitable process, whatever, either before or after receipt by the beneficiary." The IB recommends legislation to reinforce existing law so there can be no doubt that it means what it says. Congress acted last year to clarify the prohibition against assignment of veterans' benefits to third parties, and we ask that you act this year to ensure enforcement of the probation against court-ordered awards to third parties.

Although not under the jurisdiction of this Committee, we also call for legislation to remove, for all service-connected disabled military longevity retirees, the offset between their military retired pay and disability compensation. As you know, the legislation enacted near the end of the last session of Congress provides for removal of this inequitable offset for some disabled veterans. In so doing, it left the injustice in place for many other veterans. We also recommend legislation to extend the 3-year limitation on recovery taxes withheld from disability severance pay and military retired pay later determined to be exempt from taxable income.

The benefit programs Congress carefully and thoughtfully designed to assist veterans with their special needs are effective for their intended purposes only to the extent the benefits are delivered to entitled beneficiaries that seek them when they need them. In recent years, VA has failed to perform satisfactorily in both respects. Inadequate resources combined with inexperienced adjudicators and institutional emphasis on production rather than quality resulted in high error rates, improperly denied benefits, necessity to rework cases, and protracted delays in the payment of benefits to entitled veterans. Congress has taken some steps to provide more resources, and VA has taken steps to improve performance. The factors that led to the problems have not been completely corrected, however, and the dangers of VA again losing ground against case backlogs still lurk. Our recommendations in the IB address primarily these areas of concern. The President's budget submission has merged administrative expenses with the direct costs of benefit payments to veterans. In the IB, we have continued to cover the administrative expenses and related efficiency recommendations separately, as they were previously included under the General Operating Expenses (GOE) account.

We are extremely concerned about the inadequate resources requested for VBA in the President's budget. At a time when the United States has just fought a major war and has our troops involved in hostilities around the world, at a time when disabled and other veterans will likely be separating from military service in increased numbers, and at a time when demand for veterans' benefits will increase, the President's budget proposes major reductions in resources for the delivery of benefits and services to veterans. For VBA, the President's budget requests 829 fewer full-time employees (FTE) for FY 2005 than authorized at the end of the last fiscal year, FY 2003. The request is 540 FTE below the FY 2004 level. Every benefit line except Insurance Service would lose employees under the President's budget. We do not see how VBA can achieve enough productivity improvements to offset such a substantial loss of resources. The President's budget would also substantially scale back investments in ongoing programs to modernize VBA's essential information technology improvements. These two proposed reductions strike the core of the veterans' benefits delivery system. Below, I will discuss these areas individually in comparison with our requests.

In the IB section on GOE, we make two recommendations that apply to all of VBA's benefit lines, but particularly to its Compensation and Pension Service (C&P). We recommend that VBA's program directors be given line authority over their field employees who process and decide benefit claims, and we recommend that VA improve its regulations. Both of these recommendations call on VA to make institutional changes to improve services to veterans. They do not seek legislation, but may be of interest to the Committee in its oversight role.

Under VBA's current management structure, its program directors have no managerial authority over field office employees. For example, although adherence to VA policy, the laws of Congress, and quality standards are essential for VA to bring its compensation and pension claims processing up to acceptable levels of accuracy and efficiency, the C&P Director has no authority to enforce policies and performance standards in his own Service. The National Academy of Public Administration (NAPA), in a study of VBA, concluded that the program directors' lack of influence over their field office employees greatly hampers efforts to implement reforms and institute real accountability.

In addition to carefully crafting the benefit programs to meet veterans' needs, Congress carefully designed the benefits delivery system to work for veterans, not against them. By congressional design, this benevolent system is intended to be informal and to serve the veteran, not the Government. However, from our experience over the last several years, we have seen VA's regulations become more self-serving and arbitrary. We have found it necessary to ask Congress to enact legislation to override VA regulations that were inconsistent with congressional intent. We have therefore recommended that Congress scrutinize VA's rulemaking more closely as a part of its oversight role, and that Congress enact special controls on VA rulemaking if necessary.

For improvements in compensation and pension claims processing, we have directed another recommendation to VA for reforms by focusing more of its efforts on correcting the root causes for quality problems and consequent timeliness problems. For C&P Service, we have also made three recommendations to Congress pertaining to the personnel and information technology resources that are necessary for VA to continue to improve performance and meet its workload demands.

We recommend in the IB that C&P Service be authorized 7,757 FTE for FY 2005. VA had projected that its workload would allow it to draw down its FTE in FY 2005 by approximately 268 below its staffing level of 7,757 FTE at the end of FY 2003. However, those projections did not take into account an additional 391,000 claims and an additional 52,869 appellate caseload over the next 5 years VA now expects incident to legislation that expanded eligibility for Combat Related Special Compensation and authorized concurrent receipt of military retired pay and disability compensation for veterans with service-connected disabilities rated 50% or higher in degree. In addition, VA projects that it will have to rework approximately 48,000 claims to meet the requirements of a court decision that invalidated VA procedures that placed unlawful requirements upon veterans. Though most of that work should be done during FY 2004, it will likely delay work on some of C&P's inventory and carry some extra caseload over into FY 2005. This additional workload requires that VA have approximately the same direct program staffing levels for FY 2005 that it had at the end of FY 2003. The IB therefore recommends that Congress authorize 7,757 direct program FTE for C&P Service in FY 2005. The President's budget proposes 7,270 FTE, or 487 fewer direct program FTE for C&P Service in FY 2005 than in FY 2003. In addition, the President's budget requests 185 fewer FTE for management direction and support and information technology in C&P Service for FY 2005 than it had in FY 2003.

Just as VA must have sufficient staffing to match its compensation and pension claims workload, it must continue to have efficient procedures and technology for processing claims and related information. To aid in accuracy and uniformity in claims adjudication, and to achieve the greater efficiencies of modern information technology, VA began its Compensation and Pension Evaluation Redesign (CAPER) initiative during 2001. To determine and implement its optimum performance in record development, disability examinations, and claims decisions, VA is undertaking a review of its claims process with the goal of developing and deploying an integrated electronic format to aid in uniform and correct application of procedures and substantive rules and to allow for the electronic transmission of data from its source into the claims database. VA now hopes to have this system fully in place by September 2006. To achieve that goal, VA needs approximately $3.5 million in FY 2005 to continue development of this system, and the IB recommends that Congress provide this essential funding to VA. The President's budget requests only $2.7 million for this initiative.

Another aspect of systems modernization is the use of electronic files to replace manual paper transfer and storage of claims records. With the necessary imaging and other equipment, VA can acquire, store, and process claims data much more timely and efficiently, reducing task times and staffing needs. VA's project, known as "Virtual VA," has been deployed at VA's Pension Maintenance Centers and is undergoing evaluation and assessment based on experience at these three sites. With eventual full implementation, all VBA regional offices will have document imaging capabilities, and VA medical centers will have electronic access to veterans' claims folders for review in connection with disability examinations ordered by claims adjudicators. Accordingly, the IB recommends that Congress provide VA the $8 million it needs in FY 2005 to continue document preparation and scanning at the Pension Maintenance Centers and to continue development of the system for application nationwide. The President's budget requests only $1.6 million for Virtual VA.

As with C&P Service, VBA's Vocational Rehabilitation and Employment Service (VR&E) faces major challenges in meeting its responsibilities to disabled veterans under circumstances of heavy workloads and limited resources. The impact of the worldwide war on terrorism, hazardous duty in other locations around the world, and major combat operations in Iraq and Afghanistan, will undoubtedly be felt by VR&E when these veterans begin pouring into the system with the need for rehabilitation training and employment suitable to their service-connected disabilities. To sustain current levels of performance with its projected workload, VR&E needs to retain the staffing strength that it had at the end of FY 2003. In addition, the VA Secretary's VR&E Task Team has made a number of recommendations to improve vocational rehabilitation and employment services for veterans. It is projected that approximately 200 additional FTE will be needed to implement these substantial reforms in the programs, organization, and work processes of the VR&E program. At the end of FY 2003, VR&E direct program staffing was 931 FTE. The IB therefore recommends that Congress authorize 1,131 direct program FTE for VR&E in FY 2005, an increase of 200 above the FY 2003 level. The

President's budget requests only 876 FTE for FY 2005, and seeks 21 fewer FTE for management direction and support and information technology than VR&E had in FY 2003.

Similarly, VBA's Education Service expects some increase in its workload, due to legislation last year that expanded coverage of the program to cover additional types of training. VA is striving to provide more timely and efficient service to claimants seeking education benefits. Education Service reports gains in these areas during FY 2003. To continue on the course of improvement and to meet the added workload projected, Education Service must at least maintain its FY 2003 staffing level. In FY 2003, Education Service had 708 direct program FTE, and the IB recommends that Congress authorize 708 FTE for Education Service in FY 2005. Here again, we question the President's request of fewer FTE for management direction and support and information technology. The FY 2005 request is 7 FTE below the FY 2003 staffing level.

Because the United States Court of Appeals for Veterans Claims is not a part of the VA or executive branch, its funding is not included under the budget for veterans' benefits and services. The Court is nonetheless an integral part of the system of benefits for veterans, and this Committee does, of course, have oversight responsibilities and jurisdiction over any authorizing legislation pertaining to the Court and its functioning. Additionally, the United States Court of Appeals for the Federal Circuit has jurisdiction to hear appeals from decisions of the Court of Appeals for Veterans Claims, and, here again, this Committee has jurisdiction over laws that govern review of these appeals in the Federal Circuit. For this area of great importance to veterans, the IB includes several recommendations.

In previous years, we have recommended in the IB that Congress amend the standard under which the Court of Appeals for Veterans Claims reviews the propriety of factual findings by VA's administrative appellate board, the Board of Veterans' Appeals (BVA). Under the "clearly erroneous" standard, the Court was essentially upholding any finding of fact against a VA claimant that had some "plausible basis" in the record although the law mandates that VA decide a factual question in a claimant's favor unless the evidence against the claim outweighs the evidence supporting it. This mandate in law is known as the "benefit-of-the-doubt" rule. This rule is based on the time-honored principle that we owe veterans greater considerations than ordinary citizens litigating in court or seeking government assistance from other agencies and that a veteran claiming benefits is therefore entitled to the benefit of the doubt when the evidence neither proves nor disproves his or her claim. With the Court upholding adverse factual findings for which there is merely some plausible basis, BVA was completely free to ignore the law and deny a claim for VA benefits even though the supporting evidence was much stronger than, or at least as strong as, the evidence against it. The Court was turning a blind eye to erroneous and unjust denials of meritorious claims, making the benefit-of-the-doubt rule unenforceable and meaningful only to the extent VA chose to observe it. Appeals to the Court often follow from arbitrary decisions in which VA chose to ignore the rule, but these appeals were essentially futile, with meritorious claims and justice denied. To correct this grave injustice, the IB recommended that Congress amend the law to require the Court to reverse any BVA factual finding against a claimant that was clearly inconsistent with the benefit-of-the-doubt rule. To accomplish this, we recommended that the clearly erroneous standard be replaced with an instruction that the Court must reverse any finding of fact adverse to a claimant that was not reasonably supported by a preponderance of the evidence, which is weight of the evidence required for such adverse finding under the benefit-of-the-doubt rule.

Seeking to continue its immunization from meaningful judicial review, VA opposed this change, and the veterans' committees capitulated with a compromise so insubstantial that the Court has construed the new legislation as making no change whatsoever. Indeed, VA itself argued to the Court that you made no substantive change in the law by your amendments. Deserving veterans are still left with no remedy for outright violations of the law. That is unacceptable. We therefore renewed in this year's IB our previous recommendation that Congress replace the clearly erroneous standard with the requirement that the Court reverse factual findings not reasonably supported by a preponderance of the evidence. Certainly, you should not again be persuaded to accept any compromise proposed by VA that will enable VA to once more argue to the Court that you did nothing. We want to reiterate here that this issue is one that remains very important to veterans and their rights.

When Congress ended the longstanding absence of judicial review for veterans' claims, it was very concerned that the formalities typical of judicial proceedings not change the informalities of VA's administrative claims processes. The legislative history for judicial review legislation emphasizes repeatedly congressional intent to preserve this informality and pro-veteran character at the administrative level. Congress maintained in the law provisions that put the obligation on VA to develop the claims record and afford consideration to all possible theories of entitlement under all relevant laws, regulations, and other legal authorities. The veteran is not required to know or argue the legal technicalities of benefits laws. Thus, failure of BVA to consider all points of law bearing on a claim is legal error, an error of omission. Yet, the Court has refused to consider these points in appeals because the veteran failed to argue them before BVA. In effect, the Court is relieving VA of its obligations under the law and shifting them to veterans. The Court is imposing upon veterans the very thing Congress did not intend, the obligation to formally plead all the finer points of law that are often very complex and poorly understood by average laypersons. To prevent the Court from further imposing the formalities of adversarial judicial proceedings upon the non-adversarial veterans' claims process, the IB recommends legislation to prohibit judicial imposition of formal pleading or so-called "exhaustion" requirements upon the VA claims process.

Though veterans have deep frustration with some of the Court's actions, judicial review and many of the Court's precedents have added legitimacy to the process and forced VA to follow the law more carefully. Judicial review exposed deeply ingrained unlawful practices and deficiencies in VA's claims adjudication, and more than any other factor, forced VA to acknowledge these systemic defects and make fundamental reforms. As a result of the availability of judicial review and the Court you created to perform that review, veterans stand a much better chance of getting a fair decision today than they did before judicial review was authorized by your landmark legislation in 1988. We still need to make adjustments to bring the process closer to that envisioned by Congress in its 1988 legislation, however.

The Chief Judge has begun exploratory steps toward securing a site and authority for construction of a courthouse and justice center. After an appropriate site is located, Congress must enact authorizing legislation and provide necessary funding if the project is to be undertaken. The IB fully supports the project to construct a courthouse for the veterans' court. We seek the support and essential assistance of the members of this Committee in securing a site, enacting the necessary legislation, and working with your colleagues in Congress to obtain the funding required to build this courthouse and justice center for veterans.

When Congress authorized judicial review of VA's claims decisions, it also authorized, as is typically available for other Federal departments and agencies, judicial review of VA's regulations. However, Congress exempted one area of VA's rulemaking from review by the courts. Congress expressly deprived the courts of jurisdiction to review VA's *Schedule for Rating Disabilities*. We agree with the reasoning that the courts should not be empowered to intervene in VA's application of its special expertise and the exercise of its discretion in formulating criteria for evaluating the effects of disabilities. However, we believe the United States Court of Appeals for the Federal Circuit should be authorized to review and invalidate rating schedule provisions that are, on their face, contrary to the laws enacted by Congress or are arbitrary and capricious. Such narrow review would not interfere with VA's lawful and legitimate exercise of its broad discretion, and would empower the Federal Circuit to intervene in only the most egregious abuses of discretion and invalidate only the unequivocally unlawful rating schedule provisions. Today, VA is totally immune to any remedy for flatly unlawful or arbitrary and capricious actions in adopting or revising its rating schedule. The IB therefore recommends expanding Federal Circuit jurisdiction to permit that court to review challenges to VA's rating schedule on these narrow grounds.

Finally, I want to join with our IB witness who is covering veterans' medical care in this hearing in stressing the importance of putting a mechanism in place to end what has unquestionably proven to be an inadequate process for funding veterans' medical care. Year after year, the President's budget request falls well below the minimum needed to maintain medical services for sick and disabled veterans seeking those services from the medical care system established to serve them. Year after year, we must fight an uphill battle to get more realistic appropriations, and that annual battle is getting ever more difficult despite the strong advocacy of the members of this Committee, who know what resources VA really needs. To get funding to continue operation of their medical programs, veterans should not have to compete

with all the many other interests who seek part of the limited discretionary dollars. Veterans and VA should not have to face the yearly uncertainty of whether there will be sufficient funding provided to continue essential medical care services for disabled veterans. Veterans should not have to wait months to be treated for their illnesses. VA should not have to continue operating the largest medical care system in this country on the shoestring of annual appropriations and without any means to plan strategically for long-term efficiencies. We have thoroughly tested the discretionary appropriations process whereby political will, rather than actual resource needs, determines how much funding veterans' medical care receives each year. With consistent experience that funding veterans' medical care under that process has repeatedly failed, and will only continue to be unsatisfactory, the remedy is to guarantee adequate and stable funding through a permanent authorization that uses a reliable formula to project resource needs. Among all the meritorious issues to be addressed by this Committee this year, this issue is the most urgent and therefore the most important to veterans. We have received strong bipartisan support from the members of this Committee for mandatory funding, and we renew our earnest request for your support again this year.

This Committee has acted favorably on many of the recommendations of the IB in past years, and many of the recommended changes are now in law, making the programs more effective for our veterans. Working together, the IB and this Committee have made numerous improvements in the benefits and the delivery system. We thank you for your willingness to consider our views and recommendations, and we thank you for your decisive action in incorporating our recommendations into law. We hope you will again find our recommendations meritorious and will shepherd legislation through this year to adopt more of them.

STATEMENT OF

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE INDEPENDENT BUDGET

AND THE DEPARTMENT OF VETERANS' AFFAIRS BUDGET

FOR FISCAL YEAR 2005

FEBRUARY 4, 2004

Mr. Chairman and members of the Committee, as one of the four veterans services organizations publishing *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for FY 2005.

This is the eighteenth year, PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars have presented *The Independent Budget*, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 31 veterans service organizations, and medical and health care advocacy groups.

Mr. Chairman, we are becoming increasingly troubled by the delays in enacting VA appropriations. In FY 2000, VA appropriations were not enacted until October 20th, in FY 2001 October 27th, in FY 2002 November 26th, in FY 2003 February 20th, and this year, January 23rd. For the past two years alone, the VA health care system has had to struggle along at previous year's inadequate funding levels for nearly one-third of each year. This is unacceptable. These delays directly affect the health care received by veterans. This deplorable state further points to the importance of a mandatory funding mechanism for VA health care. But until that happens, we ask that this Congress move expeditiously to put the necessary funding levels in place by the start of FY 2005. We also are disappointed in the practice of using rescissions as a budgetary mechanism in the omnibus spending bills that have become far too common. These cuts also have real consequences for veterans and their families.

This year, as we did last year, *The Independent Budget* is presented in the traditional account format. The VA is once again presenting its budget in the format it unveiled last year, a format that did not find wide acceptance. The House Appropriations Committee has adopted its own format. Until this format dispute is settled, and until we have adequate data in which to analyze the VA health care system under whichever format is adopted, we will continue to utilize the traditional account structure. It can become confusing amid the din of competing dollar amounts based upon these different formats, but we ask you to compare oranges to oranges and to bear in mind that attractive numbers may not exactly match reality.

For FY 2005, *The Independent Budget* recommends a Medical Care amount of $29.791 billion. This figure does not include funds attributed to MCCF, which we believe should be used to augment a sufficient appropriated level of funding. This amount represents an increase of $3.2 billion over the amount provided in FY 2004.

The Independent Budget recommendation is a conservative one. The VA health care system, in order to fully meet all of its demands and to ameliorate the effects of chronic under-funding, could use many more dollars. *The Independent Budget* recommendation

provides for the impact of inflation on the provision of health care, and mandated salary increases of health care personnel. It provides resources to begin funding the VA's critical fourth mission to back up the Department of Defense health care system. Make no mistake about it, the VA will be spending money to comply with its new responsibilities in this area, and if specific funding is not included, then these resources will have to come directly from dollars used to care for sick veterans. It provides increased prosthetics funding and long-term care funding, and provides enough resources, we believe, to enroll Priority 8 veterans. With the VA's decision to cease enrolling Priority 8 veterans, undertaken only because of the lack of resources, we are losing an entire class of veterans, veterans who are an integral part of the VA health care system.

Of course, these recommendations are only estimates, and our crystal ball is often cloudy. Health care inflation may be higher, or lower than we have estimated. Demand may increase, or decrease. The implications, as they pertain to VA health care funding estimates, of the two-year grant of health care eligibility to recently discharged or released active duty personnel as provided in P.L. 105-363, are difficult to account for. But what we must account for, and provide for, are the necessary resources for the VA to meet its responsibilities, and this Nation's responsibilities, to sick and disabled veterans. These resources must be provided in hard dollars, and not dollars magically realized out of the thin air of "management efficiencies" and other budgetary gimmicks.

Early indications are that the Administration will once again rely on increased copayments and charges, as well as these budgetary gimmicks, in its FY 2005 budget submission. We categorically disagree with this approach. The VA must be accorded real dollars in order to care for real veterans. Shifting costs onto the back of other veterans is not the way to meet this federal responsibility. Likewise, budgetary smoke and mirrors do not meet the real health care needs of veterans.

We can no doubt expect increased fee proposals, as well as proposals to increase copayments or other means to restrict access or reduce demand. Punitive copayments are designed not so much to swell projected budget increases as they are to deter veterans

from seeking their care at VA medical facilities. Imagine the effect of these additional costs on those who have no other choice but to get care at VA. We may indeed have the greatest health care system in the world, but if you cannot get in the door we might as well have the worst.

Mr. Chairman, *The Independent Budget* makes a strong statement in opposition to copayments. The Congress gave the Secretary of Veterans Affairs the authority to set and raise fees. What was once thought of as only an administrative function has now become, in times of tight budgets, an easy way to try and find the dollars to fund health care for veterans. When appropriations are in short supply and demand for health care is high, copayments have become the new way to fund the VA out of the pockets of the veteran patient.

