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PENDING HEALTH CARE RELATED LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

JUNE 9, 2005

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PENDING HEALTH CARE RELATED LEGISLATION

THURSDAY, JUNE 9, 2005

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

The committee met, pursuant to notice, at 10:06 a.m., in room SR–418, Russell Senate Office Building, Hon. Larry Craig (chairman of the committee) presiding.

Present: Senators Craig, Thune, Akaka, Rockefeller, Murray, Obama, and Salazar.

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

Chairman CRAIG. Good morning everyone and welcome to the committee. The Senate Committee on Veterans' Affairs will be in order.

Today, the committee meets to receive testimony on several legislative proposals that have been introduced by Senators during the first session of the 109th Congress. We have a total of 10 items on the agenda today. All of the bills focus on changes in VA's health care system. They include four bills from the Ranking Member, Senator Akaka, three bills from Senator Salazar, one from Senator Obama, and one bill from Senator Specter. Last, and I certainly hope not least, legislation that I have introduced.

I am very pleased that the Secretary of Veterans Affairs, Jim Nicholson, is here this morning to offer VA's views. And I want to welcome the veterans service organizations as well. I understand we had some difficulty providing complete language from some of the bills and because of that the witnesses may be unable to comment fully on all of today's agenda. I certainly hope that the witnesses will make every effort to follow up as quickly as possible with their views so that we might have them and they will become a part of the committee's record. It is important that we know the Administration's view about legislation and what our veterans themselves also think about these individual legislative proposals.

As I mentioned, I have one bill on today's agenda, S. 1182. I outlined all of the provisions of the legislation in great detail in my statement to the Senate when I introduced the measure so I will not take up a lot of the committee's time this morning to restate what I have said, but I do want to take just a moment to highlight some of the important aspects of the bill.

S. 1182 offers a few important policy markers that I believe this committee and Congress must discuss and grapple with during the

109th Congress. The first of these is the provision of long-term care for our veterans. In S. 1182 I propose to remove from the law the so-called capacity requirement that VA maintain the same number of long-term care beds as it had in operation in 1998. I raise this provision to my colleagues' attention because I want to make it clear that I am not suggesting that VA should abandon its institutional long-term care program. Instead, I view this proposal as the first step in fostering a discussion about how we can develop a rational, sustainable and workable program for long-term care for our veterans that focuses on choices and options rather than beds and buildings. Of course in saying that, it should also be pretty clear that the current statutory mandate is not, in my opinion, a rational, workable program.

I welcome all of my colleagues' views on this discussion. I know we share a desire to ensure that the best services be available to our veterans. We also share a desire to make certain that the resources we devote to the health care system are spent as effectively as possible with no dollar wasted. I hope we can move closer toward those goals in VA's long-term care program.

Second, I want to point out that the provision in S. 1182 would allow VA to provide or pay for the first few days of hospital care for newborn babies of women veterans who give birth under VA care. VA claims to offer a comprehensive package of health care services to enrolled veterans. In my humble opinion, because the package does not offer any coverage for a newborn child it is not a comprehensive package for our women veterans. These brave women make up an increasing part of our military force and the military is changing in many ways to reflect this new reality. VA must do the same. I hope this provision will move us forward in that goal.

Finally, I want to mention the section of S. 1182 that makes improvements in VA's mental health programs. I know that many of you on this committee and in the audience have concern about returning troops and their need for mental health services. To that end, there have been a number of proposals put forward by Senators and Representatives to deal with this issue. All of them have the best intentions in mind.

My approach to this important issue is consistent with my belief that Congress should not micromanage the VA's care system. In fact over the past few years, largely on its own initiative, VA has become one of the Nation's best health care systems. So my legislation sets forth a few areas which I believe VA can expand and improve on its past successes in the provisions on mental health services. I attach a reasonable amount of money to the effort to make those improvements and I intend to monitor the progress closely from the committee. I hope other Members will join me in this approach so we can make real and necessary improvements while at the same time not trying to over manage VA's clinical care program to the detriment of other important needs.

Let me stop there and turn to our Ranking Member first who has several pieces of legislation that he may wish to speak about this morning in his opening comments, and then I will turn to the balance of the committee. With that, let me turn to Senator Akaka.

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

Senator AKAKA. Thank you very, Mr. Chairman. Again I want to reiterate my pleasure in working with you on this committee and your staff as well. I feel that we have made tremendous progress thus far, and of course, we need so much more together. I want to thank you for this hearing and welcome our good friends, Secretary Nicholson and Undersecretary Perlin and General Counsel McClain, as well as our veterans service organizations who are here.

As we have a full legislative agenda before us today I want to take just a moment here. Over the last few months I have introduced several pieces of legislation. They share a common theme. The goal of each is to make sure that returning service members get the care they need while continuing to improve care for veterans already in the system. First is legislation to allow a full 5 years of VA health coverage to returning service members without bureaucratic hassles and stringent eligibility rules. This can further the seamless relationship we talk about of military personnel from active duty to VA.

