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HEARING ON PROPOSED FISCAL YEAR 2007 BUDGET FOR DEPARTMENT OF VETERANS AFFAIRS PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

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FEBRUARY 16, 2006

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HEARING ON PROPOSED FISCAL YEAR 2007 BUDGET FOR DEPARTMENT OF VETERANS AFFAIRS PROGRAMS

THURSDAY, FEBRUARY 16, 2006

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

The Committee met, pursuant to notice, at 10:50 a.m., in room SR–418, Russell Senate Office Building, Hon. Larry E. Craig, Chairman of the Committee, presiding.

Present: Senators Craig, Graham, Thune, Akaka, Jeffords, Murray, and Obama.

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

Chairman CRAIG. Good morning, everyone. Today we will examine the President's Fiscal Year 2007 budget request for the Department of Veterans Affairs. It is by any objective standard an extraordinary budget proposal: An 11.3 percent increase in VA medical care, a 10.9 percent increase in total mandatory appropriations, and a 10.3 percent increase in total VA appropriations.

When I first learned of the President's request, I was on the one hand pleased that President Bush again made care for veterans a top priority, and on the other hand, I was sobered. I was convinced that the President's request would unite Republicans and Democrats and, if not all, most veterans advocates. Surely a budget plan proposing an 11.3 percent increase in medical care during a time of war, high deficits, and restrained discretionary spending in nearly every account unrelated to national security was one we would all support.

In the weeks since the budget numbers were released, I have listened, I have read various comments which instead suggest that the President's request ignores the reality of the full cost of war, that it breaks faith with veterans who have returned from the battlefield and, most remarkably, that this budget is somehow a cut in the care of our veterans. Boy, was I wrong.

Ladies and gentlemen, it is time to suspend the rhetoric and it is a reality check time for all of us. First, let me quickly respond to the criticism that this budget breaks faith with veterans during a time of war and from our present conflict. Every man, woman, and child in America would agree with VA's mission statement that those who have borne the battle, particularly those who have returned from the battle with physical and psychological wounds,

should be the first in line for the highest quality of care available. VA's budget tells us that just over 2 percent of its medical care patients are veterans from Operation Iraqi Freedom or Enduring Freedom. It is hard to imagine that within a $35 billion medical care budget, VA does not have funds to care for returning combat-wounded veterans, yet it is what some have insinuated.

If there is a problem here with caring for returning combat veterans, those problems have more to do with a system of priorities than it is in sustaining our capabilities. There is no lack of resource. Ten years ago, a Republican Congress and a Democratic President united with veterans organizations to modernize the delivery of health care for veterans so that limited dollars could be put to their most effective use. A values-based priority system was established, and the Secretary of Veterans Affairs was given discretion to suspend or limit enrollment to ensure that care to higher priority veterans would not deteriorate. The authority of the Secretary to limit enrollment was the safety valve that was put in place to ensure a balance between the resources Congress provided and the demand for care placed on the VA's medical system.

Let me fast forward to 2006. That is approximately 10 years. VA health care funding has nearly doubled in the intervening years. According to the President's request, double-digit growth in funding for 2007 is needed even though VA expects it will treat approximately the same number of patients it did a year earlier. The safety valve of limiting enrollment was used once and once only, in 2003. Since that time, we in Congress have shown an unwillingness to allow it to be used again, necessitating the annual double-digit increases that we see here today.

Now I come to the reality check that all of us, I would hope, could come to grips with. On its present path, the VA budget will double every 6 years or nearly every 6 years. What will occur in the near future, be it under the current discretionary funding process or under a mandatory funding formula, is that VA spending will collide with spending demands from all other areas of Government. Just as future liabilities for service Social Security, Medicare and Medicaid if left unchanged will crowd out our limited resources, so too will VA spending, and so I ask all of my colleagues and the veterans organizations what do we do in the face of this challenge.

The President has again proposed a way for us to begin the conversation about re-prioritizing veterans spending by asking veterans with no service-related disabilities to pay a little more for their own care. To be exact, he is asking them to pay an enrollment fee that equates to $21 a month and a copay of $15 a month for a 30-day supply of medicine. I sat down just this week with the Secretary of Health and Human Services. It is believed that by the end of the month, they will announce that the new prescription drug program currently being implemented will cost its recipients $27 a month.

So, I must tell you, I find these proposals imminently reasonable. If the President's proposals are not accepted, then we are forced to discuss options if we assume that we will sustain the level of funding proposed by this President. Either way, we cannot pretend the taxpayers' funding of programs that support our Nation's veterans

exist in a vacuum. It simply does not. VA's budget represents the mathematical reality that Congress will be forced to address. If we duck it in 2007, we will simply have it in our face in 2008.

I look forward to a serious discussion about these and other important issues with my colleagues, the Secretary, and the veterans organizations that so our ably represent our Nation's veterans. I hope my candor represents what I believe is a current lay of the land, and as I see it, we simply have to get down to the business of understanding where we are and not expecting that this Congress or the American taxpayers can sustain the level of funding that is represented in the chart behind me without some change in how we operate.

I will also strive during the course of this very serious discussion to continue to operate this Committee and its proceedings in a bipartisan way, but we cannot nor should we tolerate rhetoric that is simply that doesn't address the reality of the day or the simple fact that this is the single largest increase in veterans' budget that this Committee has ever seen. I recognize and honor this President for doing so, and the Secretary, but even as they do it, I am one that has to stand forward and say this is a reality check that will be very difficult to sustain in the future.

Now, before I introduce our panels, our Ranking Member has just arrived. So, Danny, we will let you get settled in.

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

Senator AKAKA. Thank you very much, Mr. Chairman. It is no secret that we work very well together and in a bipartisan manner and we look forward to continuing that. I want to thank the Chairman for all of his work and the work of his staff and mine.

I want to welcome our Secretary Nicholson and his staff, and dedicated public servants from VA.

It requires our work to add funding to ensure that VA has the financial tools to make it work. I want to work with you, Mr. Chairman, to see whether we can do this in a bipartisan manner. I know that each and every one of us wants to avoid the financial shortfall of last year. I am tremendously relieved to know that VA has made its numbers much more transparent to us. We know this was not always the case. It should have been obvious that a shortfall was imminent.

The number of veterans seeking health care kept climbing last year, and finally in the summer we heard an admission that the shortfall required immediate and drastic help from Congress. We need to be listening to the people in the field when they are telling us that they are being forced to take drastic measures to make ends meet. Rather than providing sufficient funding, this budget calls upon veterans to shoulder the costs. We are presented with recycled proposals to double the drug copayment and to charge a yearly enrollment fee for veterans who simply want to use VA care.

Let me set the record straight about the types of veterans who would be shouldering these costs. These veterans are not affluent as they have been described. They are veterans living in States like Hawaii where the cost of living is one of America's highest. We are talking about veterans making as little as $27,000 a year. The

President's solution to making room for returning servicemembers is to literally force other veterans out of the system. Indeed, we hear much about core veterans. I wonder what the health care system would be like if it were only opened to highly service-connected veterans. Access must be available to all veterans who choose to come for care, and in return, they can expect that VA will bill their insurance companies and charge modest copayments.

We hear stories about mandatory overtime and personnel shortages and contracted care because VA cannot meet the demand. We must ensure that in the years to come, VA has the resources to maintain the high customer service rating that it has today. It is also shortsighted to cut research. Many physicians choose to work at VA despite the modest pay because of the opportunity to do research. This account is something we should be adding to and not cutting. VA does solid research which benefits both veterans and non-veterans alike.

With regard to the VBA budget, I am concerned whether or not this budget provides an adequate level of staffing for compensation claims. Whatever the reason for the increase in compensation claims, VA must be prepared. Whether it is the successful benefit delivery discharge program, legislation on expanded outreach, court decisions, or reopened claims, VA must be ready to adjudicate its claims in a timely and accurate manner. Looking down the road, VA must be ready for an increased number of appeals from this increased workload.

I will continue to monitor VA's workload and rating output because our veterans deserve nothing less than their claims rated accurately and in a reasonable amount of time.

Again, I want to dearly welcome our Secretary Nicholson and your staff and welcome all of you here today.

Thank you, Mr. Chairman.

Chairman CRAIG. Senator Akaka, thank you very much for your opening statement, and let me reciprocate by saying over the past year, we have worked very well together as we have worked our way through these difficult choices and decisions. I look forward to that opportunity again.

Now let me turn to Senator Patty Murray.

Patty.

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman, and thank you, Mr. Secretary and all your staff, for being here today and for the excellent job you do.

Mr. Chairman, I listened carefully to your opening statement, and I must say that when the President's budget came forward on VA, you did hear a round of applause. I think many of us felt strongly that we appreciated the VA and the President recognizing the troubles and difficulties we went through last year and stepping up to come up with a much better number. You didn't hear a standing ovation because many of us were very concerned that although it was one step forward, it was two steps back, and I think for many of us, limiting the access to the VA through the increased fees and copayments is really a step backwards, that we

should not balance the budget on the backs of those who have served us.

As Senator Akaka very rightly put forward, who these people are and what their incomes are and how they are working was not part of what they signed up for when they went to a recruiting station. There wasn't an asterisk by the health care, and we have to take that into consideration, not only for our veterans today, but for those who are following us. So that was sort of the step backward.

And the second step backward is a deep concern that although the numbers are increased, we need to see the reality of the challenges that the VA is facing today. Overall, health care in this country is at double-digit inflation. That impacts the VA as well. We have a higher number of OIF and OEF soldiers who are returning who are accessing care not just for a month or two, but probably for a lifetime with serious injuries, 18,000 soldiers at this point who will have lifetime care.

We are seeing the Medicare prescription drug plan that is moving forward in this country where people are calling Medicare and are being told if you are a VA, don't do Medicare Part D, go to the VA, and I believe that that will increase the number of veterans who will be accessing it. We are seeing a higher number of Vietnam veterans now begin to go into the VA health care system that we have to recognize and acknowledge and see the reality of the numbers; and frankly, because in the country today, we do have a health care crisis, more and more employers are not providing health care. Those people who work for them who are veterans may for the first time in their life say, my only access to health care is now through the VA, and we are seeing an increased number there.

So the real numbers that are affecting the VA have to be taken into account. Yes, it is a better number than we had last year, but we want to see what the reality is. We want to see a VA budget based on the real needs, based on the very, very critical factors that are facing the VA today, and I for one am going to continue to advocate to make sure that every person who serves us in the Nation today, overseas at war or here at home, gets what they were promised, and I will continue to push and not give a standing ovation until we get to that.

Chairman CRAIG. Senator, thank you very much. I doubted very much that you would step back from your advocacy role that you do very well for our veterans. Thank you.

Now let me turn to Senator Jim Jeffords.

Jim.

STATEMENT OF HON. JAMES M. JEFFORDS, U.S. SENATOR FROM VERMONT

Senator JEFFORDS. Thank you, Mr. Chairman, for holding this hearing today. I would also like to thank the Secretary for joining us to discuss the President's budget request for fiscal year 2007.

I am pleased that the President has requested a 12 percent increase in the Veterans Affairs budget for the coming year. The request for a $1.5 billion increase in the medical services budget over this fiscal year is a welcoming improvement over past years, one that our veterans well deserve; however, I am concerned that this budget uses unduly optimistic assumptions about the numbers of

servicemembers who will seek care in the VA following deployment to Iraq or Afghanistan. We know that these wars will continue to generate more combat veterans, many of whom will need special services from the VA for many years to come.

This comes as the cost of health care continues to spiral. I question whether this budget is sufficient in dollars and personnel to prepare the VA for addressing the increased demands on its services. I am also concerned that projected collections for the coming year are overly optimistic and unlikely to generate the expected revenue.

Your budget predicts a 37 percent increase in collections above last year's level, but, frankly, this is not seen to be likely. Most facilities have made great efforts over the last few years to collect third-party reimbursements. So I am skeptical that they will be able to increase their collections by $700 million.

Congress last year rejected proposals to increase prescription drug copays or impose a $250 enrollment fee on middle income veterans. I doubt Congress' reaction will be different this year. I also believe this budget does not adequately fund vet centers, especially those in rural areas where reservists have been activated in large numbers. These are often areas where no military installation is available to support servicemembers or their families. These vet centers provide a service that is not found elsewhere and is critical to our servicemembers who are returning to from war.

Finally, I remain concerned that the Administration's policy of not allowing enrollment of new Priority 8 veterans. In the face of growing crisis in health care options for middle income veterans, I believe that VA's mission should be expanding to include more veterans instead of limiting its services. At a time when we have asked more and more Americans to serve their country, we must make sure that the VA is capable of providing them with the health care and other services they deserve.

I am looking forward to hearing your testimony, Mr. Secretary, and to our discussion thereafter.

Thank you, Mr. Chairman.

Chairman CRAIG. Jim, thank you very much.

Senator Obama, welcome to the Committee.

STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Senator OBAMA. Thank you so much, Mr. Chairman.

Thank you, Mr. Secretary, and to all of you who are appearing here today. Some of what I had intended to say in my opening remarks have already been stated. So I will try to keep this brief.

It has been about a year ago since we sat here and heard you, Secretary, say that a .04 percent increase in veterans health spending was going to be enough despite the fact that we had large numbers of veterans coming back from Iraq and Afghanistan, and as you will recall, just a few months later, we sat here and heard you admit that you needed $1 billion more in emergency funding to make it through the end of the year. So I am sure that neither you, nor we, want to relive that experience.

At first glance, at least, the President's 2007 budget looks like it avoids a significant fiasco, but I have to be honest about the budg-

et. I don't think we should fool ourselves or our vets into thinking that the increase that is represented in this budget is as large as the White House would like us to think it is, and we shouldn't fool ourselves into thinking that this budget represents a significant departure from this Administration's tendency to play with the numbers when it comes to the VA budget.

There continue to be some accounting gimmicks in this budget that we talked about last year that needed to be fixed. It is not clear to me that they are fixed. Some of them have been mentioned. You know, Congress has rejected 3 years in a row the proposal for a new enrollment fee and the proposal to double prescription drug copayments for Priority 7 and 8 veterans. So 3 years in a row, we have said no. I can't imagine that we are going to say yes this year. That is $800 million in revenue that is accounted for in this budget that I just don't see coming.

The VA had made management efficiency claims which make up over $1 billion in this year's budget, but the GAO, at least, says haven't been and can't be proven. So one of the concerns, and I am sure you will hopefully have a chance to respond directly to this is, if those savings prove illusory, what happens and how are you planning that possibility?

Just a couple other points I would make: With respect to banning new Priority 8 enrollments, through this ban, the VA has denied health care to about 260,000 vets who assumed upon enlistment that a working class salary of $25,000 wouldn't prevent them from receiving the health care they were promised. In Illinois, you have got 8,944 veterans who were denied health care through the ban just last year. I am deeply concerned about that.

Last year, I raised an issue with respect to funding for VA nursing home care. It appears, once again, that the President's budget cuts funding to VA nursing homes and flat-line spending for the construction of new ones. In Illinois, we have got 391,000 sixty-five and older, but only 4 State nursing homes that together have just barely above a thousand beds, and we have got a waiting list that tops 920.

Finally, I want to take this opportunity just to revisit an issue that became a top priority for me, the issue of disability payments. As you know, we had some problems last year in Illinois with respect to disability payments. I have to say, Mr. Secretary, you and Admiral Cooper and others took the time to come to Illinois, have been working on it. I appreciate that work, but I am concerned that if we continue to have low estimates of the growing demand on the system and insufficient staffing at the VA, we could see some of the same problems not just in Illinois, but across the country. So that is why this budget is so important, and I hope you can clarify some of the questions that have been raised.

Thank you, Mr. Chairman.

Chairman CRAIG. Senator, thank you very much.

We have been joined by Senator Lindsey Graham.

Senator, do you have any opening comments?

STATEMENT OF HON. LINDSEY O. GRAHAM, U.S. SENATOR FROM SOUTH CAROLINA

Senator GRAHAM. Very briefly, Mr. Chairman.

This is an important time for this Committee to be in existence. I think it is in good hands with you and the Ranking Member, and to our veteran community out there, the Nation owes you a lot, but I would argue that your need to serve the Nation never stops. So we are going to make some hard decisions.

I hope to be a recipient of some VA health care one day if I can ever get my retirement in the bank. I am 3 years away, but when that day comes, I would appreciate anything my Government could do for me, but I expect to do more for myself. If I ever get my retirement—I will probably have a pretty good retirement here from the Senate. I hope I can stay around long to enough to do that—I may have some health care of my own, and anything I get from the VA, I don't mind paying a little bit more for.

We have got to make some hard decisions. Who should be eligible and how much should they pay is a decision that can't be ignored anymore, because there is only so much money coming from the taxpayer. We are having very large increases in the VA budget, but we are having large increases in Medicare and Social Security, and 20 years from now, the money we are spending today to run the Government will be spent on three programs: Social Security, Medicare and Medicaid.

The VA part of the budget is hugely important in two ways, Mr. Chairman. It is a commitment to the people who have allowed us to be free, but it has to be an honest commitment to the next generation so they can afford to maintain a level of productivity to make freedom meaningful, and that is the dilemma this Committee faces. That is the dilemma the United States faces.

Mr. Secretary, I think you are a good man. You are the right guy at the right time, and I will join with you and the Chairman and any other Member of this Committee to ask for some sacrifice, continued sacrifice, from those who can afford it in the veterans community, understanding our priority is to take care of those who can afford it the least first.

Chairman CRAIG. Senator, thank you very much.

Our first panel this morning is the Department of Veterans Affairs. Secretary Jim Nicholson, welcome to the Committee.

The Secretary is accompanied by Jonathan Perlin, Under Secretary for Health; Daniel Cooper, Under Secretary for Benefits; William—Bill Tuerk, Under Secretary for Memorial Affairs; Jack Thompson, Deputy General Counsel; and Robert Henke, Assistant Secretary for Management.

At the outset in welcoming you, Mr. Secretary, because of last year's budget, and it was referenced here several times, we want to thank you for starting what we insisted and you agreed to would be a quarterly analysis of where we are financially as we see these numbers move and as we see the demographics shift and change. And last Wednesday, I believe it was, we had that first analysis from you and your immediate staff here with you, and we thank you very much for that. We look forward to those.

I have expressed my concern about these budgets and my support for this level of spending, but at the same time, I think all of

us recognize the importance to monitor this now more closely than we ever have before, not just for the dollars and cents of it, but as Senator Murray and others have said, for the service you offer to our veterans.

Thank you much. Please proceed.

STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JONATHAN B. PERLIN, UNDER SECRETARY FOR HEALTH; DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS; WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS; JACK THOMPSON, DEPUTY GENERAL COUNSEL; AND ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT

Secretary NICHOLSON. Thank you, Mr. Chairman, Members of the Committee. I do have a written statement that I would ask to be entered into the record.

Chairman CRAIG. Without objection, all statements and all accompanying information you provide will be made a part of our record.

Thank you.

Secretary NICHOLSON. Thank you, Mr. Chairman, for introducing the members of my team I have with me here at the table. We have many others in the room. We are blessed at the VA with an extraordinary group of dedicated competent professional people.

I am pleased to announce this morning a landmark Department of Veterans Affairs budget proposal of $80.6 billion for fiscal year 2007. This is truly historic in its scope of services to veterans.

Behind the budget figures, Mr. Chairman, is a great story, one of America's truly good news stories. So before we get down to the numbers, I would like to brag a bit on my Department's people and their successes. In fact, back home where I come from, there is a saying that it ain't bragging if it is true.

One of those truths, Mr. Chairman, is that our VA employees, all 225,000 of them, come to the aid of their communities and their fellow citizens, veterans and non-veterans alike in times of disasters and other national emergencies. To make my point, I need only to mention the heroic efforts of VA employees during Hurricane Katrina and Hurricane Rita. Not only did our staffs evacuate several hundred patients out of our hospitals in the Gulf area to other hospitals, and not only did they do it quickly and efficiently, they did it at great personal risk and great personal sacrifice and loss.

It is also a fact that the VA knows how to protect our veterans' vital health information against these kinds of catastrophic events that swept us in the Gulf Coast. Here, of course, I am talking about our electronic health care records. No matter where our New Orleans veterans were eventually relocated, their complete health records were available for uninterrupted care and treatment.

I would like, if I could, Mr. Chairman, to also read an extract of a letter that was recently published by one of the VSOs. It was a letter a father had written to them about his veteran son who came through Reagan Airport here, and unfortunately while transitioning through the airport, his luggage was stolen. He was a diabetic, a young diabetic veteran. He didn't know what to do. He

called his father, and his father thought and said call the VA hospital there in Washington. He did that, and he gave them his name, of course, and his last four digits of his social security number and his date of birth, and they dialed him up on their computers there. He was from South Carolina, I think. By the time he got in a cab and got out to that hospital, they had his total record portrayed and his unique insulin regime prepared for him and then gave him the other supplies that he needed to proceed on his trip.

That illustrates, I think, the extraordinary paradigm in medical care the VA has achieved, and it is an example of what it means as it did to the hundreds and hundreds of other patients that we relocated during our emergency work in the Gulf.

I would like to add, also, in recognition of our accomplishments during that megastorm that I was recently privileged to present Senate Resolution 263 to Gulf Region VA employees and volunteers who went there. That was a Congressional commendation for their extraordinary efforts as a first responder to a disaster of unprecedented proportions, and I would like to thank all of you in the Senate for that resolution that recognized our care-giving heroes.

Mr. Chairman, following a decade-long health care transformation, this Department stands as a recognized leader of America's health care industry and we have the credentials to prove that. The Journal of American Medical Association has applauded VA's dedication to patient safety. The Washington Monthly magazine featured VA in an article entitled The Best Care Anywhere. U.S. News and World Report described the entire VA as the home of, "top-notch health care" in its annual best hospitals issue. A RAND report ranked VA performance on 294 measures of quality as significantly higher than any other health care system in America. Even the *New York Times* just last month in an article by Paul Krugman, no less, called the VA the model for our Nation.

While these enthusiastic stories about the VA from outside are certainly always welcome, the most meaningful measure of our success comes from the millions of men and women that we serve, that we care for, our prized patients, our veterans. They are our biggest supporters. Our veterans rank our care a full 10 percentage points above their counterpart patients in private hospitals. Yes, for the sixth consecutive year, the American Customer Satisfaction Index reports that veterans are more satisfied with their health care than any other patients in America.

This, I think, speaks volumes about the competency and the compassion of the caregivers in our system. For us, the support of our veterans, the people who know us the best, is the highest level of praise that we can receive. That is what gives us our bragging rights. Because our first rate, high-quality health care, because of that, our veterans are coming to us in ever greater numbers. Fully 7.6 million are currently enrolled for our care. This year, we expect to see well over 5 million of them.

Mr. Chairman, President Bush in his 2007 budget proposal for the Department of Veterans Affairs is fulfilling his promise to our veterans with a strong budget that respects their service to our country and takes a significant step toward redeeming America's debt to our veterans, a debt that President Washington said after the end of the Revolutionary War, that we owe to these men. The

President's total request is for $80.6 billion, which is an increase of 12.2 percent over last year's record amount. It is $8.8 billion above the fiscal year 2006 level. This budget contains the largest dollar increase in discretionary funding for VA ever requested by a President.

The resources requested for VA in the 2007 budget will strengthen even further our position as the Nation's leader in delivering accessible high-quality health care that already sets the national benchmark for excellence. In addition, this budget will allow the Department to maintain its focus on benefits, on timely and accurate claims processing. The President's 2007 budget will also enable us to expand veterans' access to National and State Veterans Cemeteries.

As an integral component of our fiscal year 2007 goals, we will continue to work closely with the Department of Defense to fulfill our priority that servicemembers' transition from active duty military status to civilian life, veteran life at that point, is as smooth and is as seamless as possible.

Mr. Chairman, our written statement presents a detailed description of the President's proposal for fiscal year 2007, but I would like to take a few moments to highlight several of the key components of this historic budget. During 2007, we expect to treat 5.3 million patients, including more than 109,000 combat veterans who will have served in Operation Enduring Freedom and/or Iraqi Freedom. The 3.8 million veteran patients in priorities one through six will comprise 72 percent of our total patient population in 2007. This will be an increase of 2.1 percent in the number of patients in this core group and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percent of all veterans that we treat.

The President's 2007 budget request reflects the largest dollar increase for VA medical care ever requested by a President and includes our funding request for the three medical care appropriations, $27.5 billion for medical services, including $2.8 billion in collections, $3.2 billion for medical administration, and $3.6 billion for medical facilities. The total proposed budgetary resources of 34.3 billion for the medical care program represents an increase of 11.3 percent or 3.5 billion over the level for fiscal year 2006, and it is a 69.1 percent increase in the funding over that available to this Department at the beginning of the Bush Administration.

The VA is also focused on delivering timely, accurate, and consistent benefits to the veterans and, of course, to their families. The volume of claims receipts has grown substantially during the last few years and is now the highest that it has been in the last 15 years as we received over 788,000 claims in 2005. This trend is expected to continue. We are projecting the receipt of over 910,000 compensation and pension claims in 2006 and more than 828,000 claims in 2007.

One of the key drivers of new claims activity is the increase in the size of the active duty military force now including the reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom. This has led to a sizable growth in the number of new claims, and we expect that this pattern of growth will continue.

The natural outcome of this increasing claims workload is growth in our mandatory spending accounts which are growing even faster than our discretionary accounts. We estimate that mandatory spending will increase by 14.5 percent to over $42 billion from an estimated fiscal year 2006 level of $36.7 billion. This growth is largely in the compensation and pension accounts and reflects the combined impact of adding new veterans and beneficiaries to the rolls, the aging of our claimant veteran population, increasing levels of disability ratings for veterans already on the rolls, and annual cost of living adjustments for veterans and beneficiaries.

In addition, we expect to continue to receive a growing number of complex disability claims resulting from post-traumatic stress disorder, environmental and infectious risks, traumatic and brain injuries, complex combat-related injuries, and complications resulting from diabetes, the latter of which is approaching epidemic proportions in our veteran population. Each claim now takes more time and more resources to adjudicate. We will address our ever-growing workload challenges by improving our training and productivity, by moving work among regional offices to maximize our resources and performance, by simplifying and clarifying benefit regulations, and by improving the consistency and quality of claims processing all across our regional office benefits system.

Mr. Chairman, our veterans are leaving this life at an ever-increasing pace. Every day now, 1,800 men and women who dedicated their lives to the continuation of our democracy are being laid to rest in fields of honor. Of the 16 million World War II veterans who have proudly served us, fewer than 3.5 million now remain. By this time next year, that number is projected to be less than 3 million. Korean War veterans are now all in their seventies or eighties. Vietnam veterans, most of us at least, are resisting the notion that we are next, but, of course, we are.

It has been said that a nation is known by the way it honors its dead. I believe that and I firmly believe that America's greatness is reflected in the final tributes and perpetual care with which we respect the service of departed veterans. Buglers play taps now for more than 107,000 veterans in our national cemeteries each year. In 2007, that will increase by 5.4 percent and will be 15.1 percent more than the number that we interred just in 2005.

The President's 2007 budget request for the VA includes $160.7 million in operations and maintenance funding for the National Cemetery Administration. This represents an increase of $11.1 million or 7.4 percent over the amount for last year. We will expand access to our burial program by increasing the percent of veterans served by our burial option in the National or State Veterans Cemeteries within 75 miles of their residence to 83.8 percent in fiscal year 2007, which is a 6.7 percent increase over 2005. Our plan for the biggest expansion of the national cemeteries since the Civil War is on track.

Mr. Chairman, I started out my testimony by saying that this budget is historic, that this is a landmark proposal of funding unmatched by any previous VA budget ever. I also said that VA's 225,000 employees are doing a terrific job in taking care of our veterans. This level of competent and compassionate care was earned

by the men and the women through their blood, sweat, and tears, serving our country honorably and courageously.

Veterans don't seek the spotlight of approval, Mr. Chairman. So as Secretary of Veterans Affairs, and it is my privilege to lead our national applause in grateful thanks for every gift our veterans have given us. This proposed budget for the VA is, in my opinion, President Bush's appreciation for these heroes.

Thank you very much, Mr. Chairman.

[The prepared statement of Secretary Nicholson follows:]

PREPARED STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, good morning. I am pleased to be here today to present the President's 2007 budget proposal for the Department of Veterans Affairs (VA). The request totals $80.6 billion—$42.1 billion for entitlement programs and $38.5 billion for discretionary programs. The total request is $8.8 billion, or 12.2 percent, above the level for 2006. This budget contains the largest increase in discretionary funding for VA ever requested by a President.

With the resources requested for VA in the 2007 budget, we will be able to strengthen even further our position as the Nation's leader in delivering accessible, high-quality health care that sets the national benchmark for excellence. Whether compared to other Federal health programs or private health plans, the quality of VA health care is unsurpassed. In addition, this budget will allow the Department to maintain its focus on the timeliness and accuracy of claims processing, and to expand access to national and state veterans' cemeteries.

As an integral component of our 2007 goals, we will continue to work closely with the Department of Defense (DOD) to fulfill our priority that servicemembers' transition from active duty to civilian life is as seamless as possible.

ENSURING A SEAMLESS TRANSITION FROM ACTIVE MILITARY SERVICE TO CIVILIAN LIFE

The President's 2007 budget request provides the resources necessary to help ensure that servicemembers' transition from active duty military status to civilian life is as smooth and seamless as possible. Last year through our aggressive outreach programs, VA conducted nearly 8,200 briefings attended by over 326,000 separating servicemembers and returning Reserve and National Guard members. We will continue to stress the importance of an informed and hassle-free transition for all of our forces coming off of active duty, and their families, and especially for those who have been injured.

If active duty servicemembers, Reservists, and members of the National Guard served in a theater of combat operations, they are eligible for cost-free VA health care and nursing home care for a period of 2 years after their release from active military service provided that the care is for an illness potentially related to their combat service. VA has already facilitated transfers from military medical facilities to VA medical centers several thousand injured servicemembers returning from Operation Enduring Freedom and Operation Iraqi Freedom.

There are many other initiatives underway that are aimed at easing servicemembers' transition from active duty military status to civilian life. Within the last year, VA hired an additional 50 veterans of Operation Enduring Freedom and Operation Iraqi Freedom to enhance outreach services to veterans returning from Afghanistan and Iraq through our Vet Centers. They joined our corps of Vet Center outreach counselors hired earlier by the Department to brief servicemen and women about VA benefits and services available to them and their family members. They also encourage new veterans to use their local Vet Center as a point of entry to VA and its services. Our outreach counselors visit military installations, coordinate with military family assistance centers, and conduct one-on-one interviews with returning veterans and their families.

Last year VA signed a memorandum of agreement with Walter Reed Army Medical Center to give severely injured servicemembers practical help in finding civilian jobs. Under this agreement, VA offers vocational training and temporary jobs at our headquarters in Washington, DC to servicemembers recovering at the Army facility from traumatic injuries.

VA and DOD are working together to establish a cooperative separation exam process so that separating servicemembers only need to have one medical exam that meets both military service separation requirements and VA's disability compensation requirements.

Separating military personnel receive enhanced services through the Benefits Delivery at Discharge (BDD) program. This program enables separating servicemembers to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation. With the assistance of VA staff stationed at 140 military installations around the Nation as well as in Korea and Germany, servicemembers can begin the VA disability compensation application process 180 days prior to separation. These applications are now processed at two locations to improve efficiency and the consistency of our claims decisions. In addition, our employees conduct transition assistance briefings in Germany, Italy, Korea, England, Japan, and Spain.

MEDICAL CARE

The President's 2007 request includes total budgetary resources of $34.3 billion for the medical care program, an increase of 11.3 percent (or $3.5 billion) over the level for 2006 and 69.1 percent higher than the funding available at the beginning of the Bush Administration. The 2007 budget reflects the largest dollar increase for VA medical care ever requested by a President and includes our funding request for the three medical care appropriations—medical services ($27.5 billion, including $2.8 billion in collections); medical administration ($3.2 billion); and medical facilities ($3.6 billion).

The cornerstone of our medical care budget is providing care for veterans who need us the most—veterans with service-connected disabilities; those with lower incomes; and veterans with special health care needs. A key element of this effort is to make sure every seriously injured or ill serviceman or woman returning from combat in Operation Enduring Freedom and Operation Iraqi Freedom receives priority consideration and treatment.

INITIATIVES

The 2007 budget includes two provisions that, if enacted, will be instrumental in helping VA meet our primary goal of providing health care to those who need our medical services the most. The first provision is to implement an annual enrollment fee of $250 and the second is to increase the pharmacy copayment from $8 to $15 for a 30-day supply of drugs. Both of these provisions apply only to Priority 7 and 8 veterans who have no compensable service-connected disabilities and do have the financial means to contribute modestly to the cost of their care. Priority 7 and 8 veterans typically have other alternatives for addressing their medical care costs, including third-party health insurance coverage and Medicare, and were not eligible to receive VA medical care at all or only on a case-by-case space available basis until 1999 when new authority allowed VA to enroll them in any year that resource levels permitted.

As you know, these two initiatives are not new, and I recognize that Congress has not enacted them in the past. However, we are reintroducing them because I believe they are justifiable, fair, and reasonable policies. They are entirely consistent with the priority health care structure enacted by Congress several years ago, and would more closely align VA's fees and copayments with other public and private health care plans. The President's budget includes similar, small incremental fee increases for DOD retirees under age 65 in the TRICARE system. The VA fees would allow us to focus our resources on patients who typically do not have other health care options. Furthermore, these two provisions reduce our need for appropriated funds by $765 million as a result of the additional collections they would generate, and a modest reduction in demand.

The 2007 budget also includes a provision to eliminate the practice of offsetting or reducing VA first-party copayment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of non-service-connected disabilities would receive a bill for their entire copayment. If enacted, this provision would yield about $30 million in additional collections that could be used to provide further resources for the Department's health care system.

The combined effect of all three provisions reduces our need for appropriated funds by $795 million in 2007. I want to work with your Committee and the rest of Congress to gain your support for these proposals.

WORKLOAD

During 2007, we expect to treat nearly 5.3 million patients, of which 4.8 million are veterans, including over 100,000 combat veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom. Among the remaining patients we will treat are qualified dependents and survivors eligible for care through the Civil-

ian Health and Medical Program of the Department of Veterans Affairs (CHAM PVA), VA employees receiving preventive occupational immunizations, and patients receiving humanitarian care.

The 3.8 million veteran patients in Priorities 1–6 will comprise 79 percent of our total veteran patient population and 72 percent of our overall total patient population in 2007. This will be an increase of 2.1 percent in the number of patients in Priorities 1–6 and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percentage of all patients treated.

We have made significant improvements to the actuarial model that was used to support our 2007 budget request, including development of an enhanced methodology for determining enrollee morbidity and a more detailed analysis of enrollee reliance on VA health care compared to other medical service providers. Also, we have added new data sources, including the Social Security Death Index, which resulted in a more accurate count of enrolled veterans. Finally, we have more accurately assigned veterans into the income-based enrollment priority groups by using data from the 2000 decennial census.

VA continues to take steps to ensure the actuarial model accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue to meet the health care needs of these returning veterans and veterans from other eras seeking more of these same services.

FUNDING DRIVERS

There are three key drivers of the additional funding required to meet the demand for VA health care services in 2007:

- inflation;
- expanded utilization of services; and
- greater intensity of services provided.

The impact of the composite rate of inflation within the actuarial model increased our resource requirements for medical care by $1.2 billion, or 3.9 percent. This includes the effect of additional funds needed to meet higher payroll costs as well as the influence of growing costs for supplies, as measured in part by the medical Consumer Price Index.

VA will experience a significant increase in the utilization of health care services in 2007 as a result of four factors. First, overall utilization trends in the U.S. health care industry continue to increase. Veterans who previously came to VA for a single medical appointment now more typically require multiple appointments in many different specialty clinics. And, they return more often for follow-up appointments in any given year. To illustrate, in 2005 we treated about 5.3 million individual patients but had a total of over 58 million outpatient visits. These trends expand VA's per-patient cost of doing business. Second, we expect to see changes in the demographic characteristics of our patient population. Our patients as a group will continue to age, will have lower incomes, and will seek care for more complex medical conditions. These projected changes in the case mix of our patient population will result in greater resource needs. Third, veterans are displaying an increasing level of reliance on VA health care as opposed to using other medical care options they may have available. This increasing reliance on VA medical care is due at least in part to the positive experiences veterans have had with the Department's health care system and is a reflection of our status as the Nation's leader in delivering high-quality care. And fourth, veterans are submitting compensation claims with more, as well as more complex, disabilities claimed. Our Veterans Health Administration does the majority of disability examinations required in order to evaluate these claims. This results in the need for a disability compensation medical examination that is more complex, costly, and time consuming.

General medical practice patterns throughout the Nation have resulted in an increase in the intensity of health care services provided per patient, due to the growing use of diagnostic tests, pharmaceuticals, and other medical services. This rising intensity of care is evidenced in VA's health care system as well. This has contributed to higher quality of care and improved patient outcomes, but it requires additional resources to provide this greater intensity of services.

The combined impact of expanded utilization and greater intensity of services increased our resource requirements for medical care by nearly $1.2 billion.

QUALITY OF CARE

VA's standing as the Nation's leader in providing safe, high-quality health care is evident and has been well documented. For example:

• in December 2004 RAND investigators found that VA outperforms all other sectors of American health care across a spectrum of 294 measures of quality in disease prevention and treatment;

• the Department's health care system was featured in the January/ February 2005 edition of Washington Monthly in an article titled "The Best Care Anywhere";

• the May 18, 2005, edition of the prestigious Journal of the American Medical Association noted that VA's health care system has ". . . quickly emerged as a bright star in the constellation of safety practice, with system-wide implementation of safe practices, training programs and the establishment of four patient-safety research centers";

• the July 18, 2005, edition of the U.S. News and World Report included a special report on the best hospitals in the country titled "Military Might— Today's VA Hospitals Are Models of Top-Notch Care;" and

• on August 22, 2005, The Washington Post ran a front-page article titled "Revamped Veterans' Health Care Now a Model."

It should be noted that for the sixth consecutive year, VA set the public and private sector benchmark for health care satisfaction based on the American Customer Satisfaction Index survey conducted by the National Quality Research Center at the University of Michigan. VA's inpatient index was 83 compared to 73 for the private sector, and our outpatient index was 80 compared to 75 for the private sector.

These external acknowledgments of the superior quality of VA health care when compared to other public and private health plans reinforce the Department's own findings. We use two primary measures of health care quality—Clinical Practice Guidelines Index and Prevention Index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the Clinical Practice Guidelines Index, an internal accountability measure focusing on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to reach 78 percent in 2007, or a 1 percentage point rise over the 2006 estimate. Similarly, VA's Prevention Index, a set of measures aimed at preventive health care, including immunization, health risk assessments, and cancer screenings, is projected to remain at the estimated 2006 high rate of performance of 88 percent.

ACCESS TO CARE

With the resources requested for medical care in 2007, the Department will be able to both maintain its current high performance dealing with access to medical care as well as seek ways to continually reduce waiting times for non-urgent care. In 2007 we expect that 93.7 percent of appointments will be scheduled within 30 days of the patient's desired date. For primary care appointments, 96 percent will be scheduled within 30 days of the patient's desired date and for specialty care, 93 percent of all appointments will be scheduled within 30 days of the patient's desired date. No veteran will have to wait for emergency care.

VA is also committed to ensuring that no veteran returning from service in Operation Enduring Freedom and Operation Iraqi Freedom has to wait more than 30 days for a primary care or specialty care appointment.

We have achieved these waiting times efficiencies by developing a number of strategies to reduce waiting times for appointments in primary care and specialty clinics nationwide, to include implementing state-of-the-art appointment scheduling systems, standardizing business processes associated with scheduling practices, and ensuring that clinicians focus on those tasks that only they can perform to optimize the time available for treating patients. To further improve access and timeliness of service, VA will fully implement Advanced Clinic Access nationally, an initiative that promotes the efficient flow of patients. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In turn, this reduces unnecessary appointments, allowing for relatively greater workload and increased patient-directed scheduling.

