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VIEWS OF VETERANS' SERVICE ORGANIZATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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VIEWS OF VETERANS' SERVICE ORGANIZATIONS

THURSDAY, MARCH 18, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 8:32 a.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Souder, Mica, Terry, Blagojevich, and Sanders.

Staff present: Lawrence J. Halloran, staff director and counsel; Robert Newman and Marcia Sayer, professional staff members; Jonathan Wharton, clerk; David Rapallo, minority counsel; and Earley Green, minority staff assistant.

Mr. SHAYS. We are going to call this hearing to order.

Good morning. Our early start today is one measure of the importance the subcommittee places on the views of national veterans' service organizations. Before the crush of meetings and votes overtakes the day, and before our agenda fills for the year, we feel it is essential to hear from those who served in our country's armed forces and whose daily mission is to help others who did the same.

In previous hearings, the General Accounting Office, the Inspector General, and representatives from the Department of Veterans Affairs described the many challenges confronting a department managing a $43 billion in health, compensation, and other benefit programs for more than 25 million veterans and their families. They mentioned chronic claim processing delays, uncertain healthcare quality protections, inaccurate data systems, and budget inequities within and between regions.

Our witnesses today bring a unique perspective to these issues. They risked their lives and helped make the United States of America the great Nation it is today. It is a perspective which provided invaluable to our work and the Gulf war veterans' illnesses, and one I know will inform and improve our continuing VA in Defense Department oversight.

Welcome to all of you, and we look forward to your testimony.

What I would like to do is to invite my colleague, Robert Filner, from California—he serves on the Veterans Affairs Committee and is, I believe, the ranking member—the Benefits Subcommittee, an important subcommittee for the issues we are dealing with, so I would like to invite him to make a statement.

Then I am going to swear you in, and then we are going to hear from you all.

Mr. FILNER. Thank you, Mr. Chairman, and I do appreciate your courtesy to allow a Member of the minority to have a quick statement. I would like to submit my full statement for the record. Second, I want to thank you for all your work in the last Congress, and in the coming Congress, on the Persian Gulf war illness. You have brought us, more than anyone, closer to the truth on this issue. We still have a ways to go, but I appreciate your courage and your leadership on this issue. Last, your oversight on this issue is very important. You will hear from organizations who have put together, not only a budget guideline for us to go by, but, of course, their lifelong commitment and their organizations' commitment to veterans is unquestioned, so when they speak, it is good for us to listen. I thank you for providing the forum for them.

Most of the organizations—I think all the organizations before you—have endorsed what is called the Independent Budget for the Year 2000, and several played a role in putting that budget together. What their budget provided in a very succinct, professional, and convincing manner, what do we need to make sure that we fulfill our contract with our Nation's veterans?" They concluded that the President's budget was woefully inadequate, that approximately $3 billion more was needed just to keep even with the present budget. Many of us on the Veterans Affairs' Committee agreed with them. The budget, as submitted by the President, left the VA healthcare system drastically underfunded, in danger of actual collapse. The budget for the GI bill is far short of realistic needs and failing as a readjustment benefit and as a recruitment incentive. Desperately needed staffing increases included in the budget appear to be phony, little more than "shell games." The National Cemetery system has been underfunded for years, and the money needed for the most basic repairs and upkeep is unavailable.

These are drastic problems. This is no way to treat those who have made sure that we have a country that is worthy of defense. Veterans have been wronged by this budget, and now it is time for Congress to right that wrong.

We need, Mr. Chairman, to unite as a Congress, to unite as both parties, to unite with these organizations, to make sure an adequate budget is passed by this Congress.

I think I use a dirty word here, but the "caps," with respect to Veterans Affairs, have to be broken. There is no way that we can do justice if we are going to stay within the caps that were given to us. There is an urgency and frustration in the budget and in the testimony of these gentlemen in front of you that I have not heard before.

They are telling us that they have done more than their fair share to balance our budget, and now they expect us to be their advocates. They are reminding us that America is safe and free only because of the hardships and sacrifices that they have suffered.

Let me just read you one statement, Mr. Chairman, from the independent budget.

As the administration and Congress develop budgets and policies for the new millennium, we urge them to look up from their balance sheets and into the faces of the men and women who risked their lives to defend our country. We ask them to consider the human consequences of inadequate budgets and benefits denials for those who answered the call to military service.

I take that to heart.

They have outlined what is needed for healthcare, the GI bill, the benefits package, for Persian Gulf war veterans, Mr. Chairman. The funding, for example, in the budget that was both presented by the President and most likely will come out of Congress as it exists now, does not adequately fund the legislation for Persian Gulf war veterans that you put forward and was passed by the House and the Senate last year. Without that money, the VA system will not be able to absorb the additional Persian Gulf war veterans who will be eligible for healthcare under the new law that you led the fight for.

So we have a lot of work to do. I appreciate your kindness and courtesy, your courage, your leadership, Mr. Chairman. We have to do right by these veterans.

[The prepared statement of Hon. Bob Filner follows:]

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STATEMENT OF CONGRESSMAN BOB FILNER

before the

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS

COMMITTEE ON GOVERNMENT REFORM

March 18, 1999

MR. FILNER: Chairman Shays and Members of this Committee, I thank you for this opportunity to present an opening statement about the needs of our nation's veterans and the role of the budget that Congress will soon pass in addressing these needs.

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We are all aware that the Administration's Fiscal Year 2000 budget for veterans is completely unacceptable. For example, the VA health care system is drastically underfunded and in danger of actual collapse. The budget for the GI Bill is far short of realistic needs and failing as a readjustment benefit and as a recruitment incentive. Desperately needed staffing increases included in this budget appear to be phony--little more than transparent shell games. The National Cemetery System has been underfunded for years, and the money needed for the most basic repairs and upkeep is unavailable. These are drastic problems and they demand serious, substantial solutions! Veterans have been wronged by this budget, and it is the responsibility of Congress to right that wrong.

For many, many years, America's veterans have been good soldiers. They have done their duty and been conscientious, responsible citizens. Every time the Veterans' Affairs Committee was handed a reconciliation target, it met that target. Billions of veterans' dollars have been handed over in order to balance the budget

and eliminate the deficit. Time and time again, America's veterans answered their nation's call. The country needed their support, and America's veterans gave all that they could give.

Well, the budget deficit has been eliminated. That battle has been won. I believe that this year, it is time for America's veterans to come first. We, as a nation, owe them that.

I have listened closely to the testimony of the many veterans' service organizations as they have come to Washington to appear before the House and Senate Veterans' Affairs Committees over the past few weeks--and this Committee will hear today from several representatives of national veterans service organizations about their views on this budget.

I have also carefully studied the Independent Budget for Fiscal Year 2000, a

comprehensive policy document created by veterans for veterans and endorsed by over 50 veterans' service organizations. In this testimony and in the Independent Budget, I sense an urgency and frustration and even anger that I've not heard before. America's veterans are telling us that they have done more than their fair share--and now they expect us to be their advocates. They are reminding us that America is safe and free only because of the generations of men and women who willingly endured the hardships and sacrifices required to preserve our liberty.

As I read the Independent Budget, I was struck by this powerful statement that I would like to share with you. The signers of the Independent Budget said, "As the Administration and Congress develop budgets and policies for the new millennium, we urge them to look up from their balance sheets and into the faces of the men and women who risked their lives to defend our country. We ask them to consider the human consequences of inadequate budgets and benefit denials for those who answered the call to military service."

I took this to heart! Because, as I said earlier, the Administration budget of $43.6 billion is completely unacceptable, the Democrats on the Veterans' Affairs Committee developed a proposal, derived from the Independent Budget, that would add over $3 billion to the Administration proposal and $1.3 billion more than was proposed in the "views and estimates" prepared by the Majority of the Veterans' Affairs Committee and sent to the Budget Committee.

I would like to highlight just a few of the needs that the Democratic alternative addresses:

Health Care -- we need more funds to reverse the trend of decimating psychiatric, substance abuse and other mental health problems. We need to increase long-term care to increase the options for our growing population of elderly veterans. We need to eliminate the practice of discharging veterans who are Alzheimer's patients! New health care initiatives for veterans suffering from Hepatitis C-

related illnesses have been proposed, with no new dollars to pay for them.

Montgomery GI Bill -- we need a serious enhancement of the Montgomery GI Bill in order for it to be an effective recruiting incentive for our Armed Forces.

Veterans Benefits -- although improvements have been made, we need to continue to reduce an unacceptable case backlog that still exists in processing veterans' disability compensation claims, and we need to increase the quality of this process in order to reduce the number of appeals.

Persian Gulf Veterans -- we need adequate funding for health care in order to implement the legislation that Congress passed last year, Public Law 105-277. Without more money, our already overburdened VA health care system will be unable to absorb the additional Persian Gulf War veterans who will be eligible for health care under the new law.

Filipino World War II Veterans -- we need to include in the Congressional budget the recommendation by the President that would increase the service-connected disability compensation of Filipino World War II veterans who are U.S. citizens and living in the United States. Even though they were drafted into service by President Roosevelt, they are currently being paid half of what their American counterparts in the war receive.

Remember, the Administration's budget is simply a suggestion to Congress. It is the duty of Congress to pass the budget--and it is in our power to pass a budget that is truly responsible. To do so, we must lift the VA budget cap in order to provide a budget that is worthy of our veterans. The United States and the freedom our country represents around the world have persisted and flourished because of the sacrifices of our veterans. We must remember the faces of the men and women who made those sacrifices as we vote on the budget for veterans.

Mr. SHAYS. Thank you, Congressman Filner. Let me just say, this is—I never think of this as a majority or minority. You are an equal partner in this process and have been very helpful, and I really thank you for being here.

Mr. Blagojevich is on his way and just wants to make sure that we get started.

So I am going to introduce our witnesses. Mr. Steve Robertson, director, National Legislative Commission, the American Legion; Mr. Dennis Cullinan, director, Legislative Services, Veterans of Foreign Wars; Mr. David Woodbury, national service director, AMVETS; Mr. Rich Wannemacher, Jr., associate national legislative director, Disabled American Veterans; Mr. Rick Weidman, director of Government Relations, Vietnam Veterans of America; and Mr. Paul Sullivan, executive director, National Gulf War Resource Center.

I would invite our witnesses to stand and we will administer the oath in this committee, and then we will hear your testimony. Thank you.

[Witnesses sworn.]

Mr. SHAYS. For the record, all of our witnesses responded in the affirmative.

It is very nice to have Congressman Terry from the great State of Nebraska. I always love watching them play football among other things.

Mr. TERRY. So do I—[laughter.]

Mr. SHAYS. If we could just start in the manner I called you. And we are going to hear all your testimony. We don't have a light up there. We have a timer here. Let me just tell you our restraints. Our restraint is that technically we are supposed to adjourn by 9:30. We can go on a little beyond, but we are going to be having a top-secret briefing on our defense system and one that they have requested that we not have hearings during that time, but we can run over a little bit.

STATEMENTS OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; DENNIS CULLINAN, DIRECTOR, LEGISLATIVE SERVICES, VETERANS OF FOREIGN WARS; DAVID WOODBURY, NATIONAL SERVICE DIRECTOR, AMVETS; RICHARD WANNEMACHER, JR., ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; RICK WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; AND PAUL SULLIVAN, EXECUTIVE DIRECTOR, NATIONAL GULF WAR RESOURCE CENTER

Mr. ROBERTSON. Thank you, Mr. Chairman.

I am going to try to summarize my statement. I would request that my full statement be submitted for the record.

Mr. Chairman.

Mr. SHAYS. Yes?

Mr. ROBERTSON. My full statement be submitted——

Mr. SHAYS. Yes——

Mr. ROBERTSON [continuing]. For the record, and I will try to summarize——

Mr. SHAYS. Yes. I am going to wait until my colleague gets here to make sure that we make it official that it will be in the record, but it—[laughter]—will be.

Mr. ROBERTSON. OK, sir.

Mr. SHAYS. Thank you.

Mr. ROBERTSON. I am going to summarize my remarks so that we can open up the discussion for dialog.

The last time I took an oath like that, it wound up 20 years of military service, so I get a little edgy when I have to raise my hand.

Mr. Chairman, the American Legion appreciates this opportunity to present testimony on critical issues facing agencies and programs within your jurisdiction.

It is important to remember that the costs of war and peace go on long after the guns are silenced, the treaties are signed, the dead are buried, and the parades are over. It is our service members that take an oath of allegiance to support and defend the Constitution at the risk of personal safety. They endure many hardships and sacrifices to fulfill that promise. What awards and benefits this Nation provides them should reflect its gratitude for dedicated service. Medals and ribbons are appropriate, but do not heal the mental and physical scars of war or make a broken body whole.

Turning to issues of national security, the first area deals with Tricare, DOD's newest version of military healthcare delivery. Mr. Chairman, this single issue represents one of the biggest lies ever told to service members. If you retire from the armed forces, you and your dependents will receive medical care from the military, at no cost, for the rest of your lives.

In 1973, I was commissioned in the U.S. Air Force. This promise was made to me and, in fact, was a practiced policy. Now, military retirees are allowed to participate in a federally subsidized healthcare program called Tricare. The degree of healthcare coverage military retirees and their dependents receive is based on how much money they are willing to—or in many cases, able to—pay.

As radical as paying for an entitlement seems, they are only allowed to participate in this program until they become Medicare-eligible. Once they become Medicare-eligible, they are ineligible for Tricare. At a point in their lives when demands for quality healthcare are the greatest, they lose the very healthcare system that they have depended on for the vast majority of their adult lives.

The American Legion is not surprised to hear about the recruiting and retention problems of the Armed Forces. After all, your best recruiters are your alumni. Should you decide to hold hearings on Tricare. The American Legion is prepared to participate and offer some workable solutions.

Mr. Chairman, the next issue is concurrent receipt. The American Legion sees this issue as among the greatest inequities in the Federal Government. Under current law, if a military retiree has a VA service-connected disability, the veteran loses $1 of military longevity retirement pay for every VA compensated dollar received.

Military retirees are the only Federal retirees penalized in this manner. Concurrent receipt represents a bean-counter's compensation concept, not the thanks of a grateful Nation.

Turning now to the area of veterans' affairs, I must express the disappointment in the President's budget request for fiscal year 2000 for the VA. The entire veterans' community agrees that it is inadequate. The American Legion supports the Veterans Affairs Committee's views and estimates to add $1.9 billion and hope that Members will demand the budget resolution reflects such an increase.

Although VA funding is not directly under your jurisdiction, there are three funding mechanisms that need your attention: the Medical Care Collection Fund [MCCF], the Veterans Equitable Resource Allocation [VERA], and Medicare Subvention. All three of these programs directly impact veterans' healthcare funding systems. Again, the American Legion would welcome the opportunity to participate in any hearings you hold.

Another issue deals with legislation enacted last Congress to amend title 38 of the United States Code and now denies due process to a small percentage of veterans. Without the benefit of congressional hearings, Congress chose to deny some veterans their right to receive a service-connected disability rating for a medical condition related to their service in the Armed Forces. I can't help but notice the picture of Representative former-Chairman Brooks up there with his cigar in his hand.

The group that I am talking about, the American Legion adamantly opposes the decision to deny a select group of veterans with tobacco-related illnesses their right to receive service-connected disability, should they be able to prove that it is connected with their military service. This needs to be repealed. It was wrong; it was unethical. It was immoral; it was flat wrong to do that.

Another area of great concern is the long-term healthcare for both military retirees, their dependents, and veterans. The long-term care for military retirees, their dependents, and veterans is basically nonexistent. And it is very ironic that today, one of your other subcommittees is holding a hearing on long-term care for Federal employees, and there is nobody from the military there to represent them.

In the area of international relations, the American Legion has two areas of concern—the administration's certification of Vietnam and the Orderly Departure Program.

Thank you, Mr. Chairman, for the opportunity to testify today. I hope that this is just the first of many appearances before your committee.

[The prepared statement of Mr. Robertson follows:]

STATEMENT

BY

STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS' AFFAIRS
AND INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

ON

CRITICAL ISSUES FACING FEDERAL AGENCIES AND PROGRAMS

MARCH 18, 1999

STATEMENT OF
STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS, AND INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES
ON
CRITICAL ISSUES FACING FEDERAL AGENCIES AND PROGRAMS

MARCH 18, 1999

Mr. Chairman and Members of the Subcommittee, The American Legion appreciates this opportunity to present testimony on critical issues facing agencies and programs within your jurisdiction. My remarks are based upon formal resolutions adopted by the members of the American Legion during National Conventions or by the National Executive Committee acting on behalf of our 2.8 million members.

Although I understand the scope of this hearing, I must acknowledge at the outset an issue that pervades the operation of the VA and the military. We are simply underfunded, and have been for years. Now that we're facing surpluses in the federal budget, I would hope that members of this subcommittee will ensure the men and women who served this country in uniform can share in the good fortune earned -- at least in part -- by their sacrifices during darker days.

NATIONAL SECURITY

Tricare. At one time, military retirees and their dependents were eligible for health care in DoD medical facilities, around the world, at no cost, for the rest of their lives. Many servicemembers made career and retirement decisions based on these promises.

Military retirees and their dependents understood that the first priority of DoD health care was to take care of active-duty servicemembers. They accepted taking a "back seat" for medical and dental appointments. However, the evolution of military health care -- a change, like many others, that was driven by budgetary reasons and not the well-being of the patient -- has brought us a system that no one would have created from scratch.

For many years in many hearings, The American Legion has expressed its concerns about the current Tricare system. Specifically,

- We object to annual enrollment fees.
- We object to projected patient out-of-pocket expenses.
- We object to the fact that Medicare eligible retirees were not included in the Tricare program.

- We question whether Tricare Prime would be always available to those who live great distances from DoD medical care facilities or Tricare providers.
- We question the difficulty in forming Tricare networks due to the low fees, and
- We question the quality of health care service provided.

Another factor affecting the health-care of our military retirees is Medicare subvention. A demonstration for DoD was passed in 1997. Six sites were approved for a three-year test, involving 10,000 of the 1.2 million Medicare-eligible military retirees and their Medicare-eligible dependents. Even if Medicare subvention were fully implemented, it is estimated it would still only provide care for an estimated 50-60 percent of eligible military medical beneficiaries.

Also in the works is another test, approved by the FY 1999 National Defense Authorization Act, for demonstration projects to test the enrollment and treatment of over-65 military retirees in the Federal Employee Healthcare Benefits Program (FEHBP).

Despite all this tinkering with their health care, military retirees remain the only group of Federal employees who lose their health care benefits when they become 65 years of age. Yes, they get Medicare when they lose Tricare. But Medicare covers less than Tricare and it often must be supplemented by expensive health care insurance, which many military retirees cannot afford. The average military retiree is an E-6 and not an O-6.

Mr. Chairman, The American Legion believes this critical issue is having an adverse impact on the recruitment and retention of servicemembers in the armed forces. Clearly, the military retirement community believes their country has broken a promise with those who endured the hardships of prolonged military service.

The American Legion is prepared to offer workable solutions to meet the health care needs of military retirees and their dependents who are both Tricare-eligible and Medicare-eligible. The American Legion has developed a plan for VA in the 21st Century called the GI Bill of Health. One aspect of the GI Bill of Health plan would be to encourage DoD and HHS to offer military retirees, Medicare-eligible retirees, and their dependents enrollment in the VA health care network.

Concurrent Receipt. Under current law, if a military retiree has a VA disability, that person loses one dollar of retired pay for each dollar of VA disability compensation. This is probably one of the greatest inequities exercised by the federal government today. Few people know about it or understand it, because it directly impacts such a small percentage of Americans

Let me illustrate the problem of concurrent receipt:

Two young men enlist on the same day, go through the same training schools, the same assignments and are even wounded by the same hand grenade in combat, suffering identical injuries.

That's when their stories diverge. One makes a career of the military, while the other takes a discharge and qualifies for VA disability compensation.

Our career soldier foregoes tax-free VA disability pay for the length of his military career. Our non-retiree can enjoy the fruits of his civilian labors and collect -- if he qualifies -- VA disability compensation.

When our military careerist retires he continues to be treated differently from his boot camp friend with the identical injury. If our retiree applies for VA disability compensation, he will lose one dollar of retired pay for each dollar of VA money. Our non-careerist faces no similar offset, even if he gets a job with the federal government and later retires from federal civil service.

Continuing this comparison one step further, let's remember that our non-careerist gets lifetime coverage under the Federal Employees Health Benefits Program when he retires from federal civil service, while our military retiree loses Tricare when he becomes eligible for Medicare.

Again, Mr. Chairman and Members of the Subcommittee, The American Legion believes this represents another critical issue having an adverse impact on the recruitment and retention of servicemembers in the armed forces. Concurrent receipt represents a "bean-counter's" compensation concept, not the thanks of a grateful Nation.

The American Legion continues to support legislation introduced by Representative Bilirakis to correct this inequity in part or in whole.

Long-term care. The American Legion would also be interested to learn of DoD's strategy for long-term care for military personnel, both active-duty and military retirees, and their dependents. If a servicemember or a military retiree requires long-term care, VA is the likely provider, but what about dependents?

VETERANS AFFAIRS

Mr. Chairman and Members of the Subcommittee, without question, the most critical issue facing the veterans' community is inadequate funding in the President's budget request for FY 2000 for VA. Although this is an issue for the "money" committees, there are elements of this problem that warrant your Subcommittee's attention.

Medical Care Collection Fund (MCCF). Public Law 105-33, the Balanced Budget Act of 1997, established MCCF. For several years, the veterans' community lobbied Congress to allow VA to bill, collect, and retain all third-party reimbursement for treatment of nonservice-connected conditions. The veterans' community believed such a change would allow VA to generate much needed resources to supplement federal appropriations. What we've gotten isn't what we asked for, because much to the disappointment of the entire veterans' community, this law uses third-party reimbursements as an offset in federal funding.

Historically, federal discretionary funding covered the cost of delivering health care to priority veterans as identified in title 38, United States Code. These priority veterans include veterans now in categories 1 through 6. What we now call Category 7 veterans were never guaranteed access to VA health care.

As we see it at The American Legion, the goal is shifting at the VA from treating service-connected veterans, to treating nonservice-connected veterans. VA is now encouraged to solicit nonservice-connected veterans because they are potential payers. This is counter to our long tradition in veterans health care. Service-connected veterans ***must*** remain the top priority of health care services, treatment, and programs in the entire VA arena! This is another example where the "bean-counter's mentality" trumps the thanks of a grateful Nation.

In addition to the estimated revenues from MCCF, The American Legion believes there are still very serious managerial and operational problems with the MCCF program that adversely impact the billing and collection processes. In FY 2001, MCCF is projected to collect nearly a billion dollars. MCCF has never achieved previous goals, yet Congress continues to raise the bar.

Another problem within MCCF is its billing procedures. Put simply, they are incompatible with the private health care industry. Some third-party insurers do not recognize VA as a preferred care provider and feel no obligation to pay for services rendered there. Others do not agree with the billing rates of VA and refuse to pay or they make a nominal payment. MCCF needs to approach their mission in a more business-like manner.

Mr. Chairman and Members of the Subcommittee, The American Legion sees MCCF as a realistic revenue source. But Congress not replace health care dollars for treatment of service-connected veterans with hollow IOU notes based on MCCF.

Veterans Equitable Resource Allocation (VERA). In 1997, VA developed and began implementing this new system to allocate its annual federal health care dollars to the 22 Veterans Integrated Service Networks (VISNs). The major problem with VERA is not so much as how to divide the funding, but the amount of funding available to divide.

Although MCCF makes highly unrealistic estimates of income from non-service-connected veterans, the VERA formula pushes these very people away from VA facilities. The non-service-connected aren't included in the formulas that VERA uses to distribute VA funds.

Mr. Chairman and Members of the Subcommittee, The American Legion agrees that there must be an equitable distribution of resources, but we must avoid a situation where some facilities flourish because they enjoy a better patient mix than others.

Among the questions The American Legion asks for the committee's consideration:

- Do other federal health care agencies have VERA-like formulas for distributing dollars?
- How do VERA's Basic Care and Complex Care allocations rates compare with other federal health care programs?
- Should nonpriority veterans be part of the VERA formula?

- Does VA have a VERA-like formula for making budget requests for discretionary appropriations for Congress?
- Under VERA, can a medical facility ever increase its share or do winners continue to win and losers continue to lose?

Medicare Subvention. Under current law, VA cannot bill the government when it treats Medicare-eligible veterans for conditions unrelated to their military service. Those veterans must make their own arrangements to pay those bills, even though the government would be happy to pay under Medicare if the veterans went to a non-VA facility..

This does not make sense, especially now that more military retirees will be showing up at VA seeking medical care. For years the government has tried to persuade Medicare-eligible Americans to move into managed care programs. VA is a managed care program. It services many Medicare-eligible veterans. It would seem logical to allow a nonservice-connected veteran to choose VA as a managed care provider and for VA to be paid by Medicare.

The logic of the marriage of VA and Medicare is overwhelming. VA has specialized services often needed by veterans, such as, prosthetics rehabilitation, blind rehabilitation, and drug and alcohol rehabilitation. VA has specialized in geriatrics and long-term care. And the $5,000 that the government pays an HMO for the basic care of a Medicare-eligible patient is about half of the $2,857 that VA's VERA formula allots for basic care.