Today, any active duty service member who is discharged or separates from active duty following deployment to their Iraqi theater of combat, even Reservists or Guard who stand down but remain on duty, will be immediately eligible for VA health care for a 2-year period. There are good reasons to give returning service members more than just 2 years. Most notably, it is clear that 2 years may not be enough time for symptoms related to PTSD to manifest. Even if symptoms present in the 2-year timeframe, it might be some time before a service member decides to seek care. VA opposes this legislation on the grounds that returning veterans could enter the system like other veterans. Looking at the proposals in the President's budget and the decision to cut middle income veterans out of the system in 2003, I am not as confident and do not want to take that chance.

We also have legislation before us to specifically address mental health. I truly believe that VA mental health is in jeopardy due to budget constraints. Increased demand and flat line budget increases over the past few years have literally starved the system. The demand is about to grow. Experts have conservatively estimated that up to 20 percent of men and women who are currently serving in Iraq and Afghanistan will require treatment for a mental illness health issue.

Congress has already recognized the merits of all specialized programs, including mental health. As such, we enacted legislation that required VA to retain its ability to provide services at the levels in place in 1996. Unfortunately, the VA was not required to adjust this figure for inflation. Quite obviously, using 1996 dollars in 2005 is not working. As we are on the precipice of burgeoning demand for care we need to be talking about real dollars, not 1996 dollars, to get a true sense of VA's capacity to care for veterans with mental health needs.

Mr. Chairman, I look forward to working with you on the days ahead to move the committee's agenda forward, and today I look

forward to the views of our witnesses. Thank you very much, Mr. Chairman.

Chairman CRAIG. Senator Akaka, thank you very much for that opening statement and those pieces of legislation.

Now let me turn to Senator Salazar. The Senator has introduced three pieces of legislation that are on the agenda today for hearing. Ken, please proceed.

OPENING STATEMENT OF HON. KEN SALAZAR, U.S. SENATOR FROM COLORADO

Senator SALAZAR. Thank you very much, Chairman Craig and Senator Akaka for putting together this hearing. Thank you, Secretary Nicholson and Undersecretary Perlin and General Counsel McClain for being here as well, and all the members of the veterans service organizations who are here today.

I want to start out by commenting on what I see as a positive development here in Washington, DC. In my short time here in Washington I have seen how the poison of partisan politics can slow down the process on important legislation for the people of our country. People in Colorado and across the country are rightly concerned that Congress is sometimes more interested in partisan infighting than in working together to make their lives better. This committee, however, Mr. Chairman, under your leadership I believe is an exception. Members in this committee do have some important policy differences and the majority and minority do have different approaches for fixing some of the problems that our veterans face. But we do share much more in common than many realize.

We both recognize that the VA is under funded and facing bigger workloads every year. We recognize that the VA needs to do more to improve mental health care. We believe that there are many pockets of rural America where there is not enough access to veterans health care. We share outrage that hundreds of thousands of veterans are homeless every night. We see the need to improve outreach at vet centers to make life easier for veterans returning from Iraq and Afghanistan, and to extend low price prescription drugs to more veterans. There is much in that common agenda.

We will discuss a number of important pieces of legislation today. Senator Craig's bill has a number of very good provisions. I would like to see some changes in this bill, including the VA's nursing home capacity requirements and look forward to working with you on that legislation. Senator Akaka has introduced a number of important bills, including one I am proud to co-sponsor which will improve mental health care across the spectrum. I urge the committee to pass this legislation sponsored by Senator Akaka. I also urge the committee to review and approve Senator Obama's homeless veterans bill and to embrace the goals of Senator Specter's prescription drug bill.

I want to thank Senator Craig and Akaka for adding three simple but straightforward and important bills that I have introduced to help improve care for rural veterans, expand services for blinded vets, and to push the VA on its strategic planning for long-term care. These are three bills that are roundly supported by the VSO

community. They will improve the lives of thousands of veterans, they are fiscally responsible, and we can afford them now.

First, let me speak for a minute about Senate bill 1191, the Vets Ride Act bill for rural vets. This bill would provide critically needed transportation services in remote, rural pockets of the country by having the VA partner with veterans service organizations and State veterans service offices. In Colorado, the American Legion has partnered with Routt County State veteran service officers to fulfill this gap and provide transportation options to veterans across northwest Colorado. They rent vans, pick up elderly vets and drive them to Grand Junction to the VA medical center and put together what is essentially a 300-mile round trip to help these veterans.

Such ad hoc arrangements have developed all over the country. Although they have community support, many of these travel arrangements suffer from chronic under funding. This is an area where a relatively small amount of Federal investment can result in significantly better care for our Nation's rural veterans. I urge this committee to support my bill to create a small grant program to support VSOs and State officials through this vet ride program.