MAJOR CHANGES IN FUNDING

VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). I can assure you that the patient and cost projections associated with long-term care have been checked to ensure that they represent our real need in this area. While we aim to expand all types of extended care services, we

plan to increase the rate of growth of non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. During 2007 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 36,700. This represents a 14.4 percent increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005.

The Department's 2007 request includes nearly $3.2 billion ($339 million over the 2006 level) to provide comprehensive mental health services to veterans,

including our effort to improve timely access to these services across the country. These additional funds will help ensure that VA continues to realize the aspirations of the President's New Freedom Commission Report as embodied in VA's Mental Health Strategic Plan and to deliver exceptional, accessible mental health care.

The Department will continue to place particular emphasis on providing care to those suffering as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom from a spectrum of combat stress reactions, ranging from readjustment issues to Post-Traumatic Stress Disorder (PTSD). An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our increased outreach to veterans of the Global War on Terror, as well as increased readjustment and PTSD services. This includes the December 2005 designation of three new centers of excellence in Waco (Texas), San Diego (California), and Canandaigua (New York) devoted to advancing the understanding and care of mental health illness.

VA's medical care request includes $1.4 billion ($160 million over the 2006 level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. VA has already provided prosthetics and sensory aids to military personnel who served in Operation Enduring Freedom and Operation Iraqi Freedom and the Department will continue to provide them as needed.

MEDICAL COLLECTIONS

As a result of improvements in our medical collections processes and the initiatives presented in this budget request, we expect to collect over $2.8 billion in 2007 that will substantially supplement the resources available from appropriated sources. In 2005, we collected just under $1.9 billion. The collections estimate for 2007 is $779 million, or 37.9 percent, above the 2006 estimate. About 70 percent of the projected increase in collections is due to the provisions calling for implementation of a $250 annual enrollment fee, an increase to $15 in the pharmacy copayment, and elimination of the practice of offsetting VA first-party copayment debts with collection recoveries from third-party health plans. The remaining 30 percent of the growth in collections will result from continuing improvements in billing and collections.

We have several initiatives underway to strengthen our collections processes. These include:

• the Department is implementing a private-sector-based business model pilot, tailored to our revenue operations, to increase third-party insurance revenue and improve VA's business practices. The pilot Consolidated Patient Account Center will address all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes;

• we are working with Centers for Medicare/Medicaid Services contractors to obtain a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA health care services. This project will result in more accurate payments and better accounting for receivables through use of more reliable data for claims adjudication;

• our Insurance Identification and Verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange;

• we are testing the e-Pharmacy Claims software that provides real-time claims adjudication for outpatient pharmacy claims; and

• VA is implementing the Patient Financial Services System pilot that will increase the accuracy of bills and documentation, reduce operating costs, generate additional revenue, reduce outstanding receivables, and decrease billing times.

MEDICAL RESEARCH

The President's 2007 budget includes $399 million to support VA's medical and prosthetic research program. This amount will fund more than 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($51 million), aging ($40 million), health services delivery improvement ($36 million), heart disease ($30 million), central nervous system injuries and associated disorders ($29 million), and cancer ($28 million).

The requested funding for the medical and prosthetic research program will position the Department to buildupon its long track record of success in conducting research projects that lead to clinically useful interventions that improve veterans' health and quality of life. Examples of some of the recent contributions made by VA research to the advancement of medicine are:

• use of the antidepressant paroxetine decreases symptoms related to Post Traumatic Stress Disorder and improves memory;

• physical activity and body-weight reduction can significantly cut the risk of developing type II diabetes;

• new links have been discovered between diabetes and Alzheimer's disease; and

• vaccination against varicella-zoster (the same virus that causes chickenpox) decreases the incidence and/or severity of shingles.

In addition to VA appropriations, the Department's researchers compete and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2007. Through a combination of VA resources and funds from outside sources, the total research budget in 2007 will be almost $1.65 billion, or about $17 million more than the 2006 estimate.

GENERAL OPERATING EXPENSES

The Department 2007 resource request for General Operating Expenses (GOE) is nearly $1.5 billion. It is $131 million, or 9.7 percent, above the 2006 current estimate. Within the 2007 total funding request, $1.168 billion is for the management of the following non-medical benefits administered by the Veterans Benefits Administration (VBA)—disability compensation; pensions; education; housing; vocational rehabilitation and employment; and insurance. This is an increase of $114 million (or 10.8 percent) over the 2006 level. Our request for GOE funding also includes $313 million to support General Administration activities, an increase of $17 million, or 5.7 percent, from the current 2006 estimate.

COMPENSATION AND PENSIONS WORKLOAD, PERFORMANCE, AND STAFFING

VA is focused on delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years due to a steady and sizable increase in workload. This growing workload is the result of several factors—more claims are being filed; we are experiencing more direct contact with veterans and servicemembers, particularly those who served in Operation Enduring Freedom and Operation Iraqi Freedom; the complexity of claims is increasing; and more appeals are being filed.

The volume of claims receipts has grown substantially during the last few years and is now the highest it has been in the last 15 years as we received over 788,000 claims in 2005. This trend is expected to continue. We are projecting the receipt of over 910,000 compensation and pension claims in 2006 (which includes over 98,000 claims resulting from the special outreach requirements of recently enacted legislation) and more than 828,000 claims in 2007.

One of the key drivers of new claims activity is the size of the active duty military force. The number of active duty servicemembers as well as Reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom have increased. This has led to a sizable growth in the number of new claims, and we expect this pattern to persist. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach efforts. Our outreach efforts are critical to the men and women who are entitled to VA benefits and services. We have an obligation to extend our reach as far as possible and to spread the word to veterans about what VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise almost 60 percent of the disability claims receipts each year, and the number of such claims is climbing at a rate of two to 3 percent annually. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as

diabetes, mental illness, and cardiovascular disease. As these veterans age and their conditions worsen, we experience additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. Since the beginning of 2000, the number of veterans receiving compensation has increased 14 percent, from slightly over 2.3 million to more than 2.6 million. However, the total number of disabilities for which veterans are being compensated has increased 37 percent during this time, from nearly 6 million disabilities to 8.2 million disabilities. In addition, we expect to continue to receive a growing number of complex disability claims resulting from Post-Traumatic Stress Disorder, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. Additionally, as the Department receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors.

In addition to the growing complexity of compensation and pension claims, there are special outreach requirements that will have a significant impact on our workload and program performance. These outreach requirements will result in nearly 100,000 additional claims. As a result of the increasing volume and complexity of claims, the average number of days to complete compensation and pension claims is now projected to rise from 167 days in 2005 to 185 days in 2006, and to fall slightly to 182 days in 2007. In addition, we anticipate that our pending inventory of disability claims will climb throughout 2006 as we receive new claims, reaching nearly 418,000 by the end of this year. The inventory will fall by 5 percent during 2007 to around 397,000. Despite these significant workload challenges, we remain committed to reaching our strategic goal of processing compensation and pension claims in an average of 125 days.

We will address our ever-growing workload challenges in several ways. First, we will continue to improve our productivity as measured by the number of claims processed per staff member. Second, we will continue to move work among regional offices in order to maximize our resources and enhance our performance. Third, we will simplify and clarify benefit regulations and ensure our claims processing staff has easy access to the manuals and other reference material they need to process claims as efficiently and effectively as possible. And fourth, we will further advance our efforts to improve the consistency and quality of claims processing across regional offices.

Even though we will implement several management improvement practices, we will need additional staffing in order to address our workload challenges in claims processing. Our 2007 budget includes resources to support over 13,100 staff members (including nearly 7,900 staff in direct support of the compensation and pensions programs), or about 170 above the staffing supported by our 2006 budget.

EDUCATION AND VOCATIONAL REHABILITATION AND EMPLOYMENT PERFORMANCE

Key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 8 days during the next 2 years, falling from 33 days in 2005 to 25 days in 2007. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 69 percent in 2007, a gain of 6 percentage points over the 2005 performance level.

FUNDING FOR INITIATIVES

The 2007 request for VBA includes $3.4 million to continue development of comprehensive training and electronic performance support systems. This ongoing initiative provides technical training to compensation and pension staff through a multimedia, multi-method training approach that has a direct impact on the accuracy and consistency of our claims processing.

The 2007 resource request for VBA includes $2 million to continue the development of a skills certification instrument for assessing the knowledge base of current and new veterans' service representatives and will also result in a skills certification module for a variety of program staff. This initiative will help identify those employees who need additional training in order to better perform their duties and will allow us to improve our screening process involving applicants for higher-level positions.

NATIONAL CEMETERY ADMINISTRATION

The President's 2007 budget request for VA includes $160.7 million in operations and maintenance funding for the National Cemetery Administration (NCA). This represents an increase of $11.1 million (or 7.4 percent) over the 2006 current esti-

mate. The additional funding will be used to meet the growing workload at existing cemeteries by increasing staffing and augmenting funds for contract maintenance, supplies, and equipment. We expect to perform over 107,000 interments in 2007, or 5.4 percent more than the 2006 estimate and 15.1 percent more than the number of interments in 2005.

Our resource request also has $9.1 million to address gravesite renovations as well as headstone and marker realignment, an increase of $3.6 million from our funding for 2006. These improvements in the appearance of our national cemeteries will help us maintain the cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

We will expand access to our burial program by increasing the percent of veterans served by a burial option in a national or state veterans cemetery within 75 miles of their residence to 83.8 percent in 2007, which is 6.7 percentage points above the 2005 level. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 97 percent in 2007, or 3 percentage points higher than the 2005 performance level.

CAPITAL (CONSTRUCTION AND GRANTS TO STATES)

The President's 2007 budget request includes $714 million in capital funding for VA. Our request includes $399 million for major construction projects, $198 million for minor construction, $85 million in grants for the construction of state extended care facilities, and $32 million in grants for the construction of state veterans cemeteries.

The 2007 request for construction funding for our medical care program is $457 million—$307 million for major construction and $150 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program to renovate and modernize VA's health care infrastructure and to provide greater access to high-quality care for more veterans. When combined with the $293 million that was enacted in the Hurricane Katrina emergency funding package in late December 2005 to fund a CARES project for a new hospital in Biloxi, Mississippi, the total CARES funding since the 2006 budget totals $750 million and since the 2004 CARES report amounts to nearly $3 billion.

Our major construction request for medical care will fund the continued development of two medical facility projects—$97.5 million to address seismic corrections in Long Beach; and $52 million for a new medical facility in Denver. In addition, our request for major construction funding includes $38.2 million to construct a new nursing home care unit and new dietetics space, as well as to improve patient and staff safety by correcting seismic, fire, and life safety deficiencies at American Lake (Washington); $32.5 million for a new spinal cord injury center at Milwaukee; $25.8 million to replace the operating room suite at Columbia (Missouri); and $7 million to renovate underutilized vacant space located at the Jefferson Barracks Division campus at St. Louis as well as provide land for expansion at the Jefferson Barracks National Cemetery.

We are also requesting $53.4 million in major construction funding and $25 million in minor construction resources to support our burial program. Our request for major construction includes funds for cemetery expansion and improvement at Great Lakes, Michigan ($16.9 million), Dallas/Ft. Worth, Texas ($13 million), and Gerald B. H. Solomon, Saratoga, New York ($7.6 million). Our request will also provide $2.3 million in design funds to develop construction documents for gravesite expansion projects at Abraham Lincoln National Cemetery (Illinois) and at Quantico National Cemetery (Virginia). In addition, the major construction request includes $12 million for the development of master plans for six new national cemeteries in areas directed by the National Cemetery Expansion Act of 2003—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota County, Florida; and southeastern Pennsylvania.

INFORMATION TECHNOLOGY SERVICES

The President's 2007 budget for VA provides $1.257 billion for the non-payroll costs associated with information technology (IT) projects across the Department. This is $43.2 million, or 3.6 percent, above our 2006 budget.

The 2007 request for IT services includes $832 million for our medical care program, $55 million for our benefits programs, $4 million for our burial program, and $366 million for projects managed by our staff offices, most notably non-payroll costs in our Office of Information and Technology and Office of Management to support department-wide initiatives and operations.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. Within this overall initiative, we are requesting $51 million for ongoing development and implementation of Health*e*Vet-VistA (Veterans Health Information Systems and Technology Architecture) which will incorporate new technology, new or reengineered applications, and data standardization to continue improving veterans' health care. This system will make use of standards that will enhance the sharing of data within VA as well as with other Federal agencies and public and private sector organizations. Health data will be stored in a veteran-centric format replacing the current facility-centric system. The standardized health information can be easily shared between facilities, making patients' electronic health records available to all those providing health care to veterans.

Until Health*e*Vet-VistA is operational, we need to maintain the VistA legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides $188 million in 2007 for the VistA legacy system.

In support of the Department's education program, our 2007 request includes $3 million in non-payroll costs to continue the development of The Education Expert System. This will replace the existing benefit payment system with one that will allow the Department to automatically process education claims received electronically.

VA's 2007 request provides $57.4 million for cyber security. This ongoing initiative involves the development, deployment, and maintenance of a set of enterprise-wide security controls to better secure our IT architecture in support of all of the Department's program operations.

SUMMARY

In summary, Mr. Chairman, the $80.6 billion the President is requesting for VA in 2007 will provide the resources necessary for the Department to:

- provide timely, high-quality health care to nearly 5.3 million patients, including 4.8 million veteran patients of which 79 percent are among those who need us the most—those with service-connected disabilities, lower incomes, or special health care needs;
- address the large growth in the number of claims for compensation and pension benefits; and
- increase access to our burial program by ensuring that nearly 84 percent of veterans will be served by a burial option in a national or state veterans cemetery within 75 miles of their residence.

I look forward to working with the Members of this Committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO HON. R. JAMES NICHOLSON

MEDICAL CARE PROGRAMS

Question 1. VA has been able to offer veterans a wide-range of pharmaceutical medications over the years without breaking the bank because of its ability to manage a formulary and hold down drug cost increases. This year, however, VA shows a need for a 10 percent increase in the pharmacy budget, with little to no growth in the patient population.

A. Is VA starting to lose the ability to keep pharmacy inflation down in the 3 to 7 percent range?

B. Or is there another explanation for this fairly large growth?

Answer A and B. No, we are not losing our ability to keep pharmacy inflation under control. There are explanations for the 10 percent increase in the fiscal year 2007 pharmacy budget: the increasing number of veterans using our pharmacy services and the increases in costs per user of our pharmacy service. This increase in cost is both due to inflation and the increased availability and complexity of modern drug treatments.

Question 2. As you know, in addition to this Committee, I also sit on the Appropriations Subcommittee with jurisdiction over your Department. I have noticed that VA's health care funds are provided through numerous accounts—Medical Services, Medical Administration, Medical Facilities, and Information Technology.

A. Does this structure help VA to more accurately account for its expenditure in any or all of the areas?

B. Or does it cost a significant amount of money to account for different expenditures because VA needs to properly reflect the correct account?

Answer A and B. No, this structure does not increase the accuracy of accounting for expenditures because all the expenditures are recorded in VA's Financial Management System (FMS), by appropriation, budget object code, cost center, and year of fund availability. The accuracy of the recording is identical whether all expenditures are in a single appropriation (medical care) as it was prior to fiscal year 2004 or in three appropriations (medical services, medical administration, and medical facilities) that were created in fiscal year 2004 and now in fiscal year 2006 in four appropriations (medical services, medical administration, medical facilities, and information technology).

The change to three appropriations in fiscal year 2004 actually made local medical facility operations significantly more complex. Prior to fiscal year 2004, the medical facility director was allocated a single budget that could be used to address local operational priorities as they occurred. For example, funds could be used to address critical vacancies in nurse staffing, or security guard staffing, or food service staffing as the need arose in the support of the total patient care mission. Now each of those functions is supported by a totally separate appropriation (the nurse is in medical services, the security guard in medical administration, and the food service worker in medical facilities). Although all three individuals are critical to the successful care and treatment of the patient, the three appropriation structure has the unintended consequence of suggesting that some how the medical services appropriation is more important to the care of the patient than the other two. This is one of the most serious drawbacks of the multi-appropriation structure—it gives the false impression that the medical services appropriation is the only one of the appropriations that is related to direct patient care. All three (now four) appropriations are directly related to patient care.

The multiple appropriation structure requires a significant increase in the volume of funding transactions. For example, each appropriation is allocated to approximately 150 separate facilities or program offices. Also, the volume and complexity of the financial workload have increased significantly. For example, in fiscal year 2003, there were approximately 30,000 funding transactions to support the single appropriation structure. In fiscal year 2005, there were over 55,000 funding transactions required to support the three appropriation structure. In fiscal year 2006, based on our current experience, we anticipate approximate 70,000 funding transactions to support the four appropriation structure.

In summary, the multi-appropriation structure does not improve the accuracy of accounting for expenditures, it generates a significant increase in workload, and it reinforces a false perception that the medical services appropriation is more important than the other appropriations in the delivery of high quality healthcare services to veterans.

Question 3. VA's fiscal year 2007 budget proposes a number of new major construction projects. VA has already begun several major projects whose completion costs are not reflected in the budget request. However, the Committee will need to authorize all CARES related construction that occurs after September 30, 2006.

A. Please provide the Committee with a complete list of all of VA's major construction projects that would require authorization to either begin construction or to complete construction already underway. This list should include a breakdown of money already obligated under the existing authorization as well as the cost of completing such projects.

Answer. See listing below of major construction projects requiring authorization, total estimated cost and obligations to date of project funds.

Location	Project description	Total Est. cost ($000)	Obligations (Project funds only)
Immediate need for FY 2006 Authorization			
1. Biloxi, MS	Restoration of Hospital/Consolidation of Gulfport	$310,000	$0
2. Denver, CO	Replacement medical center facility	621,000	0
3. New Orleans, LA	Restoration/Replacement of Medical Center Facility	675,000	0

Location	Project description	Total Est. cost ($000)	Obligations (Project funds only)
Extension of Authorization of Major Construction Project Authorized Under P.L. 108–170			
1. Anchorage, AK	Outpt. Clinic/Regional Office	75,270	0
2. Cleveland, OH	Cleveland-Brecksville Consolidation	102,300	0
3. Des Moines, IA	Extended Care Building	25,000	0
4. Durham, NC	Renovate Patient Wards	9,100	354
5. Gainesville, FL	Correct Pt. Privacy Deficiency	85,200	0
6. Indianapolis, IN	7th & 8th Fl. Wards Modernization Addition	27,400	27,400
7. Las Vegas, NV	New Federal Medical Facility	406,000	0
8. Lee County, FL	Outpatient Clinic	65,100	0
9. Long Beach, CA	Seismic Corrections-Bldgs 7 &126	107,845	0
10. Los Angeles, CA	Seismic Corrections-Bldgs. 500 & 501	79,900	0
11. Orlando, FL	New Medical Center Facility	347,700	0
12. Pittsburgh, PA	Consolidation of Campuses	189,205	39,000
13. San Antonio, TX	Ward Upgrades and Expansion	19,100	702
14. San Juan, PR	Seismic Corrections-Bldg. 1	15,000	0
15. Syracuse, NY	Spinal Cord Injury Center	53,900	0
16. Tampa, FL	Spinal Cord Injury Center Expansion	7,100	0
17. Tampa, FL	Upgrade Essential Electrical Distribution Systems	49,000	0
18. Temple, TX	Blind Rehab and Psychiatric Beds	56,000	0
FY 2007 New Major Construction Projects			
1. American Lake, WA	Seismic Corrections-NHCU & Dietetics	38,220	0
2. Columbia, MO	Operating Room Suite Replacement	25,830	0
3. Fayetteville, AR	Clinical Addition	56,163	0
4. Milwaukee, WI	Spinal Cord Injury Center	32,500	0
5. St. Louis (JB), MO	Medical Facility Improvements and Cemetery Expansion	69,053	0
6. San Juan, PR	Seismic Corrections-Bldg. 1	130,200	0

Question 4. The decrease in direct appropriations for Medical and Prosthetic Research stands out against the backdrop of budget increases for medical services, medical administration, and medical facilities. Knowing that today's research will guide clinical treatment and service delivery in the years ahead, I am interested in your comments on the projected research budget.

A. Specifically, as an increasing number of younger combat injured veterans with traumatic brain injuries, amputations, spinal cord injuries, and sensory problems are seeking VA care, should we be greatly expanding our research efforts in these areas?

B. Does this budget provide enough latitude to do so, given that significant resources are already directed toward research on Geriatric Care, Alzheimer's, Parkinson's, and other disorders associate with VA's older population?

Answer A and B. VA research is increasing its focus on newly emerging needs of veterans, especially those returning from Operation Iraqi Freedom and Enduring Freedom (OIF/OEF). VA recently issued a Request for Applications (RFA) to stimulate more research in combat casualty neurotrauma, including traumatic brain injury and spinal cord injury. VA also issued an RFA to establish a Quality Enhancement Research Initiative (QUERI) Coordinating Center for implementation of best practices in polytrauma and blast-related injuries (i.e., complex, multiple injuries in unpredictable patterns, including amputations, brain injuries, eye injuries, musculoskeletal injuries and emotional adjustment problems). The Center will be expected to create and coordinate an implementation network that includes researchers, clinicians, managers and leaders with VA and the Department of Defense (DOD).

In addition, VA continues to expand its support of multidisciplinary research and examination of enabling technologies to ease the physical and psychological impacts of limb loss, including pain. While traditional amputation research has focused on mechanical limb prostheses, VA is expanding its focus to include novel approaches, such as tissue engineering and surgical treatment for residual limb lengthening, joint replacement and attachment of prostheses, as well as incorporating advanced materials, microelectro-mechanics and nanotechnologies into current prosthetic designs. One particularly innovative approach involves investigating the control of prostheses through direct brain activity. A primary goal of these activities is to generate rigorous data that can drive policy and shape clinical care guidelines.

VA also continues to support a broad mental health research portfolio. VA has recently issued a joint RFA with DOD and the National Institutes of Health (NIH) to enhance and accelerate research on the identification, prevention and treatment of combat related post-traumatic psychopathology and similar adjustment problems. Studies target active-duty or recently separated National Guard and Reserve troops involved in current and recent military operations.

In many cases, the specific needs of returning OIF/OEF veterans mirror those of veterans who served in previous conflicts. For example, a significant percentage of these returning veterans exhibit symptoms of post-traumatic stress disorder and depression that resemble those following previous deployments. Similarly, research designed to improve traumatic amputation and subsequent prosthetics care is nonetheless relevant to veterans other than those who served in OIF/OEF, including elderly patients with diabetes and vascular disease who account for the majority of the prosthetic fittings performed in VA annually. Accordingly, VA is funding OIF/OEF related research as it continues aging research. VA's research focuses on both newly emerging needs of OIF/OEF veterans as well as for VA's older population.

Question 5. VA's budget request $85 million for the State Nursing Home Grant program.

A. Please provide me with a breakdown of how this money would be allocated between new construction proposals and repairs to existing homes.

Answer. VA is assessing the fiscal year 2007 budget proposal of $85 million to determine the amount of funding that will be used for a grant to support the construction of a new 400-bed nursing home in West Los Angeles and the amount of funding that will be required for state home life safety projects. VA anticipates providing $68 million to the West Los Angeles construction project in fiscal year 2006 and providing the remaining funding to complete the project over the next few years.

Question 6. Mr. Secretary, VA is transitioning to a "federated model" of IT program management. VA's budget request reflects this transition. The total IT request represents an increase of over 3 percent. But, within that overall increase, the Office of Management will see nearly a 16 percent increase, almost doubling its IT funding within the last 2 years.

A. Why was the Office of Management singled out for such a large increase, whereas other offices—such as the Office of Information Technology—were not?

Answer. The IT increases requested by the Office of Management (OM) between fiscal years 2005 and 2007 is primarily the result of additional funding required for VA's Financial & Logistics Integrated Technology Enterprise (FLITE) project. The 2007 funding level is $20.4 million over the 2005 level. FLITE is an essential effort to move VA away from a financial system developed in the 1980's to a modem environment that will effectively integrate and standardize financial and logistical data department-wide. In addition, other 2007 OM IT increases over 2005 include funding to operate the H.R. and Payroll system ($1.7 million); E-travel ($2.0) and E-Payroll ($6.4 million).

Question 7. VA has once again proposed that VA increase prescription drug copayments to $15 for each 30-day supply of medication. Of course, Congress has previously declined to approve these fee proposals.

A. Are you wed to this specific increase on medication copayments?

Answer. We believe this increase for prescription copayments from $8 to $15 is a fair and reasonable policy. It is consistent with the priority health care structure enacted by Congress several years ago, and would more closely align VA's copayments with other public and private health care plans. The President's budget includes similar, small incremental copayment increases for DOD retirees under age 65 in the TRICARE system. The VA increase in copayment fees would allow us to focus our resources on patients who typically do not have other health care options.

B. Or, have you explored other cost-sharing options?.

Answer. Yes, VA has evaluated other alternatives, but we believe this proposal is fair and will generate sufficient revenue to allow us to focus our resources on patients who typically do not have other health care options.

COMPENSATION AND PENSION PROGRAMS

Question 1. The Administration's FY07 budget proposal estimates an output of 108 completed rating-related disability claims per direct FTE. The Independent Budget, on the other hand, recommends that staffing levels be based on 100 ratings for each direct FTE.

A. What factors were considered by VA in setting the productivity goal of 108?

Answer. VBA considered the increased experience level of employees hired over the past several years. VBA expects that the employees hired in fiscal year 2005 and those we are currently hiring and training will be able to assist in improving

timeliness and delivery of benefits to veterans in fiscal year 2007. VBA believes the increase to 108 claims per FTE is realistic and consistent with our goal of producing timely and accurate claims decisions.

B. Is there any reason to expect less productivity in FY07 than was accomplished in FY05 (101 ratings per direct FTE) and is expected in FY06 (106 ratings per direct FTE)?

Answer. We do not have reason to expect a lower level of productivity. VBA's projected output of 108 claims per FTE for fiscal year 2007 represents a 6.9 percent increase in productivity over our actual output of 101 claims per FTE in fiscal year 2005. It represents an increase in productivity of 1.9 percent over our projected fiscal year 2006 output of 106 claims per FTE.

Question 2. The Secretary has authority to furnish office space in VA facilities to representatives who assist veterans in pursuing their claims before VA.

A. Does VA track the cost of providing representatives with office space in VA facilities?

Answer A. VA provides space to authorized Veterans Service Organizations free of charge. We do not track the cost.

B. If so, how much will VA expend on that in FY07? Answer B. That information is not available.

C. What measures, if any, does VA take to ensure that those representatives are competent to assist veterans in pursuing claims for VA benefits?

Answer C. As provided in 38 CFR § 14.628(d)(1)(v), VA requires that all VSOs have a plan for training qualified claims representatives and take affirmative action in the area of training as a condition for recognition. VA relies, in large part, on the training programs of the VSOs to ensure that individuals employed by those organizations are adequately trained and supervised. We have found this process to be a suitable and efficient means for ensuring that VSO representatives are adequately trained. In order to emphasize the importance of maintaining such training programs, VA's Office of General Counsel has previously sent inquiries to several of the larger VSOs to verify the sufficiency of their programs. The information received from VSOs in response to these inquiries did not reveal any significant deficiencies.

VBA does offer training for accredited veterans service officers involved in the claims development process under the TRIP (Training, Responsibility, Involvement, and Preparation of Claims) Program. Participating VSOs are provided with training aimed at improving the quality of claims submissions. Those accredited VSOs who successfully complete TRIP training are also given restricted access to some VA computer applications that are used in the claims development process. The TRIP Program is designed to ensure that VSOs understand the claims development process. VSOs who successfully complete the training then can help expedite the claims they submit by working with veterans to obtain the evidence needed from non-Federal sources.

D. Is a minimum level of training or experience required?

Answer. See response to 2.C above.

Question 3. In testimony submitted to this Committee last year, VA indicated that it would "consider ways to prevent the protracted piece-meal submission of evidence and the delays it causes, while protecting due process rights of claimants."

A. What is the status of that effort?

B. Would legislative action be needed to accomplish that objective?

Answer A and B. Following a May 26, 2005, Senate Committee on Veterans' Affairs hearing, VBA was asked to comment on recommendations made by former U.S. Court of Appeals for Veterans Claims (Veterans Court) Chief Judge Kenneth Kramer for improving the VA claims adjudication and appeal system, including his recommendation to close the record at an earlier stage in the appeal process. We responded that "[w]e recognize . . . that an open record contributes to protracted appeal processing and therefore to delay in deciding appeals. We will consider ways to prevent the protracted piece-meal submission of evidence and the delays it causes, while protecting due process rights of claimants."

The laws currently governing VA's administrative appeal process contemplate that VA (1) will continue to develop the record after a claimant has filed a notice of disagreement (NOD), which commences the appeals process, in order to resolve the disagreement either by granting the benefit or through withdrawal of the NOD; (2) afford the appellant an opportunity for a hearing; and (3) obtain an advisory medical opinion when warranted by the medical complexity of the case.

VA must implement the development contemplated by these laws in accordance with procedures required by governing statutes and fair process concerns recognized by the Veterans Court. The courts have held that procedural fairness in an administrative proceeding generally requires an adequate opportunity to know the evidence

to be relied upon and to rebut it. *See Wirtz* v. *Baldor Elec. Co.,* 337 F.2d 518, 528 (D.C. Cir. 1963) (citing cases). The Veterans Court has held that, before the Board of Veterans' Appeals (Board) relies, in rendering a decision, on any evidence (in that case a medical treatise) obtained after the issuance of the most recent statement of the case or supplemental statement of the case with respect to the claim at issue, the Board is required to provide the appellant with reasonable notice of the evidence and of the reliance proposed to be placed on it, as well as reasonable opportunity to respond. *Thurber* v. *Brown,* 5 Vet. App. 119, 126 (1993). In another case, the Veterans Court held that a claimant is entitled to submit evidence as well as present argument or comment in response to additional evidence, in that case a medical-adviser opinion, obtained by the Board. *Austin* v. *Brown,* 6 Vet. App. 547, 551 (1994). More recently, the U.S. Court of Appeals for the Federal Circuit held that the Board may not consider additional evidence without either remanding the case to the agency of original jurisdiction (AOJ) for initial consideration or obtaining the appellant's waiver permitting the Board to consider the evidence in the first instance. Disabled Am. Veterans v. Secretary of Veterans Affairs, 327 F.3d 1339, 1353 (Fed. Cir. 2003). VA has promulgated and amended its regulations in accordance with these court decisions.

VA has most recently focused its efforts to limit piecemeal submission of evidence on litigation designed to prevent judicial interpretations of the Veterans Claims Assistance Act of 2000 (VCAA) that would delay appellate decisionmaking through protracted evidence development. For example, in two cases recently decided by the Veterans Court, *Dingess* v. *Nicholson and Hartman* v. *Nicholson,* VA argued that the VCAA does not require VA to provide notice of the information and evidence necessary to substantiate a claim each time the Department renders a decision on a claim and the claimant files a NOD with that decision. The same issue is raised in several Veterans Court decisions that VA has appealed to the Federal Circuit. The Veterans Court held in *Dinqess* and *Hartman* that, assuming VA has provided proper notice, VCAA notice is no longer required once a decision awarding service connection, a disability rating, and an effective date has been made by VA. In addition, in *Mayfield* v. *Nicholson,* which was recently decided by the Federal Circuit, the claimant contended that VA was required to provide VCAA notice after the Board remanded the case to the AOJ for compliance with the VCAA and obtained a medical opinion that proved to be adverse to the claim. The Federal Circuit held that VA must provide VCAA notice before VA decides the claim and in a form that enables the claimant to understand the process, the information that is needed, and who will be responsible for obtaining the information. The VCAA provides a claimant with 1 year after VA sends VCAA notice to provide VA with the information and evidence necessary to substantiate the claim, although VA could issue a decision before the end of the 1-year period.

Question 4. In testimony presented to this Committee last year, it was posited that attorneys representing claimants before VA would have an ethical obligation to screen claims for merit and to counsel their clients against filing frivolous claims.

A. Would an initial screening process that discourages the filing of non-meritorious claims have a beneficial effect on VA's claims processing system?

Answer. Following his testimony at the May 26, 2005, Senate Committee on Veterans' Affairs hearing, Mr. Robert V. Chisholm was asked to respond to a post-hearing question concerning the obligation of attorney representatives to counsel their clients against filing claims for veterans benefits that may not be meritorious. Mr. Chisholm responded that the American Bar Association's Model Rules of Professional Conduct and parallel State rules "impose an ethical obligation upon an attorney to examine a claim for its merit and to counsel the client against filing a claim if it is frivolous and without merit."

VBA's current procedures include an initial screening process to immediately review all incoming applications for veterans benefits to determine whether a claim requires: (1) expedited action because of the nature of the claim or the facts; (2) immediate referral to the rating activity because all evidence was submitted with the claim; (3) further development because it is incomplete; or (4) immediate denial because the claim cannot be substantiated. VBA performs a routine check of all original claims for disability compensation to check for: (1) the proper signature for the claim; (2) the benefit sought and type of claim; (3) character of discharge; (4) service verification; (5) basic eligibility for the benefit sought; (6) completeness of application; and (7) acceptable dependency information. If there is a legal bar to entitlement, such as lack of qualifying service or character of discharge, VBA denies the claim without referring it to the rating activity. However, in the absence of a statutory bar to entitlement, VBA does not deny any claim until it has complied with VA's statutory duty to assist in obtaining evidence necessary to substantiate the claim. VA must provide assistance unless there is no reasonable possibility that as-

sistance would aid in substantiating the claim. Prior screening of claims by claimants' representatives would save VA the burden of evaluating, and in some cases developing, claims that will ultimately prove incapable of substantiation.

Question 5. In the Administration budget proposal, it is noted that the Veterans Claims Assistance Act of 2000 "significantly increased both the length and complexity of claims development" and "add led] more steps to claims process."

A. Have those additional steps led to improved outcomes for veterans or improved satisfaction with the process?

Answer. Following the Court of Appeals for Veterans Claims decision in Morton v. West, VA was required to deny claims without rendering assistance to a veteran when the claim was determined to be "not well grounded." The Veterans Claims Assistance Act (VCAA) eliminated the "well grounded" requirement. Consequently, when VA now receives a substantially complete application for benefits, the claimant is provided with a VCAA notice, which details what further information or evidence is needed to substantiate the claim. The notice identifies the information or evidence that VA will try to obtain and the information or evidence the veteran must submit. VA then provides assistance in obtaining the evidence in all disability claims except in very limited circumstances described by statute. VA provides the veteran with a decision and an explanation of the reasons for the decision. We believe the provision requiring assistance in virtually all claims is a significant improvement for claimants.

We have no data to suggest that, for those veterans who submit claims that would have met the previous "well grounded" test, providing the VCAA notice has affected the eventual outcome of the claim. We believe it has, however, lengthened the time to get to that decision and lengthened the appeals process as well, with numerous opportunities for remands based solely on issues of technical compliance with VCCA notice provisions.

The most recent customer satisfaction data we have indicates that in 2004 overall customer satisfaction with the compensation and pension claims process was 60.9 percent, a slight improvement over 2003 when it was 59.4 percent.

Question 6. Your testimony points to increased utilization of VA medical services as one of the key cost drivers of the system. One primary example of increased utilization you cite is the number of disability examinations performed at VA medical facilities.

A. How are requests for disability examinations managed by facility directors given that demand for medical care services is high?

Answer. No Response.

B. Would utilizing contract disability examiners free up direct labor hours so that clinicians could focus on medixcal care?

Answer. No Response.

C. How much does it cost to perform a thorough and accurate disability examination?

Answer. No Response.

D. How much does it cost a contract examiner?

Answer. No Response.

Question 7. Over the past 5 years VA has seen a two-fold increase in the number of claims filed with 8 or more claimed service-connected conditions.

A. Are there particular cohorts of veterans responsible for filing claims with 8 or more issues, e.g., OIE/OEF, military retirees, etc.?

Answer. VBA does not currently collect this type of data. However, claims filed under the Benefits Delivery at Discharge (BDD) program typically contain a larger number of issues.

B. How many disabilities on a claim with 8 or more issues does VA, on average, end up establishing service-connection?

Answer. VBA does not currently have a mechanism to collect this information. However, we are working to develop a means to associate the disabilities claimed with the service-connected disabilities granted through extraction of data from the Modern Award Processing-Development (MAP-D) and Rating Board Automation 2000 (RBA2000) systems.

C. What is the highest number of issues ever claimed by a veteran on one claim? What is the highest number ever granted by VA?

Answer. VBA does not currently collect this information. However, a claim decided in August 2005 initially included approximately 400 conditions. During the claims development process, this number was narrowed to 281 issues, by consolidating similar or repeated entries. The final Rating Decision further consolidated this to 84 "rated" disabilities. Of those, serviceconnection was granted for 39 disabilities. The combined evaluation was 100 percent.

D. In the interest of fairness to other claimants and efficient processing of legitimate, claimed disabilities with scarce resources, would it make sense for Congress to consider a cap on the number of issues that could be claimed by any one veteran?

Answer. Since the circumstances of each veteran claiming disability compensation are unique, it is fair to consider each claim on its own merits, regardless of the number or types of issues claimed. The number of issues is not the only cause of longer processing times. The increasing complexity of the legal requirements surrounding the claims process has also extended the time veterans must wait for decisions on their claims.

Question 8. While VA expects well over 800,000 disability claims in FY07, the number of claimed service-connected disabilities on each individual claim will be far greater.

A. What is the total number of disability decisions VA expects to make within the 849,000 claims it will receive?

Answer. VA cannot capture this data precisely. However, information currently available to us indicates that a veteran requests compensation for three conditions on average in his or her disability claim. Therefore, we estimate decisions on 2,457,000 claimed conditions in fiscal year 2007.

Question 9. The budget estimates that disability claims workload will increase in FY07, but that direct FTE to handle that workload will decrease.

A. Why does VA propose a significant increase in Management Direction and Support FTE for Compensation and Pension in FY07?

Answer. The 2007 budget does not actually propose a significant increase in management support; rather it correctly identifies indirect FTE required to support direct VBA FTE for all business lines. The 2006 President's Budget erroneously understated total management support FTE, resulting in a misallocation of management support FTE to the Compensation and Pension business line. The 2007 budget submission correctly identifies the total number of management support FTE based upon our most recent execution records and equitably allocates these FTE across all business lines.

B. Isn't the need for FTE most acute in the field, where the claims will be received, and not in Management Direction and Support?

Answer. Yes. VBA is committed to ensuring that our field offices have sufficient FTE to directly meet our veterans' needs. Historically, VBA has increased FTE in functions that directly support veterans, while decreasing indirect support functions. For example, since 2002, VBA has increased direct FTE by nearly 100 while management support has decreased by over 180.

Question 10. Section 1103 of title 38, United States Code, bars the payment of disability compensation to veterans on account of diseases or injuries attributable to the use of tobacco products while in serve. However, this bar does not apply to diseases or injuries that manifest while in service, even if attributed to the use of tobacco products.

A. For prospective claims only, what would be the cost savings associated with barring all service-connected compensation for diseases or disabilities attributed to the use of tobacco products, irrespective of whether such disease manifested before or after military service?

Answer. VA is working on that estimate and will provide it as soon as it is completed.

Question 11. VA expects a 10 percent increase in the number of veterans on the disability compensation roles over just a 2-year period. In my first decade in the senate (from 1991 to 2001), there was only a 5 percent increase in the disability roles.

A. Is this acceleration a trend VA expects will continue?

Answer. The number of original compensation claims received by VA has increased from 111,672 in fiscal year 2000 to 210,504 in fiscal year 2005. The number of veterans receiving compensation has increased by 261,595 during the same period. We expect the number of veterans receiving compensation to continue to grow in the foreseeable future. Among the reasons for the growth are the current conflicts in Iraq, Afghanistan, and the Global War on Terrorism; the increased size of the active force as a result of the mobilization of large numbers of Guard and reserve military personnel; and the impact of Combat Related Special Compensation (CRSC) and Concurrent Retirement and Disability Pay (CRDP).