Tobacco Related Illnesses. The 105th Congress amended title 38 of the United States Code to deny denied a small, select group of veterans an earned benefit. This legislation did not originate from the congressional Veterans' Affairs Committees, but rather from the Senate Budget Committee. Once again, budgetary issues, not simple right and wrong or the needs of ill veterans, dictated national policy.

Despite the prevalence of tobacco in our culture and our military service, it wasn't until 1993 that President Clinton and the -then VA Secretary Jesse Brown asked the VA General Counsel to determine if a tobacco-related illness could be a service-connected disability. The VA General Counsel said, Yes it could be. In 1997, the VA General Counsel set three conditions for a service-connected disability rating:

1. The veteran must have a tobacco-related illness; and
2. The veteran must be addicted to nicotine; and
3. The addiction must have existed while on active-duty in the armed forces.

These criteria set a high threshold for determining service-connection, but the rationale is sound. The VA General Counsel's benchmarks are fair and just. Since 1993 until the enactment of Section 1103, title 38, USC, VA has granted less than 10 percent of the tobacco-related illness claims.

Let's remember that until the late 1980s the use of tobacco products was an accepted element of the military culture. The federal government has a long, well-documented history of supplying tobacco products to military servicemembers dating back to 1776. It was not until the 1990s that

the Department of Defense began to actively discourage the use of tobacco products by servicemembers.

What does Section 1103, USC, really do? Strangely enough, it permits recognition of a service-connected disability for a servicemember who uses tobacco products today, develops a tobacco-related illness, and separates because of this medical condition. The key element is the development of a tobacco-related illness now, today, while on active duty,

Not eligible -- because they were healthy when they were discharged -- are the veterans of World War I, World War II, Korea, and Vietnam who were provided free cigarettes in C-rations and squad packs and who never heard of nicotine addiction or the hazards of smoking.

Section 1103, title 38, USC, goes after the those veterans who answered the Nation's call to arms, served honorably, and picked up a bad habit while on active-duty. Many of these veterans, now in their golden years, are just beginning to experience the ravages that long-term tobacco use can produce on the human body..

The enactment of Section 1103, title 38, USC, is a prime example of revisionism in action. Denying access to VA health care to veterans, who became addicted to nicotine while on active-duty and now suffer from tobacco-related illnesses is immoral, unethical, and flat ***WRONG***! Clearly, the federal government and society played influential roles in the use of tobacco-products.

Mr. Chairman and Member of the Subcommittee, The American Legion urges the repeal of Section 1103, title 38, USC.

Persian Gulf War Veterans' Illnesses. Mr. Chairman, The American Legion greatly appreciates your tireless advocacy on behalf of Gulf War veterans. The hearings you held from 1996 to 1998 generated significant momentum to Gulf War veterans' legislation passed by Congress in October 1998.

The most significant unresolved issue regarding Gulf War veterans' illnesses is that there are no medical treatments yet identified that can alleviate the symptoms suffered by some Gulf War veterans. Clinical trials that may identify effective medical treatments have only just begun, and it will likely be several years before their findings result in more effective care for sick Gulf War veterans. Although this issue is now being addressed, it is The American Legion's intention that this delay not occur after our next war. Providing disabled veterans with effective medical treatments should be our first priority after armed conflicts.

Specialized Services. For years a forte of VA has been its specialized services. Unfortunately, these unique services are among the most expensive to operate and are highly vulnerable for termination. These services include blind rehabilitation, spinal cord injury, prosthetics rehabilitation, long-term care, drug and alcohol rehabilitation, PTSD counseling, and others. The Subcommittee may be interested in finding out how many of these specialized services have been terminated nationally. The American Legion believes these programs for the service-connected disabled veterans deserve the highest priorities of funding.

INTERNATIONAL RELATIONS

The Administration's Certification of Vietnam. The American Legion has been -- and continues to be -- critical of this Administration's decision in 1994 to lift the trade embargo with Vietnam, and we strongly oppose any further economic or diplomatic recognition of that country. The American Legion concluded that, without appropriate leverage, it would be difficult if not impossible to gain Vietnam's cooperation to the point necessary to achieve the fullest possible accounting of our missing American servicemembers.

Unquestionably, the unresolved cases of our missing American servicemembers are a constant painful reminder of what should be the single highest priority of this Nation and its government. For many of us, especially the family members and fellow war veterans, there is also a deep personal commitment to bring about the fullest possible accounting of these missing patriots, many of whom gave their last full measure of devotion in our efforts to establish and maintain the principles of freedom and democracy.

The American Legion does not agree with the policy of this Administration with respect to the series of favorable actions it has taken toward Vietnam, absent a good-faith demonstration of increasing unilateral cooperation toward achieving the fullest possible accounting of our POW's and MIA's. Likewise we do not agree with the President's determination "the Socialist Republic of Vietnam is cooperating in good faith with the United States . . . related to achieving the fullest possible accounting for Americans unaccounted for as a result of the Vietnam War," which was certified on March 4, 1999. Vietnam has cooperated with remains recovery activities, but this alone cannot and should not be interpreted as "total cooperation," particularly when Vietnam has been unresponsive to requests for access to archives and records made by officials of this Administration.

The Orderly Departure Program. The American Legion is deeply concerned about the plight of the former United States government employees in Vietnam who have applied for a special program for their resettlement to the United States. The group consists of about 11,000 people, including our former employees and their immediate family members. Six thousand of these cases have been adjudicated and rejected by the Immigration and Naturalization Service, and five thousand cases are still pending, although they signed up for the program many years ago. The Orderly Departure Program, established for the processing of refugees from Vietnam for resettlement in the United States, is fast coming to an end without having resolved the situation of these deserving individuals.

This is unacceptable to The American Legion. These people are former employees who served our government for five years or more, and have suffered greatly as a result of that association. We have a moral obligation to provide assistance to them in emigrating from Vietnam and resettling in this country. They were invited by this government to apply for a special program established in their behalf, and they did so, rather than fleeing by boat as did so many thousands of other Vietnamese.

The American Legion urges in the strongest possible terms, that the Administration take prompt and decisive action to favorably resolve the situation of those who served us in such difficult times, and who have subsequently suffered as a result of their alignment with the United States government.

SUMMARY

As you requested, The American Legion has offered this Subcommittee several recommendations for future oversight hearings. As always, The American Legion looks forward to working with Members of the Subcommittee on all of these critical issues.

Mr. Chairman and Members of the Subcommittee, many of the issues addressed today concern military personnel, military retirees, veterans, and their families. Less than 10 percent of the United States' population are veterans. Even among that small percentage, even less are actual combat veterans. But in the veterans' community, a veteran is a veteran, whether in combat or peacetime. There is one common bond, honorable military service.

Some Members of Congress have questioned the federal government's cost of military and veterans health care. But think about the next Persian Gulf War -- how much would it cost to hire private health care providers to deploy overseas to operate and live in field hospitals close to the theater of operation? The next question is if the "mother of all ground actions" occurs and hundreds of thousands of wounded servicemembers return home, how much will it cost you to put them in private hospitals, or even such medical centers as Walter Reed Army Medical Center or Bethesda Navy Medical Center. What private health care providers will exceed the compassionate care provide by the dedicated VA personnel.

Ask you colleagues about DoD and VA hospital care. Senators Cleland (GA), Inouye (HI), Frist (TN), Hagel (NE), Kerrey (NE), Kerry (MA), McCain (AZ), and Thurmond (SC) can provide you with first hand knowledge. These are excellent systems being forced to make health care decision on a dollar basis rather than on a medical basis. America's veterans and their families deserve so much better.

Everyone is pleased to have a balanced budget, but it was just a few years ago that the Cold War ended. What do you calculate the *peace dividend* amounts to today? Peace dividend is a term we haven't heard much lately. Before we start trying to fix new programs like the Social Security and Medicare, let's go back and fix programs that were earned entitlements; military and veterans health care.

On Veterans' Day, it sure would be easier explaining new, innovative improvements in these systems rather than justifying facility closures and the rationing of health care.

Mr. Chairman and Members of the Subcommittee, that concludes this statement.

Mr. SHAYS. Thank you very much. You covered a lot in 6 minutes. [Laughter.]

Mr. Dennis Cullinan.

Mr. CULLINAN. Thank you very much, Mr. Chairman, and members of the subcommittee and concerned Members of Congress.

On behalf of the men and women of the Veterans of Foreign Wars, I would express our deep appreciation for inviting us to participate in today's important hearing.

Mr. Chairman, in preparation for this hearing, in discussions with your staff, I asked what it was that I should address here today. And it was suggested to me that I should talk about those things that truly trouble us, as an organization, an organization of veterans' advocates—the things that wake us up at 3 a.m.—and those are some of the things that I intend to discuss here today.

Securing sufficient funding for the VA medical care system has now taken on such a note of urgency that if we fail in this regard, its continuing existence as a viable healthcare provider for veterans is very much in doubt. Similarly, inadequate funding continues to undermine the effectiveness of the Veterans Benefits Administration, and veterans are suffering as a consequence.

The administration's proposed fiscal year 2000 budget for the Department of Veterans Affairs would be devastating to our Nation's veterans. If the Congress does not step forward and increase the funding provided for this purpose, VA's ability to provide quality, timely, accessible healthcare for veterans will do irreparable harm.

The VFW hears daily complaints of increasing waiting times for veterans to see a specialty provider, such as an orthopedic doctor or a dermatologist. This is happening throughout the country. More egregious in the specific, however, is the 1-year wait for hip replacement surgery in Ann Arbor, and the 1-year wait for dentures in Maine, and the 1-year wait for dermatology appointments in New Orleans.

Then there is the veteran in Louisiana who is 50 percent service-connected, has a significant skin condition, and cannot get a dermatology appointment for 7 months. A 100 percent service-connected disabled veteran in a private nursing home under VA contract in Rhode Island since Korea for his service-connected condition, was told that VA could no longer afford the cost of keeping him there, and that he could afford to pay for his own care, himself. His removal from the home was only halted through VFW intervention.

A New Jersey veteran in a VA nursing home for 15 years was threatened with expulsion. This was due to cost-driven mission change to eliminate all long-term care. Once again, it was only VFW intervention that prevented him from being thrown out.

These are only a few of the examples of the tragic, nationwide epidemic, an epidemic of increased waiting times and delays in getting appointments which, in these examples, can only be interpreted as a denial of care. And it will get worse, this year and next, because of this proposed budget, if the Congress doesn't act.

Mr. Chairman, you are, of course, familiar with the numbers, the statistics, but this is a situation—this is a human tragedy in the making, a human tragedy that needs to be addressed before more veterans suffer, wrongly and for no good reason.

There are other issues to be addressed—the aging veteran population. As you know, Mr. Chairman, at this point in time, long-term care is not mandated under law and because of cost-driven mission changes like the one I cited just earlier, long-term care capability is being steadily eroded, eliminated from the Department of Veterans Affairs. This, in the face of a rapidly aging population, just at a time when our World War II veterans need such care, the VA's already limited capability is being diminished. This is wrong.

Another area of concern—waiting times to receive treatments in specialty clinics continues to get worse. Calls from veterans have indicated, for instance, more than a 1-year delay to receive dentures in Network 1 and more than a 1-year delay to receive orthopedic surgery in Network 11. We have also seen an increase in the number of calls received about obtaining timely appointments in clinics such as cardiology, dermatology, podiatry, ophthalmology, and a variety of other specialty clinics. Pharmacy waiting times have worsened over the past year. Calls about 1- and 2-hours' waiting times to receiving medications are commonplace. Waiting times are increasing because staff has been reduced, and the outpatient workload has increased. With staffing reductions to take place in the near future, this problem will surely get worse.

And then there are other upcoming challenges; you referenced it briefly earlier. The VA is about to undertake treating veterans suffering from hepatitis C, and they have to do this. This is the only correct and right thing to do, but the money to pay for it isn't there. This can only result in tragedy, if not remedied.

Emergency room care is another issue. Right now, there are veterans who would go for emergency room care—service-connected veterans—who would seek emergency room care outside of VA, and VA won't cover the costs, even if it is for their service-connected problem.

And a newer horizon—you discussed Persian Gulf briefly earlier. Persian Gulf is an issue which has yet to be resolved, although much progress has been made in the right direction. But this augers for future challenges. In this day and age, there are going to be more and more small conflicts. And with these small conflicts, they will have their own particular problems. A tough thing to meet, and the last thing we need is a reduction of funding.

I would also say here, addressing the issue of the caps, the VFW, of course, salutes the action in the Senate Budget Committee the day before yesterday, in providing an additional $1.1 billion in discretionary money for VA. Of course, VA hardly has that money at this point in time, and we only urge that the House follow suit.

In fact——

Mr. SHAYS. Could I ask, is that—you said $1.1 million?

Mr. CULLINAN. Billion.

Mr. SHAYS. Billion; I am sorry—$1.1 billion. But is that above the President's budget or above——

Mr. CULLINAN. That is above the——

Mr. SHAYS. Or above the baseline——

Mr. CULLINAN. Yes, that is above——

Mr. SHAYS [continuing]. That we had last year, or we are in this year?

Mr. CULLINAN. It is above the baseline. It is above the baseline.

Mr. SHAYS. So it is significantly more than——

Mr. CULLINAN. Although——

Mr. SHAYS. Yes.

Mr. CULLINAN [continuing]. In spending authority.

The point I would make here, though, is even more is required. The independent budget has identified the need for about $3.2 billion. Nonetheless, we salute the fact that they took the initiative to go that far, and we ask that the House, now, even go further.

The Veterans Benefit Administration continues to encounter serious problems in its ability to render quality, timely decisions in the adjudication of veterans' claims for benefits, especially those for compensation. Contributing to these problems is the escalating amount of appeals—now slightly over 100,000—to be processed in those offices, primarily in response to the number of remands from the Board of Veterans Appeals.

We are absolutely convinced that inadequate staffing is now the root cause of the Veterans Benefit Administration quality problems. Statistics confirm this supposition. The VBA has gone from 13,856 employees in fiscal year 1992 to approximately 11,200 presently, a 20 percent reduction in less than 6 years.

What is immediately required is an infusion of additional employees to replace normal attrition. And I would add to that that they need to be carefully trained employees who have the inclination and the intellectual wherewithal to undertake that highly rigorous calling.

The "Fiscal Year 1999 Veterans' Independent Budget and Policy" document provides justification for an increase of 500 employees in the compensation and pension service. Congress must now immediately act and provide the necessary appropriated funding to reverse the deleterious employee reduction in VBA, if we hope to have any further success toward achieving the goal of timely and proper claims adjudication for veterans.

Once again, this is not simply a matter of statistics, but it is a human tragedy that needs to be addressed.

Mr. Chairman, and members of the subcommittee, this concludes my written statement. Once again, I will thank you for having included us in this important forum, and I will, of course, be happy to respond to any questions you have.

[The prepared statement of Mr. Cullinan follows:]

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS' AFFAIRS AND INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

CRITICAL ISSUES AFFECTING VA

WASHINGTON, D.C. THURSDAY, MARCH 18, 1999

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars, I would like to express our deep appreciation for you inviting us to participate in this most important hearing. Securing sufficient funding for the VA Medical Care system has now taken on a note of such urgency that if we fail in this regard, its continuing existence as a viable health care provider for veterans will be very much in doubt. Similarly, inadequate funding continues to undermine the effectiveness of the Veterans Benefits Administration and veterans are suffering as a consequence.

First under discussion is the Veterans Health Administration. The Administration's proposed FY 2000 budget for the Department of Veterans Affairs would be devastating to our nation's veterans. If the Congress does not step forward and increase the funding provided for this purpose, VA's ability to provide quality, timely, accessible health care for veterans will be done irreparable harm.

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The VFW hears daily complaints of increased waiting times for veterans to see a specialty provider, such as an Orthopedic Doctor or a Dermatologist. This is happening throughout the country.

More egregious in the specifics, however, is the one-year's wait for hip replacement surgery in Ann Arbor, Michigan, and the one-year's wait for dentures in Maine, and the one-year's wait for a dermatology appointment in New Orleans, Louisiana.

Then there is the veteran in Louisiana who is 50% service-connected, has a significant skin condition, and cannot get a Dermatology appointment for seven months. A 100% service-disabled veteran in a private nursing home under VA contract in Rhode Island since Korea for his service-connected condition was told that VA could no longer afford the cost of keeping him there. He was told he could afford to pay for his own care. His removal from the home was only halted through VFW's intervention.

A New Jersey veteran in a VA nursing home for 15 years was threatened with expulsion. This was due to a cost driven mission change to eliminate all long-term care. Once again, it was only VFW's intervention that prevented him from being thrown out.

These are only a few examples of a tragic nationwide epidemic. An epidemic of increased waiting times and delays in getting appointments which, in these examples, can only be interpreted as a denial of care. And it WILL get worse this year and next because of this proposed budget.

For a fourth year in a row, the health care appropriations is flat lined at just over $17 billion. This provides for absolutely no increase to cover new programs or inflation. Inflation alone will account for nearly $1 billion. The Administration's budget is worse than a flat line budget; it's a "negative growth" budget that threatens the health and well being of veterans.

This funding proposal is an unrealistic and unfair budget that will not meet the needs of America's veterans. It is unfair in that, in the presence of the largest budget surplus in recent history, while other federal agencies will have double-digit increases, veterans are being asked to once again sacrifice what is essentially a negative growth budget -- a budget that indeed threatens the very existence of the veterans health care system.

The Veterans of Foreign Wars recently reached a milestone of assisting over 10,000 individuals in an expanded outreach program. Our 1-800-VFW-1899 Helpline Poster Program was designed to reach out and to assist more of our Nation's veterans. This is in addition to the tens of thousands of veterans, their dependents and survivors, which the VFW assists annually through its national network of service officers.

The VFW Helpline was established in September 1997. Since then it has grown steadily and has served over 11,000 veterans. At the current time, the Helpline receives over 250 calls a week and responds to them within 24 hours. The primary purposes of this program is, first, to assist the individual veteran and second, to collect information to help us assess the impact of the many changes taking place in VA health care and benefits delivery. These changes include the impact the Veterans Equitable Resource Allocation system (VERA) and the budgetary constraints may have on providing quality, timely, accessible health care and delivery of benefits to veterans.

The main source of information comes from our toll free Helpline. We "publicize" the Helpline number monthly in our VFW Magazine, have placed public service announcements in newspapers nationally, and have developed a "Poster" program in cooperation with the VA. This unique opportunity has allowed us to build upon the partnership between the VFW and the VA in serving America's veterans. Thanks to the cooperation of the VA, the VFW has been allowed to place posters in highly visible and permanent locations throughout VA health care facilities.

The toll free number on these posters serves as an additional contact point for veterans to voice their questions, compliments, issues or concerns. Publicity has been critical in increasing awareness of the Helpline. The VFW's Tactical Assessment Center receives the calls that are then assigned to VFW Field Representatives, other National staff, or Department Service Officers as appropriate. The Tactical Assessment Center monitors 57 VA health care issues and 30 VA benefits issues.

We have found that communications between VA health care providers and veteran patients continue to get worse. Veterans complain that their providers do not talk with them and providers tell us that they no longer have enough time to spend with each veteran. Providers are being made to see more patients per hour forcing them to curtail or even eliminate much needed patient consultation. Veterans tell us they are dissatisfied with this type of treatment and they feel it has resulted in a decrease in quality.

Providers must be allowed the discretion to spend as much time as is needed with their patients. It is not acceptable that a veteran leaves a provider's office without a clear understanding of his treatment plan, his medications, and not knowing when the next appointment will be. We believe this connection between what is actually happening and what the providers and veterans feel is best is the result of an inadequate budget forcing management to make health care decisions. Health care decisions must be left to the health care providers. As the effectiveness of operational funds decrease due to a flat line budget, inflation, pay raises, and other unavailable increases in health care, we will surely see this problem get worse.

As the aging veterans population rapidly continues to rise, veterans are more and more likely to require nursing home care. While this need continues to grow, the VA has been closing nursing home beds throughout the country at a rate that, in our opinion, appears indiscriminate. A recent survey of VA facilities found that more than 300 nursing home beds have closed in the Northeast alone and more than 1,000 beds have been closed nationwide in the last two years. It is all too clear that current budget

restraints and the pressure to shift from inpatient to outpatient care are the culprits of these closings.

Calls received, however, indicate an increasing demand for nursing home beds that are being ignored by the VA. A typical call begins, "Can you help me get my husband into the VA nursing home?" Or, "The VA is putting my father out of the nursing home and there is no where for him to go." Or, "The VA threatened to put my grandfather out on the front lawn of the hospital because they do not have a bed for him in the nursing home". Or, "The VA just called and told me to come pick up my husband". Or, "Why can't I get my husband who fought in WWII into the VA. I can't take care of him any more with his Alzheimer's."

Until Congress and the Administration adequately address long-term care, veterans who require nursing home care, and their families, will continue to feel ignored. Until the VA comes out with clear directions on the provision of nursing home care in VA facilities, we will continue to see empty nursing home beds, such as in East Orange, New Jersey. We will also continue to see attempts to eliminate and further restrict nursing home care, both in VA facilities and those provided in the community, as we have seen in Providence, Rhode Island, VAMC; and facility Directors will continue to tell us that they "just can't afford it anymore".

Waiting times to receive treatment in specialty clinics continues to get worse. Calls from veterans have indicated, for instance, more than a one-year's delay to receive dentures in Network 1, and more than a one-year's delay to receive orthopedic surgery in Network 11. We have also seen an increase in the number of calls received about obtaining timely appointments in clinics such as Cardiology, Dermatology, Podiatry, Ophthalmology, and a variety of other specialty clinics.

The implementation to primary care was designed to alleviate the overcrowded conditions in the specialty clinics. This goal has not been realized in all cases. Some facilities, such as West Los Angeles, only have one-third of their veterans enrolled in a

primary care clinic. The vast majority of their veterans are followed in specialty clinics. While the majority of veterans being seen for follow-up appointments in primary care clinics are seen in a timely manner, the same cannot be said for an initial appointment for a physical exam. In some cases veterans are told they will have to wait months for their initial physical. West Palm Beach, Salisbury, and Gainesville, Florida all have six-months' waits for initial physical exams.

Pharmacy waiting times seem to have worsened over the past year. Calls about one and two-hours' waiting times to receive medications are commonplace. Waiting times are increasing because staff has been reduced and the outpatient workload has increased. With staffing reductions due to take place in the future, this problem will surely get worse.

There is a multitude of reasons why this transformation into primary care has slowed down, but they are all the result of inadequate budgeting. We are told that facilities have no more space for additional clinics and they have no money to convert empty inpatient space into clinic areas. Further, there is resistance from physicians in specialty clinics to discharge veterans to primary care; and they have little money to hire additional primary care providers or additional primary care providers are not available for the salary they are offering.

The closing of inpatient beds is also occurring at a faster rate than outpatient clinics can keep up with. The outpatient workload has increased by approximately 5 million visits over the last three years while the inpatient workload has decreased by approximately 125,000.

In the final analysis, years of inadequate funding have led the VA Health Care system to a desperate pass.

The Veterans Benefits Administration continues to encounter serious problems in its ability to render quality, timely decisions in the adjudication of veterans' claims for

benefits, especially those for compensation. Contributing to these problems is the escalating amount of appeals -- now slightly more than 100,000 -- to be processed in those offices, primarily in response to the number of remands from the Board of Veterans Appeals.

Integral to the Under Secretary for Benefits's approach to attack this problem of quality decision-making at the regional office level will be the successful accomplishment of the goals and initiatives espoused in the Veteran Benefits Administration's Business Process Reengineering (BPR) plan submitted as part of the VA's Fiscal Year 1998 budget and, more recently, incorporated in the VA's Strategic Plan. Specifically, it is the vision for fiscal year 2002 to process all claims in an average 60 days, with a 97 percent accuracy rate, and no greater than a 20 percent BVA remand rate.

But, we still have hope for the VA. This optimism resides primarily in the many initiatives the VBA has undertaken to correct both quality and timeliness deficiencies. Three are absolutely critical to us. They are the Post-decision review process (particularly, the Decision Review Officer program); the Pre-discharge Claims Development, Examinations and Ratings program for our active duty military; and the out-basing of rating veterans service representatives in the VA medical centers.

We are absolutely convinced that inadequate staffing is now the root cause of VBA's quality problems. Statistics confirm this supposition. The VBA has gone from 13,856 Full-Time Equivalent Employees (FTEEs) in Fiscal Year 1992 to approximately 11,200 presently, a 20% reduction in less than six years.

What is immediately required is an infusion of additional FTEEs to replace normal attrition. The Fiscal Year 1999 Veterans Independent Budget and Policy provided justification for an increase of 500 FTEEs in the Compensation and Pension Service while maintaining FTEEs at the FY '97 level in VBA's other components (business lines). (Yet, the Administration recommended, and Congress accepted, a further

overall 125 FTE reduction in VBA from the 1998 level as part of the fiscal year 1999 budget proposal.)