Second, the blind vets, Senate bill 1190, the Blinded Veterans Continuum of Care Act improves care for blinded veterans by increasing the number of outpatient specialists at VA medical centers. This is another area where a relatively small Federal investment can make a major difference in the quality of life for veterans. There are 135,000 blinded veterans, including 1,400 in Colorado today. For these veterans, the right type of expert long-term care can mean the difference between being imprisoned at home, unable to work, and living independent, rewarding lives. It is literally a difference between night and day.

In 1996, the VA introduced blind rehabilitation outpatient specialists at a small number of facilities. These programs offer training with living skills, mobility, and technology. They offer outpatient and in-home care. They provide pre-screening and follow-up care for blind rehabilitation centers. While the program has grown, there are still not enough of them to meet the demand. The bill I propose would expand this successful program and ensure that thousands more blind veterans have the services they need.

Finally, Mr. Chairman, Senate bill 1189 on long-term care would require the VA to publish its strategic plan for long term within the 6 months. Last month at a hearing of this committee, Undersecretary Perlin and Members of this committee and myself had an ongoing dialog about the vision for long-term care that Dr. Perlin so eloquently stated. I believe we need to move forward and put that vision into a strategic plan.

The CARES Commission recommended that VA develop a strategic plan for long-term care. More than a year later I know that the VA is still working on that plan, and I believe making progress. My bill simply sets a deadline. It also includes some reasonable but critical requirements on that plan. For instance, the plan, I believe, should include cost and quality analysis of the entire spectrum of care for veterans. A comprehensive plan will not only help the VA but also help Congress in its oversight of the important challenge of long-term care for our veterans.

I thank you again, Chairman Craig, for your leadership and, Senator Akaka, for your participation in leadership of this committee. Thank you.

Chairman CRAIG. Ken, thank you for those explanations of your legislation.

Senator Murray, do you have any opening comments?

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

Senator MURRAY. I do. Thank you very much, Mr. Chairman, and thank you to all of our panelists for being here today to testify on these important pieces of legislation.

Mr. Chairman, I really share my colleagues' concern regarding the need for increased access to health care for our American veterans and I am really disappointed that inadequate funding has really led to some severe barriers for health care for a lot of our veterans. I support many of the proposals that are before us today, especially Ranking Member Akaka's veterans mental health care capacity enhancement act.

A few months ago I had the opportunity to visit with some troops from Washington State in Iraq and they told me their biggest concern is health care for their families and themselves once they finish their tour of duty. I have also held field hearings and I have spoken with veterans from all over my State about their need for health care. The veterans I have met with in Washington State have made it very clear that reductions in mental health resources are coming at the worst possible time, just as veterans from Iraq and Afghanistan are returning home with PTSD and other mental health concerns. The VA does not have the resources available to handle their needs.

I also have some concerns with other parts of the legislation being reviewed today. Specifically, I just want to say that I do oppose the provision in S. 1182 that repeals the Millennium bill's long-term care bed census requirements. This committee just heard a few weeks ago from Alfie Alvarado-Ramos, the assistant director of Washington State Department of Veterans Affairs and president of the National Association of State Veterans Homes, about the demand that is increasing for long-term care facilities. The population of veterans over the age of 85, the most likely to need VA long-term care, is expected to double over the next 10 years.

I believe the Administration and this committee need to aggressively look at serious solutions to meet that need and not back away from our commitment and avoid the problem.

Secretary Nicholson, I looked over your testimony and I am happy to hear that you do support increased mental health resources for our veterans, and especially for those soldiers and sailors and airmen and marines that are returning from overseas. Over the past month I met with some Guardsmen and Reservists in Washington State who just got back from Iraq and many of them commented to me on the need for increased resources for mental health needs, especially in the area PTSD. I think it is really vital that we provide the resources to them and the VA to help them integrate back into our communities and prevent the long-term psychological and health damage that can result.

As you know, Mr. Secretary, I supported increased funding for that and other needs as part of my veterans amendment to the supplemental, and I was disappointed that the Administration did not support us on this. I am very concerned that this committee is going to move with some very important needed VA programs just to see them under funded by billions of dollars by the VA, and limiting our ability for veterans to get access to these program. The current funding reality is a major reason why I support Senator Johnson's assured funding for veterans health care act which would make VA health care funding mandatory.

So with that said, I look forward to your testimony, Secretary Nicholson, on how the VA is going to pay for these expanded services while still maintaining our current levels of service.

Thanks very much, Mr. Chairman.

Chairman CRAIG. Senator Murray, Patty, thank you very much.

Let me turn to Senator Obama. A bit out of order, but Senator Rockefeller has agreed here. The Senator has to go to another committee as soon as he can and yet he has a couple of pieces of legislation before this committee so, Senator, we will turn to you.

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

Senator OBAMA. Thank you so much, Mr. Chairman, and let me thank my senior colleague—senior in experience, not in years—Jay Rockefeller for letting me go first.

First of all before I begin, let me thank Secretary Nicholson. He had committed to come to Illinois to talk about disparities in payments for disability veterans. I just want to let the committee know that Secretary Nicholson is a man of his word. He came, met with veterans there, and responded. We very much appreciate that and we will be working with him diligently to solve some of those issues.