This projected growth takes into account the offsetting increased death rate among older veteran populations. The number of World War II veterans on the rolls is rapidly declining due to age and the Korean War population on the rolls, the next oldest veteran group, is comparatively small. In the near term, the impact of deaths in these two veteran populations receiving compensation will slow but not reverse the growth trend in the number of veterans receiving compensation. The rapidly

growing Guff War Era veteran population is now the third largest population of veterans on the rolls. We believe that original claim rates will return to more traditional levels only when the full impacts of the conflict, CRDP, and CRSC have been experienced.

Question 12. VA projects double-digit mandatory spending growth.

A. In addition to the growth of the number of veterans on the compensation roles, what accounts for the large increase in mandatory spending?

Answer. Factors that influence average payments are the annual cost of living adjustments (COLAs), an increase in the average degree of disability per veteran, an increase in the number of individual unemployability (IU) cases, and an increase in the number of special monthly compensation (SMC) cases. Enacted legislation that provides new or expanded benefits also contributes to the rise in mandatory spending.

• The 4.1 percent COLA in 2006 and 10 months of the anticipated 2.6 percent COLA for 2007 are expected to add $784 million to Compensation and Pension Program mandatory spending in 2007.

• The average degree of disability per veteran increased from 33.2 percent in 2000 to 38.3 percent in 2005 and is expected to continue increasing in 2007 and beyond.

• Veterans who are rated 60 percent and above are eligible for IU. Those who qualify because they are unable to maintain employment due to a service-connected disability are compensated at the 100 percent benefit rate. The number of veterans receiving IU benefits increased by 20,774 in 2005.

• Special monthly compensation is a monetary benefit paid in addition to or in place of the zero to 100 percent combined degree of disability for special circumstances, such as loss of use of one hand. In 2004, there were 207,637 veterans receiving SMC in 2005 the number rose to 230,713.

B. Is this trend expected to continue?

Answer. The C&P forecasting model is based on historical data and trends. While our projections take many factors into account, like those cited above, there are other variables that cannot be anticipated. These include court decisions, enacted legislation, and the number of troops deployed. Based on all available information, we expect continued growth in mandatory spending.

Question 13. The Independent Budget suggests that experienced, well-trained personnel are essential to improve timeliness and accuracy of claims adjudication.

A. What is the average number of years of experience, i.e., years as a VA employee, for VA's VSRs and RVSRs?

Answer. The average VSR has just over 4 years of Federal service, while the average RVSR has approximately 15 years.

B. Is the trend toward a more experienced workforce or less experienced one?

Answer. The average years of VA experience for RVSRs is projected to decline in the near term, as many of our current RVSRs are at or near retirement age. Most of the RVSR vacancies resulting from retirements will be filled from the ranks of our VSRs, who generally have much less VA experience. Since most of our VSR hires will continue to be new to the Federal workforce, we do not project the average VA experience level of our VSRs to increase significantly in the near term.

C. Is there a correlation between the average years of experience of the workforce and positive or negative performance?

Answer. Performance is affected by many factors including the complexity of claims, claims volume, policy and regulatory changes, years of experience, and others. We have not conducted any analyses to determine what, if any, correlation exists between the average years of experience of RVSRs or VSRs and performance.

Question 14. You anticipate an extra 98,000 disability claims to be filed in FY06 as a result of specialized outreach in six states directed by the recently enacted Appropriations bill (Publics Law 109–114).

A. What effect will the influx of these claims have on disability claims processing performance nationwide?

Answer. VBA estimates that the number of days required to complete a claim will rise in the near term from 167 days in fiscal year 2005 to 185 days in fiscal year 2006. We project that timeliness will again begin to improve in the latter part of fiscal year 2007 as we are able to complete the processing of some of this additional workload and the inventory again begins to decline.

B. What performance impact will there be on the Regional Offices in the six states in question?

Answer. The regional offices in the six states most directly affected by this special outreach effort do not have the resources to handle the large workload increases that are anticipated. Therefore, regional offices and resource centers across the Nation will be called upon to assist these six offices through workload brokering ar-

rangements. While the greatest impact will still likely be on the performance in the six regional offices, our brokering strategy will help to minimize the impact on the veteran populations in these states.

C. As veterans respond to this outreach by filing claims, how many do you anticipate being successful?

Answer. We cannot predict how many veterans will receive increased evaluations. Available data indicates that the ten most prevalent service-connected conditions are in the areas of the musculoskeletal system, the skin, hearing, neurological conditions, mental disorders, the cardiovascular system, the respiratory system, the endocrine system (mostly type II diabetes), the genitourinary system, and vision. Many of the conditions related to these ten areas are chronic and progressive. It is therefore reasonable to assume that, in cases involving these conditions where the veteran has not filed a claim for increase in many years, a significant number of claims could result in increased benefits.

Question 15. I was particularly struck by one aspect of VA's 2004 pension program evaluation report which suggested that 5 percent of pension participants who are veterans, and 13 percent of participants who are spouses, have no health care coverage.

A. How is it possible that recipients of VA cash benefits are unaware of their eligibility for VA health care?

Answer. With each compensation, pension, and dependency indemnity compensation award notification letter, we include information about health care benefits. For example, VA Form 21–8769, Disability Pension Award Attachment, states: "Veterans who are entitled to pension and/or special monthly pension (aid and attendance or housebound benefits) as determined by the Veterans Benefits Administration are eligible for medical care through the VA health care system. If you are interested in obtaining VA medical care, you may contact your nearest VA health care facility or the VA Health Benefits Center at 1–877–222–8387."

B. What is VA doing to let these beneficiaries know that VA will provide them with coverage?

Answer. See response to 15A.

EDUCATION PROGRAM

Question 1. From FY01 to FY03, the timeliness of decisions on original education claims improved remarkably. During FY04 and FY05, however, there was a deterioration of that improvement.

A. Will the additional 34 direct FTE requested for the Education Service for FY07 allow VA to regain that lost ground?

Answer. We believe the additional 34 FTE requested for 2007, together with the additional FTE allotted for 2006, will enable us to achieve the 2007 target of 25 days, on average, to process original claims.

Question 2. In 2004, Congress created a new education program (Chapter 1607) for Guard and Reserve personnel activated after September 11, 2001. According to the Administration's FY07 budget proposal, no Chapter 1607 benefits were paid during FY05.

A. How many Chapter 1607 claims are now pending?

Answer. As of Monday, March 27, 2006, 8,833 claims were pending.

B. Will those pending claims be decided this fiscal year?

Answer. Yes.

C. Does the budget proposal devote sufficient resources to handling the Chapter 1607 workload during fiscal year 2007?

Answer. The majority of the Chapter 1607 claims in 2006 and 2007 will come from Guard and Reserve personnel who are converting to Chapter 1607 from the less generous Chapter 1606 program. The additional resources required for this conversion are minimal. Resources in the fiscal year 2007 budget are sufficient to handle the anticipated workload from those with eligibility for Chapter 1607 only, as well as those who are converting from Chapter 1606.

Question 3. Last year, the Veterans Advisory Committee on Education recommended that three education programs (Chapter 30, Chapter 1606, and Chapter 1607) be replaced with a single program applicable to all members of the Armed Forces. VA personnel and personnel from the Department of Defense subsequently formed a working group to assess the merits of that recommendation.

A. What the status of the working group's efforts?

Answer. Acknowledging that the three programs differ by design, the group members first reviewed the specific purposes of each program to identify the unique and essential elements of each. The group must agree next on those features from each program that would need to be incorporated into a new program. Also, the group

must discuss the issues to be considered in bringing hundreds of thousands of beneficiaries receiving benefits under three separate programs into a single program.

B. When will that group finish its assessment of the proposed changes?

Answer. While no deadline was established for the group to complete its work, an assessment of the merits of the recommendation is likely within the next 90 days.

Question 4. Currently, veterans cannot electronically access important information regarding their VA education benefits and may have to endure delays in receiving this information telephonically.

A. Would allowing students to access information electronically increase the efficiency and convenience of the VA education benefits system?

Answer. Yes, if students had access to additional account information it would benefit both the student and VA. Many of our calls are claim specific, so allowing students access to additional on-line information would reduce the number of calls and allow VA employees more time to process the students' claims.

B. What steps have been taken or will be taken to provide veterans with electronic access to all relevant information regarding their education benefits?

Answer. Students are currently able to obtain some monthly payment information from our automated phone system. They are able to verify their enrollment information via the telephone and our Web Automated Verification of Enrollment (WAVE) system. Our WAVE system also allows them to view a portion of their VA record, change their mailing address, and establish or change a direct deposit.

We are currently looking at the feasibility of providing the student with information on our web site. The information would consist of a listing of information (forms) VA received on their claims and an estimated timeframe when their claims will be processed.

VOCATIONAL REHABILITATION AND EMPLOYMENT PROGRAM

Question 1. The Vocational Rehabilitation and Employment (VR&E) program would receive a significant increase in FTE under the Administration's budget proposal.

A. How many of those additional FTE will be Employment Coordinators?

B. In total, how many Employment Coordinator does VR&E plan to utilize in FY07 and what functions will they perform?

C. Do those functions overlap with functions performed by Disabled Veterans' Outreach Program (DVOP) specialists?

D. To what extent—if any—will VR&E rely on DVOP specialists to provide employment services to VR&E participants?

Answer. A and B. The fiscal year 2007 budget allocates 107 additional FTE to VR&E. The first priority in filling the positions will be the new Employment Coordinator (EC) position, second will be Rehabilitation Counselors, and third, Contract Specialists. Exact numbers will be determined based on hiring in the interim.

In keeping with the VR&E Task Force recommendations and to ensure that service-connected disabled veterans who are participating in a vocational rehabilitation program are provided with comprehensive employment services, VR&E plans to have at least one employment coordinator at every regional office. All existing Employment Specialists have been permanently re-assigned to Employment Coordinator positions and the Employment Specialist position has been abolished.

The duties/functions of the Employment Coordinator include:

- Providing comprehensive vocational assessment, case management, marketing, and placement services;
- Serving as an integral resource in support of the delivery of employment exploration and readiness services;
- Assisting vocational rehabilitation counselors to accurately assess a veteran's current feasibility for achievement of a vocational goal;
- Recommending an appropriate vocational rehabilitation plan through one of five possible service delivery options (tracks) with the goal of suitable employment or independent living; and
- Assisting veterans to access VetSuccess.gov, VR&E's newly developed "online" employment resource that provides orientation to VR&E programs, expert vocational advice, rich labor market resources, and career development tools.

Answer C. Employment Coordinators do not provide services that are duplicative of those tasks performed by the Department of Labor's Disabled Veterans' Outreach Program (DVOP) specialists. VR&E Employment Coordinators serve as "triage" team members to help disabled veterans make informed choices regarding selection of an employment goal and services needed to reach those goals. ECs provide oversight, consultation, and coordination of services for "job-ready" veterans which requires close coordination with DVOPs.

Answer D. VR&E's Employment Coordinators work in partnership with DVOPs and Local Veterans Employment Representatives (LVERs) to ensure that veterans with service-connected disabilities have access to suitable employment opportunities. DVOPs/LVERs staff are included in the roll-out activities associated with the national deployment of the new 5-Track Employment model. The Five Track Employment model provides employment services to veterans with the most serious service-connected disabilities. It assists these veterans with work accommodations, resume/interviewing skills, training in small business operations, apprenticeships, independent living skills training, and other services. VR&E's 5-Track Employment Model training sessions currently underway at the National Veterans' Training Institute (NVTI) include local DVOPs. Also, DVOPs co-located within VR&E will now have access to the technology to provide comprehensive employment services through VR&E's job labs and *VetSuccess.gov*.

Question 2. According to the Administration's budget proposal, VR&E personnel have been conducting outreach to employers to help create employment opportunities for veterans. These activities appear to mirror functions performed by an employment program administered by the Department of Labor (DOL)—the Local Veterans' Employment Representative program.

A. To what extend do VA and DOL coordinate to ensure that redundant functions are not being performed?

Answer. VA, through the VR&E Program, and DOL work in partnership to conduct outreach and identify employment opportunities. VR&E focuses outreach activities specifically on identifying opportunities for disabled veterans and works with potential employers to educate and train them in the challenges that disabilities present both to the veteran and the employer.

Question 3. In February 2005, the VA Inspector General found that VA was "at risk of paying excessive prices" on 241 contracts for assessments, rehabilitation, training, and employment services for veteran participants.

A. What amount does VR&E plan to expend on contract services in FY07?

Answer. VR&E anticipates spending approximately $28 million in total contract funds in fiscal year 2007, distributed as follows:

- $9 million General operating expenses (GOE)
- $13 million General readjustment benefits
- $6 million Educationallvocational counseling (Chapter 36)

B. What steps have been taken to ensure that VA does not pay an excessive price for those contracts services?

Answer. VR&E uses several methods to ensure that we do not pay excessively for services. Market analyses, cost comparisons, and competitive bidding processes are employed before contracting with service providers. At the regional office level, each VR&E division has a warranted contracting officer who is authorized to establish the spending limit under each contract. Individual case managers who have completed training as contracting officer technical representatives are authorized to expend funds within those limits. All vouchers are individually approved by someone other than the authorizing official before payment is issued. In general, the three parts of the process—obligating funds, authorizing funds, and making payments—are performed by different employees to ensure propriety of payment. At the national level, the VR&E Service Quality Assurance Program incorporates review of contracting activities in both the individual case reviews and regional office site visits.

C. Will VR&E have adequate resources to provide all necessary services and assistance to those veterans?

Answer. VR&E Service anticipates that the requested level of resources will be adequate to provide the necessary training, rehabilitative, and employment services and assistance to all veterans requiring VR&E benefits.

Question 4. In FY07, VR&E expects an increase in workload in part due to seriously injured veterans retiring from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

A. How many OIF/OEF veterans do VR&E expect to participate in VR&E programs during FY07?

Answer. VR&E anticipates a small increase in workload in fiscal year 2007 due specifically to OIF/OEF participants. However, the number of new applications for VR&E benefits has not increased significantly since the onset of OIF/OEF. The typical VR&E claimant does not apply for benefits until approximately 6 years after separation from military duty. We do expect an increase in applications from seriously disabled veterans due to OIF/OEF. That increase alone, however, does not represent a large increase in overall activity.

B. Will those veterans be given priority of service?

Answer. Persons with serious disabilities are given a high priority in processing. We make every effort to ensure that initial contact is made while the veteran is still in a military treatment facility, and we follow-up after the person is discharged to his or her place of residence.

C. Will VR&E have adequate resources to provide all necessary services and assistance to those veterans?

Answer. The resources requested for the VR&E program will be adequate to serve the OIF/OEF applicants.

HOUSING PROGRAM

Question 1. The budget request assumes the continued loss of FTE for VA's housing program. Yet the budget also assumes increased default and foreclosure rates in 2006 and 2007.

A. How does VA expect to keep its Foreclosure Avoidance Through Servicing (FATS) ratio at a high level if the staff available to perform that servicing is diminished?

Answer. The Loan Guaranty Service continues to improve efficiency through the consolidation, delegation, and automation of many functions. This flexible approach to resource utilization has allowed the entire program to maintain high performance metrics with fewer personnel. The Loan Administration function benefits from this delegation and automation, and we do not foresee that the FATS ratio will decline.

Question 2. The budget notes that there were 8,963 "reinstatements" with VA's direct assistance in 2005.

A. Is a "reinstatement" synonymous with a "foreclosure avoided"?

Answer. Yes. Reinstatement means that the loan was returned to a current status and a foreclosure avoided. The 8,963 reinstatements noted in the budget refer specifically to "successful interventions" where VA intervened with the loan holder on behalf of the veteran to arrange a repayment plan, forbearance agreement, delay in foreclosure, or similar agreement, and the veteran was able to reinstate the loan based on that agreement.

B. VA lists four methods it uses to assist veterans in avoiding a foreclosure (successful intervention, refunding, voluntary conveyance, and compromise claim). Please detail for me the breakdown of how many of each method was used in 2005, and the cost savings associated with each of those methods.

Answer. For fiscal year 2005, VA completed the following alternatives to foreclosure:

Alternative to foreclosure	Number completed FY 2005	Estimated Savings FY 2005
Successful intervention	8,963	$180M
Voluntary conveyances & compromise claims	1,650	$3M
Refunded loans	855	N/A
Total	11,468	$183M

Question 3. On September 30, 2008, the authorization for VA to guaranty adjustable rate mortgage (ARM) and hybrid ARM loans will expire. The Committee will need information about veterans and lenders' interest in these loans before it extends that authorization.

A. How many ARM and hybrid ARM loans has VA guaranteed thus far?

Answer. Through February 2006, a total of 219,935 ARM loans have been guaranteed. Of these, 144,428 were traditional, 1-year ARMs and 75,507 were hybrid ARMs. In the following table, ARM loans are divided into the two periods under which VA was authorized to offer ARMs (2004–present, and 1993–1996). Note also that hybrid ARMs were not available until 2004.

Second authorization period	Hybrid ARMs	Regular ARMs	Total
FYTD 2006	2,090	98	2,188
2005	18,480	269	18,749
2004	54,937	4,790	59,727
Total '04–'06	75,507	5,157	80,664
Cumulative total	75,507	144,428	219,935

B. Are there data available on foreclosure rated associated with these loans?

Response. Data is available only on the traditional, 1–year ARM loans guaranteed during the years 1993–1996, for which the foreclosure rate is 9.9 percent.

VA's authority to offer traditional, 1-year ARMs was discontinued after this initial pilot program and not reauthorized until fiscal year 2004. A full and accurate representation of the foreclosure rate for a loan cohort cannot be provided until 5–7 years after a loan is guaranteed. Consequently, traditional 1–year ARM loans guaranteed in fiscal year 2004 and fiscal year 2005 have not matured enough to offer an accurate picture.

The hybrid ARM program was not authorized until 2004, so loans made under this program are also not mature enough to offer a true sense of their rate of foreclosure. However, we can say with certainty that hybrid ARMs foreclose at a lower rate than traditional, 1-year ARM loans.

INSURANCE PROGRAMS

Question 1. The budget notes that "[d] isbursements, which are loans, cash surrenders and death claim awards, are considered the most important service provided by the Insurance Program to veterans and beneficiaries."

A. What is the total number of such disbursements the Insurance Program Expects to make in 2007?

Answer. 180,825.

B. What is the 5-year trend on the annual number of disbursements?

Answer:

Fiscal year	2007	2008	2009	2010	2011
Projected disbursements	180,825	177,102	172,279	165,271	158,480

C. As the number of disbursements decline in the coming years, and the number of veterans insured under the five closed insurance programs VA administers also declines, can we expect to see a declining FTE request for VA's Insurance Program?

Answer. Yes. The Insurance Service projects a gradual decline of approximately 3 percent in FTE per year as the projected Insurance workload also declines.

D. When is that decline expected, and how does VBA plan to use available space at the Philadelphia Regional Office and Insurance Center once the FTE drawdown begins?

Answer. Insurance's FTE request for 2007 is 422 FTE. Although we have not officially formulated our FTE budget request for 2008 and beyond, we expect our FTE to decline by about 3 percent a year based on our decline in disbursements and other workload. This would equate to a decline of approximately 12 FTE per year.

However, these losses might be offset by increases in other areas of insurance, such as increases in Service-Disabled Veterans Insurance applications, which have increased over the past several years. Insurance always strives to provide benefits and services at the lowest achievable administrative cost and will continue to look for ways to consolidate office space. Although our projected annual loss of 12 FTE will be spread throughout Insurance and will not represent large areas of contiguous space, we will make every effort to consolidate our personnel and activities. Space that is freed up in this way can be made available to VBA, VA, or GSA. For example, in 1999 Insurance completed a project to convert key insurance documents to images. Completing this project allowed us to retire over 2.5 million insurance folders and make available 30,000 square feet of space. That space ultimately became the Pension Maintenance Center, currently accommodating 156 FTE.

Question 2. I noted that the 2005 Program Assessment Rating Tool (PART) score of the VA Insurance Program was only 74 percent, or "Moderately Effective."

A. How does this PART score square with the American Customer Satisfaction Index (ACSI) assessment of the VA Insurance Program, which scored the Insurance Program significantly higher than its private sector competitors?

Answer. First, it should be noted that "moderately effective" is the second highest rating that can be achieved. The American Customer Satisfaction Index (ACSI) measures the satisfaction of our customers with the service we provide. The PART process, as indicated in the chart below, covers several additional areas. Therefore, the ACSI and other benchmarks are considered only within the Program Results and Accountability area. Furthermore, factors other than ACSI and similar benchmark results are encompassed within that area.

PART Section	PART Score (%)	Score Weighting (%)	Weighted PART Score
Program Purpose and Design	100	20	20
Strategic Planning	88	10	9
Program Management	86	20	17
Program Results and Accountability	53	50	27
Final PART Score	.....	.....	74

B. Was there a particular aspect of the Insurance Program that the PART identified as ineffective that was not covered in the ACSI score?

Answer. The only area where the Insurance Program did not score well was in the area of Program Results and Accountability. The other three sections yielded scores at or near the maximum. One of the reasons given by OMB for the low score in the results and accountability section was the lack of historical performance measures to determine whether the level of insurance coverage is sufficient to meet each individual's life insurance needs. Although we had been collecting and utilizing performance data for many years, it had not been included and tracked in previous budget submissions. We have now begun to do so. Certain targets and goals will be revised as appropriate and used in future submissions.

BURIAL PROGRAMS

Question 1. A 2001 report identified $280 million worth of needed repairs at VA National Cemeteries. Is my understanding that $160 million of repairs remain?

A. How much is in this budget to meet those repair needs?

Answer. The fiscal year 2007 budget request includes $108 million for national cemetery maintenance. This funding will support mowing and trimming, routine maintenance as well as repair projects to correct deficiencies that impact cemetery appearance. Of this amount, $28 million is for gravesite renovation and cemetery infrastructure repair projects. This reflects an increase of $8 million over the fiscal year 2006 level of $20 million.

B. What is the target date for all $280 million worth of repairs to be funded and completed?

Answer. The Veterans Millennium Health Care and Benefits Act Report to Congress identified the need for 928 repair projects at an estimated cost of $280 million. Through fiscal year 2005, NCA has completed an estimated $88 million of the repairs identified in the report, including work on 208 projects. Work on additional repair projects is currently in process.

With the resources included in this budget, approximately $144 million of the $280 million identified in the Millennium report will remain outstanding. In some cases, the recommended repairs involve materials and processes that, while achieving the same results, are different from NCA's established methods. NCA will use the most cost-effective method in accomplishing these repairs. In addition, cemetery staff will be used, and have been used, to complete some repairs during routine maintenance.

A multi-year effort will be required, and VA is committed to ensuring that a dignified and respectful setting appropriate for each national cemetery is achieved. In planning to complete the large number of repair projects identified in the report, repair projects are evaluated and prioritized on an annual basis to take into account the current condition of cemetery assets. This assessment is conducted within the Department's budget and planning processes. The funding request in the 2007 budget will allow VA to continue to make steady progress in improving the appearance of its national cemeteries and complete all currently identified cemetery repair projects within 5 years.

Question 2. Recent news accounts suggest potential delays in purchasing land for the establishment of a Southeastern Pennsylvania national cemetery.

A. Is this true? Is so, when must the purchase of available land occur in order to keep VA on pace to meet its goal to have this cemetery operational by 2009?

Answer. The VA needs to complete the land acquisition process and have title to the property in order to begin cemetery design when fiscal year 2007 funding becomes available. There is sufficient time to resolve all local land use issues concerning the preferred site, Dolington, near Washington Crossing in southern Bucks County. The site will be acquired using funds appropriated in fiscal year 2006 for that purpose. Funds to begin design are included in the President's fiscal year 2007 budget request. The architectural and engineering design team has been selected, and will begin the design process when funds are appropriated in fiscal year 2007.

This timeline will allow VA to meet its goal to open this new cemetery in the fall of 2008.

B. Are there any land acquisition problems in the five other areas where VA seeks to establish cemeteries in accordance with Public Law 108–109?

Answer. VA has not experienced any problems in the site selection and land acquisition process for the other five areas where new national cemeteries will be established: Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; and Sarasota County, Florida. Potential sites in each of these five areas have been identified, and environmental assessments are currently being conducted in order to assess the suitability of these sites for cemetery development. Funds appropriated in 2006 will be used to acquire land in each area. The 2007 President's budget includes funding to begin the design development process.

GENERAL ADMINISTRATION

Question 1. VA has met all of the statutory minimum goals with respect to the percentage of total VA procurement dollars going to certain small business concerns, with one exception: the 3 percent goal for service-disabled veteran-owned small businesses.

A. What is VA doing to meet the 3 percent goal which, many would say, is the most important of its small business goals given its overall agency mission?

Answer. VA continues to make progress in implementing a very ambitious and proactive implementation plan for Executive Order (E.O.) 13360, The Service Disabled Veteran Executive Order. The plan appears to be taking root, as accomplishments in the SDVOSB category increased to 2.09 percent in fiscal year 2005, up from 1.25 percent in fiscal year 2004. In addition, there has been increased use of the set-aside and sole source award authorities provided under P.L. 108–183, the Veterans Benefits Act of 2003. VA is not considering a different or alternative strategy at this time. The visibility of veteran entrepreneurial programs and the commitment of VA's senior leadership to these programs continues to increase as E.O. 13360 is more fully implemented.

Data from the Federal Procurement Data System—Next Generation (FPDS-NG) shows VA acquisition professionals continue to increase use of the authorities under P.L. 108–183:

FY	Number of transactions	Dollar amount
2004 Set-Asides	32	$4,357,094
2004 Sole Source	14	2,740,769
2005 Set-Asides	266	76,295,124
2005 Sole Source	56	13,593,062

In fiscal year 2006, through January 31, 2006, a total of 73 acquisitions has been set-aside for competition among SDVOSBs using this authority. The value of the resulting contracts total $9,805,460. During this same period, a total of 13 acquisitions were awarded to SDVOSBs using the sole source authority of the Act. The value of the resulting contracts total $1,058,276.

The VA has directed that existing individual performance plans be modified to incorporate the SDVOSB and Veteran-Owned Small Business (VOSB) socioeconomic procurement preference program goals as significant elements in the performance plans of all VA employees involved in the acquisition process, and that this change be included in new and ensuing performance plans. This includes the performance plans of VA senior executives such as network directors and facility directors, as well as acquisition professionals, program managers and other officials responsible for overseeing acquisition operations or developing work statements or specifications, or who otherwise define VA acquisition requirements, and includes purchase card holders.

VA's Office of Acquisition and Materiel Management has issued a number of Information Letters (IL), that are directive in nature, setting forth specific requirements to be followed by VA's acquisition and logistics community in contracting with SDVOSBs and VOSBs in order to enhance acquisition opportunities for these firms. One such requirement establishes that contracting officers shall not add items to their respective prime vendor contracts, contracts usually held by large businesses, nor shall they order standardized items from prime vendor contracts when the items are available from SDVOSBs through the Federal Supply Schedule (FSS) Program. In those instances, VA contracting officers may order directly from the SDVOSB.

VA has proposed significant changes to the VA Acquisition Regulations (VAAR) that will soon be published for public comment. One important change proposed would be to allow set-aside provisions under the Veterans Benefits Act of 2003 to be applied to FSS acquisitions. Another proposed change would allow VA acquisition professionals to deviate from using FSS or national contracts as a priority source when VA can purchase identical items from SDVOSBs under comparable contract terms at the same or lower price than the FSS or national contract price.

Heads of VA contracting activities are required to consider the SDVOSB goal when formulating advanced procurement plans and their Forecast of Contracting Opportunities (FCO). These plans shall be updated at least quarterly and reviewed against SDVOSB sources identified in VA's Vendor Information Pages (VIP) Database accessible through the VetBiz.gov web portal. When contracting officers identify VOSBs and SDVOSBs not contained in the VIP Data base, they are to initiate a provisional entry in the data base for that firm.

The VA directed that VA's FCO shall ensure all opportunities are forecasted and that forecasted opportunities identify SDVOSB set-asides sufficient for the respective contracting activity to achieve the 3 percent statutory goal.

VA has instituted a "Rule of Two," whereby contracting officers are required to solicit at least one SDVOSB and one VOSB whenever the acquisition cannot be totally set-aside for SDVOSBs or awarded pursuant to the sole source authority of P.L. 108–183.

VA contracting officers are strongly encouraged to consider the socioeconomic status, especially those identified as a SDVOSB/VOSB, when selecting FSS contractors for competition, consistent with FAR Subpart 8.4.

In fiscal year 2005, the Center for Veterans Enterprise (CVE) and Office of Small and Disadvantaged Business Utilization (OSDBU) attended 200 conferences and meetings as speakers, exhibitors, panelists, matchmakers and facilitators, with over 28,000 participants attending these events. As part of VA's small business outreach efforts, OSDBU provides and distributes information on the Veterans Benefits Act of 2003, E.O. 13360, and VA's approved implementation strategy for the E.O. at each event attended. Events include small business conferences, trade and industry shows, Procurement Technical Assistance Center (PTAC) conferences and training sessions, and large business/prime contractor-sponsored events.

CVE provides advice and assistance to SDVOSBs in the Federal marketplace: U.S. Small Business Administration (SBA), the Association of Small Business Development Centers, and the Association of Procurement Technical Assistance Centers. Core services provided by CVE include: Business Coaching, Web Portal, VetBiz Vendor Information Pages (VIP) Data base and Community Events.

Question 2. How does VA's Office of Small and Disadvantage Business Utilization (OSDBU) interact with the Small Business Administration's Office of Veterans Business Development?

Answer. On a quarterly basis, the Associate Administrator of the Office of Veterans Business Development (OVBD) and VA's OSDBU Director meet with the Board of Directors of the National Veterans Business Development Corporation, doing business as The Veterans Corporation (NC). These are three of the organizations identified under Public Law 106–50, the Veterans Entrepreneurship and Small Business Development Act of 1999, to assist veterans in establishing and expanding businesses. During these 2-day meetings, joint plans are established for specific projects and outreach support.

In addition, the Administrator of SBA has appointed an Advisory Committee on Veterans Affairs which also meets quarterly. The Chairman of the Committee and the Associate Administrator of OVBD regularly exchange information with VA's OSDBU Director. Further, VA's OSDBU Director has formally briefed the Board at several of their meetings. VA and SBA staff often appear together at small business conferences to answer veterans' questions. SBA's Advisory Committee on Veterans Business Affairs is planning to conduct approximately 10 town hall meetings this year and has extended an invitation to VA to join those programs.

SBA and VA personnel mutually support the informal Veterans Business Interagency Council which consists of volunteers with responsibilities under E.O. 13360, for Improving Procurement Opportunities for Service-Disabled Veterans. This group meets monthly and is currently involved in planning the Second Annual Veterans Business Conference to be held in June 2006.

Question 3. What are the statutory responsibilities of VA's OSDBU with respect to administration of Small Business Act requirements?

Answer. The SDVOSB Set-Aside program was enacted by Public Law 108–183 (December 16, 2003) and promulgated in Federal Acquisition Regulation (FAR) Subpart Part 19.14 and in the 13 CFR 125.

Predecessor legislation established a network of government agencies and organizations who work cooperatively to ensure that veterans are supported in the formation and expansion of businesses. Two of these fundamental statutes are: Public Law 106–50 and Public Law 105–135 which required the first formal partnership between organizations and which further established the Veterans Business Outreach Program.

As a result, VA personnel spent $207,320,465, or 2.09 percent of our prime contract dollars with SDVOSBs in fiscal year 2005. This figure represents awards from all available programs, including 266 competitive SDVOSB set-aside actions and another 56 actions under the SDVOSB direct sourcing authority.

A detailed listing of Public Law 106–50 responsibilities involving VA follows:

- Support the Veterans Corporation (Sec 33)
- Support SBA's Veterans Advisory Board (Sec 203)
- VA, SBA and the Association of Small Business Development Centers shall (Sec 302):

1. Conduct studies
2. Provide training & counseling to veterans
3. Provide technical assistance re: international trade & technology transfer markets
4. Provide assistance & information regarding procurement opportunities with Federal, State & local government agencies
5. Establish an information clearinghouse to collect and distribute information, including by electronic means, on assistance programs of Federal, State & Local Governments, and of the private sector, including information on office locations, key personnel, telephone numbers, mail and electronic addresses, and contracting and subcontracting opportunities.
6. Accomplish Subcontracting Goals with Veterans and Service-Disabled Veterans (Sec 501 & Public Law 106–554 Sec 808)
7. Accomplish Prime Contracting Goals with SDVOSBs (Sec 501)
8. Secretary of Veterans Affairs shall (Sec 604):
   i. Coordinate with SBA and the U.S. Department of Labor (DOL) an annual notice to business owners informing them of available assistance
   ii. Coordinate Vocational Rehabilitation Services with the DOL's Veterans Employment and Training Service to enhance Self-Employment Opportunities.

Question 4. VA's OSDBU is listed in the budget under the Office of the Secretary, yet a summary of employment and obligations for OSDBU Is not available (as they are for other Office of the Secretary functions).

Please provide the Committee with that information for OSDBU.

Answer. Under Public Law 95–507, VA's OSDBU Director must report to the Secretary or Deputy Secretary of Veterans Affairs. OSDBU obtains its budget resources through the Supply Fund Appropriation, a revolving account. That summary information is located in Volume 2 on pages 9–8 to 9–11. Details of OSDBU's fiscal year 2005 obligations, the fiscal year 2006 budget allotment and the fiscal year 2007 estimate are found in Attachment 2.

Question 5. I note a precipitous decline in the percent of cases before the Board of Contract Appeals that are resolved using Alternative Dispute Resolution (ADR) techniques.

Can you explain this decline in the use of ADR?

Answer. The Department is uncertain of the causes of the low percentage of cases that are reported using ADR. The Department offers ADR as the preferred option for dispute resolution, to all parties before BCA. Parties have not complained to the Board or raised any intrinsic causes that would account for a decreased ADR use in BCA cases. ADR is, of course, voluntary for the parties. The parties must request it, the Board cannot compel it.

We note that, when data as to low usage was collected, the BCA's case docketing system, which tracks all CDA docketed appeals, did not capture ADR data on CDA docketed appeals in which ADR was used but did not result in complete resolution of the appeal.

The Department has advocated early use of ADR in the pre-appeal state of disputes for several years. Effective use of ADR in the pre-appeal stage may result in fewer docketed contract appeals because the parties have used ADR successfully in the pre-appeal stage to resolve their dispute. As noted above, BCA's case tracking system has not previously consistently captured data on pre-appeal ADR use to resolve a dispute. BCA is improving its tracking system to consistently capture such data and to capture data concerning CDA cases where ADR techniques are used but do not result in a settlement.

VA is also developing new strategies to promote increased use of ADR in resolving cases. For example, two strategies being developed are (1) increasing education and training of Department Contracting Officers and Contracting Officer Technical Representatives in the awareness and use ADR and (2) updating Department policy and guidance on ADR use and practice.

We note that, under Public Law 109–163, the National Defense Authorization Act of fiscal year 2006, effective January 1, 2006, the civilian agency BCAs will be consolidated into a newly formed Civilian Board of Contract Appeals (CBCA) located in the General Services Administration. VA will still provide a pre-CDA ADR option. However, ADR provided after a filed and docketed appeal will be provided by the newly formed CBCA. The details of the consolidation have not been resolved.

Question 6. Does the Board of Veterans Appeals (BVA) give expedited consideration to cases on appeal from veterans from Operation Iraqi Freedom or Operation Enduring Freedom? Under what circumstances does BVA advance a case on the docket for special consideration?

Answer. BVA does not give expedited consideration to appeals based on the particular circumstances of a veteran's service, including participation in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF).

By statute, an appeal must be considered by BVA in regular order according to its place on our docket, 38 U.S.C. subscript 7107(a)(1); 38 CFR subscript 20,900(b). A docket number is assigned to an appeal when the VA Form 9 or "substantive appeal" is received from the appellant and entered into our case tracking system by the agency of original jurisdiction (AOJ), usually a VA regional office or medical center. After the AOJ certifies the appeal and transfers the appeal records to BVA, the case is distributed to a Veterans Law Judge for consideration in the order in which the appeal was entered onto the BVA docket.

A case may be advanced on the docket on motion for earlier consideration and determination. 38 U.S.C. subscript 7107(a)(2); 38 CFR subscript 20,900(c). A motion for advancement on the docket may be granted if the case involves an interpretation of law of general application affecting other claimants, if the appellant is seriously ill or is under severe financial hardship, or if other sufficent cause is shown. Examples of other sufficient cause include, but are not limited to, administrative error resulting in significant delay in docketing the case, or the advanced age of the appellant. Advanced age is defined by the regulation as 75 or more years of age.

In addition to cases that are advanced on the docket, the law requires that BVA take action to provide for the expeditious treatment of any claim that is remanded to VA by the U.S. Court of Appeals for Veterans Claims (Court). 38 U.S.C. subscript 7112. To implement this requirement, BVA regulations provide their expeditious treatment will be accorded to cases remanded by the Court "without regard to [their] place on the Board's docket." 38 CFR subscript 20,900(d).

Question 7. VA's budget asks that the Office of General Counsel receive an increase of $4.166 million in budget authority to fund the fiscal year 2007 2.2 percent pay raise as well as $600 thousand to hire 6 additional attorneys and paralegals to help with an increased caseload.

A. Please provide the Committee with data on the caseloads of those staff who work in the areas of personnel law, medical malpractice defense, benefits law, land property and acquisition law related to the VA's CARES initiative.

B. What are the 5-year trend data on these caseloads?

Answer A and B. The Office of General Counsel does not maintain per-staff caseload data on the categories of cases identified in the question, and does not segregate data on CARES-related work within its property-and acquisition law case information. However, we report below our caseload trends for personnel law, medical malpractice, benefits law and business law (business law includes property and acquisitions law).

The statistical data follows.