For Medical and Prosthetic research, *The Independent Budget* is recommending $460 million. This represents a $54 million increase over the FY 2004 amount, and matches this Committee's recommendation last year. This program is a vital part of veterans' health care, and an essential mission for our national health care system. We must provide additional dollars for VA research as we provide additional funding for our other national research endeavors. Over the course of five years, the budget for the National Institutes of Health was doubled. We should seek a similar commitment for VA research.

In closing, the VA health care system faces two chronic problems. The first is underfunding which I have already outlined. The second is a lack of consistent funding. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them.

Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive.

The only solution we can see is for this Committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it. We look forward to working with this Committee in order to begin the process of moving a bill through the House and Senate as soon as possible.

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

RICHARD B. FULLER

Richard B. Fuller is the National Legislative Director of the Paralyzed Veterans of America (PVA), a non-profit veterans service organization chartered by the United States Congress to represent the interests of its members, veterans with spinal cord injury or dysfunction, and all Americans with disabilities. PVA's primary legislative focus centers on issues supporting the Department of Veterans Affairs health care system and the specialized services VA provides to PVA members. He is responsible for coordinating the organization's legislative and oversight activities on all veterans' benefits and services, as well as oversight on all federal health systems – Medicare and Medicaid – and research activities which benefit veterans as well as all Americans with disabilities.

Mr. Fuller served for eight years on the professional staff of the Committee on Veterans' Affairs of the U.S. House of Representatives with primary responsibilities in areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research and provider non-profit organizations in Washington, DC.

Mr. Fuller was Director of Public Affairs of the House Committee on Veterans' Affairs from 1979-1981. He served on the professional staff of the Subcommittee on Education, Training and Employment and for the Subcommittee on Hospitals and Health Care until 1987. In 1987, he joined the national government relation's staff of PVA, serving first as Associate Legislative Director, and then as National Legislative Director. In 1991, he joined a Washington D.C. health care consulting firm representing the public policy and legislative interests of several national medical and research societies, including: the American Federation for Clinical Research; the American Gastroenterological Association; the American Geriatrics Society; and the National Association of Veterans Research and Education Foundations. He returned to PVA in 1993 to lead the organization's outreach efforts on national and state health-care reform.

Mr. Fuller graduated with a Bachelor of Arts degree from Duke University in 1968. He served in the United States Air Force from 1968-1972, stationed two and one-half years in Vietnam and Southeast Asia as an aircrew Vietnamese linguist with the Air Force Security Service.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $220,000 (estimated).

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $179,000.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $242,000.

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TESTIMONY

of

Richard Jones
AMVETS National Legislative Director

before the

Committee on Veterans' Affairs
U.S. House of Representatives

on

The Independent Budget

and

The Department of Veterans' Affairs Budget for Fiscal Year 2005

Wednesday, February 4, 2004, 10:00 AM
334 Cannon House Office Building

Mr. Chairman, Ranking Member Evans, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations at this hearing on the VA's budget request for fiscal year 2005. We are pleased to provide you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2005 programs of the Department of Veterans Affairs. AMVETS testifies before you today as a co-author of *The Independent Budget*.

This is the 18th year AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Indeed, we are proud that over 30 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality health care. Veterans must be guaranteed access to a full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans healthcare system and to the advancement of American medicine.

In addition, the budget must recognize that VA trains most of the nation's healthcare workforce. The VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The Veterans Health Administration is the most cost effective application of federal healthcare dollars, providing benefits and services at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA.

Noting the mission of the VA, it is important to understand the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must address the continuing backlog in veterans waiting for health care and it must address, as well, VA's benefits casework backlog. There are severely disabled veterans and those needing home-based healthcare in those backlogs, and I think we can all agree that this situation should be addressed and corrected.

As we look to fiscal year 2005, we watch a live lesson about the challenges inherent to inadequate funding. Due to a lack of resources, VA took action on January 17, 2003, to ban healthcare access to 164,000 veterans who could have enrolled last year. This ban remains in force, despite substantial increases in healthcare funding over the past 2 years. It is remarkable that after blocking entry to these so-called "high income" veterans, VA issued a healthcare directive (VHA Directive 2003-003, January 17, 2003) to its workers instructing them to send banned veterans to Community Social Work for assistance.

It is hoped that recently passed provisions contained in the fiscal year 2004 appropriations bill, which aim to overcome VHA Directive 2003-003, will remedy this breach of faith. When an individual commits to the defense of the rest of us, undertakes training that is inherently more dangerous than the typical civilian occupation, and stands ready to go into harm's way so that others need not, this country's gratitude should not be demonstrated with a simple referral, however courteous and sincere, to the welfare line.

Looking to the new year, *The Independent Budget* recommends Congress provide $29.8 billion to fund VA medical care for fiscal year 2005, an increase of nearly $3.1 above fiscal year 2004. We ask Congress to recognize that the VA healthcare system is an excellent investment for America. It can only bring quality health care, however, if it receives adequate funding.

We also ask Congress to understand that there are other potential challenges regarding veterans health care especially in regard to a new generation of veterans returning from Iraq, Afghanistan and the war on terrorism. By last year's count, more than 80,000 veterans who returned from the war have sought VA health care. And, it is likely the demand will remain strong for the foreseeable future. To facilitate their care, it is important that Congress work with the administration to accelerate the development of a seamless, transferable lifetime medical record between the DoD and VA.

It is also important to clearly state that AMVETS along with its IB partners strongly support shifting VA healthcare funding from discretionary funding to mandatory. Mandatory funding would give some certainty to healthcare services. VA facilities would not have to deal with the uncertainty of discretionary funding, which has proven inconsistent and inadequate. We believe that mandatory funding would provide a comprehensive solution to the current funding problem. Once healthcare funding matched the actual average cost of care for veterans enrolled in the system, with annual indexing for inflation, the VA can fulfill its mission.

The National Cemetery Administration

Before I address budget recommendations for the National Cemetery Administration, I would like members of the Committee to know that AMVETS fully appreciates the strong leadership and continuing support demonstrated by members of the House Veterans' Affairs Committee. AMVETS is truly grateful to those who serve on this important committee. Through your work, you have distinguished yourselves as willing to lead the country in addressing issues important to veterans and their families.

Since its establishment, the National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 120 national cemeteries.

Currently, the National Cemetery Administration maintains more than 2.6 million grave sites on approximately 14,000 acres of cemetery land, while providing nearly 90,000 interments annually.

VA is scheduled to open new cemeteries in Atlanta, GA; Oklahoma City, OK; Pittsburgh, PA; Detroit, MI; Miami, FL; and Sacramento, CA. Also under legislation passed last year (P.L. 108-109), VA is directed to design and construct cemeteries at six new national locations in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida.

The strong effort to build new cemeteries recognizes the dramatic increases in the interment rate of veterans, and clearly, will necessitate increases in funding if the NCA is to carry out its statutory mandates. Without the strong commitment of Congress and its authorizing and appropriations

committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

The members of *The Independent Budget* urge Congress and the administration to significantly boost NCA resources for Fiscal Year 2005. It should be recognized that not only is the interment rate increasing and the construction of new facilities accelerating, but there are repair and upgrades needed. The *Study on Improvements to Veterans Cemeteries*, a comprehensive report submitted in 2002 by VA to Congress on conditions at each cemetery, identified nearly $300 million in over 900 projects for gravesite renovation, repair, upgrade, and maintenance.

As any public facilities manager knows, failure to correct identified deficiencies in a timely fashion result in continued, often more rapid, deterioration of facilities and increasing costs related to necessary repair. The *IBVSOs* agree with this assessment and believe that Congress needs to carefully consider this report to address the condition of NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors. We recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems.

Volume 3 of the *Study* describes veterans cemeteries as national shrines saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces. "The commitment of the nation," the report says, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual…even long after the visits of families and loved ones."

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries…shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43:24 1003©)) Moreover, many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect and nurture this national treasure, the system has and continues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a

world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

The members of *The Independent Budget* recommend that Congress provide $175 million in fiscal year 2005 for the operational requirements of NCA, the national Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces. This is an increase of nearly $30 million over current year funding.

Clearly, the aging veteran population has created great demands on NCA operations. Nearly 655,000 veterans deaths are estimated in 2005 with the death rate peaking at 690,000 in 2009; of these, it is expected that 109,000 will seek burial in a national cemetery. As veteran deaths accelerate, it is obvious the demand for veterans' burial benefits will increase.

The State Cemetery Grants Program:

For funding the State Cemetery Grants Program, the members of *The Independent Budget* recommend $37 million for the new fiscal year. The intent of the State Cemetery Grants Program is to develop a true complement to, not a replacement for, our federal system of national cemeteries.

With enactment of the Veterans Programs Enhancement Act of 1998, the NCA has been able to strengthen its partnership with States and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

During fiscal year 2004, the IBVSOs anticipate fast-track openings at new cemeteries under construction: Boise, Idaho (the last State in the United States without a veterans cemetery); Wakeeny, Kansas (300 miles east of Denver and west of Kansas City, serving rural areas in western Kansas); Winchendon, Massachusetts (serving the densely populated northern part of the State); and Suffolk, Virginia (serving 200,000 veterans in the Tidewater area).

To augment support for veterans who desire burial in state facilities, members of *The Independent Budget* support increasing the plot allowance to $725 from the current level of $300. The plot allowance now covers less than 6 percent of funeral costs. Increasing the burial benefit to $725 would make the amount nearly proportional to the benefit paid in 1973. In addition, we firmly

believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

The Independent Budget veterans service organizations (IBVSOs) also request Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from $2,000 to $4,000. Prior to action in the last Congress, increasing the amount $2,000, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the nonservice-connected benefit from $300 to $1,225, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Richard "Rick" Jones
National Legislative Director

Richard "Rick" Jones joined AMVETS as the National Legislative Director on January 4, 2001. As legislative director, he is the primary individual responsible for promoting AMVETS legislative, national security, and foreign affairs goals before the Departments of State, Defense, and Veterans Affairs, and the Congress of the United States.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas; Fitzsimmons General Hospital in Denver, Colorado; and Moncrief Community Hospital in Columbia, South Carolina. At Moncrief Hospital, Rick was selected to assist in processing the first members of the all-volunteer Army.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as committee staff for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans' Affairs, he served two years as Republican staff director for the subcommittee on housing and memorial affairs and two years as Republican professional staff on funding issues related to veterans affairs' budget and appropriations.

Rick and his wife Nancy have three children, Sarah, Katherine, and David, and reside in Springfield, Virginia.

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February 4, 2004

The Honorable Christopher Smith, Chairman
House Veterans' Affairs Committee
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Smith:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the prior two years, from any agency or program relevant to the February 4, 2004, Committee hearing on the VA's budget request for Fiscal Year 2005.

Sincerely,

Richard Jones
National Legislative Director

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's CONSTRUCTION BUDGET FOR FISCAL YEAR 2005

WASHINGTON, D.C. FEBRUARY 4, 2004

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.7 million men and women of the Veterans of Foreign Wars of the U.S. and our Ladies Auxiliary, I would express our deep appreciation for being included in today's important legislative hearing to discuss the budget for the Department of Veterans Affairs (VA). As a constituent member of the Independent Budget for VA, the VFW is responsible for the Construction portion of the VA budget so I will limit today's testimony to that area.

The Department of Veterans Affairs construction budget includes major construction, minor construction, grants for construction of state extended care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund.

A historical overview of VA Major and Minor Construction clearly shows that since 1993 VA's construction budget and annual appropriations for both major and minor projects continue to drop sharply to the current low level.

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AREA CODE 202-543-2239 ● FAX 202-543-6719

While at the time of this writing we have not been provided with a copy of the President's FY 2005 budget VA recommendation for review, information available to us indicates that along with gross funding deficiencies in practically every VA account, VA construction is to be dramatically and most detrimentally short-changed as well. We look forward to working with the members of this Committee and indeed the entire congress to correct this disgraceful administration funding package for our nation's sick and disabled veterans in need.

Most unfortunately, VA construction funding has been in steady decline. The FY 1993 combined total was $600 million; however, by FY 2003, the total had decreased to only about $300 million. VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets. It also flies in the face of moral as well as statutory mandates to provide for the short and long-term care needs of our most seriously service connected veterans. It is our understanding that the administration will once again propose counting State Nursing Home Beds as part of its own long-term capacity. We view this as a disgraceful attempt to circumvent both the letter and intent of the law with a number of our most deserving and vulnerable veterans suffering as a consequence.

In a study completed in 1998, Price Waterhouse was asked to determine the spending level required to ensure that VHA's investment in facility assets would be adequately protected against adverse deterioration and to keep the average condition of facilities at an appropriate level. Price Waterhouse concluded that the VHA was significantly underfunding its construction spending, and based on their observations across the industry, appropriate annual spending should be between 2% and 4% of the plant replacement value (PRV) on reinvestment to replace aging facilities. Price Waterhouse considered reinvestment to be improvements funded from the major and minor construction appropriations. PRV for the VHA is

approximately $35 billion. The 2%–4% range would therefore equate to annual funding of $700 million to $1.4 billion

There continues to be major resistance to fund an adequate construction budget before the Capital Asset Realignment for Enhanced Services (CARES) process has been completed. We have been supportive of the CARES process from the beginning, as long as the primary emphasis is on the "ES"—enhanced services; however, we believe that it is poor policy to defer all VA construction needs until CARES is complete.

Currently, most VA medical centers, with an average age of 54 years, are in critical need of repair. Sadly, the prospect of system-wide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance, and renovations of VA facilities.

While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-term care and small size facilities. These data should include such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; the cost associated with contracting for care in the community; the cost related to shutting down and disposing of property to include asbestos removal; the cost to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements.

We acknowledge that the VA Office of Facilities Management has assembled construction cost data for various functional building types; however, the inclusion of the aforementioned cost could provide the rationale for reconsidering some decisions.

In additional, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The VFW and other IBVSOs are concerned that when CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans' access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

We recommend that Congress appropriate **$571 million** to the Major Construction Account for FY2005. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims. Allocated as follows:

Seismic Improvements $285,000
Clinical Improvements 25,000
Patient Environment 10,000
Research Infrastructure Upgrade and Replacement 50,000
Advance Planning Fund 60,000
Asbestos Abatement 60,000
National Cemetery Administration 81,000
IB Recommended FY 2005 Appropriation $571,000

We also call for the Congress to appropriate **$545 million** to the Minor Construction Account for FY 2005. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, a staff office account, and an emergency fund account. Increases provide for inpatient and outpatient care

and support, infrastructure, physical plant, and historic preservation projects. Allocated as follows:

Inpatient Care Support $130,000
Outpatient Care and Support 100,000
Infrastructure and Physical Plant 150,000
Historic Preservation Grant Program 25,000
Other 25,000
VBA Regional Office Program 35,000
National Cemetery Program 35,000
VA Research Facility Improvement and Renovation 45,000
IB Recommendation FY 2005 Appropriation $545,000

Annually, the VHA submits a list of Top 20 Priority Major Medical Construction Projects to Congress, which identifies the major medical construction projects that have the highest priority within VA. This list includes buildings that have been deemed at "significant" seismic risk and buildings that are at "exceptionally high risk" of catastrophic collapse or major damage. Currently, 890 of VA's 5,300 buildings have been classified as significant seismic risk, and 73 VHA buildings are at exceptionally high risk.

Four exceptionally high-risk seismic correction projects—Palo Alto, San Francisco, West Los Angeles, and Long Beach—were included in VA's recent budget submission; however, none of these seismic projects were funded. These four facilities have been classified as the most exceptionally high risk for catastrophic collapse or major damage.

The IBVSOs believe, as we have indicated in the past, that there is ill advised resistance to funding any major construction projects before the CARES process has been completed, and this includes correcting seismic deficiencies in VHA facilities. Regardless of the recommendations of the CARES program on facility realignments, it is our contention that VA must maintain and improve its existing facilities to support the delivery of health-care services in a risk-free environment for veterans and VA employees alike.

Most seismic correction projects should include patient-care enhancements as part of their total scope. Also, consideration must be given to enhanced service recommendations provided for CARES. Due to the lengthy and widespread disruption to ongoing hospital operations that are associated with most seismic projects, it would be prudent to make qualitative medical care upgrades at the same time.

We contend that Congress should appropriate $285 million to correct seismic deficiencies. Further VA should schedule facility improvements projects and CARES recommendations concurrently with seismic corrections.

In another area, we point to the fact that VA's health-care facility infrastructure is grossly undercapitalized. Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission of Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES, VA's construction budget continues to be inadequate.

In *The Independent Budget for Fiscal Year 2004*, we cited the recommendations of the interim report of the ***President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF)***. That report was made final in May 2003. To underscore the importance of this issue, we will cite the recommendation of the PTF again this year.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64% of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2% of plant replacement value for its entire facility infrastructure. A minimum of 5% to

8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the DOD adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

It was also recommended by the PTF that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure."

The PTF also indicated that "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within 4 years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF believes that VA must accomplish three key objectives:

> (1) invest adequately in the necessary infrastructure to ensure safe, functional environments for healthcare delivery;
>
> (2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and
>
> (3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

Additionally, it was recommended by the PTF that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels."

The VFW supports the Price Waterhouse recommendation that VA spend at least 2% of the value of its buildings or $700 million annually on upkeep. Together with the IBVSOs, we believe that $400 million should be appropriated in FY 2005 with continued increases in the following years until an appropriate level of funding that will forestall the continued deterioration of VA properties is achieved.

Congress should appropriate no less than $400 million for nonrecurring maintenance in FY 2005 to provide for adequate building maintenance. VA should direct no less than $400 million for nonrecurring maintenance in FY 2005. VA should also make annual increments in nonrecurring maintenance in the future until 2% of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

It has been suggested that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another. Although the space inventories may be accurate, the basic assumption regarding viability of space reuse is not.

Medical facility planning is a complex task because of the intricate relationships that must be provided between functional elements and the demanding technical requirements of the sophisticated equipment that must be accommodated. For these reasons, space in medical facilities is rarely interchangeable—except at a prohibitive cost. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a space deficiency in a second floor surgery because there is no functional adjacency. Medical space has very critical inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. In order to maintain these adjacencies, departmental expansions or relocations usually trigger

extensive "domino" impacts on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Some permanent features of medical space, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different technical requirements based on these permanent characteristics. Laboratory or clinical space, for example, is not interchangeable with patient ward space because of the need for different column spacing and perimeter configuration. Patient rooms need natural light and column locations that are compatible with patient room layouts. Laboratories should have long structural bays and function best without windows. If the "shell" space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more.

Using renovated space rather than new construction yields only marginal cost savings. Build out of a "gut" renovation to accommodate medical functions usually costs approximately 85% of the cost of similar new construction. If the renovation plan is less efficient, or the "domino" impact costs are greater, the small potential savings are easily lost. Renovation projects often cost more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve desirable functional adjacencies, but they are rarely economical.

Early VA medical centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most main hospitals have been consolidated into large, tall "modern" structures. Over time, these central medical towers have become surrounded by radiating wings and connecting corridors leading to secondary structures. Many current VA medical centers are built around prototypical "Bradley buildings." These structures were rapidly constructed in the 1940s and 1950s for returning World War II veterans.

Fifty years ago, these brick facilities were easily site-adapted and inexpensive to build, but today they provide a very poor chassis for a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The older hospital's wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts by contemporary standards. The Bradley hospital's central service core with a few small elevator shafts is inadequate for the vertical distribution of modern medical services.

In addition, much of the currently vacant space is not situated in prime locations. If the space were, it would have been previously renovated or demolished to clear the way for new additions. Unused space is typically located in outlying buildings or on upper floor levels. Its permanent characteristics often make it unsuitable for modern medical functions.

VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved and protected. Some space may be appropriate for enhanced use. Some may be appropriate for demolition. While it is tempting to focus on unused space, it should not be a major determinant in CARES realignments. Each medical center should develop a plan to find appropriate uses for its vacant properties.

Mr. Chairman and distinguished members of this Committee, this concludes my statement and I will be happy to respond to any questions you may have.

Dennis M. Cullinan, Director
National Legislative Service
Veterans of Foreign Wars of the United States

Dennis Cullinan was appointed to the position of Director, VFW National Legislative Service in August 1997. Before this promotion he served in a number of Washington Office positions to include several years as the Deputy Director of the Legislative Service and Director of the VFW Action Corps.

Mr. Cullinan served in the United States Navy during the Vietnam War. He was an electronics technician aboard the USS Intrepid, and completed three tours in Vietnamese waters. Following his military service he attended Catholic University in the Netherlands for two years, and then returned to his hometown of Buffalo, New York to complete his undergraduate degree at the State University of New York, where he also completed his master's degree in English.

Mr. Cullinan spent several years teaching freshmen composition and creative writing. He joined the VFW Washington Office staff in 1983 as a Service Officer Trainee with the National Veterans Service.

Active participants in a local rowing club, his wife and he reside in Lakeridge, Virginia. Dennis is a Life Member of VFW Post 7916.

The Veterans of Foreign Wars in not in receipt of any Federal grants or contracts.