Mr. Chairman, Ranking Member Akaka, I would like to thank you for holding this hearing so that this committee can learn more about pending veterans health care legislation. I am very impressed with the pieces of legislation that have been presented by the various Members of the committee. I am also pleased that a bill that I have introduced, the Sheltering All Veterans Everywhere Act, or SAVE Act, made it on the docket for today's hearing.

As many of you know, our Nation's veterans suffer from homelessness at a rate far higher than the average population. The VA estimates that more than 250,000 veterans are homeless on any given night, and that more than 500,000 experience homelessness at some point each year. That is obviously an embarrassment to the Nation that veterans who served our country would find themselves disproportionately in such circumstances. Male veterans are twice as likely to become homeless as their non-veteran counterparts. Female veterans are almost four times more likely to become homeless than their non-veteran counterparts. Those are remarkable statistics.

The bill I introduced will reauthorize and expand several important homeless veterans programs. I am proud that the SAVE Act has the support of more than 10 national homeless and veterans advocacy groups, groups ranging from the National Coalition for

Homeless Veterans to the Paralyzed Veterans of America, from the Volunteers of America to the American Legion, have all endorsed the bill that I have proposed.

I thank very much the Chairman, the Ranking Member, and my colleagues on the committee for considering this bill. I look forward to working with my colleagues on this and other important veterans health care initiatives.

Secretary Nicholson, I understand that you were not able to prepare a VA position on the SAVE Act in time for this hearing, so I just want to make sure that you will be willing to submit for the record VA's position on the bill and look forward to reading your response. So thank you very much.

Chairman CRAIG. Senator Obama, thank you. Before you came in I did make mention that some of the text of the legislation was not available and that the record will be left open so that the Administration can produce testimony for these pieces of legislation for the record.

Senator OBAMA. Thank you, Mr. Chairman.

Chairman CRAIG. Now let me turn to certainly one of the senior Members of this committee, Senator Jay Rockefeller.

Senator.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I will be extremely brief because I also have to go to a committee hearing. Actually, just so Secretary Nicholson does not have to think that all problems are veterans problems, it is interesting in our aviation transportation security, two-thirds of all the planes that fly around in the air at any given moment are private, corporate, individual, or whatever. They are subject to no security whatsoever. People getting on, people getting off. It's amazing. So we have spent billions on the commercial and not a nickel on the other.

I just wanted to pay my respects to the Chairman and to the Ranking Member; say that I agree very much with Patty Murray when she indicated about the Millennium Act; express some reservations on Senator Specter's S. 416; obviously support the Salazar bills, and the homeless and other bills. But simply just to say that this all becomes important. I had to make two more phone calls to West Virginia mothers last night about soldiers who had been killed. Not wounded, but killed. And it goes on. They will not be veterans, but this is all going on and it just makes it tremendously important for us to do the right thing.

So I wanted to stop by, even if I could only say that. I thank the Chairman whose leadership is always good, for his courtesy, and I thank the Secretary.

Chairman CRAIG. Jay, thank you very much.

Now let us turn to our first panel. In part, they have been introduced by other of our colleagues, but let me formally welcome to the committee and our first panel, the Honorable Jim Nicholson, Secretary of Veterans Affairs. He is accompanied by the Honorable Jonathan Perlin, Undersecretary for Health, and the Honorable Tim McClain, General Counsel to the Veterans Affairs or the Administration. We thank you for being here.

Mr. Secretary, please proceed.

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

Secretary NICHOLSON. Thank you, Mr. Chairman, and good morning Senator Salazar, Senator Murray. I appreciate your being here. I also would mention that I have to be very careful this morning because my sister is also here visiting from Colorado as part of Senator Allard's——

Chairman CRAIG. Why don't you introduce her to the committee?

Secretary NICHOLSON. All right, there she is. We call her Bunny.

Chairman CRAIG. Good morning; welcome.

Also, before you proceed, somebody brought a pipe organ in with them. Would you turn it on vibrate? Thank you.

Please proceed.

Secretary NICHOLSON. Just to mention, my sister is a very respected advocate for children, used to be in Colorado, now nationally. She lectures nationally and I am very proud of her.

With your permission, Mr. Chairman, I would like to summarize my written testimony and submit the full text of my remarks for the record.

Chairman CRAIG. Without objection, your full comments will be a part of the record.

Secretary NICHOLSON. This year marks the Department of Veterans Affairs' 75th anniversary. The creation of the Veterans Administration in 1930 was a watershed event for America's citizen soldiers. VA's birth represented the realization of the four pillars of President Lincoln's promise: the steel and stone of VA facilities where veterans receive the care and benefits they earned in freedom's defense, the compassion and commitment of VA employees to serve their fellow citizens who had selflessly served them, the law of the land as legislated for veterans by the Congress of the United States on behalf of a grateful Nation, and the stewardship of the Chief Executive and Commander in Chief sworn to care for him and her who shall have borne the battle.