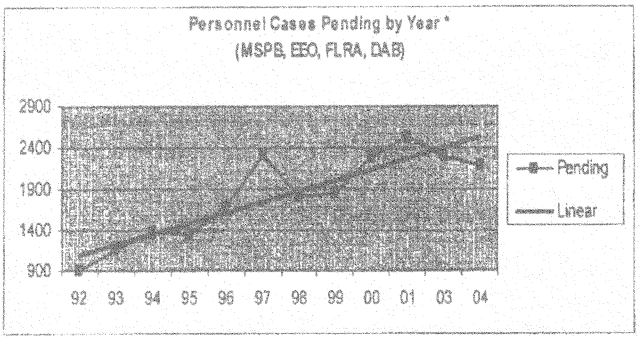


Figure 1. Personnel Law

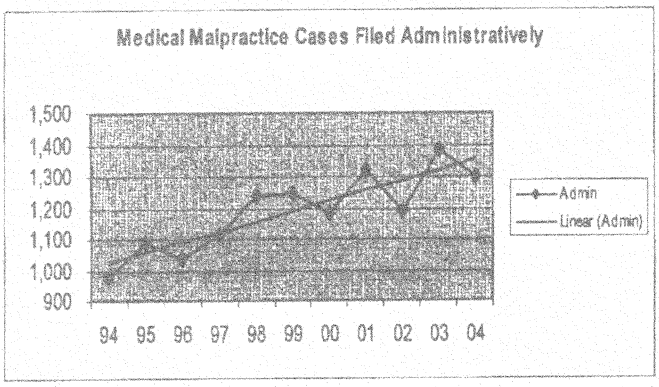


Figure 2. Medical Malpractice Cases Filed Administratively

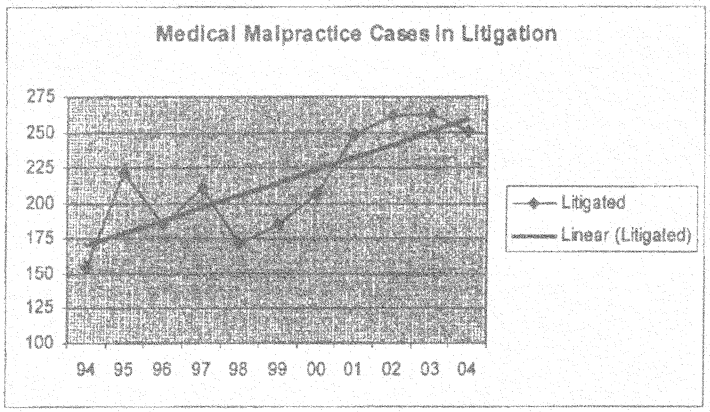
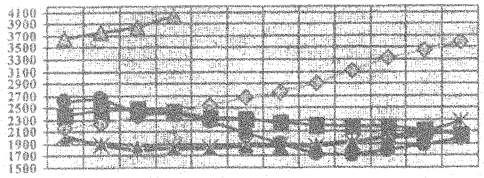
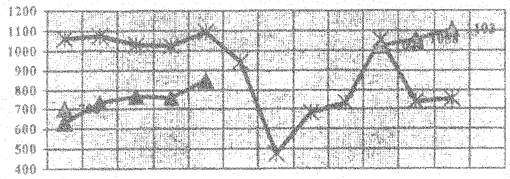


Figure 3. Medical Malpractice Cases in Litigation



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Case Flow FY 2006	3,648	3,767	3,853	4,033								
Case Flow FY 2005	2,161	2,226	2,348	2,410	2,551	2,673	2,761	2,899	3,113	3,313	3,438	3,589
Case Flow FY 2004	1,980	1,924	1,873	1,806	1,820	1,853	1,853	1,902	1,937	1,978	2,033	2,120
Case Flow FY 2003	2,371	2,457	2,488	2,440	2,346	2,321	2,252	2,207	2,189	2,188	2,122	2,037
Case Flow FY 2002	2,050	1,882	1,798	1,830	1,844	1,895	1,867	1,859	1,925	2,027	2,079	2,266
Cases Flow 2001	2,608	2,644	2,416	2,428	2,266	2,081	1,899	1,724	1,715	1,791	1,885	1,982

Figure 4. Benefits Law Case Flow Workload Report



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY 06	633	737	767	758	847							
FY 05	1064	1076	1029	1026	1092	944	478	685	733	1057	739	751
FY 04	700									1022	1058	1103

Note: FY 2005 demonstrated an anomalous drop in workload due to several settlements. We expect that the FY 2006 workload to continue rising.

Figure 5. Business Law Workload Report

C. Is there a per-FTE caseload threshold that, if breached, would have a detrimental impact on OGC's performance?

Answer. Over the past 5 years, we have carefully monitored the case loads of our attorneys to ensure the quality and timeliness of their work did not suffer as the result of a net decline in staffing. During this period, there have been times when the per capita case loads in certain of our Regional Counsel Offices and in the Professional Staff Group that supports litigation before the Court of Veterans Claims have risen dramatically. In some cases, increased per capita case loads have risen to over 70 cases, and in those situations we have noticed a decline in the depth of research, the quality of written products and the level of personal involvement with our clients in the field. We reduced those case loads as soon as the budget allowed us to do so, and through that process determined that the optimum case load per attorney is 50 cases. This work load ensures that our attorneys are challenged, yet allows them to provide the quality and timeliness of work that our clients require and that our veterans deserve.

Question 8. What problem has VA encountered in its joint VA/DOD data sharing efforts? What information exchange problems have been encountered once a veteran has been transferred from DOD to VA and what is being done to correct these problems from an IT standpoint?

Answer. To provide a seamless transition as servicemembers move from DOD to VA, VA needs information on the servicemembers who will be transitioning to VA for care and benefits, particularly those who are severely injured in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). On June 29, 2005, DOD and VA signed a Memorandum of Understanding (MOU) for the purpose of sharing data between DOD and VA. The Departments have made significant progress in sharing pertinent health information as servicemembers and veterans are transferred from Military Treatment Facilities to VA medical centers. VA's Polytrauma Rehabilitation Centers have read only access to electronic medical information at Walter Reed and Bethesda. VA staff has and continues to train clinicians to access and utilize this information. While this is a major accomplishment, some limitations still remain. DOD's medical record is not fully electronic; consequently, not all medical information can be shared electronically. VA's Polytrauma Rehabilitation Centers have initiated monthly video-teleconferences with the treatment teams at Walter Reed Army Medical Center and Bethesda National Naval Medical Center. This has proven to be an effective means of communicating information that is not typically documented in the medical record.

From an IT standpoint, VA and DOD have made significant progress toward achieving interoperability of available electronic medical information. In 2002, VA and DOD implemented the Federal Health Information Exchange (FHIE). FHIE supports the one-way transfer of all clinically pertinent electronic data from the DOD Composite Health Care System (CHCS) to clinicians from the Veterans Health Administration (VHA) and to benefits workers from the Veterans Benefits Administration (VBA). Upon a servicemember's separation or retirement from DOD, DOD sends that servicemember's data to a shared secure FHIE repository where the data are available for viewing by VA personnel using the VA Computerized Patient Record System (CPRS). FHIE is operational at all VA medical centers and facilities.

To date, DOD has transferred records on approximately 3.3 million unique servicemembers to the shared FHIE repository. Of this 3.3 million, over 2 million have registered to receive medical treatment or benefits from VA. FHIE data available for viewing by VA include outpatient pharmacy, laboratory, radiology reports, consults, admission, disposition and transfer data, and diagnostic coding data from the standard ambulatory data record.

Using FHIE, VA also has access to military pre- and post-deployment health assessment data from DOD Forms 2795 and 2796. DOD has transmitted more than 515,000 pre- and post-deployment health assessments on over 266,000 separated servicemembers. DOD continues to send monthly transmissions of these data to VA as more members separate or retire. These assessment data provide useful information to VA clinicians including information about exposures and other stressors related to deployments. In March 2006, DOD completed an initial load of over 700,000 pre- and post-deployment health assessments for demobilized National Guard and Reservists. VA and DOD are now working together to ensure that National Guard and Reserve data also are collected and included in the monthly transmissions.

In addition to the one-way transfer of electronic medical data through FHIE, VA and DOD have developed the capability to share electronic medical records bidirectionally to use in the care of shared patients. The VA/DOD Bidirectional Health Information Exchange (BHIE) automatically match patient identities for active DOD military servicemembers and their dependents with their electronic health records at VA facilities. It also supports the real-time bidirectional exchange of out-

patient pharmacy data, allergy information, lab results, and radiology reports. BHIE data is available at eight DOD host sites. These DOD sites include locations that receive large numbers of Operation Enduring Freedom and Operation Iraqi Freedom combat veterans, such as the Walter Reed Army Medical Center, the Bethesda National Naval Medical Center, and the Landstuhl Army Medical Center. DOD data from these host sites are available at every VA site of care, and staff at those DOD facilities has full access to this information from every VA facility.

Both FHIE and BHIE provide interoperability of data through existing health information systems for VA and DOD. VA and DOD are now migrating these technologies to next-generation health information systems and implementing a plan to share data between those systems. The first release of this interface, known as "CHDR," will support interoperability between the DOD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR) and will allow VA and DOD to conduct drug-drug and drug-allergy interaction checking between VA and DOD pharmacy systems. In January 2006, the Departments completed formalized interagency testing and conducted a successful demonstration using the production version of CHDR for VA and Military Health System IT leadership. The Departments are now working closely with an interagency staff in El Paso, Texas, to complete CHDR production testing in a patient care environment between the William Beaumont Army Medical Center and the VA El Paso Healthcare System no later than July 2006.

VA is working closely with DOD to expand the scope of clinical information that is shared. Recently, the Departments initiated a pilot to explore the feasibility of sharing scanned paper records to provide VA electronic access to clinical data that was not previously available in electronic format. VA and DOD also are closely collaborating on the development of next generation imaging technology that will facilitate the sharing of radiological images between DOD and VA.

Question 9A. What is the status of the Security Program administered by the CIO through the Office of Cyber and Information Security (OCIS)?

Answer. VA significantly improved its security posture by completing certification and accreditation activities for one hundred percent of the Department's operational information technology systems. This major accomplishment provides VA senior management officials with the information necessary to authorize processing for those systems based on an acceptable level of risk, and the planned remediation of known system vulnerabilities during fiscal year 2006. Also VA enhanced its ability to effectively implement the Department-wide Information Security Program through an over 70 percent increase in the number of individuals who have completed the role-based training requirements of the Department's Cyber Security Professionalization (CSP) program, to 773 participants. Moreover, VA has made great strides in the implementation of the Department-wide Security Operations Center (SOC) that provides the integration and continuous operation of information technology security program elements, such as vulnerability scanning, intrusion detection, and incident response, into a Critical Infrastructure Protection Program to ensure adequate protection of mission-essential assets and provide VA management an "at a glance" view of VA's security posture and potential vulnerabilities. Finally, VA has laid the groundwork for the implementation of the Security Configuration Management Program, which will establish an enterprise-wide configuration management, to include upgrading and removing those information technology assets currently using operating systems that do not have adequate security features, and providing real-time security patch updates to system software. This program is essential to eliminate vulnerabilities that expose VA systems to inappropriate access and manipulation. All these major programs buildupon and enhance the Department's centralized information security program administered by the CIO through the Office of Cyber & information Security.

Question 9B. What is the cost estimate for any required remedial action?

Answer. While VA's certification and accreditation effort was a resounding success, it did reveal that the Department has a number of deficiencies on its more than 450 major applications and general support systems that must be addressed through some type of remedial action. The Office of Cyber & Information Security collected estimates from VA system owners on the cost of these remedial actions. The costs as outlined below are included in fiscal year 2006 appropriation and fiscal year 2007 President's Budget:

Administration or Staff Office	FY 2006	FY 2007
VHA	$33,632,373	$19,785,204
VBA	2,543,050	2,243,435
Office of Management	700,000	200,000
Office of Information & Technology Austin Automation Center	1,795,200	501,304
Other Staff Office Systems & NCA	750,000	500,000
Total VA	39,420,623	23,229,943

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO HON. R. JAMES NICHOLSON

Mr. Secretary, I understand that the VA Pittsburgh major construction project is currently moving on schedule and within budget. However, exclusion of scheduled funding in the FY07 budget is building in a delay for this critical project.

Question 1. What is the rationale for excluding construction funding from the FY07 budget?

Answer. In developing the Department's fiscal year 2007 major construction budget within the resources available, a number of factors were considered including the extent of any delay that might be incurred to projects should funding not be included in the budget. Pittsburgh is a multi-phased project with funding currently available for six of the eight phases. The delay in funding will cause one phase, the Ambulatory Care facility at the Heinz Division, to incur a few months delay. The Behavioral Health phase will not be delayed. During fiscal years 2006 and 2007, significant construction will be ongoing at the Pittsburgh facilities. In allocating funding in the fiscal year 2007 budget, the Department endeavored to move as many projects forward as possible within the resources available.

Question 2. At the University Drive campus, I understand that the parking garage is under construction and is slated for completion during FY07 clearing the way for construction to begin on the Behavioral Health building. When does VA expect the garage to be complete? When does VA plan to begin construction if the Behavioral Health building? How much of a delay will be caused at University Drive by exclusion of funding in FY07?

Answer. The schedule is to complete the parking garage in late FY07 and to immediately begin activation and use. The Behavioral Health building is scheduled to start very soon thereafter in the first quarter of FY08 without delay.

Question 3. At the Heinz campus, I understand that the new Domiciliary and Administrative buildings are set to begin in FY06. It is also my understanding that construction of the Ambulatory Care building is not contingent upon completion of these other projects. Why, then, has funding been delayed for this project? When does VA plan to begin construction of the Ambulatory Care building? How much of a delay will be caused at the Heinz campus by exclusion of funding in FY07?

Answer. Please refer to the answer to question 1. It is expected that construction will begin as soon as funds are available in fiscal year 2008.

Question 4. Given that VA Pittsburgh is described as a "model for all VA" in the Capital Advisory Board report that you received in November of 2005, would you agree that VA would want to proceed with this project and not intentionally delay its scheduled completion?

Answer. Pittsburgh is a high priority project for the VA and we would not want to jeopardize its completion by unnecessary delays.

Question 5. Mr. Secretary, I understand that the VA Pittsburgh project is one of only three projects that will actually lead to a closing of a current VA medical center (the Highland Drive campus). The closing of this older site will lead to enhancements to VA care and reduce expenses associated with maintaining excess and obsolete space. However, VA has already made a commitment that the Highland Campus can not be closed until the entire Pittsburgh project is completed. As such, Mr. Secretary, is VA creating inefficiencies by delaying completion of this project?

Answer. VA anticipates minimal delay in the completion of the multi-phased project at Pittsburgh.

Question 6. Mr. Secretary, it is important to keep all approved VA construction on schedule and on budget. Can you achieve that if the budget calls for delaying the VA Pittsburgh project that is currently ahead of schedule and on budget?

Answer. We strive to keep projects on schedule. In this instance, we anticipate only a minimal delay.

Office of the Secretary
Office of Small and Disadvantaged Business Utilization
Summary of Employment and Obligations
(dollars in thousands) – OSDBU and CVE

	2005 Actual	2006 Budget Allotment	2007 Estimate	Increase (+) Decrease (-)
Obligations:				
Personal Services	$2,228	$2,873	$2,982	+109
Travel	$ 150	$ 157	$ 165	+ 8
Transportation of Things	$ 10	$ 5	$ 5	+ 0
Rents, Communications And Utility	$ 340	$ 309	$ 324	+ 15
Printing & Reproduction	$ 94	$ 85	$ 96	+ 11
Other Services	$1,102	$1,051	$1,108	+ 57
Supplies & Materials	$ 90	$ 106	$ 110	+ 4
Equipment	$ 40	$ 135	$ 144	+ 9
Total Obligations	$4,054	$4,721	$4,934	+213
Total Budget Authority	$4,054	$4,721	$4,934	+213

	2005 Actual	2006 Budget Estimate	2006 Current Estimate	2007 Estimate	Inc (+) Dec (-)
OSDBU	13	15	13	15	+2
CVE	11	15	15	15	0
Appropriated Total	24	30	28	30	+2

Office of the Secretary
Office of Small and Disadvantaged Business Utilization
Summary of Employment and Obligations
(dollars in thousands) – OSDBU

	2005 Actual	2006 Budget Allotment	2007 Estimate	Increase (+) Decrease (-)
Obligations:				
Personal Services	$1,318	$1,348	$1,389	+ 41
Travel	$ 70	$ 74	$ 78	+ 4
Transportation of Things	$ 5	$ 5	$ 5	+ 0
Rents, Communications And Utility	$ 180	$ 166	$ 174	+ 8
Printing & Reproduction	$ 4	$ 10	$ 16	+ 6
Other Services	$ 200	$ 200	$ 219	+ 19
Supplies & Materials	$ 70	$ 71	$ 74	+ 4
Equipment	$ 30	$ 25	$ 30	+ 9
Total Obligations	$1,877	$1,899	$1,985	+85
Total Budget Authority	$1,877	$1,899	$1,985	+85

	2005 Actual	2006 Budget Estimate	2006 Current Estimate	2007 Estimate	Inc (+) Dec (-)
OSDBU	13	15	13	15	+2
CVE	11	15	15	15	0
Appropriated Total	24	30	28	30	+2

Office of the Secretary
Office of Small and Disadvantaged Business Utilization
Summary of Employment and Obligations
(dollars in thousands) – CVE

	2005 Actual	2006 Budget Allotment	2007 Estimate	Increase (+) Decrease (-)
Obligations:				
Personal Services	$ 910	$1,525	$1,593	+ 68
Travel	$ 80	$ 83	$ 87	+ 4
Transportation of Things	$ 5	$ 0	$ 0	+ 0
Rents, Communications And Utility	$ 160	$ 143	$ 150	+ 7
Printing & Reproduction	$ 90	$ 75	$ 80	+ 5
Other Services	$ 902	$ 851	$ 889	+ 38
Supplies & Materials	$ 20	$ 35	$ 36	+ 1
Equipment	$ 10	$ 110	$ 114	+ 4
Total Obligations	$2,177	$2,822	$2,949	+127
Total Budget Authority	$2,177	$2,822	$2,949	+127

	2005 Actual	2006 Budget Estimate	2006 Current Estimate	2007 Estimate	Inc (+) Dec (-)
OSDBU	13	15	13	15	+2
CVE	11	15	15	15	0
Appropriated Total	24	30	28	30	+2

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN ENSIGN TO HON. R. JAMES NICHOLSON

Question 1. Should a veteran have to meet a higher standard of blindness than a social security beneficiary in order to receive disability for blindness? Do they currently?

Answer. Veterans generally do not have to meet a higher standard of blindness than a social security applicant in order to receive VA disability compensation for blindness. Under the VA rating schedule veterans receive compensation for visual impairment at lower levels of impairment than those that would qualify an applicant for social security disability. Compensation can be paid for both visual acuity impairment and field of vision impairment at levels that do not qualify as legal blindness.

Since VA only compensates for disabilities that were incurred during or aggravated by military service, we do not consider the disabling effect of visual impairment in an eye that is not service connected. However, if the criteria for blindness under VA regulations in one eye are met as a result of service-connected disability and the criteria for blindness under VA regulations in the other eye are met as a result of nonservice-connected disability, VA will pay compensation as though the impairments in both eyes were service-connected, provided the nonserviceconnected disability is not the result of the veteran's own willful misconduct.

Question 2. What is the current number of veterans who are only service connected for blindness in one eye that have anatomical loss of one eye, blindness in one eye with light perception only, or blindness rated at 5/200 visual acuity?

Answer. As of December 31, 2005, the most current data available, there are a total of 16,186 veterans who are service connected for blindness in one eye, that have anatomical loss of one eye, blindness in one eye with light perception only, or blindness rated at 5/200 visual acuity.

Question 3. How many OIF/OEF veterans have been service connected for blindness in one eye, and for blindness in both eyes?

Answer. VA identifies veterans by the wartime period in which they served, or by peacetime. The conflicts in Afghanistan and Iraq fall within the Gulf War Era, which began in 1990. As of December 31, 2005, the most current data available, there are 1,405 veterans of the Gulf War Era who are service-connected for blindness in one or both eyes.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN R. THUNE TO HON. R. JAMES NICHOLSON

Question 1. I believe the VA and the IHS have a Memorandum of Understanding to encourage cooperation and resource sharing between the two agencies. I'm wondering if you could update me broadly on the collaboration efforts between the VA and the Indian Health Service, and whether there's a likelihood that the existing IHS Service Unit in Wagner, SD could somehow be integrated with the proposed CBOC to be built In Wagner. This integration could be mutually beneficial to the IHS and the VA, particularly in light of the large number of Native American veterans we have in that area.

Answer. VHA and the Indian Health Service have made great progress in collaborations on twenty three different project initiatives. VHA and IHS routinely meet on a monthly basis to review the progress on each of the initiatives and to identify new opportunities for collaboration.

The Sioux Falls VA Medical Center, the parent facility to the Wagner CBOC, has an active and mutually beneficial working relationship with the Indian Health Service in South Dakota. Their most recent sharing agreement was established in March 2006.

At this time, the Wagner CBOC remains in the VISN 23 plan. Before the CBOC can be established, it must receive formal VA and Congressional review and approval. Because IHS has recently discussed changes in their presence at Wagner, VA feels it would be premature to discuss specific potential sharing arrangements. However, the overall sharing possibilities are a cause for excitement in both agencies. At the time VHA submits a formal plan for a CBOC, we will explore collaboration possibilities with the IHS Regional Director, and will include such proposals in our plan.

Question 2. While I support standardization when it comes to IT issues within the VA because it would be an important management efficiency, I am opposed to the standardization of diabetes monitoring supplies and monitoring equipment because I think there will be expensive health implications over the long term if we do so. With regard to diabetes standardization, the 2006 VA Appropriations Act specifi-

cally prohibits the VA from replacing the current system by which VISN businesses select and contract for blood glucose testing supplies and monitoring equipment. However, I'm told that some VISN directors are not conforming, and are preparing for a national standardization of diabetes monitoring supplies and equipment in spite of the prohibition in the law. Could you tell me what the present status is, and what directives you've given to the VISN directors on this issue? Are you doing what is required by the 2006 VA Appropriations Act with regard to this issue?

Answer. VA is not pursuing a proposal to standardize self-monitoring blood glucose equipment through a single national contract.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO HON. R. JAMES NICHOLSON

Question 1. The increase in the prescription drug copayment and the annual enrollment fee are measures that will deter Priority 7 and 8 veterans from coming to VA for care. Part of the rationale for this move is that many of these veterans have other forms of insurance. Why would VA seek to discourage these veterans from coming if their care is predominantly financed through a small copayment and VA billing their insurance company?

Answer A large majority of Priority 7 and 8 enrollees (68 percent of Priority 7 and 59 percent of Priority 8) are covered under Medicare, which does not reimburse VA for the care provided. Under current cost-sharing policies, the average Priority 7 and 8 patient is projected to use approximately $3,692 in health care services in fiscal year 2007. VA is expected to collect an average of $358 in first-party copayments and an average $338 in third-party collections from those patients.

Question 2. As you are aware, GAO recently reported that the management efficiencies built into the past few years' budget requests are essentially unfounded. This year, it is my understanding that the efficiencies contained in the budget proposal are in the "clinical" arena, rather than in "management." Based on VA information, is it my understanding that much of these savings are to come from the pharmacy benefits program, mostly by negotiating even deeper discounts on drugs—yet, this was also a major facet of the "management" savings. Please explain what will happen if these savings also fail to materialize.

Answer. To clarify, the GAO did not find that VA has not attained the budgeted efficiencies, but rather that there were not consistent processes across the organization for calculating them. The fiscal year 2007 budget request reflects cumulative efficiencies attained in fiscal year 2005 and fiscal year 2006 expected to continue in fiscal year 2007.

VA is estimating additional efficiencies of $197 million in the 2007 budget request, of which $107 million is in clinical efficiencies and $90 million is in pharmaceutical cost efficiencies. VA expects that these savings will materialize because the estimates are consistent with historical VA management and cost trends. VA also has a methodology for measuring and reporting the accomplishment of the clinical and pharmaceutical cost efficiencies estimates.

Question 3. I'm very concerned that VA does not have enough doctors and nurses to care for our veterans. For example, in the budget proposal before us today, a 14 percent increase is projected for Inpatient, Home and Community-Based Care beds, as well as an 8 percent increase in the number of patients treated. Yet, despite these increased demands, VA is projecting less than 1 percent increase for physicians— nd a flat-line increase for nurses. How will VA be able to maintain the current level of high-quality care for our veterans if staffing levels are not keeping pace with demand?

Answer. VA's professional staff continually strives for increasing efficiencies while improving the quality of care of our veterans. For example, Advanced Clinic Access programs and reduction of missed appoints improve system efficiency. In addition, advances in technology will continue to allow us to provide more home and community- based services to an increasing number of veterans without a commensurate increase in staff. Veterans receive care based on their assessed needs. Although physicians and nurses provide direct medical care and interventions, other disciplines are often involved in the delivery of patient care, especially in home and community-based care. Other health care professionals augment the services provided by nurses and doctors.

Question 4. Public Law 108–445 was designed to reduce VA's dependency on contract physicians, as it completely restructured VA's physician and dentist pay scales. Yet, I note a significant increase in the FY07 budget request for specialty physician contracts. Please explain how the Physician Pay bill has impacted how VA budgets

for contract physicians. Shouldn't we be seeing a corresponding decrease in the amount of money requested to contract specialty services?

Answer. The legislation for the new pay system for physicians and dentists was effective January 8, 2006. As of this date, we are assessing the financial impact of the conversion process for physicians and dentists who were employed as of January 8, 2006. Recruitment efforts to reduce contract costs by employing staff at rates that are commensurate with local labor market trends are underway. Most clinical turnover and contract changes for affiliated medical centers occur in conjunction with the academic year, which begins July 1. VHA expects to offset some contract costs through the use of flexibilities provided for in Public Law 108–445; however, the results of these initiatives will likely not be seen until fiscal year 2008.

Question 5. Do the Veterans Benefits Administration's production requirements for claims adjudication allow for thorough development and careful consideration of disability claims?

Answer. The performance standards for Veteran Service Representatives (VSRs), who have primary responsibility for the development of evidence to support claims decisions, include a production element. However, that element is only one component of the VSR performance standards. Another critical requirement is that each VSR's output meet a quality standard, which is verified through local management review and oversight.

Similarly, the standards for Rating Veterans Service Representatives (RVSRs) include production and accuracy components. The production standard for RVSRs assigns a weighted value to each type of claim according to its complexity. Since the more complex and time-consuming claims are afforded greater weight by the production standard, RVSRs are able to carefully consider each disability claim without adversely affecting the quality of the decision.

These standards have been tested and are regularly reassessed to ensure that they are appropriate and maintain the quality of service veterans deserve and expect.

Question 6. Is VA's Vocational Rehabilitation and Employment Service appropriately staffed given the high numbers of OIF/OEF veterans who reside in rural areas?

Answer. VBA's Vocational Rehabilitation and Employment (VR&E) Program has more than 120 out-based sites that serve veterans residing in areas not convenient to a VA regional office. In addition, contractors are utilized to supplement and complement the services provided by VR&E staff. We believe that our regional office and outbased staffs, along with the contract support, are adequate to ensure quality service to all OIF/OEF veterans.

Question 7. I mentioned during last year's budget hearing that I am concerned that VA cannot always absorb changes in law, anticipated or not, without falling behind. In 2005, it took 167 days to rate a claim and that the number is expected to increase again before dropping in 2007. How long will it take to get back down to the 2005 level?

Answer. The average days to process a claim is projected to rise to 185 days in fiscal year 2006. This projected increase is based on the expectation that we will receive nearly 100,000 additional claims as a result of the outreach required by the Veterans Affairs Appropriations Act of 2006. Timeliness will again begin to improve in the latter part of fiscal year 2007 as we are able to complete the processing of some of this additional workload and the inventory again begins to decline. If our projections hold true, timeliness improvements to the level achieved in fiscal year 2005 would not be realized until late in fiscal year 2008.

Question 8. I am very concerned VA may not have enough doctors and nurses to take care of our veterans. Despite a projected increase in demand for care, VA plans for an increase of just 100 Physicians. Additionally, there is a flat line on staffing of Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses and Nursing Assistants. How do we ensure that we maintain the current quality care for our veterans while it appears our staffing levels are not keeping pace with demand?

Answer. VA's professional staff continually strives for increasing efficiencies while improving the quality of care of our veterans. For example, Advanced Clinic Access programs and reduction of missed appoints improve system efficiency. In addition, advances in technology will continue to allow us to provide more home and community-based services to an increasing number of veterans without a commensurate increase in staff. Veterans receive care based on their assessed needs. Although physicians and nurses provide direct medical care and interventions, other disciplines are often involved in the delivery of patient care, especially in home and community-based care. Other health care professionals augment the services provided by nurses and doctors.

Programs are in place to assure there is an adequate supply of trained health care personnel to meet VHA workforce needs. The programs are the Employee Incentive Scholarship Program (EISP) the Education Debt Reduction Program (EDRP), and the National Recruitment and Marketing Program. The purpose of these programs is to assist in ensuring there is an adequate supply of trained health care personnel to meet VHA workforce needs.

• VHA helps ensure that nurses are educationally prepared to provide the highest quality of health care to veterans across the full range of clinical practice roles. As of September 30, 2005, participants who received awards to serve in registered nursing appointments upon completion of their education programs accounted for 93.2 percent of all the EISP participants. VHA implemented EISP in March 2000. Academic year 2000/2001 was the first full year of operation. At the conclusion of fiscal year 2005, VHA had awarded a total of 5,521 EISP scholarships to employees. Just over 50 percent of those recipients have already completed their academic programs while others continue to progress toward degree completion. Registered nurses accounted for 2,599 of the 2790 employees who successfully completed their degrees; 37 employees successfully completed programs preparing them as Licensed Practical/Vocational Nurses and four completed programs as Certified Registered Nurse Anesthetists. Upon degree completion, each employee is required to fulfill an obligated service period of 1 to 3 years.

• Beginning in fiscal year 2004, VHA implemented a variation of the typical scholarship program and created a program that would provide replacement salary and benefits for employees completing their degree within 2 years if working toward a degree as a registered nurse and within 1 year for those seeking LPN/LVN licensure. There are 262 employees seeking degrees as registered nurses and 32 LPN/LVN seeking participants. This program shortens the length of time to obtain a degree and become a licensed professional by allowing employees to attend school on a full time basis.

• Implemented by VA in May 2002, EDRP serves as both recruitment and a retention tool. VA authorized 4,379 EDRP awards through fiscal year 2005 with a total multi-year value of approximately $74.4 million through fiscal year 2011. Registered nurses accounted for the largest number of awards (2,061 awards or 47.1 percent), followed by pharmacists (665 awards or 15.2 percent) and physicians (564 awards or 12.9 percent). Data was reviewed for EDRP recipients hired from program inception through July 2005. The evaluation compared resignation rates between employees who received EDRP awards and those who did not receive EDRP awards. A study to evaluate potential budget needs to expand EDRP as a recruitment and retention tool is underway as a result of the preliminary findings that show a significant difference in attrition for employees not receiving awards. The results for the 48-month period during which EDRP had been operational in VHA show that for nurses, the resignation rate for EDRP recipients is 14.3 percent while the resignation rate for non-EDRP recipients is 28 percent—which represents a 13.7 percent difference. VHA obligates approximately $1.31 million annually for new Nurse EDRP awards, and $4.3 million annually for all nursing EDRP awards (includes a 5-year cohort).

• VA Healthcare Retention & Recruitment Office (HRRO) manages a national recruitment website for healthcare and allied healthcare occupations, and manages the national recruitment-marketing program for employment marketing/ad placement in professional journals, internet employment sites, television and radio. HRRO also supports a national presence by distributing employment information at national and regional professional meetings and job fairs.

Question 9. Last year, VA briefed my staff that VA would save over $25 million in 2006 and $82 million in 2007 through Management Analysis and Business Process Reengineering. VA stated that these savings would result in an FTE Reinvestment of 484 in 2006 and 1,564 in 2007. Yet, we have been unable to find these savings or the FTE Reinvestment accounted for in the fiscal year 2007 Budget proposal. Please explain why these funds are not accounted for in the budget.

The Department of Veterans Affairs was criticized by the Government Accountability Office (GAO) and others for lacking a methodology sufficiently rigorous for making the kinds of health care management efficiency savings assumptions reflected in the President's budget request for fiscal years 2003 through 2006. GAO went on to say that VA also lacked adequate support for the $1.3 billion in actual management efficiency savings reported for fiscal years 2003 and 2004 because we lacked a sound methodology and adequate documentation for calculating and reporting management efficiency savings.

VA agreed with the GAO findings and is in the process of developing an improved methodology method for tracking and reporting actual savings achieved through implementation of proposed management efficiencies.

As a result, VA chose not to identify any specific management efficiency initiatives in the Department's fiscal year 2007 Budget Request that might serve as a basis for budgetary offsets.

However, VA will continue to implement the Management Analysis and Business Process Reengineering (MA/BPR) initiative as outlined to your staff in July 2005. Indeed, we are only now embarking on the first two pilot studies. VA expects to begin studies of the laundry and food service operations in each of VHA's Veterans' Integrated Service Networks (VISNs) by the end of the fiscal year. These studies are expected to be nine to twelve months in duration.

As part of the MA/BPR implementation strategy, VA has developed a web-based Business Improvement Tracking System (BITS) to capture true baseline costs and key performance indicators; estimated costs, projected savings, and key performance indicators associated with the redesigned or reengineered organization to be implemented; and finally, actual costs, savings and key performance indicators associated with the Most Efficient Organization as actually implemented. At a minimum, cost data to be collected will include:

- Personnel—including salaries, fringe benefits, overtime, shift differential pay, and holiday and weekend pay;
- Material and supply costs;
- Overhead costs;
- Consulting expenses; and
- One time costs to perform the study and or implement the MEO.

VA has every confidence that we will meet or exceed the projected savings previously identified with the MA/BPR initiative. VA also anticipates that estimated savings will be integrated with the budget once we are confident in the savings realized through implementation of the MEOs. VA's Office of Policy and Planning would be happy to brief you or your staff at your convenience on the method we will employ to track costs and savings through each stage of the MA/BPR process when those savings are actually realized.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO HON. R. JAMES NICHOLSON

Question 1. Secretary Nicholson, last year was your first year, and I realize that you "inherited" a budget, but there were real problems with that budget. What steps have been taken to improve the process so that we don't have similar problems with the models and estimates in the future?

In particular, what has been done to improve and update the models for long term care costs, which I believe will continue to grow as our WWII population ages and needs more intensive care?

Answer. In response to your first question regarding VA's model and estimates, we have made significant improvements to the actuarial model that was used to support our 2007 budget request, including development of an enhanced methodology for determining enrollee morbidity and a more detailed analysis of enrollee reliance on VA health care compared to other medical service providers. Also, we have added new data sources, including the Social Security Death Index, which resulted in a more accurate count of enrolled veterans. Finally, we have more accurately assigned veterans into the income-based enrollment priority groups by using data from the 2000 decennial census.

VA continues to take steps to ensure the actuarial model accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue to meet the health care needs of these returning veterans and veterans from other eras seeking more of these same services.

In response to your second question regarding the long-term care costs, the Department of Veterans Affairs (VA) developed the long-term care (LTC) demand model to estimate enrolled veteran demand for nursing home and home-and community-based care (HCBC). The model also projects what portion of enrolled veterans would prefer to seek care with VA. By the end of calendar year 2006, the LTC demand model will be updated to include functional status and LTC utilization data from the 2004 National Long Term Care Survey and 2005 VA Survey of Enrollees. VA is also making several refinements to the model, including a methodology that

will allow VA to better estimate LTC demand for those veterans who are cognitively impaired.

Assessing demand for LTC services is very complex and multi-factorial. The model uses data on veteran demographics, trends in disability rates, and utilization of services to estimate the type and amount of LTC services that enrolled veterans will seek from VA. The model evolves as new data and methodologies become available.

In terms of overall veteran demographics, it is apparent that there is a growing need for LTC services for elderly and disabled veterans. The number of veterans over age 85 will more than double to 1.28 million by fiscal year 2010 and peak at 1.32 million in fiscal year 2012. These veterans are the most vulnerable of the older veteran population and are especially likely to require not only LTC but also health care services of all types. In addition, VA is providing a spectrum of LTC services for a small but growing number of younger veterans who have suffered polytraumatic injuries in the current armed conflicts in Iraq and Afghanistan.

Question 2. When I travel back to West Virginia, I try to visit our Vet Centers and meet with staff and veterans recently returned from Iraq and Afghanistan. I listen, and I learn a great deal. I am pleased to see that VA is hiring more outreach workers to ensure that returning vets, including Guards and Reservists know that they can get help. But what is VA doing to improve and support the Vet Centers which are seeing more veterans, many with compelling mental health concerns?

Answer. In the wake of the hostilities in Afghanistan and Iraq, the Vet Centers have prioritized providing timely and effective services to veterans of the Global War on Terrorism (GWOT) returning from combat duty in Afghanistan and Iraq. National Guard and Reserve component personnel who served in the combat theaters in Afghanistan and Iraq are also eligible for outreach and readjustment counseling through VA's Vet Centers. The Vet Center program's outreach campaign to intervene early and inform the new veterans has been enhanced through the hiring of 100 new outreach workers from the ranks of recently separated GWOT veterans. The initial 50 GWOT veteran employees were authorized by the Under Secretary for Health in February 2004, and another 50 were authorized in March 2005. Located close to demobilization sites and National Guard and Reserve component facilities, the mission of the GWOT outreach specialists is to provide information that will facilitate the early provision of VA services to returning veterans and family members immediately upon their separation from the military. The proactive outreach campaign currently underway is providing VA with over 11,000 outreach contacts from OEF/OIF veterans on a monthly basis. VA's career conversion of the initial 50 GWOT veteran employees has added $2.5 million to the Vet Center program's recurring budget.

VA has also requested a $7 million increase for the Vet Center program in fiscal year 2007 to help support the anticipated increase in workload from veteran returnees from Afghanistan and Iraq. Based upon the first 4 months of actual veteran visits for fiscal year 2006, VA is projecting a total of approximately 1.2 million veteran visits at its Vet Centers by the end of fiscal year 2006. This is an increase of 150,000 visits for the Vet Center program compared to fiscal year 2005.

Question 3. In West Virginia, we have over 4000 returning Guards and Reservists in addition to active duty military. What are we doing to be sure that these soldiers get the full care they need within 2-year limits to VA coverage? What special efforts are being made to ensure that they get the service-connection needed to continue to receive VA care? Is 2 years enough time to offer mental health care to Guards and Reservists who have endured horrific conditions in Iraq with road side bombs? Isn't it true that it takes some veteran's time before they are willing to seek mental health care?

Answer. VHA has coordinated with the Veterans Benefits Administration to ensure that information communicated through the Transition Assistance Program (TAP) provides detailed information concerning availability of VA health care benefits for returning veterans. Special emphasis has been placed upon informing servicemembers, prior to their discharge or release from active duty, of the enhanced enrollment authority available to combat veterans. In addition, VHA medical facilities have coordinated with the Department of Defense (DOD) in its new Post Deployment Health Reassessment (PDHRA) program. VHA has participated at PDHRA exam sites and by accepting referrals from physical exam locations and DOD contractor call centers. VA is working in very close partnership with DOD to provide follow-up evaluation and care to Reserve and Guard servicemembers identified by the PDHRA screen. The PDHRA will be offered to over 250,000 Reserve and Guard servicemembers who were mobilized during the period September 11, 2001, to September 30, 2005. Approximately 113,000 Reserve and Guard servicemembers are required to undergo a PDHRA screen in fiscal year 2006. As of January 31, 2006, over 52 percent of all Reserve and Guard servicemembers completing the

PDHRA were referred to VA for care. Through January 2006, VHA has coordinated with DOD in its PDHRA assessment of almost 2,200 Reserve and National Guard veterans. The VA Seamless Transition Office has published guidelines and facilitated VA medical centers efforts to establish direct liaison with local Reserve and National Guard units to establish venues for VA benefit briefings and "on-the-spot" assistance with enrollment applications for VHA health care benefits. This combination of enhanced traditional transition services such as TAP, together with VA's close coordination with DOD and its Reserve Component units, helps to ensure that veterans have timely and seamless access to the full range of VA benefits that are available for them. In addition, Readjustment Counseling Service has been funded to hire 100 GWOT outreach workers to help Reserve and Guard servicemembers and their families access VA care. Readjustment Counseling Service, in partnership with Walter Reed Army Research Institute (WRARI), will be training all Vet Center staff during fiscal year 2006 on the WRAIR Battlemind Training Program. Battlemind is a behavioral health program to help servicemembers make the transition from the battle front to the home front. The focus will be on Reserve and Guard servicemembers and their families. Establishment of the VA Office of Seamless Transition is tangible evidence of VA's commitment to improve the delivery of benefits to America's newest veterans. The VA Office of Seamless Transition, in partnership with the National Guard Bureau, provided a week-long training program to the National Guard Bureau's newly hired 54 benefit advisors stationed in each State and Territory. The benefit advisors will help Guard servicemembers and their families in access VA care along with other community care.

The combat veteran health care benefit helps ensure that these high-priority veterans have ready access to the full range of VA health care benefits. VA staff involved in care coordination for these veterans has been provided guidance on sensitive issues related to their combat-related injuries, and they routinely assist these veterans in their filing for VA disability compensation and other benefits.