The Administration's Fiscal Year 2000 on FTEEs for the VBA is not very good, either. Even though there is a recommendation for an increase in 440 FTEEs for the Compensation and Pension Service, that gain is accompanied by reductions, for example, of 115 in Loan Guaranty and 120 in Information Technology support. Overall, there is only a net gain of 164 FTEEs for all of VBA. Further 100 of the FTEEs reduction in Loan Guaranty will be transferred to the Compensation and Pension Service only upon the acceptance of a contracting-out project. Consequently, most of the 440 increase in FTEEs will probably occur very late in the fiscal year, if at all.

Congress must now immediately act and provide the necessary appropriated funding to reverse this deleterious FTEE reduction in the VBA if we hope to have any further success toward the Business Performance Review (BPR) goals of reduced claims timeliness, improved rating decision quality, and lower BVA remand rate.

Mr. Chairman and members of the subcommittee, this concludes my written statement. Once again I thank you for having included us in this important forum. I will be happy to respond to any written questions you may have. Thank you.

Mr. SHAYS. Thank you very much.

Mr. Woodbury.

Mr. WOODBURY. Mr. Chairman, AMVETS——

Mr. SHAYS. Could you move the mic closer to you, and I think push it down a little bit.

Mr. WOODBURY. OK.

Mr. SHAYS. And it won't stay down. [Laughter.]

Mr. WOODBURY. Can you hear me all right?

Mr. SHAYS. It worked fine.

Mr. WOODBURY. We appreciate the opportunity to join you this morning and provide testimony in support of your oversight responsibilities concerning National Security, Veterans Affairs, and International Relations issues.

Now, Mr. Chairman, at a time in our history when unemployment is approaching record lows, the economy is strong, and, for the first time in several decades, the national debate seems increasingly focused on what to do with budget surpluses, Americans generally may be content with their circumstances. One can reasonably argue that, indeed, times are good. They are, unless you happen to be in the military or a veteran seeking healthcare or other benefits to which you may be legally entitled. From their perspective, they sense that America's gratitude for their service, patriotism, and sacrifice may be a thing of the past.

We believe that, as a matter of urgent priority, your agenda for the 106th Congress ought to embrace the precept that without national security, there can be no long-term Social Security. National security is underwritten by the men and women in uniform today and the veterans who preceded them. Were it not for their selfless, dedicated, and professional commitment to our Nation through military service, the freedoms we enjoy might be significantly diminished. "What have you done for me lately?" seems to be a question many have difficulty answering today. We seem incapable of recognizing that today's military personnel, like the millions of veterans who preceded them, maintain a 24-hour vigil around the world in defense of America's freedoms. Their personal sacrifices today, and throughout our history, seem now to go unnoticed and unappreciated.

We are at peace today, thanks to our historically strong military posture. Yet, even in the absence of war, we have forces positioned around the world ready to respond to national tasking. Whenever this Nation calls, they answer. And yet when they call out for assistance, seemingly very few hear their plea. The message veterans are hearing loud and clear is that they are no longer important—the national agenda has other more vital issues with which to deal.

Mr. Chairman, within the very broad continuum of oversight responsibilities with which your committee is tasked, it seems to us there are several related issues. For example, we do not believe it is coincidental at a time when America is enjoying unprecedented prosperity, that defense preparedness is down, personnel retention within the military is down, and vital programs, keyed to helping those veterans whose sacrifices helped to get us to this preeminent international position continue to receive benign neglect. These trends are troubling. The message to both our active-duty military and veterans alike is that their service, patriotism, and sacrifices

are no longer valued to the degree they once were. We believe this message has to be reversed.

The Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance is now a matter of public record. It discusses a number of key issues affecting both active duty military and veterans which we believe deserve careful review and action from the 106th Congress.

Separately, AMVETS, in partnership with the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars has introduced its Independent Budget for Fiscal Year 2000. It identifies a funding shortfall in the Department of Veterans Affairs budget in excess of $3 billion, compared to the Clinton/Gore fiscal year 2000 submission.

As you are aware, the House Committee on Veterans Affairs recently recommended a $1.9 billion increase to the administration's VA budget, and while we commend Chairman Stump for the leadership and support he continues to provide, this recommendation still leaves us at least $1 billion short of the funds required to sustain VA's programs at an adequate level.

We believe we cannot continue to ignore our responsibilities to provide the support our veterans have earned. We need to fully fund VA at the level required to fulfill its mandate and, continue to hold its leadership accountable for the stewardship of those funds allocated.

The Clinton budgets have historically ignored this commitment. It is time to correct that problem. Failure to do so will result in a continuing downward spiral in VA's ability to deliver quality healthcare and other benefits which veterans have earned and have a right to expect.

Finally, Mr. Chairman, there is the issue of America's national security. We need to pay attention to the lessons of history. Every time we have failed to sustain a strong, capable military, war has been the result. Americans today should be deeply concerned by the news that the military services are losing their people, are failing to achieve their recruiting goals, and are unable to man ships, aircraft, and other weapon systems at acceptable operating standards due to funding shortages.

Considering recent reports that China may now have both the technology and means to deploy nuclear weapons, that the more subtle threat of international terrorism is increasingly possible, and that the threat of chemical and/or biological agents is rising, our way of life continues to be very much at risk.

America may be at peace, but considering events around the world, it is, at best, an uneasy international environment in which we live.

For these reasons, we strongly support recent initiatives to increase DOD funding levels. We need to sustain our investment in national defense. The price is not too great for the value received.

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

[The prepared statement of Mr. Woodbury follows:]

SERVING
WITH
PRIDE

STATEMENT OF

David E. Woodbury
AMVETS National Service Director

for the
House Subcommittee on National Security,
Veterans Affairs and International Relations

Thursday, March 18, 1999
2154 Rayburn House Office Building

A M V E T S

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Mr. Chairman, I am Dave Woodbury, National Service Director for AMVETS. We appreciate the opportunity to join you this morning to provide testimony in support of your oversight responsibilities concerning National Security, Veterans Affairs and International Relations. Neither AMVETS nor I have been the recipient of any federal grants or contracts during fiscal year 1999 or the previous two years.

At a time in our history when unemployment is approaching record lows, the economy is strong, and, for the first time in several decades the national debate seems increasingly focused on what to do with budget surpluses rather than how to deal with deficits, Americans generally may be content with their circumstances. One can reasonably argue that indeed, times are good. They are – unless you happen to be a veteran seeking health care or other benefits to which you may be legally entitled from the various federal agencies tasked with providing them.

We believe that America's commitment to its veterans, codified and consistently reaffirmed by federal statutes throughout our history, is not being satisfied today. Indeed, the perception among America's veteran population is reaching similar conclusions. Increasingly, they sense that "a grateful nation" may not be – that other priorities now consume the nation's consciousness – that veteran's issues are no longer important.

We believe that as a matter of urgent priority, your agenda for the 106th Congress ought to embrace the concept that without national security there can be no long-term social security. Were it not for the dedicated men and women who, through their selfless commitment to military service, continue to underwrite our nation's security interests, the freedom we enjoy might not exist. There is a very clear linkage between the service our men and women in uniform perform around the world and the international economic preeminence we enjoy. The sacrifices made by our military forces today, and the veterans whose legacy they inherited, seem sometimes, to be forgotten. "What have you done for me lately?" seems to be the question many have difficulty answering. We seem incapable of recognizing that today's military personnel, like the millions of veterans who preceded them, maintain a 24 hour vigil around the world in defense of America's interests. Their personal sacrifices today and throughout our history seem to go unnoticed and unappreciated.

The good news is that, thanks to our historically strong military, today we are at peace. Yet, even in the absence of war, we have forces in Bosnia, Somalia, in the Middle East, Europe and Asia, protecting America's national security interests. When the nation calls, they answer. And yet, when they call out for assistance, seemingly very few hear their plea. The message veterans are hearing loud and clear is that they are no longer important – the national agenda has other critical issues with which to deal with.

Mr. Chairman, within the broad continuum of oversight responsibilities with which your committee is tasked, it seems to us there are several common themes. For example, we do not believe it is coincidental that at a time when America is enjoying unprecedented prosperity, that defense preparedness is down, personnel retention within the military is down, and vital programs, keyed to assisting those veterans whose sacrifices and service to our nation have played such a significant role throughout our history, continue to receive benign neglect. These trends are troubling. The message to active duty military and veterans alike is that their service, patriotism and sacrifices are no longer valued to the degree they once were. We believe this message must be reversed.

Your Committee has received the report from the Congressional Commission on Servicemembers and Veterans Transition Assistance. It discusses a number of key issues affecting both active duty military and veterans which we believe deserve careful review and action from the 106th Congress. Their report is now a matter of public record and, in the interest of time, will not be specifically addressed by me this morning.

Separately, AMVETS, in partnership with the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars has recently published its "Independent Budget – Fiscal Year 2000". It identifies a funding shortfall in Department of Veterans' Affairs programs in excess of $3 billion dollars compared to the Clinton/Gore FY 2000 budget submission. As you are aware, the House Committee on Veterans Affairs recently recommended a $1.9 billion increase to the Administration's VA budget and, while we commend Chairman Stump for the leadership and support he continues to provide, this recommendation still leaves us at least $1 billion short of the funds required to sustain VA's programs at an adequate level to care for our veteran population. We cannot continue to ignore our responsibilities to provide the care and support our veterans have earned. We need to fully fund the Department of Veterans Affairs in terms of its

tasking and continue to hold its leadership accountable for the stewardship of those funds allocated for and on behalf of veterans.

Mr. Chairman, we're talking about the men and women we have sent and continue to send into harm's way in support of this nation's security interests. We have told them their service is valued, honored, even cherished – that a grateful nation will never forget their contributions and will indeed care for them in their times of need. However, the Clinton budgets have historically ignored this commitment. Indeed, to a significant degree, so too has Congress.

As a result, the VA's ability to deliver quality health care and other benefits to veterans has been further diminished and will continue to deteriorate unless funding levels are increased. For example, this year we are already seeing the prospects of increased staff layoffs at VA Medical Centers across the nation. The result is devastating to veterans and their families. As a result of inadequate staffing at medical centers, the number of anecdotal reports we are receiving of veterans being seriously injured during in-patient periods is increasing. Several have broken hips, legs, and arms as a result of falls from beds; others have experienced similar injuries just trying to get to the bathroom. With insufficient staff to assist them, some might reasonably argue that our hospitalized veterans are more at risk within the medical centers responsible for their treatment than they are at home.

At a time when VHA is trying to reach out to veterans by expanding accessibility to local clinics, the quality of care is nevertheless diminished due to staff reductions. And, where funding offsets have been required to pay for out reach clinics, VA Medical Centers have taken the hit. For example, acute-care bed capacity has been reduced by 48 percent and staffing by 11 percent at a time when the number of patients treated has increased by 10 percent. Current trends are going in the wrong direction and in the process, quality health care is suffering.

The Veterans Benefit Administration faces similar challenges. It is an organization in transition. Under Secretary Joe Thompson, together with his senior management team, have embarked on an ambitious agenda to fix the benefit claims process so that service to veterans is performed timely, accurately and professionally. VBA is proceeding aggressively in a number of areas ranging from training or re-training its employees to engaging the Veteran Service Organizations in a re-engineered partnership to better serve

veterans. We believe that today, VBA has an exceptional opportunity to achieve the results it seeks. The key, however, will be adequate funding to provide both the personnel and technological innovations necessary.

In the past six years, VBA's work force has diminished by 19 percent. During the same period, its workload has increased by 21 percent. And, at a time when technology allows us to streamline management processes, VBA must still rely on moving paper from one desk to another using antiquated administrative procedures. The challenges which have historically plagued VBA are not insurmountable. We need to allow them to enter the 21st century by fully funding their requirements. Failure to do so simply guarantees failure.

And finally, Mr. Chairman, there is America's national security. There is a complacency in the nation today – the Berlin Wall is gone, the Soviet Union is theoretically no longer a threat, the Warsaw Pact is just a memory. I do not know who told them but many Americans today seem convinced that a strong military is irrelevant today. That perhaps a better utilization of DoD resources would be to shift them to other social programs. We seem incapable of learning from history. We are at peace today because of a strong, well-trained military, supported by a patriotic citizenry and an industrial capacity second to none. If we intend to sustain our level of influence as the dominant industrial and economic power in the world, we need to pay attention to the lessons from history. Every time we have failed to sustain a strong, capable military force war has been the result.

During the Gulf War, Americans saw what a well trained, properly equipped military force is capable of doing. From their homes, they watched the "smart bombs" and missiles perform as they were designed. They watched our military personnel perform with dedication and professionalism. What was not as clearly visible to them was the years of research, development and testing that was the precursor to the introduction of the weapons inventory, command and control systems and intelligence gathering capabilities used in that war. They may have been unaware of the extraordinary efforts within DoD, with congressional support, which produced an all volunteer force capable of executing its assigned tasks.

Americans today should be deeply concerned by the news that the Services are losing their people, are failing to achieve their recruiting goals, and are unable to maintain current ships, aircraft and other weapons systems at

optimal operating standards. And, considering recent reports that China may now have both the technology and means to deploy nuclear weapons, the continued, albeit more subtle threat of international terrorist activity, and the threat of chemical and/or biological agents, our way of life continues to be very much at risk. For these reasons, we strongly support recent initiatives to increase DoD funding levels. We need to sustain our investments in national defense because in the absence of a strong, credible national security posture, we are increasingly at risk. The price is not too great for the value received.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Committee members may have.

Mr. SHAYS. Thank you.

I just want to recognize the presence of our ranking member, Mr. Blagojevich, and, also, Mr. Sanders.

And what we will do is, keep on going and hear our testimony. So, Mr. Wannemacher, you are up.

Mr. WANNEMACHER. Thank you very much, and I want to say that we really appreciate the opportunity to appear here before you. I am pleased to appear before you and present the views of more than 1 million men and women who are disabled veterans from all wars.

On the critical issues facing the Department of Veterans Affairs, many challenges confront VA today, and we appreciate the opportunity to discuss them with you.

One of those challenges is the institution of the appropriate measures to address the unique problems of our Persian Gulf war veterans. Mr. Chairman, you have already devoted a great deal of attention to that effort, and we especially want to take this opportunity to express our appreciation and commend you for your leadership on this issue.

In many ways, VA is an agency in crisis. While some of the problems are complex and difficult to overcome, others are susceptible to relatively straightforward, practical solutions, but have been neglected for various reasons. Whether simple or complex, the problems and their causes, in most instances, are well defined, but the remedies are either held hostage by politics of the Federal budget or depend on the will of VA management to take decisive action.

Unquestionably, insufficient funding must bear a major share of the blame for the current sad state of veterans' programs. Regrettably, as obvious as it is that many of VA's woes are directly or indirectly consequent to degradation of years of inadequate resources, the administration's fiscal year 2000 budget provides no relief. Indeed, the recommended funding for healthcare is so insufficient that it only pushes VA closer to the precipice. That reality has become undeniable. While they are not unanimous in their assessment of the extent of the shortfall, your colleagues on the Veterans Affairs Committee recognize the problem.

With inadequate resources, VA is already rationing healthcare and denying or delaying urgently needed services to a large number of veterans.

If Congress does not substantially increase appropriation for healthcare, VA medical center directors will be forced to do some of the following things—and they will have to do them in Vermont, Connecticut, Nebraska, California, and Illinois: eliminate entire primary care teams; discontinue healthcare for thousands of sick and disabled elderly veterans who are currently enrolled and depend on this healthcare as their only source of healthcare; to terminate or furlough thousands of VA medical care employees across the country; close entire VA medical centers; discontinue contract nursing home care; shut down hospice care units; and discontinue kidney dialysis for service-connected veterans and other eligible veterans.

We also note that VERA has been given a bad name—especially in the Northeast—since its inception. But the more the inadequacy

of the budget, the worse the name is going to become, because all that VERA is, is the distribution system of the budget.

For medical care, the administration has requested a budget authority of $18.1 billion, which includes $17.306 billion for appropriated funds, and then relies on $749 million to be collected for the treatment of non-service-connected medical conditions.

The independent budget, which Congressman Filner so eloquently referred to, is an annual alternative assessment, compiled by the DAV, PVA, AMVETS, and Veterans of Foreign Wars, and we have calculated—as you have just heard from my colleague—a $3 billion deficit. Regardless of that amount of inadequacy, the impact in practical terms is shocking, partly attributed to both the immediate effects of the budget and partly because of the cumulative effects of past budgets that did not provide the resources necessary to maintain the system at the current service levels. For well over a decade, VA has been faced with the dilemma of ever-increasing demand for medical care and perennial inadequate budgets.

VA has never been able to meet its target for third-party reimbursement. In fact, the best year that they did was in 1996 when they received 35 percent of what they had projected. In hearings before the House Veterans Affairs Committee last month, Dr. Garthwaite identified that currently this year, they are not going to meet their budget requests for third-party reimbursement. Now we inflate the projections, and the VA is really going to suffer.

Also suffering is the prosthetics budget, which is frozen again this year at $319 million. This is $56 million below what the IB had recommended and is incorporated in that $3.2 billion budget that the independent budget recommended.

Mr. SHAYS. I am going to ask you to speak maybe for 2 more minutes?

Mr. WANNEMACHER. OK.

Mr. SHAYS. Thanks.

Mr. WANNEMACHER. The budget also reflects that one of the most critical issues facing VA is hepatitis C. The VA estimates that there is $135.7 million in new healthcare spending that will occur in the year 2000. We applaud the administration for taking this step of discovery, however, the budget does not provide any new funding. Given the new challenges and the potential for hepatitis C epidemic represents, there must be a measure of comprehensive process to identify, treat, and educate all veterans who may be at risk for this disease. A registry of infected veterans would permit VA to track outcomes and keep veterans notified of new developments. VA must monitor its facilities and ensure that they follow the proper treatment modalities.

This will conclude my remarks, and I thank you very much for the opportunity.

[The prepared statement of Mr. Wannemacher follows:]

STATEMENT OF
RICHARD A. WANNEMACHER, JR.
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND
INTERNATIONAL RELATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 18, 1999

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you to present the views of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary on critical issues facing the Department of Veterans Affairs (VA). Many challenges confront VA today, and we appreciate the opportunity to discuss them with you.

One of those challenges is the institution of appropriate measures to address the unique problems of our Persian Gulf War veterans. Mr. Chairman, you have already devoted a great deal of attention to that effort, and we especially want to take this opportunity to express our appreciation and commend you for your leadership on that issue.

In many ways, VA is an agency in crisis. While some of the problems are complex and difficult to overcome, others are susceptible to relatively straightforward practical solutions, but have been neglected for various reasons. Whether simple or complex, the problems and their causes, in most instances, are well defined, but the remedies are either held hostage by the politics of the Federal budget or depend on the will of VA management to take decisive action.

PRESIDENT'S FISCAL YEAR 2000 VA BUDGET

Unquestionably, insufficient funding must bear a major share of the blame for the current sad state of veterans' programs. Regrettably, as obvious as it is that many of VA's woes are directly or indirectly consequent to degradation from years of inadequate resources, the Administration's budget for FY 2000 provides no relief. Indeed, the recommended funding for health care is so insufficient that it only pushes VA closer to the precipice. That reality has become undeniable. While they are not unanimous in their assessments of the extent of the shortfall, your colleagues on the Veterans' Affairs Committee recognize the problem well.

For medical care, the Administration has requested budget authority of $18.1 billion, which includes $17.306 billion in appropriations and $749 million from projected insurance collections for the treatment of nonservice-connected conditions. The requested appropriation is

the same as last year, in accordance with the President's 5-year budget plan that calls for no increase for medical care.

The *Independent Budget (IB)*, an annual alternative assessment by the DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW), has calculated the deficiency as $3 billion. Regardless of the dollar amount of the inadequacy, the impact in practical terms is shocking, partly attributable to the immediate effects of the budget and partly because of the cumulative effects of past budgets that did not provide the resources necessary to maintain the system at current service levels. For well over a decade, VA has been faced with the dilemma of ever-increasing demand for medical care and perennially inadequate budgets.

In a memorandum to Veterans Affairs Secretary Togo D. West, Jr., VA Under Secretary for Health, Dr. Kenneth W. Kizer, said the VA faces "the very real prospect of...mandatory employee furloughs, severe curtailment of services or elimination of programs, and possible unnecessary facility closures." During a February 24, 1999, hearing before the Subcommittee on Health of the House Veterans' Affairs Committee on the FY 2000 VA budget, the director of one of the Veterans Integrated Service Networks (VISNs) indicated that furloughs would have to be considered as well as the closure of as many as three facilities within his network if the budget is not increased. Hospital directors privately indicate that they will have to choose between a range of drastic measures if they are required to operate within the constraints of the proposed budget:

- disenroll and discontinue health care for thousands of sick, disabled, and elderly veterans who are currently enrolled for VA medical care and depend on it as their sole source of treatment
- eliminate entire primary care teams
- terminate or furlough thousands of VA medical care employees across the country
- close entire VA medical care facilities
- reduce or discontinue inpatient nursing care
- shut down hospice care units
- discontinue kidney dialysis for service-connected and other eligible veterans

VA's health care system simply cannot continue to fulfill its mission and obligation to meet the health care needs of our Nation's veterans without an infusion of additional funding to save it from collapse. Members from both the majority and minority in the House Veterans' Affairs Committee are openly calling this budget plan a "house of cards" because it promises expanded services and treatment for more veterans without any request for increased funding to cover the costs of that care. The Administration's plan also relies on optimistic projections of collections from insurers for health care funding. However, VA has historically fallen short of projections in its collections from private insurers.

VA has never met its targets for third-party collections—a fact Dr. Garthwaite, VA's Deputy Under Secretary for Health, acknowledged in a April 24, 1999, hearing before the Health Subcommittee of the House Veterans' Affairs Committee. An external review reflected the following: "In Fiscal Year 1996, VHA sought recovery of about $1.6 billion of its costs but only recovered 35% of the billed amount, or $563 million. Not only was this a low dollar amount, it also represented a decrease of more that 5% under the previous year's collections."[1] The report went on to note that, in FY 1997, the MCCR recoveries were $524 million and in FY 1998 to $598 million. This year's target of $625 million is unrealistic. Under the current rate of collections, VA is not likely to achieve this year's level, nor will it achieve the targeted level of $749 million for FY 2000. Under the best case scenario, that is, a collection level based on the successful ratio of 1996, a cost of 34¢ for every dollar collected, VA would be $189 million short of its goal for FY 2000.

The perpetual volatility in the health care marketplace has made it more and more difficult for VA to make its collection quota. It is relatively easy to bill an insurer, but as VA's own numbers show, it is more difficult to collect. This is because a number of factors come into play. Currently, 85% of all insured Americans are under some form of managed care, and few insurers recognize VA as a network provider eligible for reimbursement. Additionally, the shift from inpatient to outpatient care continues to make collections more difficult. Because of the lower reimbursement rate for outpatient visits, VA must collect third-party reimbursement on approximately 20 outpatient bills to produce recoveries equivalent to one inpatient bill.

VA's billing system also exacerbates the collection problem. Although VA is working to change its antiquated billing system, many insurers will continue to deny claims if the claims are not based on actual charges. VA, however, continues to bill according to average costs.

It is important to note that there is no longer any appropriation to guarantee to offset VA collection shortages. If the money is not collected, patients cannot be treated. VA is relying on collection to support its new workload, an expected increase of 54,000 patients in FY 2000. The question that must be asked is where is VA going to get the money to treat these new veterans when it is already hard pressed to take care of its current workload? VA already has a large number of veterans enrolled for medical care that it cannot treat because of limited staff and resources. In addition to this "unmet need," VA is already forced to ration health care among sick veterans to the point that only the most severely ill are hospitalized and others with urgent medical needs wait months for clinic appointments.

To meet budget constraints, VA plans to reduce its staffing level by 7,830 more employees in FY 2000 alone. Such reduction in staff will necessarily result in a reduction in the critical staff to patient ratio. This is particularly troubling because studies have shown a direct correlation between quality of care and patient staffing levels.

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[1] Coopers & Lybrand L.L.P., *VA MCCR National Study: Cost Assessment and Best Practices* 1-1 (Apr. 21, 1998).

The State Nursing Home Grant program is projected to be cut by 55% under the Administration's budget. This is truly a disregard for the Private Ryan's of World War II. Currently, $1.3 billion is needed to fund planned state home construction projects. However, VA will be able to provide only $40 million in grants or less than 3% of the current state need.

VA plans to increase outpatient care by $587 million; this is almost a dollar-for-dollar shift from savings generated by reductions in inpatient care. Although we strongly support the expanded use of outpatient care, it appears that VA is making this shift without the necessary capital investment in such basics as supplies and equipment. In the FY 2000 budget, equipment purchases are reduced by 27% and land and structures by 37%. How can VA adequately support the addition of 89 new outpatient clinics without the necessary investment in the equipment, supplies, structures, and staff? This is another example of attempting to do a lot more with even less than before.

We are very concerned that the Administration's Patient's Bill of Rights excludes some veterans from having access to emergency health care. The Administration's FY 2000 budget discriminates within the veteran population by stating that only compensably disabled veterans should have access to emergency health care, even if your only health care provider is the VA. There are approximately 3.1 million veterans who use VA services. Under this proposal only 940,000 veterans will have emergency services eligibility.