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR,
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS
FY 2005 BUDGET REQUEST

FEBRUARY 4, 2004

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present the views of the 2.8 million members of The American Legion regarding the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2005 budget request. The American Legion continues to advocate adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. As America's soldiers, sailors, airmen, and Marines continue to fight in more than 130 countries worldwide, this nation must fulfill its obligation "...to care for him who has borne the battle, and for his widow and his orphan."

In the FY 2005 VA budget request, there is a continued emphasis on focusing resources for medical treatment of the *core-mission veteran population*. The term *core-mission veteran population* does not appear in Title 38, United States Code. In 1996, Congress passed VA eligibility reform legislation. It was not until 1998 that VA finally established the rules to enforce the statute. Eligibility reform ensured all eligible veterans could seek health care through VA, not simply those designated as the *core-mission veteran population*. Tailoring the veteran population to meet the budget was not the intent of Congress when it reformed access eligibility. The American Legion believes VA must be funded at a level that will ensure all eligible veterans have access to the VA health care system. The VA budget must reflect the true demand for care.

Once again, the Administration attempts to place the burden of financing VA health care on the backs of veterans. The FY 2005 budget request contains provisions that would increase prescription co-payments and create an annual enrollment fee. These legislative initiatives target those Priority Group 7 and 8 veterans who are currently enrolled in the system. At the same time, VA continues to deny enrollment of any future Priority Group 8 veterans who could help shoulder this burden. These are the very veterans required to pay VA's co-payments and make third-party reimbursements for their health care. Rationing health care to America's veterans is not the solution to VA's accessibility crisis. The American Legion supports repealing the suspension of enrollment of Priority Group 8 veterans.

We applaud the Administration efforts to alleviate co-payments for veterans receiving hospice care and former prisoners of war. The American Legion supports provisions within the budget request that would increase the income threshold from the Pensions level of $9,894 to the aid and attendance level of $16,509 for certain Priority Group 2-5 veterans. This would help reduce the pharmacy co-payment for those veterans struggling to meet the sky-rocketing cost of health care.

In addition, The American Legion supports provisions to allow VA to pay for emergency room care at non-VA facilities for enrolled veterans. This will prevent any delays in treating life threatening injuries or illnesses for enrolled veterans not in close proximity to a VA facility. During visits to VA facilities under The American Legion's "System Worth Saving" initiative, Past National Commander, Ronald Conley discovered many VA facilities operated under a "divert" policy that imperiled veterans by denying them immediate access to health care.

The American Legion is equally concerned with VA's continued efforts to create the new "VA Advantage" Medicare plan that would offer limited health care services to Priority Group 8 veterans 65 or older with Medicare Part B. Keep in mind that only nonservice-connected veterans who fall above the geographical means test and are Medicare-eligible will be considered

under this proposal. Priority Group 8 veterans who are not Medicare-eligible will simply continue to be denied access to VA medical care.

Indian Health Services and TRICARE for Life are classic examples of effective Medicare and Medicaid Federal partners. Since over half of VA's enrolled patient population are Medicare-eligible veterans, The American Legion strongly believes Congress should consider passing legislation to ensure VA is reimbursed for treatment of Medicare-eligible veterans for allowable, nonservice-connected medical conditions.

The FY 2005 budget request must provide an adequate level of funding to eliminate the backlog of veterans waiting to receive care, to meet the needs of returning servicemembers who must now receive health care from VA, and to once again allow Priority Group 8 veterans to receive timely access to quality VA medical care through the very system created to meet their unique health care needs.

THE AMERICAN LEGION'S BUDGET REQUEST FOR SELECTED DISCRETIONARY PROGRAMS FOR VA IN FY 2005

The American Legion strongly recommends Congress provide VA with the following specified funding in FY 2005:

Accounts	Budget Request
Medical Care	$30 billion*
Medical & Prosthetics Research	$445 million
Construction	
• Major	$325 million
• Minor	$255 million
State Grants for Extended Care Facilities	$120 million
State Grants for Veterans' Cemeteries	$40 million
National Cemetery Administration	$160 million
General Administration	$1.8 billion

* Third-party reimbursements should supplement rather than offset discretionary funding

VETERANS HEALTH ADMINISTRATION

MEDICAL CARE

Over the past 20 years, VA has dramatically transformed its medical care delivery system from a struggling collection of hospitals and homes to an integrated health care system of excellence that leads private and other government health care providers in almost every measure. The quality of care that is provided through the VA health care system is exemplary. However, the quality of care is irrelevant when access to that care is impeded.

Today, there are over 25 million veterans. As more veterans choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. The American Legion fully supported the enactment of Public Law 104-262, the Veteran's Health Care Eligibility Reform Act that opened enrollment in the VA health care system. Many veterans who, until this time, were restricted from VA health care in the 1980s were once again able to gain access. Veterans recognize that the Veterans Health Administration provides affordable, quality care that they cannot receive anywhere else.

The astronomical growth of Priority Groups 7 and 8 veterans seeking health care at their local VA medical facility resulted in over 300,000 veterans being placed on waiting lists regardless of

their assigned Priority Group. As mentioned earlier, FY 2003 saw the suspension of enrollment of new Priority Group 8 veterans due to this growth in enrollees. The American Legion does not agree with the decision to deny health care to veterans simply to ease the backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate budget.

The simple fact is VHA does not have the funding needed to treat all veterans seeking care from VA. VHA operates under a constant cloud of fiscal uncertainty. The FY 2004 VA appropriations battle delayed much-needed funds until more than five months into the fiscal year. Future spending projections, staffing levels, equipment purchases, and structural improvements are all stalled if the funding is not a certainty. Delayed funding means delayed services for deserving veterans who rely on VA for their care.

In an effort to provide a stable and adequate funding process, The American Legion supports mandatory funding for veterans' medical care, as well as Medicare reimbursement for VA.

MANDATORY FUNDING FOR VETERANS MEDICAL CARE

The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans. The American Legion has called for the current discretionary funding process, in which VA must compete with other agencies for scarce budget dollars, to be replaced by a mandatory funding formula for VA medical care. VA must be adequately funded to meet its own growth and end intolerable waiting periods.

For over a decade, The American Legion has advocated allowing veterans to spend their health care dollars on the health care system of their choice. The American Legion believes the VHA can efficiently expand to meet the health care needs of the men and women who have honorably served this nation in its armed forces – in war and in peace.

When Congress opened access to the VA health care system, many veterans believed VA was their best health care option and newly eligible veterans began seeking care at VA. Since the Centers for Medicare and Medicaid Services (CMS), the nation's largest public health insurance program, does not offer its beneficiaries the full continuum of care or a substantive prescription benefit program, many Medicare-eligible veterans chose to enroll in VHA specifically to receive quality health care and access to an affordable prescription program. Although the Department of Defense's TRICARE and TRICARE for Life require military retirees to make co-payments or pay premiums, they do not provide for specialized care (like long-term care) many military retirees may need; therefore, many military retirees chose to also enroll for VA care to meet their unfulfilled medical needs.

Veterans continue to suffer as a result of a system that has been routinely under funded and is now ill-equipped to handle the large influx of veterans waiting to use their services. Veterans continue to endure extensive waiting times for medical appointments, as well as unacceptably long waiting times for claims adjudication.

Funding for VA health care currently falls under discretionary spending within the Federal budget. The VA health care budget competes with other agencies and programs for limited Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

However, under mandatory spending, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing annual appropriations for the earned health care benefits of veterans.

The American Legion believes it is disingenuous for the government to promise health care to veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who unselfishly put our nation's priorities in front of their own needs. Mandatory funding for VA health care will help ensure timely access to quality health care for America's veterans.

Mandatory funding of VA medical care would not prohibit the use of other revenue streams to meet fiscal obligations, such as co-payments and third-party reimbursements from all health care insurers, both public and private.

THIRD PARTY REIMBURSEMENT AND MEDICAL CARE COLLECTION FUNDS

Public Law 105-33, the Balanced Budget Act of 1997, established the VA Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third party insurance, outpatient prescription copayments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Government.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the Treasury account, but remain within VHA and are used as operating funds. Instead, in developing a budget proposal, the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect to the VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery.

Implementation by VHA of the Revenue Cycle Enhancement Plan has a dramatic effect on the amount of revenue collected. Resuming in early FY 2002 it has resulted in significantly higher receipts than projected. VHA doubled the amount expected in FY 2004 from $1.3 billion to 2.1 billion. However, any system can stand improving and agency models are available that clearly illustrate the efficiencies that can be gained through practical application. Considering that VA is prohibited from collecting third-party reimbursements from the nation's largest health care insurer – CMS - and the vast majority of VA enrolled patient population are Medicare-eligible, VA's MCCF program has the potential of becoming even more effective in the recovery of third-party reimbursements.

MEDICARE REIMBURSEMENT TO MCCF

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

Since VA is working with CMS contractors for the purpose of providing VA with a Medicare-equivalent remittance advice (MRA) for veterans who are using VA services and are covered by Medicare, The American Legion recommends including all Medicare-eligible veterans assigned to Priority Groups 7 and 8. Under the Veterans Equitable Resource Allocation (VERA) formula, enrolled Priority Group 7 and 8 veterans are not included in the current VERA formula that ultimately results in an inequitable distribution in resources.

The FY 2005 budget optimistically projects a $2.4 billion revenue stream attributed to third-party collections, but still supports the suspension of Priority Group 8 veterans from enrolling in VA.

As The American Legion continues to visit VA facilities nationwide as part of the "System Worth Saving" initiative, we are hearing first-hand from facility leadership of the problems that exist with increased third-party collection rates. During a recent visit to a VAMC, the facility staff stated that their FY 2004 MCCF collection goal was "not realistic". They added that the goal is probably "not attainable as long as Category 7 & 8 veterans who bring in the MCCF dollars are excluded from using the system".

The American Legion recommends $30 billion for Medical Care in FY 2005 in addition to MCCF collections, as well as eliminating the MCCF offset and authorizing VA to collect

third-party reimbursements from Medicare for the treatment of allowable, nonservice-connected medical conditions.

MEDICAL AND PROSTHETICS RESEARCH

VA Medical and Prosthetic Research has a history of productivity in advancing medical knowledge and improving health care, not only for veterans, but all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The VA Medical and Prosthetic Research budget has not kept pace with inflation during the past 15 years. It is essential that Congress and the Administration support strong medical and prosthetic research programs within VA so that veterans and all citizens continue to benefit from the exceptional research capability of the Department.

The American Legion supports adequate funding for VA biomedical research activities. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans - such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others - jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $445 million for Medical & Prosthetics Research in FY 2005.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

MAJOR CONSTRUCTION

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. Buildings continue to be neglected and the persistent deterioration results in unsafe environments similar to unsanitary conditions discovered at the VAMC in Kansas City, Missouri. Of course, those that pay the price of this neglect are the veterans who are receiving care at these facilities.

A 1998 study recommended that VA fund two to four percent of Plant Replacement Value (PRV) per year to reinvest in new facilities to replace aging facilities. The conclusion of this analysis was that VA's reinvestment rate of .84 percent was significantly lower than the benchmark of two percent. This equates to hundreds of millions of dollars that conceivably could be used for major construction projects. Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse yet funding continues to be woefully short of what is actually needed to correct this problem.

The American Legion supports legislation that would provide $1.8 billion over the next three fiscal years to improve, replace, update, renovate or establish facilities within the existing VA infrastructure. These funds would be exempt from 38 USC § 8103 (a) (2) which requires enabling legislation for construction procurements in excess of $4 million or leases in excess of $600,000 per year. This money would be available at the discretion of VA for:

- Seismic protection
- Life safety upgrades
- Utility improvements
- Accommodations for disabled persons

Facilities eligible for improvements include:

- Blind rehabilitation centers

- Inpatient and residential programs for seriously mentally ill veterans and veterans with substance abuse disorders
- Physical medicine and rehabilitation activities
- Long term care including adult day care, nursing facilities and geriatric research and education facilities
- Amputation care facilities including prosthetics and orthotics and sensory aids
- Spinal cord and traumatic brain injury centers
- Women's veterans' health programs
- Hospice and palliative care facilities

The American Legion is concerned that veterans are needlessly being placed in harm way within existing VA facilities. There are over 60 patient care and other related use buildings in danger of collapse or heavy damage in the event of an earthquake. The sorely needed seismic corrections, along with the necessary ambulatory care and patient safety projects, will require a significant increase in funding to address VHA's current major construction requirements. This legislation will go a long way toward correcting these deficiencies.

The American Legion further supports legislation that would authorize the following major medical construction projects at the amounts specified:

- Construction of two bed towers to consolidate inpatient sites in inner-city Chicago at the West Side Division in an amount not to exceed $98.5 million.
- Construction in Clarke County, Nevada of a multi-specialty outpatient clinic to replace the leased Las Vegas ambulatory care center and a satellite office for the Veterans Benefits Administration in an amount not to exceed $97.3 million.
- Seismic corrections to strengthen Medical Center Building 1 at VA health Care System at San Diego, California not to exceed $48.6 million.
- Renovation of all inpatient care wards at the VA West Haven, Connecticut healthcare facility at a cost not to exceed $50 million.

The American Legion recommends $325 Million for Major Construction in FY 2005.

MINOR CONSTRUCTION

Similar to VA's major construction program, VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase is crucial.

The American Legion recommends $255 Million for Minor Construction in FY 2005.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

State Veterans Homes were founded for indigent and disabled Civil War veterans beginning in the late 1800s and have continued to serve subsequent generations of veterans for over one hundred years. Under the provisions of 38 USC, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans Homes. Today, there are 109 State Veterans Homes facilities in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. The State Veterans Home Program has proven to be a cost-effective provider of quality care to many of the nation's veterans and this program is an important adjunct to VA's own nursing, hospital, and domiciliary programs. The Grants for Construction of State Veterans Home Program provides funding for 65 percent of the total cost of building new veterans homes. VA has not been able to keep pace with the number of grant applications; and currently there is over $120 million in unfunded new construction projects pending.

Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system. The American Legion supports increasing the amount of authorized per diem payments (40 percent) for nursing home and domiciliary care provided to veterans in State Veterans Homes. The American Legion also supports the provision of prescription drugs and over-the-counter medications to State Homes Aid & Attendance patients, along with the

payment of authorized per diem to State Veterans Homes. Additionally, VA should allow for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans Home. The National Association of State Veterans Homes and VA should develop mutual planning efforts, enhanced medical sharing agreements, and enhanced-use construction contracts with qualified providers.

The American Legion recommends $120 Million for the State Extended Care Facility Grants Program in FY 2005.

NURSING HOME CARE

Except for the occasional congressional initiative to build nursing homes in individual states or congressional districts and some CARES planning initiatives, VA has no plans to expand its own nursing home capacity.

VA has failed to fulfill the promise of its landmark mid-1980's study, *Caring for the Older Veteran*. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and non-institutional bases. This has not been achieved.

The Millennium Act required VA to maintain its in-house NHU bed capacity at the 1998 level of 13,391. This capacity has significantly eroded rather than been maintained. In 1999, there were 12,653 VA NHU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9,900 beds in 2003 and 8,500 in 2004. VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act.

VA should be required to maintain its nursing home capacity as intended by Congress. VA must create incentives and receive appropriate funding to maintain its NHCU beds rather than abandon them to alternative sources. These beds are a vital component of the VA Long Term Care (LTC) continuum of care, and they are essential in addressing the needs of the aging veteran population.

According to VA's FY 2002 Annual Accountability Report Statistical Appendix, in September 2002, there were 93,071 World War II and Korean War era veterans receiving compensation for service-connected disabilities rated seventy percent or higher. The American Legion opposes provisions in the FY 2005 budget request that would reduce funding for VA nursing homes by $270.5 million and reduce staffing by 2,500 full time employees. VA should comply with the intent of Congress to maintain an adequate LTC nursing home capacity for those disabled veterans who are in the most resource intensive groups; clinically complex, special care, extensive care and special rehabilitation case mix groups. The nation has a special obligation to these veterans. They are entitled to the best care that the VA has to offer.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care, domiciliary, and outpatient mental health care needs into the future, specifically to 2012 and 2022, these critical health care services were omitted from the CARES planning. An extensive look, such as that proposed by the CARES initiative, cannot possibly be accomplished when an assessment of need for those services is missing from the process.

The Draft National Plan contains several proposals to realign campuses and consolidate services. These realignments were introduced in the eleventh hour, with no stakeholder input sought by VA. There are 13 such realignments proposed in the plan. The American Legion does not support the closing of a VA facility just for the sake of saving money while veterans are denied care.

The Draft National CARES Plan expects substantial renovations and expansions as consolidations happen. A great deal of money will have to be allocated up front to ensure the new construction and renovations are completed. The American Legion understands that CARES is an ongoing process and when dealing with vacant space and renovations, incremental changes may have to take place. The price tag for all of the construction and renovations proposed is in the billions of dollars. With the proposed consolidations and transferring of services, it is imperative that veterans not experience delays in the delivery of their care. No facilities should be closed, disposed of, or downsized until the proposed movement of services is complete and veterans are being treated in the new locations.

Funding should be provided to ensure that any realignment resulting from the CARES initiative does not lead to the suspension of services for veterans seeking care.

VETERANS BENEFITS ADMINISTRATION

Over the years, Congress has established a system of laws that provide veterans and their survivors a spectrum of the services and benefits earned by virtue of the veteran's service in the Armed Forces of the United States. Since 1938, VA has had the responsibility of implementing these laws in a pro-claimant, informal, ex parte, and nonadversarial manner. The American Legion continues to closely monitor the programs and policies of the Veterans Benefits Administration (VBA) and assess whether or not these are truly meeting the needs of veterans and their families. The American Legion has a number of concerns about the current state of claims adjudication and the level and quality of service being provided by VBA and the Board of Veterans Appeals.

The American Legion emphasizes that it is committed to ensuring that VA carries out its historic and statutory responsibility to provide medical care and benefits to those who have served and sacrificed in the defense of this nation. Veterans have the right to expect that VA will adjudicate their claims fairly and impartially within a reasonable period of time. We believe there are still too many instances where veterans and other claimants are being arbitrarily denied the benefits to which they are entitled.

Over the course of FY 2002 and FY 2003, VBA has been able to make notable progress towards realizing Secretary Principi's often stated goal of the reducing the number of pending cases down to 250,000 and cutting the average processing time down to 100 days by the end of this month. This has been a major challenge for VBA. In March 2002, at its peak, the regional offices had a backlog of over 423,000 cases that required rating action. Of these, 40 percent were over six months old. There were another 147,000 cases in which some other type of action was pending. In addition, there were approximately 107,000 pending appeals, which included over 22,000 cases that had been remanded by the Board of Veterans Appeals. In human terms, thousands of these sick and disabled veterans or their survivors were waiting a year or more for a regional office to make a decision on their claim. If the claim was denied and they pursued an appeal, their wait could extend another two to three years or more. Such delays caused increased stress as well as serious financial hardship. The American Legion has commended the Secretary for his commitment to improving the regional office claims adjudication process. Recognizing the fact that many of these backlogged claims were from elderly veterans, one of the Secretary's first service improvement initiatives was the establishment of the Tiger Team at the Cleveland VA Regional Office. This unit has been primarily responsible for expedited action on the claims of older veterans, particularly those aged 70 and older, whose cases have been pending for a year or more.

The Tiger Team initiative has been a success and they too should be commended for their efforts and dedication. However, it is regrettable that a sick and disabled veteran has to wait months, if not a year or more for action on their claim for benefits. Because of processing delays and necessity of an appeal to the Board of Veterans Appeals (the Board or BVA) or the Federal courts, many veterans have died before receiving a final decision on their case. In the view of The American Legion, the regional offices should be more concerned with people than process.

It is clear that there has been a dramatic reduction in the claims backlog in the past year and a half. This decline means that regional offices are taking less time to adjudicate claims than in the past. Last year at this time, there were some 358,000 claims awaiting final action. Of these, almost 36 percent were over 6 months old. At the end of August, VBA reported there were

about 265,000 pending claims and, of these, about 20 percent are over 6 months old. The average processing time has been reduced from 224 days in June 2002 to about 160 days currently. However, given the complexities of the claims adjudication process and requirements of the law, numbers do not tell the whole story and "faster" is not always "better."

In its annual budget request over the past several years, VBA has reported a steady decrease in claims adjudication error rate. At the end of 1997, the error rate had been 36 percent. In 1998, it was 30 percent. It increased slightly in 1999 to 32 percent. In 2000, there was a dramatic increase to 41 percent. The reported error rate declined to 22 percent in 2001. It was 20 percent in 2002 and, in 2003, it had declined to only 12 percent. The error rate goal for FY 2004 is 10 percent. Over this same period, The American Legion's regional office quality review visits do not confirm a substantial and dramatic improvement in the overall error rate.

There is little doubt that the vast majority of regional office adjudicators are dedicated, hardworking men and women. They continue to operate under tremendous stress to meet the Department's and veterans' expectations. However, The American Legion believes the effectiveness of VBA's quality improvement efforts has been severely compromised by the drive to achieve the Secretary's mandated production quotas. Veterans and other claimants are being short-changed by VBA policies and procedures that tend to promote less than adequate claims development, premature denials, and under-evaluations.