VA has placed emphasis on identification and treatment of combat related mental health problems. We are aware of the 2-year enhanced combat veteran eligibility period. However, the VA Readjustment Counseling (Vet Centers) benefit provides all combat veterans access to VA counseling with no time limits from their discharge date or subject to income thresholds. Vet Centers often refer patients to VA health care facilities when required and assist with submission of claims for service-connected compensation, specifically in cases where income thresholds may limit a veteran's access to enrollment in the VA health benefits program.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JAMES M. JEFFORDS TO HON. R. JAMES NICHOLSON

Question 1. Mr. Secretary, you would be very proud of the work being done at the Vet Centers in my state of Vermont. Vermont has one of the highest per-capita percentage of Guard and Reserve forces in Iraq and Afghanistan, and sustained some of the highest number of casualties per-capita. The Vet Centers have been outstanding in their efforts to find help to veterans and administer to their needs.

Vermont still has about half of its Guard and Reserve forces in theater, and these groups have sustained heavy losses. Yet the Vet Centers and their outreach operations are not being scaled up to meet this need. These centers provide a unique service that is hugely important to reserve forces in areas far from military bases. Can you explain to me why the President's budget does not provide a greater increase in funding for Vet Centers?

Answer. In the wake of the hostilities in Afghanistan and Iraq, the Vet Centers have prioritized providing timely and effective services to veterans of the Global War on Terrorism (GWOT) returning from combat duty in Afghanistan and Iraq. National Guard and Reserve component personnel who served in the combat theaters in Afghanistan and Iraq are also eligible for outreach and readjustment counseling through VA's Vet Centers. The Vet Center program's outreach campaign to intervene early and inform the new veterans has been enhanced through the hiring of 100 new outreach workers from the ranks of recently separated GWOT veterans. The initial 50 GWOT veteran employees were authorized by the Under Secretary for Health in February 2004, and another 50 were authorized in March 2005. Located close to demobilization sites and National Guard and Reserve component facilities, the mission of the GWOT outreach specialists is to provide information that will facilitate the early provision of VA services to returning veterans and family members immediately upon their separation from the military. The proactive outreach campaign currently underway is providing VA with over 11,000 outreach contacts from OEF/OIF veterans on a monthly basis. VA's career conversion of the ini-

tial 50 GWOT veteran employees has added $2.5 million to the Vet Center program's recurring budget.

VA has also requested a $7 million increase for the Vet Center program in fiscal year 2007 to help support the anticipated increase in workload from veteran returnees from Afghanistan and Iraq. Based upon the first 4 months of actual veteran visits for fiscal year 2006, VA is projecting a total of approximately 1.2 million veteran visits at its Vet Centers by the end of fiscal year 2006. This is an increase of 150,000 visits for the Vet Center program compared to fiscal year 2005.

Question 2. Mr. Secretary, I am concerned by the proposal to cut the highly acclaimed VA medical and prosthetic research account by $13 million. This is a critical area, where medical technology is constantly improving and where no veteran should have to settle for less than the state-of-the-art medical device.

While the VA has yet to provide a significant number of prosthetic devices to Gulf War veterans, these numbers will surely rise as more veterans transfer out of the defense health care system and demand more services from the VA. These veterans also have the right to demand that the VA be intensely focused on developing better prosthetic devices and using technology to improve their quality of life.

I would appreciate your comment on the proposed cuts in medical and prosthetic research.

Answer. The Department of Veterans Affairs (VA) is committed to improving the impact of its research program by ensuring that resources are targeted to the most pressing problems and spent on programs that prove to be most effective at developing new insights into their solutions.

VA is projecting total resources of $1.649 billion in fiscal year 2007 which is an increase of $17 million or 1.1 percent over the 2006 level. These resources consist of $399 million in direct appropriation; $366 million in medical care support funding; $676 million in other Federal grants such as from Department of Defense and the National Institute for Health; and $208 million from private or university funding.

In fiscal year 2007, VA expects to fund about 2,045 direct projects and 2,839 full-time equivalents. In fiscal year 2006 and 2007, the research account no longer pays for its IT equipment because the central Information Technology (IT) Systems appropriation now pays for this type of equipment. The funding which will support IT projects for research is about $15 million in each of these fiscal years.

The goals for research are to ensure a balance among the competing needs for meritorious projects, to evaluate and fund existing programs at appropriate levels, and to fund new projects to ensure the advancement of health care for our veterans. Strategies to accomplish these goals include using attrition, transitioning to shorter durations of awards, and conducting competitive reviews of research centers. VA is using performance-based criteria to decide whether to modify, terminate, or expand programs.

VA research is increasing its focus on newly emerging needs of veterans, especially those returning from Operation Iraqi Freedom and Enduring Freedom (OIF/OEF). This includes research in prosthetics and amputation health care. VA continues to expand its support of multidisciplinary research and examination of enabling technologies to ease the physical and psychological impacts of limb loss, including pain. While traditional amputation research has focused on mechanical limb prostheses, VA is expanding its focus to include novel approaches, such as tissue engineering and surgical treatment for residual limb lengthening, joint replacement and attachment of prostheses, as well as incorporating advanced materials, microelectro-mechanics and nanotechnologies into current prosthetic designs. One particularly innovative approach involves investigating the control of prostheses through direct brain activity. A primary goal of these activities is to generate rigorous data that can drive policy and shape clinical care guidelines.

Question 3. Mr. Secretary, the current widespread call-up of the Guard and Reserve units has gone far beyond anything we have seen in recent times. There are Vermont Guard units serving in Iraq who were last activated for Federal service for the battle of Gettysburg. Deploying large numbers of National Guard troops has put great strains on the system of support for the Guard member, and the member's family.

It is long established practice that the VA cares only for the veteran, and services are not provided to the veteran's immediate family.

I urge a reconsideration of this policy however, particularly as it relates to mental health services. This need is particularly urgent in the many areas of the country with no military bases nearby to provide services. It has long been known that a soldier's effectiveness on the battlefield is compromised if he or she is worrying about problems at home. The sudden activation of Guard units with no previous expectation of combat duty has been very disruptive to families and therefore to

servicemembers. The VA, and particularly the Vet Centers, have the expertise to deal effectively with these problems—an expertise that is not readily found in most communities.

Have you given thought, Mr. Secretary, to allowing for mental health services for the families of activated Guard and Reservists?

Answer. The care of families of those on active duty is a responsibility of the Department of Defense. VA would certainly be willing to work with the Department of Defense in any way possible to assist in addressing the concerns you raise.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. BARACK OBAMA TO HON. R. JAMES NICHOLSON

Question 1. An Amendment in last year's VA appropriations law requires a letter to be sent to veterans in six states, including Illinois, regarding their right to seek a re-review of past claims. When can Illinois veterans expect their letters from VA, and what can they expect after they receive those letters?

Answer. From May 9 through May 16, 2006, VA released the mailing to veterans in the six states. Veterans receiving VA compensation in these states were sent a cover letter with an enclosure that explains the reasons for the mailing, the bases upon which their benefits claim might be reconsidered, and instructions for filing a claim for increased benefits.

For veterans who do file such a claim, VA will obtain any VA and private medical treatment records identified by the veteran and schedule a re-evaluation examination for any conditions the veteran claims have worsened. If the veteran believes any conditions previously found unrelated to service by VA should be service connected, VA will ask the veteran for new and material evidence to support that claim. If the veteran claims new conditions (not previously reviewed by VA) are related to service, VA will review the veteran's service medical records and, if necessary, request an examination or medical opinion. If the veteran claims that he or she has additional conditions that are secondary to a condition already determined by VA to be service-connected, VA will develop relevant evidence and, if necessary, request an examination or medical opinion.

Question 2. Nationwide, you are projecting an increase in the wait time for processing claims by 20 days from 2005 to 2007. If that is the case, why haven't you requested increases in staffing levels to meet the increased demand and keep the wait time low, or perhaps even reduce it from its current average?

Answer. The increase in average days to process was projected as a result of the special outreach to veterans mandated by the Veterans Affairs Appropriations Act of 2006. Nearly 100,000 claims are projected to result from this special outreach, but we then project claims receipts to return to more normal levels (i.e., increases of 2 to 3 percent a year over 2005 levels). Because of the significant training time and resources required for newly hired decisionmakers to become productive, additional FTE in 2007 would not have an immediate impact on processing timeliness or inventory reductions. However, VBA expects that the employees hired in fiscal year 2005 and those we are currently hiring and training will be able to assist in improving timeliness and delivery of benefits to veterans in fiscal year 2007.

Question 3. In Illinois, we have 391,000 veterans 65 and older, but only four state nursing homes that together have just more than 1,000 beds and a waiting list topping 920. What is the rationale behind flatlining Federal funding for state veterans nursing home construction when the demand for such care is high?

Answer. VA supports State Veterans Home construction and renovation through the State Home Construction Grant Program, which provides matching funds to assist states in purchasing, constructing, and renovating properties to serve as nursing homes, domiciliaries, and adult day health care centers. Funding allocated to this program must be balanced against other health care needs of veterans. States are invited to submit applications to compete for construction and renovation support. All applications are ranked annually by a process established in regulation into a priority list that is approved annually by the Secretary. Projects are then funded in priority order until available funds are exhausted. Highest priority is given to renovation projects needed to correct life safety deficiencies and for construction of new capacity in geographic areas of need. VHA has funded all life safety project submissions that qualify for this grant program for fiscal years 2000–2006. VA provided a grant to the State of Illinois to assist in construction of a new 40-bed dementia unit at the Manteno State Veterans Home in 2002. That facility is now operational. VA provided a grant of $4.2 million to reimburse the State of Illinois for costs of construction of a new 106-bed nursing home in Quincy in 2005. Construction of that home was completed in 2002, but it has not yet been made oper-

ational by the state. VA has received applications for an 80-bed addition at the LaSalle facility and a new 200-bed nursing home at a location to be determined later by the state. When Illinois commits state matching funds for these two projects, they will become eligible for a VA grant. When they receive a grant will depend upon their priority ranking and the funds available to VA for this program.

Question 4. This year's budget uses some of the same accounting gimmicks that we've seen in the past, making the increase in this year's request seem larger than it is. First, you have included $800 million in funds from your proposed enrollment fee and prescription drug copay increase, both of which have been rejected repeatedly by Congress. Second, you include "efficiencies" of $1.1 billion, but the GAO has found that these savings claims cannot be substantiated. That is nearly $2 billion that either does not exist, or cannot be accounted for. So the $3.5 billion increase we've been hearing about is likely to be much less—maybe even less than half of that sum. How do we avoid another shortfall if that $2 billion never appears?

Answer. VA's budget request reflects the total amount of resources required to provide quality health care to the number of veterans projected seek that care in VA facilities. VA further proposes fee policies as a potential reduction to the full cost of health care as options for the Congress to consider. To further address the increasing health care demand and to ensure that VA continues to provide timely, high-quality health care to our core population, those policy proposals apply only to Priority 7 and 8 veterans who have no compensable service-connected disabilities and do have the financial means to contribute modestly to the cost of care. The first proposal is to implement an annual enrollment fee of $250 and the second is to increase the pharmacy copayment from $8 to $15 for a 30-day supply of drugs. These proposals are similar to those included in the 2007 President's budget for career military retirees under the age of 65 in the DOD health care system to align more closely with other public and private plans. The budget also includes a provision to eliminate the practice of offsetting or reducing VA first-party copayment debts with collection recoveries from third-party health plans. The three proposals, if accepted, reduce the need for appropriated funds by $795.5 million. If these three proposals are not enacted, VA will require an additional $795.5 million in direct appropriation.

The GAO report cited above stated on page 12 that "Although VA does not have a reliable basis for determining whether it has achieved its savings, it does not mean that new savings have not occurred." The recent GAO report did not find that actual efficiencies were not realized in fiscal years 2003 or 2004. To the contrary, during both years unobligated balances were carried forward and wait lists were dramatically reduced enhancing the overall quality of care delivered to our Nation's veterans. VA is confident that the savings of $197 million (less than 1 percent of the medical care budget) in new efficiencies for fiscal year 2007, is reasonable and attainable.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. KEN SALAZAR TO HON. R. JAMES NICHOLSON

Question 1. I am very pleased that the budget contains $52 million in construction funding for the VA hospital at Fitzsimons. Because that hospital means so much to the veterans' community in my state, it means a great deal to me, and I want to thank you for your personal involvement in that project. My question is: how can we be sure this funding will be enough to cover the startup costs of the Fitzsimons hospital? And how can we do a better job of ensuring the projected costs of that project are accurate?

Answer. In addition to $52 million in the current budget request, $30 million in advance planning funds were appropriated in fiscal year 2004. Additionally, the Department plans to reprogram $25 million from reserves to the project. Taken together, these funds will be sufficient to acquire the property; prepare construction design documents; and clear and prepare the site.

Workload projections have changed since our initial programming efforts were completed in September 2004. VA is currently re-validating the design program for the Replacement Medical Center Facility and plans to begin preliminary design efforts this fiscal year. Cost projections based on completed schematic designs will be a more reliable forecast of our future funding needs.

Question 2. The President's budget once again proposes to increase premiums and copayments for Priority 7 and 8 veterans, of which there are over 27,000 in my state of Colorado. Why does the Administration insist on including the revenue that would be generated from these policies—which have been consistently rejected by

Congress—in its budget assumptions? Wouldn't it serve our Nation's veterans better to be more realistic in these assumptions?

Answer. We are reintroducing them because we believe they are justifiable, fair, and reasonable policies. They are entirely consistent with the priority health care structure enacted by Congress several years ago, and would more closely align VA's fees and co-payments with other public and private health care plans. The President's budget includes similar, small incremental fee increases for DOD retirees under age 65 in the TRICARE system. The VA fees would allow us to focus our resources on patients who typically do not have other health care options. Furthermore, these two provisions reduce our need for appropriated funds by $765 million as a result of the additional collections they would generate, and a modest reduction in demand.

The 2007 budget also includes a provision to eliminate the practice of offsetting or reducing VA first-party copayment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of non-service-connected disabilities would receive a bill for their entire copayment. If enacted, this provision would yield about $30 million in additional collections that could be used to provide further resources for the Department's health care system.

The combined effect of all three provisions reduces our need for appropriated funds by $795.5 million in 2007.

Question 3. What can the VA do under the current budget climate to adequately prepare for the influx of veterans who fought in Iraq and Afghanistan into the VA system, particularly the Veterans Health Administration?

Answer. The President's 2007 budget request provides the resources necessary to help ensure that the transition for servicemembers from active duty military status to civilian life is as smooth and seamless as possible. Last year through our aggressive outreach programs, VA conducted nearly 8,200 briefings attended by over 326,000 separating servicemembers and returning Reserve and National Guard members. We will continue to stress the importance of an informed and hassle-free transition for all of our forces coming off of active duty, their families, and especially for those who have been injured.

If active duty servicemembers, Reservists, and members of the National Guard served in a theater of combat operations, they are eligible for cost-free VA health care and nursing home care for a period of 2 years after their release from active military service provided that the care is for an illness potentially related to their combat service. VA has already facilitated transfers from military medical facilities to VA medical centers for several thousand injured servicemembers returning from Operation Enduring Freedom and Operation Iraqi Freedom.

There are many other initiatives underway that are aimed at easing the transition for servicemembers from active duty military status to civilian life. Within the last year, VA hired an additional 50 veterans of Operation Enduring Freedom and Operation Iraqi Freedom to enhance outreach services to veterans returning from Afghanistan and Iraq through our Vet Centers. They joined our corps of Vet Center outreach counselors hired earlier by the Department to brief servicemen and women about VA benefits and services available to them and their family members. They also encourage new veterans to use their local Vet Center as a point of entry to VA and its services. Our outreach counselors visit military installations, coordinate with military family assistance centers, and conduct one-on-one interviews with returning veterans and their families.

Last year, VA signed a memorandum of agreement with Walter Reed Army Medical Center to give severely injured servicemembers practical help in finding civilian jobs. Under this agreement, VA off ers vocational training and temporary jobs at our headquarters in Washington, DC, to servicemembers recovering at the Army facility from traumatic injuries.

VA and DOD are working together to establish a cooperative separation exam process so that separating servicemembers only need to have one medical exam that meets both military service separation requirements and VA's disability compensation requirements.

VA is also committed to ensuring that no veteran returning from service in Operation Enduring Freedom and Operation Iraqi Freedom has to wait more than 30 days for a primary care or specialty care appointment.

VA continues to take steps to ensure the actuarial model accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue

to meet the health care needs of these returning veterans and veterans from other eras seeking more of these same services.

Chairman CRAIG. Mr. Secretary, thank you very much for those opening comments, and I think this Committee has appreciated the relationship that we have developed with you and all of those who are with you as we work through these issues and as we serve our veterans.

We will go through several rounds of questions for a reasonable period of time. We have another panel, and we want to get this done in a timely fashion. So the record will be open for any additional detailed questions that we might seek.

Mr. Secretary, a major driver in the increases suggested by the Independent Budget is the assumption that VA's patient population will increase by 6.3 percent. Now, as I have mentioned, in your budget estimates, the growth is approximately 1 percent. How confident are you in the projections you have based this entire health budget on?

Secretary NICHOLSON. We are very confident. We have spent a lot of time on this. We did go back to the model that the Department has used for years. It is the largest model in the world, probably. They model over a hundred million lives, mostly for other private insurers and actuarials, but we also, as some would say, have applied some Kentucky windage to it, because it doesn't model everything that we do, and while it does model for times of combat, we also went in beyond the model and looked at that because we are at war; and, believe me, we have been over it many times back at the Department and conclude that we think we are on target.

Chairman CRAIG. This is the same modeling service that was used last year?

Secretary NICHOLSON. Yes, it is, but in fairness to those who developed the budget for last year—I wasn't here—as we do in this cycling that we are in, we are sitting here working on the 2007 budget right now, and most of this work was done in 2005. So it is based on 2004 data. When they did the budget for last year, they were modeling real data off of 2002 and there was no war in Iraq. So there is a sharp change in circumstance. Now, of course, that is not the case. We are budgeting real and modeling real data, including that combat reality.

Chairman CRAIG. And you are confident that based on where we are in these conflicts we are involved in, that these figures reflect the incoming men and women who will need our care?

Secretary NICHOLSON. Yes, sir. I am confident. This has gotten a lot of scrutiny and devil's advocacy in our Department. So I am confident.

I will say this is a dynamic business and a dynamic environment that we are in. It was pointed out by one of the opening statements of one of the Members of the Committee about some of the States looking at Medicaid recipients with the view toward seeing if they maybe want to go to the VA to get their health care. So there are these dynamic elements out there, and that is why I think that it is so wise that you suggested and we readily agreed to come to you quarterly, meaning that we prepare ourselves and know where we are with our numbers and report to you quarterly. We also, I would add parenthetically, are doing that monthly now with OMB.

Chairman CRAIG. Probably one of the more controversial areas of your budget proposal deals with the issue of enrollment fees for Priority 7 and 8. You have heard several express their concern and frustration this morning. You have heard my expression about how we fit all of this in reality with budgets and budget needs. You estimate that nearly 200,000 current users of the VA system would choose not to continue using VA if the proposal were put in place. To what do you attribute the drop in users? That would be my first question.

Are we pricing veterans out of the system, or will these initiatives cause veterans to go without health care coverage? Obviously, those are the concerns we all have as we start putting a price tag to these priority groups.

Secretary NICHOLSON. First of all, Mr. Chairman, we have good data that suggest that of that number who would decide not henceforth to use the VA as a result of that, 95 percent of them have other health coverage. So we would not be driving them away from health coverage and making them uncovered.

Chairman CRAIG. By that, you mean their own insurance or other access?

Secretary NICHOLSON. Yes, sir, or Medicare or another alternative. There are different ways to analyze this. One certainly is an equitable basis. By that I mean, we have priorities. You have established priorities of veterans by law for us, enabling us to take care of those who depend on us the most. Enhanced resources would be a result of our proposal. There is another strong equity argument for this, which I think is very compelling being a retired member of the military myself, which is that our retirees who are on TRICARE pay annual enrollment fees, pay copays, and they pay them in amounts that are significantly higher than we are asking in this proposal, and we are asking it just from category seven and eight veterans who are veterans, who have no service-connected disability and who are working.

Chairman CRAIG. Thank you. My time is up. Let me turn to our Ranking Member Senator Akaka.

Danny.

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

Mr. Secretary, thank you for your statement on the budget. As a World War II veteran along with Senators Warner, Stevens, Inouye, and Lautenberg, and as a Member of this Committee for the past 16 years, I want you to know that I feel strongly that we really need to work together for our veterans.

We need to calculate VA's true costs which must include the cost of war. We have fiscal limitations, however, and we need to look at our priorities and re-evaluate them if we are going to maintain a strong all-volunteer military. We must treat our veterans well which means they should not be begging for service.

Mr. Secretary, I am very concerned that this budget, like last year's proposal, does not adequately address the needs of returning servicemembers. The most recent data from the Department indicates that IOF and OEF veterans are coming to VA at the rate of nearly 30 percent, yet this proposal actually predicts that VA will see a decrease in the number of these veterans. While I understand

that we are reducing the size of our forces deployed overseas, those who come back will still have the automatic eligibility for 2 years of care.

Can you, Mr. Secretary, please elaborate on how you arrived at these numbers?

Secretary NICHOLSON. Thank you, Senator. That is an important question, and that is a priority category of veterans that you are addressing with your question, those returnees from the combat zone, OIF and OEF. If you look at what we have seen so far, in our medical facilities, we have seen approximately 120,000, and in our Vet Centers we have seen approximately another 50,000 who come in and inquire about benefits and so forth and sometimes just to commiserate. We are showing 109,000 OEF/OIF veterans, and that is based on our projections as well as coordination with the Department of Defense, getting their release schedules sooner with more particularity, and it is improving. So that is in part a metric of that number.

Senator AKAKA. Mr. Secretary, I want to ask about the proposed cuts to the VA research program. I asked this question in my first round because I feel research is a critically important program. Researchers see patients in addition to conducting research, and they come to work at VA because they can do both in a high-quality setting. So when we cut research, we are cutting research staff and that, in turn, can jeopardize the quality of care for the entire system.

Mr. Secretary, can you please detail the full impact that these cuts will have?

Secretary NICHOLSON. I appreciate that question, Senator Akaka, and I think it is sort of confusing the way that appears in our budget, but we are, in fact, not requesting less in research. What happened last year, I don't know if you will recall, but we were given more in research than we requested because of particular research that we have been directed to ramp up and get underway on Gulf War illness in conjunction with the Southwest Medical Center in Dallas. So that was overlaying what we had requested. So that is taken care of.

So we are requesting more than we requested last year in research.

Senator AKAKA. Thank you very much for that response, Mr. Secretary. My time has expired.

Chairman CRAIG. Senator, thank you.

Senator Murray.

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

Mr. Secretary, veterans are telling me that CMS, their doctors, and their pharmacists are all telling them when they to go to enroll in Medicare Part D that if they are a veteran to go into the veteran system rather than enroll in Medicare. Are you seeing an impact on that at this time? Are you seeing increased numbers because of that?

Secretary NICHOLSON. Not that I am aware of. We are hearing those same anecdotal things, but we are not seeing a material impact of that yet, no.

Senator MURRAY. Have you increased your budget to account for that?

Secretary NICHOLSON. No, we have not.

Senator MURRAY. OK. I am also confused by something you just mentioned to Senator Akaka, and that is the OIF and OEF veterans who are returning and the access numbers. I believe you said that you estimated to serve 109,000. Correct?

Secretary NICHOLSON. In the medical centers.

Senator MURRAY. In the medical centers. And that you have, indeed, served, I believe you said 120,000 plus 50,000 or 170,000.

Secretary NICHOLSON. Approximately 120,000 in our medical facilities and another 50,000 have visited our Vet Centers. We don't dispense medical care per se at the Vet Centers, but we do provide advice, counseling, resource referrals and so forth.

Senator MURRAY. All right. But your budget projects a hundred thousand. So you are not projecting for an increase in the number of OIF and OEF veterans who are returning, yet we know that there are a high number who are going to be needing access for everything from PTSD to injuries to health care?

Secretary NICHOLSON. I am going to ask Dr. Perlin to respond to that, because it is a matter of the cumulative versus the particular care.

Would you address that, Dr. Perlin?

Dr. PERLIN. Yes, sir. Just as Secretary Nicholson said, Senator Murray, cumulatively, we will have seen more veterans. Fortunately, most come to us as young and active and generally healthy population, and many don't go on to require additional health care, and so cumulatively, the numbers the Secretary gave are absolutely correct.

With respect to those who will not seek care in 2007, we estimate about 109,000 ultimately will be using VA for health care services during that fiscal year.

Senator MURRAY. Well, I am very confused by that, because many of our Generals are telling me, many of our returning veterans, and, in fact, I was at the VA center in Seattle last week, that a very high number of veterans who are returning will seek care, particularly for post-traumatic stress syndrome, but it looks to me like with your numbers, you are projecting a decreased number over last year, which you estimate at 109,000. You served 120,000 plus 50,000 at your vet clinics, and now you are only projecting 100,000 for next year, so less?

Dr. PERLIN. No. If I might, the number that the Secretary cited as 120,000 cumulatively, including some veterans from fiscal year 2004 as well. So, again, it is the particular year versus the cumulative number of veterans. The number of veterans in a particular year who will require health care is less than the cumulative number of veterans who will have received health care at VA at any given time.

Secretary NICHOLSON. That was the total. That 120,000 was the total.

Senator MURRAY. OK. Do you believe there will be an increased number of OIF and OEF veterans who will be seeking access for care in fiscal 2007 and did you budget for that?

Dr. PERLIN. Our budget estimates approximately 109,200, and that is included in this budget.

Senator MURRAY. OK. Well, we will be watching that very closely as to the actual number who are, because I am hearing on the ground that it will be higher than that, and that will have a critical impact on our budget.

Let me ask you on the ban on category eight, are you making that a permanent ban?

Secretary NICHOLSON. No. We do not anticipate any change in that at this time.

Senator MURRAY. Is it just temporary?

Secretary NICHOLSON. Yes.

Senator MURRAY. Well, I will tell you, a lot of veterans are telling me that they feel like they have to have a service-connected disability or be indigent, or the doors to the VA will be shut, and I think that is something we seriously all have to recognize is not what we want to be projected as an image.

I just have a few seconds left, and I wanted to ask you two questions. So I will just leave them on the table for you. I would like you to get a response back to me. One of them is I am hearing from a number of our Vietnam vets that the impact of Agent Orange and Gulf War Syndrome from the Gulf War often doesn't become apparent until many years later and that they are concerned that men and women who served in Vietnam accessing a regular physician at this time may not have their symptoms recognized by a physician who is not at a VA and doesn't necessarily think to even ask them if they are a veteran, and the same for Gulf War Syndrome, that someone who served in the Gulf War may be seeing the effects of that, but a regular physician has no clue to even ask if they are a veteran.

I would like to hear back from you separately, because my time is out, if we are doing outreach particularly to those veterans to make sure that they realize that there may be out-year impacts to that. I would like to hear back from you on our efforts on that.

Secondarily, and my time is out, is I am still hearing about hiring freezes all over the country, and I would like to hear from you directly are there hiring freezes in place and, if not, why are we hearing about positions not being filled? Why are we hearing about high burnout rate of our VA staff? We are hearing about a high turnovers continually on the ground. So, is there a hiring freeze in place today anywhere in the VA system?

Secretary NICHOLSON. There is not a hiring freeze anywhere. There was in some locations a hiring freeze when we were operating under the continuing resolution.

Senator MURRAY. Is the VA just having difficulty hiring people to replace people who are leaving?

Secretary NICHOLSON. No. I would say we are not experiencing an unusual difficulty. You know, nurses particularly remain a challenge, although you have given us some good new tools to hire, to incentivize nurses, better pay and better much better educational benefits and much more flexible work schedules.

No. I don't think that we are having an unusually difficult time, and there is not a freeze.

Senator MURRAY. Well, I appreciate your comments in that.

Mr. Chairman, I do think this is a conversation this Committee should have, because on the ground, that is what I am hearing,

high burn out rates, high turnovers, lack of ability to hire staff. Is it the pay? Is it the hard work? Is it what they are seeing? Because our VA system needs to make sure that we have high-quality care for our veterans who come there.

Chairman CRAIG. Well, thank you, Senator, points well made, and especially those as it relates to as we settle into the prescription drug program that Congress has passed that is now being implemented at a very rapid rate and the consequence of that and is there a population shift going on out there. I think we will need to monitor that closely, and certainly those returning from OEF and OIF, we will monitor that with the Secretary's staff, the value of those quarterly meetings, also the value of this Committee and the work we will do here.

Yes.

Secretary NICHOLSON. Mr. Chairman, could I just add another comment to Senator Murray?

Chairman CRAIG. Yes.

Secretary NICHOLSON. Dr. Perlin just handed me a note that said that our turnover rate among nurses is one-half of the national average turnover rate among nurses and that we have since the first of the year, which is now 6 weeks, added 500 FTE to our rolls.

Senator MURRAY. Hired or added?

Secretary NICHOLSON. Hired 500 new employees.

Chairman CRAIG. Thank you.

Senator Jeffords, Jim.

Senator JEFFORDS. In prior wars, the Department of Defense and VA were not well-equipped to deal with the servicemembers' mental health issues. Post-traumatic stress disorder was barely understood and little was known about successful treatment. Today, we know a great deal more about post-traumatic stress disorder and how to treat it, thanks in part to the groundbreaking work done by the VA's National Center for Post-Traumatic Stress Disorder.

The Center has proven that recognition of early symptoms and effective treatment can prevent the full manifestation of PTSD, but this takes a strong force of trained professionals who are able to do intensive work with veterans upon return from the combat zone and who can follow up regularly with veterans to prevent destabilizing changes in their conditions. I appreciate the VA's proposed increase of global war terror counselors, but I am concerned that the proposed increase in mental services is not sufficient to meet next year's needs.

I would appreciate your comments on this.

Secretary NICHOLSON. Well, thank you, Senator Jeffords, and we remain very proud of our PTSD research facility in your State at White River Junction. We have some of the world's foremost experts there doing very important research, and I would point out to you several things. We are making a real concerted effort as part of our seamless transition endeavor, which is putting people forward to brief servicemembers before they deploy back, before the Reserve and Guard units disassemble back in their home States on benefits in general and emphasizing the symptoms of PTSD, post-traumatic stress disorder, for obvious reasons. They have just been through a very unusual human experience. When they have the kind of encounters that they do, and now I am echoing what I have

been told by the experts, these are quite usual reactions to that unusual experience of combat or the environment in Iraq or Afghanistan, and that they shouldn't think they are losing their mind. There should be no stigma attached to this by others or self-imposed, and we are trying to reach out to them to understand that about themselves and know that there are good treatment regimes for that.

I think we are having some success and we are certainly getting the resources to do this with. For example, now in every one of our 154 major medical centers, we have a certified expert on PTSD. In our four polytrauma centers, we have enhanced our PTSD treatment. In the polytrauma facilities these are people that are very seriously injured in more than one way physically. We have $339 million in this budget request for mental health. We have an increase of $40 million in here for PTSD alone.

So this is an obvious area of some concern to us both on the health side and the benefit side. Our responsibility, we feel, number one, is to try to make people healthy, how do you get them restored to the kind of people that they were prior to raising their hand and volunteering and serving us, and then to those that we cannot do that, we compensate them. That is why we are trying strenuously to get them to come in to us for treatment.

Senator JEFFORDS. We all know that in addition to funding, the other critical component to delivering high-quality health care is personnel. The VA has an extremely dedicated and efficient workforce. I commend you for that, an area in which Vermont VA has received special recognition and we are proud of that. However, without sufficient personnel to run a high-quality system and to react to new challenges, the value of additional funding is lost. For many years, Vermont's Veterans Hospital has been asked to do more with fewer people. Now faced with the return of a large number of National Guard troops from Iraq and Afghanistan, the VA is being asked to provide superior care with only a slight, slight increase in personnel.

Health care delivery and benefits processing come down in the end to people. Without the personnel numbers, the VA won't be able to deliver the care that veterans deserve, it appears to us. I would appreciate knowing why there aren't greater increases in personnel in this budget to ensure proper delivery of VA services.

Secretary NICHOLSON. Well, respectfully, sir, I would say, as I did in my opening statement, that the people that we are taking care of in our system are very satisfied, that is veterans are very expressive of their satisfaction, and that was measured by an outside independent agency, and we have a strong budget request, maintaining a very high personnel level. So we don't think that we are going to be undermanned and shorthanded in this budget cycle, and we are asking for more people, a net increase, I think, of around 650 in the VHA side and several hundred, I think, in the benefits side.

But if we get into a situation where we are not doing the kind of job that we should be doing, we will seek to redress that with the transfer of people or hiring new people if necessary.

Senator JEFFORDS. I know my time has expired, but I would like to have a follow-up on that sometime.

Chairman CRAIG. We will do that. I am also going to admonish us to submit things in writing so that we give the other panel that is waiting full attention too.

Thank you, Jim.

Let me turn to Senator Graham.

Lindsey.

Senator GRAHAM. Thank you, Mr. Chairman.

Why should there be two health care systems, one for veterans and one for military retirees?

Secretary NICHOLSON. That is a good question, Senator Graham. I have actually had that conversation with the President.

Senator GRAHAM. What did he say?

Secretary NICHOLSON. Well, he was asking the question.

Chairman CRAIG. Is this an on-the-record or off-the-record comment here?

Senator GRAHAM. I just threw that out there to wake everybody up.

I really do believe that is a great question and we need to answer it wisely because it could be a win-win situation. We have got 1.7 million people eligible for TRICARE as military retirees. They have families, and the VA is doing a great job, and the more people you have in the system, we would have to put more money, obviously. I think the broader services you could provide people, it could be a big benefit for veteran community. You could have military retirees accessing VA health care facilities. You could have the VA accessing military health care.

We need to think big here. We need to serve people well, do away with duplication where possible, get the best bang for taxpayer dollar and serve people.

So I just throw that out there, Mr. Chairman. I know you have been very open-minded about looking for models in the future, and one last comment about that: In the Department of Defense budget, it is projected that 12 percent of their entire budget is health care costs. We are literally asking commanders down the road to pick between bullets and planes and ships and health care, and we need to take that pressure off the Department of Defense budget, give it to people like yourself and your organization who are really good at taking care of people as their primary mission.

So I would just ask this Committee to try to think about the answer to that question, where should we go in the future?

Category seven and eight veterans, who are they? Who is a category seven and eight veteran?

Secretary NICHOLSON. Could I respond to the first part of your question?

Senator GRAHAM. Yes, sir.

Secretary NICHOLSON. Because I did have that conversation with the President and we have had it with other people in and out of the military. One of the things you have to keep in mind is the deployability of the medical assets.

Senator GRAHAM. You will need a medical footprint in the military, but the retiree people are not going to be deployed, I hope.

Secretary NICHOLSON. Was that your question, addressing the retired military?

Senator GRAHAM. Yes.

Secretary NICHOLSON. Not the active military?

Senator GRAHAM. Right. We will need a military footprint for active duty people and their families because they are in the fight, but there are a bunch of us, me included, hopefully one day that will be retired that are getting health care that might benefit from a merger of the system and the country might benefit. Certainly, the Department of Defense would benefit.

The question is why does the Department of Defense take care of retiree health care? That is the big question. Their job is to fight and win the wars.

Now back to category seven and eight. Who is a category eight veteran?

Secretary NICHOLSON. Senator Graham, the Congress when it reformed VA benefits created eight categories, as you know.

Senator GRAHAM. Right.

Secretary NICHOLSON. And the least in the rank of priority are the category eights. A category eight veteran is a veteran—first of all, a veteran is a person who has served in the military of our country and was separated under conditions other than dishonorable. A category eight veteran, then, is that veteran who during his service had no service-connected disability or injury.

Senator GRAHAM. A non-retiree?

Secretary NICHOLSON. A non-retiree.

Senator GRAHAM. Who typically serves 2 to 4 years?

Secretary NICHOLSON. I am pausing. I think a category eight could be a retiree.

Senator GRAHAM. It could be a retiree?

Secretary NICHOLSON. Yes, because a Priority 8 veteran is one who has no service disability.

Senator GRAHAM. They should be getting health care on the DOD side.

Secretary NICHOLSON. They could be getting care from DOD.

Senator GRAHAM. Well, OK.

Secretary NICHOLSON. An eight, then, is one who has an income above a geographically based means, and a seven is that same veteran whose income is below that, but above another income threshold that distinguishes between a Priority 7 and a Priority 5.

Senator GRAHAM. The reason I asked that question is there are some revenue-raisers, for lack of a better term here, in your proposal which I think makes sense to me, because a category—I want to introduce into the record some answers to questions submitted several years ago where the DAV and other veterans groups suggested that category seven and eight veterans should pay their own way. And right now, you are proposing an enrollment fee, and what I want the Committee to understand, very quickly, is that if you are a retiree in TRICARE, you pay an enrollment fee. If you are a National Guard member, thanks to the help of the bipartisan group, now you are eligible for TRICARE for the first time in the history of our country, but you and your family pay an enrollment fee and a premium.

So I would argue that if we are asking category seven and eight veterans to pay an enrollment fee, that is not unfair, because we are asking people who served for 20 years to pay one. We are asking people who are still serving to pay one in the Guard and Re-

serves, and we need to think of this in terms of what is best for those people in category one and two because there is a limited amount of money.

With that, I will close.

Chairman CRAIG. Thank you, Senator Graham.

Senator Thune.

STATEMENT OF HON. JOHN THUNE, U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Mr. Chairman, and thank you, Secretary Nicholson and your team, for being here and presenting the President's 2007 budget request for the VA. As you know, budgets are an indication of where we as a Government place our priorities, and clearly by looking at that chart, the support that we provide to our veterans is a high priority and has received consistent increases in funding, and I think having said that, that there is always room for improvement and we obviously want to work with you to see that we are ensuring our veterans receive the benefits that they deserve.

I also would add, because I had an opportunity last week to visit the transitional care unit of the Sioux Falls VA Medical Center as part of National Salute to Hospitalized Veterans Week, and I met with several of our veterans and came away, as I always do whenever I meet with them, with a great appreciation for the sacrifices that they have made for our country and the responsibility that we have as a Government to ensure that they are given the benefits that they have earned through their noble service. So like all Members of this Committee, I am committed to working on their behalf.

I will say, too, in visiting with some of the employees there at the VA that I came away with somewhat a different point of view, perhaps, than Senator Murray had articulated earlier, that they were very bullish and upbeat and people who take very seriously and are very dedicated to the job that they have, and I am sure that that varies from facility to facility, but clearly the feedback that I was getting both from the veterans and from the people who work at the VA Medical Center there was very positive, and so I consistently, of course, ask them for things that we can do better and how we can perform a better job for our veterans.

But I would like to ask one question, if I might, because it is a little peculiar to my area of the country, because I serve a large number of rural veterans and, therefore, I am always looking for ways to improve the access to VA health care that they have. One of the ways to improve access for our rural veterans is through community-based outpatient clinics, and we have had a number of those in my State that have been put in place. Vision 23 has targeted more recently the communities of Wagner and Watertown for the implementation of new CBOCs by the Year 2012, and that proposal was made through the 2004 CARES decision, Capital Realignment for Enhanced Services decision, because Vision 23 is currently below access standards.

So I guess I am just wondering if someone on the panel might be able to update me on the progress of implementing that decision as it relates to developing community-based outpatient clinics.

Secretary NICHOLSON. Yes. I can respond to that, Senator Thune. We are looking at Wagner and Watertown in the fiscal year 2007 cycle. There are considerably other locations throughout the country that are also in our scope, but they are also there. We are looking at it.

Senator THUNE. Well, I appreciate your considered support of that concept. It has been a very effective tool. We have one in Aberdeen, South Dakota and Pierre and Sioux City, Iowa just across the border. In understanding the geography of the West, there are long distances and also the climate of the West, it is not easy at certain times of the year to get to some of these facilities. So it has been a very effective tool and I am told a cost-effective one as well in the sense that in some ways if you are able to serve people through the committee out-patient clinics, that it does help keep costs down in some of the hospitals.