It is ironic that nearly one year ago, the President signed an executive order requiring Medicare, Medicaid, Department of Defense (DoD), the Federal Employees Health Plan, and, we thought the VA, to provide emergency services to all of their enrollees or eligible beneficiaries. This does not appear to be the case. Under this budget, the Administration has excluded 2.1 million veterans and said that they cannot have the same level of services as the other groups. The provision of emergency services is an issue of parity. Through a policy of exclusion from a service considered basic in any health plan, the Administration has put veterans last, not first.

It has been our hope that the VA research budget would parallel the increases projected for the National Institutes of Health (NIH) budget. Over the next 5 years, the NIH budget is expected to double. It is noteworthy that while the research projects are expected to stay at the FY 99 level of slightly over 2,100 projects, there will be almost 100 fewer people to support the various research initiatives. According to the VA, the loss of 98 employees will make the program more efficient. This is a particularly troubling recommendation because not only will there be fewer researchers engaged in actual research, but there will also be significantly less support coming from the medical care budget to support research activities, such as adequate lab facilities, equipment, and supplies. To make a bad story worse, researchers, because of increased patient care responsibilities, have less time to devote to important research efforts to improve the quality of life for veterans. Under the 30-20-10 formula, there are fewer doctors and more patients, consequently the VA research effort has become a casualty of trying to do more with less.

The prosthetic budget has been frozen at this year's level of $319 million. This is $56 million less than the *IB* recommendation. The budget inadequacies will cause the rationing of

prosthetics and durable goods or cause substantial delay in receiving them. During a February 11, 1999, hearing before the House Veterans' Affairs Committee, VISN 10 Director Laura Miller testified that she was facing a $5 million shortfall within the prosthetics account. We are hearing of unacceptable delays veterans experience in obtaining prosthetics. Also, current VA prosthetics policy, based on budget constraints, forces veterans to obtain prosthetics only from vendors willing to provide them at 14% below the amount Medicare will pay for the same prosthetic device or service. We fear that this practice will result in inferior service or quality in the artificial limbs and other prosthetic devices provided to veterans. It is shameful that our Nation's disabled veterans are not provided services at least equal to Medicare beneficiaries.

The budget reflects that one of the most critical issues facing the VA is hepatitis C. The VA estimates that an additional $135.7 million in new health care spending will occur in FY 2000. We applaud the Administration for taking the initial steps in identifying and treating this disease; however, the budget does not provide new funding for the testing and treatment of hepatitis C.

Today, I have only touched on the major health care failings of the FY 2000 budget. I believe that there are countless other examples of the Administration's total lack of commitment to those who served this country in the Armed Forces. The huge staff reductions, coupled with inadequate resources, will cripple the VA's ability to provide high quality services to veterans. It is hard to understand in light of today's robust economy with a large surplus, that this Administration could have such a callous disregard for those who served.

We owe our very existence as a nation to our veterans, and their programs should always be a priority for Federal funding. However, our Nation's veterans are at risk because of the deterioration of the VA health care system due to underfunding. We are concerned that VA will be unable to avert disaster for much longer under such perilous circumstances.

QUALITY OF CARE

Quality is achieved when health care providers are given the freedom and resources to practice the most effective and scientifically proven medicine available. It should also be based on agreement about standards of care and the reduction of variations in practice. An integral part of health care requires the creation of a system that is patient focused coupled with procedures that ensure timely access to appropriate care.

DAV is currently conducting an independent survey of VA medical facilities. We have asked our 189 hospital service coordinators (HSCs) stationed throughout the Nation to provide us with a monthly assessment of appointment scheduling times, scheduled appointment waiting times, and staffing ratios. The survey indicates that the VA's health care system is suffering from the long-term effects of economic asphyxiation. The survey shows veterans are having to wait longer to see a VA health care professional for services, some must wait for months for a specialty clinic appointment.

The delays experienced by veterans are just one indication of how stagnant funding and an increased demand for services are stressing the VA health care system.

We submit that, to fulfill its mission of providing quality, effective medical care to the Nation's veterans, the VA health delivery system must encompass, as a minimum:

- Assurance that health care quality is maintained and protected within the VA health care system;
- Entitlement to guaranteed access to a full continuum of care from preventive through hospice;
- Guaranteed funding through adequate appropriations;
- Fair and equitable distribution of resources in treating the greatest number of veterans having priority to VA health care;
- Provision of clinically necessary medications, supplies, prosthetic devices and other over-the-counter supplies;
- Preservation of VA's mission and role as a provider of special services in areas such as blindness, amputation, aging, mental health, and long-term care;
- Maintain the integrity of an independent health care delivery system as representing the primary responsible entity for the delivery of health care services to entitled veterans;
- Maintain an adequate workforce of highly skilled and trained health care providers who are adequately compensated;
- Maintain a strong veteran-focused research program; and
- Third party reimbursements which includes Medicare Subvention that supplements and does not supplant Congressional appropriations.

Additionally, given the new challenge that a potential hepatitis C epidemic presents, there must be a measurable and comprehensive process to identify, treat, and educate all veterans who may be at risk for this disease. A registry of infected veterans would permit VA to track outcomes and keep veterans notified of new developments. VA must monitor its facilities to ensure that they follow appropriate treatment modalities.

VETERANS EQUITABLE RESOURCE ALLOCATION (VERA) FUNDING

An example of how cost is negatively impacting the delivery of health care is in mental health services. It is our belief that VERA distorts the clinical strategic planning process for

"high cost patients." VERA reimburses facilities at a rate of approximately $38,000 per year per special category veteran (spinal cord injury; serious mental illness; amputation and blind rehabilitation). For the seriously mentally ill (SMI) veteran who is in a long-term care bed, which costs $100,000 or more annually, the facility administrators view the maintenance of these beds as an intrinsically losing proposition. It is not possible to turn over the beds three times a year, which is the VERA break even point, for those veterans who truly need long-term care. Therefore, there is a very strong incentive to close such beds. There are many patients in those beds who really should be in the community, and this is certainly true throughout the United States.

Clinicians may or may not be making all appropriate efforts to develop community support programs for these veterans, but the decisions about the very existence of long-term psychiatric beds are being made by administrators who are driven by the strong fiscal considerations inherent in a capitation model.

There are no known bed-sizing methodologies for long-term SMI needs, so it becomes impossible to point to objective evidence that there are too few beds. We believe, clinical assessment of such needs has become secondary to fiscal assessment and that VERA has caused a rapid deinstitutionalization of SMI veterans. There has been no systematic effort to assess if this is done well or poorly. It may vary from place to place. We hope that VA is not contributing to the well-known trans-institutionalization from hospital to jails, or to homelessness, that some of state efforts have created. For instance, in California, the Los Angeles County jail is now the largest institution for individuals with schizophrenia in the country. Properly done, deinstitutionalization can, in certain cases, dramatically improve veterans' lives, but it requires understanding, timely planning, and reinvestment of a significant portion of inpatient resources into community support efforts. VHA has no idea what the current and near future impact really is. There is no ongoing assessment of reinvestment, and efforts to examine this have been resisted as promoting "special interests." VERA may force funding changes to occur faster than clinical changes can reasonably occur. This is particularly evident in the Northeast, which is being hit hard due to its distribution of long-term medical, nursing home and psychiatric beds. Even with clinical leadership committed to thoughtful and speedy return of institutionalized veterans to community settings, it still takes a significant period of time to do this safely. There is no apparent process in place to assess what the clinical impact is likely to be of staff reductions occurring before beds are actually closed. It is dangerous to push the system to change by decreasing the staffing first.

CONSOLIDATION OF VA AND DOD HEALTH CARE

The Commission of Servicemembers and Veterans Transition Assistance made recommendations to combine VA and DoD health care funding, management, and delivery under one system. Obviously, veterans would not be well served by DoD because their needs would be secondary to weapons systems and institutional priorities of the defense establishment. If the recommendation envisions VA providing DoD's health care services, we note that the VA's

health care delivery system is already suffering from years of inadequate resources and has difficulty just meeting the needs of veterans.

The Commission's most objectionable recommendation was that VA should be able to charge veterans' health insurers for treatment of service-connected disabilities, thus recommending that the Government shift its obligation to the private sector. Throughout our Nation's history, the costs of war and national defense have been the responsibility of the Federal Government. We cannot now, as a matter of Government convenience, merely abandon what is clearly a Government obligation. This would represent a departure from our core national values and is an insult to those who bear the risks and burdens of our national defense.

Another important issue affecting medical care is Medicare Subvention. DAV has historically called for the enactment of legislation for Medicare Reimbursement (Subvention) for the treatment of non-core group (category C) Medicare-eligible veterans.

During the 105th Congress, Representatives William M. Thomas (R-CA) and Bob Stump (R-AZ), introduced H.R. 3828 the "Veterans Medicare Access Improvement Act of 1998."

As we noted at the time, we are concerned about any legislative proposal that would shift responsibility for service-connected veterans' health care away from VA, the agency dedicated to veterans programs only, to another agency that does not have veterans interests as its priority.

The Federal Government, through the VA, must always maintain its fiduciary responsibility and moral obligation to provide and maintain a health care delivery system dedicated to meeting the special needs of this Nation's service-connected disabled veterans. Therefore, enactment of legislation that diminishes and potentially eliminates that responsibility by allowing Medicare to pay for the treatment of service-connected conditions is highly objectionable to DAV.

GULF WAR ILLNESSES

Mr. Chairman, your Subcommittee has done more than any other Committee or Subcommittee in the House or Senate to not only unravel the mysteries surrounding Gulf War illnesses—etiology, treatments, and cure—but to keep our Government from reneging on its promise to care for those veterans who suffer from illness, injury, or disability as a result of their service to their country and to continue its research projects. The members of this Subcommittee have heard first hand from many Gulf War veterans about the problems they experience in accessing VA health care, receiving adequate care, and receiving earned benefits. Therefore, I will not belabor these points other than to say that VA and DoD must do better providing for the needs of sick and disabled Gulf War veterans.

Recently, the DAV participated in a research planning conference conducted by the Centers for Disease Control and Prevention in Atlanta, Georgia. We were very encouraged by the words of Representative Bernard Sanders (I-VT) when he told the researchers to do more

than merely exchange ideas at the Conference and charged them to return home to find answers and solutions to the mysteries surrounding Gulf War illnesses. He encouraged them to look at all possible avenues, including alternative methods of treatment. DAV strongly supports adequate funding for research projects to examine the etiology, treatment and cure of the illnesses affecting Gulf War veterans.

Additionally, we note with concern that legislation, Public Law 105-227, signed into law at the end of the 105th Congress, authorizing the Secretary of Veterans Affairs to enter into agreement with the National Academy of Sciences (NAS) to investigate toxins and illnesses associated with service in the Persian Gulf theater, has not been implemented. This agreement between the VA and the NAS will help the Secretary establish, for the first time, presumptions of service connection for any diagnosed illnesses determined by NAS to have been incurred in or aggravated by active duty in Southwest Asia during the Persian Gulf War. We are concerned about the VA's delay in entering into this agreement in a timely fashion.

Gulf War veterans have waited too long to have their problems adequately addressed by VA, DoD, and other government agencies. Now is the time for VA to move forward with its statutory obligation under Public Law 105-227.

VETERANS BENEFITS ADMINISTRATION (VBA)

The effectiveness of benefits delivery is of primary importance to DAV, an organization whose more than one million members are service-connected disabled veterans. Today, we have more than 25 million living veterans and approximately 44 million family members of living and deceased veterans. Our citizens highly value patriotic service in the Nation's Armed Forces. The depth of their appreciation is revealed in part by the comprehensive benefit programs created to meet the special needs of veterans consequent to that service. To meet this foremost national obligation, we must place the highest priority upon ensuring that these benefits are administered in a way that most effectively fulfills their beneficial purposes. The measure of how well we deliver on our solemn promises is how well we provide these services to our veterans, our most deserving citizens. Certainly, an effective delivery system is essential if these benefits are to serve their intended goals. Undue delay and inaccuracy in eligibility determinations defeat the beneficial purposes of even the most carefully crafted programs. Overall, VBA and many of its dedicated employees dispense a variety of benefits to veterans everyday in a highly professional and effective manner. Unfortunately, for a variety of reasons—some of which I will discuss later—VBA is, at the same time, in some areas falling short in meeting the Nation's commitments to our veterans.

One of VA's three administrations, VBA is responsible for operating the nonmedical benefit programs. The array of benefits and services are designed to address the effects of service-connected disabilities and death, the needs of indigent disabled wartime veterans and their survivors, the various lost opportunities and disadvantages that result from the interruption of civilian life to perform military service, the insurability of veterans against death and disability, and the burial costs of veterans.

VBA furnishes these benefits and services to veterans and their eligible family members or survivors through a nationwide system of field offices. Program direction and control is performed at VA's Central Office (VACO) here in Washington, D.C. Form follows function in VBA's organizational structure. Because the major programs, or "product lines," naturally constitute the fundamental elements of this administration, VBA's organizational structure is built around the operational requirements of these benefit programs. They are (1) compensation, pensions, and related ancillary benefits, (2) vocational rehabilitation, (3) education programs, (4) housing programs, and (5) insurance programs. These business lines are represented in VACO by Compensation and Pension Service (C&P), Vocational Rehabilitation and Counseling Service (VR&C), Education Service, and Loan Guaranty Service. VA's Insurance Service administers its insurance programs at the Insurance Center, collocated with VA's regional office in Philadelphia, Pennsylvania. Until recently, all but Insurance Service had counterpart organizations in essentially all of VA's regional offices. With completion of VA's consolidation initiatives, only C& P and VR& C will be mirrored by full-service operations in the various regional offices. VBA has already consolidated processing of education benefit claims to four Regional Processing Offices (RPOs), housed in VA's Atlanta, Buffalo, Muskogee, and St. Louis regional offices. Loan Guaranty Service is consolidating most of its field operations to nine Regional Loan Centers (RLCs). The education and loan guaranty programs will retain some presence in the regional offices to perform necessary local activities. VBA has recently emulated the Veterans Health Administration's creation of "Veterans Integrated Service Networks" (VISNs) by grouping VBA field offices into nine "Service Delivery Networks" (SDNs). While not an intermediate level of management for the substantive policy aspects of benefit programs, the facilities within a SDN cooperatively manage resources and service delivery to veterans in the geographic area of the SDN.

VBA is headed by VA's Under Secretary for Benefits. In addition to its field office operations and line management, VBA includes various associated staff functions. With its more than 11,000 employees, it is a large, geographically-dispersed organization, with responsibility for diverse benefits and laws.

Insofar as VBA can achieve economies of scale by the consolidation of education claims processing and home loan guaranties without diminishing the level or quality of services to claimants, its streamlining of operations is appropriate. To the extent realignments or consolidations achieve cost savings without tradeoffs in levels of service, they are justified. However, compensation and pension, and vocational rehabilitation and counseling, have innate differences that require direct and local personal service. Similarly, VBA must retain at all of its field operations personnel qualified to provide information and claims filing assistance for all of its benefits. VA's strategic plan appears to recognize the advantages and necessity of personal service because it envisions increasing the number of access points for veterans seeking benefits or claims assistance and puts new and increased emphasis on customer service. VA plans to establish satellite offices with out-based decisionmakers and is in the process of expanding its presence at military separation sites, where it accepts and processes claims for separating servicemembers. Information on veterans' benefits will be more widely available through automated telephone systems and the Internet.

Even more than evidenced by the structural changes of consolidation of some functions and the expansion of others, VBA is an organization in the midst of extensive change as it struggles to improve its performance. After years of doing business by essentially the same methods, widespread customer dissatisfaction, intensified outside scrutiny, and consequent revelations of inefficiency have forced initiation of comprehensive reforms. Nowhere is the source of claimants' frustrations greater, and the proportions of that inefficiency and the VA response to it more evident, than in the compensation and pension claims processes. After it discovered startling deficiencies through an in-depth and candid self-examination, C&P Service arrived at some sobering conclusions about its methods and its proficiency. In response, it developed a multifaceted plan to reengineer its business processes. The success of this Business Process Reengineering (BPR) plan depends heavily on the accomplishment of all of its elements because they are, to a great extent, interdependent.

The core problems VA identified through its study, were already perceived and well understood by many in the veterans' community. We knew, for example, that quality was the major problem—one that immediately adversely impacted on VA claimants who were erroneously deprived of benefits and one that seriously degraded VA's efficiency, and timeliness, by requiring repeat work to properly resolve claims. Several factors were responsible for this lack of quality, most notably: an institutional culture that did not value, or at least did not stress, quality as a foremost goal; management emphasis on quantity over quality, that is, a focus on production and artificial measures of outputs, known as "end products"; quality control criteria that did not accurately reflect accuracy of decisionmaking, adherence to law, and observance of established claims processing procedures; and a lack of accountability for, and mechanisms to enforce, quality. Incidentally, inadequate resources also must be blamed for contributing to the circumstances and environment that led to this situation, and inadequate resources have impeded C&P's ability to implement reforms and overcome the problems.

The solutions set forth in the BPR plan follow logically from the identified deficiencies. All elements of the plan are geared toward the objective of prompt, accurate, courteous, and efficient delivery of benefits.

A redesigned claims process is the centerpiece of the BPR plan. The new integrated claims adjudication procedure replaces a segmented, compartmentalized structure. The long-standing "assembly line" system is not conducive to the type of personalized service and accountability for quality envisioned in the BPR plan. Decisionmakers have little or no direct interaction with claimants, and each employee in the sequential process is concerned only with his or her task and not responsible for the completion of the adjudication or quality of the whole product. Under the redesigned process, a more highly skilled and better trained team performs all activities necessary to complete the adjudication. The team works more closely with the claimant and representative and has ownership of the claim and accountability for its proper handling and disposition. A claimant who disagrees with the decision can have a "second look" by a decision review officer (DRO) who has the authority to change the decision on the existing evidence or upon consideration of new testimonial or documentary evidence. Should the claimant continue to disagree, the DRO will have ensured that the record is properly and

completely developed and that the case is ready for review by the Board of Veterans' Appeals (BVA). Thus, this new system is designed to lead to the discovery of all pertinent evidence, enhance understanding between the claimant and VA, improve quality of the service and accuracy of the decision, and dispose of the claim or allow it to proceed to appellate review in much less time than the previous procedure. To make these adjudicators and DROs more skilled and proficient than adjudicators have been, the plan includes better information technology to assist in claims management and decisionmaking, more extensive training, and certification by testing and demonstrated competence. Quality will be measured more thoroughly.

As acknowledged in Volume 4, "General Operating Expenses," page 2-20, of VA's budget submission for fiscal year (FY) 2000, we cannot expect immediate results from this plan, however. VA having already lost so much ground in its efforts to get control over the large pending workload, it is important to understand that, because of the complexity inherent in compensation and pension determinations, correcting the systemic problems in VA's claims adjudication system is not susceptible to a quick remedy. Unlike most of the other benefit determinations, which involve application of simple, straightforward eligibility criteria, decisions on disability causation and degree require experienced and well-informed judgments that are cognizant of, and properly take into consideration, the many nuances of medical conditions and their implications in the individual cases. Quality cannot be improved and production increased until current decisionmakers are properly indoctrinated and retrained along with the infusion and proper training of substantial numbers of new claims adjudicators. In the short term, that may very well mean that we must tolerate protracted claims processing times, as well as repeat work.

Indeed, VA's timeliness has declined even further recently. VA statistics for the past seven years show that, after increasing from 3,405,413 claims in FY 1992 to 3,450,547 in FY 1993, the volume of C&P claims received has declined each year since FY 1994. In FY 1994, VA received 3,360,654 C&P claims. That number dropped to 2,279,009 in FY 1998. During the same period, the completed workload had decreased, however. The completed workload increased from 3,259,021 claims in FY 1992 to 3,440,154 in FY 1993, but has shown a steady decline in every year since, except FY 1996, and was down to 2,238,221 claims completed in FY 1998. Consequently, the pending workload is again on the rise after having declined for five successive years between FY 1992 and FY 1996. VA reduced its pending C&P workload from 538,135 claims in FY 1992 to 342,683 in FY 1996. Pending claims increased to 398,257 at the end of FY 1997 and 445,582 at the end of FY 1998. Claims are pending for longer times as a result. The percentage of claims pending for more than six months rose from 20% in FY 1996 to 33% in FY 1998. The percentage of claims pending for more than 1 year rose from 11.1% in FY 1996 to 16.4% in FY 1998. The average age of all C&P claims rose from 60 days in FY 1996 to 88 days in FY 1998. Of these, compensation claims requiring rating action took even longer. The average age of original compensation claims grew from 92 days in FY 1996 to 123 days in FY 1998. The average age of reopened compensation claims grew from 83 days in FY 1996 to 128 days in FY 1998. The average number of days to process a claim grew significantly during FY 1998. For original compensation claims, the average grew from 133 days in FY 1997 to 168 days in FY 1998. In January 1999, that average had grown to 205 days. For reopened compensation claims, the average days to process grew from 101 days in FY 1997 to 138 in FY

1998. That average had grown to 170 days in January 1999. These averages also significantly increased for dependency and indemnity compensation (DIC) and pension claims.

Within the C&P claims pending in the regional offices, the number and percentage of cases in an appellate status also continue to grow. At the end of FY 1996, of the 342,683 claims pending, 74,573, or 22%, were in appeals status. At the end of FY 1998, of the 445,582 claims pending, 102,834, or 23%, were in appeals status.

VA projects the number of C&P claims will increase from 2,279,009 in FY 1998 to 2,311,870 in FY 1999. That makes all of these worsening statistics look even more troublesome, despite VA's projection that it will decrease its pending C&P workload from the 445,582 claims pending at the end of FY 1998 to 410,000 by the end of FY 1999.

While we already see the effects of the new quality measures, we do not see significant changes in the quality itself, and perhaps will not until new standards are imposed and enforced. Quality in claims development and decisions will determine the amount of repeat work and percentage of cases in appellate status.

In 1997, VA replaced its Quality Assurance program with its newly developed Systemic Technical Accuracy Review (STAR) program. An initial sample review under STAR, completed in December 1997, revealed a 36% error rate, or 64% accuracy, in rating actions. In November 1998, the accuracy for rating actions was 71.6% in the three SDNs for which the STAR review has been completed. VA's goal for FY 1999 is 75% accuracy. While these accuracy rates might appear shocking, we are encouraged that they represent an effort to be more objective and honest about quality. We believe they are evidence that C&P is working in earnest to assess and correct its problems. We would be much more disturbed if C&P continued to report, as it once consistently did, accuracy of 97% or higher, which was simply not a true measure of quality.

While we recognize that improvements in quality will, for the most part, be delayed until VA implements its training and other initiatives to raise the proficiency of its adjudicators, we believe VA could do more to improve quality now. Part of the quality problem is the institutional mindset and culture of indifference to quality and accuracy that is so widespread in VA field offices. VBA has communicated to its regional office management the depth of the problems, the urgency of the situation, and the change that must take place. We do not believe that message is being communicated, or adequately communicated, to decisionmakers, however. They seem oblivious to VBA's new vision and the necessity to properly apply all pertinent law and strive for technical accuracy. Arbitrariness and recalcitrance remain. Often they seem to lack knowledge or understanding of the law. What is worse, however, is their unwillingness to apply it when brought to their attention by our representatives.

We believe VBA will be unable to effectively enforce accountability by its adjudicators until C&P Service has line authority over them. In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed much of VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action permeates VBA. In turn, field personnel perceived VBA's Central Office staff as incapable of

taking firm action. NAPA said that a number of executives interviewed by its study team indicated VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that, until VBA is willing to deal with this conflict and modify its decentralized management style, it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding C&P especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability. NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability. Until VBA firmly resolves to take the action necessary to bring about a change in attitudes and an end to the intransigence, its other efforts will likely fail to realize their full potential.

Although all of VBA is challenged by the necessity to provide better service with fewer resources, the other services in VBA have not faced difficulties of the magnitude and complexity of those faced by C&P Service. Each of the other services have performed in-depth self-examination as part of the strategic planning process, however. That self-examination and formulation of strategies to meet program missions and goals is an ongoing process, of course. While improvements are certainly possible and necessary, overall, we believe VR&C, Loan Guaranty Service, Education Service, and Insurance Service are doing a commendable job for the Nation's veterans and taxpayers. We continue to watch the general trend toward privatization of many of their activities with some hesitation, however. Lenders and educational institutions can and perhaps should perform a variety of functions such as underwriting and certification, but the nature and amount of responsibilities the Government can properly delegate to private concerns are limited. Eligibility determinations under VA laws must remain a responsibility of the Government. Veterans must continue to have meaningful recourse for erroneous actions and poor service. Appeals and other remedies are available when VA makes mistakes or provides poor service, but veterans and their representatives do not have the same remedies or courses of action when the matter in question is the responsibility of a private entity.

CONCLUSION

We hope that our statement is helpful to you. We appreciate the Subcommittee's interest in these issues and the opportunity to present our views.

Mr. SHAYS. Thank you very much.

Mr. Weidman.

Mr. WEIDMAN. Thank you, Mr. Chairman. We appreciate the opportunity for Vietnam Veterans of America to share some of our concerns with you and your distinguished colleagues here this morning.

I would just second everything my colleagues had to say about the budget.

The budget is so woefully inadequate, one doesn't even know how to comment on the irresponsibility of this administration submitting such a woefully inadequate budget.