The lack of proper and appropriate action on thousands of claims continues to result in a high level of claimant dissatisfaction and a steady influx of new appeals to the regional offices. There are now over 134,000 pending appeals with some 111,500 requiring adjudicative action. Even though there is a concerted effort to resolve appeals at the regional office through the Decision Review Officer program, most of these cases will eventually go to the Board of Veterans Appeals for a final decision on the merits of the claim.

The straight line staffing level requested for FY 2004 is based on the assumption that, with the accomplishment of the Secretary's backlog reduction goals, VBA would be able to refocus its efforts to more effectively address the quality-related problems and other long-standing issues. Given past performance, The American Legion continues to believe that this is an unrealistic policy and will not afford VBA the flexibility to cope with current workload demands, let alone some unanticipated contingency, such as supporting the Department of Defense new Combat-related Special Compensation Program and the additional resources that will be required to comply with the *Huston* decision. The American Legion recognizes that VBA has made a concerted effort to hire additional staff in the last several years. This policy of continuing growth is both prudent and necessary, given the increasingly complex nature of the claims and appeals process, the heavy volume of new claims, and the ongoing need to build up the core adjudication staff in anticipation of the retirement of the more experienced regional office decision makers.

The American Legion is concerned with support in the budget request for legislation that would reverse the *Allen vs. Principi* court decision. Clearly, the intent of this proposal is to overturn the 2001 decision of the United States Court of Appeals for the Federal Circuit (the Federal Circuit or the Court) in *Allen v. Principi* 237 F.3d 1368 (Fed. Cir., 2001). The Court held that Congress, in enacting P.L. 96-466, the "Omnibus Budget Reconciliation Act of 1990" (OBRA 90), did not intend to preclude compensation for an alcohol or drug-related disability resulting from or secondary to a non-willful misconduct service-connected disability. Prior to OBRA 90, VA considered alcoholism and drug abuse disabilities unrelated to a service connected psychiatric disorder as willful misconduct. The term "willful misconduct" was defined in VA regulations as a deliberate and intentional act involving conscious wrongdoing or known prohibited action, with knowledge of or wanton and reckless disregard of the probable consequences.

However, the definition noted that the mere technical violation of police regulations and ordinances would not, per se, constitute willful misconduct unless it is the proximate cause of injury, disease, or death. VA's policy was that the misconduct bar to benefits did not apply to those veterans whose alcohol or drug addiction was secondary to a service connection mental or physical disability. OBRA 90 specifically provided in 38 U.S.C. §§ 1110 and 1131, that an injury or disease resulting from the abuse of alcohol or drugs is not considered to have been incurred in the line of duty and VA may not pay compensation for disabilities that are the result of "the veteran's own willful misconduct or alcohol or drug abuse." Under OBRA 90, VA as a

matter of policy and practice, would not grant secondary service connection for substance abuse, but would, where appropriate, incorporate the symptoms of alcohol and drug abuse into the overall evaluation of the primary service connected disability. As an example, a veteran may have been rated for "PTSD with alcoholism." In 1998, the United States Court of Appeals for Veterans Claims (CVAC), in *Barela v. West* (11 Vet. App. 280) (1998), held that, while OBRA 90 provided for service connection of alcohol and drug-related disabilities as being secondary to a service connected disability, VA could not pay compensation for such disabilities.

BOARD OF VETERANS APPEALS

The reduction in the number and the average processing time of pending claims represents only one aspect of VA's overall case backlog, since not all claims can or should be approved. When a veteran or other claimant receives an unfavorable decision either denying the claim in whole or in part, they have the right to appeal. The number of appeals filed each year is a direct reflection of the level of claimant satisfaction with the quality of the regional office adjudication. The action taken by the Board of Veterans Appeals (BVA) is a further reflection and commentary on the quality of regional office decision-making. Of those appeals decided in the first 10 months of FY 2003, the Board affirmed the decisions of the regional office only 38 percent of the time and rejected their decision in about 59 percent of the cases. Such poor performance by the regional office adjudicators is of grave concern to The American Legion, since it represents a tremendous waste of time and taxpayers' money, and a hardship for thousands of veterans and their families. Clearly, VBA's efforts to date have not effectively addressed the persistent systemic problems that adversely affect regional office claims processing and adjudication.

COURT OF APPEALS FOR VETERANS CLAIMS AND THE COURT OF APPEALS FOR THE FEDERAL CIRCUIT

The regulations and procedures of both the VBA and the BVA will be fundamentally changed by several recent court decisions. The courts have held that VA, as a matter of policy, had promulgated regulations that were misleading, basically unfair, and a violation of claimants' right to full due process.

In 2002, there was a combined effort by the Board of Veterans Appeals and VBA to try and improve the timeliness and quality of action on remanded appeals. By alleviating some of the regional offices' appellate workload, this would enable the regional offices to devote more resources to resolving previous remands and further reduce the backlog of pending claims. This initiative was prompted by the fact that remands often sat in a regional office for months or even years with little or no action taken. In many instances, the development that was done would be inadequate or incomplete and the Board had to remand the case two or three times, which meant greater delay and hardship for the appellant. Rather than sending a case back to the regional office, a unit was established within the Board to undertake the development specified in the remand decision. If the decision included a benefit grant, the unit could initiate the award, so there would be no delay in payment. The American Legion supported the intent of this service improvement effort.

In a decision early last summer, the United States Court of Appeals for the Federal Circuit held that the BVA's Development Unit was unlawful. As a result, there are about 8,000 remands plus new remands that are in the process of being transferred from the BVA Development Unit to VBA's Appeals Management Center (AMC), which is located at the Washington VA Regional Office, for further development and readjudication. While generally supportive of the effort to try and improve the handling of remands, there are problems in handling cases where the Board has awarded benefits. The lack of action by the AMC to expedite payment action has prompted several veterans to contact The American Legion for assistance. We are hopeful that appropriate steps have now been taken by VBA to ensure this type of problem does not recur. The AMC is projected to be fully staffed and operational by December 2003. In the interim, remands are being referred to the Huntington, West Virginia Regional Office and the Tiger Team in Cleveland for action. However, the prior BVA Development Unit initiative and the current AMC leave unaddressed the larger and more difficult issues relating to poor regional office decision-making, incomplete development, inadequate VCAA notices, and premature denials. Furthermore, there does not appear to be any incentive for the regional offices to improve their case development, nor is there any disincentive to keep them from certifying cases, because the

AMC have to do what they should have done. VBA must ensure that the AMC does not become a dumping ground for the regional offices.

In a system with tens of thousands of claims to be processed, there is a constant tension between management's need to have cases decided as quickly as possible and the statutory need to protect the claimant's right by ensuring that any decision made is proper and consistent with the law and regulations. For the past two and a half years, VBA management has been emphasizing speed and production volume. Under such pressure, there has been a tendency among some VBA managers and adjudicators to ignore the law and VA's own regulations and put bureaucratic convenience ahead of quality decision making and the welfare and well being of the individual veteran and his or her family.

In the opinion of The American Legion, one of the key impediments to progress on improving the quality of regional office decision making and, thereby, claimant satisfaction, has been VBA's lack of compliance with both the letter and spirit of the "Veterans' Claims Assistance Act of 2000" (PL 106-475) (VCAA). The American Legion was actively involved in the development of this landmark legislation. It was designed to overcome the deficiencies and lack of clarity in the way VBA communicated with claimants and the way in which it developed claims. It made clear the exact nature and extent of VA's obligations and responsibilities to notify and to assist claimants. The idea was that, if claims were better developed, they could be promptly and more accurately adjudicated, thereby improving service to claimants. In the long run, these improvements should also reduce the overall appeals workload for the regional offices and the Board of Veterans Appeals. It was to be a "win/win" situation for all parties. However, as we have seen thus far, VBA has generally given lip service to the requirements of VCAA.

While claimants are provided what is termed a "VCAA" letter, little time or effort goes into trying to help the individual veteran understand his or her claim and what evidence is going to be needed and who is responsible for developing it. Such letters usually lack essential information regarding the individual's claim and the evidence needed to grant the benefit sought in the particular case. These are unnecessarily long, confusing, nonspecific letters, which are filled with bureaucratic jargon. In some of the cases reviewed during The American Legion's regional office quality review visits, the information in many VCAA letters was found to be incorrect or not even appropriate to the claim. Rather than facilitating the adjudication process, as they were intended, these notice letters set the stage for an appeal to the BVA and the Federal courts.

The American Legion's concerns regarding the deficiencies in the VCAA letters have been brought to Secretary Principi's attention as well as discussed in testimony before the Veterans' Affairs Committees on a number of occasions. Despite these efforts, VBA policy on the use of this type of letter remained unchanged. However, as a result of the July 2003 decision by the United States Court of Appeals for Veterans Claims (CVAC), in *Huston v. Principi,* VBA will now be forced to comply with the duty to notify and duty to assist provisions of title 38, United States Code, sections 5103(a) and 5103A. VA will now be obligated to clearly tell the claimant what evidence to submit in order to obtain the benefits claimed. The American Legion is disappointed that it took a court order to make VBA do what it should have been doing since the enactment of the VCAA. We will be watching very closely how VBA and Board of Veterans Appeals implement the *Huston* decision. Continued strong oversight by the Veterans' Affairs Committees will also be important in ensuring the VBA is, in fact, meeting its historic and statutory responsibilities to the veterans of this nation.

GI BILL EDUCATIONAL BENEFITS

The American Legion commends the 108th Congress for its actions to improve the current Montgomery GI Bill (MGIB). A stronger MGIB is necessary to provide the nation with the caliber of individuals needed in today's Armed Forces. The American Legion appreciates the efforts that this Congress has made to address the overall recruitment needs of the Armed Forces and to focus on the current and future educational requirements of the All-Volunteer Force.

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. This is directly related to the fact that current GI Bill benefits have not kept pace with the increasing cost of education. Costs for attending the average four-year public institution, as a commuter student during the 1999-2000 academic year

was nearly $9,000. PL 106-419 recently raised the basic monthly rate of reimbursement under MGIB to $650 per month for a successful four-year enlistment and $528 for an individual whose initial active duty obligation was less than three years. The current educational assistance allowance for persons training full-time under the MGIB – Selected Reserve is $263 per month.

The Servicemen's Readjustment Act of 1944, the original GI Bill, provided millions of members of the Armed Forces an opportunity to seek higher education. Many of these individuals may not have been afforded this opportunity without the generous provisions of that act. Consequently, these servicemen and servicewomen made a substantial contribution not only to their own careers, but also to the economic well being of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Between 1944 and 1956, when the original GI Bill ended, the total educational cost of the World War II bill was $14.5 billion. The Department of Labor estimates that the government actually made a profit because veterans who had graduated from college generally earned higher salaries and therefore paid more taxes. Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only improving their career potential, but also, making a greater contribution to their community, state, and nation.

The American Legion recommends the following improvements to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify
- The educational cost index should be reviewed and adjusted annually,
- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package,
- Enrollment in the MGIB shall be automatic upon enlistment, however; benefits will not be awarded unless eligibility criteria have been met,
- The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated,
- If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay those loans,
- If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of Title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB,
- A veteran may request an accelerated payment of all monthly educational benefits upon meeting the criteria for eligibility for MGIB financial payments, with the payment provided directly to the educational institution.
- Separating service members and veterans seeking a license, credential, or to start their own business must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device,
- Eligible veterans shall have 10 years after discharge to utilize MGIB educational benefits,
- Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years from their date of separation to use MGIB educational benefits.

HOME LOAN GUARANTY PROGRAM

The American Legion believes that the current limit of VA Home Loan Guarantee of $252,500 should be raised to $300,000 and that higher limits be established for areas of the country where justified by prevailing real estate market conditions. In San Francisco, California in 2002 the median price of a home was $482,300, an actual decrease of .3 percent from 2001. In Boston, Massachusetts the median price of a home was $358,000; in the New York City Metro area, 285,600; and here in Washington D.C. the median home cost $229,100 in 2002, up 19.8 percent from $183,700 in 2001. Clearly, in these cities, the difference between many veterans being able to secure financing for a decent home for his or her family and being shut out of the market is due to the inadequate levels of the VA Home Loan Guarantee Program.

The American Legion also supports the recognition of VA Home Loan Guaranty benefits in cases where both members of a married couple are eligible for the benefit. If both members are eligible to receive the benefit, both members should be allowed to use the benefit.

The American Legion is also concerned with a provision in the budget request supporting legislation that would limit the VA Home Loan program to one-time use for military members who separate after the legislation is passed and for all current veterans five years after enactment. Veterans have earned the right to this benefit and it should not be limited to one-time usage.

The VA Home Loan program is one of the core elements of the original Servicemen Readjustment Act of 1944, the GI Bill of Rights. This legislation is often referred to as "one of the most important pieces of social legislation ever enacted." Successful participation in the VA Home Loan program should be rewarded, not restricted or terminated. Due to the transient nature of our society, many Americans may experience several relocations based on business opportunities or upgrades in their financial situations. Living the American dream of homeownership should be encouraged and promoted as continuous economic stimulus opportunity.

NATIONAL CEMETERY ADMINISTRATION (NCA)

THE NATIONAL CEMETERY SYSTEM

VA's National Cemetery Administration (NCA) is comprised of 120 cemeteries in 39 states and Puerto Rico as well as 33 soldiers' lots and monuments. NCA was established by Congress and approved by President Abraham Lincoln in 1862 to provide for the proper burial and registration of graves of Civil War dead. Since 1973, annual interments in NCA have increased from 36,400 to over 84,800. Annual burials are expected to increase to more than 115,000 in the year 2010 as the veteran population ages. Currently 59 national cemeteries are closed for casket burials. Most of these can accept cremation burials, however, and all of them can inter the spouse or eligible children of a family member already buried. Another 22 national cemeteries are expected to close by the year 2005, but efforts are underway to forestall some of these closures by acquiring adjacent properties.

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding, however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take twenty-eight years to complete. The American Legion supports the Under Secretary for Memorial Affairs in his goal of completing the NCA's National Shrine Commitment in five years. This Commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must increased to reflect the true requirements of the National Cemetery Administration to fulfill this Commitment.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or state cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

P.L. 107-117 required NCA to build six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five (Atlanta, Detroit, South Florida, Pittsburgh and Sacramento) are in various stages of completion. Additional acreage is currently under development in 10 national cemeteries, columbaria are being installed in 4 and additional land for gravesite development has been acquired at national cemeteries in 5 states. 9 national cemeteries are expected to close to new interments between 2005 and 2010. The rate of interments in national cemeteries has increased from 36,400 in 1978 to 84,800 in 2001. This rate is expected to rise to 115, 000 in 2015.

The average time to complete construction of a national cemetery is 7 years. The report of a study conducted pursuant the Millennium Bill concluded that an additional 31 national cemeteries will be required to meet the burial option demand through 2020. Legislation is currently pending in this session that will authorize the establishment of 10 new national cemeteries in areas of the country facing a shortage of burial space. Together with the 6 national cemeteries under development, this will go a long way toward fulfilling this need. NCA will be

able to keep pace with current demand for burial space if this legislation is enacted and fully funded this year.

The American Legion urges Congress to provide sufficient major construction appropriations to permit NCA to accomplish its mandate of ensuring that burial in a national cemetery is a realistic option for 90 percent of our nation's veterans.

The American Legion recommends $156 Million for the National Cemetery Administration in FY 2005.

STATE CEMETERY GRANTS PROGRAM

The National Cemetery Administration (NCA) administers a program of grants to states to assist them in establishing or improving state-operated veterans cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, the matched-funds program helps to provide additional burial space for veterans in locations where there are no nearby national cemeteries. Through FY 2002, more than $169 million in grants has been awarded to states and the Territories of Guam and the Northern Marianas, including 5 new state cemeteries and the improvement and/or expansion of 9 existing ones.

Under the Veterans Programs Enhancement Act of 1998, PL 105-261, VA may now provide up to 100 percent of the development cost for an approved project. For establishment of new cemeteries, VA can provide for operating equipment. States are solely responsible for the acquisition of the necessary land.

The American Legion recommends $40 Million for the State Cemetery Grants Program in FY 2005.

Mr. Chairman, this concludes my testimony. I again thank the Committee for this opportunity to express the views of The American Legion on VA's FY 2005 Budget Request and look forward to working with you and the members of the Committee to ensure VA is funded at a level that will allow all veterans to receive the care they have earned through their service.

Non Commissioned Officers Association of the United States of America
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STATEMENT

of

THE NON COMMISSIONED OFFICERS ASSOCIATION
OF THE UNITED STATES OF AMERICA (NCOA)

On the

FY 2005 DEPARTMENT OF VETERANS AFFAIRS
BUDGET REQUEST FOR FISCAL YEAR 2005

Before the
HOUSE COMMITTEE ON VETERANS AFFAIRS

On

February 4, 2004

Presented by

RICHARD C. SCHNEIDER
NATIONAL DIRECTOR, VETERANS AND STATE AFFAIRS

Chartered by the United States Congress

The Non Commissioned Officers Association of the USA (NCOA) would like to thank Chairman Chris Smith and the distinguished members of the Committee for the opportunity to present the Association's crystal ball glimpse of the Department of Veterans Affairs FY2005 Budget Request. We note that only eight workdays ago VA formally recognized receipt of its budget for 2004 nearly four months into its budget year. Up to that time, the VA was operating on a continuing resolution based on 2003 spending levels. Just Monday of this week the Department of Veterans Affairs (DVA) shared the Administration's 2005 Budget Request for the Department. NCOA recognizes that the Committee is correctly pursuing information from the Veteran Service Organizations, Coalitions and Others to set its strategy to provide the necessary budget emphasis within the 108th Congress to adequately execute the defined mission of the DVA. .

INTRODUCTION

NCOA as you are aware represents active duty enlisted servicemembers of all military services, the United States Coast Guard, Guard and Reserve Forces as well as veterans of all components. The association represents these members through every stage of their military career from enlistment to their eventual separation, retirement and on to their final military honors rendered by a grateful Nation. As such, the Association defines well describes its membership service as "cradle, or enlistment, to grave" and than continues to provide services to the veterans surviving family members.

The Association's representation of enlisted members from all services and components makes it unique in that regard and provides a full and comprehensive perspective on veteran and survivor issues for the Administration and this Congress.

NCOA while relying on Legislative Resolutions developed by its membership also is especially cognizant of its vital responsibilities to be in the forefront of issues impacting the large numbers of active duty, Guard and Reserve members in harm's way deployed around the world in America's War against Terrorism. Beyond the military members deployed, this association is ever mindful of their spouses and family members on the home front. These marvelous military families live with not only the heartbreak and frustration of separation but the reality of that separation when compounded with the anguish of daily televised and news reporting of personnel either killed or wounded.

THE QUESTION TODAY

What is the NCOA perspective and priorities for the FY 2005 budget appropriation for the Department of Veterans Affairs?

The answer to that question is rooted not only in prior fiscal years' inadequate appropriations but also in the increased demands for service.

Inadequate Fiscal Appropriations:

- It's important to reflect that the past nine fiscal years have been characterized by five years where fiscal growth was nearly steady state yielding an increase of less that 3 percent; followed by four years (through 2003) of notable budget growth which while significant paled in comparison to the events of a nearly completed decade in which:

  Veterans Benefit Administration
  - Benefit Claim Backlog caused extreme processing delays.
  - Significant numbers of new original claims entering the pipeline
  - High VBA employee retirement turnover; lack of hiring authority
  - Training Issue
  - Flawed technology innovations to expedite claim processes
  - Poor quality of adjudicated claims resulting in appealed decisions
  - Presumptive Findings established for Agent Orange; undiagnosed Illnesses of Persian Gulf War
  - Backlog of Claims at Board of Veteran Appeals
  - Significant numbers of Court and VBA remanded claims

  Veterans Health Administration:
  - Medical inflation far outpaced budget increases.
  - Transformation of VHA from Inpatient to Outpatient System
  - Significant reduction in Mental Health and Substance Abuse Beds and as importantly reductions in mental health professionals.
  - Reduction in VHA employees
  - Establishment of Veterans Integrated Service Networks
  - Open Enrollment allowing non-service connected (NSC) veterans access to VA health care
  - Unprecedented growth of Veterans enrolling for heath care
  - Failed expectation that most NSC veterans would have health insurance for medical care cost recovery
  - August 1997 VA authorized to retain collections from health insurers and veteran copayments at local medical centers or in regional networks which were previously returned to the Department of Treasury
  - Establishment of Community Based Outpatient Clinics
  - Health care support to End Chronic Veteran Homelessness in a Decade
  - Suspension of New Enrollment for NSC Priority 8 Veterans
  - Unsuccessful efforts to secure TRICARE and MEDICARE Subvention Funding

Increased Demands for VA Service

NCOA notes that the Department is still in the process of transformation in its efforts to best serve America's veterans. Its work to continues to optimize efficient benefits delivery, veteran access to health care, achieve performance standards in benefit claim processing, clinical/specialty appointments, and increase the availability of national and state cemeteries to meet the burial demands of an aging veteran population.

Steady progress while being achieved in the transformation of VA to meet mission and service delivery requirements takes place as large numbers of veterans return from the War on Terrorism in Afghanistan and Iraq. VA reports that already more than 83,000 returning veterans have sought health care at VA medical facilities for one or more medical conditions. Reports indicate that over 10,000 wounded active duty personnel are being released from military hospitals and as veterans will file their service connected benefit claims and concurrently begin a lifetime of health care treatment and support from VA medical facilities. These veterans are in this Association's judgment only the start of countless hundreds of thousands of active duty, Guard and Reserve personnel whose rotation this year and in the future in support of wartime contingency requirements will result in disability claim processing and health care needs. This new group of war time veterans enters the system at a time when DoD, Medical Researchers and VA are still working the issue of Undiagnosed Gulf War Illnesses of those who served in the same war theater in the early 1990s.