So one other question I have here, just as a follow-up, and, Dr. Perlin, we have had some discussions about this: Where is the VA with respect to the question about consolidation of IT services? That is something that this Committee has probed previously in hearings that the Chairman has had conducted on the subject.

And maybe you have already asked that question. I don't know.

Chairman CRAIG. Not today, but that is on going.

Senator THUNE. I would be curious to get an update on that, if I might.

Secretary NICHOLSON. I will respond initially and then ask Dr. Perlin if he wants to add anything. This is an area, fair to say, that is undergoing a major transformation inside the VA and needs to. We are very proud of the achievements that we have made in transforming and changing the culture so that we are uniformly on electronic medical records. We now need to get as good in the information technology, because there are certain organic structures within the VA that tend to make it want to be stove pipes, a big medical arm, a benefit arm, a burial arm, and in the benefits particularly, there are many other smaller arms such as the sixth largest life insurance company in the United States and GI benefits and home loan guarantees and so forth. We realize that we could make substantial savings by the centralization and the standardization of information technology and information-sharing within this large agency, and so we are underway in what we are calling a federated model of what we are doing, which is making the Assistant Secretary for information technology in charge strategically of the budgeting and the personnel now for IT within the agency.

But because it is federated and not totally centralized in that model, we will allow, particularly, say people of the medical arm to model their own unique software for a research application or a certain medical application, because it just doesn't make sense to me to take that all the way from them and centralize that at the headquarters of the VA. Even in this federated model, I will tell you very frankly that we are having to butt up against a system that is not used to this. They are losing people because we are bringing people out of some of these administrations and putting them into a central IT facility.

It is a very important area. It needs to happen. I am committed to it. I would like to get it done without your having to tell us by law to do it.

And with that, I will ask Dr. Perlin if he wants to add anything.

Dr. PERLIN. Thank you, Mr. Secretary.

Senator Thune, we appreciate your great support to the electronic health record. Like the President, I think you have seen the data where one in five laboratory tests in the country are repeated because previous records were not available, not in VA. For less than $80 per patient per year, we have those records every time. So that has improved our quality, our safety, our efficiency, even in the compassion with which we deliver health care services.

In fact, just today, it was announced that VA won a Government excellence award for improvement in the ability to transfer health information from the Department of Defense, the bi-directional health information exchange, and so there is a great history. Also, just as the Secretary said, veterans should never have to face three VAs, and the opportunity to achieve some consolidation, some economies of scale through sharing and the purchasing of infrastructure while maintaining and even improving our ability to serve veterans of the Nation with topnotch electronic health records is their aspiration, and we are well on the way.

Senator THUNE. Thank you. Thank you very much. I appreciate that.

Mr. Chairman, thank you.

Chairman CRAIG. John, I appreciate that question. The Secretary and I and the Chairman on the House side have dialogued about this. As you know, the Chairman on the House side, Chairman Buyer, would like to legislate a specific model. I must say the Secretary is working very hard at this moment. I am willing to give them some running room. I say that because of the reputation they have established with their medical health records. Now, if they were the FBI, I would suggest that we don't do that, but this is not the case here and I know they are working hard to make these transitions.

And we will monitor it very closely. I am appreciative of your interest in it. I think it is critically important we get there as we transition this agency into the information age in that sense.

Senator JEFFORDS. Mr. Chairman.

Chairman CRAIG. Yes.

Senator JEFFORDS. I have other questions, but I would say that I would be willing to submit them for the record.

Chairman CRAIG. Jim, thank you very much.

Senator Akaka, we do need to move on to our second panel and I appreciate that consideration. So thank you. We would ask all of our Members who have additional questions to submit them to the Secretary and those who are with him. I have several and we will do that.

Again, to you, Mr. Secretary, and to all who are with you, we thank you very much for your openness and your candidness this morning as we work our way through this. It is obviously a high priority to this Congress and to America and we thank you for your leadership in these areas.

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

Chairman CRAIG. Gentlemen, trust me. It is not your presence or that which you are about to say that has emptied out the room. Again, let me thank the veterans service organizations for being before the Committee today, and let me introduce Steve Robertson, Director, National Legislative Commission of the American Legion; Quentin Kinderman, Deputy Director, National Legislative Service, Veterans of Foreign Wars; Brian Lawrence, Assistant National Legislative Director, Disabled American Veterans; Carl Blake, Senior Associate Legislative Director, Paralyzed Veterans of America; and David Greineder, Deputy National Legislative Director, AMVETS.

Gentlemen, we understand some of you will take pieces of the unified budget. We appreciate that. Others will not.

So we will start, Steve, with you. Please proceed.

STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. ROBERTSON. Thank you, Mr. Chairman.

Mr. Chairman, I had some wonderful opening oral remarks that I wanted to make, and I am asking to submit them to the record because I think there are some questions that need to be answered that your colleagues have asked.

Chairman CRAIG. All right.

Mr. ROBERTSON. And I would also like my written statement to be made part of the record.

Chairman CRAIG. All of your written statements and any accompanying information will become a part of our official record.

Mr. ROBERTSON. I have to comment on a couple of the remarks that were made, number one, concerning the projected patient growth. They talked specifically about priority groups areas five and six. If I am not mistaken, I believe that that is the area that the OIF, OEF troops fall into, the priority group six, and from what we have seen talking to the veterans and visits in the field, I think that there is going to be a lot more people coming back to the system. As you know, for 2 years, they are allowed to use the VA system, and I think that you are going to have a lot more repeat customers for a number of reasons. We know that the unemployment rate amongst those veterans is significantly high right now, and without any health care coverage, VA is going to be their health care coverage of choice.

We also were concerned with the statements about the number of the veterans that may be forced out because of the enrollment fees and the copayments and the statement about 95 percent of those veterans having insurance coverage, and I think it was pointed out that some of them are going to be TRICARE-eligible veterans. That is their extra health care coverage. Ironically, TRICARE is going to be increasing its premiums, and they are projecting over 600,000 leaving the system rather than paying the higher rates.

So there is kind of a cross-figure here of how many are going to leave the system from the VA for other health care coverage and the ones that TRICARE thinks may be leaving the system because of their increases. The problem is that we may have a lot of veterans that are out there looking for other options.

There is also an impact on your MCCF. If you are projecting moneys from third-party collections and veterans that are supposed to be paying these copayments and insurance companies that are supposed to be reimbursing, if they are leaving the system, what impact are you going to have on your MCCF collections?

Obviously, the elephant in the room on third-party collections is Medicare. If I go in and register as a Priority 7 or 8 veteran, they are going to ask me who is your primary insurance coverage so that they bill them for third-party reimbursements. If I say Medicare, that is the largest insurance company in the United States, and VA cannot collect $1 even if the veteran is paying Part A, Part B; and with the proposed enrollment fee, you are asking him to pay even more money to use the system that is an earned benefit.

That is a major problem. In fact, in our budget, nowhere is VA credited for the mandatory dollars in Medicare money that it is saving Medicare by not being able to bill them. So I think that that is something else that needs to be seriously looked at. As you know, many of the major veterans organizations have asked about the possibility of having hearings to talk about alternative funding sources for the VA, and mandatory funding is obviously one of those items that we have talked about. In the 14 years that I have been working on Capitol Hill, we have never, ever, ever questioned the funding formula for VBA, never, and if the money came up short, there was a supplemental to restore it, because we know that every dollar of mandatory money is an earned benefit. It has been proven, disability ratings, death benefits, pension, whatever.

It just seems ironic that when you come to health care for a disabled veteran, that that funding is under existing appropriations, whatever we can get from year to year. A Medicare patient is guaranteed, guaranteed, their funding. For people that are Medicare eligible, for people that are Social Security, I understand the consequences of having mandatory funding. I understand why that is necessary, but their contribution has been purely monetary and longevity of life. We do not present a flag at the funeral services of Social Security beneficiaries or Medicare beneficiaries as a thanks of a grateful Nation.

I guess what concerned me the most was the question that was asked, and I thought it was a very good question, about what is a seven and what is an eight. The difference between a seven and eight in some cases is their ZIP Code. The HUD geographical index is what separates a seven and an eight, so that if a veteran lives in Boise, he may qualify where a gentleman that lives in—I mean a gentleman that lives in Hawaii may qualify where the veteran in Boise may not, just because of the location of where they live.

There are also service-connected disabled veterans that are part of group eight. They are non-compensable. So there are service-connected veterans in both those categories. Now, I understand that they allow those veterans to enroll because they have service-connected disabilities, but you need to know who is in that group. There are also combat veterans that fall into category seven and eight, and yet there are no veterans that fall into the lower core groups that aren't combat veterans.

So I think there is a need to go back and revisit some of those criteria.

The enrollment fees, I think are very unfair in one particular light. It doesn't buy you anything. It doesn't give you anymore timely access to care. In fact, for sevens and eights, they are the last on the priority list for getting timely access to care. So we are asking people who may have insurance companies to reimburse the VA who are Medicare-Medicaid eligible that pay their premiums who may be in TRICARE to pay an additional fee because they are having to make a decision that is not maybe their best health care decision. It is their best financial decision. I think veterans earn a better choice than that.

Thank you, Mr. Chairman. I appreciate your allowing me to go a little over the time.

[The prepared statement of Mr. Robertson follows:]

PREPARED STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. Chairman of the Committee:

On September 20, 2005, The American Legion's newly elected National Commander, Thomas L. Bock presented the views of its 2.7 million members on issues under the jurisdiction of your Committee. At the conclusion of The American Legion's 87th National Convention in Honolulu, Hawaii, over 3,100 delegates adopted 42 organizational resolutions with 36 having legislative intent. These organizational mandates will add to the legislative portfolio of The American Legion for the remainder of the 109th Congress.

As Legionnaires gathered at the National Convention to once again determine the path of the Nation's largest veterans' service organization, it was with respect for those who have worn the uniform before us, friendship for those with whom we served and admiration for those who currently defend the freedoms of this great Nation. Each generation of America's veterans has earned the right to quality health care and transitional programs available through the Department of Veterans Affairs (VA). The American Legion will continue to work with this Committee and your colleagues in the House to ensure that VA is indeed capable of providing ". . . care for him who shall have borne the battle and for his widow and his orphan."

The Administration's VA budget request for 2007 has been hailed for adding nearly $3 billion in real appropriations for veterans' health care, compared to 2006. Although there is a real increase in actual funding in some areas, it still relies on assumed collections from initiatives that seek to place the burden of payment on the veterans seeking treatment from VA. It's a budget request built on charging new annual enrollment fees for VA care, nearly doubling drug copayments, charging veterans for uncollected reimbursement from third-party payers, assumed efficiency savings. Even VA documents indicate that these proposals may lead to the loss of more than a million enrolled veterans from VA.

This budget request relies on $1.1 billion in cost-saving "efficiencies"—the subject of a recent Government Accountability Office report that criticized past VA healthcare projections from the president's Office of Management and Budget. The American Legion is extremely disappointed that this budget request continues to count "phantom savings" as real healthcare dollars. Real veterans are suffering from real injuries and VA needs real dollars to treat them. Any increases in VA funding should be the result of actual funds and not assumed savings based on management efficiencies.

The Military Construction and Veterans Affairs Appropriations Subcommittee, chaired by Senator Hutchison expressed concern over VA being underfunded due to unrealized legislative proposals that seek to charge veterans copayments and increased copayments. The American Legion agrees fully with the recommendation of that Subcommittee last year that VA "request a funding level that adequately represents the real needs of veterans without devising new fees."

The American Legion is also concerned with the highly ambitious anticipated increase in third-party collections from insurance companies expected in fiscal year 2007. VA's estimate for third-party collections in 2006 was just over $2 billion and the fiscal year 2007 budget request is relying on collecting almost $800 million more. The majority of which are expected to come from new enrollments and increased prescription copayments. Again, these numbers do not reflect actual funds and should not be considered a real increase to the VA budget. In early 2005, VA had $3 billion in uncollected debts. Assumed collections do not equate to real dollars

and veterans health care should not be reliant on possible collections that never match the demand for dollars. Such miscalculations result in real budgetary shortfalls that lead to reduced care and treatment; hiring freezes; delays in nonrecurring maintenance; and, other tough spending decisions.

VA Research will also suffer from this budget request. It takes a $13 million bite out of VA research in medical care support and relies on increased dollars from Federal Resources and other Non-Federal Resources. Reliance on other Federal and Non-Federal Resources subjects VA research funding to an overall decrease in funding if those resources are forced to slash their respective budgets. Medical Care Support funding should be increased, not decreased. The medical advances resulting from VA research not only benefit the veteran patient, but they also benefit all Americans. Over the years many medical breakthrough have resulted from research initiatives within VA healthcare facilities and through partnerships with civilian medical schools. Adequate funding to continue the important research of VA must be provided. Such budgetary shortfalls make VA's recruiting and retention of medical researchers extremely challenging.

Additionally, The American Legion is disappointed in the lack of importance placed on the ever-increasing VA claims backlog in the proposed budget for fiscal year 2007. A new group of veterans are returning home with service-connected disabilities. VA must not only be prepared to assist with those new claims, but VA must be manned at a level that will prevent the backlog from continuing to increase. With a large number of Federal employees approaching retirement age VA is facing a major loss of experienced employees vital to the success of the agency. This budget fails to plan for the impending retirement of a large number of claims adjudicators from the VA workforce.

It is imperative that any budget request submitted for VA reflects a true estimate of the patient population. The under-estimated number of VA patients returning from Iraq and Afghanistan contributed to the $1.5 billion budget shortfall for VA health care in 2005. While we applaud Congress for responding with supplemental funding for VA in 2005, the estimates must accurately reflect the demand for care VA can expect.

With that in mind and on behalf of The American Legion, I reiterate the following budgetary recommendations for VA's discretionary funding in fiscal year 2007:

BUDGET RECOMMENDATIONS FOR SELECTED DISCRETIONARY PROGRAMS FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2007

Program	President's budget request	Legion's FY 2007 request
Medical Care Including:	$32.1 billion	
• Medical Services	$25.5 billion	
• Medical Administration	$3.1 billion	$33.5 billion
• Medical Facilities	$3.5 billion	
Medical Care Collections	($2.8 billion)	$2.1 billion
Emergency Supplemental		
Medical & Prosthetics Research	$399 million	$469 million
Construction		
• Major	$399 million	$343 million
-CARES		$1 billion
• Minor	$198 million	$274 million
State Extended Care Facilities	$85 million	$250 million
State Veterans' Cemeteries	$32 million	$44 million

BUDGET RECOMMENDATIONS FOR SELECTED DISCRETIONARY PROGRAMS FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2007—Continued

Program	President's budget request	Legion's FY 2007 request
NCA Operations	$161 million	$174 million
General Administration	$1.5 billion	$1.9 billion

* Third-party reimbursements should supplement rather than offset discretionary funding.

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. This inadequacy has become even more apparent in light of the congressionally imposed moratorium on construction funding during the CARES process. The American Legion is both relieved and encouraged to see that the first 2 years worth of VA designated high-priority projects include critically needed seismic corrections to nine vulnerable structures in California and Puerto Rico. The American Legion has consistently expressed its concern about veterans being treated in unsafe 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. We believe these designated seismic projects, other seismic corrections and life safety upgrades, should be dealt with first on an emergency basis.

The American Legion opposes the use of medical care appropriations for construction and urges Congress to separately and fully fund these projects.

The American Legion recommends $343 million for Major Construction and a separate $1 billion for the implementation of the CARES recommendations in fiscal year 2007.

Minor Construction

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 over the previous funding level is crucial. We question the transfer of prior-year minor construction funds into CARES. During our site visits to all VHA medical centers over the past 3 years, we noted a recurrent theme in which facilities managers are routinely forced to divert funds from other priorities to repair roofs, replace boilers and upgrade utilities and life safety and other critical systems. The American Legion believes that these funds should be used for the purposes for which they were intended and that the "transfer authority" does not include monies designated for patient care.

The American Legion recommends $274 million for Minor Construction in fiscal year 2007.

THE AGING OF AMERICA'S VETERANS

A landmark July 1984 study, Caring for the Older Veteran, predicted that a "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA Long Term Care (LTC) system if not properly planned for. The most recent available data from VA, 2000 Census-based VetPop2001 Adjusted, show there were 25.6 million veterans in 2002. Of that number, 9.76 million, or 37 percent are aged 65 or older. According to the 2003 National Survey of Veteran Enrollees' Health and Reliance on VA enrolled in VA health care 14 percent of the veteran population was under the age of 45, 39 percent were between the ages of 45 and 64, and 47 percent of veterans were 65 years or older. Compared to the 2001 Survey, in which the age distribution was 21 percent, 41 percent and 39 percent, respectively, it is clear that the "demographic imperative" predicted by the 1984 study is now upon us.

The study cited an "imminent need to provide a coherent and comprehensive approach to long-term care for veterans." Twenty-one years hence, the coherent and comprehensive approach called for has yet to materialize. The American Legion supports a requirement to mandate that VA publish a Long Term Care Strategic Plan.

The Veterans Millennium Health Care and Benefits Act of 1999 provided VA authority to act on these projections. Based on an "aging in place" continuum of care model, VA was mandated to begin providing a variety of non-institutional services to aging veterans, including; home-based primary care, contract home health care, adult day health care, homemaker and home health aides, respite care, telehealth and geriatric evaluation and management.

On March 29, 2002, GAO issued a report that stated that nearly 2 years after The Millennium Act's passage, VA had not implemented its response to the requirements that all eligible veterans be offered adult day health care, respite care and geriatric evaluation. At the time of GAO's inquiry, access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an Average Daily Census of 68,238) in non-institutional settings, VA only spent 8 percent of its LTC budget on these services. Additionally, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day health care in non-institutional settings.

By May 22, 2003, over 1 year later, GAO testified before the House Veterans' Affairs Subcommittee on Health that things had not improved and that veterans' access to non-institutional LTC was still limited by service gaps and facility restrictions. GAO's assessment showed that for four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. GAO summed up the problem nicely when it testified that "[f]aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

In the area of nursing home care, VA is equally recalcitrant in implementing the mandates of the Millennium Act. The Act required VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001, 11,969 in 2002 and 12,339 beds in 2003. VHA estimates it had 11,000 beds in 2004 and projects only 8,500 beds for fiscal year 2005. VA claims that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. Providing adequate inpatient LTC capacity is good policy and good medicine. The American Legion opposes attempts to repeal 38 U.S.C. § 1710B(b).

The American Legion believes that VA should take its responsibility to America's aging veterans much more seriously and provide the quality of care mandated by Congress. Congress should do its part and provide adequate funding to VA to implement its mandates.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious; for fiscal year 2004 VA paid a per diem of $59.48 for each veteran it places in SVHs, compared to the $354.00 VA said it cost in fiscal year 2002 to maintain a veteran for 1 day in its own NHCUs.

Under the provisions of title 38, U.S.C., VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 109 SVHs in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans homes. 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. State authorizing legislation has been enacted and state funds have been committed. The West Los Angeles State Veterans Home, alone, is a $125 million project. Delaying this and other projects will result in cost overruns from increasing building materials costs and may lead states to cancel these much-needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to just 50 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 and 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 American Legion recommends $250 million for the State Extended Care Facility Construction Grants Program in fiscal year 2007.

MEDICAL SCHOOL AFFILIATIONS

VHA and its medical school affiliates have enjoyed a long-standing and exemplary relationship for nearly 60 years that continues to thrive and evolve to the present day. Currently, there are 126 accredited medical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than 30,000 medical residents and 22,000 medical students receive a portion of their medical training in VA facilities annually. VA estimates that 70 percent of its physician workforce has university appointments. At some medical schools, 95 percent of medical staff at affiliated VAMCs has dual appointments.

VHA conducts the largest coordinated education and training program for health care professions in the Nation and medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the Nation. Medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology and cutting edge research; VHA research has made countless contributions to improve the quality of life for veterans and the general population.

The American Legion affirms its strong commitment and support for the mutually beneficial affiliations between VHA and the medical schools of this Nation.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service 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. Most recently, VA research has shown that an experimental vaccine against shingles prevented about 51 percent of cases of shingles, a painful nerve and skin infection, and dramatically reduced its severity and complications in vaccinated persons who got shingles. Over 3,800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The American Legion supports adequate funding for VA research activities, including basic biomedical research as well as bench-to-bedside projects. 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 $469 million for Medical and Prosthetics Research in fiscal year 2007.

HOMELESS VETERANS

VA has estimated that there are at least 250,000 homeless veterans in America and approximately 500,000 veterans experience homelessness in a given year. Most homeless veterans are single men; however, the number of single women with children has drastically increased within the last few years. Homeless female veterans tend to be younger, are more likely to be married, and are less likely to be employed. They are also more likely to suffer from serious psychiatric illness.

Approximately 40 percent of homeless veterans suffer from mental illness and 80 percent have alcohol or other drug abuse problems. It cannot go unnoticed that the increase in homeless veterans coincides with the under-funding of VA health care, which resulted in the downsizing of inpatient mental health capabilities in VA hospitals across the country. Since 1996, VA has closed 64 percent of its psychiatric beds and 90 percent of its substance abuse beds. It is no surprise that many of these displaced patients end up in jail, or on the streets. The American Legion applauds VA's recent plan to restore a good portion of this capacity. The American Legion believes there should be a focus on the prevention of homelessness, not just measures to respond to it. Preventing it is the most important step to ending it.

The American Legion has a vision to assist in ending homelessness among veterans, by ensuring services are available to respond to veterans and their families in need before they experience homelessness. Toward that objective, The American Legion in partnership with the National Coalition for Homeless Veterans created a Homeless Veterans Task Force in the fall of 2002. The mission of the Task Force is to develop and implement solutions to end homelessness among veterans through collaborating with government agencies, homeless providers and other veteran service organizations. In the last 2 years, 16 homeless veterans workshops were con-

ducted during The American Legion National Leadership Conferences, National Convention and Mid-Winter Conferences. Currently, there are 51 Homeless Veterans Chairpersons within The American Legion who act as liaison to Federal, state and community homeless agencies and monitor fundraising, volunteerism, advocacy and homeless prevention activities within participating American Legion Departments. The American Legion Homeless Veterans Outreach Award is presented to the Department that made the greatest effort to end veteran homelessness within their area. At last year's National Convention, the Department of Indiana was presented this award.

The current Administration has vowed to end the scourge of homelessness within 10 years. The clock is running on this commitment, yet words far exceed deeds. While less than 9 percent of the Nation's population are veterans, 34 percent of the Nation's homeless are veterans and of those 75 percent are wartime veterans.

Homelessness in America is a travesty. Veterans' homelessness is a national disgrace. Left unattended and forgotten, these men and women, who once proudly wore the uniforms of this Nation's Armed Forces and defended her shores, are now wandering streets in desperate need of medical and psychiatric attention and financial support. While there have been great strides in ending homelessness among America's veterans, there is much more that needs to be done. We must not forget them. The American Legion supports funding that will lead to the goal of ending homelessness in the next 10 years.

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and per Diem Program under the Homeless Veterans Comprehensive Services Programs Act of 1992, P.L. 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

The American Legion strongly supports changing the grant and Per Diem Program to be funded on a 5-year period instead of annually. The American Legion also supports a funding level increase of $200 million annually.

NATIONAL CEMETERY ADMINISTRATION

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

National Cemetery Expansion

The NCA's budget proposal totals $161 million and 1,589 FTE for fiscal year 2007. The fiscal year 2007 outlay proposal earmarks $53 million for major and $25 million for minor construction. This reflects cemetery expansion projects in Dallas/Fort Worth and Saratoga, NY as well as Phase 1B development at Great Lakes.

The American Legion supported P.L. 108–109, the National Cemetery Expansion Act of 2003 authorizing VA to establish new national cemeteries to serve veterans in the areas of: Bakersfield, Calif.; Birmingham, Ala.; Jacksonville, Fla.; Sarasota County, Fla.; southeastern Pennsylvania; and Columbia-Greenville, S.C. All six areas have veteran populations exceeding 170,000, which is the threshold VA has established for new national cemeteries.

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.

National Shrine Commitment

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 NCA's goal of completing the National Shrine Commitment in 5 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 be increased to reflect the true requirements of the NCA to fulfill this Commitment.

The American Legion recommends $174 million for the National Cemetery Administration in fiscal year 2007.

State Cemetery Construction Grants Program

The fiscal year 2007 budget requested $32 million for State Veterans Cemetery Grant Program. This is "no-year money" and so any monies not spent in the previous fiscal year can be carried over into the next fiscal year. This program is not intended to replace National Cemeteries, but to complement them. Grants for state-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries. States are planning to open 18 new state cemeteries between 2007 and 2010.

Individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery.

The American Legion recommends $47 million for the State Cemetery Grants Program in fiscal year 2007.

DEPARTMENT OF LABOR

Veterans' Employment and Training Service

The American Legion's position regarding VETS is that it should remain a national program with Federal oversight and accountability. The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment. The American Legion views the VETS program as one of the best-kept secrets in the Federal Government. It is comprised of many dedicated individuals who struggle to maintain a quality program without substantial increases in both funding and staffing.

Annually, DOD discharges approximately 250,000 servicemembers. Recently separated service personnel are likely to seek immediate employment or continue their formal or vocational education. In order for the VETS program to assist these veterans to achieve their goals, it needs to:

- Improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans.
- Provide employers with a labor pool of quality applicants with marketable and transferable job skills.
- Provide information on identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels.
- Eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market.
- Strive to be a proactive agent between the business and veterans' communities in order to provide greater employment opportunities for veterans.

The American Legion believes staffing levels for Disabled Veterans' Outreach Program (DVOP) specialists and Local Veterans' Employment Representatives (LVERs) should match the needs of the veteran community in each state and not be based solely on the fiscal needs of the state government. Such services will continue to be crucial as today's active duty servicemembers, especially those returning from combat in Iraq and Afghanistan, transition into the civilian world. Education and vocational training and employment opportunities will enable these veterans to succeed in their future endeavors. Adequate funding will allow the programs to increase staffing to provide comprehensive case management job assistance to disabled and other eligible veterans.

Title 38 U.S.C. § 4103A requires that all DVOP specialists shall be qualified veterans and that preference be given to qualified disabled veterans in appointment to DVOP specialist positions. 38 U.S.C. § 4104(a)(4) states:

> "[I]n the appointment of local veterans' employment representatives on or after July 1, 1988, preference shall be given to qualified eligible veterans or eligible persons. Preference shall be accorded first to qualified service-connected disabled veterans; then, if no such disabled veteran is available, to qualified eligible veterans; and, if no such eligible veteran is available, then to qualified eligible persons."

The American Legion believes that the military experience is essential to understanding the unique needs of the veteran and that all LVERs, as well as all DVOPs, should be veterans.

The American Legion recommends a funding level of $342 million for the Veterans' Employment and Training Service in fiscal year 2007.

MANDATORY FUNDING FOR VETERANS HEALTH CARE

A new generation of young Americans is once again deployed around the world, answering the Nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for the freedom, liberty and security of us all. Also like those who fought before them, today's veterans deserve the due respect of a grateful Nation when they return home.

Unfortunately, without urgent changes in health care funding, new veterans will soon discover their battles are not over. They will be forced to fight for the life of a health care system that was designed specifically for their unique needs. Just as the veterans of the 20th century did, they will be forced to fight for the care each one is eligible to receive.

The American Legion continues to believe that the solution to the Veterans Health Administration (VHA) recurring fiscal difficulties will only be achieved when its funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA's health care budget competes with other agencies and programs for 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.

Under mandatory funding, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care benefits of enrolled veterans.

The American Legion is pleased to support legislation pending in the 109th Congress that would establish a system of capitation-based funding for VHA by combining the total enrolled veteran population with the number of non-veterans who received services from VHA, then dividing that number into 120 percent of the current VHA budget or to another amount, depending on the bill. This baseline per-capita amount is then adjusted for medical inflation each year and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for VHA for each succeeding fiscal year. This new funding system would provide the bulk of VHA's Medical Services funding, except funding of the State Extended Care Facilities Construction Grant Program, which would be separately authorized, and third-party reimbursements. Annual funding would be without fiscal year limitation, meaning that any savings VHA realized in a fiscal year would be retained rather than returned to the Treasury, providing VHA with incentives to develop efficiencies and creating a pool of funds for enhanced services, needed capital improvements, expanded research and development and other purposes.

The Veterans Health Administration is now struggling to maintain its global preeminence in 21st century health care with funding methods that were developed in the 19th century. No other modern health care organization could be expected to survive under such a system. The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans.

Mr. Chairman, as a member of the Partnership for Veterans Health Care Budget Reform, we strongly encourage you to hold a hearing on the VA funding process to explore the best way to meet the budgetary needs of VA health care.

MEDICAL CARE COLLECTIONS FUND

The Balanced Budget Act of 1997, P.L. 105–33, established the VA Medical Care Collections Fund (MCCF), requiring that amounts collected or recovered from third party payers 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. In fiscal year 2004, VHA collected $1.7 billion, a significant increase over the $540 million collected in fiscal year 2001. In fiscal year 2005 VA collected $1.9 billion and the VA fiscal year 2006 budget estimate called for $2.1 billion to supplement appropriations, a 10.8 percent increase over fiscal year 2005. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans.

Government Accountability Office (GAO) reports have described continuing problems in VHA's ability to capture insurance data in a timely and correct manner and raised concerns about VHA's ability to maximize its third-party collections. At three medical centers visited, GAO found inability to verify insurance, accepting partial payment as full, inconsistent compliance with collections follow-up, insufficient documentation by VA physicians, insufficient automation and a shortage of qualified

billing coders were key deficiencies contributing to the shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used as operating funds. When developing the agency's budget proposal, the total appropriations request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect on 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 opposes offsetting annual VA discretionary funding by the MCCF recovery.

Medicare

As do all other citizens, veterans pay into the Medicare system without choice throughout their working lives. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system they cannot use their Medicare benefits to reimburse allowable treatment and services received in VA health care facilities. VA, unlike the Department of Defense or Indian Health Services, cannot bill Medicare for the treatment of allowable Medicare eligible veterans' nonservice-connected medical conditions. This prohibition constitutes a multibillion-dollar annual subsidy to the Medicare Trust Fund. The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the allowable treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

Mr. Chairman, nowhere in this budget request does VA receive any credit for the real savings in mandatory appropriations through VA not billing Medicare for the care and treatment of Medicare-eligible enrolled veterans. By denying VA the opportunity to bill Medicare for the treatment of Medicare-eligible veterans, the VA is picking up the care and cost of thousands of veteran patients who would otherwise be billing Medicare for treatment from another health care provider.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES

VA's Capital Asset Realignment for Enhanced Service (CARES) has entered into the final steps of the process—implementation and integration. The CARES decision released in May 2004 directed VHA to conduct 18 feasibility studies at those health care delivery sites where final decisions could not be made due to inaccurate and incomplete information. The 18 studies fall into two broad categories: (1) studies of sites where no specific decisions have been made to date for the delivery of health care, i.e., do we decide to merge these facilities or not; and (2) studies of sites where the Secretary's decision defines the health care solution to be implemented, i.e., how to best use or re-use the campus as a capital planning decision. VHA contracted Pricewaterhouse Cooper (PwC) to identify and determine the best approach to provide veterans with health care services equal to or better than is currently provided and evaluate in terms of access, quality, and cost effectiveness, while maximizing any potential re-use of all or portions of the current real property inventory. The entire process was scheduled for 13 months with a completion date of no later than February 2006.

One of the components of the CARES Phase II process was stakeholder input. In order to ensure the concept was not lost during the ongoing studies, Local Advisory Panels (LAPs) were set up at each of the study sites. The membership of the LAPs consist of key stakeholders including community leaders, veterans groups, VA affiliated medical schools and VA representation. The LAPs are to hold four public meetings to gather and share stakeholder input during the yearlong studies. Ideally, PwC and LAPs will work together to develop options that PwC will eventually present to the Secretary. The American Legion was concerned when the first meetings had to be pushed back from March to the end of April. This could only mean that the final decision was going to be delayed. VA was already behind their established timeline. When the meetings were finally held, The American Legion was present at every single one. We will ensure our presence at all of LAPs throughout the process. The American Legion intends to hold accountable those who are entrusted to provide the best health care services to the most deserving population—the Nation's veterans.

The implementation of the CARES decision promises to be long. VA has estimated that it will require $1 billion per year for the next 6 years, with continuing substantial infrastructure investments into the future. The American Legion is opposed to CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency

preparedness, organizational capacity for services such as long-term care and Homeland Security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process. Without that oversight, plans and promised services may be overlooked.

CONCLUSION

Thank you for the opportunity for The American Legion to reiterate its budget recommendations for fiscal year 2007.

Clearly, The American Legion remains deeply concerned with VA medical funding in recent years. Repeatedly, the President advanced seriously flawed legislative initiatives that undermined the "thanks of a grateful Nation." Fortunately, Congress joined the veterans' community in rejecting them. The American Legion will continue to oppose any "enrollment fees" targeted toward a selected group of veterans with the goal of discouraging enrollment or that does not guarantee timely access to quality health care in return.

The American Legion has joined with eight other veterans' service organizations in calling for an immediate fix of the broken annual Federal appropriations process that is budget driven rather than demand driven. In recent years, the Office of Management and Budget's budgetary recommendations to Congress fell well short of the mark. Congress, not OMB, is responsible for providing adequate funding for VA medical care. We do not see lengthy discussions on the "right amount" for funding Social Security benefits, Medicare, Veterans' Compensation and Pension, TRICARE for Life or even your salaries as Members of Congress because they are scored as mandatory funding items and, therefore, an entitlement—funding that is guaranteed.

If an entitlement is a statement of national priority, where should the care and treatment of veterans rank among Federal spending programs?

The American Legion respectfully requests a future Committee hearing on evaluating the best funding methodology for VA medical care. This hearing would also address alternative revenue streams to complement annual Federal appropriations.

Mr. Chairman, that concludes my testimony.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO STEVE ROBINSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Thank you for allowing The American Legion an opportunity to testify on the President's budget request for VA funding in fiscal year 2007. As always, The American Legion welcomes your additional questions provided in your February 22 letter to me:

Question 1. Does the Legion believe that at some point it is reasonable to place less emphasis on the construction of new homes and instead focus on the maintenance of the existing structures? If so, where is that point of reduced emphasis?

Answer. Requests for State Extended Care determined a need for extended care should be the driving force behind decreases, then the emphasis on new Facilities Grants come from individual states that have facilities to accommodate their veterans' community. That the funding of grants. As that demand for new requests construction should decrease as well.

The American Legion places equal emphasis on the construction of new homes as well as the maintenance of existing homes.

Question 2. What is the increase in patient population that the American Legion expects to see for fiscal year 2007?

Answer. Clearly, there is a significant number of Priority Group 8 veterans currently being denied enrollment and access to quality health care is determined by the Priority Group assignment. As more and more Americans become uninsured, those uninsured veterans may turn to VA for their health care needs, but only if they qualify as Priority Group 1–7 veterans. The American Legion is concerned as to the limited options available to those Priority Group 8 veterans with no health care coverage. Without access to preventive medicine, they may very well become VA patients at a later date when their medical condition becomes much more serious and more costly to treat.

The American Legion also believes VA has under-estimated the number of recently separated Operation Enduring Freedom and Operation Iraqi Freedom veterans seeking health care from VA. These newest wartime veterans are guaranteed free VA health care for 2 years after discharge. Once that 2-year timeline has passed these veterans are reassigned to their respective Priority Group. The question remains will they continue to receive timely access to VA health care after that

2-year window is closed and they are reassigned to other Priority Groups like 7 and 8, or will they be denied access.

As we hear reports of recently separated veterans having a higher unemployment rate than their non-veteran counterparts, we anticipate an increase in potential Priority Group 5 veterans who are economically indigent or Priority Group 7 veterans who are beneath the HUD geographical index threshold.

Question 3. What is the basis for that (State Cemetery Grant Program) recommended increase? Are there states with approved applications for cemetery construction or expansion that cannot be funded within the $32 million requested by the Administration?

Answer. Grants for state-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries. Currently, there are 61 operating state cemeteries in 32 states. In fiscal year 2004, NCA supported State cemeteries provided more than 19,000 interments. NCA currently has 43 active applications for grants to build new state cemeteries and expand existing ones.

Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all states. Therefore, individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery. The American Legion recommends $47 million for the State Cemetery Grants Program in fiscal year 2007.

The American Legion believes the recommended funding level should meet the requirements of the approved applications for cemetery construction. It is inevitable that more states will be considering the State Cemetery Grant Program and funding needs to be available to meet this increasing demand.

Your continued leadership on behalf of America's military personnel and veterans is greatly appreciated.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO STEVE ROBINSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Question 1. I would like to know your opinion on VA's proposed $250 user fee and increase in the prescription drug copayment for Priority 7 and 8 veterans, a plan the Administration has tried to implement for the past few years. In the American Legion's testimony in particular, I believe you described this as an attempt "to balance the VA budget on the backs of America's veterans." What would the real impact be if Congress enacted these proposals?

Answer. The American Legion adamantly opposes both of these legislative initiatives for one major reason—upon enrollment, these veterans agreed to make copayments and allow third-party reimbursements from their health insurance providers. The proposed "annual enrollment fee" is really a "user fee" to generate additional revenue from an earned benefit from a grateful Nation. This "user fee" provides absolutely no "value" since it does not guarantee the veteran timely access to care (not even VA own access standards are guaranteed).

This is also an issue of fairness:

- Why should a Medicare-eligible veteran (paying Part A and Part B premiums) be required to make an additional payment to the Federal Government, when VA is prohibited from collecting any third-party reimbursements for allowable treatment of nonservice-connected medical conditions?
- Why should an insured veteran be required to make an additional payment to the Federal Government, when VA is receiving third-party reimbursements from his or her private health insurance company?
- Why should a Native American veteran be required to make an additional payment to the Federal Government, when Indian Health Service does not?
- Why should a military retiree be required to make an additional payment to the Federal Government, when enrolled in TRICARE or TRICARE for Life?

The prescription copayment is another "revenue enhancer" in that there is absolutely no bearing between the amount of the copayment and VA's cost for the medication. VA enjoys deep discounts on the purchase of medications, yet the proposed increase in copayment has absolutely not correlation to the medications received by the Priority Group 7 or 8 veteran—in fact, their copayment could very well exceed the actual cost of the medication to VA.

The real impact of these initiatives would be placing fiscal barriers before Priority Group 7 and 8 veterans forcing financial-based decisions rather than health-based

decisions—the sicker the veteran, the more costly the medication. For many veterans on fixed incomes, these initiatives would create avoidable hardships.

Question 2. The President is clear on who should be eligible for VA health care: those with service-connected health needs. I would like to ask you all a three-point question related to this topic. Do you think the system as we know it today, can survive if eligibility is severely narrowed? Can we continue to train nearly half of all physicians in the U.S.; maintain specialty programs unparalleled in the community; and teach the rest of the health care system about quality management if eligibility is limited to service-connected health care needs? And last, don't we want veterans who have other forms of insurance to come into the system to help finance it?

Answer. The system as we know it today would indeed suffers drastically if eligibility is severely narrowed. Attempting to solve VA's crisis of under-funding by denying veterans access to the VA health care system is not the answer. The Administration and Congress must provide VA with a budget that will allow all eligible veterans access to the system and not attempt to narrow eligibility to meet an inadequate budget.

Narrowing eligibility to the VA healthcare system will also drastically limit the partnerships and affiliations that VA enjoys with medical schools nationwide. VA has served as a training ground for nearly half of all U.S. physicians for years and as a result of that partnership, VA has lead the way in developing major medical advances that have benefited every American, not just the veteran patients at VAs. VA would suffer dramatically if eligibility continues to be narrowed.