I am reminded of a story repeated to me by a wonderful woman who is a national VA voluntary services coordinator for our colleagues at the Jewish war veterans. She told us a story that her father had told her often about adequate funding and resources for whatever it is you are trying to accomplish.

There was a man in his village in Lithuania who decided that, in order to economize, he would feed his horse a little bit less every day. And that way, the horse wouldn't notice. When he got down to one straw a day, the horse died.

It is not too precipitous to say that the VA system is literally being starved to death. You can go to any VA medical center in the country and see the effects of the budget cuts that my colleagues have so eloquently pointed out in some detail.

But I would urge you, not only to go to the VA medical centers in your district, but you can go right up to North Capitol here and try and explain to veterans at the VA medical center here in Washington why it is that we are building an atrium which will not add one whit—not add one whit—to the quality of care or the range of services in medical care available to them. At the same time, VA is cutting back on prosthetics in that hospital, with people unable to get what they need, and at the same time that the rehabilitation staff and physical therapy staff have been reduced by almost 50 percent. This is a tough one. You can try and explain to them it is a different part of the budget, but that is not what the veteran sees. So the need for additional resources is clear and apparent and pressing at this point.

Within the context of these budget cuts it becomes, then, also, a convenient excuse about why they are not doing other things that they should be doing.

Having said that, Vietnam Veterans of America believes strongly that VA needs to make some fundamental changes in how it allocates those dollars, and that begins with a "mind set" of the entire veterans' benefits and services structure. At the VA medical system, in particular, it begins at the front door. When you tell people who are not familiar with this system, that no one asks when you walk through the front door of a VA hospital in detail, "What did you do in the war, Dad? What did you do in the war, Mom?" They are astonished, because they believe that the VA system is there to, in fact, to address the needs of veterans, as veterans. It simply does not happen.

A glaring example of that would be hepatitis C. Another would be the maladies of DU exposure and perhaps heavy-metal poisoning that the Gulf war veterans have suffered through.

What we are advocating here, and what we have talked with Dr. Keyser and Dr. Garthwaite about—and will continue to press—is for VA to be VA. The mission doesn't really change. The means of accomplishing that mission changes, but the mission, from our point of view, is veterans' healthcare and not a general hospital system that happens to be for veterans and "let's see what we can do for those poor old guys and poor old gals." It is a covenant that we made between the people of the United States and the men and women who placed their life and limb on the line in defense of the Constitution of the United States that cannot be—it is that sacred. It is that fundamental to our democracy that we honor that.

But one way of honoring that covenant is to make sure we utilize our resources the best, and that begins with the military history that documents all of the things that one may have been subject to, given the time one served, what era, where one served, what branch of service, and what one actually did. That can be easily, and with virtually no expense, within 3 to 6 months, put on all of the computers and done at intake, as everybody comes into the VA system, to pick up on their neuro-psychiatric problems, to pick up on yellow fever for World War II vets, strongliodies and melioidosis among Vietnam veterans, et cetera.

Why is this important, and what does this have to do with money? We churn people back and forth through this system simply because we do not focus on "wellness," which takes into account the entire human being.

I want to just comment on two other things—or three things—that are productive lines of inquiry that I would suggest that you and your distinguished colleagues, Mr. Chairman, address during the remainder of this year.

The first has to do with the battlefield as a "hazardous workplace." All too often, we have not thought of it that way. That would get into agent orange and other adverse health impacts for those of us who served in Vietnam—but in every battlefield, not just in the Gulf war, but every battlefield in the future, given the exotic weapons, will become more and more a "toxicological" soup. The efforts to understand what we are getting into, and the effect on our troops and personnel, as well as on the civilian populace, is something that we believe DOD has not adequately addressed. And the time to address it is before you deploy the weapons, as well as going back and not deny, deny, obfuscate, for the men and women who have already been exposed.

So we would urge you to follow through with that because, frankly, it doesn't matter whether it is the retinopathies that veterans suffer are due to post-traumatic stress disorder or whether they are due to exposure to agent orange or one of the other chemicals we were exposed to in Vietnam.

Second is the whole area of zeroing in on the Ranch Hand study, in particular. They are differing, widely and dramatically, from their own protocol and the way in which they are carried out; the pace is being deliberately slowed down, we believe, and there are significant issues there where we would be pleased to work with your staff.

And last, but not least, is the issue of studies. I know that your jurisdiction may not cover HHS and others at this point, but it

would be worth zeroing in on "where are research dollars being spent?" The problem for Vietnam veterans is that the alliance and the Ranch Hand study is that it is too small a sample size. We need to initiate other studies that can be turned around relatively quickly, such as following up on the National Vietnam Veterans Readjustment study, et cetera. NIEHS needs to put resources in that.

And last, but not least, in that regard, Mr. Chairman, is take a look at how VA uses its research dollars. The research dollars are not there in order to just to benefit the medical schools, although they may, as a commitment to the primary mission of VA. The research dollars should be there in order to look into and better treat the needs of veterans, as veterans. But very few of those research dollars are being used to deal with agent orange, post-traumatic stress disorder, DU, et cetera, and other kinds of maladies that are specific and particular to veterans, as veterans.

Mr. Chairman, thank you very much for this time. And I look forward to answering any questions you may have, sir.

[The prepared statement of Mr. Weidman follows:]

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

STATEMENT

OF

RICHARD F. WEIDMAN
DIRECTOR OF GOVERNMENT RELATIONS
VIETNAM VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY,
VETERANS AFFAIRS, AND
INTERNATIONAL RELATIONS

2154 RAYBURN HOUSE OFFICE BUILDING
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MARCH 18, 1999

Mr. Chairman, on behalf of Vietnam Veterans of America, I thank you for the opportunity to present testimony here today before you and your distinguished colleagues on this subcommittee.

The challenges facing those of us who are concerned with the health and welfare of veterans of every generation are varied and can seem virtually overwhelming to many veterans. It may be fairly said that the context within which those of us who share this concern, both those of you within the Congress, and those of us who are advocates have perhaps not seemed this daunting in many years.

You asked that we offer comments and thoughts on a number of issues that parallel those issues addressed by the General Accounting Office (GAO) and the Inspector General, and others. We will comment briefly on these issues, in an order which we hope will prove to be of assistance to you and your colleagues.

FY 2000 VA Budget

The Administration's Request for FY 2000 for the Veterans Health Care system was so woefully inadequate that nothing in our collective memory at VA even comes close by comparison. Vietnam Veterans of America (VVA) has expressed deep concern about the leadership of the United States Department of Veterans Affairs in regard to the health care services in the recent past. We have expressed particular concern in regard to the operation of the "Specialized Services" Programs such as treatment for the Blind and Visually Impaired, Spinal Cord Injury, Prosthetics, the program for Seriously, Mentally Ill, and the programs designed to effectively deal with Post Traumatic Stress Disorder and other neuro-psychiatric wounds of war. This VA budget request for FY 2000 only intensifies those deep concerns.

The Veterans Health Administration (VHA), as the system of VA Medical Centers, Outpatient Clinics, Community Care Facilities, and VA Vet Centers is known, is a sprawling and vast collection of sites designed to deliver a multitude of medical treatment and care, and related services. VVA grants that it is difficult to manage such a large system, but we do believe that it is possible to do a much better job than has always been the case in the past, if there are adequate resources available to accomplish the mission. Even if the Congress restores the funding for VHA to a reasonable level, VVA has great concern that the organizational capacity of the VA to properly address Post Traumatic Stress Disorder, Seriously Mentally Ill, and other specialized services is being systematically destroyed under the current decentralized Veterans Integrated Service Network (VISN) system. The mind set and expertise of the clinicians that has made some of these programs most effective is being lost (because the clinicians are being removed), and will be very difficult to replace or restore even should additional funding for this purpose become available in the future. The time to

act to ensure continuity of these services is now.

VVA believes that the central core of the budget problem facing all of us who care deeply about the delivery of quality care to veterans is simply this:

> The VA medical structure is set up to allocate resources utilizing a prospective payment model. However, this prospective payment model is within a closed system. If one puts too few resources into this closed system, the increased competition for resources will start to choke off needed resources to the smaller parts of the system (which has been the case for the past two years, and is certainly the case in FY 1999). If far too few resources are put into the system (as is proposed in the Administration's FY 2000 budget submittal), then the system begins to cannibalize itself in truly major ways, straining the overall system to the point of possible collapse.

Certainly the VA itself recognizes this fact, which we believe is why the VHA reportedly submitted a request to the President's Office of Management & Budget (OMB) that was between $19.4 Billion and $19.6 Billion for FY 2000.

It is now public knowledge that VHA does not have the money to maintain the system as currently configured because of a significant shortfall in operating resources in the current year (FY 1999). VHA has asked for authority to move forward with cutbacks that include closing of facilities and shifting or reducing staff beginning immediately. It is our understanding that approximately forty sites are already authorized for such actions. In the wake of the testimony of Secretary West presenting the request to the full Committee on Veterans Affairs on February 11, it is now common knowledge that VHA requested authority to proceed with planning for additional reductions to deal with a shortfall of at least $1.4 Billion (apparently to be dealt with by what is euphemistically called "management efficiencies") in what was already a system preparing for significant retrenchment.

There have been proposals put forth to add between $1.9 Billion to $3.1 Billion to the request by the President. We hope that the Budget Committee will recognize that at least another $2 to $3 Billion is needed just to keep the current system operable while major meaningful reforms are implemented. Vietnam Veterans of America agrees with those who say that the VA can do a better job of utilizing the funds they do have to accomplish their core mission of "Caring for him (or her) who hath borne the battle, and for his widow and orphans."

First, it has been reported that one of the reasons why OMB reduced the request of VHA is that VHA finished FY 1998 with approximately $600 Million in "savings." We stress that these so called "savings" represent veterans who did not get help for neuro-psychiatric wounds of war and are still an untapped economic resource languishing in public shelters or on the street because there was no effective substance abuse treatment available. These "savings" represent

veterans suffering from Post Traumatic Stress Disorder, rated by the VA at 100% total and permanent disability who can only see a psychiatrist once every four months, for forty minutes (and many others who never get any such treatment at all). These "savings" represent the aged World War II veteran who is denied a motorized wheelchair, even though he no longer has the arm strength to be truly mobile in his hand propelled chair. In short, these "savings" represent legitimate services that could be delivered effectively to veterans (including service connected disabled) that would help them achieve the greatest degree of wellness and autonomy possible.

Vietnam Veterans of America holds that the purpose of the VA medical system is literally what is stated in their motto, which is "To care for he (or she) who hath borne the battle, his widow and his orphan." To accomplish this mission statement, one has to establish a "Veterans Health Care System" that is focused on the needs the individual has as a veteran. One cannot possibly do this effectively if you do not take a complete military history, do a psychosocial work up where indicated, and test for such conditions and illnesses as the individual might well have been exposed because of the era of the military service, branch of service, duty stations (e.g., Vietnam theater of operations), military occupational specialty, etc.

Perhaps the most glaring example of this is Hepatitis C for Vietnam veterans, but there are many more such conditions such as stronglioides and meliodiasis for those who served on the ground in Vietnam, other tropical diseases for World War II veterans who served in the South Pacific, and "workplace hazards" specific to what the veteran did in military service to country, and when and where he or she did it.

This taking of a military and medical history is just plain common sense, and it is also good practice of medicine. It is absolutely necessary if we are committed to a "wellness" model of returning the individual to the highest degree of self sufficiency and autonomy possible. VVA holds that this not only makes sense, it is our duty as a Nation to do this right. Further, we believe that it should be the explicitly stated goal of every veterans program to help the individual become as self sufficient as possible, and to us this means assisting the individual return to a state of readiness where he or she can obtain and sustain meaningful work. This may not be possible to achieve in every instance, but it should be the goal.

All of the medical experts will tell you that if one practices medicine in such a way as to help the person achieve "wellness" as opposed to just performing medical procedures for the immediate complaint reported by the patient, then it results in less overall cost to the system. The studies done at West Los Angeles VA Medical Center in regard to taking a true "holistic" approach would seem to bear out the cost savings that occur within the Fiscal Year alone, never mind the future years.

If the system can be made to systematically concentrate on the needs of veterans as veterans in a rigorously holistic manner, then we will reduce "churning" and prevent many chronic problems

from becoming so acute that repeated and/or prolonged inpatient care is required.

VVA President George C. Duggins and the organization's national officers and Board of Directors have clearly delineated our direction for 1999. The themes of our advocacy reinforce what we have always stood for as an organization: that we tell the truth and act honestly; and that we demand that our government always tell us the truth and that veterans be treated justly and with respect. VVA also demands accountability for the effectiveness as well as the efficiency of each government program charged with helping veterans and their families.

VVA has a set of guidelines we believe every government veterans program should abide by. Each program should have as its goal helping veterans return to the greatest degree possible of self sufficiency or wellness of the whole person. Each program should be making progress toward that goal and should be doing so in the most cost-efficient and cost-effective manner possible.

Dole Commission Study

The report of the Congressional Commission on Service Members and Veterans Transition Assistance, popularly known as the "Dole Commission" Study, was released in January. The report has caused many in the veterans' community, in Congress, and the federal government to re-think how we are doing the job of assisting veterans. The release of the report provides an opportunity and presents a challenge for all of us in the veterans community to take a second look at how we are pursuing our goals.

VVA suggests that it may be time to think a new about the range of veterans programs. We must take care to keep what is working well and not change things simply for the sake of change. However, it may well be time to restructure some services that clearly are not performing well. The call for doing so is reflected in many of the resolutions passed by the 1997 VVA National Convention. That includes resolutions dealing with small-business development assistance for veterans, particularly disabled veterans; the need to inject accountability and private-sector principles of rewarding good performance into employment and training programs for veterans; and changes other vital veterans programs.

Agent Orange

On Feb. 11, the National Academy of Sciences (NAS) released its latest review of the scientific evidence regarding adverse health effects from exposure to Agent Orange and other toxins in Southeast Asia during the Vietnam War. We have known for a long time that the NAS reports are only as good as the reports they review. VVA believes that many more cost-effective, quick turn around studies should be funded by this session of Congress. However, the fact remains that the practical results for veterans of this review by NAS was virtually the same as

its 1996 report.

VVA has joined with the NAS in calling for more and larger studies and for efforts that can be accomplished quickly. The need for oversight hearings on the Ranch Hand Study is even more pressing now. While VVA president George Duggins has expressed our continued faith in NAS, he noted that simple justice demands answers to Agent Orange/dioxin questions before most of us are dead.

The day after the release of the NAS report, Duggins wrote to Secretary of Veterans Affairs Togo West asking the Secretary to join us in pushing for more quality studies, particularly ones that focus on the impact on the health of Vietnam veterans of one or more of the chemicals in Agent Orange, as well as the many other toxins present in our ``work environment'' during the Vietnam War. The NAS report should give us renewed vigor to pursue the introduction and enactment of comprehensive legislation on Agent Orange and the toxic battlefield during the 106th Congress. As noted above, the problem is that the NAS can only review those studies that actually exist, and therein lies the conundrum. The need for a much faster pace of analyzing the data and publishing findings of the "Ranch hand" study is apparent. At least a significant part of the solution would lie in making the raw data available to the general scientific community through the National Institutes of Health immediately. In this manner, independent researchers and university based scientists could perform analyses that would bolster the confidence of Vietnam veterans that we were getting the real truth of the findings and data.

Need for more research studies

While VVA will pursue legislation mandating additional studies, the Subcommittee may wish to pursue why the National Institutes of Health, National Institute of Environmental Health Sciences, the U.S. Department of Veterans affairs and other appropriate Federal entities are not utilizing existing funds and authority to initiate studies of the adverse health impact of Agent Orange and other toxins present on the battlefield of Vietnam and subsequent wars. Many studies can be produced relatively quickly, such as following up on the National Vietnam Veterans Readjustment Study (NVVRS), or doing an analysis of death certificates of Vietnam veterans and their offspring since 1970. There are numerous avenues of research that can and must be pursued if Vietnam veterans are to have answers before more than half of us are dead.

At present, far too much reliance has by default fallen onto the small sample size study of participants in Operation Ranch Hand, which has many problematic aspects, not the least of which is the Air Force investigating itself. While VVA believes that the Ranch Hand study should continue under the Air Force, we strongly urge that the Air Force be made to conform to its own protocol in every way. Among other things, VVA urges that at least three additional scientists nominated by veterans service organizations be added to the civilian oversight "Peer Review"committee, and that the committee be required to meet at least three times per year in order to exercise due diligence in regard to civilian oversight of this study. VVA would be

pleased to work with you and your staff< Mr. Chairman, should you wish to follow up on specifics of this issue.

'Holistic Approach To Veterans In Need'

VVA is committed to work for introduction of and enactment of the "Service Members and Veterans' Self Sufficiency Act." This proposal for legislation calls, among other things, for making mental-health and PTSD services available in all areas of the country and expanding existing drug and alcohol detoxification programs to every VAMC. The bill also calls for substantive changes in the areas of transitional housing and subsidized apartments and a ten-year extension of the Homeless Veteran Reintegration Program.

Agent Orange Legislation

VVA's agenda also includes pressing the urgent case for enactment of the "Comprehensive Agent Orange and Toxic Chemicals Act of 1999." This proposal provides for multifaceted, in-depth research in Vietnam and in this country. Along those lines, VVA also will work to strengthen the Scientific Advisory Group in order to ascertain civilian control of the ongoing Operation Ranch Hand Study. Additionally, VVA will work to ensure scrutiny of the standards imposed for categorization of risk of each disease or condition considered by the NAS in its latest review. There is some concern that the standards imposed on diabetes may have been unduly raised or applied in a manner that was markedly different than the standards imposed on other conditions.

VVA will also continue to press for additional birth defects studies and presumptive connections where indicated, including among Vietnam veterans' children and grandchildren, and for greater responsiveness of programs administered by Health and Human Services. Of particular note is the effort to foster studies that examine the combined effects of two or more of the toxic agents that affected military personnel in Southeast Asia.

"Let Va Health Care System Focus on Veterans Health Care."

VVA will work for introduction and early enactment of the "Veterans Comprehensive Health Care Act of 1999." That proposal would include language that will allow veterans' military histories to be used as a diagnostic tool. It also calls for testing, treatment, and compensation for veterans with Hepatitis C and for implementing a holistic approach in the VA system for the care of PTSD, mental health, and sexual-trauma patients. The act also would set up a former-POW health registry that includes POW health studies and the designation of an ombudsman at each VAMC for former POWs.

Veterans Preference

In the employment and business arenas, VVA will work to strengthen the "Veterans Employment Opportunities Act of 1998," which strengthens the enforcement mechanisms for "veterans' preference" in Federal employment.. Among other things, there is a need to eliminate the targeting of veteran-held jobs during federal workforce reductions and to bolster veterans preference in hiring and retention.

Need For an Accountable System of Veterans Employment And Training Services

VVA has also proposed the "Veteran Family Preservation Act of 1999", sometimes known as veterans' ``one stop'' multi-service center concept. That proposed initiative calls for, among other things, the re-education and training of veterans; an expansion of the Work Therapy Program; and a mandatory DVOP out stationed at each Vet Center, VA Vocational Rehabilitation site, at appropriate community based veterans service provider organizations, and other sites.

Self Employment and Small Business Development

VVA is working closely with Rep. Jim Talent, Senator Bond and others for the creation of the proposed National Veterans Business Development Corporation. Frankly, VVA is puzzled as to why there has not been more responsiveness from the Small Business Administration to attempt to put some substance into the "special consideration" for veterans required under Public Law 93-237, given the seeming real commitment on the part of Administrator Alvarez. We would be pleased to work with you Mr. Chairman, toward any line of inquiry you wish to pursue that would help move Federal agencies to be more responsive to veterans, particularly disabled veterans.

Standardize Dates of Vietnam Era Veterans

VVA will work to secure the enactment of legislation that would extend IRS eligibility dates from the mid-1950s to May 31, 1975, to qualify as an in-country Vietnam veteran and also would modify the inclusive dates for Vietnam-era veterans. As of now, the Internal Revenue Service has a different set of dates for various veterans organizations. On the eve of the twenty fifth anniversary of the Vietnam War, it is time to get this standardized.

POW/MIA

On the POW/MIA front, VVA will work for enactment of legislation that would create a permanent Select Committee on Prisoners of War and Missing In Action in the U.S. House of Representatives. In lieu of the establishment of such a committee or subcommittee in the near term, an oversight hearing by you would be most appreciated.

Veterans Benefits

Vietnam Veterans of America (VVA) strongly believes that it is the right of every veteran to have a compensation system that is uniform, straightforward, and fair, no matter where one currently lives in the country. VVA maintains that veterans have *earned* this right by virtue of their military service.

This claims adjudication system not only must be fair, it must appear to the veteran to be fair. Frankly, there is such a perception of bad history among veterans about VA claims at this point, the VBA must work all the harder at improvement of the system in order to demonstrate that it is fair and equitable.

An element of this perception of fairness is that the system be timely and be open. What we mean by this is that no veteran should have difficulty in discovering the status of his or her claim, or evidence pertaining to that claim. This should be a fairly basic element of any drive for reform or improvement in the system, yet VVA hears of difficulty in discerning such status of receipt of evidence from individual veterans on almost a daily basis. Even more problematic in this regard is the length of time taken to arrive at any decision, no matter what the perception of the quality of that decision might be. Although VBA states that the length of time to adjudicate a claim is now about 128 days, there seems to be some question as to "when this clock starts ticking." From the point of view of an individual veteran, it appears to take much longer that the four months alleged by the VBA.

We would be remiss if we did not also address the "quality assurance" problem, which in lay man terms means that there is a grievous lack of consistency in the substance of decisions from VARO to VARO, and even from adjudicator to adjudicator within the same VARO. It would appear that there are unexplainable variances in the awards for virtually the same circumstances by the same adjudicator. These irrational variances are simply unacceptable, and foster disrespect for the entire process by the veterans subject to this system. It is the responsibility of the Undersecretary and the VA to take all steps necessary to address this key problem of consistency and "quality assurance" at the earliest possible date.

Contact with VBA "Clinically Contra-indicated"

VVA hears not only from veteran advocates outside of VA about perceived problems with the VBA adjudication process, but often from physicians and other health-care providers who render care within the VA structure. These fine clinicians report that problems with timely and accurate adjudication have a negative impact on their efforts to provide proper medical care. There are several aspects to these reports. We note that for many veterans (if not indeed most), one of the primary reasons for seeking service connection for the onset of adverse medical conditions is this is perceived as necessary in order to receive the clinical care the veteran wants and needs. This perception appears to be particularly common among veterans

and care providers to veterans who have need of the specialized services, such as treatment that may involve prosthetics or treatment for neuro-psychiatric conditions, including Post-traumatic Stress Disorder (PTSD).

This perception may, in fact, become a reality of denial of care to veterans, at least for those veterans who are classified as "Category 7," if the Administration's draconian budget request for the Veterans Health Administration is enacted as submitted. Because of these worries, and other factors having to do with the nature of the VBA process, many of the psychologists, psychiatrists, and other mental health counselors tell us that *contact with VBA is virtually contra-indicated clinically* for veterans in treatment and recovery. These contacts with the local VA Regional Office of VBA are so often of such a nature to exacerbate symptomology of Post-traumatic Stress Disorder and other neuro-psychiatric wounds of war. In other words, the veteran in treatment is often significantly set back by contact with the benefits structure. While you and I know that these are two separate and distinct parts of the VA, to the veteran who is a "whole person" it is all VA, and so often disrupts the trust level with the clinician. VA believes that we can and must do better with the handling of claims. We must ensure that the process is both in reality and perception an equitable, consistent, and open process, which is rational and fair on a nationwide basis.

Hepatitis C

Last year, in an effort to determine how well VA is adjudicating hepatitis C claims, VVA reviewed selected Board of Veterans' Appeals (BVA) decisions denying service connection for hepatitis C. (This was the subject of our testimony to this committee last July 16.) What we discovered strongly indicated the need for a statute allowing presumptive service connection for hepatitis C. As reflected by the BVA decisions we discussed, the VA Regional Offices and BVA, and apparently some VA doctors conducting C & P exams, were very uninformed about hepatitis C. This led to wrongful denials, some of which were unfair to the sick veteran claimant.

The premise behind presumptive service connection is that in certain claims, often involving complex, technical scientific issues (such as radiation or dioxin exposure), or certain types of service (such as prisoner of war service), it would be unfair to burden the sick veteran with proving all the elements of service connection. Our analysis of selected BVA cases last year showed the need for a statute allowing presumptive service connection for hepatitis C. Veterans were being wrongfully denied service connection—and therefore health care—because they lacked the funds or the knowledge to obtain a doctor's opinion as to the etiology of their hepatitis C. Congress should help these sick veterans by passing appropriate legislation.

Hepatitis C is most often transmitted through blood, including transfusions and other medical procedures. The BVA decisions showed that some VA adjudicators do not recognize this

medical fact. Hepatitis C has been found to have a latency period of at least 30 years, during which it may show no symptoms at all. The BVA decisions showed that some VA adjudicators do not recognize this either. Lastly, hepatitis C was not identified until the 1980's. A reliable test for hepatitis C was not available until 1991. Again the BVA decisions showed that some VA adjudicators do not understand these facts. In addition to being ignorant about the medical aspects of hepatitis C, VA generally did not offer assistance to a veteran who is not sufficiently educated and wealthy to obtain a medical opinion supporting his claim.