Also contributing to increased demands for VA services is the growing number of woman veterans applying for disability compensation and using VA health care for their medical needs. Women make up approximately 14 percent of the military force and whose utilization of VA is expected to top 10 percent in the immediate foreseeable future. Their medical needs requires logistical preparation, medical specialties, and development of quality procedures for their care. Additionally, VA is a proactive leader in the Nation's effort to eliminate Chronic Homelessness among Veterans in a decade. Their service requirement will entail claim development, appeal processes, and the full array of physical rehabilitation and mental health services. Without these systems in place their movement from the streets and alleyways to a productive life style will not be permanent. And, significant numbers of senior veterans emerge in today's VA nationwide community with the needs for nursing homes, Long Term Care, day care, hospice and other end of life support along with respite care for their family support providers.

In 2003, VA Actions recognized that:

- That the number of veterans seeking health care appointments and the continued projected growth in service-connected and NSC veterans exceeded patient services available.

  These factors are undiminished in FY 2004 and will remain prevalent in FY 2005.
- Severely disabled veterans were waiting months for primary and specialty care appointments

The system while improved still requires extraordinary efforts to serve the medical needs of all veterans.

- VA's cardiac care program was not as effective as civilian programs and required system wide change.
- Eligible veterans seeking enrollment for VA health care were waiting over a year for their required clinical appointments.
- There was a need to establish special provisions allow a window of opportunity to access VA pharmaceuticals for veterans awaiting clinical appointments who had current civilian prescriptions.
- For the second year in a row VA would have to deny new Priority Group 8 veterans from enrolling for VA health care.
- The existing potential to enroll a new Priority Group 8 - Medicare Plus Choice veteran to enroll for VA health care.
- VA had served more than 4.5 million of the over 7.2 Million veterans enrolled for VA health care.

VA has cited its FY 2004 Budget as a Record Budget. While NCOA would have preferred additional resources allocated to VA we remain confident that with the Nation fully engaged in the War on Terrorism that the FY 2005 Appropriation will be reflect significant increases to further the restoration of VA programs

The FY04 "numbers do look good" until you think about them. Among the major items are $28.4 Billion for health care projected as an increase of approximately $2.9 Billion over the previous year. Included in that number is $1.7 Billion in VA Collections (co-payments and fees paid by veterans and third party insurers for medical services and pharmaceuticals received). These Collections were originally programmed in 1997 as "retained by VA for use at local medical centers or in regional networks" to provide additional services and clinics as opposed to becoming a major offsetting segment of the annual VA appropriation. Now veterans health care copayments originally deemed to be temporary and only brought to bear because of the national deficit and budget crisis has not only been extended beyond the original sunset provision now pay the bill for the care and support of all veterans. The budget authority also provisions the transfer of over $500 Million to health care construction. The real medical budget growth appears lower than projected when adjusted for veterans paying the bill for their health care and the budget numbers allowing utilization in construction.

The VBA budget must be sufficient to fully man Regional and Satellite processing centers. Without adequate manning, training programs, and completion of transformation projects in IT and consolidation programs, VA will see claims backlogs which had significantly decreased over the fast two years begin to falter and begin to grow as the service requirements of our new war era veterans enter the system.

Also to be integrated in the current or future year fiscal programs is the initial implementation of the Recommendations of the Presidents Task Force (PTF) designed to improve the health care of the nation's veterans through joint DoD and VA initiatives and improve benefits delivery by development of an automated patient clinical health care record initiated when an individual begins military service.

The issue of Priority Group 8 Access to VA Health Care and TRICARE reimbursement to VA for DoD beneficiary health care must be resolved. Here it appears that VA's inability to guarantee a 7 day standard for clinical appointment and a standard within 30 days for specialty appointments preclude either TRICARE or Medicare Subvention Funding related to the envisioned VA Medicare plus Choice care program.

NCOA strongly recommends that VA's health care program be a mandatory funding program to guarantee veteran health care for enrolled veterans.

These financial requirements in the FY 2005 appropriation must be sufficient to continue the transformation of VA.

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

NCOA recognizes that VA Health Administration has begun to study this 21st Century approach to medicine more actively involving mental health practitioners as an active component of the healing team.

It is apparent that the VA Mental Health Program currently lacks adequate staffing to support VA clinics, substance abuse (drug and alcohol) programs, homeless veterans, rehabilitation programs, and geriatric programs. NCOA on site visits has recognized that mental health professionals have their workload distributed by specific hours to different locations in support of veterans programs. Reductions in mental health bed spaces throughout VA are a deterrent to quality health care. This Association differs with the perspective that outcomes are the same in either inpatient or outpatient settings. Homeless veterans and those suffering substance abuse problems need structured control in their environment as opposed to weekday group sessions that leave them living under bridges or associating with people with like substance problems.

The investment in mental health transformation will take years and considerable appropriated budget costs but the time and expense will result in cost savings and better total health care of veterans.

NCOA would share the additional following program priorities for the Committee of Veterans Affairs to consider for 2005.

- Further expansion of Concurrent Receipt Entitlement to veterans rated lower than 50 percent.

- Clarification on the intent of the 108th Congress relative Concurrent Receipt of DIC benefits and Military Survivor Benefits. Was the Intent of Congress to allow survivors to receive both entitlements?

- Allow DIC widow(er) who remarries after age 55 to retain DIC status and benefits.
- Authorize a one-time MGIB open enrollment opportunity be authorized for VEAP-era non-participants this year.
- Allow active drilling Guard and Reserve personnel whose MGIB benefits entitlement is expired with unused remaining benefits be granted an additional 5 years to use the benefit if activated and deployed to a combat theater.

NCOA is scheduled to present its annual legislative agenda to the Joint Session of the Committees on Veterans Affairs at which time additional membership legislation elements will be provided.

Conclusion

This Association remains confident that the Veteran Budget for 2005 will receive maximum bipartisan support and provide ample resources to care for America's veterans. We know the heart of this Nation is with our combat forces in harm's way, with the families of those killed and wounded in action. We must care for "those who have borne the battle, and their families.

Thank you for the opportunity to present this testimony.

DISCLOSURE OF FEDERAL GRANTS AND CONTRACTS

The Non Commissioned Officers 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.

BIOGRAPHY

of

Richard C. Schneider
National Director of State/Veterans Affairs

Mr. Schneider is the National Director of State/Veterans Affairs, Non Commissioned Officers Association of the United States of America. His responsibilities include executive management of all NCOA programs that support America's veterans. These include service transition, employment, benefit rights and adjudication processes. He directs 473 NCOA Veteran Service Officers located in the United States and overseas. Additionally, he provides legislative focus for 46 NCOA State Legislative Coordinators, which represent NCOA in State Legislative Affairs. Mr. Schneider concurrently serves as the Executive Director of the NCOA National Defense Foundation. In this capacity, he is responsible for the Association's Voter Registration Program including the operation of the National Voter Registration and Information Center in cooperation with the Department of Defense. He also serves as Executive Director of the NCOA National Defense Foundation which benefits veterans of America's Uniformed Services and other Foundation designated humanitarian outreaches.

Mr. Schneider was born in New Jersey. He was raised in the Garden State attending elementary and secondary schools in Lyndhurst. He has a Bachelor of Science from the University of Southern Colorado (1972) and a Master of Arts from the University of Northern Colorado (1974).

He serves on the following Councils and Committees:

Department of Veterans Affairs:
- Secretary's Advisory Committee on the Readjustment of Veterans
- Secretary's Advisory Committee on Homeless Veterans

Department of Labor:
- Secretary's Advisory Committee on Veterans' Employment and Training
- National Veteran Service Organizations
- Chairman, Veterans Organization Homeless Council, Washington DC

He served in the United States Air Force from August 1957 to September 1990. Mr. Schneider retired in the grade of Chief Master Sergeant. He held significant assignments in management and personnel planning throughout his military career. His military decorations include the Legion of Merit, the Meritorious Service Medal with two Oak Leaf Clusters and the Air Force Commendation Medal with four Oak Leaf Clusters. His overseas assignments have included: England, Scotland, Republic of Vietnam, and Germany

He is currently the Secretary, Board of Directors, Pentagon Federal Credit Union, Alexandria, VA.

Mr. Schneider is married to the former Anne Ferguson of Prestwick, Ayrshire, Scotland. They have four children: three daughters, Kristin, Leslie, and Fiona; and a son, Richard.

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STATEMENT
of
THE MILITARY COALITION
on the
FY 2005 Department of Veterans Affairs
Budget Request

February 4, 2004

Presented by

Colonel Robert F. Norton, USA (Ret.)
Deputy Director, Government Relations
Military Officers Association of America

Co-Chair, Veterans Committee
The Military Coalition

Master Sergeant Morgan Brown, USAF (Ret.)
Legislative Assistant
Air Force Sergeants Association

Co-Chair, Veterans Committee
The Military Coalition

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE, on behalf of The Military Coalition, a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful for this opportunity to express the Coalition's views on the FY 2005 Department of Veterans Affairs Budget Request. This testimony provides the collective views of the following organizations, which represent 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

- Air Force Association
- Air Force Sergeants Association
- Air Force Women Officers Associated
- American Logistics Association
- AMVETS (American Veterans)
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
- Commissioned Officers Association of the U.S. Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Gold Star Wives of America, Inc.
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Association
- Military Chaplains Association of the United States of America
- Military Officers Association of America
- Military Order of the Purple Heart
- National Association for Uniformed Services
- National Guard Association of the United States
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Naval Reserve Association
- Navy League of the United States
- Non Commissioned Officers Association
- Reserve Officers Association
- The Retired Enlisted Association
- The Society of Medical Consultants to the Armed Forces
- United Armed Forces Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars
- Veterans' Widows International Network

The Military Coalition, Inc., does not receive any grants or contracts from the federal government.

Biography of Robert F. Norton, COL, USA (Ret.)
Deputy Director, Government Relations, MOAA
Co-Chair, Veterans' Committee, The Military Coalition

A native New Yorker, Bob Norton was born in Brooklyn and raised on Long Island. Following graduation from college in 1966, he enlisted in the U.S. Army as a private, completed officer candidate school, and was commissioned a second lieutenant of infantry in August 1967. He served a tour in South Vietnam (1968-1969) as a civil affairs platoon leader supporting the 196th Infantry Brigade in I Corps. He transferred to the U.S. Army Reserve in 1969 and pursued a teaching career at the secondary school level. He joined the 356th Civil Affairs Brigade (USAR), Bronx, NY and served in various staff positions from 1972-1978.

Colonel Norton volunteered for active duty in 1978 and was among the first group of USAR officers to affiliate with the "active Guard and Reserve" (AGR) program on full-time active duty. He specialized in manpower, personnel, and quality-of-life programs for the Army's reserve forces. Assignments included the Office of the Deputy Chief of Staff for Personnel, Army Staff; advisor to the Asst. Secretary of the Army (Manpower & Reserve Affairs); and personnel policy and plans officer for the Chief, Army Reserve.

Colonel Norton served two tours in the Office of the Secretary of Defense (OSD). He was responsible for implementing the Reserve Montgomery GI Bill as a staff officer in Reserve Affairs, OSD. From 1989 –1994, he was the senior military assistant to the Assistant Secretary of Defense for Reserve Affairs, where he was responsible for advising the Asst. Secretary and coordinating a staff of over 90 military and civilian personnel. During this tour, Reserve Affairs oversaw the call-up of more than 250,000 National Guard and Reserve component troops for the Persian Gulf War. Colonel Norton completed his career as special assistant to the Principal Deputy Asst. Secretary of Defense, Special Operations / Low Intensity Conflict and retired in 1995.

In 1995, Colonel Norton joined Analytic Services, Inc. (ANSER), Arlington, VA as a senior operational planner supporting various clients including United Nations humanitarian organizations and the U.S. Air Force's counterproliferation office. He joined MOAA's national headquarters as Deputy Director of Government Relations in March 1997.

Colonel Norton holds a B.A. in philosophy from Niagara University (1966) and a Master of Science (Education) from Canisius College, Buffalo (1971). He is a graduate of the U.S. Army Command and General Staff College, the U.S. Army War College, and Harvard University's Senior Officials in National Security course at the Kennedy School of Government.

Colonel Norton's military awards include the Legion of Merit, Defense Superior Service Medal, Bronze Star, Vietnam Service Medal, Armed Forces Reserve Medal, Army Staff Identification Badge and Office of the Secretary of Defense Identification Badge.

Colonel Norton is married to the former Colleen Krebs. The Nortons have two grown children and reside in Derwood, Maryland.

Biography of Morgan D. Brown, MSgt, USAF (Ret.)
Legislative Assistant
Air Force Sergeants Association
Co-Chair, Veterans' Committee, The Military Coalition

MSgt (Ret.) Morgan D. Brown is the Legislative Assistant for the Air Force Sergeants Association. Born and raised in Belmont, NY (Allegany County), he graduated from Belmont Central High School in June, 1981. After graduation he entered the United States Air Force and completed Basic Military Training, Law Enforcement Specialist training, and the Military Working Dog (MWD), Patrol Dog Course, all at Lackland AFB, Texas.

In 1982, he was assigned to Clark AB, Republic of the Philippines, where he served as an MWD handler and trainer. In January, 1985, he was reassigned to Cannon AFB, NM, and performed duties as a Law Enforcement Patrolman, Narcotic Detector Dog Handler, Explosive Detector Dog Handler, and Assistant NCOIC, Quality Control. In 1988 he was reassigned to Clark AB for a second time, serving in a variety of leadership positions, including Superintendent of the largest MWD kennel in the United States Armed Forces. During this tour, MSgt Brown played a key role in ensuring the safety of over 200 personnel and nearly 170 MWDs during the eruption of Mt. Pinatubo which destroyed the base in 1991.

In 1992, he was assigned to Griffiss AFB in upstate NY where he served as Kennelmaster until 1995 when he was selected for Presidential Support Duty at Andrews AFB, MD. From 1995 through 1998, he managed all MWD operations in support of Presidential and VIP operations on Andrews AFB. He was appointed Superintendent of the Airmen Orientation Center in 1999, and taught courses to nearly 500 first term-first duty station airman on general Air Force and Andrews AFB policy. During the same year, he volunteered to be retrained as a First Sergeant and graduated from the First Sergeants Academy at Maxwell AFB, AL, in August 1999. He was then assigned to the 789 Communications Squadron, Andrews AFB, MD, serving in this position until his retirement in 2002.

After retirement, MSgt Brown accepted his current position with the Air Force Sergeants Association and serves as one of AFSA's representatives on legislative matters to the White House, Congress, DoD, Air Force, other government agencies, and other associations. He has a Associates of Applied Science from the University of Health Sciences, Texas. His decorations include the Meritorious Service Medal with two oak leaf clusters, the Air Force Commendation Medal with three oak leaf clusters, and the Air Force Achievement Medal with three oak leaf clusters.

Morgan is the single parent of one son, Anthony, age 15.

VETERANS HEALTH CARE

Demand for VA health care continues to outstrip available capacity. Only by locking out Priority 8 veterans – a policy entering its second year – and by employing other workarounds, has management been able to reduce waiting times in high-demand areas. Presently, there are about seven million veterans enrolled in VA care and nearly five million veterans sought care in the system in 2003.

In examining the Administration's budget request for veterans' health care in FY 2005, the Coalition believes that the Committee should address the following concerns:

Presidential Task Force (PTF) Recommendations. TMC is disappointed that the Administration has not taken more aggressive action to implement the recommendations of the President's own task force to improve delivery of health care for our nation's veterans. The PTF recommended that Congress provide full funding for all veterans enrolled in Priority Groups 1-7 and to resolve the situation of Priority 8 veterans' care. Sadly, however, it appears that little attention has been paid to this fundamental recommendation in the PTF Report. No legislation has been sent up to establish full funding for enrolled veterans – either by a mandatory mechanism or some other means -- and the future care of locked out Priority 8 veterans is still unresolved.

The Military Coalition recommends that the Committee and Congress take up the PTF Report recommendations and establish a sustainable full-funding mechanism in law and resolve Priority 8 veteran access and funding.

Other health care funding issues that should be addressed include:

- *VA access standards.* TMC pointed out during the PTF commission's deliberations that true collaboration between the DoD and VA health systems could not occur unless the VA were able to meet TRICARE access standards. In the TRICARE system, routine appointments must be scheduled within seven days and specialty care within 30 days. The VA could meet the PTF's recommendation for full funding for veterans enrolled in PG 1-7 if Congress ratified VA's own access standards in law and required funding to those standards. Since the VA is a recognized national leader in quality-of-care, patient safety programs and other measures of excellence, it stands to reason that it should be required to meet its own access standards. Quality without access is not true quality-of-care. ***TMC strongly recommends that the Committee direct and fund adoption of VA health care access standards similar to those of the TRICARE program.***

- *Returning Veterans.* VA recently released information showing that as of last fall, nearly 84,000 veterans who had returned from Afghanistan and Iraq had sought care in VA facilities for one or more conditions. Almost 60,000 of these returning veterans were from the National Guard and Reserve forces. With the largest troop rotation since World War II now underway, the VA is likely to experience continuing strong demand for its services from this new generation of veterans. The question is whether the VA is fully resourced to meet the new demand as well as to care for its growing geriatric population with its own special needs. TMC commends the VA policy that permits Guard and Reserve veterans of designated military campaigns to have initial access to VA health care without regard to a priority group determination; that is, they are nominally assigned to Priority Group 6 during the first two years of their care in a VA facility. ***TMC strongly recommends that the Committee ensure the health care needs of returning veterans be fully funded, including any needed upgrades for specialty care services such as family counseling and clinical services for PTSD.***

- *"Seamless, transferable medical records".* A new generation of veterans resulting from the Afghanistan – Iraq war highlights the importance of accelerating development of DoD – VA plans to seamlessly transfer medical information and records between the two federal departments. TMC appreciates the leadership of Representatives Steve Buyer (R-IN) and Darlene Hooley (D-OR) for holding an Oversight and Investigations Subcommittee hearing on this issue last November. Current plans call for implementing records transfers "seamlessly" by 2006 or 2007 at the earliest. Yet, as pointed out at the hearing, the technology already exists to accomplish the goal. In a time when the United States has two robots exploring the surface of Mars, it should not be too much to ask for the government and Congress to provide the funding and oversight to accelerate fielding this initiative. A lifetime service medical record could help veterans obtain early, accurate and fair VA disability ratings, and facilitate pre- and post-deployment research that will advance standards of care. ***TMC strongly recommends accelerated funding for the development of a "seamless, transferable, lifetime medical record" for service men and women and investment in supporting information management / technologies for the two departments.***

- *Preserving Access to Earned Health Benefits – no "forced choice".* TMC appreciates the leadership shown by Congress in protecting dual-eligible veterans' access to all earned health care benefits. Dual-eligible veterans are military retirees whose careers of service to the nation entitles them to lifetime health coverage under TRICARE and eligibility for enrollment in VA health care. However, some government officials believe that military retired veterans should be compelled to relinquish one health benefit or the other, a concept we call "forced choice." A better solution is to develop effective reimbursement procedures between DoD and VA, and we note some progress in this area by the DoD – VA Health Executive Council. Agency-level coordination mechanisms must be designed in ways that foster budget coordination and reconciliation without placing the burden or the blame on the backs of those who have earned dual-access to VA and DoD health care services. ***TMC appreciates Congress' continued support in opposing "forced choice" proposals that would compel dual-eligible veterans to relinquish access to either DoD or VA-sponsored health care services.***

- *VA 'CARES' and DoD Facilities Planning Processes.* DoD and VA together have identified 60 sharing initiatives at the facility level; DoD has earmarked 20 of these projects as "priority" initiatives. Moreover, as a consequence of a requirement in the FY 2003 National Defense Authorization Act, VA and DoD announced in October 2003 a series of eight demonstrations to test improving business collaboration in the participating health facilities. It is not clear whether any of these projects correlate with outcome measures in the VA's Capital Asset Realignment for Enhanced Services (CARES) program or the DoD's preparation for the next round of base realignment and closure (BRAC) process. In any case, TMC maintains that these projects must include as an outcome measure the enhancement of service to eligible veterans and servicemembers. ***TMC urges the Committee closely monitor VA-DoD facilities' collaboration and to judge sharing projects on whether they improve access and quality of care for all eligible beneficiaries.***

- *Resolving Priority Group 8 Access and Funding.* More than a year ago, the VA announced a plan to establish a "Medicare + Choice" plan for certain Medicare-eligible veterans with no disabilities and incomes above a zipcode-based means-test – Priority Group 8 veterans. TMC endorsed the proposal before this Committee last February. But we pointed out the inconsistency in access standards between Medicare + Choice plans and the VA. If Medicare access standards were to be met for the Medicare + Choice plan participants, then the VA should be resourced to meet the same standards for all other enrollees. TMC also noted that Medicare + Choice plans have not been well received in the private sector. Notwithstanding those caveats, TMC continues to endorse the concept of authorizing Medicare reimbursement – VA subvention – in VA facilities. In addition, TMC continues to support allowing all Medicare-eligible veterans to be able to choose the VA as their Medicare provider for non-service connected care. At the end of the day, TMC believes that VA Medicare Subvention will save the government money, enhance access to care for our nation's older veterans, and enable the VA to improve the coordination of care for these veterans. ***TMC recommends the Committee support adequate funding for the VA Medicare + Choice plan. TMC continues to support Medicare reimbursement for non-service connected care for all enrolled Medicare-eligible veterans.***

VETERANS BENEFITS

Disability Claims Backlog and Process Improvement. TMC commends the Veterans Benefits Administration for substantial progress in reducing the unacceptably high numbers of backlogged disability claims. VBA recently announced that it had reached a steady state of 250,000 claims in progress. There have also been some notable improvements in the average time to process an initial claim. That being said, TMC believes that more can and must be done to continue the progress made to date and to prevent against slippage. TMC believes the key to sustained improvements in claims processing rests on adequate funding to attract and retain a high-quality workforce of claims-workers supported by investment in information management and technology.