I am taking the liberty of mentioning our 75th anniversary, Mr. Chairman, one, because I am proud to lead such a fine and honorable organization, and two, because even after 75 years it is clear as I read the legislation you and your colleagues are proposing that the Congress and VA, despite some differences, are still partners and advocates for our Nation's veterans.

Mr. Chairman, we are certainly in step with provisions of the Veterans Health Care Improvements Act of 2005. My written response reflects that harmonious occasion when legislators and the White House are able to plow common ground together. I commend you, Mr. Chairman, for your prescience in creating and crafting legislation that will certainly benefit America's deserving veterans, young and old, who depend on my department to be there for them fairly, compassionately, and sensibly.

Your legislation addresses the same issues President Bush identified as needing timely and equitable corrections in order to level the playing field of out-of-pocket reimbursements for emergency care costs. Consistency and fairness must go hand-in-hand and we fully support your efforts on our veterans behalf.

Mr. Chairman, you and I know all too well the impact PTSD and other mental health disorders have not only had on servicemen and women who bear that burden, but also on their families, and their friends, employers, and the communities who look to us for compassionate care for their loved ones and fellow citizens. Any legislative path that we can travel to help alleviate mental health suffering of our young men and women returning from their overseas duties is a path we must take, and I commend you for paving that path with durable and considerate legislation.

Mr. Chairman, I also want to applaud you for understanding the mechanics of my department, how we accomplish the good work we do, and how certain laws have impeded our ability to fulfill our health care promise to our veterans. Your bill repeals two laws that are outdated, unnecessary, and costly to VA's mission. Most importantly, your legislation removes the barriers to caring for veterans where they may need care the most, at home or in settings of their choice.

With respect to Senate bills 481, 614, and 716, Mr. Chairman, we either do not concur with the assumptions on which the legislation is based, or we take issue with the consequences of the legislation, or we believe that we are already providing veterans with the services proposed in the bill, rendering redundant the legislative intent. In the interest of time I will reserve my comments on our specific differences should the Members of the committee have questions following my statement.

Finally, Mr. Chairman, there are several additional draft bills that we have not yet had an opportunity to carefully review. One is titled the Sheltering All Veterans Everywhere Act. While I cannot comment on the specific bill, I do want to state for the record that VA is a relentless advocate for stemming, reversing, and eliminating the tide of homelessness that overwhelms literally hundreds of thousands of veterans every year. The Department of Veterans Affairs devotes more than $1.1 billion every year to provide health care services to more than 100,000 homeless veterans. The Veterans Health Administration has provided specialized services to 300,000 veterans under its homeless-specific programs.

Mr. Chairman, 11 years ago in 1994, VA began awarding funds under the Homeless Grant and Per Diem Program. By the end of this fiscal year we will have awarded approximately $90 million in funding to 350 organizations to create 10,000 transitional housing beds, more than 40 service centers, and 100 vans for transportation. We would not be so successful without the partnerships we have forged with businesses, communities, and faith-based nonprofit organizations. I will put our record of compassionate care for homeless veterans up to any bright light inspection. I am proud of our record on behalf of homeless veterans, and the VA always is a champion for any man or woman who is outside looking in. In fact, I currently chair the intergovernmental agency for homelessness in the Federal Government.

Mr. Chairman, the VA is moving at a very brisk pace these days. We are leading in health care. We are ahead of the curve in the use of new electronic records management technologies. We are exploring innovative rehabilitation therapies and prosthetics. We are expanding our community care base. We are in a major facilities

realignment and expansion. We are more sensitive than ever to our aging veterans' needs. We are developing new employment opportunities for our veterans returning from Southwest Asia. We are honoring our fallen veterans and we are providing benefits and compensation in record amounts.

Our good works are too many to enumerate in the time I have left, but let me just say in closing that as we look back over the last 75 years of service to America's veterans, VA's success would not have been possible without the bonds of cooperation between the Congress and the Administration. William Wrigley once said, when two men in a business always agree, one of them is unnecessary. Mr. Chairman, over the years there have been many collegial disagreements about process between our respective institutions. But those differences, in the end, strengthened our mutual progress to care for him and her who bore the battle.

Thank you, Mr. Chairman. I would be pleased to answer any questions you or the committee members may have.

[The prepared statement of Mr. Nicholson follows:]

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

Good afternoon Mr. Chairman and Members of the committee:

I am pleased to be here this morning to present the Department's views on several different bills being considered by the committee. They cover a wide range of subjects related to VA's provision of health care services to veterans.

VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005

Mr. Chairman, I will begin by commenting on your draft bill that includes an array of provisions, many of which would carry out proposals that were included in the President's budget submitted to Congress earlier this year. We strongly support enactment of this measure and we appreciate your inclusion of provisions to carry out the President's plans for assisting veterans and for assisting the Department to carry out its mission.