Although VVA was committed to seeing justice done for veterans with hepatitis C, what occurred at VVA's Leadership Conference later in July made the issue "hit home" for the organization's leaders and members. At the conference, 166 veterans took the hepatitis C test, and 19 tested either positive or "inconclusive" for hepatitis C. Among those who tested "inconclusive" was VVA National President George C. Duggins. Fortunately for him, the follow-up tests were negative for the disease. But after all re-testing was done, 14 veterans were found to have hepatitis C. This is an infection rate of 8.4%, compared to the infection rate of 1.8% in the general U.S. population. These findings left no doubt about the fact that hepatitis C was indeed a veterans' epidemic.

Following the VVA Leadership Conference, VVA began meeting with members of Congress and their staffs, pressing the need for hepatitis C legislation. One key question that arose is which veterans would be entitled to the presumption that they were infected during service. The simplest answer was to use the VA's own lists of risk factors for infection, contained in a June 11, 1998 memo from the VA Under Secretary for Health, Dr. Kenneth W. Kizer. The memo ordered the VA medical facilities to conduct a blood test of any veteran with one of 10 listed risk factors.

A basic principle in veterans benefits law is that a veteran cannot get service connected for injuries or diseases resulting from "willful misconduct," such as drunk driving. VVA therefore recommended that the legislation not include intravenous drug or cocaine use, both of which are risk factors for hepatitis C infection. (Cocaine use can cause infection since small amounts of blood from the user's nose can be passed from the straw or tube to anyone sharing them). Although having multiple sexual partners is considered by VA doctors to be a risk factor, the legislation as drafted does not include this factor.

Earlier this year, Senator Olympia J. Snowe (R-ME) introduced legislation (Bill No. S. 71) establishing presumptive service for veterans with hepatitis C. Rep.Vic Snyder (D-AR) introduced identical legislation (Bill No. H.R. 1020) in the House of Representatives last week. The bill was co-sponsored by Representatives Lane Evans (D-IL), Christopher H. Smith (R-NJ), Bob Filner (D-CA), Corrine Brown (D-FL), Julia M. Carson (D-IN), Neil Abercrombie (D-HI), Carolyn McCarthy (D-NY), David Minge (D-MN), and Ronnie Shows (D-MS).

Last fall, Director of VA's Compensation and Pension Service Robert J. Epley issued a memorandum to all VA Regional Offices regarding hepatitis C claims. The main point of the memo was that if a veteran proves that he or she was exposed to one of the known risk factors for hepatitis C infection in service, and now has the hepatitis C virus, his claim is "well grounded." The memo goes on to instruct that since the claim is well grounded, VA will obtain a medical opinion as to whether the veteran was infected in service. (Presumably this is done pursuant to VA's "duty to assist.") If the VA doctor finds that it is "at least as likely as not" that the veteran was infected during service, VA must grant service connection.

While VVA certainly applauds VA for issuing this memo, we believe legislation is still necessary unless and until the Secretary of Veterans Affairs does what should be done, which is to take executive action to declare hepatitis C as presumptively service connected, which he has both the authority and the evidence to accomplish. What is not acceptable is the current situation. First, this memo does not have the force of law (as would a statute or regulation). VA Regional Offices (VARO) may fail to abide by its instructions and the veteran has no right to appeal to BVA based on this failure. The current state of quality assurance within the VBA has been what can only generously described as "uneven at best." Second, even if most or all of the VA Regional Offices follow the memo, VA's doctors may simply not be aware of the current state of knowledge about how hepatitis C is transmitted, leading them to render faulty opinions resulting in unfair denials. Thirdly, the VA will likely be deluged with hepatitis C claims over the next decade. Establishing the presumption by statute will significantly reduce the processing time for these (and therefore other types of) VA claims.

Getting these sick veterans service connected by the VA will give them and their families some money to live on (payments depend on the level of disability) and (paramount to most veterans) access to VA medical treatment. Early detection and treatment of hepatitis C prevents liver disease, which would lower health care expenditures greatly. Most important, it will save veterans lives.

Lack of Consistency of Veterans Benefits Decisions

The VA Regional Offices' (VARO's) implementation of the U.S. Court of Veterans Appeals' (now the U.S. Court of Appeals for Veterans Claims) decisions has generated a great deal of controversy over the years. The Court's Chief Judge, Frank Q. Nebeker, expressed outrage at VA's failure to implement the Court's decisions, in his opening remarks at its 1994 Judicial Conference. It is interesting to note that despite then VA Secretary Jesse Brown's promise at the conference, to improve VA's implementation, Chief Judge Nebeker testified to Congress in April 1997 that VA had made little improvements in implementing the Court's decisions at the VARO level. He made similar remarks at the Court's Judicial Conference this past September.

On a widespread basis, the VARO's continue to fail to follow the Court's decisions. This can be seen from a review of the BVA's FY 1998 statistics, which show that 17% of BVA decisions were reversals (at least of one of the claims appealed) and another 41% were remands (same caveat). The VBA's own quality review statistics (STAR program) reflect many chronic errors which violate Court precedent, such as inadequate medical examinations. VVA believes that one means of improving VARO decision quality would be to allow claimants the right to hire an attorney to represent them in their claim at the VARO, as discussed below.

One part of the solution to the currently unacceptable situation is for Congress to broaden the scope of proceedings before the VA in which veterans can engage attorneys on a fee basis. VVA believes that according veterans the same rights as accused criminals and those seeking Social Security and other Federal benefits will assist in ensuring the quality of the process at the VARO level. The Veterans Judicial Review Act (VJRA) should be modified to encourage the participation of attorneys on a fee basis before the VA at the early stages of the claim process, at least after an initial denial by the VA Regional Office (VARO). Sound policy reasons support such a structural change.

A second and more achievable means of moving the Veterans Benefits Administration toward greater fairness, consistency, and accuracy is to continue to press them by means of Congressional oversight. VVA would note, however, that proper resources to accomplish this mission of "re-inventing" veterans' benefits must be made available in order to achieve this task. We ask that the Chairman and distinguished members of this Subcommittee use your powers of persuasion and leadership to ensure that all key components of VA receive at least $1.9 Billion to $3.1 Billion more than the President's request.

Again, Mr. Chairman, thank you for allowing VVA to present some of our concerns to you here today. I will be happy to answer any questions.

Mr. SHAYS. Thank you very much.

Mr. Sullivan.

Mr. SULLIVAN. Chairman Shays, members of the subcommittee, on behalf of the 56 member organizations of the National Gulf War Resource Center, I appreciate the opportunity to testify today regarding matters important to the Gulf war veteran community.

Mr. Chairman, every day Gulf war veterans are reminded of the fact that the Gulf war rages on in Iraq with 1 million Iraqis dead, plus the fact that another Gulf war rages in the homes of more than 110,000 veterans here in America. More than 1 million United States troops are serving, or have served, in the Gulf war. More than 110,000 of those claim illnesses related to the war. An unexpectedly high number of 235,000 Gulf war veterans have sought healthcare at the Department of Veterans Affairs since 1991.

There are long-term consequences to war, and the war against Iraq is no different—only the many types of new toxic exposures are different. Here is what veterans want to know, Congressmen.

"Why are my family, my friends, and I ill? How, when, and where can I get the right medical treatment for my toxic contamination? Who will cover the costs, especially if the VA healthcare budget is underfunded? Finally, how can we prevent such needless tragedies in the future?"

Due to failures at the Departments of Veterans Affairs and the Department of Defense, Gulf war veterans were given the burden of being forced to show we were ill and to show we were exposed to toxins. Specific evidence—a lot of it revealed by this subcommittee—shows Gulf war veterans are seriously ill at higher rates than non-deployed veterans.

More to the point, according to the Department of Veterans Affairs data, as of January 1, 1999, Gulf war veterans who served in the Gulf region between 1990 and 1991 are 39 percent more likely to have a service-connected disability than those of the era who did not deploy. The future appears ominous, Congressmen. Veterans who served from 1990 to 1991 in the Gulf war are 53 percent more likely to have filed a claim. This may mean many more VA claims are in the pipeline.

The military now admits widespread toxic exposures to depleted uranium, hundreds of thousands; chemical warfare agents, 100,000; oil well fire pollution, hundreds of thousands; pesticides, hundreds of thousands; and military-administered experimental drugs, more than 100,000—plus more poisons.

Mr. Chairman, I will focus on only 4 subjects out of the 15 points listed in our written testimony, and I ask that it be entered into the record.

The first subject that deserves your full attention is the immediate implementation of Public Law 105–277. Mr. Chairman, I am going to digress for a minute—and on behalf of the Gulf war veterans, Congressman Sanders, Congressman Filner, we thank you. That is now the law of the land.

Implementing the Public Law is our top priority for 1999. President Clinton signed the Persian Gulf War Veterans Act of 1998 into law on October 21, 1998. It orders the VA to sign an agreement with the National Academy of Sciences within 60 days to investigate the more than 30 toxins associated with the illnesses and

to study the illnesses more prevalent among Gulf war veterans. The VA has failed to enter into that agreement. The VA's behavior results in delays in new medical research, new treatment programs, new claims filings, timely adjudication of claims, and the granting of service-connection to disabled veterans. In short, no healthcare.

Under-explored areas of toxic research include: depleted uranium, oil well fires, chemical warfare agents, experimental shots and pills, pesticides, and synergistic combinations of these. Areas of more prevalent adverse outcomes among veterans include Lou Gehrig's disease and other neurological disorders, cancers, immunological disorders, reproductive disorders, and birth defects among the children of Gulf war veterans.

On December 8, 1998, the VA asked the Department of Justice to review the new law. On March 12, 1999—Congressmen, I have great news, the Department of Justice advised the VA that Public Law 105–277 is valid and effective. Now the law must be implemented.

We believe the VA must fund outreach about the new law to veterans and those assisting veterans with filing claims. The Resource Center stands ready to assist the VA with that outreach.

The Resource Center is not alone in our support for the new law. The independent budget, endorsed by more than 50 veterans' groups, also calls for the immediate and full implementation of the new law.

The second subject, Mr. Chairman, that merits your immediate attention is the Resource Center's support for funding of private research as well as research by the CDC, VA, and DOD. Three weeks ago Congressman Sanders and 16 Gulf war veterans groups attended the CDC conference in Atlanta. The Resource Center believes that appropriate CDC research should be funded—not discussed—that Gulf war veterans and our advocates should participate in all research review panels, that more conferences should be held, and that Gulf war veterans should be included in future conferences.

Because the Gulf war rages on today in Iraq, with more than 1 million Iraqi dead, the best Government and private-sector research is needed now into the many toxic exposures present in the Gulf. This will improve medical care, improve toxic detection and protection doctrine and training, plus improve the Government's tarnished reputation among Gulf war veterans.

Our third subject that merits your attention is the VA budget. We believe the VA needs $3.2 million more than what was proposed by the administration and $1.3 billion more than what was approved by the House Veterans Affairs Committee.

Since the current economic boom has created a Federal budget surplus, the VA budget cap should be lifted.

Gulf war veterans are deeply concerned about underfunding at the VA. This is because under Public Law 105–277, more than 235,000 Gulf war veterans—out of 1.2 million eligible—are entering an already overburdened VA healthcare system. Flat-lining appropriations during the war, while expenses soar and the number of patients demanding care increases, is a recipe for disaster.

Our fourth subject is that we hope you hold additional hearings on anthrax and depleted uranium.

We understand you announced hearings for March 24 on the experimental anthrax vaccine. Gulf war veterans have a lot of questions about that, and we hope that your hearings will address that.

In conclusion, Mr. Chairman, after legislative victory was declared with the passage of Public Law 105–277, Gulf war veterans thought the VA would get the message and start addressing this issue with vigor. With their delays, it is clear the VA still doesn't get it.

The new law and our efforts on behalf of veterans may all be in vain unless there are ongoing congressional hearings, unless Public Law 105–277 is implemented, unless vigorous, unbiased research is funded, unless the VA has full funding for healthcare, and unless there is extensive outreach to Gulf war veterans.

Finally, the Resource Center strongly believes that research delayed or not funding equals healthcare denied for more than 100,000 sick Gulf war veterans. How long must we wait, twisting in the wind, sick, and dying? How long? How long, Mr. Chairman?

Thank you.

[The prepared statement of Mr. Sullivan follows:]

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Testimony of

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Before the

Committee on Government Reform

Subcommittee on National Security,
Veterans Affairs, and
International Relations

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March 18, 1999

NATIONAL GULF WAR RESOURCE CENTER

Chairman Shays, members of the subcommittee, on behalf of the fifty-six member organizations of the National Gulf War Resource Center, I appreciate this opportunity to testify today regarding matters important to the Gulf War veteran community. Mr. Chairman, every day Gulf War veterans are reminded of that the fact the Gulf War rages in Iraq today plus the fact another Gulf War rages in the homes of more than 110,000 veterans here in America.

More than one million U.S. troops are serving or have served in the Gulf War. More than 110,000 of those claim illnesses related to the Gulf War. An unexpectedly high number of 235,000 Gulf War veterans have sought health care at the Department of Veterans Affairs since 1991.

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(1) Why are my family, my friends, and I ill?
(2) How, when and where can I get the right medical treatment for my toxic contamination?
(3) Who will cover the costs, especially if the VA healthcare budget is underfunded?
(4) Finally, how can we prevent such needless tragedies in the future?

Due to failures at the Departments of Veterans Affairs and Defense, Gulf War veterans were forced to show we were ill and to show we were exposed to toxins. Scientific evidence shows Gulf War veterans are seriously ill at higher rates than non-deployed veterans. The military now admits widespread toxic exposures to depleted uranium, chemical warfare agents, oil well fire pollution, pesticides, and military-administered experimental drugs, and more poisons.

NGWRC's Top Four Priorities

Mr. Chairman, I will focus only on four subjects out of the fifteen points listed in our written testimony. Our mission is narrowly focused: the NGWRC is an international coalition of advocates and organizations providing information, support, and referrals to service providers for all those concerned with the Gulf War, especially Gulf War illnesses.

1. Immediate Implementation of Public Law 105-277.

The first subject that deserves your full attention is the immediate implementation of Public Law 105-277. This is the NGWRC's top priority for 1999. President Clinton signed the "Persian Gulf War Veterans Act of 1998" into law on October 21, 1998. It orders the VA to sign an agreement with the National Academy of Sciences within 60 days to investigate more than thirty toxins associated the illnesses and to study illnesses more prevalent among Gulf War veterans. The VA has failed to enter into that agreement. The Gulf War veteran community is frustrated with the VA's continuing failures.

Gulf War veterans and their families view the illnesses as a health care crisis. The VA's behavior results in delays in new medical research, new treatment programs, new claims filing, timely adjudication of claims, and the granting of service-connection to disabled veterans. Under-

explored areas of toxic research include: depleted uranium, oil well fires, chemical warfare agents, experimental shots and pills, pesticides, and synergistic combinations of these. Areas of more prevalent adverse outcomes among veterans include Lou Gehrig's disease (ALS) and other neurological disorders, cancers, immunological disorders, reproductive disorders, and birth defects among the children of Gulf War veterans.

On December 8, 1998, the VA asked the Department of Justice to review the new law. On March 12, 1999, DoJ advised the VA that the VA-NAS research contract and the VA compensation requirements of Public Law 105-277 should stand. Now the law must be implemented. As part of implementation, we believe the VA must fund outreach about the new law to veterans and those assisting veterans with filing claims. The NGWRC stands ready to assist the VA with outreach.

The NGWRC is not alone in our support for Public Law 105-277. The "Independent Budget -- Fiscal Year 2000," endorsed by more than 50 veterans organizations, also calls for the immediate and full implementation of Public Law 105-277.

2. Support Funding for Private and Government Research

The second subject that merits your immediate attention is the NGWRC's support for funding of private research as well as research by the Centers for Disease Control, VA, and DoD. Three weeks ago, the CDC held a successful research planning conference in Atlanta, Georgia, attended by sixteen NGWRC groups.

The NGWRC believes that appropriate CDC research should be funded, that Gulf War veterans and our advocates should participate in all research review panels, that more conferences should be held, and that Gulf War veterans should be included in all future conferences.

Because the Gulf War rages on today in Iraq with more than one million Iraqi dead, the best government and private sector research is needed now into the many toxic exposures present in the Gulf region. This will improve medical care, improve toxic detection and protection doctrine and training, plus improve the government's tarnished reputation among Gulf War veterans.

3. Full Funding for VA's FY2000 Healthcare Budget

Our third subject that merits your attention is the VA budget for Fiscal Year 2000. President Clinton's proposed VA budget flat-lines VA healthcare funding while payroll expenses, medical equipment prices, and prescription drug purchases are rising faster than inflation. The NGWRC believes the VA needs more than what was proposed by the Administration to meet minimum requirements for proper healthcare delivery at the VA, especially for Gulf War veterans. Since the current economic boom created a Federal budget surplus, the VA budget cap should be lifted in order to care for America's men and women who protect freedom and democracy so well.

Gulf War veterans are deeply concerned about under-funding at the VA. This is because under Public Law 105-277, as many as 235,000 veterans (out of 1.2 million eligible), are entering an already overburdened VA healthcare system. Flat-lining appropriations, during war while expenses soar and the number of patients demanding care increases, is a recipe for disaster.

NATIONAL GULF WAR RESOURCE CENTER

4. More Hearings on Gulf War Illnesses

The fourth subject that merits your attention is the need for hearings into the experimental anthrax vaccine and the use of depleted uranium radioactive toxic waste as ammunition. We applaud your recent announcement to hold hearings March 24 regarding the experimental anthrax vaccine.

The NGWRC is on record as opposing the Food and Drug Administration's "Interim Rule" allowing the Pentagon to use experimental drugs on soldiers without informed consent, a clear violation of the Nuremberg Code protecting people against involuntary experimentation.

The NGWRC is the leading veterans organization pressing for answers about the experimental anthrax vaccine. Currently, the vaccine is not approved for use by the FDA as protection against unknown strains of anthrax biological warfare agents. Therefore, Gulf War veterans have four main concerns about the completeness of Pentagon briefings about the vaccine:

(1) The plant manufacturing experimental anthrax vaccines was cited for quality control problems. How serious is this? Are there on-going purity and safety problems?

(2) Some experimental anthrax vaccine lots may have had their shelf-life extended. Is this safe? Is this proper? How many received such shots? Is this an on-going problem?

(3) If soldiers refused, some were threatened with the loss of pay, the loss of rank, additional weeks of forced labor, and some were even threatened with the forcible administration of the experimental anthrax vaccine. Is this legal? Is this moral? Is this an appropriate policy?

(4) Many active duty servicemembers are concerned about the possible link between Gulf War illnesses and the experimental anthrax vaccine. When will the DoD address this with new research?

The NGWRC also asks this subcommittee to hold hearings on depleted uranium. DU is a radioactive toxic waste used as anti-tank ammunition for the first time during the Gulf War. Pre-war reports by the DoD implicate DU as causing adverse health effects, including cancers, reproductive disorders, and kidney problems.

Currently, Gulf War veterans are experiencing serious health effects that may be related to radioactive and toxic waste contamination, including having DU appear in semen samples taken six years after exposure. The NGWRC prepared an extensive report on DU. It shows that 315 tons of radioactive and toxic DU dust continue to contaminate wide areas of Kuwait, Saudi Arabia, Iraq. The United States also has many areas of DU contamination.

Conclusion

In conclusion, Mr. Chairman, after legislative victory was declared with the passage of Public Law 105-277, Gulf War veterans thought the VA would get the message and start addressing this issue with vigor. With their delays, it is clear the VA still doesn't get it.

The new law and our efforts on behalf of veterans may all be in vain unless there are on-going congressional hearings, unless Public Law 105-277 is implemented, unless vigorous, unbiased research is funded, unless the VA has full funding for healthcare, and unless there is extensive outreach to Gulf War veterans.

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The NGWRC strongly believes that research delayed or not funded equals healthcare denied for more than 110,000 ill Gulf War veterans. How long must we wait twisting in the wind, sick and dying? How many more of us will fall ill and die due to a lack of implementation, a lack of research, and a lack of funding? How many more?

Other Subjects of Importance to Gulf War Veterans:

5. Block Title IV, Section 413 of H.R. 606.

The Congressional Commission on Servicemembers and Veterans Transition Assistance proposes ending the Gulf War on paper, retroactive to February 28, 1993, an arbitrary date with no basis in fact or law. Ending the Gulf War will result in as many as 400,000 veterans losing healthcare and employment benefits eligibility, including the new Public Law 105-277.

Entitlements should remain in effect as long as there is fighting, especially since out troops are still being exposed to depleted uranium, experimental anthrax vaccines, experimental pyridostigmine bromide pills, and other wartime toxic hazards. Eliminating earned benefits during an armed conflict sets a bad precedent for the future and sends the wrong message to active duty troops and prospective enlistees. Also, the people and Congress decide if our nation remains at war, not a blue ribbon commission on veterans' benefits.

6. Implementation of key sections of Public Law 105-368.

Signed into law on November 11, 1998 as the Veterans Programs Enhancement Act, the VA program to follow-up Gulf War veterans' families, unfinished since 1994, needs completion. The establishment of an oversight panel to include veterans needs to begin work promptly. If VHA funding is reduced, then the VA will not be able to extend healthcare to ill Gulf War veterans.

The NGWRC supports an open-ended presumption period for undiagnosed illnesses and for the prompt development of a case definition(s) for Gulf War illnesses, as this should expedite much-needed treatment programs. Budget caps should be removed to care for America's veterans.

7. Better government cooperation, development of data, and lines of responsibility.

There are no agreed upon terms for 'Gulf War veteran' and little accessible data about those who served and their illnesses. There are also several coordinating boards, oversight boards, and agencies investigating Gulf War illnesses. The NGWRC believes one person at the three main agencies investigating the issue, VA, DoD, and CDC, each have a full-time, clearly identified point of contact. At present, there is no VA 'Gulf War issues czar.'

At present, the DoD representative on this issue is also the full-time Undersecretary of the Army who fails to attend most of his own meetings. The CDC is increasing their research role and should also have a single person appointed to this high-profile capacity. With unemployment and homelessness rising among Gulf War veterans in a healthy economy, better objective data about the

needs of Gulf War veterans is required to develop prompt, responsive policies.

At present, the NGWRC is very disappointed with the poor level of inquiry by the Office of the Special Assistant for Gulf War Illnesses, especially their false claim that depleted uranium is not a health hazard when the medical research before and since the start of the war clearly implicate depleted uranium -- up to and including the finding of DU in veterans' semen.

The NGWRC remains concerned that much information about many toxic exposures remains classified due to the fact the Gulf War continues. Access to this information by appropriate private and government scientists (not associated with the military) should be considered.

8. Need for outreach to Gulf War veterans about toxins and VA benefits eligibility.

As discussed above, with bombshell announcements about chemical warfare agent and depleted uranium contamination as well as the enactment of new, complex benefits laws, it is vital to train VA personnel, veterans service organization claims representatives, state and county level veterans representatives, and veterans about the new laws and the proper methods to file claims. This is a long-term priority where veterans, VSOs, and the VA can cooperate from the very start with the implementation of a new, complex law.

9. Research and Healthcare for DoD civilians deployed in support of Gulf War.

The NGWRC remains concerned about complaints about illnesses among DoD civilian workers sent to the Gulf region in support of the war. These civilians should be included in any research and benefits considered for those ill due to deployment or toxic exposure.

10. Former Frozen Iraqi assets now under the control of the U.S. Treasury Dept.

When Iraq invaded Kuwait, the U.S. government seized Iraqi assets in the U.S. The funds remain the property of the U.S. and are awaiting the enactment of legislation before distribution may begin. Precedent dating to the Revolutionary War holds that veterans, especially those families of the deceased or veterans who are ill, should have the ability to file a claim against these assets. Veterans may still file claims against these undistributed U.S. funds. The NGWRC supports H.R. 618, the "Gulf War Veterans' Iraqi Claims Protection Act of 1999."

11. Include U.S. troops stationed in Israel and Turkey for Gulf War benefits.

Currently, although these veterans may receive awards for their Gulf War service, they are not eligible for certain VA benefits, including those under the Byrd Amendment. The NGWRC believes that since Israel was struck by repeated SCUD attacks and since Turkey was the staging point of thousands of missions over Iraq, service in these nations should be included on the Gulf theater list.

NATIONAL GULF WAR RESOURCE CENTER

12. Revocation of FDA "Interim Rule" allowing use of experimental drugs on troops.

As discussed above, in December 1990, the DoD received a waiver or 'interim rule' from the Food and Drug Administration to use experimental drugs on U.S. troops to protect against chemical and biological warfare agents -- a laudable goal. However, the DoD failed to note who received the shots and what the side-effects were. There are well-founded instances of contamination, the DoD has threatened to use force to administer the experimental drugs, and the DoD has used expired drugs on troops. Without informed consent, without thorough record keeping, and without research to determine the effectiveness or side effects, we believe the use of experimental drugs on U.S. troops violates the Nuremberg Code and it should end.