Prior to "eligibility reform" in 1996, VA was a hospital-based system treating primarily only service-connected disabled and economically indigent veterans. The greatest complaints The American Legion received was concerning the quality of care, followed closely by the draconian rules and regulations concerning who was entitled to what degree of care in which setting. Once "eligibility reform" was enacted, VA transformed into the "best health care delivery system in the entire industry."

Veterans began seeing the quality care being provided in the most appropriate setting. Prior to 1996, only 2.5 million entitled veterans could use the VA health care system. Today, nearly 8 million veterans are enrolled (and over 250,000 more denied enrollment), of which 5.5 million were actual patients. The cost of care per veteran is "rock-bottom" compared to any other health care delivery system. If VA reverted back to the pre-1996 numbers, most of the medical centers and outpatient clinics would be underutilized and not cost-effective. Veterans would, once again, be the victim of budgetary constraints rather than health care needs.

"Eligibility reform" significantly changed the patient population. Clearly, this is advantageous to training of health care professionals and medical research. The more diverse the patient population, the greater the educational and research opportunities available for health care professionals to address. The entire health care community is clearly gainfully employed; in fact, the demand resulted in the prohibition (in January 2003) against enrollment of any new Priority Group 8 veterans (except the new OEF/OIF veterans reassigned after 2-years of "free" health care). Without question, since "eligibility reform" VA has become the "role model" for the rest of the health care industry (public and private) to emulate.

The "failure" of "eligibility reform" is the prohibition on VA from receiving third-party reimbursements from the treatment of allowable, nonservice-connected medical conditions from enrolled Medicare-eligible veterans. In fact, VA isn't even credited with the billions of dollars in annual savings in mandatory funds due to this restriction. Over half of VA patient population is Medicare-eligibility. Second, OMB and CBO score third-party reimbursement as an offset rather than a supplement. Repeatedly, the MCCF projection has exceeded VA ability to collect—the end result is a real budgetary shortfall within the system.

Prohibition of enrollment of Priority Group 8 veterans simply because they have the "fiscal means" to make copayments and "other health care options" (third-party insurance coverage) is somewhat confusing. Why "lock the doors" to paying customers? The prohibition is based on "individual worth" rather than the honorable military service that made them eligible in the first place.

Ironically, the current Priority Group System has service-connected disabled veterans in Priority Groups 6–8 and nonservice-connected disabled veterans in Priority Groups 4 and 5. Seems that all service-connected disabled veterans would be included Priority Groups 1–3 at a minimum.

Question 3. This year's Medical and Prosthetics Research Budget request actually amounts to a cut of about $13 million in appropriated dollars—which in turns translates to the loss of 286 employees and 96 projects. By VA's own account, this will result in the reduction of projects in areas such as aging, cancer, heart-disease re-

search, and traumatic injury. This is yet another year of proposed cuts to VA's Research Program by the President. What are your thoughts on the Administration's vision for the future of VA research? What impact do these continuing assaults on the program have on physician satisfaction and recruitment?

Answer. As a Nation at war, especially with returning severely wounded veterans in unprecedented numbers, this decision seems illogical. Clearly, this Nation owes these solider-citizens the very best medical and prosthetics care. For decades, VA's medical and prosthetics research is well documented as world-class. VA research has benefited not only the veterans' community, but many of its groundbreaking achievements have benefited the nonveterans' community as well.

Job security is a major factor in attracting and retaining the best of the best researchers. A questionable annual funding level is the quickest vehicle for losing dedicated and capable health care professions that strive for meaningful gains through medical and prosthetics research. VA provides a fertile and rewarding research environment. Save a nickel and lose a fortune is never good business practice.

Question 4. As you may know, VA assisted me in attending college after I left military service. I am thankful for my education and the opportunities in life that have been afforded me because of that education. I am concerned that some in military service may not receive benefits that mirror their service comment. Can you please explain that main nuances of the Total Force MGIB restructuring?

Answer. This bill would provide MGIB reimbursement rate levels based on an individual's service in the Armed Forces, including the National Guard and Reserve.

1. The first tier—similar to the current Montgomery GI Bill—Active Duty (MGIB–AD) 3-year rate—would be provided to all who enlist for active duty. Service entrants would receive 36 months of benefits at the AD rate.

2. The second tier or level would be for all who enlist or re-enlist in the Selected Reserves for 6 years, and this would entitle them to 36 months of benefits at a pro-rata amount of the active duty rate (the suggested rate is 35 percent of the MGIB-AD rate).

3. The third tier would be for members of the Selected Reserves or Inactive Ready Reserves who are activated for at least 90 days. They would receive 1 month of benefit for each month of activation, up to a total of 36 months, at the active duty rate. The intent is to provide the same level of benefit as the active duty rate for the same level of service.

3a. These months of full benefits would replace, month for month, any Selected Reserves entitlements at the second tier.

3b. The maximum benefit a member of the Selected Reserves could receive under this program would be the equivalent of 36 months at the active duty rate.

An individual would have up to 10 years to use the active duty or activated-service benefit from their last date of active/activated duty or reserve service, whichever is later. A Selected Reservist could use remaining second tier MGIB benefits as long as he/she were satisfactorily participating in the Selected Reserves, and for up to 10 years following separation from the reserves, in the case of separation for disability or qualification for a reserve retirement at age 60.

Question 5. The Independent Budget suggests that the VA Schedule for Ratings Disabilities does not provide a compensable evaluation for hearing loss. The Independent Budget asserts that a general principle of disability compensation is that ratings are not offset by artificial restoration because of use of prosthetics. Can you point to other areas in the VA Rating Schedule where ratings are not offset by this artificial restoration?

Answer. Because The American Legion is not a partner in the Independent Budget we choose not to respond to this IB specific issue.

Question 6. The Independent Budget calls for VA to establish recruiting programs that will enable VHA to remain competitive for hiring nurses by using private-sector marketing strategies. Can you give some examples of what they could do to become more competitive?

Answer. During the CARES process, The American Legion made a recommendation that VA give serious consideration toward creating its own nursing school program on VAMC campuses where excess space could be better utilized as classrooms and dormitory facilities. This would expand VA educational role in a potentially critical-shortage of health care providers—nurses. Additionally, Magnet certification of a hospital has proven to be a powerful recruitment and retention tool for nurses.

Question 7. Public Law 108–445, the Department of Veterans Affairs Personnel Enhancement Act of 2004, was intended to reform the pay and performance system used by VA for hiring and retaining its physicians and dentists. Can you give us a sense of how well you feel VA has implemented this legislation and if it can and will assist VA in attracting and retaining the best and brightest physicians?

Answer. As stated previously, job security is a great motivator. Uncertain annual appropriations that result in "management efficiencies" that are budget-driven rather than health care delivery-driven does not promote a healthy vocational environment that is rewarding and attractive to career-development. A personnel shortage that increases an already demanding workload does not enhance recruitment and retention. Failure to procure state-of-the-arts technology, failure to replace broken medical equipment, or medical supply shortages due simply to budgetary shortfalls create more reasons for leaving than staying.

Once again, I apologize for the delay in responding to your questions. The American Legion deeply appreciates your continued support of and leadership for critical issues concerning America's veterans and their families.

Chairman CRAIG. Steve, thank you very much.

Quentin. We will proceed with you.

STATEMENT OF QUENTIN KINDERMAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. KINDERMAN. Thank you, Mr. Chairman. Since I am part of the Independent Budget partnership, I think I will stay on script.

Chairman CRAIG. Fine enough.

Mr. KINDERMAN. I do associate myself with his remarks, and we have got a few other things to say on that subject. So I hope we will have an opportunity for a dialogue.

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars, I thank you for the opportunity to present our views today. We are part of the Independent Budget partnership with four veterans organizations represented here. My remarks will be limited to the VA's construction programs.

The President has asked for a total of $704 million for construction. This is $209 million cut from the previous year's funding level, and is over $1.4 billion less than we, as part of the IB, have called for. Over the past several years, the construction budget has been overshadowed by the Capital Assets Realignment for Enhanced Services, CARES, process. CARES, which aims to reorganize the VA health care system to properly plan for the future and in turn realize improved health care services for veterans and greater efficiency, has been a long and difficult process. We will continue to support CARES as long as VA returns to its primary emphasis and intent, the "ES" portion of CARES, namely enhanced services.

We accept that the locations and missions of some VA facilities may need to change to improve veterans' access to CARES and to allow more resources to be devoted to medical care. In July of 2004, then Secretary Principi testified on the House side that CARES reflects a need for additional investments of about $1 billion a year for the next 5 years to modernize VA's medical care infrastructure and enhance veterans' access to medical care. Using that as a baseline and accounting for the 18 CARES-related projects still being assessed, the IB calls for $860 million to be allocated for CARES projects. We must, however, keep in mind that as projects advance and ground is broken, the funding levels will be increased dramatically.

Over the last several years, the funding for major construction has ebbed. This moratorium was caused by the planning for the CARES process, which I think is understandable, but now is the time to move forward and advance this important plan. Delays cost

money with the rate of construction inflation roughly 9 percent nationwide and regionally as high as 35 percent in some parts of the South. This inflation is driven by international concerns. The emerging world is running up the price of steel. Delays will only increase the amount of money Congress will need to provide to maintain this Nation's commitment to veterans' health care.

Of particular importance is the funding for seismic corrections. Currently 890 of VA's 5,300 buildings have been deemed at significant seismic risk and 73 VA hospital buildings are at exceptionally high risk of catastrophic collapse or major damage in the event on an earthquake.

As you prepare your views and estimates and the entire Congress begins the budget process, there are a few other issues we feel you should keep in mind. With the reticence over the last few years to provide construction funding, the amount appropriated for maintenance has lagged far behind what has been necessary. These small projects, such as replacing a roof or improving the fire alarm system, are necessary for safety of patients, but also to maintain the integrity of the building so that it is viable for its entire life span. Accordingly, VA should spend no less than $1.6 billion for nonrecurring maintenance in fiscal year 2007. Unfortunately, the Administration has only allocated $514 million for maintenance, which only makes the already backlogged maintenance list grow longer.

The VA needs to cover deferred maintenance. In fact, during the VA's own assessment, which is conducted on 3-year cycles, the investment necessary to bring all facilities currently rated "D" or "F" on a scale from "A" to "F" up to an acceptable level is $4.9 billion. There should not be a choice between fixing a roof and medical supplies. Funding for maintenance is allocated to the VISN level using the VERA methodology. While this moves money to the growing demands for veterans health care, it tends to move the money away from the oldest capital structures which need the most maintenance. It also increases the tendency in some VISNS to use maintenance money to address shortfalls in medical care funding.

Mr. Chairman, 2006 has presented major challenges for the VA, Congress, and veterans. The unprecedented requests for multiple emergency supplementals in 2005 to provide necessary funding for a VA that was rapidly running out of money is a step that none of us want to see again. That is why it is so vitally important that we get things right the first time this year. What we learned last year is that no matter how sophisticated a model one uses to forecast health care, it must account for real world situations and be adaptable to account for any emerging developments.

Thank you for the opportunity to testify today.

[The prepared statement of Mr. Kinderman follows:]

PREPARED STATEMENT OF QUENTIN KINDERMAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW), this Nation's largest combat veterans organization, I would like to thank you for the opportunity to testify today on the fiscal year 2007 budget for the Department of Veterans Affairs (VA).

Today, I am not just representing the VFW, but also the Independent Budget (IB). The IB is a partnership of four veterans' service organizations, AMVETS, Disabled

American Veterans, Paralyzed Veterans of America, and the VFW. For today's hearing, the VFW's testimony will be limited to VA's construction programs.

The VA construction budget includes major construction, minor construction, grants for construction of state extended-care facilities, and grants for state veterans' cemeteries. The President has asked for a total of $714 million for construction. This is a $209 million cut from the previous year's funding level, and is over $1.4 billion less than what we, as part of the IB, have called for.

Over the last few years, the construction budget has been overshadowed by the Capital Assets Realignment for Enhanced Services (CARES) process. CARES, which aims to reorganize the VA health care system to properly plan for the future, and, in turn, realize improved health care service for veterans, has been a long and difficult process.

We will continue to support CARES as long as VA returns to its primary emphasis and intent: the "ES" portion of CARES. We accept that locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the maintenance of old buildings, and to accommodate more modern methods of health-care delivery. Accordingly, we concur with VA's plans to proceed with the feasibility studies of the remaining 18 facilities contained in the Secretary's decision document. We note that those processes are moving forward on the local level with establishment of local advisory committees and public hearings, allowing the veterans, who are stakeholders in this complex process, to have a voice. We support this transparent approach to public policy, and intend to remain active in it.

In July 2004, the previous VA Secretary testified before the Subcommittee on Health of the House Veterans' Affairs Committee. He stated that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care."

Using that as a baseline, and accounting for the 18 CARES-related projects being assessed, the IB calls for $860 million to be allocated for CARES projects. We must, however, keep in mind that as projects advance and as ground is broken, funding levels will need to be increased dramatically.

Over the last few years, the funding for major construction has ebbed. This moratorium was caused by the planning of the CARES process. There was much political resistance to funding any projects before the planning process took place. Now that it has occurred, it is time to move forward, and advance this important plan.

Delays cost money. With the rate of construction inflation roughly 9 percent nationwide (and regionally as high as 35 percent in some parts of the South), pushing these projects further into the future will only increase the amount of money Congress will need to provide to maintain this Nation's commitment to veterans' health care.

Under the major construction account, we are calling for a total investment of $1.447 billion, which includes the CARES funding outlined above:

Construction, Major Appropriation: FY 2007 IB Recommendation

[Dollars in thousands]

CARES	$860,000
Architectural Master Plans Program	100,000
Historic Preservation Grant Program	25,000
Seismic	285,000
Advanced Planning Fund (VHA)	43,000
Asbestos Abatement	6,000
Claims Analyses	3,000
Judgment Fund	10,000
Hazardous Waste	3,000
NCA	89,000
Design Fund	6,000
Advanced Planning Fund	11,000
Staff Offices	6,000
Total, Major Construction	$1,447,000

The President's request comes far below that, providing just $399 million for major construction.

Of particular importance on that list is the funding for seismic corrections. Currently, 890 of VA's 5,300 buildings have been deemed at "significant" seismic risk, and 73 VHA buildings are at "exceptionally high risk" of catastrophic collapse or major damage. We understand that the list of major construction priorities that VA has provided to Congress includes the seven facilities most at risk of damage. Accordingly, this will increase VA's need for construction funding. This is a chance to be proactive and fix a problem before the health and safety of VA's patients and workers is further compromised.

We also call for funding for an architectural master plan. Without this plan, the benefits of CARES will be jeopardized by hasty and shortsighted construction planning. Currently VA plans construction in a reactive manner—i.e., first funding the project then fitting it on the site. Furthermore, there is no planning process that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into the proverbial corner. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. The development of master plans will prevent shortsighted construction that restricts, rather than expands, future options. As the cost of construction rises with inflation, the importance of optimal planning becomes paramount.

We believe that architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care. These programs should be addressed as quickly as possible.

For Minor Construction, VFW and the IB are calling for $505 million in funding. The President has called for $198 million, which is about $1 million less than fiscal year 2006's level.

Construction, Minor Appropriation: FY 2007 Recommendation

[Dollars in thousands]

CARES/Non-CARES	$392,000
NCA	32,000
VBA	38,000
Staff	6,000
Advanced Planning Fund	35,000
Inspector General	2,000
Total, Minor Construction	$505,000

The funds for minor construction comprise construction projects costing less than $7 million. This appropriation includes funding for the National Cemetery Administration, the Veterans Benefits Administration, and the Inspector General.

As you prepare your views and estimates, and as the entire Congress begins the budget process, there are a few other issues we feel you should keep in mind.

With the reticence over the last few years to provide construction funding, the amount appropriated for maintenance has lagged far behind what has been needed. Price-Waterhouse, following standard industry practices, has recommended that VA spend at least 2–4 percent of the value of its building for nonrecurring maintenance. These small projects, such as replacing a roof or improving the fire alarm system, are necessary for the safety of patients, but also to maintain the integrity of the building so that it is viable for its entire lifespan. Accordingly, VA should spend no less than $1.6 billion for nonrecurring maintenance in fiscal year 2007. Unfortunately, the Administration has only allocated $514 million for maintenance, which will only make the already backlogged maintenance lists grow.

Further, because maintenance comes out the medical care account, not the construction budget, much of the funding for the last few years has been used to provide medical care. VA needs to cover deferred maintenance. In fact, according to VA's own assessment, which is conducted on 3-year cycles, the investment necessary to bring all facilities currently rated "D" or "F" up to an acceptable level is $4.9 billion. There should not be a choice between fixing a roof and buying medical supplies. It is Congress' job to properly allocate funding for both.

It is also important that VA recapitalize their infrastructure beyond nonrecurring maintenance. Properly reinvesting in facilities extends their useable life, and saves costs over the long run. Both Price-Waterhouse and the American Society of Hospital Engineers say that a 35 to 50-year recapitalization rate is required for VA facilities. Of note, most hospitals rely on a 25-year or less rate of recapitalization. VA

traditionally has a historically low rate of recapitalization. From fiscal years 1996–2001, for example, it was just a paltry 0.64 percent of VA's total plant replacement value. To overcome this shortfall, a minimum of 5–8 percent 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. Congress must ensure that VA has adequate funding to ensure the life of its infrastructure.

Before I conclude, there is one more important issue I would like to raise. Last year's disastrous storms in the Gulf Coast region resulted in the total destruction of the Gulfport VA Medical Center, near-destruction of the New Orleans VA Medical Center, and major damage to other VA facilities in the region. Understand that we have the deepest sympathies for the veterans and VA staff in the Gulf Coast region, but we urge Congress not to allow a diversion of funds VA needs to revamp infrastructure nationwide. The Gulf emergency must be managed with a special allocation outside VA's regular construction and medical care appropriations. It would be patently unfair to delay other projects for lack of funds necessitated by reallocation of available funds to the Gulf Coast region.

Mr. Chairman, fiscal year 2006 has presented major challenges for VA, Congress, and veterans. The unprecedented request for multiple emergency supplementals in 2005 to provide necessary funding for a VA that was rapidly running out of money is a step that none of us want to see again. That is why it is so vitally important that we get things right the first time this year. What we learned last year is that no matter how sophisticated a model one uses to forecast health care, it must account for real word situations and be adaptable to account for any emerging developments.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the Committee may have.

Chairman CRAIG. Quentin, thank you very much.

Now let's turn to Brian Lawrence. Welcome.

STATEMENT OF BRIAN LAWRENCE, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. LAWRENCE. Good afternoon, Mr. Chairman. I am pleased to appear before you on behalf of the 1.2 million members of the Disabled American Veterans, and I will be presenting the IB recommendations regarding the Veterans Benefit Administration.

We view adequate staffing levels for the VBA business lines is one of the most important issues for consideration in this component of the VA budget. So I will first address recommended numbers of full-time employees, or FTEs, and, time permitting, I will include some IB recommendations regarding programs.

The level of funding sought in the President's 2007 budget would increase VA operating expense by nearly $114 million. That is a 10.8 percent increase over last year's level, and we are greatly encouraged that the Administration has proposed a substantial increase in resources. The need for such an increase has become critical, and we deeply appreciate the President's bearing on this issue.

With the proposed budget, VBA staffing would be increased in 2007 by 173 FTEs. C and P service would be authorized at approximately 9,500 which is a total increase of 14; however, the number of FTE under the subcategory direct compensation would be reduced by 149. The net gain of FTE would be as a result of increases in other VBA activities. This recommendation is somewhat perplexing since one of the Administration's stated goals is to decrease the number of backlogged compensation claims.

Additionally, ongoing hostilities in Iraq and Afghanistan and an aging veteran population will almost certainly increase the number of claims for compensation. In the 5-year period from the end of fiscal year 2000 to the end of fiscal year 2005, the volume of disability

claims increased 36 percent or on average 7.2 percent annually. VA projects that the number of claims will increase only 3 percent during 2006 and 2 percent in 2007, but even with those modest projections for increased work, the number of direct program FTEs should be increased, especially since VA estimates that above of the projected increases in regular claims work, it will receive an additional 98,000 claims from its outreach to veterans in the six States with the lowest average compensation payments.

It appears VA contemplates an exceptional increase in the claims backlog during these 2 years despite the fact that it projects an increase in production. In the IB, we have recommended a substantially higher staffing level that we believe reflects a more realistic assessment of what VA needs to deliver in benefits in a timely manner. The IB recommends that the fiscal year 2006 staffing of 9,431 FTE for C and P be increased to 10,820, and I would invite your attention to the IB and my written statement for the bases of that recommendation.

Similarly, we have recommended staffing levels for the educational program and vocational rehabilitation and employment programs that we think are necessary to get the job done in an acceptable manner. Though the Administration's budget seeks an increase for these programs, the IB recommendations are slightly higher. In addition to ensuring that VBA has resources necessary to accomplish its mission, Congress must also make adjustments to the program from time to time to address increases in the cost of living and needs for other improvements. The IB makes a number of such recommendations, and we invite your attention to that section of the IB.

Before closing, I would also like to add that the DAV encourages the Committee to conduct hearings in the upcoming year to consider alternative methods for VA health care system.

Thank you, Mr. Chairman. That completes my statement. I will be happy to answer any questions.

[The prepared statement of Mr. Lawrence follows:]

PREPARED STATEMENT OF BRIAN LAWRENCE, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

I am pleased to appear before you on behalf of the Disabled American Veterans (DAV), which is one of the four member organizations of the Independent Budget (IB). We are grateful for the opportunity comment on, and compare, the President's proposed fiscal year (FY) 2007 budget for veterans' programs with the recommendations of the 2007 IB. As you know, the IB is a budget and policy document that sets forth the collective views of the DAV, AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW). Each organization has a principal responsibility for a major component of the budget. My testimony focuses on Department of Veterans (VA) benefit programs, which are administered by the Veterans Benefits Administration (VBA). VBA is further divided into the following services: Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Loan Guaranty, and Insurance. VBA and its constituent departments are funded under the General Operating Expenses (GOE).

The level of funding sought in the President's 2007 budget would increase VBA operating expenses by nearly $114 million, a 10.8 percent increase over last year's level. We are greatly encouraged that the Administration has proposed a substantial increase in resources for VBA. The need for such an increase has become critical, and we deeply appreciate the President's bearing on this issue.

We view adequate staffing levels for the VBA business lines as the most important issue for consideration in this component of the VA budget. While the Adminis-

tration's move is in the right direction, we believe sufficient staffing levels for VBA are more closely reflected by the following IB recommendations regarding VBA services.

C&P SERVICE

With the Administration's proposed budget, VBA staffing would be increased in fiscal year 2007 by 173 full-time employees (FTE). C&P Service would be authorized 9,445 FTE, which is a total increase of 14; however, the number of FTE under the subcategory, Direct Compensation, would be reduced by 149. The net gain of FTE would be as a result of increases in other VBA activities.

This recommendation is somewhat perplexing since one of the Administration's stated goals is to decrease the number of backlogged compensation claims. Additionally, ongoing hostilities in Iraq and Afghanistan and an aging veteran population will almost certainly increase the number of claims for compensation. In the 5-year period from the end of fiscal year 2000 to the end of fiscal year 2005, the volume of disability claims increased 36 percent, or an average of 7.2 percent annually. However VA projects that the number of disability claims will increase by only 3 percent during 2006 and 2 percent in 2007. Even with such modest projections for increased work, the Administration's budget request for fewer direct program FTE will result in a greater amount of pending claims. What makes this proposed reduction in staffing all the more questionable is VA's estimate that, above these projected increases in regular claims work, it will receive an additional 98,000 claims from its outreach to veterans in the six states with the lowest average compensation payments, as mandated by last year's legislation. VA admittedly anticipates increases in the already unacceptable claims backlogs in these 2 years, despite the fact that VA projects it will increase its 2005 production by 75,102 completed claims in 2006 and 85,740 completed claims in 2007. The backlog of pending rating cases would grow from 346,292 at the end of fiscal year 2005 to 417,852 cases at the end of fiscal year 2006, and 396,834 in fiscal year 2007.

The IB recommends 10,820 FTE for C&P Services. In its budget submission for fiscal year 2006, VA projected production based on an output of 109 claims per direct program FTE. The IB organizations have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromised quality, higher error and appeal rates, and even more overload on the system. In addition to recommending staffing levels more commensurate with the workload, we have maintained that VA should invest more in training adjudicators and that it should hold them accountable for higher standards of accuracy. In response to survey questions from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards if they make sure they have sufficient evidence for rating each case and thoroughly review the evidence. Most attributed VA's inability to make timely and high quality decisions to insufficient staff. They indicated that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, we believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program FTE. Based on an estimated 930,000 claims in fiscal year 2007, 9,300 direct program FTE would be required to handle the caseload efficiently. With the fiscal year 2006 level of 1,520 support FTE added, this would require C&P to be authorized 10,820 total FTE for fiscal year 2007.

For Education Service, the President's budget seeks funding for 34 additional direct program FTE and 10 additional support FTE. This recommendation would bring the total number of FTE to 930. While we appreciate the additional support, we believe the President's recommended staffing level for Education Service falls short of what is needed. As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during fiscal year 2004 and fiscal year 2005, direct program FTE were reduced from 708 at the end of fiscal year 2003 to 675 at the end of fiscal year 2005. Based on experience during fiscal year 2004 and fiscal year 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in fiscal year 2007. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the

number of direct program FTE at the end of fiscal year 2003 in relation to the workload at that time, VBA must increase direct program staffing in its Education Service by 149 for direct-program FTE. In total, the IB recommends that Education Service should be provided 1,033 FTE for fiscal year 2007.

For VR&E Service, the President's budget seeks funding for 1,255 FTE. The IB recommends 1,375 FTE for this business line. VR&E's workload is expected to continue to increase primarily as a consequence of the war in Iraq and ongoing hostilities in Afghanistan. Also, given its increased reliance on contract services, VR&E needs approximately 50 additional FTE dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA Vocational Rehabilitation and Employment Task Force recommended in its March 2004 report the creation of new staff positions and training for this purpose. Other new initiatives recommended by the Task Force also require an investment of personnel resources. To meet its increasing workload and implement reforms to improve the effectiveness and efficiency of its programs, it is projected that VR&E will need a minimum of 1,375 direct program FTE in fiscal year 2007.

OTHER SUGGESTED BENEFIT IMPROVEMENTS

The benefit programs are effective for their intended purposes only to the extent VBA can deliver benefits to entitled veterans and dependents in a timely fashion. However, in addition to ensuring that VBA has the resources necessary to accomplish its mission in that manner, Congress must also make adjustments to the programs from time to time to address increases in the cost of living and needed improvements. The IB makes a number of recommendations to adjust rates and improve the benefit programs administered by VBA. Some of those recommendations are:

- cost-of-living-adjustments for compensation, specially adapted housing grants, and automobile grants, with provisions for automatic annual increases in the housing and automobile grants based on increases in the cost of living
- a presumption of service connection for hearing loss and tinnitus for combat veterans and veterans who had military duties involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma
- removal of the provision that makes persons who first entered service before June 30, 1985, ineligible for the Montgomery GI Bill, along with other improvements to the program
- no increase in, and eventual repeal of, funding fees for VA home loan guaranty
- increase in the maximum coverage and adjustment of the premium rates for Service-Disabled Veterans' Life Insurance
- increase in the maximum coverage available on policies of Veterans' Mortgage Life Insurance
- legislation to restore protections for veterans' benefits against awards to third parties in divorce actions.

We invite the Committee's attention to the section of the IB addressing the Benefit Programs for details on these and other IB recommendations for improvement.

Another important component of our system of veterans' benefits is the right to appeal VA's benefits decisions to an independent court. The IB includes recommendations to improve the processes of judicial review in veterans' benefits matters. Again, we invite the Committee's attention to the IB for the details of these recommendations. In addition, the IB recommends that Congress enact legislation to authorize and fund construction of a courthouse and justice center for the United States Court of Appeals for Veterans Claims.

CLOSING

In preparing the IB, the four partners draw upon their extensive experience with the workings of veterans' programs, their firsthand knowledge of the needs of America's veterans, and the information gained from their continual monitoring of workloads and demands upon, as well as the performance of, the veterans' benefits system. Historically, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families, and we hope you will give our recommendations full and serious consideration again this year.

Chairman CRAIG. Brian, thank you very much.

Carl, please proceed.

STATEMENT OF CARL BLAKE, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Mr. Chairman.

PVA is pleased to present our views today on behalf of the Independent Budget regarding the fiscal year 2007 VA health care budget request. We are proud that this will mark the twentieth year that PVA along with AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars have presented the IB, a comprehensive budget and policy document that reflects the true funding needs of the VA.

Mr. Chairman, we would like to thank you for taking time out of your busy schedule a couple of weeks ago to come acknowledge this anniversary with us.

Chairman CRAIG. Absolutely.

Mr. BLAKE. The Independent Budget uses commonly accepted estimates of inflation, health care costs, and health care demand to develop our funding recommendations. This year, the document is endorsed by over 60 veteran service organizations and medical and health care advocacy groups. For the first time, a reasonable starting point has been established by the President to fund the VA health care system. For fiscal year 2007, the Administration has requested $31.5 billion for total veterans health care. Although this is a significant step forward, we still have some concerns about proposals, as has been discussed today.

The IB for fiscal year 2007 recommends approximately $32.4 billion for total medical care, an increase of 3.7 billion over the fiscal year 2006 appropriation and about $900 million over the Administration's request. We believe that the recommendations of the IB have been validated once again this year as the Administration indicated that it will actually take about $25.5 billion to fund medical services, an amount that was very close to what we recommended; however, they only request 24.7 billion in appropriated dollars. The Administration hopes to add an additional $800 million by instituting a new enrollment fee and an increase in the prescription drug copayments.

We are deeply concerned that, once again, the President's recommendation proposes a $250 new enrollment fee for Priority 7 and 8 veterans and an increase in prescription drug copayments from 8 to 15 dollars. These proposals will put serious financial strain on many veterans, including certain PVA members with non-service-connected spinal cord injuries. These veterans, because of their catastrophic disabilities, are enrolled in priority category four as veterans; however, due to a glitch in the drafting of eligibility reform legislation in 1996, because of their income, they are still required to pay all fees and copays as though they are Priority 7 and eight veterans. We urge the Committee to look at this and to take corrective action.

The VA estimates that these proposals will force nearly 200,000 veterans out of the system and more than 1 million to choose not to enroll. Congress has soundly rejected these proposals for the past few years, and we would urge you to do so once again.

Our health care recommendation does not include additional money to provide for the health care needs of category eight veterans; however, it is included in our bottom line for total discre-

tionary funds needed by the VA to provide health care to these veterans. Despite our clear desire to have the VA health care system open to these veterans, Congress and the Administration has shown little desire to overturn this policy decision. The VA estimates that a total of over 1 million category eight veterans will have been denied enrollment into the VA health care system by fiscal year 2007. We believe that it would take approximately $684 million to meet the health care needs of these veterans if the system were reopened.

For medical and prosthetic research, the Administration has recommended $399 million, a cut of approximately $13 million below the fiscal year 2006 appropriation. The Independent Budget recommends $460 million. Research is a vital part of veterans health care and a central mission for our national health care system. Despite a reasonable request this year, the budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of how much money it is going to get and when it is going to get that money. In order to address this problem, the IB has proposed, once again, that funding for veterans health care be removed from the discretionary budget process and be made mandatory.

In closing, Mr. Chairman, I would just like to address one point made by Senator Graham regarding retiree health care versus veterans health care. I think it is important that we understand that retirees are not part of a health care system. They have access to a health insurance plan known as TRICARE. It is an entitlement for both them and their families. Veterans have access to the VA health care system which is, in fact, a direct provider of care. Because it is subjected to the discretionary process of the budget, these veterans could be cut out of the VA health care system at any time. This is not, in fact, true of TRICARE enrollees. They will be able to get their care regardless of what the funding situation may be.

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

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Chairman Craig, Ranking Member Akaka, and Members of the Committee, 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 fiscal year 2007.

We are proud that this will mark the 20th year that PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars, have presented the Independent Budget, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs (VA). 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 60 veterans' service organizations, and medical and health care advocacy groups.

Last year proved to be perhaps the most unique year ever in the debate over the VA budget. The VA was forced to admit that it did not have the resources necessary to meet the demands being placed on its health care system. Congress was forced to react quickly and decisively to address this situation. These events served to validate the recommendations made every year, by the Independent Budget.

For the first time, a reasonable starting point was offered by the President to fund the VA health care system. For fiscal year 2007, the Administration has requested $31.5 billion for veterans' health care, a $2.8 billion increase over the fiscal year 2006 appropriation. Although this is a significant step forward, we still have some concerns about proposals contained within the request.

The Independent Budget for fiscal year 2007 recommends approximately $32.4 billion for veterans' health care, an increase of $3.7 billion over the fiscal year 2006 appropriation and about $900 million over the Administration's request. The medical care recommendation is comprised of three accounts—Medical Services, Medical Administration, and Medical Facilities—with the bulk of the funding going to Medical Services.

For fiscal year 2007, the Independent Budget recommends approximately $26 billion for Medical Services, an increase of $3.5 billion over the fiscal year 2006 appropriation and nearly $1.3 billion more than the request of the Administration. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$23,350,760,000
Increase in Patient Workload	1,470,817,000
Increase in FTE	118,886,000
Policy Initiatives	1,050,000,000
Total fiscal year 2007 Medical Services	25,990,463,000

In order to develop our current services estimate, we used the Obligations by Object in the President's Budget to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific accounts within the overall account. Our inflation rates are based on 5-year averages of different inflation categories from the Consumer Price Index-All Urban Consumers (CPI-U) published by the Bureau of Labor Statistics every month.

Our increase in patient workload is based on a 6.3 percent increase in workload. The policy initiatives include $500 million for improvement of mental health and long term care services, $250 million for funding the fourth mission, and $300 million to support centralized prosthetics funding. In previous testimony, the VA testified that it is already spending more than $250 million per year on homeland security, emergency preparedness, and fourth mission requirements.

For Medical Administration, the IB recommends approximately $2.9 billion. The Administration requested approximately $3.2 billion for this account. The difference in our recommendations centers around the fact that we assumed that for fiscal year 2006, the entire $1.2 billion for Information Technology was removed from the Medical Administration account as set for in the fiscal year 2006 appropriations bill. However, the Administration assumed only a portion of this amount being removed from this account, thereby giving them a higher figure to start with. Finally, for Medical Facilities the IB recommends approximately $3.5 billion, approximately $100 million less than what the Administration recommends.

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

We are deeply concerned that once again the President's recommendation proposes the $250 enrollment fee for Priority 7 and 8 veterans and an increase in prescription drug copayments from $8 to $15. These proposals will put a serious financial strain on many veterans, including certain PVA members with non-service connected spinal cord injuries. These veterans, because of their catastrophic disabilities, are enrolled in VA health care as Priority 4 veterans. However, due to a glitch in the drafting of eligibility reform legislation in 1996, because of their income, they are still required to pay all copayments and fees as though they are Priority 7 or 8 veterans. We urge the Committee to correct this unfair situation.

The VA estimates that these proposals will force nearly 200,000 veterans to leave the system and more than 1,000,000 veterans will choose not to enroll. Congress has soundly rejected these proposals for the past 3 years and we urge you to do so once again.

Our health care recommendation does not include additional money to provide for the health care needs of Category 8 veterans being denied enrollment into the system. However, it is included in our bottom line for total discretionary dollars needed by the VA to provide health care to all eligible veterans. Despite our clear desire

to have the VA health care system open to these veterans, Congress and the Administration have shown little desire to overturn this policy decision. The VA estimates that a total of over 1,000,000 Category 8 veterans will have been denied enrollment into the VA health care system by fiscal year 2007. Assuming a utilization rate of 20 percent, we believe that it would take approximately $684 million to meet the health care needs of these veterans, if the system were reopened. We believe that the system should be reopened to these veterans and this money appropriated on top of our medical care recommendation for this purpose.

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

In order to address the problem of adequate resources provided in a timely manner, the Independent Budget has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. 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.

Making veterans health care funding mandatory would not create a new entitlement, rather, it would change the manner of health care funding, removing the VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process. We look forward to working with this Committee in order to begin the process of moving a bill through the House, and the Senate, as soon as possible.

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. It is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of the Independent Budget.

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

Chairman CRAIG. Carl, thank you much.

David, we will turn to you.

STATEMENT OF DAVID G. GREINEDER, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. GREINEDER. Thank you, Mr. Chairman. As a co-author of The Independent Budget, AMVETS is pleased to give you our best estimates on the resources necessary to carry out our responsible NCA budget for fiscal year 2007. The Administration requests $160.7 million in discretionary funding for NCA operation, $53.4 million for major construction, $25 million for minor construction, as well as $32 million for the State Cemetery Grant Program. The members of the Independent Budget recommend Congress provide $214 million for the operational requirements of NCA, the National Shrine Initiative, and the backlog of repairs. In total, our funding recommendation for NCA represents a $54 million increase over the Administration's request, an increase almost entirely aimed at the National Shrine Initiative.

The members of the Independent Budget and the veteran and military groups who endorse our recommendations asked Congress to establish a 5-year $250 million National Shrine Initiative to re-

store and improve the condition and character of NCA cemeteries. We recommend $50 million for fiscal year 2007 to begin this program.

As the veterans population ages and the global war on terrorism continues, demand for NCA services, unfortunately, will remain high. In recent years, the burial rate has averaged more than 90,000 interments per year and is expected to exceed 110,000 before too long. To meet this demand for services, the IB recommends hiring an additional 30 FTE for fiscal year 2007, an increase of 7 over the Administration's request. Additional employees are necessary to staff and maintain existing and new national cemeteries across the country.

For funding the State Cemetery Grants program, the IB recommends $37 million for fiscal year 2007. The State Cemeteries Grant Program is an important component of NCA. It assists States in increasing their burial services to veterans, especially those living in less densely populated areas not currently served by a national veterans cemetery. The grants to States play a crucial role in achieving NCA's strategic target of providing 90 percent of veterans a burial option within 75 miles of their residence. In fact, 18 new State cemeteries are planning to open between 2007 and 2010.

The State grant program provides up to 100 percent of the development cost for an improved cemetery project, including design, construction, and administration. In addition, new equipment such as mowers and backhoes can be provided for new State cemeteries. Through the partnership between the State and Federal Governments, VA has more than double acreage available and has accommodated more than a 100 percent increase in burials.

The Independent Budget also recommends Congress to review a series of burial benefits that have eroded in value over the years. While these benefits were never intended to cover the full cost of burial, they now pay for only a fraction of what they covered in 1973. These recommendations are contained in my written statement, but I would like to say our recommendations, which represent a modest increase, would restore the allowance to its original proportion of expense and tell veterans that their sacrifice is given the appreciation it deserves.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.6 million soldiers who died in every war or conflict are honored by burial in a national cemetery. Each Memorial Day and Veterans Day, we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than a final resting place. They are hallowed ground to those who died in our defense and a memorial to those who survive.

Mr. Chairman, this concludes my statement. Thank you again for the opportunity to testify before you this morning.

[The prepared statement of Mr. Greineder follows:]

PREPARED STATEMENT OF DAVID G. GREINEDER, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Chairman Craig, Ranking Member Akaka, and Members of the Committee:

AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for

fiscal year 2007. My name is David G. Greineder, Deputy National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA in fiscal year 2007.

AMVETS testifies before you as a co-author of The Independent Budget. Since 1987, AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled their resources to produce a unique document, one that has stood the test of time. It is hard to believe that twenty years have elapsed since the first Independent Budget was formulated.

The IB, as it has come to be called, is our blueprint for building the kind of programs veterans deserve. Indeed, we are proud that over 60 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decisionmakers 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 have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of health care services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

Today, I will specifically address the National Cemetery Administration (NCA), however, I would like to briefly comment on the Administration's budget request coming out of the Office of Management and Budget (OMB) just last week.