One major provision in the bill would expand VA's authority to assist with payment for emergency-care costs that veterans incur in private hospitals. As you may know, a major study found that veterans with cardiac emergencies, despite having health insurance, often deliberately forgo emergency treatment at the closest community hospital (where they might incur out-of-pocket expenses) in favor of receiving care from the nearest VA facility at no or minimal cost. Delaying needed emergency medical treatment can jeopardize their health status and hinder the Department's ability to timely and successfully manage their emergent medical conditions. Under current law, a veteran who obtains emergency care in the private sector for a nonservice-connected condition is not eligible for VA reimbursement for the related expenses if the veteran has any insurance or other coverage for the cost of the care, in whole or in part. Your proposal would amend the law to enable the Department to reimburse a veteran for out-of-pocket expenses not covered by insurance or other coverage, thereby ensuring that veterans, whether insured or not, have consistent access to optimal care for emergency health conditions.

Unfortunately, the stress of combat leaves scars on many veterans. Your bill contains several new authorities that will help assist us in caring for those returning from overseas who are suffering from PTSD and other mental health disorders. The bill also contains a provision to exempt former POWs from having to pay co-payments in connection with the receipt of extended-care services, and a second provision to exempt veterans from co-payments for hospice care in a hospital or at home. These provisions will be extremely beneficial to the affected veterans. The bill would also authorize time-limited care for newborn children when veterans deliver the children under VA auspices.

Finally, Mr. Chairman, your bill contains two provisions that would repeal laws that have seriously hindered our efforts at VA to provide veterans with high-quality care by the best and most cost-effective means. The bill would repeal a law that requires VA to maintain at least the same staffing and level of extended-care services in Department facilities as was provided in fiscal year 1998. That law has seriously

limited our ability to provide or pay for extended care services for veterans in a variety of institutional and non-institutional settings outside VA, including private nursing homes in the community and State nursing home facilities. As you know, many veterans prefer to remain in their homes and communities, and it is often cost-effective to provide care in those settings. Your bill would also repeal an old law that generally bars the Department from using appropriated funds to compare the costs of providing services directly, or by contract, which impedes our ability to obtain the best possible value for veterans. On a government-wide basis, public-private competitions completed in FYs 2003 and 2004 are estimated to generate savings, or cost avoidances, for the taxpayer of more than $2.5 billion over the next 3 to 5 years. The tailored and responsible use of competitive sourcing at VA will help the Department free up resources that can be dedicated to our veterans.

S. 481

Several years ago, Congress enacted a law authorizing VA to provide treatment to veterans returning from combat service for conditions that might be related to that service, even when there is not sufficient evidence to conclude that the condition is attributable to service. VA can provide that treatment for a 2-year period following release from service, during which it would be expected that the veteran might apply for service-connection for the condition.

S. 481 would extend the period of eligibility under this law from 2 years to 5 years. Apparently, the intent is to ensure that a combat veteran can continue receiving VA care for 5 years, rather than just 2 years. We do not believe this measure is necessary.

The current 2-year post-combat eligibility period provides ample opportunity for a veteran to apply for enrollment in the VA system. When such a veteran does enroll, VA places that veteran in enrollment priority category 6 during the 2-year period, and provides cost-free care for any disorder that may be attributable to the combat service. VA will also provide care for any other disorder, but the veteran would be charged any co-payments that may apply based upon the veteran's income. At the end of the 2-year period, the veteran could continue receiving VA care, but would be placed in the appropriate priority group, and might be subject to co-payments for all care.

S. 614

Mr. Chairman, S. 614 is a bill that is identical to a measure that was considered during the 108th Congress, when the Department voiced its opposition. It would provide all Medicare-eligible veterans with a new prescription drug benefit through VA. Specifically, the bill would provide this new benefit to Medicare-eligible veterans with a compensable service-connected disability. It would be in addition to the health care benefits they are currently eligible to receive from VA. Those who do not have a compensable service-connected disability could choose to receive the new prescription drug benefit in lieu of all other VA health care benefits.

Before this committee last year, Deputy Secretary Mansfield testified that it is not clear how the VA benefit proposed in this bill would interact with the new Medicare benefit. As you know, we are now a year closer to full implementation of that new Medicare benefit. We continue to have the same concerns. Mr. Mansfield also stated that the proposal could have significant effects on other public and private health care programs by jeopardizing the current discount prices VA receives on pharmaceuticals. That concern also remains. Additionally, enactment of this measure could encourage situations where a veteran is receiving care and prescriptions from VA, and from outside sources, yielding increased costs, increased confusion, and decreased patient safety. Accordingly, I again must say that we cannot support this bill.

S. 716

I next turn to S. 716, which deals with VA's outreach to veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) regarding services they can receive from VA's Readjustment Counseling Program and other VA mental health programs. The bill would specify that VA may provide bereavement counseling to the families of those who die in active military service. We fully support the intent of S. 716, and in fact are currently carrying out most of its requirements. That being the case, enactment of the bill is unnecessary.