13. Preservation of DVOPs and LVERs at the Department of Labor.

The NGWRC supports the active participation of the Department of Labor with the employment and transition needs of Gulf War veterans. This includes adequate funding and support for DVOPs and LVERs in the reemployment process. In the long term, this saves tax dollars by reducing the amount of unemployment compensation paid to veterans. It attempts to restore veterans to where they should have been if not involved in war. Finally, the NGWRC supports the awarding of civilian licenses and certificates for comparable military training. This should smooth the transition of servicemembers into civilian life.

14. Support for VA's Vet Centers (Readjustment Counseling Services).

The NGWRC believes one of the most effective outreach and assistance tools used by the VA is its highly successful Vet Centers, established in 1979 under Public Law 96-22. This earned benefit was extended to Gulf War veterans in 1991 under Public Law 102-25.

More than 80,000 Gulf War veterans have utilized readjustment counseling services at the community level. This superb program should be preserved and expanded, especially in light of the dramatic increase in combat stressors, military deployments overseas, and increases in awareness of sexual trauma in the military.

15. Consideration of a national "Gulf War Memorial" in Washington, DC.

A resolution was introduced in the 105th Congress to establish a national "Gulf War Memorial" in Washington, DC. While the NGWRC supports this idea as fitting and proper and with clear precedent, we believe it is premature for two reasons.

First, the Gulf War should end, both in fact and in law, before any memorial is considered. Second, if a memorial is erected, is should at a minimum include those who died due to their service, those who fell ill and died, those missing, and those civilians who died since the start of the war in 1990.

Mr. SHAYS. Thank you, Mr. Sullivan.

Let me just get some housekeeping out of the way, first, before I go into our questions.

I ask unanimous consent that all members of the subcommittee be permitted to place any opening statement into the record, and that the record remain open for 3 days for that purpose. And without objection, so ordered.

I further ask unanimous consent that all witnesses be permitted to include their written statement in the record. And without objection, so ordered.

Let me say, at the outset, it is wonderful to have all of you here and to have you put on the record what we need to know and what we need to focus on. And say that this committee—as you know, but stating this for general conversation—we don't appropriate and we don't authorize. We look at programs for waste, fraud, and abuse. But we have an advantage the other committees don't have. One is that we have an interdisciplinary look; we have VA and DOD. And, frankly, I asked to chair this committee and brought VA with us—because it was under the other committee I chaired—so that we would have the advantage of looking at, for instance, Mr. Weidman, your point that we need to track a veteran, a soldier, sailor, Air Force, Marine record from day one. And that when they get in the VA, the first question that should be asked is, "What did you do in the service?"—and go from there.

And so we can rightly apportion, then, work with the authorizing committees to have them become law or have them be appropriations, and that is, in fact, what we did with the whole issue of our look at the Gulf war illnesses. So we are interdisciplinary and we can look at.

And the other thing is that we are going to sometimes offend the service organizations, because we don't know your organization as closely as say the veterans do or the DOD does, but, in that, we are going to break out of the box. For instance, I might ask a question of, "Why don't we just give a veteran a card?" And I know some of you don't like that, but I am going to want that dialog. And that they can go to any hospital in the world and get the best healthcare. Now I know there are answers to that. I know that the hospitals focus in on the special needs of veterans, and I know that you want to know there is a place, and I know those other questions, but I am going to want that kind of dialog as well.

Mr. Blagojevich is going to start the questions off. We are going to, obviously, just keep moving because we don't want to have a break and then have to have you come back.

Mr. BLAGOJEVICH. Thank you, Mr. Chairman.

I have a question for the whole panel, and it is a very broad question. I think it is probably a good way to start out.

And what I have noticed as a common theme, irrespective of what war the veteran fought in is that there seems to be two factors that you guys are lamenting: insufficiency of funding and lack of access to healthcare, which are, I think from a moral perspective, very troubling.

If you can just briefly, anybody in the panel, or as many of you that would like, tell us about how we got in this position and why that happened.

Shall I just isolate somebody or do one of you want to volunteer?

Mr. WANNEMACHER. Well, I would just say that, as you recognized, it doesn't matter which war you are in, we all became disabled or have—because of our economics—become eligible for VA healthcare. Whether it be VA pensions or VA compensation, all of us are eligible for VA education benefits. And we all fought different wars for the same purposes, and that was to keep America free. None of us went to war as a Republican or a Democrat. We all went to serve that American flag that sits behind you. And the inadequacy is in my written statement and in my oral statement, also.

The consistent inadequacy of the budget has caused the Veterans Administration to be trying to stay ahead. And now they are at a point where they have reached a wall. The efficiencies have been taken away within the VA. There are still some efficiencies that might be able to be found, but as veterans' age, consistently age, they need healthcare, and the budget just hasn't kept up with that.

Mr. ROBERTSON. The American Legion agrees with that. The escalating cost of healthcare in the private sector has just driven the price through the ceiling. And year after year, after year, after year, after year, the veterans' organizations kept saying, "You are falling behind; you are falling behind. You are a dinosaur system, and the rest of the world is out here in this type of managed care healthcare."

The problem is, is at one time, the VA healthcare system was probably "the example" of medical care in the country. We are affiliated with 107 medical schools. This is a teaching institution for the future generations of healthcare providers. And we are watching this system implode on itself.

And everybody is saying, "Well, you know, we will just throw a little bucks this way and a little bucks that way, and it will pacify them for another year." We have gotten to the point where veterans are being said, "You have got to leave a long-term care facility, and we will drop you off at the homeless shelter."

We are at a point when veterans come back from a war like the Persian Gulf and say, "We are sick; we need help. We need medical attention." And you are telling us, "Prove to us you are sick."

My God, let's talk logic here. That is not difficult to understand. If you send me halfway around the world, and I come back and say, "I am sick," you have an obligation to take care of me. I did your job; now you do yours.

Mr. WOODBURY. There is a more fundamental reason, I think, sir. VA and DOD are easy marks in the appropriation process. If you are trying to make a "bogey" in some other program that may be more political expedient, you can get the money from DOD; you can get the money from VA, and you don't have the advocacy in that appropriation forum that you have here. And I think that is one reason we got ourselves in this position in the first place.

Mr. WEIDMAN. It is the public conception that VA does everything for all veterans that people have that make it an issue that becomes difficult to address. So if you feed that horse a little bit less and a little bit less each year, and the VA hospital is still down the road, and you haven't gotten the message out that veterans quite literally are dying albeit because they are denied needed care

under, "cost savings," VA denies that is happening. And it is true, people aren't turned away, but, you know, "they use euphemism" about reorganization.

One of my favorites is they reorganized the Alcohol and Drug Treatment Program in Albany, Stratton VA Medical Center. What "reorganization" was, they closed the program there and have a van every 2 weeks to take somebody 200-miles-plus to Batavia. And folks who were ready to dry out and get clean weren't going to wait 2 weeks. Therefore, they discontinued the van because nobody used it. It is that kind of euphemism of not denial of care.

And make no mistake about it; the savings mean services denied to veterans, and I think that is how, little by little, we slipped into the point where the horse is just about to die.

Mr. CULLINAN. I would just add to that. I agree with my colleague's apocryhal tale of the horse and the straw. And it doesn't just pertain to funding. It pertains to the efficiencies and the reductions and the realignments that have been going on in the VA for over 10 years now, perhaps 20 years.

It is an ongoing—it has happened gradually, slowly. We have protested; we protested, but seldom were we heeded.

Mr. SULLIVAN. Congressman, I would quickly answer that by saying the public and many Members of Congress—I have met with them—are under some bizarre false impression that the Gulf war ended. There is a war going on, and when a war like World War II or Vietnam ends, that doesn't mean that since the soldiers are home, they are suddenly healthy and everything is done. There is a public impression that the day the war is declared over that there is closure. That is not true with war.

And the main thing I would like to impress upon the Members here is that the Gulf war is continuing; we are bombing them every day, and it is the most insane, moral outrage to consider cutting veterans' benefits and healthcare while our troops are dropping bombs and getting shot at and breathing in DU and receiving experimental anthrax shots. It is insane.

Mr. BLAGOJEVICH. Thank you very much.

Mr. SHAYS. Mr. Terry.

Mr. TERRY. Thank you, Mr. Chairman.

I have a short statement that will lead into a question that, really, you hinted or stated in your statement, Mr. Chairman, and that is, "What is the future role of the VA hospitals?"

Let me just say that I am not a veteran, but I am here because I am very interested in the issues. I truly believe that, even though there was no law passed, but this Government made promises of healthcare. We need to uphold that promise that was in the recruiting propaganda that you were given, the promises that you were given when you made that oath. One of the tasks I have assigned myself is to try and uphold that.

Again, that may require that we think out of the box on occasion. How do we do that? If the No. 1 goal is to ensure half the healthcare, my first question is going to be exactly what the chairman raised. Does that necessarily mean a separate healthcare physical system? Do we need the brick and the mortar of the VA hospital? And let me tell you, I have taken your advice. I visited our VA hospital; we have a great one in Omaha, NE. A guy I have

coffee with almost every morning that has heart problems that is connected to—that is a service-connected disability—moved back to Omaha from Texas because he thought our facility was one of the best in the area or in the Nation.

But I also hear, in visiting our VA facility, that they are becoming more like a regular hospital with their administrative duties, and having to fill out codes. What I am saying is, in many ways, they are operating like the University of Nebraska Hospital that is only 10 blocks away. So my first question is, why do we need a separate system if our goal is to ensure healthcare?

Mr. CULLINAN. Mr. Terry, I would just say, first of all, some of our best friends through the years have been non-veterans in the Congress, so you should know that.

Mr. TERRY. Good, and I appreciate that.

Mr. CULLINAN. And I will briefly address—really, what you have introduced here is a complete separate hearing or hearings.

Mr. TERRY. Yes.

Mr. CULLINAN. What I would say, though, off the cuff, is that, first of all, VA has a very special mission and a very special expertise—caring for combat, disabled veterans. You know, through the years, they have been in the forefront in everything from trauma injury to prosthetics to certain pharmacological concerns for veterans serving from, you know, tropical maladies. So there is that issue.

Then there is another point. If it weren't for the Department of Veterans Affairs, do we really believe that would somehow keep the cost down to the system? Do we really believe that private providers would somehow fill the gap for VA? We don't think so, both from the perspective of cost and from the perspective of those specialty areas.

You know, let's face it, if it weren't for the Department of Veterans Affairs, I mean we would still have 100-pound wheelchairs and probably wooden prosthetics. The reason for that is, is that years ago, there was no money in it so the private sector didn't pursue it. And that is true of a host of other areas as well, so it is important.

Does VA have to change the way it does business? Yes, of course it does, and it is starting to do that. There is some pain and some trauma, in a metaphorical sense. But we also—along with the complaints that we hear, we hear from veterans who like the fact that there is now an outpatient clinic, reasonably within access to their home.

Mr. ROBERTSON. Mr. Chairman, Mr. Congressman, in answer to your question, if Desert Storm had produced the "mother of all ground actions" and our guys had been exposed to chemical and biological agents that required long-term care, name me the private hospital that would like 100,000 troops showing up at their doors with diseases that maybe they don't know how to take care of. You are talking about a system that is the backup to the Department of Defense, that when it is time for the balloon to go up and the DOD people deploy overseas and fight on the battlegrounds and serve at field hospitals, there is not a whole lot of private physicians that are going to want to walk away from their practice and their 3 o'clock tea times to go fight in the Persian Gulf.

So I think that there is a real mission that you need to look at that is very valuable that the VA provides, and that is the backup to the Department of Defense.

In answer to your question, Mr. Shays, about the credit card—you have a system like that, and it is called "Medicare," and it is not working very well either.

Mr. WEIDMAN. I would just add, Mr. Terry, to that entire issue, that if VA truly addresses the needs of veterans' healthcare in a full and holistic way, then we need VA.

You may know already, sir, that over $1.2 billion is already contracted out in medical services by VHA. I suspect that number is going to go up dramatically in the future.

The real question at the heart of what you are talking about is changing the power of relationships between the VA versus the veteran who walks through the front door. That is our interest. And if it took something like that in order to change that "power relationship" between the individual veteran who seeks care, then maybe that is the way to, at least, look to proceed. But the real question here—is VA hospital system, Veterans Health Administration, currently addressing the needs of veterans, as veterans?

What I am talking about that, incidentally, is that all too often when a veteran walks into a VA hospital in Omaha or anyplace else in this country, they are regarded as a supplicant, as a supplicant, and not as a veteran who is deserving of dignity and respect—or at least are made to feel that way by certain staff.

It is always remarkable to me how many people get good treatment at the VA healthcare system, given how messed up the system is and anatomizing in many ways. Contrary to people preserving their dignity in the very way in which it is set up. And if you can change that "power relationship" and have quality assurance within the VA to focus on the needs of veterans, as veterans, then, by all means, you absolutely need a separate VA healthcare system.

Mr. WANNEMACHER. Just a short—the DAV did an analysis comparing Medicare and VA. We took the $17 billion that VA has and the appropriation from Medicare and we showed—our executive director, Dave Gorman, did a commentary. "In Modern Healthcare," February 12, Mr. Gorman said there is a real good reason why the Federal Government just can't even afford to provide the same healthcare that the VA does.

One thing that wasn't mentioned—it was mentioned about being an educator in that, but the research that VA provides, also, is for the American economy. There would be, you know, we have already discovered the pacemaker, the CAT scan, the virtual elimination of tuberculosis—things that wouldn't have happened without the Veterans Administration, just like there would be a lot of advances that wouldn't have happened without the space program. And to say that the Veterans Administration should just go away like a bad penny is completely unwarranted.

And I agree with what was said, too—many of our strongest advocates aren't veterans. You hear the rhetoric that, "Well, the Congress isn't doing the right thing because there is a decreasing veteran population." I don't believe that; we don't believe that.

Mr. SULLIVAN. Congressman, if I may answer your question. I am considered a very, very harsh critic of the VA. The Resource Center has been very, very vigorous in attacking the VA for not doing what they are supposed to do to help out Gulf war veterans.

That said, there are some people at the VA who really care and who really work hard. And we have gone more to being harshly critical to keeping them honest in their work. And toward that end, the VA is actually looking into radioactive depleted uranium toxic waste contamination among Gulf war veterans. A lot of that came about as the work of the publicity of this committee. That is something that only the VA can do. Who else is going to breath in lungfulls of radioactive toxic waste on a battlefield in a foreign country?

The second is the vet centers—that is a beautiful VA program that is a legacy of Vietnam veterans that opened up the door for readjustment counseling for combat veterans of the Gulf war when they came back. With that program, we may see reductions, the saving of lives, because people had someplace to go to talk about their war experiences.

That is something that only the VA is going to do, and it is a moral and legal contract. So we may criticize the VA, up and down until tomorrow, but it is something that we need, and it has to be there because we are still fighting a war right now.

Mr. SHAYS. Let me tell you how I am going to suggest we continue. Obviously, each member is really not going to be able to ask a lot of questions. We really have six excellent witnesses. The purpose of this first hearing is to kind of just introduce the issues, just to expose us. Be assured, we are not going to recommend or do anything without extensive research and involvement with your organizations, as it relates to the VA.

We are really trying to determine what our agenda should be. Should we focus in on what the hospitals do? Should there be a different system, a combined system? I mean, obviously, we all agree on the funding issue. So I just want to make that point.

The other point I am going to make is that I am going to leave at 10 o'clock, but I am going to give the gavel to any Member who is going to stay—be it a Republican or Democrat, and we can close the hearing with a Democrat, for instance.

Bernie, you may want to go on for awhile, and I will just give you the gavel, but, also, acknowledge that Mr. Filner is here, and since he is not an official member of this committee, he is just having to wait until the end if he does want to ask questions. But his involvement in this issue is paramount, and we will be inviting him to participate in any future hearings we have.

Also, may I just acknowledge the presence of Mr. Mica, who chairs the committee I used to chair, which has HHS. And so he gets involved in this issue, and we will be sharing some work with him as well—and Mr. Souder, who serves, I think, on both committees as well.

Mr. Sanders.

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

And we welcome Mr. Filner and congratulate him for his outstanding work that he has done for veterans.

And, Mr. Chairman, let me congratulate you for the work that you have done over the last several years in Gulf war illness.

Steve, thank you very much for coming to Vermont to be part of the Gulf war illness conference that we have. And, Rick, thank you very much for your advice on agent orange, and that is something that I hope very much, Mr. Chairman—I think there is a scandal out there, and I think we should get to it. And, Paul, thank you so much for all the great work you have done on Gulf war illness. And, Dennis, and, David, and, Robert, I look forward to working with you.

I am the only Independent in the U.S. Congress, so I sometimes look at things a little bit different than my colleagues, and sometimes a little bit franker than my colleagues. Sometimes I say things that I regret having said after I say them, but that is——

Mr. SHAYS. That just relates to your personality, not—[laughter.]

Mr. SANDERS. That is my personality—[laughter]—I know, but I can't help it.

So, let me be as straightforward as I can.

I consider myself, along with some of the folks up here, to be a very strong defender of veterans, and do you know why? I happen to be an anti-war Congressman; I vote against the wars. But I happen to think that when a man or woman takes the oath and goes out and puts their life on the line and does everything that is being asked of them, then this Government has the moral responsibility of fulfilling its end of the bargain. And if it doesn't do that, if that contract between the Government and the men and women who put their lives on the line is broken, then, this country does not stand for very much at all. So, while we can argue about the wisdom of this or that war, after the decision is made, it is the moral obligation of this Government to stand with the people who are making the ultimate sacrifice.

Now I happen to believe that the way the U.S. Congress, and various administrations, have treated veterans is an absolute disgrace. At this moment now, I am spending far more time than I ever wanted to making sure that the VA hospital in White River Junction, VT, has the services that it needs, that it treats our people with the minimum standards that are required. But I know that problem exists all over the country, and it is an outrage.

Now I think it was Dennis who may have made the point—I don't know that—who talked about this problem going on for 10 or 20 years under the Reagan administration, under the Bush administration, under the Clinton administration, OK?

Now what I have a hard time understanding is that with millions of millions of folks in your organizations, with an understanding we are all politicians, and when I go home in my State and I say, "Do you think we should treat veterans with respect and provide the care they need?" Everybody says that we should. So I don't understand how for 20 years, under Republican administrations and under Democratic administrations, veterans have not gotten their fair share.

I don't know if you have not been doing your job. I don't know if we have not been doing our job, but somebody has screwed up royally. Because I am tired of getting calls from veterans in the State of Vermont who tell me that they are not getting the care that they need. And Mr. Filner is getting those calls; and every Member here is getting those calls.

Now I want to get back—and here is where I am going to get into some trouble. I came in a little bit later and I think, David, you were talking. And you were telling me how we need that old antiballistic missile system to protect us from North Korea. Right?

Or whatever—I may have not gotten the whole point.

Well, I find it amazing that when we need a few billion dollars—and I am not sure that your proposal—your independent budget may be too conservative—I would suggest that you need more than that. But be that as it may, I find it rather amazing that President Clinton is proposing $110 billion more for the military over the next 5 years. The Republicans thinks that is much too little; they want to put $150 billion into the military over the next 5 years. And you are sitting here telling us that you need a few billion dollars for the veterans.

So when I go down on the floor today in opposition to the ballistic missile system, you know what I am going to say? I am going to say, "Scratch that system and use that money for veterans' medical care."

And I want to know where your voice was 2 years ago on the Balanced Budget Amendment, when we gave tax breaks to billionaires. We have $115 billion in tax breaks, most of which went to the very wealthy—but apparently we don't have enough money for the veterans. We didn't have a few billion dollars to make sure that our hospitals were open.

Now I am glad you are here telling us how important it is to have a ballistic missile system. But when I hear the guys who make billions off the ballistic missile systems, I don't hear them telling us that it is important that we have an adequate veterans' care.

So let me, respectfully, make this suggestion about how we can all work better together. I am going to do everything I can to go beyond this budget. I don't think that is enough. I don't want to get any more calls from veterans in the State of Vermont that they are not getting the care. I want more outreach, because I think the VA hospital is not outreaching enough, bringing in enough veterans.

I would respectfully make a suggestion that the veterans' organizations fight like hell to protect the veterans, in terms of the healthcare needs, that we start an investigation about agent orange, that we are going to make some progress, finally, in dealing with Gulf war illness, that we want to understand the scandal of radiation illness and why the VA and the DOD did not react appropriately to that, and that we want this Government to keep its contract to the veterans.

As citizens of this country, you have every right in the world to give your opinions on defense spending, and so forth and so on. But I would hope very much that your focus would be on the needs of veterans and work with us on those issues, because I don't hear the guys from the DOD and the big contracts because Lockheed-Martin doesn't come in here and say, "Worry about the veterans." Lockheed-Martin has enough lobbyists in here to take good care of themselves.

So now I have gotten you all angry. Steve, am I crazy?

Mr. ROBERTSON. No, sir, you are not. And just for the record, I want to tell you that the biggest opponents of war are sitting at this table. We've been there, done that, got the t-shirt, and we adamantly don't like war. But that, also, is part of our philosophy in the American Legion, is to maintain a strong national defense, to prevent us from doing this again.

My son just went into the Army Reserves, and I don't want to see him going overseas into combat, any more than you do. But I think that there is a balance that we have to strike. And the American Legion and my colleagues here from the other organizations have been fighting. But you have got to remember, Congressman, we represent less than 1 percent of the U.S. population. And you are right; there is a lot of people that aren't in there fighting and battling with us on our side on these issues, because we don't impact their lives day in and day out. They forget the freedoms that they enjoy were purchased with the blood of our comrades and many of ourselves. And, you know, it is kind of, you know, "when you need me, I am here; otherwise, get out of my way and don't bother me." That is why, we, as veterans' organizations and military service organizations are supposed to be the conscience of this country to remind you when the scale is being tipped in the wrong direction. And we are screaming. And I will tell you—I will be very honest with you, Congressman. When military war decorated combat service-connected veterans start showing up in homeless shelters instead of long-term care facilities, when hospitals are closing around the country and veterans are going home to die, you will start hearing more people become involved, because it will be family members who are saying, "How can our country reach this level of disrespect for those who have won the freedoms and are willing to die tomorrow to protect you again?" And if they call me tomorrow, I will pack my bag, and I will be on the next plane if that is what it is going to take to keep these freedoms.

Mr. SANDERS. Steve, my question is, what goes on when people are proposing tens of billions of dollars in tax breaks, right now, and you are here asking for a few billion dollars for veterans? And every person up here understands they are needed. What is going on?

Mr. ROBERTSON. The American Legion doesn't—[laughter]—endorse tax breaks.

Mr. SANDERS. I am not even asking——

Mr. ROBERTSON. It is not part of our legislative portfolio.

Mr. SANDERS. No. No, I am not suggesting that you do. But, why—why, in your judgment, does that go on, Rick?

Mr. WEIDMAN. I think it really comes back to that whole analogy of slowly starving the horse. Somehow people don't get it—as long as we don't close the hospital in my district. The administration's budget was the equivalent of closing 26 hospitals. Some of us suggested to the Veterans Affairs Committee that they take the unprecedented step of bringing it immediately to the floor and rejecting it, or unanimously, sending it back to the President, and said, "For God's sake, send us a serious budget that is going to address the healthcare needs of veterans." And they did not do it.

If you take the next step—some of us suggested, privately, but not publicly, that you take the step of—if you close some hospitals

first, instead of reducing all hospitals by little bits, starving each one of the facilities. And you closed all the hospitals in the budget committee members' district, by God, you would have another $10 billion for the system. You would, wouldn't you? But because it is by attrition. I think that is one element.

The second thing is that popular conception that I talked about before that veterans have too much, that is still driven by a lot of people in our society. If you think about it for a minute, if any other discrete group of Americans had their healthcare costs frozen for 5 years in a row—suppose that the Congress had decided to do that for African-Americans, all African-Americans, suppose the Congress had tried to do that for all women, suppose the Congress had tried to do that for everybody of Lithuanian descent, then all hell would have broken loose. But somehow, somehow, because it is veterans, people think they can get away with it.

Mr. Mica, I am glad to see is here, because he played an extraordinary role in trying to put some teeth back into the veterans preferences. The same sorts of remarks that the Federal unions made about veterans, they would not dare make about any other discreet group of Americans. And Mr. Mica knows all too well what I am talking about here. Well, they would say, "We want a quality work force, therefore, we don't want veterans' preference." Excuse me? The same people you trusted with the weapons that could destroy the world, that were worth billions of dollars 2 years ago, now aren't worthy of being a GS–9? And shuffling papers? Excuse me?

I mean it is just extraordinary. People deny that there is "veticism" within their society that is every bit alive and well as sexism and racism within this society, but it is there.

Veterans are for Veterans' Day and for Memorial Day, and in between time, those guys with funny hats can take care of themselves because they already have too much. We have to change that perception.