The administration's budget requests a total of $80.6 billion for the Department of Veterans Affairs. Included in the spending plan is nearly $31.5 billion for veterans' health care. However, an estimated $2.8 billion actually would come out of veterans' pockets, not the Federal treasury. AMVETS, along with our Independent Budget partners, recommend Congress provide $32.4 billion for veterans health care, an increase of $3.7 over the fiscal year 2006 appropriation, and $1 billion over the Administration's fiscal year 2007 budget request.

AMVETS notes that the Administration has re-introduced several proposals aimed at increasing revenues (via collections) through a $250 enrollment fee and copayment increase from $8 to $15. These new fees will have a dramatic impact on veterans. According to estimates, they will force over one million veterans, almost half of the Priority 7 and Priority 8 veterans, to drop out of the VA healthcare system. AMVETS disagrees with this policy and we ask Congress to reject it.

It is no secret that the VA healthcare system is the best in the country, and responsible for great advances in medical science. It is highly successful in containing cost and provides excellent care. The VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system can provide a wide array of specialized services to veterans like those with spinal cord injuries and blindness. This type of care is very expensive and would be almost impossible for veterans to obtain outside of VA.

The system also prides itself in research and development, which AMVETS strongly supports because of its contributions to veterans' healthcare and the common good. Public investments in research projects have lead to an explosion of knowledge that promises to advance science and unlock new strategies for treatment and prevention.

Because veterans depend so much on VA and its services, AMVETS believes it is absolutely critical that the VA healthcare system be fully funded. It is important our Nation keep its promise to care for the veterans who made so many sacrifices to ensure the freedom of so many. With the expected increase in the number of veterans, a need to increase VA health care spending should be an immediate priority this year. We must remain insistent about funding the needs of the system, and the recruitment and retention of vital health care professionals, especially registered nurses. Chronic under funding has led to rationing of care through reduced services, lengthy delays in appointments, higher copayments and, in too many cases, sick and disabled veterans being turned away from treatment.

One option, and we believe the best choice, to ensure VA has access to adequate and timely resources is through mandatory, or assured, funding. I would like to clearly state that AMVETS along with its Independent Budget partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. We recommend this action because the current discretionary system is not working. Moving to mandatory funding would give certainty to healthcare services. VA facilities would not have to deal with the uncertainty of discretionary funding, which has been inconsistent and inadequate for far too long. Most importantly, mandatory funding would provide a comprehensive and permanent solution to the current funding problem.

THE NATIONAL CEMETERY ADMINISTRATION

Before I address the budget recommendation for the NCA, I would like to acknowledge the dedicated and committed NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and increasing workload. The devoted staff provides aid and comfort to hurting veterans' families in a very difficult time, and we thank them for their consolation.

The Department of Veterans Affairs National Cemetery Administration currently maintains more than 2.6 million gravesites at 125 national cemeteries in 39 states and Puerto Rico. There are approximately 14,500 acres of cemetery land within established installations in the NCA. Over half are undeveloped and have the potential to provide more than 3.6 million gravesites. Of the 125 national cemeteries, 62 are open to all interments; 19 can accommodate cremated remains and family members of those already interred; and 41 are closed to new interments.

VA estimates that about 26.6 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, and the Global War on Terrorism, as well as peacetime veterans. With the aging veterans population continuing to climb, nearly 676,000 veteran deaths are estimated in 2008, with the death rate increasing annually and peaking at 690,000 by 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

The Administration requests $160.7 million and 23 additional FTE for NCA for fiscal year 2007. The members of the Independent Budget recommend that Congress provide $214 million and 30 FTE 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.

In regards to the National Shrine Initiative, if the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries. The Independent Budget recommends Congress provide $50 million in fiscal year 2007 to begin a 5-year, $250 million program to restore and improve the condition and character of NCA cemeteries.

The National Shrine Initiative is in response to the 2002 Independent Study on Improvements to Veterans Cemeteries. Volume 2 of the Study identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the Study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

THE STATE CEMETERY GRANTS PROGRAM

For funding the State Cemetery Grants Program (SCGP), the members of the Independent Budget recommend $37 million for fiscal year 2007, an increase of $5 million over the Administration proposal. The State Cemetery Grants Program is an important element to the NCA. It complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans.

Six western states do not have a single national veterans cemetery: Idaho, Montana, Nevada, North Dakota, Utah, and Wyoming. The large land areas and spread out population centers in these and most western states make it difficult for them to meet the "170,000 veterans within 75 miles" national veterans cemetery requirement. Recognizing these challenges, VA has implemented several incentives to assist states in establishing a veterans cemetery. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1973, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

BURIAL BENEFITS

There has been serious erosion in the value of burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they

now pay for only a small fraction of what they covered in 1973 when the Federal Government first started paying burial benefits.

In 2001, the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately 6 percent of funeral costs. The Independent Budget recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

In the 108th Congress, the burial allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. The Independent Budget recommends increasing the service-connected benefit from $2,000 to $4,100, bringing it up to a proportionate level of burial costs. The non-service-connected burial benefit was last adjusted in 1978, and also covers just 6 percent of funeral costs. The Independent Budget recommends increasing the non-service-connected benefit from $300 to $1,270. These modest increases will make a more meaningful contribution to the burial costs for our veterans.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.6 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans, they are hallowed ground to those who died in our defense, and a memorial to those who survived.

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

Chairman CRAIG. Gentlemen, thank you, all, very much for your testimony and your advocacy as we work our way through these difficult questions, but important ones to be asked and ultimately the budget to be developed for 2007.

I think all of us are generally pleased and satisfied with the levels of increases as a comparative measure against last year's budget proposals initially and where Congress ultimately took the VA budget. The issue that concerns me most, and I am not going to sit here and tell you that we have the votes to pass what the Administration has proposed as it relates to new revenue measures, but those revenue measures recognize in both real dollars and dollars saved upwards of 800 million, somewhere in that figure, I understand.

If we are to assume that Congress does not choose to do that, the ultimate question will be how do we replace those dollars if we are to stay at least at those levels of funding. I don't need to tell you the difficulty that is underway at this time with overall budgets, because we are talking better than three-quarters of a billion that would need to be replaced. That is one of the difficulties that we are going to struggle with.

So, Steve, I don't question, or I should say, I accept your challenge. I think we have to collectively look at alternative revenue sources, and you know my position on mandatory spending. To just move that veterans health care and other veterans benefits over to mandatory—obviously some of the veterans benefits are mandatory—doesn't solve the problem in any respect. I believe my opening statement was reflective of very, very big issues that this Congress is simply ignoring at this moment. The onslaught of baby-boomers, the Medicare budgets, Medicaid budgets, Social Security, and our very clear need to serve our veterans. All of those are rapidly consuming all discretionary spending and ultimately could con-

sume all of the Federal budget and the defense budget if we are not to make significant changes in the out years.

Those are our projections, budget projections, in reality that nobody is refuting at this moment, both sides. Democrat, Republican, all of our best thinkers do not dispute those facts, and the consequence of simply offsetting them by tax increases is to deny the reality of an economy that will employ these folks out there who are seeking employment for and lagging behind as it relates to those leaving service at this moment.

So those are the struggles we are in, and I don't deny that in any way. Those are tough choices to be made. So in the coming months, I accept your challenge to look at, to vet ourselves through, if you will, alternatives and realities as to where we go. TRICARE, an entitlement? Well, I suspect it isn't if you don't pay the fees. You have got to pay the cost to get through the gate. That is not an entitlement. That is an insurance program.

You know, I don't deny the importance of health care to anyone, but I do and I am going to be very curious about who might opt in and who might opt out as it relates to any increase anywhere. When all of a sudden the citizen is exposed to the health care market, there is a very real reality check that they have to make if, in fact, they have been shouldered inside a health care environment before, and, I mean, those are the simple realities that we are all facing when we look at health care costs today.

So, I think I am obviously anxious to sustain a very robust and quality health care delivery system for our veterans, but those are some of the kinds of things I am going to struggle with.

Let me ask one question that concerns me as it relates to the area of disability compensation. VA expects a backlog of disability compensation claims to grow in 2006 and the amount of time it takes to adjudicate disability claims to worsen as a result of the 98,000 extra claims it expects will be filed by veterans responding to congressionally mandated outreach in six States.

I have been told that VA expects very few of these claims to be successful. I am concerned that these new claims filed by recently separated combat veterans may be delayed as a result of this policy and that 98,000 veterans are being set up for failure. Would any of you give me your thoughts on this? Would you recommend that Congress revisit this policy?

Mr. KINDERMAN. Mr. Chairman, first of all, VA for a long period of time has been running a 15 percent error rate in their decisions. We catch some of those decisions with our advocates. We don't catch them all.

Chairman CRAIG. Right.

Mr. KINDERMAN. So I think it is grossly optimistic of the VA to think that these are claims that are not going to be worth revisiting. Having said that, picking out the six States that at a point in time had the lowest average payment, I think is probably not the most rational way to approach any cumulative error rate and bad decisionmaking in VA.

If I could just expand a little bit on that, I understand your position. I understand your challenge, and I understand what you have to do this year to keep the budget going, but I really do believe that the solutions to all VA's issues is in the long run the decisions that

you make that are not going to affect just the budget this year, but set in motion things that will happen in the long term. Maybe with this generation, as they get older, you will have a better outcome and the expense curve won't be going up, and the tax contributions of that generation will be going up instead. I think those are decisions that we can't allow the current crisis to cloud at this point in time.

We want to work with you on that. I think it includes the benefits programs. We heard Secretary Nicholson in his well-justified pride talking about the VA health care system, which I think is a jewel for this country. It is one of the few major health care systems that is working well. Pushing 200,000 of the people that it now serves onto Medicare just creates a bigger problem for you in other areas. You said in your opening statement MEDICARE is crowding out the other parts of the budget as well.

So I think we can't look at it just in the short context of one budget. We have to make decisions like we are suggesting in CARES that are going to have great long-term effects to make the infrastructure what it should be for future generations.

Mr. ROBERTSON. Mr. Chairman.

Chairman CRAIG. Steve.

Mr. ROBERTSON. This is a much bigger issue than VA budgeting, because this is really a national security issue. When I came in the service in 1973, there were a lot of decisions I made about a career that were based upon what was available and what the Government was promising me, that if I got hurt, they would compensate me, that if I needed medical attention, it would be there.

When my wife, who is completing over 20 years of military service in September of this year, when she made her decision to stay in the military, a lot of those same benefits were there. Our son, who just returned from Iraq about 6 months ago, is of a different view. He is beginning to ask himself is it worth staying in.

I think that when you make a promise, you have to do everything in your power to keep that promise. The biggest problem I see with the VBA right now is the lack of experienced adjudicators. That contributes to the slowness of claims processing. It contributes to the inaccuracy rates and causes remands, which begin to stack up.

I think that there really needs to be a focus on getting people into the VBA that will make it a career, that are willing to stay for 30 years or more as a Federal employee, doing the business of taking care of veterans and reviewing the process. If people are coming into the system and just using the VBA as stepping stone to another Federal job, that is not the solution, because it takes about 5 years for an adjudicator to become confident, and I think that is where the focus needs to be, whether we need to readjust pay scales to where it makes it an attractive position to make a career in, whether there is advancement, whether there is recurring training that makes sure that we are keeping the best and the brightest sharp.

We are trying to do our part at the local level. We have classes for service officers trying to make better case development so that it makes it easier for the adjudicators. But this is a much bigger problem than just this budget, and I really think that it has a re-

tention and recruitment impact on national defense, which we all know is the highest priority of this country. That is the highest priority.

Chairman CRAIG. Thank you.

Let me turn to Senator Akaka. I have never limited the Ranking Member to one question. I did make a comment and ask one question.

Danny, for sake of time, please proceed with discretion.

Senator AKAKA. Yes.

Chairman CRAIG. All right.

Senator AKAKA. Thank you very much, Mr. Chairman. I have enjoyed working with you on the challenges that have been made by our second panelists.

Mr. Robertson, I am very concerned about reports that we are getting that veterans from Afghanistan and Iraq are becoming homeless. In your testimony, you state that 40 percent of homeless veterans suffer from mental illness, and we look upon that as PTSD. Further, you add that 34 percent of the Nation's homeless are veterans, and 75 percent of those are war-time veterans. Looking at the veterans' needs, this is tremendous.

My question to you is, what more should this Nation be doing to keep young veterans off the street?

Mr. ROBERTSON. Mr. Akaka, thank you for the question. Secretary Principi during his tenure made a challenge to try to end homelessness in the veterans community over the next 10 years, and the American Legion has been very aggressive in that effort. In fact, we have created a homeless veterans task force within our organization. I think it is in every State now where we are trying to collect additional data and to take proactive actions to try to solve some of the problems.

We have homeless programs that are actually in place where we are housing veterans across the country that are homeless. In fact, we are beginning to see Iraqi War veterans showing up at some of our shelters in need of assistance. We are trying to help them with employment issues. We are very concerned with some of the changes that recently occurred in VETS, the Veterans Employment Training, over in DOL. We are not really sure they have got their act together since the Jobs for Veterans Act passed in 2003, and we are not sure that the recently separated veterans are getting the attention that they needed.

Clearly, PTSD is a major concern of the young men and women that are coming back. Because of the type of warfare that we are fighting, this is quite different than just about any other combat that we have had since, I guess, World War II. So we are trying to stay on top of that and referring them to the VETS centers across the country. Many of them are reluctant to come forward because the stigma that is still attached to admitting that you are having mental health problems.

So we are trying to educate our members to reach out to the veterans in their community and address those exact problems.

Senator AKAKA. In keeping with our time constraints, I would like to ask the rest of you to make comments on the following: What more should this Nation be doing to keep young veterans from being homeless?

Mr. KINDERMAN. Senator Akaka, I am no expert on homelessness, but I think it is characterized by a very large dynamic, that there is a lot of turnover in the population of homeless, and it is very difficult to get any sort of really good information in order to base programs on. So I would urge the Committee to make sure that the VA and other agencies that have a role in helping veterans who are homeless or down on their luck or are suffering from PTSD or some of the attendant problems that go along with PTSD to aggressively reach out and get that information, because without the information on that population, and it changes quickly, any program is at great risk of being misdirected.

Senator AKAKA. Thank you.

Mr. LAWRENCE. Senator, I think probably one of the key issues to solving homelessness has probably been previously, is identifying problems prior to separation—I know there are steps being made in that regard—and also helping these veterans establish benefits so they have some financial support, the ones that do have problems prior to their separation.

The Benefits Delivery at Discharge Centers, BDD Centers, have had a high rate of success. They have had the lowest amount of errors in their rating decisions, and they are also the most efficient way of delivering benefits to veterans as they are getting out, and the veterans have a higher satisfaction rate, and, again, there is a lower turnover rate on those decisions.

So one of the things that we would recommend is increasing the number of BDD Centers, or Benefits Delivery at Discharge Centers.

Senator AKAKA. Thank you very much.

Mr. BLAKE. Senator Akaka, along those lines, also one of the other things that we have been an advocate for as a participant in the National Coalition for Homeless Veterans, as I know some of the other organizations here are, we have been a strong advocate for the Homeless Veterans Reintegration Program that is managed by the Veterans Employment Training Service. It is authorized, I believe, at $50 million, and yet the amount of funds that program receives every year is significantly less than that, and yet its success rate is well proven and is perhaps the most cost-effective and cost-efficient program in the Federal Government, and yet it continues to do so with a significantly lower budget than what it is authorized for.

So I think that is something else that we can look at down the road for improving, because that program has proven to be so successful in keeping veterans off the street and getting veterans who are on the street back out into society and becoming fully functioning citizens again.

Senator AKAKA. Thank you.

Mr. GREINEDER. Senator, I certainly agree with all the statements of my colleagues here, and on behalf of AMVETS, I think we need to seriously talk to separating veterans and take a look at the transition assistance program in making sure that these transitioning servicemembers have and understand all the benefits that are available to them to prevent homelessness to begin with. I think if we start there, we can prevent a large percentage of homelessness in the streets.

Senator AKAKA. Thank you very much for your responses.

Mr. Chairman, I would like to submit my questions for the record.

Chairman CRAIG. Without objection, of course, Senator Akaka, that will be done, and I have additional questions that will be addressed to you all. I appreciate not only your question, obviously, Senator Akaka, and I have held one hearing and we are going to monitor and follow up very closely what is going on over at the Department of Labor with the VETS program.

I agree with the observation that we don't think they get it yet either as well as it needs to be or as it relates to what the intent of the change of public policy was in that area, because this is an important issue and those numbers are abnormally high in an environment and in an economy where it can be pretty well judged we are nearly at full employment. Except in spots around the Nation, the economy in general is very good. So if you were experiencing a high level of unemployment in the civilian population, you would understand that a little better. We are not. There is a very real disconnect there by all reality that certainly we have got to address.

Well, gentleman, thank you again, and to the organizations you represent, as I have said and I say most sincerely, for your great dedication to America's veterans. This Committee will do its job and we will work to get a budget out that meets, obviously, these demands. We have a foundational base with the Administration's budget that is by all accounts substantially stronger than a year ago, and we will see where it takes us as we work both here as an authorizing Committee and with the appropriating committee to work our way through this, of course in conjunction with the House and where they choose to go.

So, again, thank you for your presence, and I don't have to tell you to stay tuned. I know you will and you will be back before us again. We appreciate working with you.

Thank you.

The Committee will stand adjourned.

[Whereupon, at 1:10 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Mr. Chairman, Secretary Nicholson, and my colleagues, I am pleased to see what seems to be a better budget for our veterans, especially for additional funding for VA health care. Last year was problematic for the VA health budget, and I hope that we never have to go through such a struggle again. I was pleased that Chairman Craig sought quarterly reports on the VA budget and I would like to be kept apprised of these updates.

VA health care funding has been on a steady rise, but it has to be. We are serving more and more veterans. We have brave men and women returning from Iraq and Afghanistan, too many with devastating physical wounds that will require a lifetime of care. Others will need mental health care to cope with the problems of Post-Traumatic Stress Disorder (PSTD) and the challenge of returning to civilian life after grueling combat duty in Kabul or Baghdad.

It takes a real toll on a soldier to deal with this type of combat. I learned this through private roundtables with recently returned veterans in West Virginia, and meeting soldiers currently serving in the field.

Simultaneously, we face the aging of our World War II veterans, known as the Greatest Generation. The needs of these veterans must also be met with the dignity they truly deserve.

I know that the VA health care budget is $3.5 billion more, but the real questions are:

- Is this budget enough to meet the compelling and immediate needs of our veterans from every era?
- Is it sufficient to maintain the high quality of care that VA has achieved and sufficient to appropriately staff our VA medical centers and our Vet Centers?

VA certainly deserves congratulations for its quality ratings for its health care. This is a real accomplishment, and our veterans deserve no less than the best care in America. How can we retain this distinction and the quality if we do not have a consistent, reliable funding stream for our VA health care system?

Also, I understand that the Administration once again is suggesting enrollment fees and nearly doubling the costs of each prescription drug for our veterans. Many older veterans have multiple daily prescriptions so this proposal really does impose a hardship. I oppose such fees, and I hope Congress will reject now as it has in the past. Caring for all of our veterans is a solemn obligation in my view, and we should not impose fees on them to drive some out of VA care or to cover costs that the Administration won't. VA health care must be among our highest priorities.

As always, I stand ready to work with my colleagues to deliver the best care for our veterans.

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

I want to thank Chairman Craig, Senator Akaka, Secretary Nicholson and representatives of the Nation's largest Veterans Service Organizations for all of their hard work.

The budget request before the Committee today is an improvement over the budget request we considered a year ago. I am particularly encouraged that, in the wake of last year's troubling shortfall, the budget includes a relatively substantial increase in funding for veterans' medical services.

As our Nation struggles with a growing healthcare crisis, we can all agree that the VA healthcare system serves as an example for how healthcare should be provided. In addition, through its medical research programs, the VA is frequently responsible for great strides in medical science that contribute significantly to the quality of healthcare services across the country.

Given the significance of the Veterans Health Administration to our Nation's healthcare system, and the paramount importance of providing our Nation's veterans with the high-quality care that our government has promised them, we owe it to our servicemembers, our veterans, and our Nation to be honest about our needs, and to provide funding adequate to meet those needs.

While, as I mentioned, I believe this budget does a better job of meeting those standards than the one we considered a year ago, I remain troubled by a handful of proposals that, if enacted, will serve to undercut our mission to provide quality healthcare to our Nation's veterans, and to provide support to a system that has been consistently exemplary.

For example, the Administration has once again proposed to raise premiums and copays for Priority 7 and 8 veterans, and has factored into its budget calculations the revenue it expects to generate from such policies. But we all know the impact these policies will have on veterans in our states—over 27,000 veterans in my state of Colorado alone would be forced out of the system. That's why this Committee has rejected them on several previous occasions, and it's why I expect we will roundly reject them again.

I'm also troubled by the proposal to cut $13 million from the VA's medial research programs. In light of the enormous contributions VA scientists have made to the field of healthcare, we should be giving these programs more funding, not less.

Finally, with more and more servicemembers returning from Iraq and Afghanistan, we need to fully confront the uphill battle we face with respect to providing these veterans with the care they deserve, and that we have promised to them.

So, as we laud the positive aspects of the budget that is before us, let's also not kid ourselves about the very real challenges we face. Let's work to meet those challenges head on.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO THE INDEPENDENT BUDGET (AMVETS, PARALYZED VETERANS OF AMERICA, DISABLED AMERICAN VETERANS AND VETERAN OF FOREIGN WARS OF THE UNITED STATES)

Question 1. The Independent Budget recommends $26 billion for medical services. As I read the Administration's budget—even without the new fees—the President is asking for $26.9 billion. I understand you don't assume collections. But, Congress does. Assuming collections at last year's level, is the President's budget adequate to meet the health care needs you identify in the Independent Budget? To what use would you recommend over $2 billion in collections be put if not to support all of the medical services and policy initiatives contained in the IB? And if collections were obligated on the services you recommend, wouldn't those services then become part of VA's medical care baseline and, therefore, need to be included in future annual budget requests?

Answer. The Independent Budget has never considered medical care collections as part of its recommendation for health care funding. We believe that adequate funding should be provided through direct appropriations. We certainly do not believe that collections from care provided from some veterans be used to subsidize the care of other veterans. In fact, we believe that any money raised through collections should be used as a supplement to, not a substitute for, direct appropriations. In the past, the Office of Management and Budget (0MB) has used projections for collections to offset requesting real dollars needed. As a result, the VA has been forced to operate with severe under funding.

We also do not believe that it is a safe decision to assume that the VA will be able to achieve its collection levels that it estimates. We recognize that the VA did a very good job last year. However, historically the VA has done a terrible job. In previous years, the VA never came close to achieving the collection levels it projected.

We do believe that the $2 billion could be used to overturn the policy decision that currently restricts Category 8 veterans from being able to enroll in the VA health care system. The money could also be used to expedite much needed construction to upgrade the ever-aging infrastructure of the VA.

Question 2. VA expects the backlog of disability compensation claims to grow in fiscal year 2006 and the amount of time it takes to adjudicate disability claims to worsen as a result of 98,000 claims it expects will be filed by veterans responding to Congressionally mandated outreach in six states. I am told that VA expects very few of these claims to be successful. I am concerned that new claims filed by recently separated combat veterans, and other veterans awaiting an initial decision, may be delayed as a result of this policy, and that 98,000 veterans are already in

receipt of compensation would be given false hope of a successful outcome. What are your thoughts on this? Would you recommend that Congress revisit this policy?

Answer. We share Chairman Craig's concern. While this provision has the good intention of ensuring that veterans in the lowest average payment states receive levels of compensation and service-connection consistent with the law, the review mandated by law is unlikely to accomplish that goal. Once a VA rating decision denying service-connection becomes final, it can only be revised based on clear and unmistakable error. Some cases will, no doubt be reversed on this basis, given that VA has an established error rate of 15 percent and some of these errors would have resulted in CUE. Generally, this is a difficult standard to meet, and most historic ratings will not be changed on this basis.

More likely, since VA plans to send these letters to veterans currently receiving disability compensation, will be numerous responses from veterans who believe that their current condition is under evaluated, either as a result of the previous evaluation by VA, or as a result of deterioration over time. Unless VA can determine that the veteran is not stating that the condition has gotten worse, they should treat these as claims for increase, schedule an examination, solicit supporting evidence from the veteran, and rate (evaluate) the veteran's condition, and provide notification and due process. Thus, this outreach will provide for an increase in benefits for some proportion of the veterans who respond to it.

VA estimates that about 16 percent of the letter recipients will respond. We think that within this population, a large number will have meritorious claims, especially among those who first seek clarification of the VA letter from VA or VSO representatives, and file a claim for an increased evaluation. However, entertaining these claims with what may be a confusing letter will prove to be an inefficient use of, VA resources. While a number of veterans may receive increased benefits as a result of this process, the review would add a great deal of work to a system that is already overburdened. It is highly unlikely that VA could get all these cases worked during the current fiscal year.

Since this is an undertaking of significant impact both on VA's resources, and implications for the veteran population, we have reservations about the investment of so many VA resources on the basis of historic statistics that are not completely understood. The diversion of resources to accomplish this effort rather than to a coherent strategy to improve, service to the larger veteran constituency is not be the best strategy, especially given the pressing need to serve veterans returning from the war zones. Unless Congress is willing to provide the resources necessary to accomplish this initiative, and still improve benefits delivery in general, this does not best serve the interests of America's veterans.

Question 3. I noticed that the Independent Budget recommends an increase in patient population of 6.3 percent. Even without the new fees, VA only assumes a growth of just over 1 percent. To what do you attribute this glaring difference in the projection of patient population? Is the IB based. on historical trends or a different actuarial model?

Answer. The IB projector for the increase in patient population is based on recent historical, trends. It is important to note that last year the VA projected a very similar growth rate and it proved to be terribly wrong. The VA estimated that the growth rate for fiscal year 2005 would be 2.3 percent when in fact it was approximately 5.2 percent. This seems to be proof positive that the VA's actuarial model is seriously flawed.

In formulating our projection, we returned to data provided by the VA in 2004. Based on projections made by the VA in budget testimony in February 2004, and including the actual growth in the patient Population last year (5.2 percent), we project a growth rate of approximately 6.3 percent.

We believe that it is disingenuous for the VA to assume a reduction in the number of Operation Iraqi Freedom and Operation Enduring Freedom veterans seeking care in the VA. We do not see any trends in the conflicts overseas that would suggest that this is an accurate assumption.

Furthermore, the VA assumes that more than 200,000 veterans will leave the system as a result of enactment of their legislative proposals. This would automatically skew their projected growth rate downwards. However, recognizing the fact that these proposals have been soundly rejected in the past, these veterans have to be added back to the total, thereby driving the growth rate back up.

Question 4. I know that each of your organizations is opposing the proposal to levy a $250 enrollment fee on Priority 7 and 8 veterans. I also know that opposition to higher income veterans contributing to the cost of their care was not always your policy. When—and why—did the views of each of your organizations change with respect to the idea that some veterans should contribute financially to the cost of their health care at VA?

Answer. We originally acquiesced to copayments to be assessed against "higher income" veterans as part of budget reconciliation. When the Omnibus Budget Reconciliation Act was considered, the veterans service organizations were forced to make a choice between accepting these copayments or face broader cuts across the spectrum of veterans' programs. We accepted the copayments under the agreement that implementation of these policies were only temporary relief measures. We did not accept ongoing extension of these policies in subsequent years. In fact, once a budget surplus was achieved, the prescription copayments were actually increased to the previous level of $7.

We also believe that the $250 enrollment fee is an altogether different proposition from prescription and health care copayments. This is unlike any proposal that we have ever considered, much less accepted. With this enrollment fee, veterans will not have access to care at all if they do not pay this fee up front. We oppose this strong-arm tactic to force veterans to choose between access to care or no care.

Ouestion 5. Mr. Blake, I was struck by your characterization of the President's proposed enrollment fee. Is it really fair to say that $21 per month would put a "serious financial strain" on veterans who make over $26,000 per year?

Answer. Yes, it is. Veterans who live on the margin in Category 7 or 8 making $26,000 per year or only a little more will be significantly impacted by this proposal. Many of these veterans live on fixed incomes and rely on the VA health care system to get the services they need. Furthermore, it is not as if they pay nothing for their care now. They are still required to pay for every prescription that they receive as well as every visit that they make to a VA medical facility. They are not getting a free ride, from the system. It is very easy for any one of us to claim that it is not much of a burden when we are not living under the same constraints.

Likewise, although $250 may not seem like a great deal of money to veterans living in high cost-of-living areas as determined by means testing, veterans who live in areas that are covered by the minimum income threshold will experience a significant impact.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO THE INDEPENDENT BUDGET (AMVETS, PARALYZED VETERANS OF AMERICA, DISABLED AMERICAN VETERANS AND VETERANS OF FOREIGN WARS OF THE UNITED STATES)

Question 1. I would like to know your opinion on VA's proposed $250 user fee and increase in the prescription drug copayment for Priority 7 and 8 veterans, a plan the Administration has tried to implement for the past few years. In the American Legion's testimony in particular, I believe you described this as an attempt "to balance the VA budget on the backs of America's veterans." What would the real impact be if Congress enacted these proposals?

Answer. We are deeply concerned that once again the President's recommendation proposes the $250 enrollment fee for Priority 7 and 8 veterans and an increase in prescription drug copayments from $8 to $15. These proposals will put a serious financial strain on many veterans, including certain PVA members with non-service connected spinal cord injuries. Veterans who live on the margin in Category 7 or 8 making $26,000 per year or only a little more will be significantly impacted by this proposal. Many of these veterans live on fixed incomes and rely on the VA health care system to get the services they need. Furthermore, it is not as if they pay nothing for their care now. They are still required to pay for every prescription that they receive as well as every visit that they make to a VA medical facility. They are not getting a free ride from the system. It is very easy for any one of us to claim that it is not much of a burden when we are not living under the same constraints.

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The VA estimates that these proposals will force nearly 200,000 veterans to leave the system and more than 1,000,000 veterans will choose not to enroll. Congress has soundly rejected these proposals for the past 3 years and we urge you to do so once again.

Question 2. The President is clear on who should be eligible for VA health care: those with service-connected health needs. I would like to ask you all a three-part question related to this topic. Do you think the system as we know it today, can survive if eligibility is severely narrowed? Can we continue to train nearly half of all physicians in the U.S.; maintain specialty programs unparalleled in the community; and teach the rest of the health care system about quality management if eligibility is limited to service-connected health needs? And last, don't we want veterans who have other forms of insurance to come into the system to help finance it?

Answer. We do not believe that the current VA health care system can be sustained if eligibility is curbed and the patient population is reduced. The VA health care system is the number one health care system in America because of the broad range of patients that it has seen over the years. Eligibility reform allowed the VA to see patients with all types of disabilities and illnesses. It developed many treatments and techniques, as well as high-tech equipment, through clinical trials with the many veteran patients it has seen.

Likewise, the VA is able to train a large number of physicians only because of the vast number of patients that come to the system. Limiting access only serves to limit the opportunity for physicians to interact with patients. The relationship that VA medical facilities have developed with local medical schools and colleges and universities is essential to the training of professional medical staff. In fact, VA is currently partnered with more than 100 medical schools and more than 1,000 colleges and universities. Each year, about 83,000 health professionals are trained in VA medical centers. More than half of the physicians practicing in the United States had some of their professional education in the VA health care system.

Question 3. This year's Medical and Prosthetics Research budget request actually amounts to a cut of about $13 million in appropriated dollars—which in turn translates to the loss of 286 employees and 96 projects. By VA's own account, this will result in the reduction of projects in areas such as aging, cancer, heart disease research, and traumatic injury. This is yet another year of proposed cuts to VA's Research Program by the President. What are your thoughts on the Administration's vision for the future of VA research? What impact do these continuing assaults on the program have on physician satisfaction and recruitment?

Answer. We are concerned that continued efforts to cut funding for the Medical and Prosthetic Research accounts send the wrong message about the future of these programs. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in comparison to the growth rate of other Federal research initiatives. The Administration's request only serves to further dilute the quality of VA research projects.

One of the primary factors that allow the VA to recruit high-quality physicians is the availability of research opportunities. Clinical research opportunities in the VA health care system are second to none.

We also believe that additional funding needs to be provided for rehabilitation research. The development of new and better techniques allows catastrophically disabled veterans to become more active and independent in society. Furthermore, advanced rehabilitation can only lead to a happier and healthier life for these men and women.

Question 4. As you may know, VA assisted me in attending college after I left military service. I am thankful for my education and the opportunities in life that have been afforded me because of that education. I am concerned that some in military service many not receive benefits that mirror their service commitment. Can you please explain the main nuances of the Total Force MGIB restructuring?

Answer. The Total Force Montgomery GI Bill recognizes that our Nation's Armed Forces today—active duty, National Guard and Reserve—train, deploy, and fight together as one team. But educational benefits for the Guard and Reserve members on the team have not kept pace in proportion to the service they carry out today in defense of our great Nation.

The "main nuances" of the Total Force MGIB include:

1. A clearer alignment of education benefit levels or rates according to service rendered. Since 9/11, National Guard and Reserve GI Bill benefits have dropped sharply compared to active duty rates. When the MGIB was fielded in 1985, reserve benefits paid 47 cents to the dollar of active duty benefits—and, that ratio kept pace until 1999. Then, the rates began to plummet year by year even as tens of thousands of reservists were being sent into harm's way. The reason for this is that when Congress acted to raise active duty GI Bill benefits under Title 38 jurisdiction, no action was taken to adjust the reserve rates (Title 10) in proportion to the active duty program. This disconnect happened because the MGIB is a divided house in statute. The Total Force MGIB proposal seeks to integrate all MGIB programs under Title 38 to ensure that future benefit adjustments can be made in proportion

to the service performed. Any funding to support transferring these programs to Title 38 should come from the Department of Defense.

2. Establishment of a transition or readjustment authority for reserve MGIB benefits earned on Federal active duty in support of a contingency operation. When the greatest generation returned home from World War II it took advantage of educational benefits and training under the historic GI Bill. When mobilized members of the National Guard and Reserve return home today from their deployments they also have earned educational benefits from a grateful Nation under Chapter 1607 of Title 10 (the second reserve MGIB program enacted by Congress in the fiscal year 2005 defense authorization act). But any benefits not used during their service contract are forfeited at separation. For example, a young woman who enlisted in the Hawaii National Guard after high school in 2001 incurs a 6-year service agreement. Let's assume this Guard member was mobilized in June 2005 and will return home from Iraq in September 2006, a fifteen month hitch. She plans to complete her service in June 2007 (six years) and use the $22,334 MGIB benefits (60 percent of the active duty benefit in accordance with Chapter 1607 of Title 10) she earned during her mobilization to attend the University of Hawaii. Unfortunately, under current law, she forfeits all of her mobilization MGIB benefits if she leaves the Guard. The Total Force MGIB proposal would eliminate this unfair feature by establishment of a readjustment/transition feature to benefits earned during a Federal mobilization.

3. Combining the reserve and active duty MGIB programs under "one tent" in the U.S. Code—Title 38; that is, the reserve MGIB programs under DOD's jurisdiction would be joined with the active duty MGIB program managed by the Department of Veterans Affairs under the Veterans Benefits code. The problems identified above are the direct result of programs that are not properly synchronized to accomplish the purposes Congress set out for the MGIB: support for military recruitment and reenlistment, readjustment on completion of service, and increased competitiveness for the Nation's economy. When the MGIB was first enacted during the cold war, national security planners and Congress never envisioned that reservists would be used in every operational mission as they are today. Today the reserves serve as both a strategic and operational force, and they will do so for the foreseeable future. By integrating the MGIB programs under a single structure, benefits can be better aligned to carry out the MGIB's mission of supporting our military force while enabling all our veterans the opportunity to reintegrate in society when their honorable service is completed.

Question 5. The Independent Budget suggests that the VA Schedule for Ratings Disabilities does not provide a compensable evaluation for hearing loss. The Independent Budget asserts that a general principle of disability compensation is that ratings are not offset by artificial restoration because of use of prosthetics. Can you point to other areas in the VA Rating Schedule where ratings are not offset by this artificial restoration?

Answer. Probably the most compelling area of the Schedule that illustrates why compensation should not be offset by the functionality restored by prosthesis is the portion dealing with amputations. For example, a veteran receiving full compensation for amputation of a lower extremity may still be able to ambulate with the aid of a prosthetic limb. It is difficult to imagine that any person with the slightest sense of compassion would suggest that such a heavy sacrifice does not warrant compensation just because advances in medical technology allow the veteran to walk.

Question 6. The Independent Budget calls for VA to establish recruiting programs that will enable VHA to remain competitive for hiring nurses by using private-sector marketing strategies. Can you give some examples of what they could do to become more competitive?

Answer. The serious shortage of nurses in the United States is affecting all sectors of the health arena, both public and private. The private sector has adapted well in the competition for attracting nursing staff from a finite number of nurses in the profession by utilizing a wide variety of incentives to attract and retain staff. An excellent incentive that private health care systems use that the VA could benefit from are extending education benefits to nursing staff. This could be done through an employee scholarship program or similar incentive program.

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

We also believe that the VA should encourage all of its medical facilities to achieve the Magnet status. Magnet designations distinguish health care organiza-

tions that have a proven level of excellence in nursing care. Hospitals that achieve the Magnet status have excellent patient outcomes and higher rates of nurse retention and job satisfaction. The American Nurses Association previously testified to the importance of Magnet designations in recruiting and retaining a high quality nursing staff.

Question 7. Public Law 108–445, the "Department of Veterans Affairs Personnel Enhancement Act of 2004," was intended to reform the pay and performance system used by VA for hiring and retaining its physician and dentists. Can you give us a sense of how well you feel VA has implemented this legislation and if it can and will assist VA in attracting and retaining the best and brightest physicians?

Answer. It is clear that Public Law 108–445 provides for a physician and dentist pay system that adjusts to market conditions without the need for intervening legislation while retaining some of the attractive elements of the civil service-like system that currently exists. Subsequently, two goals were identified to achieve the aforementioned "[T]o provide VA with a system that is appropriately flexible . . . for the recruitment and retention of doctors and dentists to care for veterans," and "physicians and dentists would be assured that their salaries will not be reduced during their service with VA." In addition, recognizing that physicians and dentists are at the "front-lines" of medicine, such that they know what is needed to provide care for veterans, the law requires that practicing physicians have a significant role in making recommendations to the Secretary or his or her designee as to the appropriate levels of salaries paid to members of their professions.

While we recognize the need for pay system enhancements to better recruit and retain VA health care providers, we note that the end product is to provide timely access to quality medical care for our Nation's disabled veterans. In light of recent history wherein VA health care has not been properly funded to meet the demand, we share the growing concern amongst the frontline of VA regarding the ability to provide the funds necessary to maximize the use of the new three tier pay system for physicians and dentists.

According to the Department of Labor, "Physicians and surgeons held about 567,000 jobs in 2004; approximately 1 out of 7 was self-employed and not incorporated. About 60 percent of salaried physicians and surgeons were in office of physicians, and 16 percent were employed by private hospitals. Others practiced in Federal, State, and local governments, including hospitals, colleges, universities, and professional schools; private colleges, universities, and professional schools; and outpatient care centers." We are concerned that the Medical Group Management Association (MGMA) survey data was not utilized in the recommended physician and dentist pay group and rate changes for the new pay system. Understanding that the MGMA represents a very different employment setting than VHA and that it is based solely on private practice income, VA's recruitment and retention initiative is not insulated against private practice and is subject to market forces captured in large part by the MGMA survey.

Another cause for concern is obvious disregard of the Committee's explicit instruction for stakeholder input from VHA frontline personnel and transparency of the process in the making of the new pay system; particularly with the various committees and the compensation pay panel charged with making recommendations to the Secretary as to the appropriate levels of salaries. We also note that a number of professional associations and employee representatives were excluded from these deliberations. Therefore, we are greatly concerned about the impact this new pay system will have on frontline employees having been left out of the process, and the subsequent effect on prospective VA health care providers.

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