TMC strongly recommends adequately funding the Veterans' Benefits Administration to meet its manpower, training, and IM / IT requirements in order to sustain ongoing improvements in reducing the claims backlog.

Retention of Dependency and Indemnity Compensation (DIC) for Remarried Spouses. TMC commends this Committee and Congress for legislation last year to allow retention of DIC for eligible surviving spouses who remarry after age 57. TMC strongly endorses the view that Congress intended for remarried spouses with military Survivor Benefit Plan (SBP) annuities to be allowed concurrently to receive their earned SBP benefits and the DIC payments related to their sponsor's

service-connected death.

TMC thanks the Committee for the Age-57 DIC remarriage provision and strongly recommends that it be reduced to age-55, in line with ALL other Federal survivor benefit programs.

Restoring Selected Reserve GI Bill Benefits (Chapter 1606, Title 10 USC). More than 350,000 National Guard and Reserve servicemembers have been mobilized since September 11, 2001, and many thousands are now preparing to deploy to Iraq. Many of these troops are part or full time students, but their benefits have not kept pace, proportionately, with recent increases in basic education benefits under the Montgomery GI Bill (MGIB) authorized in Chapter 39, Title 38 USC.

Only two benefit increases have been legislated in the Chapter 1606, Title 10 USC program since its inception in 1985 (other than cost-of-living increases). In 1985, Reserve MGIB rates were set at 47% of active duty MGIB rates. The 47% ratio held steady and even increased slightly over the next 14 years until the late Nineties. With the final installment of a three-step increase in Chapter 30 benefits last October, Reserve benefits fell to about 29% of the Chapter 30 rate, $282 compared to $985 per month for full-time study. To restore proportional parity, Reserve rates should increase to $463 per month for full-time study under Chapter 1606.

TMC recommends that the Committee support stairstep increases to the Reserve MGIB authorized under Chap. 1606, Title 10 USC, in three increments of $77 over the next three years to restore proportional parity with basic MGIB benefits. For the longer term, TMC believes that the Reserve MGIB authority, other than the Reserve "kickers" authority, should be incorporated into Title 38.

MGIB Enrollment Window for VEAP-decliners. Active duty career servicemembers who entered service during the Veterans Education Assistance Program (VEAP) era (1 January 1977 - 30 June 1985) but who declined to take it are the only group of currently serving members – other than service academy graduates and certain ROTC scholarship recipients -- who have not been offered an opportunity to enroll in the Montgomery GI Bill (MGIB). There are about 90,000 currently serving members in this situation. Many were told by service officials to turn down VEAP enrollment when they entered service because the "new GI Bill is coming". These are the NCOs and officers who are leading our younger troops in battle in Afghanistan and Iraq, taking the fight to those who would threaten our nation's homeland. Yet these career servicemembers soon will exit the service with no education benefits to help them achieve their post-service goals like all other veterans.

The last VEAP "conversion" program for those with a VEAP account yielded an extremely low "take" rate and the cost to the government was minuscule compared to budget estimates. Because VEAP "decliners" can expect to pay a sizable MGIB enrollment premium, TMC believes that few will take advantage of it. But at least these American heroes should have the option to take the MGIB or leave it on the table.

TMC recommends the Committee authorize a MGIB sign-up window for career servicemembers who declined VEAP when they entered service.

Benchmarking MGIB Benefits. Basic MGIB benefits authorized under Chapter 30, 38 USC will account for only about 63% of the average cost of a four-year public college or university for academic year 2003-2004. Next year, a veteran can expect to pay on average about $1690 per month for full-time study at a four-year public college or university (according to Dept. of Education data) but receive just $985 in MGIB benefits. Since the majority of veterans are married when they separate, it is increasingly difficult for them to achieve their educational and training goals absent an education and training benefits package that keeps pace with inflation.

As members of The Partnership for Veterans Education, TMC members continue to support the goal of tying future MGIB benefit increases to a recognized government index of the average cost of a four-year public college or university education.

Concurrent Receipt (CR) and Combat Related Special Compensation (CRSC). The Military Coalition applauds Congress for the landmark provisions in the FY 2004 National Defense Authorization Act that expand CRSC to all retirees with combat-related disabilities and authorizes -- for the first time ever -- the unconditional concurrent receipt of retired pay and veterans' disability compensation for retirees with disabilities of at least 50 percent. Severely disabled retirees everywhere are extremely grateful for this legislation that reverses an unfair practice that has disadvantaged them for over a century.

The Coalition has long held that retired pay is earned compensation for completing a career of arduous uniformed service while disability compensation from the Department of Veterans Affairs is paid for loss of function and future earning potential caused by a service-connected disability.

While last year's concurrent receipt provisions will benefit tens of thousands of severely disabled retirees, an equal number were left behind. The fiscal challenge notwithstanding, the principle behind eliminating the disability offset for those with disabilities of 50 percent is just as valid for those with disabilities of 40 percent and below and the Coalition urges the Committee to do what it can to extend this principle to the thousands of disabled retirees who were left out of last year's legislation.

We understand that a significant concern among some lawmakers that prevented broader concurrent receipt action was the need for a review of the VA disability system. The Coalition believes much of the concern is misplaced, and we are confident that the VA disability rating system will be judged fair and equitable.

TMC supports the Veterans Disability Benefits Commission established in last year's defense authorization. Congress established the Commission to carry out a study of the benefits under law that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. TMC stands ready to assist the Commission and participate in the debate with relevant information and data affecting the full spectrum of disabled veterans and their families and survivors.

The Military Coalition urges the Committee to ensure that the Veterans' Disability Benefits Commission focus on the fundamental principles that have served as the foundation for both the DoD disability retirement system and VA disability compensation processes -- principles of fairness, due process, and the unique aspect that military service is "24/7." We look forward to completion of the review and revalidation of the process as important steps toward resolving the remaining concurrent receipt inequity.

On a related front, legislation provided in the last two defense bills to authorize Combat Related Special Compensation (CRSC) has been slow in implementation because of the requirement to connect retiree disabilities directly to combat, a combat-related event, or combat-type training. This validation requires the Services to retrieve VA medical records - a process that is slow and cumbersome. It is unfortunate that many qualifying retirees are still waiting, some as long as eight months, for the compensation that was authorized by the FY 2003 defense bill. These combat-disabled retired veterans should have received far better treatment.

The Military Coalition urges the Committee to ensure adequate funding for the administration of the Veterans' Disability Benefits Commission; additional resources as may be necessary for VA to support timely DoD review of CR / CRSC applications; and, we strongly recommend ultimate elimination of the retired pay offset for all disabled retirees.

Conclusion

The Military Coalition greatly appreciates the opportunity to present our views on funding priorities for the administration's FY 2005 budget submission for the Department of Veterans Affairs. TMC is very appreciative of the strong support provided to servicemembers and veterans last year and we look forward to working with the leadership of the Committee and its distinguished members to ensure full funding for veterans health care and benefits programs.

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

Statement
Of

VIETNAM VETERANS OF AMERICA

Presented by

Richard F. Weidman
Director, Government Relations

Before the

House Committee on Veterans' Affairs

Regarding
The President's FY 2005 Budget Request
For the
U.S. Department of Veterans Affairs

334 Cannon House Office Building
Washington, D.C.

February 4, 2003

Mr. Chairman, on behalf of Vietnam Veterans of America (VVA) and our National President Thomas H. Corey, I thank you and your distinguished colleagues for the opportunity to present our views with regard to the President's proposed FY 2005 budget for the Department of Veterans Affairs (VA) to provide vitally needed health care to our nation's veterans.

VVA holds that the essence and purpose of the VA medical system is literally what is stated in the VA's motto, "To care for him who hath borne the battle, his widow and his orphan." Regrettably, the budget proposed for FY 2005 makes a mockery of President Abraham Lincoln's words.

VVA believes that the VA requires an increase to at least $31.31 billion in "hard" appropriated dollars for FY 2005 for the Medical Care account alone in order to keep pace with even the most conservative estimate of medical inflation. That would be an increase of $1.81 billion in the Medical Care account, exclusive of third party collections, over what the Veterans Health Administration (VHA) has acknowledged was really the amount ($28.5 billion) needed for minimal operation of the veterans health care system for all statutorily eligible veterans for FY 2004. This would match the estimated 6% increase in medical inflation projected by the Center for Medicare and Medicaid Services (CMMS) of the Social Security Administration for FY 2005.

In addition, VVA strongly believes that VHA needs a minimum of $1 billion added to the Medical Care account to be devoted solely to the restoration of organizational capacity in mental health care staff, as well as core staff in other "specialized services," acute care, and areas such as Hepatitis C. This investment is needed now if the veterans health care system is to even begin to meet its statutory mission in the future. For all of the VHA, including Medical and Prosthetic Research and Medical Administration and Miscellaneous Operating Expenses, VVA believes that a total of $31.4 billion for FY 2005 is not only warranted, but necessary.

VVA, like many of our colleagues in the veterans' service organization community, enthusiastically endorses the Independent Budget of the Veterans Service Organizations (IBVSO). While VVA estimates a larger figure for the Medical Care account, we concur on virtually every other cost estimate rendered by IBVSO.

As the distinguished Members of this panel know, VVA last July published a "White Paper: The Position of Vietnam Veterans of America on Health Care Funding for All Veterans" (accessible on the web at http://www.vva.org/legiss/white paper.pdf). Graphs in this document used the extremely conservative inflation figures for Medicare to show that, on a per capita basis, funding for the VHA Medical Care account lags woefully behind even that very under-funded program. Extending that same methodology, had veterans health care funding simply kept pace with Medicare, on a per capita basis, since 1996, we should have expected a request from the President for FY 2005 of approximately $38 billion for the Medical Care account alone. This is what we mean we speak of the eroded funding base. This problem did not start with this Administration, yet three years into this Administration's watch, the problem of the eroded funding base has not been addressed, much less resolved.

By comparison to what is really needed, the President's request of $27.052 billion is inadequate for the full and proper operation of the veterans health care system even if it were restricted to only Priority 1-6 veterans, whose numbers have increased significantly since 1996 (actually more than Categories 7 & 8).

As in past years, VVA believes strongly that the vitally needed funding increases noted above must be accompanied by management systems improvements and reforms. We are referring to a financial tracking system in which statements of accounts allow for tracking expenditures of specific fields and areas of interest (e.g., Hepatitis C). We also maintain that it is long overdue for the VA to establish a real-time Management Information System that can inform the Secretary and his top aides precisely what resources are available where at any given time. These tools must be developed and implemented to track essential data, even if Congress has to mandate creation and proper maintenance of such tools.

VVA also maintains that there must also be significantly greater accountability for performance from senior managers. This must be enforced with sanctions as well as bonuses. In this area, much more needs to be done if the system is to be responsive to the needs of the veterans it serves.

Most Americans believe that health care for veterans is a government obligation to those men and women who stepped forward to defend the freedoms we hold dear. A new generation of Americans now bears the burden of defending our country. We must keep faith with their dedication by making anew the commitment to ensure that the funding to care for their injuries and disabilities is not relegated to a discretionary outlay by the nation they have sworn to defend.

Budgets, of course, are a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does the "discretionary" funding proposed for FY 2005 for the care of men and women who have defend this country say about America? We know what the proposed budget for veterans' health care says. What will be the answer that Congress gives to this proposal? VVA believes that you in Congress must resoundingly say that this proposal is not nearly adequate enough for the men and women who serve in harm's way today, nor for those men and women of previous generations who hath borne the battle defending our Constitution in years past.

Last January, VVA defended the Secretary of Veterans Affairs when, faced with dire fiscal realities, he created a new Category 8 for prioritizing medical care at the VA and "temporarily" suspended new enrollments of veterans in that category. Triage is hard. I had to do triage as an Army medic in Vietnam. It was the hardest thing I have ever had to do. The Secretary then had the political courage to take what appeared to be the only proper choice under the circumstances. The question we all asked at the time was: How did it come to pass that Secretary Principi, who cares deeply about the veterans he serves, felt he had to take such an action?

America's veterans should not have to be triaged.

To our surprise, within a month VA projections for services through the year 2023 made the assumption that Priority 8 veterans would be denied access to the health care system. The reaction

of the VVA leadership was, and is, that that is some heck of a "temporary" suspension! Triage is a short-term ordering of resources to save lives. Denial of access to medical care for twenty years is not triage but a flat-out denial of medical care to those who have been declared by you in Congress as eligible to receive such care. VVA now believes that others in the Administration took the Secretary's temporary move as a *de* facto opening to violate the intent of the law and permanently deny ever more veterans health care which they earned by virtue of their military service and for which they are statutorily eligible.

If it is the intent is to alter the eligibility of veterans to access VA health care as defined by the 1996 eligibility law, then the only proper way to do that is for the Administration to ask for Congress to change the law. If that is the intent, then let the Administration make the proposal openly and honestly. Then let us have a free and open debate, so that our elected representatives can hear from the American people and decide what course of action to take. VVA does not anticipate, though, that such a proposal will be advanced through the front door. Rather, it is our fear that this backdoor undermining of the VA health care system will continue so long as Congress permits this *de facto* change of eligibility to continue.

VVA believes, and we know that most of the distinguished Members of this Committee believe, that as a nation we can and must do better to provide proper funding for the veterans health care system than we have done. Our nation's veterans have been shortchanged despite laudatory efforts by the leadership on both sides of the aisle on this Committee, and by the efforts of many other friends in Congress. VVA is deeply grateful to you for the political and moral courage you have exhibited in the last year. Without your efforts, the situation could be much more dire than it is. Yet, here we are again.

To fix the system, we believe that a method of funding the VA's medical operations that removes it from the vagaries and uncertainties of the shrinking discretionary budget must be instituted. To this end, VVA is proud to be a member of the Partnership for Veterans Health Care Budget Reform, which for the first time has the major veterans service organizations on the same page on the issue of funding for the veterans health care system. VVA is in full support of legislation that will provide full mandatory health care funding. We look forward to working closely with the Members of this Committee toward achieving such funding reform this session of this Congress.

As was amply demonstrated in the "White Paper: The Position of Vietnam Veterans of America on Health Care Funding for All Veterans," the resources appropriated to the VA to treat veterans is eroding, even when measured against funding for Medicare (which is itself grossly under-funded). It appears to be impossible to close the structural funding gap that has eroded the funding base through the ordinary budget process, considering that we are more than $8 billion short in this regard. Therefore, we believe the only way to restore the system to viability is to make VA health care funding mandatory, on a per capita basis, indexed to medical inflation.

VVA recently took the extraordinary step of filing suit in Federal District Court against the Secretary of Veterans Affairs to cease and desist restrictions imposed on outreach. This was a very difficult step for us, as our leadership holds this Secretary in particularly high regard. We know the Honorable Anthony J. Principi to be a man of real integrity and deep commitment to the individual

veteran who needs assistance. He has a distinguished record of service to country in both military and civilian life. This was, therefore, a step taken with great reluctance in an attempt to ensure that the need to inform veterans of their rights to medical care and other vital services is being met. Had the VA system been properly funded, it is unlikely that VVA would ever have to resort to redress by the Court, particularly given the leadership of Secretary Principi.

Denial of information about services and care available to veterans is effectively denial of those services and that care. Much has been made about the putative distinction (which eludes us) between "marketing" of veterans' health care and other vitally needed services, and "outreach" to veterans to inform them of the health care and other services which they are eligible to receive. What has happened since a memorandum was issued by the VHA last February is that activities to inform veterans have been significantly curtailed, no matter what nomenclature one wishes to use to describe those activities.

The day before VVA filed suit on January 22, 2004 (and before our final decision to proceed), I had the opportunity at a public meeting to take an informal show of hands by the Directors of the Veterans Integrated Service Networks (VISNs) about such activities. In response to the question, "How many are doing more outreach activities today than one year ago?" only one VISN Director raised his hand. Five or six raised their hand in response to the question, "How many are doing about the same level of outreach as one year ago?" The remaining twelve or thirteen Directors raised their hand in response to the question, "How many of you are doing somewhat to significantly less outreach today than you were one year ago?"

It is true that since the Omnibus funding bill has been passed the Secretary has ordered that waiting times in excess of six months to see a primary care physician be reduced to zero within 90 days. We applaud Secretary Principi and support him and the VHA in this effort. In some cases the waiting times really are being reduced, and in some cases VA staff is learning how "to game the system" to make it appear that waiting times of more than 30 days are being reduced or eliminated.

However, VVA must point out that the waiting times for many veterans is being reduced by denial of the right to enroll for such services. This is akin to the recent announcement of a significant drop in the nation's unemployment rate. I think all Americans were pleased to hear that unemployment is down, until we learned that the unemployment rate dropped because so many Americans were no longer counted in the statistics because they were so discouraged they had stopped looking for work.

The waiting lines and times are reduced at VA because of the number of veterans who have become discouraged waiting and dropped out of the potential pool of VHA enrollees – and potential users – or because they are now systematically excluded from the pool of potential users of health care at VHA, or because they have no knowledge of those benefits and services. Many Priority 8 veterans have no health insurance, and do not have the cash to pay for health care straight up. So they do without.

Many veterans do not know that if they served in Vietnam they should be tested for prostate cancer regularly as the rate of prostate cancer among "in country" veterans is several times the rate

for non-veterans in our cohort. Nor do they know that prostate cancer is a service-connected presumptive condition for them. Even if they do know this, some do not get tested because they cannot afford it, and they cannot access the VHA system because they earn more than the HUD guidelines for income in their area. At the same time, because of the reductions in outreach (which were never very good regarding Agent Orange to begin with), those same veterans have even less of a chance to receive the information and education on this potential service-connected hazard because the funds are not there.

Many of these same veterans who served in Vietnam served in combat. Did they bear the battle? VVA thinks so. Yet they are on their own, not knowing that they are at an increased risk for prostate cancer as well as other diseases and conditions because of exposures in military service. When they get sick enough, if they have no other option, and if their spouse does not have a decent job, they may become poor enough for long enough become eligible for VA health care services. Only later it is possible that they may be deemed service-connected disabled, if they are lucky enough to stumble upon someone who knows enough to help them file a claim, and if they do not die before the claim is adjudicated after a long wait.

Can we collectively do better for our nation's veterans? VVA thinks we can, but only if sufficient funds are appropriated and greater accountability for use of those funds is demanded and codified.

In regard to the issue of accountability, VVA believes that the quality of much of the health care at VHA is generally good to excellent for those who can gain access to that care. What is lacking, however, is enough emphasis that this is a *veterans* health care system and not just a general health care system that happens to serve veterans. There are wounds, diseases, maladies, and conditions that are potentially dangerous to one's long-term health that are endemic to each conflict and theater of operation and/or particular circumstances of service.

Taking a military and medical history is just plain good common sense, and it is also good practice of medicine. This is absolutely necessary if we are committed to a wellness model of returning the individual to the highest degree of self-sufficiency and autonomy possible. VVA holds that this not only makes sense, but that it is our duty as a nation to do this, and do it right. Proper diagnosis means asking the right questions, and this simply does not happen often enough. The situation is much better than it was a few years ago, but much remains to be done.

The stated commitment in the strategic planning documents of both the VA as a whole and the VHA in particular give us hope that the VA is moving in the right direction toward becoming a true veterans health care system that is properly focused on the "veteran-ness" of those whom this system is designed to serve. VVA applauds Secretary Principi and Undersecretary Roswell for these first formal steps, but urge measurable objectives and timetables that are adhered to if their stated goals are to be achieved.

VVA must note that we continue to be deeply concerned by the "Capital Asset Realignment for Enhanced Services" (CARES) process. CARES is theoretically a data-driven system yet it has bad data based on existing services after several years of devastating cuts, particularly to the

specialized services, which represent the core of the VA mission. These cuts have been especially severe in mental health.

To compound the bad data set (which should have included a proper needs assessment of the veterans' population in each "market"), the VA is applying a formula that makes the late Rube Goldberg's overly complicated machines look simple by comparison. Even more importantly, this current "CARES formula" is a civilian formula, designed for healthy middle-class Americans who can afford to purchase HMO or PPO health-care coverage. That is not the population whom the VHA serves.