Beginning this May, it will be a relatively small effort, but a lot of veterans are going to be focusing, the night of the 27th or 28th, at a march on Washington, with a view toward 2000, of really feeling them all up, 1931. And if it takes going back to the damn streets to do it, then that is what we ought to do in order to crack through this myth. We have been marginalized, at the same time everybody is paying a pieoa a couple of times a year. And sometimes folks say, "The only good vet is a dead vet." That is why they honor us on Veterans' Day and Memorial Day, for christ sake. What happens in between? And I don't think it is an issue of whether—the percentage within this society. I really don't believe it is that. One of the finest veterans' advocates I have ever met is on your staff, Jim Rader. There is a lot of people walking around in Vermont because of Jim's work at the vet center in the early 1980's. However, within the context of the society at large, there is a Gulf, particularly in the generation in power right now, between those of us who went—irrespectively of what we thought about the policy—and those of us who did not go. And I don't think you have to have served in order to be a veterans' advocate, and you and Mr. Filner certainly are representative of that. But it is true that, within the Congress, when it comes to the nut of where the dough goes, suddenly folks aren't there; $1.1 billion the Senate

Budget Committee finally provided on top of the President's budget. And if you take the Medicare inflation rate for the last decade and apply the same rate of Medicare and the Federal funding of Medicaid, whichever—but a lot of people believe is inadequate—the VA budget now would be over $22 billion a year for VHA.

Mr. SHAYS. Let me just recognize Mr. Mica—but also say, I know some of you had an obligation. If you do, feel free to go. I know one reason we started it was because of the briefing on the floor, but also because some of you had an obligation or two.

I am going to ask Mr. Mica to have the floor. And then, Bernie, you know, give you back the gavel if you want to be here and if you want to pursue the questioning.

So, Mr. Mica, you have the floor.

And I am going to just apologize for leaving, but I have a budget meeting that I have to go to, and then I want to try to get on the floor to some of that hearing. I have not voted against performance of the Defense, and I am leaning close to doing that, thinking that we really need to do that.

So, I will give Mr. Mica the floor.

Mr. MICA [presiding]. I thank you, Mr. Shays, Mr. Chairman, for holding this meeting, and I am really pleased to see that we have organized this subcommittee in this fashion. I had recommended that to the Speaker and to Mr. Burton and others that we have National Security, Veterans Affairs, and International Relations because I think that we do need to conduct investigations. We do need to conduct oversight, and this is a very good beginning.

So I thank you, Mr. Chairman. I thank you for your testimony, and I also want to thank you for helping me to get a few things passed, although, as you all know, it has been very difficult, both on veterans' preference and expanding healthcare access for our veterans, our military, and dependents.

The availability of healthcare really disturbs me. Even this past weekend, I was the recipient of calls at home for, in fact, a veteran who was a survivor of the Bataan death march who was not receiving adequate care, who I personally know and admire. Those things really disturb me, when someone who—this man has literally been through hell and back, and is one of the few survivors we have, and to have to grovel for healthcare at his age is just shameful for all of us. But, trying to do something about this—this is not the only case. I hear it all the time from people—the delays, the access to specialty care, the waiting lists. Some of them die before they ever get treatment or even to proper diagnosis, which disturbs me even more. So I think what we need to do is look at how we can develop that.

One of the things that we did try to do was open the Federal Employees' Health Benefits Program, which will have a small demonstration project. Are there other areas that you think we can—and we need some immediate attention. We can't—[laughter]—the tendency of Congress is to have a study, a demo project—[laughter]—and most of the people die before we get to where we want to be. But are there any specific ideas that you have that we could address in the very short-term, in this session now past, that would bring healthcare immediately to these people who are on waiting lists, who need special kinds of treatments, both for that type of

treatment. Then the other area I have a grave concern for is long-term care, because of the aging demographics of particularly our World War II and our Korean war—some of those veterans. Long-term care is a disaster right now in trying to place folks. And sometimes when we find the placement, it separates the veteran from the family in a very awkward fashion.

So those are two areas, and maybe you could comment with some suggestions.

Mr. CULLINAN. Mr. Mica, for one thing, we are urging that the Federal employee benefit package, the pilot you just referenced, that should be implemented fully and now. We don't see any reason to wait. Can that be accomplished quickly in this Congress? Probably not.

We are looking for additional funding streams outside of the conventional appropriations process—Medicare subvention, allowing VA to collect and retain Medicare dollars for the care it provides for Medicare-eligible veterans for their non-service-connected disabilities. Can that be accomplished in this Congress? I don't know; I would hope so, but when I say, "I don't know," I am really saying, "I think not."

There are any number of areas. Right now VA has opened—right now, it has pledged to enroll all seven categories of veterans who come to it seeking healthcare. Does VA have the money to sustain that? If this administration's budget goes forward, without amendment or improvement, no, it doesn't. There is something right now. But to sustain that effort, to sustain VA and its ability to care for all veterans who want to enroll into the system, that is something that we can do right now that will be of a measurable benefit to veterans.

Mr. MICA. Thank you.

Mr. ROBERTSON. Yes, sir. Under the Medicare subvention, Medicare plus choice, why a veteran can't say, "I am Medicare-eligible; I am not service-connected; I am not currently entitled to VA healthcare at no cost?" Why they cannot choose the VA healthcare system, as their healthcare provider, is beyond me. And could that be done in one Congress? I think absolutely. I think that the House Republican leadership in—what was it—in 1992, when they came, had their contract with America, and showed how much you could do in 100 days.

Well, I think if you set your mind to it in a bipartisan manner, that anything can be accomplished in this chamber. And I would strongly encourage that be a quick-fix. That is something that I think would last for—be part of a solution to your Medicare problems. If you have a managed care system that you can put these people into, and it would bring money into the VA healthcare system to offset those costs.

The other thing that is kind of a problem is the MCCF, the Medical Care Collection Fund, offsets third-party reimbursements against discretionary funding. Discretionary funding was designed to take care of service-connected veterans. But what happens under the budget accounting is that they reduce the third-party reimbursements rather than add that as a supplement, so that VA benefits as they collect more money for treating non-service-connected veterans.

What you are doing now is you are using discretionary dollars which are supposed to be healthcare dollars to pay for non-service-connected conditions, and that is wrong. That is fundamentally wrong.

Those are two things that I would recommend.

Mr. MICA. Sir.

Mr. WANNEMACHER. The Medicare subvention bill that was on the floor last year that Representatives Thomas and Stump had, the DAV's—only objection was that VA didn't have an accounting system that was going to be able to guarantee that only service-connected disabilities were going to be charged. The DAV has long endorsed—and the independent budget has long endorsed—Medicare subvention, and we call for it again this year. And as Steve mentioned, in 100 days, you could get a lot of things completed.

For a short term, you could probably do some things that would help the Montgomery GI bill proposal that was made by the Transition Commission. There are some good recommendations in there, and we support that. We have seen some language that there is about $881 million that would have to be appropriated to provide an education tool for the Montgomery GI bill. There is also some homeless projects. We have seen some language on some homeless projects that could assist. It is only about $5 million needed to enhance Homeless Veterans Reintegration Program.

Those are a couple, and I would be glad to submit some others for you.

Mr. MICA. I would appreciate, actually, all of you following up. I will try to get one of my staff assigned to that. I no longer chair Civil Service, but we can get one of our subcommittee staffers to work with you.

Did you have anything you wanted to add, then? Then, I am going to turn to Mr. Souder.

Mr. WEIDMAN. I think it could be done in one Congress, Mr. Mica.

But the real problem is, is breaking out of the mind set as "business as usual," and people say, well—in fact the majority counsel for the House of Veterans Affairs Committee said that to me about Vietnam Veterans of America legislative agenda. "This would be great if you were starting over." And I said, "Maybe we need to. Have you taken a look at what is going on?" Those aren't hypothetical stories about VA hospitals, for instance, in the State of New York, discharging homeless veterans after 4 o'clock because they know that the State-funded shelters have to take them. I mean those are real stories happening in Mr. Lazio's district right now. And we do need the drive, and if certainly this committee can help raise that conscientious among your colleagues—and I might add, as importantly, among the public at large, because even in Florida—in your district, Mr. Mica—people think that veterans are well-taken care of. They do not understand that veterans are not being well-taken care of, that people are literally being denied services that are vital, that keep them alive.

Mr. MICA. Thank you.

Mr. SULLIVAN. Congressman, specifically related to Gulf war veterans, because the Gulf war is a toxic soup with things that folks never dreamed that would be on the battlefield, like radioactive

toxic waste and mixes of pesticides and experimental pills to protect people against chemical warfare agents, plus chemical warfare agents—the main thing Gulf war veterans are looking for in healthcare is, the VA and DOD have acknowledged widespread contamination to radioactive toxic waste. At first they said it was nobody; then it was 30; then it was 100; then it was 800. Now it is hundreds of thousands, Congressman. When will the VA launch a comprehensive program into depleted uranium contamination? The stuff is radioactive. We are finding depleted uranium now, Congressman, in the semen of Gulf war veterans. They want to know "what does this mean? Should I have kids?" This is right in their face. Gen-X, that is my generation, the young folks are asking every morning. "Do we want to have kids?" I mean that is a healthcare issue right in our face that has implications for generations.

It also has implications on the experimental anthrax shot the Pentagon is using. We need to know what kind of health effects that has. Veterans want to know, when is the Pentagon going to do some new research on this experimental vaccine? They love to say, "Oh, it is FDA-approved." There is no FDA approval for the use of a vaccine against an unknown biological airborne agent. The Pentagon is lying through their teeth. Now what we have to find out is, when are we going to get healthcare for the known and unknown, or yet to be known, side-effects of the use of these experimental vaccines?

That is what Gulf war veterans want to know in a healthcare answer, because the Gulf war was an exotic, toxic soup of stuff, and we are waiting for answers, and we are trying to get healthcare.

Thank you, sir.

Mr. MICA. Thank you, each of you, for your testimony. I look forward to working with you. I think this is a good beginning and a good opportunity to get an overview, and, hopefully, our subcommittee with this new responsibility, can be effective. Thank you.

And I would like to recognize now, the gentleman from Indiana.

Mr. SOUDER. I thank the chairman.

One, I wanted just to say up front that I don't believe that veterans' benefits ought to be separated or be viewed as put in contrast with weapon systems, whether they be anti-ballistic missile systems or other strong national defense, because the last thing we want to do is have any current soldier go into war and not have the best plane, the best weapons; that is a nightmare. And as a country—as the gentleman from the Legion said—we need to make sure that we are protected as best as possible, because our goal is "peace," not "war," and as few wounded veterans and as few civilians as possible.

At the same time, a number of these things, if we don't address them, if we don't treat veterans fairly, in addition to the equity question, when we are in a voluntary military, it becomes a problematic question of how we are going to recruit if we are not fair. Or are we going to go back to draft days? So, it is not only an equity question, it is a practical question that we are facing as a Government.

We all have many cases in our district. I have had a couple that have come up to me with an unusual wrinkle, and I wondered, first off, if—I have gone through your testimony. I saw a couple of references that were tangential to this, but I would appreciate it if you can make some allusions here or check back, because it may be something we can actually, fundamentally, address, in addition to the broader questions that you have raised today.

One veteran—and it has to do not so much with war-related injuries, because while the veterans' facilities are tightening down and moving to more outpatient, it seems that if it is a direct war-related injury, they are still trying to accommodate that. But there are many injuries or health problems that come up that weren't directly war-related, and then as they try to seek outpatient service, what I have been running into, is something like what we seen in senior citizens case of almost it is requiring a "spend down" of any assets that the individual has or using those up before they are eligible for care, which wouldn't have happened in a veterans' hospital.

And, in particular, I had one whose wife was working as a greeter at Wal-Mart, but because he had another pension, her salary as a greeter at Wal-Mart, part-time, put him over the cap, where he would lose his benefits if she didn't quit her greeting job. And the argument was that his income sources were less than the welfare benefits cap, and that veterans aren't even up to what a welfare recipient can earn in the discretionary income.

A similar, but a different variation of this—and then if you can comment on these—that another veteran came to me the other week where we, I think—it is a similar thing on tax cuts and economic growth. Most veterans, after they leave the military, have other jobs in the society. So they want to make sure our society is functioning, that they have those jobs, but then that means, often, that they have other benefits they have accumulated which bring in pensions in addition to military pensions or sources of income.

And this person was told—he was, I think, in the veterans' hospital for 90 days, but because it wasn't long-term care—it wasn't war-related, he now had to leave. The problem was, is to get the intensive care that he now needed, it was going to cost a large amount of dollars. But because he had assets and a pension, he was not eligible for the subsidy because he was above the so-called income level. Yet, once he paid his home health costs of a constant care, that would use up all of his income.

So part of my question here is, do you hear variations like this? Because there are two fixes to this, possibly, at a minimum could be. One is, is that the cost of the care related to your income should be a calculation. A second should be that there is no way a veteran should be treated less than anyone else in the society, and wherever we have an income test for benefit of eligibility, that the veterans ought to be at the high-end of any scale like that, not at the low end.

Mr. CULLINAN. Mr. Souder. In the first instance, you are referring to a healthcare benefit?

Mr. SOUDER. Yes.

Mr. CULLINAN. It is not supposed to work that way. And we have a staff who would be glad—[laughter]—more than happy to look into it. It is absolutely not supposed to work that way.

The second instance, you are touching on the issue of long-term care. A number of us mentioned earlier, long-term care is not mandated under law, and that is the problem. And VA, for budgetary reasons, is actually eliminating, paring-down, its ability—its already eliminated ability to provide long-term care.

So really the answer is, is to get it mandated under law. In other words, we want at least some veterans to be guaranteed long-term care, under law. Then, we expect that the appropriations support should follow to sustain that.

You know, second, in the issue—with respect to long-term care, there are, given our current budget—what we would prefer is, is a guarantee for all veterans long-term care, period. Given the current budgetary climate, we are not going to realize that soon, so perhaps, then, there are veterans who would like to buy into VA as a long-term care provider. We would certainly support that effort as well.

There are certain veterans—if a veteran needs long-term care by virtue of a service-connected disability, he or she should get it—no co-payments, no means test, nothing. There are other veterans, though, who, of course—the veteran population is considerably older than the aggregate, than the population at large. There are a number of veterans who are seeking access to VA's long-term care provider. Right now, they are not getting it. As I already mentioned, VA is paring away its limited ability to do that. These veterans should be able to buy into VA, as a long-term care provider. And there are a number of veterans, especially among military retirees, but other veterans as well, who are very comfortable with VA and VA services. They should have that option.

Mr. WANNEMACHER. I would just like to say, Mr. Souder, the scenario that you put up, that veteran—right now the VA is caring for all categories, whether they are service-connected, non-service-connected, multi-millionaires; they can all receive healthcare, under the proposal. But what you are referring to, that individual that you referred to is classified, because he is receiving non-service-connected pension, is classified as a category 4. If he exceeded his income, he would be classified as a category 7. And, under the current law, categories 7's are subject to co-payments, so he would have to pay a co-payment on his medical care, and that is probably what the frustration was. You know, if my wife works, I am going to be classified as a category 7 and, then, not entitled to VA pension and, then, be subject to the co-payment.

And just one thing in your opening statement you said about defense and not subjecting veterans to that. There is something that you might want to share with your colleagues, that the response would be without sacrifices made by veterans, we would not have the level of peace and prosperity we enjoy today. The President, when he recommended that the virtual integration of VA and Department of Defense, when he said that, without Defense, there would be no veterans, that is arrogance. That is sheer arrogance. This country has to be a backup for DOD. The Veterans Administration has to be able to provide the services for veterans, and to

think that DOD—that veterans owes something to DOD is just ludicrous.

Mr. ROBERTSON. Congressman, the long-term healthcare issue is not unique—the problems they are facing are not unique to the veterans community. We all know that.

The American Legion, several years ago—4 years ago—developed a plan that we called the GI Bill of Health. And it sets up the VA healthcare as a network, in which veterans that are entitled to healthcare, i.e., service-connected veterans and the other categories of veterans that qualify economically, et cetera, would get their healthcare covered by the Federal Government. All the other veterans, and their dependents, that wanted to use the VA healthcare system could buy into the system, just like they would be buying healthcare from Great West or Aetna or whoever was selling those policies.

The idea being that veterans would be willing to pay for a system that they wanted, a system that they could depend on in their golden years, that there would be options for specialized services, that if I wanted to buy into a long-term care program, I could pay the VA, at the age of 45, start paying them, in the event, that somewhere down the road, my wife and I would need to be in a long-term care facility. This seems like a logical business-like approach to meeting this problem.

One of the tragedies that we see in the veterans community, is that we get a veteran taken care of in a State veterans' home, only to have his wife who he has been married to for 60 years at the other end of the State in a federally subsidized home, and the next time they are going to see each other is at a funeral.

That is a tragedy. On the side of a VA hospital it says, "to care for him who has borne the battle, and for his widow and his orphan." We are doing a good job in relative terms taking care of the veteran, but those other two are completely out of the box.

And maybe it is time to look at a quasi-Federal Government-type healthcare system for veterans. Because you remember, military retirees—a lot of people forget this—but military retirees are veterans, and we have them right now having brought battles over in Tricare trying to figure out a place to go. And to show you how the Government works, DOD has contracted with however many private healthcare companies, for-profit companies, to run Tricare, when VA has the same type of network already in place. So why are we paying a private-sector company to refer people back to military healthcare or back to veterans healthcare? That just doesn't make sense. We think that there can be some headway made in this area, and maybe address some of the long-term care problems.

Mr. MICA. I thank the gentleman from Indiana.

And I would like to recognize Mr. Filner, from California.

Mr. FILNER. Thank you, and I thank you for your courtesy.

Just quickly, a lot of these issues will be moot if a budget is not adequate, so I think, you know, we all have to focus on the budget at this moment. And I would just—I guess in the tradition of Mr. Sanders, be very frank. We all have flailed the President's budget—Democrat, Republican, all VSO's, bipartisan, nonpartisan—but let's get off—the President made a suggestion. Budget, by law and

Constitution, is Congress. He made his ideas, you guys, in my opinion, have to move on band. He kept within, by the way, the budget caps that the majority of Congress passed. So, it is not his budget, it is really the balanced budget's budget.

I don't see you flailing at the Veterans Affairs Committee budget that just came out. I mean the Legion now supports it, which, even by the independent budget, is too small. So I think we have to turn our attention to the congressional budget and start attacking that and making us accountable.

Steve, you said your members are only 1 percent of the population or—I mean the combined, I guess. Just give me those 2 million people, and I will pass anything in the Congress. You guys have incredible power to deal with this issue.

As I understand the process—and my colleagues can correct me if I am wrong—we have a budget resolution. It will be the next stage in this process. It looks to me that the leadership of the Congress is committed to keeping within the caps that we had previously agreed to, which means that we are $3 billion, plus, short of what we need for veterans.

I think your membership has to demand of their representatives—I don't care, Republican, Democrat—that they don't vote for that resolution unless there is a $3 billion increase for veterans. Because what will happen in the politics—and you have been all through this many times—if there are no changing of those caps, folks are going to use you and give lip service to you. They are going to propose "X" billion dollar increase if we cut the Housing budget, cut the EPA budget. So we are all in a completely unattainable situation. They are going to pit us, one against another, and say, "Oh, you are not for veterans. You voted to keep the EPA." And I will make the same argument about the EPA that you made about the Defense Department, you know—[laughter]—so unless we increase those caps, we are dead, in my opinion. And that is coming up next week, I think—at least in the House.

So I think you have to switch your attention away from the President's budget. It has nothing to do with anything right now, and say, "Unless we get $3 billion more in that budget resolution to be accountable to you." We are all giving lip service; everybody is talking the talk. You know, we are all for you. But unless they vote against that thing, it doesn't mean anything, because there is nothing we can do after that vote, except with untenably pitting forces against one another, to raise the level of the budget to what we have talked about today.

So, I—that is a political issue; I don't think it is partisan, but I think you all have to begin to attack the congressional budget—[laughter]—and not the Presidential budget, and hold us accountable for that next vote that is going to occur.

Mr. WANNEMACHER. Congressman, I——

Mr. SULLIVAN. Congressman Filner, I would like to be able to restate what the Gulf war veterans said.

We believe the VA needs $3.2 billion more than what was proposed by the administration and $1.3 billion more than what was approved by the House Veterans Affairs Committee. Since the current economic boom created a Federal budget surplus, the VA budget cap should be lifted. Flat-lining appropriations during war, while expenses soar and the number of patients demanding care increases, is a recipe for disaster.

They might as well just close the VA.

Mr. WANNEMACHER. Congressman——

Mr. FILNER. I would hope that the other five would agree with you. [Laughter.]

Mr. WANNEMACHER. We would agree with that, and we, as you know, we had our members—we were in town all this weekend, and they were all sent out to talk about lifting the caps. And I want to tell you that last year, Congress had no problem lifting the caps when Transportation identified a need. They took away $15 billion from the VA account. We wouldn't be in this situation today if it wasn't for what happened last year. So we encourage all of you that are still here, and I hope you pass it on that the Veterans Administrations appropriations are just inadequate and we need additional resources.

Mr. SANDERS. So you are in agreement with what Paul said——

Mr. WANNEMACHER. Absolutely.

Mr. SANDERS [continuing]. In terms of lifting the caps?

Mr. WANNEMACHER. Exactly.

Mr. SANDERS. Is that true for all of you?

Mr. CULLINAN. For our part, we are agitating to lift the caps. We have our people addressing that specific issue. You may have seen in the Congressional Monitor that we were specifically saying, "Raise the caps."

Once again, am I optimistic? We are doing the right thing. We are agitating to get those caps lifted. Are we going to do it?

Mr. SANDERS. OK. One of the reasons——

Mr. ROBERTSON. Well, I am the odd man out, because the American Legion, last October, testified before a joint session of the Veterans Affairs Committee and said that we felt that we were $1.9 billion low now, on what our current funding levels were. And we asked the President's budget to include that increase. We have been consistent with that number. We are at a point where we are talking about need versus wants.

We, in our estimation, believe that the $1.9 is a solid figure to meet the current needs of the VA. Does it make the best VA in the world? No; but what we are talking about is what we need to keep from shutting down hospitals and turning people away. Do we need additional funding? Yes. And I, you know, the $3 billion number is probably a good number to make us whole again.

And the American Legion started our lobbying efforts last October before the budgets were even introduced, and we have continued that process. We, too, will have people in this next week that will be attending a conference here in Washington. But we are using the Internet, we are using our magazines and our other publications to make sure that everybody understands what needs to be done as far as the appropriations process.

And just for the record—and I don't think I am speaking out of the school—and folks from the independent budget can correct me if I am incorrect in my statement. But almost every year, the independent budget has been around $2 to $3 billion increase request, historically, for the last 10 years that I can remember.

I am sorry, go ahead.

Mr. CULLINAN. I know that this isn't quite the forum for this. Actually, a number of years ago, the independent budget's baseline

was adjusted. And, actually, this touches on a question that you posited a little while ago, Mr. Sanders. How do we get into this past?

Perhaps we are trying to be too reasonable; I don't know. Perhaps we are trying to be all too reasonable. I think that you would say that we are. When we adjusted our baseline, the situation then, we were about $6 to $7 billion out of whack with reality. For the sake of creditability, that baseline was adjusted. Was that wrong? I mean you would say, "Yes." I can see you——

Mr. SANDERS. I think I would——

Mr. ROBERTSON. But that is the problem we have had, is that we have had two tiers—what we have been asking for versus what we have been getting, and that gap has gotten wider over the years to where we are at in the situation we are now.

So, do we all agree that, yes, we need a lot more money? You are absolutely right.

What we are facing right now is what we are going to be able to achieve. We are only talking $1.1 billion difference between the two groups of numbers that we are throwing out here, but the important thing is that it sets the baseline for 2001. That is the thing I am concerned about. If we wind up getting nothing, then we have got—looking at a $4 billion request for next year to make up for the shortfall we had this year.

Mr. WEIDMAN. I just wanted to add in, Mr. Filner, that the difference between the $1.9 and the $3.2 billion—there is no guarantee that the budget committee is going to come up even $1.9 billion. What we are looking for is some leadership out of the administration. Our executive directors all met with Vice President Gore on Tuesday and said, "You have to do something." Frankly, we are not getting that leadership out of the Secretary of Veterans Affairs that we have every right to expect. Images of Nero come to mind. We need to have the leadership of the administration. If the administration decides to get into this budget battle as a player, those caps can be lifted and, frankly, would make the jobs of those of you who are pushing for $3 easier. You would have to break the budget cap just to $1.9 billion. We need Presidential leadership on this. Forty commitments to harms way in the last 6 years. That seems to me to merit a response on the part of the President to say, "Gosh, we goofed on the VA budget. We are going to try to get into this and raise the caps and do what is necessary in order to start down the road toward fixing this problem."

Mr. FILNER. I thank the gentleman, and the leadership has to come from everywhere, because they are not going to be broken, even for the $1.9 billion or $1.1 billion that the Senate passed anything, unless we have leadership and your folks are politically involved at the grassroots.

Thank you, Mr. Mica.

Mr. MICA. Well, I want to thank the panelists of the various veterans service organizations for being with us today, for helping us launch our effort with this subcommittee which, again, is entitled National Security, Veterans Affairs, and International Relations.

I think we have had a good airing of some of the challenges that face us, and I tend to be an optimist. I think if we all work together that we can make some great progress, particularly in this time

when we are fortunate, as a Congress and a Nation, to have a small, annualized surplus. Certainly, our veterans should be first in line as a priority of the Congress and the country.

With there being no further business to come before this subcommittee this morning, I call this meeting adjourned.

[Whereupon, at 10:32 a.m., the subcommittee was adjourned.]