Specifically, S. 716 would require that VA employ 50 new individuals, all of whom must be veterans of either Operation Enduring Freedom or Operation Iraqi Freedom, to provide outreach to other veterans when they return from service in those operations. As we have previously advised the committee, last year VA employed

and trained an additional 50 veterans from the ranks of those recently separated from OEF/OIF to work in Vet Centers providing outreach, and we have committed to hiring an additional 50 veterans this year. The 50 persons hired last year were all given career-conditional appointments. That means that these veterans can expect to retain their employment. This bill further provides that any limitation on the duration of employment for these employees is terminated, and it would require that the additional 50 appointments that we make this year also receive career-conditional appointments. The latter provision is imprudent.

We do not intend to terminate any of the positions in question, but at the same time we do not expect that the conflicts in Central Asia will continue indefinitely. We hope the day will come when we will no longer have to undertake the outreach contemplated by this bill. If the need for these positions ends at some point in the future, the employees would likely move into other positions in VA, or be eliminated by attrition. However, to permit wise and efficient stewardship of the Department, we urge amendment of this legislation so as not to restrict the nature and duration of the appointments we make.

S. 716 would also more explicitly provide that VA has authority to provide bereavement counseling for the families of deceased active duty servicepersons, including parents, and that VA can provide the counseling in Vet Centers. In August 2003, former Secretary Principi directed that Vet Centers develop a program to provide such bereavement counseling, and we are now actively providing that service. In the operation of that program, we have permitted counseling various members of the family, including the parents of the deceased. Since the inception of the program, the families of over 365 servicepersons who have died on active duty have been referred to the Vet Centers for counseling assistance, and the Centers have provided services to over 555 family members. The average number of counseling sessions provided to each family member has been six. Program clinical experience has been that most families need a supportive therapeutic environment to assist them in processing the immediate stages of grief and to stabilize their situation sufficient to mobilize their own coping resources.

Finally, S. 716 would authorize $180 million to be appropriated for the provision of readjustment counseling and related mental health services through Vet Centers. In the current fiscal year, VHA allocated a total of $94 million for all Readjustment Counseling Service activities. We estimate that the additional services that this bill would direct, and that we are in fact already implementing, will require only about $8 million. There is no necessity or justification for nearly doubling the amount we spend on Readjustment Counseling Service.

Mr. Chairman, the agenda for today's hearing also includes three additional draft bills identified as the "Mental Health Capacity Enhancement Act of 2005," the "Neighbor Islands Veterans Health Care Improvements Act," and the "Sheltering All Veterans Everywhere Act." Because we received copies of these draft bills only very recently, we do not have cleared positions on the measures. We will provide written comments on those bills for the record.

Mr. Chairman, this completes my prepared statement. I would be happy to answer any questions you may have.

Chairman CRAIG. Mr. Secretary, thank you for those opening comments and we will have a series of questions to address some of these legislative issues.

You mentioned, Jim, the importance of changing the law to ensure that veterans who use community facilities for emergency care are treated the same financially as those who use the VA center. Is VA confident that the criteria you will use to define an emergency will be fair enough to ensure veterans are not unreasonably denied coverage, but tight enough to ensure that we do not begin providing all primary care in emergency room settings? It is a fine line.

Secretary NICHOLSON. That is a very good question, Mr. Chairman. First, let me say that the spirit of this is to cover that situation which is occurring in increasing numbers where a veteran has become so accustomed to service in a VA hospital, and he may even have insurance or other benefits, but experiences an emergency condition and is insistent that he go to a VA hospital for treatment, either because of the comfort level, and/or because of his fear that

this is going to be too expensive if he goes to a nearby private hospital. We are seeing an increasing number of situations like that, so this would cover that and give them the confidence that they can go to that nearest hospital and get the most immediate emergent care and it would not be a cost burden on them.

Your question is a good one: Would they take advantage of this and would that become the way that they start going for normal emergency room care. And the answer to that is that there is a standard in medicine which is called the reasonable review criteria and a veteran would have to have a serious condition, the most prevalent of which would be chest pains, indicating serious possibilities. He could not go there for a flu shot, he could not go there for a cold. It would not cover that. That would not fulfill that reasonable review criteria that they apply to this.

Chairman CRAIG. I know that we will be concerned about that, that it would be, as I have said, good enough to work and yet not so good that that becomes the primary care approach for our veterans. Choices will need to be made in this instance.

Obviously, with the introduction of my legislation, 1182, and concern about long-term care, already some of my colleagues have spoken to that and it does remove the capacity requirement for long-term care beds. I, for one, believe we should work toward establishing a program of long-term care services, not just a bed count. I said in my opening comments, I used the phrase focusing on choices and options instead of buildings and concrete. We, and certainly the Veterans Administration, over the years have gotten involved in building an awful lot of buildings. Therefore, then the political base to support them comes up, even though some of them might be half full and not serving the purpose that they did 20 or 30 or 40 years ago. We get bound up in that.