This formula posits one to three presentations in each veteran, whereas VHA averages five to seven presentations in each unique veteran who comes to VHA for care. The current formula does not take into account the wounds of war nor the terrible toxic exposures that result in higher incidence of cancers and other maladies. Nor does it take into account mental health or the neuro-psychiatric wounds of war. It does not take into account the fast-growing need for long-term care for veterans of several generations. And lastly, it does not take into account future veterans, including those serving today in Iraq, Afghanistan, the southern Philippines, and other zones in the war on terrorism.

This inadequate CARES formula and process, soon to become the standard so-called strategic planning process for veterans health care, is logical only in that it is a highly organized and grossly complicated way of going wrong with confidence. Or, at least there is confidence on the part of the planners and the Office of Management & Budget, which should give the rest of us cause for careful reconsideration of the wisdom of this very flawed process.

The Administration's budget request for FY 2005 fits right in, unfortunately, with this effort to plan the future resources for our nation's veterans by constructing a model that grossly underestimates the medical care needs of veterans now and in the future, particularly medical care related to military service, as a way of holding down costs – at any cost to veterans.

It has been suggested that the totally inadequate request for medical care for FY 2005 is payback for Congress having sought to add $1.3 billion to the FY 2004 request the President sent up one year ago. By holding this figure down, OMB has been allowed to take funds that should have been expended already and use that "carryover" as an excuse not to ask for even a respectable increase, much less to request an amount that meets what the situation calls for in regard to properly funding the VHA system. This is gamesmanship of the worst order, and it should be seen as such, and publicly labeled as such, by each Member of Congress.

The question that confronts us today is: How do we secure enough resources to keep the system going long enough, and strong enough, to discuss and debate how to make it work better to accomplish the goals we all share in this hearing room? The ordinary processes of Congress in fashioning a budget are not such as to allow for the adding of the $2.5-3 billion in taxpayer dollars it will take just to preserve even the current inadequate organizational capacity to deliver services, much less provide proper outreach and education, as well as access to all who have earned the right to decent veterans health care.

In the business-as-usual scenario, it is unlikely that much more than $1 billion will be added to the Administration's request for health care, inasmuch as the budget process is played as a zero-sum game. In this model, any money not requested by the President must come from somewhere else. The only solution to this annual dilemma is to enact mandatory health care funding at a proper level to restore and maintain the veterans health care system.

VVA urges you to move forward legislation that would make per captita funding of the veterans health care system mandatory, at a figure for each veteran at the same level per capita as FY 1996, adjusted and compounded for medical inflation for each year since.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer any questions that you may have of me. Again, Vietnam Veterans of America thanks you and your distinguished colleagues for your tenacious leadership on so many veterans' health care issues, and for considering our views on this issue of vital importance to veterans of every generation.

Vietnam Veterans of America

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

VIETNAM VETERANS OF AMERICA
Funding Statement
February 4, 2004

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

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

For Further Information, Contact:

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February 27, 2004

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Room 335
Cannon House Office Building
Washington, D.C. 20515

The Honorable Lane Evans
Ranking Member
Committee on Veterans' Affairs
.U.S. House of Representatives
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Evans,

On behalf of the Mortgage Bankers Association, the National Association of Home Builders and the National Association of Realtors, this statement is submitted with respect to the hearings the House Committee on Veterans' Affairs, held on February 4, 2004, on the Administration's Fiscal Year 2005 Budget for the Department of Veterans Affairs (VA). We respectfully request that it be made part of the record of the Committee hearings.

The VA budget contains a proposal with respect to the VA Home Loan Guaranty Program that would limit program loan veteran eligibility to a one-time use. Under the proposal, the one-time use of the loan program would apply to any person who becomes a veteran after the proposal becomes law. The provision would not apply to current eligible veterans for a period of five years. It is our understanding that this proposal carries a cost figure of $91 million.

Eliminating subsequent use of the VA benefit under the program would affect a large number of veterans. In 2003, over 45,000 veterans bought a home with a subsequent use of their VA benefit. This represents over 30% of the VA program purchase loan activity last year. In fact, subsequent use of the VA loan benefit has grown in importance to veterans, from one in five purchase loans using subsequent use in 1993 to nearly one in three purchase loans last year.

The VA's multi-use loans enjoy a lower foreclosure rate than initial-use loans and, as a result, lower the overall cost of the VA home loan benefit. Since 1994, the foreclosure rate for multi-use loans has been 39% lower than initial-use loans. This is reflected in the fact, as pointed out above, that the proposed change will cost the government $91 million. It is not in the interest of veterans or the Department of Veterans Affairs to remove the subsequent use benefit of the loan guaranty program.

It is important to note that two of the Nation's prestigious veterans groups, the American Legion and the Disabled American Veterans, have expressed strong opposition to the proposal.

The undersigned associations strongly urge the Committee to reject this proposal. Subsequent veterans' use of the program was recognized by Congress as a valid and valuable tool for veteran homeownership and a suitable recognition of a veteran's service to this country. It should not be curtailed.

Mortgage Bankers Association
National Association of Home Builders
National Association of Realtors

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Lane Evans
Committee on Veterans Affairs
February 4, 2004

Hearing on VA Budget for Fiscal Year 2005

Medical Questions

Question 1: Last year, you testified to the Committee that VA would be able to eliminate waiting times with the funding VA requested for fiscal year 2003. I want to commend you, because I believe we have seen a substantial decrease in the number of veterans waiting more than six months for care, but there are still approximately 30,000 veterans on the list. You've stated that you intend to reduce the number of veterans waiting to 0 by April 2004.

a. Are there still veterans in certain areas of the country who are more adversely impacted by waiting time problems than others?

b. Will waiting times re-emerge as a problem under the 2005 budget request?

Response:

a. Yes, there are some veterans who are more adversely impacted with longer waiting times, especially in Veterans Integrated Service Networks 8 and 20. Why these two VISNS? Is it temporary, is something being done to take care of problems?? The following initiatives are being taken to address the waiting times issue.

- incorporating Advanced Clinic Access concepts;
- hiring new providers;
- contracting/fee basis care;
- expanding CBOC contracts;
- improving consult management;
- establishing nurse-directed, pre-screening clinics for new patients;
- increasing access to specialists through telemedicine;
- reviewing data and feedback of data to providers; and
- maximizing clinic scheduling efficiency by allotting open slots to see new patients and continuing to provide education of clerks to avoid scheduling errors.

b. No, we do not foresee any re-emerging problem as a result of the FY 2005 budget request. It is anticipated that both the initiatives listed above and the performance measures (standards) created for addressing the wait times issue will result in significant reductions for veterans awaiting their appointments.

The following standards reflect VA's focused efforts to minimize any impact to veterans:

- Percent of primary care appointments scheduled within 30 days of a veteran's desired appointment date (during a month).
- Percent of appointments for specialty clinics (the top 47 in volume) within 30 days of a veteran's desired appointment date (during a month).
- Percent of appointments for 50 primary care and specialty care clinics within 90 days of a veteran's desired appointment date (during a month).
- Number of new enrollees waiting for their first clinic appointment to be scheduled.
- Number of 50 percent or greater service-connected veterans on a wait list over 30 days from their desired appointment date.

These standards are monitored and reviewed on a monthly basis and discussed with VHA Network and facility directors during quarterly performance reviews.

Question 2: How many veterans have been served by your transitional drug benefit program for waiting veterans? What has VA's cost been for this program?

Response: As of December 1, 2003, the Transitional Pharmacy Benefit has served approximately 7,500 veterans. Through this date, the VA has calculated the total drug ingredient cost to be $2.75 million. Overall, the labor component through the first 20 weeks has been calculated to cost $915,126.

Question 3: Congress was recently forced to re-appropriate $270 million that remained in VA's unobligated balances as part of its fiscal year 2004 budget. You stated that it is likely you will carryover up to $800 million in this fiscal year. Congress works hard to make substantial increases in VA's budget to allow VA to carry out its mission. Why is it that VA was and is unable to spend those funds when some programs, such as mental health and long-term care seem ready to absorb them?

Response: Each year VA has a certain amount of carryover funds. This can occur for several reasons. For example, if an appropriation is not passed until January, as was the case in FY 2003 and FY 2004, some of our planned financial actions have to be delayed. The effect of this delay is that some high priority requirements must be pushed into the following year, resulting in carryover funds.

Question 4: As you know, the FY 2004 budget request contained almost a billion dollars in management efficiencies—this year the Administration is targeting another $380 million in efficiencies. What are VA's specific plans for meeting the target for FY 2004? Your budget request specifies standardized purchasing as an efficiency it will pursue in fiscal year 2005; what are the steps VA is taking to ensure it will meet this target?

Response: VA is proposing additional management savings of $340 million in FY 2005, which is 1.2 percent of our total costs. Management efficiencies will be generated

primarily from standardization of pharmaceutical, medical, and other supplies. Remaining savings will be generated from improved capital asset management and increased employee productivity.

We have streamlined our national standardization procedures of medical, surgical, and prosthetics products. The Department has just accomplished its first joint standardization of medical and surgical products with DoD. Our continued efforts in joint procurements of medical equipment, supplies, and commodities are anticipated to increase savings in FY 2004 and 2005.

We are also developing a mandatory national medical and surgical prime vendor program that is scheduled to be fully implemented in FY 2005. The primary goal of this program is to provide a customized distribution system that meets or exceeds customer requirements by providing cost-effective just-in-time distribution, inventory and electronic catalog ordering processes from a broad number of vendors that are delivered from one primary distribution source. This system reduces warehouse space required to store inventory, reduces inventory shrinkage, and diminishes the volume of expired inventories.

We have initiated private label drug repackaging which will significantly reduce our costs for drugs that are in short supply. The first drug bought in bulk and packaged for VA will save $55 million in the first year (2004).

Further, we will be completing the full implementation of the Generic Inventory Package, which captures all recurring inventory information and provides management previously unrealized opportunities to minimize warehoused inventory quantities. In addition, structures are currently being implemented to ensure implementation of the VA National Item File (NIF) that will serve to identify each unique product purchased for pharmaceuticals, prosthetic devices, and medical-surgical supplies. The NIF will improve VA Procurement organizational effectiveness, leverage our purchasing power, and facilitate standardization of commodities.

Question 5: Last year, your testimony may have led some on this Committee to believe that eligibility reform compelled VA to open its doors to all veterans and offer them benefits such as sensory aids and pharmaceutical drugs. In fact, it was VA that specified its medical benefits package by regulation and made the decision to enroll all veterans. I know, Mr. Secretary, you now have misgivings about the VA's ability to treat so-called higher-income veterans, but should this issue really be linked to eligibility reform? Would you turn back the clock on what services VA is permitted to offer veterans by virtue of their priority for health care services?

Response: VA is fully committed to Eligibility Reform, which is founded on the principle that providing high quality, comprehensive health care ensures the best possible health outcomes for the veterans we serve. While Eligibility Reform opened VA health care to all veterans, it also established an enrollment system based on priority levels as a tool to manage demand for VA health care within available resources. By law, the VA

Secretary must decide annually whether VA has adequate resources to provide timely, high quality care for all enrolled veterans. Each year, VA reviews actuarial projections of the expected demand for VA health care in light of the expected budgetary resources and develops policies accordingly.

The decision to suspend enrollment of Priority 8 veterans and the cost-sharing policies proposed in the FY 2005 Budget follow from this mandated use of enrollment priority levels to manage demand for care within available resources. VA strongly believes that these policies represent the best opportunity for VA to secure the necessary resources to serve our core population -- veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

Question 6: Staff attended VA's budget briefing February 2, 2004, and learned of your proposal to finance insured veterans' share of co-payments for emergency care. They were told that this was responsive to the recent Cardiac Care study that indicated veterans might be trying to reach VA instead of going to a nearby hospital for care in an emergency. Is there also some chance that some of the problems identified in that study are due to VA's reluctance to use fee-based care in emergencies? Does VA plan to follow up this study with a root cause analysis?

Response: We do not believe the problems identified relate to use of current authority, but to the limitations of that authority.

Under 38 U.S.C. §1703, VA has contractual authority with non-VA facilities to prospectively authorize payment of emergency non-VA hospital care and/or medical services for certain veterans.

Section 1725 of title 38 U.S.C. provides for non-VA emergency coverage of non-service connected conditions for a veteran:

a) who is an enrolled or active VA health care participant, and personally liable for the emergency treatment in the non-VA facility;
b) who has no other health care coverage;
c) who has no recourse against a third party for payment;
d) when Departmental or other federal facilities were not feasibly available and
e) until such time as a transfer to VA can safely occur; and
f) who is not eligible under authority provided by 38 U.S.C. § 1728?

Section 1728 of title 38 U.S.C. provides for the non-VA emergency coverage of service connected and, in certain instances, non-service connected conditions of a veteran. This authority also provides coverage for a veteran whose disability is permanent and total or in receipt of Vocational Rehabilitation benefits. The following conditions must be met:

a) the needed care must have been emergent and
b) Departmental or other federal facilities were not feasibly available.

VA expended approximately $352 million in FY 2003 through its non-VA Fee Contract Hospital and Inpatient Ancillary programs, which includes payment under 38 U.S.C. §§ 1725 and 1728.

Question 7: I would certainly differ with your interpretation that this budget "continues our effort to expand access to long-term care". The Crossroads report recommended that VA maintain the level of care in its nursing home beds, increase the number of state home beds, and double or triple the resources committed to home and community based services. Your budget would reduce the average daily census in nursing homes by 5000 from the FY 1998 levels. In your view is every one of the veterans likely to be affected by this proposal better off at home? Does nursing home care have any rightful place on VA's continuum of care?

Response: While VA expects to meet most of the new need for long-term care through home and community-based settings, we remain committed to providing to institutional long-term care when this best serves the needs of veterans. It is our goal to provide care in the least restrictive setting that is compatible with a veteran's medical condition and personal circumstances. We attempt to give preference to home and community-based settings and reserve nursing home care for situations where the veteran can no longer be safely cared for in home or community settings, or when respite or rehabilitative care is needed. Undoubtedly, some veterans will continue to require nursing home care, and VA will continue to maintain both institutional and non-institutional capacity.

Question 8: There is a severe threat confronting VA's state home partners. States are being compelled to seek VA's per diem payments as a veteran's third-party liability and offset them against Medicaid payments to the state homes. We were told last week by the National Association of State Veterans Homes that this approach may have a profound effect on their future operations and even cause some homes to close their doors. Does VA have a position on this?

Response: The requirement that VA per diem payments be offset against Medicaid payments to the state homes is a statutory requirement enforced by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services. VA does not have a position on this policy.

Question 9: Staff were briefed on February 2, 2004, that VA plans to use the authority granted in the Omnibus Appropriations Act to divert $400 million from fiscal year 2004 VA medical care funds to the CARES investment fund. Have you identified where, specifically, VA will find resources of this magnitude? Will certain programs' operations be affected?

Response: The current plans are simply to maintain the flexibility to exercise our authority to transfer $400 million to the CARES major construction appropriation. This matter will be reassessed in the early summer to determine if the current plans can actually be executed without adversely affecting other medical programs.

Question 10: Under this budget request, VA plans to cut funds for medical and prosthetic research by $50 million. Will these funds come from grants or administrative support or both?

Response: VA will divide the reduction evenly between grants and Medical Care (administrative) support. The planned reductions are broken down as follows:

Description	Dollars ($000)	FTE
Bio-medical Laboratory Science Research	($14,202)	(85)
Health Services Research	($3,004)	(17)
Rehabilitation Research	(#3,687)	(21)
Clinical Science Research	($4,233)	(26)
Major/Minor Construction	$0	0
Medical Care Support	($25,128)	(350)
Totals	**($50,255)**	**(499)**

Question 11: As I understand it, VA has treated more than 80,000 veterans that have returned from recent deployments in Afghanistan and Iraq. Will this request adequately support these "new" veterans' needs and those of the servicemembers who will soon return from deployments?

Response: VA has seen about 10,000 veterans who were deployed to Afghanistan and Iraq and has been able to treat them within current budget resources. Based on this experience to date, we intend to continue to provide comprehensive health care to these veterans within the requested budget.

Question 12: During testimony, you compared the enrollment-like fee recommended by the FY 05 budget to the $254 dollar fee paid by some individuals for TriCare Prime. How does the proposed enrollment-like fee by VA relate to TriCare Standard?

Response: VA's proposed $250 fee is not a fee charged simply for enrolling in the VA health care system. It is an annual user fee assessed only on those enrollees who actually receive treatment from VA. TriCare Prime, charges individual retirees an annual premium of $230. TriCare Standard, while not charging an annual fee, does charge these individuals a 25% out-of-pocket co pay. Persons eligible to receive care under both systems must determine from a comparison of such things as applicable co-payments, anticipated primary and specialty care needs, and anticipated prescription drug needs, whether it would be more beneficial to use TriCare Standard or the VA health care system.

Question 13: The VA budget handout addresses a loss in VA Nursing Home and Community Nursing Home census and indicates a general shift in institutional long term care to state nursing homes. The Budget also shows a dramatic increase in non-institutional long term health care indicating an 87% increase in the "census numbers" from 1998. GAO, on January 28, 2004, submitted testimony voicing concern about the

comparability of the numbers used to report non-institutional care. They focused on what item was being counted, enrollments or visits.

Counting enrollments alone may not reflect services rendered. One way to build census numbers is to count visits. But, is the duration and quality of these visits standardized? Are shorter visits of lower quality increasing the reported census numbers? How do you account for census in non-institutional long term patients?

Response: We agree that different ways of counting workload provide different information and incentives. Each method has advantages and disadvantages. VA is developing 3 measures of workload activity for non-institutional Home and Community Based Care (H&CBC) services: Enrollment Days or Census; Patients Treated; and Visits.

"Enrollment Days or Census" shows the number of veterans who are receiving care through each H&CBC program divided by the number of days in the year. The measure is same one used by the Centers for Medicare and Medicaid Services (CMS). It is similar to Bed Days of Care/Average Daily Census in the nursing home programs and allows for direct comparisons. It is used for budget and planning purposes. Currently, census information is only available for the Home Based Primary Care Program. VA expects to have enrollment data for all H&CBC services in late 2005.

"Patients Treated" is an alternative measure of workload and indicates the total number of veterans served throughout the year in each H&CBC program. It offers insight into the length of placement in H&CBC and is presently available for all programs.

The final workload measure, "Visits," is best used as an internal management tool, to assess utilization and staffing levels. Visits, divided by days in the year, offer one view of yearly attendance. However, this measure undercounts VA's efforts. Visit information is available for all H&CBC programs.

Since the mid-1990s, for the purpose of the President's budget and all other reports, VA has used visits (divided by days in the year) as the workload measure for all H&CBC programs, except HBPC, which uses enrollment, the preferred measure. VA anticipates the full use of enrollment data for all H&CBC programs for the FY 2007 budget cycle.

At a national level, VA does not monitor the length of visits. For reporting purposes, only one visit per program per day is counted. For example, if a veteran receives two Skilled Nursing visits in a day, only one visit is counted. If a veteran receives one Skilled Nursing visit and one Homemaker/Home Health Aide visit in a day, two visits are counted, one in each program. Complaints on the length of visits are rare.

Question 14: Several Members expressed interest in recouping costs from the National Institutes of Health for research associated with third party NIH grants conducted on VA property. Has the HHS Secretary responded to VA's request for indirect costs? What was that response? [Please submit a copy for the record] What

has specifically been accomplished to break the perceived impasse, what is the most senior executive level that this has been discussed, and what action would be necessary at what executive level to resolve this situation?

Response: The Administration does not support reimbursements from the NIH to the VA or any other Federal agency. However, the President's Budget includes an initiative for the VA to assess pharmaceutical companies for the indirect administrative costs associated with the clinical drug trials we conduct for these organizations.

Question 15: Regarding the research budget, what revenues may be anticipated in future years from patents and intellectual property rights springing from VA research? How much of the FY-05 research budget $50,000,000 cutback could such revenues offset?

Response: VA expects to receive at least $350,000 in royalties during FY 2005, a 300 percent increase over FY 2003. The Department expects this revenue stream to increase in future years as the number of patents increases but does not currently have information to estimate beyond FY 2005.

Benefits Questions

Question 1: Please provide examples of the kind of information the Department of Defense has shared with the Department of Veterans Affairs in order to assist transitioning servicemembers in accessing VA services in a timely manner. Is the information being provided adequate for you to effectively plan for providing timely and adequate health care for our military personnel as they return from Iraq and Afghanistan? Could you provide details as to the resources that are available and how they will be utilized to assist our transitioning service personnel?

Response: The Department of Veterans Affairs (VA) and Department of Defense (DoD) are working closely to ensure that VA can provide information to returning injured servicemembers about benefits and services available to them from VA. VA currently receives DoD data identifying a service member as medically retired or discharged. VA's Seamless Transition Task Force has implemented processes so that all ill or injured Operation Enduring Freedom and Operation Iraqi Freedom servicemembers will be informed of their eligibility for benefits while in a military treatment facility.

Currently, VA has five full-time employees and one contract employee at Walter Reed Army Medical Center in Washington, D. C., and one part-time employee at the Bethesda Naval Medical Center in Maryland to provide transition services. On an as-needed basis, similar teams work with patients at three other DoD medical treatment facilities that are treating seriously wounded troops: Eisenhower Army Medical Center, Brooke Army Medical Center, and Madigan Army Medical Center. As of May 26, 2004, 2,516 returning servicemembers who were hospitalized at DoD facilities have been assisted through this program.

During FY 2003, VBA military services coordinators conducted over 5,300 Transition Assistance Program and Military Services Briefings attended by almost 198,000 active duty personnel and their families residing in the United States. We also conducted 472 briefings attended by 12,947 servicemembers based overseas. We provided similar briefings during FY 2003 and the 1st quarter of FY 2004 to over 64,000 Reserve/Guard members.

Question 2: I believe improving management efficiencies is extremely important. This budget, like previous budgets, uses management efficiencies to cover costs. Please provide a list of the specific management efficiencies relied upon in the budget and the dollar amount expected to be saved from each such management efficiency. Please provide the same information for the management efficiency savings realized in fiscal year 2003.

Response: In August 2003, VA awarded a contract to Ocwen Federal Bank FSB to manage and sell all properties VA acquires due to foreclosure. The transition of all VA's inventory of properties to Ocwen was completed in January 2004. This contract will allow the Loan Guaranty Program to operate at lower FTE levels. The contract is estimated to save $14.2 million over the 4.5-year performance period.

VBA's budget requests include several management efficiencies essential for VBA program improvement, most notably within the Compensation and Pension programs:

- MAP-D (Modern Award Processing – Development): MAP-D is an automated application that enables veteran service representatives to develop and track claims. It also enhances customer service because case status is available to all stations and any regional office can respond to a claimant inquiry. MAP-D allows local managers and executives at the Area and Central Office level to get up-to-date information on specific claim cycle times.

- BDD (Benefit Delivery at Discharge): Active duty personnel are able to file for VA service-connected disability benefits immediately prior to the date they separate or retire from active duty. If a servicemember files a claim for service-connected disability benefits under the BDD program, evidence is developed and/or a medical examination requested and a decision is issued prior to, or in close proximity to, his or her separation from active duty. This program is provided to servicemembers in the United States, as well as in Germany and Korea where there are large concentrations of U. S. military personnel. More than 25,000 separating servicemembers utilize this program each year, significantly shortening the time from separation to final decision on their disability compensation claims.

- Pension Consolidation: The purpose of this effort was to move the maintenance of VA's pension programs from 57 regional offices to three VA centers in St. Paul, Milwaukee, and Philadelphia. As a result, pension work is being processed with fewer personnel and the quality of decisions on pension claims has improved. Moreover, the reorganization has freed up staff at the regional offices to focus on delivery of compensation benefits and has thereby contributed to reducing the pending compensation workload.

- TPSS (Training and Performance Support System): TPSS provides computer-based training programs for key technical positions in VBA. It is designed to improve training consistency and reduce costs. TPSS for rating specialists is fully available throughout the country.

- SIPA (Systematic Individual Performance Assessment): SIPA involves the review and assessment of claims developed by individual employees, and is designed to enable field managers to monitor quality and individual performance. Quality has improved over the last two years as a result of all of our quality improvement initiatives, and we have set more stringent national goals for 2004.

Although there is no direct cost savings associated with the following initiatives, they have enabled us to increase production and improve the timeliness and quality of service delivery.

- CPI (Claims Processing Improvement) Model: Under the CPI Model, every Veterans Service Center is organized into six specialized teams: Triage, Pre-determination, Rating, Post Determination, Appeal, and Public Contact. The CPI Model is designed to reduce the number of tasks performed by decision makers, increase the quality of decisions, and reduce the amount of time it takes to adjudicate a claim. We believe this change in process is one of the key components that enabled VBA to reduce the number of pending claims to 253,000 at the end of 2003.

- CAPRI (Compensation and Pension Record Interchange): CAPRI provides VBA employees with online access to a veteran's electronic medical records in the VHA records system, integrates the results of rating examinations into a veteran's electronic medical records, and allows VBA personnel to request and print VHA rating exams. CAPRI provides disability decision makers with greater access in a more manageable way to the medical information created as part of VHA's care delivery, and enables VBA to rate some cases without an examination and to better focus those examinations that are still needed.

Question 3: According to the Administration's budget proposal, VBA is expected to lose 829 full time employee equivalents between 2003 and 2005. How many claims per FTEE were decided in FY 2002 and 2003? How many claims per FTEE does VBA project will be decided in 2005? Please describe what specific management improvements will enable VBA to process claims with a reduced workforce without loss of timeliness and quality. Do the reductions in VBA staff assume that there will be no court cases having a major impact on VBA's claims processing in 2004 and 2005?

Response: The staffing level for the Compensation Program remained stable in the FY 2005 budget, with a modest increase of five direct FTE for an estimated total of 6,040. VBA's primary C&P claims processing goals for fiscal year 2004 are to reduce its rating inventory to 250,000 claims, improve rating timeliness to 100 days, and increase rating quality to 90%. Achieving these targets will optimally position the organization as it enters fiscal year 2005. With its workload under control, VBA will be able to maintain its performance despite a decrease in personnel. To ensure VBA's performance objectives are met, several initiatives over the past few years have been implemented.

Since 2001, VBA has added 1,800 decision makers in the C&P business lines. As these new employees gained proficiency in their duties, VBA's performance dramatically improved, particularly in fiscal year 2003. In fiscal year 2002, approximately 105 rating-related claims were completed per FTEE[1]. In comparison, approximately 109 rating-related claims were completed per FTEE in fiscal year 2003[2]. VBA projects 110 rating-related claims will be completed per FTEE in fiscal year 2005. It is important to note that these estimates are based on end-of-year C&P business lines FTEE levels and the number of rating claims completed for that year, and do not factor

[1] Based on end-of-year C&P business line FTEE level of 7,589.7 and 796,814 rating claims completed
[2] Based on end-of-year C&P business line FTEE level of 7,596.3 and 827,194 rating claims completed

in the other work performed by adjudication employees, including non-rating claims, public contact, outreach, and fiduciary activities.

Initiatives have been implemented to ensure accountability for performance at all levels of the VBA organization. In Fiscal Year 2002, the performance appraisal plan for the directors of VA's regional offices was revised to include evaluations based on the station's inventory, timeliness, and quality levels. Additionally, national performance plans were implemented two years ago for the key technical positions of Veterans Service Representative, Rating Veterans Service Representative, and Decision Review Officer. Individual productivity and quality requirements are included in each of these plans.

A new model of claims processing designed to reduce the number of tasks performed by decision makers was implemented at the close of fiscal year 2002. Every regional office's Veterans Service Center is now organized into six specialized teams. The efficiencies gained through this reorganization are evident in VA's continued performance improvements.

Other streamlining initiatives have contributed to the reduction in VBA's inventory of pending claims and improvements in timeliness and quality. Three Pension Maintenance Centers were established in fiscal year 2002 to consolidate this very complex, labor-intensive component of VBA's workload. Efficiencies continue to be gained as this consolidation of pension processing nears completion. VBA established the Appeals Management Center (AMC) in Washington DC in fiscal year 2003 to concentrate the expertise needed to timely process cases remanded by the Board of Veterans Appeals. The AMC enables regional offices to concentrate resources on other claims processing areas.

Information technology applications that have been recently deployed have also contributed to increased production and quality within VBA. These applications have automated processes previously performed manually, thereby accelerating many aspects of claims adjudication and avoiding some of the errors inherent in manual processing. Prominent among these applications are Rating Board Automation (RBA) 2000, which supports the creation of rating board documents; Modern Award Processing (MAP), which enables veteran service representatives to develop and track pending claims; and SHARE, which allows employees to obtain information from various automated resources outside VBA, such as Social Security Administration files.

The reduction in staff does not include projections of court cases that may have a major impact on VBA's claims processing in 2004 and 2005, since such renderings and their ramifications are virtually impossible to forecast.

Question 4: Please provide comparison data for fiscal years 1994 through 2002 concerning:

- liquidation rates for subsequent use of home loans versus all others
- interest rate reduction loans versus all loans

- active duty personnel to veterans
- reservists versus all others.

Response: Please see the attached spreadsheets.

Question 5: Please describe any steps the Department has taken or is considering to improve access to veterans residing in rural areas.

Response: Many outreach efforts have been developed or enhanced to allow veterans not residing near a regional office or medical center the same opportunity to receive more information and apply for benefits and services. The broadest effort has been the revisions made to the VA website, www.va.gov.

In all benefits programs VA has means to improve access to veterans in rural areas. The Vocational Rehabilitation and Employment (VR&E) Program has 120 out based offices that provide increased access points. Veterans everywhere already have full access to the home loan guaranty benefit because private sector mortgage lenders help VA in providing this benefit anywhere in the country. Many lenders have made their lending activities available over the internet.

In the Education Program VA offers several access and outreach efforts that provide access to VA education benefits to veterans in rural areas. We use mailings as part of our outreach activities. Also, veterans have access to education benefit information via www.gibill.va.gov and through the "Ask a Question and Answers" feature on the web site. Beneficiaries can certify monthly attendance using the WAVE (Web Automated Verification of Enrollment) on the web, the Cert IVR (1-877-823-2378), or by calling an Education Case Manager. Additionally, Education Case Managers are available via 1-888-GIBILL-1 to provide information and answer questions.

VBA's Insurance Service conducts outreach efforts by mail, and makes phone calls to certain severely disabled veterans, including those living in rural areas. There is a robust web site that provides self-service insurance transactions and an e-mail address. It has a toll-free telephone number allowing veterans to hear pre-recorded messages, leave messages, and accesses their insurance records via an IVR (Interactive Voice Response) system available 24 hours seven days a week.

In addition, VA has enhanced the training opportunities for county veterans' service organizations and other veteran's service organizations in our Training, Responsibility, Involvement and Preparation of Claims (TRIP) program. County veterans service officers serving veterans living in rural areas are now better equipped to explain VA benefits to veterans and assist them in developing the evidence to support their claims.

Ted Strickland

Question 1: Please provide a redacted list of the claims for which benefits have been awarded pursuant to the court's decision in *Allen v. Principi*. For each claim where benefits were awarded as a result of the *Allen* decision, please provide the following information:

- primary service-connected disability (including diagnostic code and rating) which was associated with *Allen* award,
- disabilities secondarily granted service-connection under the *Allen* decision (including diagnostic code and rating for each disability),
- the increased amount of disability benefits paid on each disability,
- the increased amount of disability benefits paid on each claim per month as the result of the Allen decision, and
- the regional office which issued the decision.

Response: When the Federal Circuit issued *Allen v. Principi*, we instructed our field stations to stay adjudication of these claims pending a determination whether to appeal the decision. While some stations retained logs of these claims, most of these logs no longer exist. Because of the variety of disabilities that can result from use of alcohol and drugs, it is impossible for us to track on-going awards based on the *Allen* decision. Nonetheless, the following is a summary of some identified cases:

VARO Denver

(1) Primary disability: PTSD - DC 9411 - 10%
Allen disability: alcohol abuse and depressive disorder - DC 9434-9411
Combined degree: 100%
Increased monthly compensation: $1,779

(2) Primary disability: PTSD - DC 9411 - 50%
Allen disability: alcohol abuse DC 9411 (rated with PTSD)
Combined degree: 50%
Increased monthly compensation: $0

(3) Primary disability: PTSD - DC 9411 - 50%
Allen disability: alcohol abuse - DC 9411 (rated with PTSD)
Combined degree: 50%
Increased monthly compensation: $0

(4) Primary disability: PTSD - DC 9411 - 50%
Allen disability: alcohol abuse - DC 9411
Combined degree: 70%
Increased monthly compensation: $552 (NOTE: vet deceased. Accrued benefits of $7281 paid)

(5) Primary disability: Bipolar disorder - DC 9432 - 70%
Allen disability: alcohol abuse - DC 9432 (rated with bipolar disorder)
Combined degree: 70%
Increased monthly compensation: $0

(6) Primary disability: PTSD - DC 9411 (note this was a death rating)
Allen disability: respiratory arrest due to acute ethanol overdose (death)
Monthly DIC awarded: $182 (child)

(7) Primary disability: Anxiety/depressive disorder - DC 9413-9434 - 10%
Allen disability: alcohol dependency - DC 9413-9434 (rated with primary disability)
Combined degree: 10%
Increased monthly compensation: $0

(8) Primary disability: PTSD - DC 9411 - 70%
Allen disability: alcohol abuse - DC 9411 (rated with PTSD)
Combined degree: 70%
Increased monthly compensation: $0

(9) Primary disability: Major depression - DC 9405 - 100%
Allen disability: alcohol abuse - DC 9405 (rated with major depression)
Combined degree: 100%
Increased monthly compensation: $0

(10) Primary disability: PTSD - DC 9411 - 70%
Allen disability: marijuana abuse - DC 9411 (rated with PTSD)
Combined degree: 70%
Increased monthly compensation: $0

VARO Wichita

(1) Primary disability: PTSD - DC 9411 - 50%
Allen disability: alcoholism/polysubstance abuse - DC 9399-9326 - 0%
Combined degree: 50%
Increased monthly compensation: $0

(2) Primary disability: PTSD - DC 9411 - 100%
Allen disability: alcoholism - DC 9399-9303 - 0%
Combined degree: 100%
Increased monthly compensation: $0

(3) Primary disability: PTSD - DC 9411 - 70% + TDIU (individual unemployables)
Allen disability: alcoholism - DC 9399-9327 - 0%
Combined degree: 70% + TDIU
Increased monthly compensation: $0

(4) Primary disability: PTSD - DC 9411 - 100%
Allen disability: alcoholism - DC 9399-9303 - 0%
Combined degree: 100%
Increased monthly compensation: $0

VARO Sioux Falls

(1) Primary disability: PTSD - DC 9411 - 70%
Allen disability: alcohol abuse resulting in immediate death (MVA)
DIC benefits payable: unknown

VARO White River Junction

(1) Primary disability: PTSD - DC 9411 - 50%
Allen disability: alcoholism - DC 9411 (rated with PTSD)
Combined degree: 70%
Increased monthly compensation: $522

VARO Milwaukee

(1) Primary disability: PTSD - DC 9411 - UNK
Allen disability: myocardial infarction resulting in death - DC 7006
Monthly DIC for child: $410

(2) Primary disability: anxiety disorder - DC 9413 - 30%
Allen disability: alcohol abuse - DC 9413 (rated with anxiety disorder)
Combined degree: 30%
Increased monthly compensation: $0

(3) Primary disability: PTSD - DC 9411 - UNK (deceased)
Allen disability: liver cancer/end stage liver disease
DIC monthly payment: $935

VARO Buffalo

(1) Primary disability: UNK (veteran deceased)
Allen disability: Unknown
DIC monthly payment: $935

Comparison of Fiscal Year Liquidation Rates

Reservists vs All Others

As of end of Month September 2003

				All Others				Reservists				Reservist rate	
Fiscal	Total	Total		Total	% of	Liquidations		Total	% of	Liquidations		compared to	
Year*	Guaranteed	Liquidated	%	Number	Total	Num	%	Number	Total	Num	%	All others Rate	
2003	254,552	16	0.01%	247,377	97.2%	16	0.01%	7175	**2.8%**		0.00%	100.0%	Lower
2002	254,552	16	0.01%	247,377	97.2%	16	0.01%	7175	**2.8%**		0.00%	100.0%	Lower
2001	269,816	609	0.23%	261,206	96.8%	593	0.23%	8,610	**3.2%**	16	0.19%	18.1%	Lower
2000	184,660	2,280	1.23%	177,805	96.3%	2,224	1.25%	6,855	**3.7%**	56	0.82%	34.7%	Lower
1999	404,081	7,574	1.87%	391,204	96.8%	7,398	1.89%	12,877	**3.2%**	176	1.37%	27.7%	Lower
1998	409,101	11,949	2.92%	395,496	96.7%	11,641	2.94%	13,605	**3.3%**	308	2.26%	23.1%	Lower
1997	260,516	12,078	4.64%	250,499	96.2%	11,765	4.70%	10,017	**3.8%**	313	3.12%	33.5%	Lower
1996	315,063	20,591	6.54%	304,116	96.5%	20,067	6.60%	10,947	**3.5%**	524	4.79%	27.5%	Lower
1995	249,877	17,727	7.09%	240,544	96.3%	17,235	7.17%	9,333	**3.7%**	492	5.27%	26.4%	Lower
1994	493,627	29,804	6.04%	483,657	98.0%	29,306	6.06%	9,970	**2.0%**	498	4.99%	17.6%	Lower
1993	475,216	28,123	5.92%	469,519	98.8%	27,848	5.93%	5,697	**1.2%**	275	4.83%	18.6%	Lower
	3,061,957	130,735	4.27%	2,974,046	97.1%	128,077	4.31%	87,911	**2.9%**	2,658	3.02%	29.8%	Lower

***Based on Date of Loan**

(KPM - 26A2B) 10/22/2003

Source: SAS GILFYLIQ

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Comparison of Fiscal Year Liquidation Rates
Subsequent Use for Veterans Versus All Loans
As of September 30, 2003

				Subsequest Use - Veterans**					
Fiscal Year*	Total Guaranteed	Total Liquidated	%	Total Number	% of Total	Liquidated Num	%	Compared to Overall Rate	
2002	304,802	482	0.16%	46,119	15.1%	55	0.12%	24.6%	Lower
2001	271,361	2,757	1.02%	46,793	17.2%	309	0.66%	35.0%	Lower
2000	184,781	4,323	2.34%	43,991	23.8%	631	1.43%	38.7%	Lower
1999	404,156	11,396	2.82%	56,217	13.9%	1,120	1.99%	29.3%	Lower
1998	409,249	15,373	3.76%	56,217	13.7%	1,268	2.26%	40.0%	Lower
1997	260,600	13,729	5.27%	46,168	17.7%	1,334	2.89%	45.2%	Lower
1996	315,131	22,165	7.03%	49,981	15.9%	2,070	4.14%	41.1%	Lower
1995	249,917	18,642	7.46%	42,352	16.9%	1,841	4.35%	41.7%	Lower
1994	493,665	30,888	6.26%	49,960	10.1%	2,463	4.93%	21.2%	Lower
	2,893,662	119,755	4.14%	437,798	15.1%	11,091	2.53%	38.8	Lower

** Excludes IRRRLs on veterans only

* Bassed on Date of Loan

Source: 264 PA
SAS Progam "USEFYLIQ"
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(01/09/2004 AMH)

Comparison of Fiscal Year Purchase Loan Liquidation Rates
Service Personnel to Veterans
Over Age 30
As of February 28, 2003

Fiscal Year*	Total	Liquidations Num	Liquidations %	Veterans Total Number	Veterans % of Total	Veterans Liquidated Num	Veterans Liquidated %	Service Personnel Total Number	Service Personnel % of Total	Service Personnel Liquidated Num	Service Personnel Liquidated %	Over Age 30 Svc. Personnel Rate compared to Veteran Rate	
2002	120,077	25	0.02%	99,094	82.5%	22	0.02%	20,983	17.5%	3	0.01%		
2001	132,482	649	0.49%	112,067	84.6%	603	0.54%	20,415	15.4%	46	0.23%	58.1%	Lower
2000	134,135	2,092	1.56%	115,992	86.5%	1,918	1.65%	18,143	13.5%	174	0.96%	42.0%	Lower
1999	168,549	3,981	2.36%	146,644	87.0%	3,642	2.48%	21,905	13.0%	339	1.55%	37.7%	Lower
1998	168,720	5,386	3.19%	144,126	85.4%	4,819	3.34%	24,594	14.6%	567	2.31%	31.0%	Lower
1997	158,503	6,732	4.25%	132,992	83.9%	5,895	4.43%	25,511	16.1%	837	3.28%	26.0%	Lower
1996	172,392	10,569	6.13%	143,628	83.3%	9,143	6.37%	28,764	16.7%	1,426	4.96%	22.1%	Lower
1995	164,071	10,745	6.55%	135,799	82.8%	9,226	6.79%	28,272	17.2%	1,519	5.37%	20.9%	Lower
1994	188,004	12,851	6.84%	155,332	82.6%	10,861	6.99%	32,672	17.4%	1,990	6.09%	12.9%	Lower
1993	185,338	12,079	6.52%	149,785	80.8%	10,103	6.75%	35,553	19.2%	1,976	5.56%	17.6%	Lower
	1,592,271	65,109	4.09%	1,335,459	83.9%	56,232	4.21%	256,812	16.1%	8,877	3.46%	-17.9%	Lower

*Based on Date of Loan

Excel: H:265b2\excel\ten yr frcl trend.xls
SAS GILFYLIQ
Prepared 3/07/2003 (264A)

Air Force Sergeants Association
International Headquarters, P.O. Box 50, Temple Hills, MD 20757-0050 • Phone: (301) 899-3500

March 12, 2004

The Honorable Lane Evans
Ranking Democratic Member, Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515-6335

Dear Ranking Member Evans,

The following is provided in response to your question from a recent committee hearing on the FY 2005 Department of Veterans Affair Budget for FY 2005.

According to the VA, $127 million would be saved by repealing the Allen decision. According to the CBO, that amount is only $4 million. You asked if we had any information concerning the number of veterans who have been awarded benefits under the Allen decision.

AFSA does not have Veteran Service Officers and we do not provide individual assistance on VA-related actions such as claims and appeals. Therefore, we do not have any information on the number of veterans receiving benefits as a result of the Allen decision.

Sincerely,

MORGAN D. BROWN
Manager, Legislative Affairs