So I guess my concern and my question is: Does VA share the basic belief reflected in 1182? And if so, and I think you have made some comment on that, can you share with the committee some of the thoughts and considerations of what should be included in such a program if, obviously, our approach is toward long-term care but we are not going to put hundreds of millions of dollars into beds and facilities?

Secretary NICHOLSON. Again, I think a very good question, an important one, because I think the answer is that this should be determined not by some mechanistic set number but by the need and by the imperative that we provide the right care at the right place. The standard I think now in long-term care is for it to be as least restrictive as possible, and yet for it to be adequate, and to have people be as close as they can to their regular habitat, their family, their friends, their community. To the extent that we can facilitate that, and that ability is growing, the new tools that we have for telemedicine and communication, and there are clinic programs so that the need, at least some objective number to fill beds we do not think is appropriate.

Chairman CRAIG. Thank you very much. Let me turn to my colleague, Ranking Member Senator Akaka.

Danny.

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

Secretary Nicholson, Senators Salazar, Murray and Rockefeller and I have new mental health legislation. In fairness, I know that you did not receive this legislation with much advance time, and I think VA would be most concerned with the provision to adjust capacity requirements for inflation and I mentioned that in my statement. The goal is to use current year dollars rather than 1996 dollars for determining if VA is meeting its specialized care requirements.

Mr. Secretary, what is your view of this?

Secretary NICHOLSON. Yes, Senator, I would say that we would like to have more time to analyze this and to think about it. We have stepped up our program on mental health in our request for next fiscal year an additional $100 million requested for this. We screen every veteran at enrollment for PTSD. We screen every veteran at their annual physical for PTSD. Our clinics are providing screening and referral services. We have over 850 of them, plus over 200 vet centers. So there is a lot being done.

It is a concern. It is a priority of ours, because as we have heard already this morning about the anticipation of this being problematic from those returning from Operations Iraqi and Enduring Freedom. I was over there myself a few weeks ago with the Chairman and some other Members of Congress talking to troops and commanders, and there is an anticipation that we need to get on top of this and intercept it early and treat it early because that is the best way to deal with it.

Senator AKAKA. Undersecretary Dr. Perlin, back at your confirmation hearing I asked you where the mental health strategic plan was and you indicated it was forthcoming at that time. This is a critical document. As I understand it, it sets forth an agenda for mental health which has been lacking up to this point. Given the growing and even burgeoning demand for mental health, we need this plan. If it is being held up at OMB, I certainly would like to know about that.

Dr. Perlin, when will we be receiving that report?

Dr. PERLIN. Senator, thank you very much for your endorsement of the mental health strategic plan. I am very proud of this plan that takes its roots from the President's new Freedom Commission on Mental Health, which seeks a new vision which looks not to maintenance of patients with mental illness but to restoration of function and recovery. It is a very bold plan and I am proud to tell you that that plan can be shared now. We will make sure that you have a copy of that plan.

The plan is being used in the system as a working document, and with Secretary Nicholson's encouragement, the additional $100 million in the budget for 2005, another $100 million in 2006 are focusing on the high priority areas you and Chairman Craig and others on this committee have mentioned: PTSD, outreach to OIF and OEF veterans. My own personal focus is on increasing access to specialty mental health care services, increasing access to substance use treatment, and increasing access for community health services for individuals with serious mental illness like schizophrenia, psychosis, with a program we call mental health intensive case management which is known as assertive case management in the community.

So we will get you that this afternoon.

Senator AKAKA. Thank you very much.

Mr. Chairman, I have other questions but my time is almost up.

Chairman CRAIG. We will return for a second round.

Senator Salazar.

Senator SALAZAR. Thank you very much.

Secretary Nicholson, I would like your reaction to the legislation that I introduced in three bills that I talked about 1189, 1190, and 1191. Let us take them one at a time. One, the rural VSO assistance for vet rides. A simple bill. Basically, it would provide grant money to VSOs to help especially in the transportation of vets who live far away from where they can receive their medical care. I have seen it happen firsthand in our native State of Colorado up in the northwestern part of the State. I would hope that you would be able to support this legislation.

Secretary NICHOLSON. Senator Salazar, I appreciate the spirit behind the legislation and, again, we have not had enough time with this so we do not have a final cleared position on this, but I want you to know that there is a great deal of this going on and there has been for a long time. The VSO community has been providing this. The Disabled American Veterans in particular, with the assistance of Ford Motor which provided vans, provide literally hundreds of thousands of trips for veterans to go for medical care in this country every year. It is being done by people who are volunteers. They have the compassion and the feeling for what they are doing. There may be exceptions out there, but in general our read on it is that it is working pretty darn well and that we do not need Federal Government intervention of money into that relationship.

Senator SALAZAR. Let me just say, I would appreciate getting a formal response from you on this, but I will tell you that I think what the VSO organizations do out there, Secretary Nicholson, is a wonderful, compassionate work on behalf of our veterans and I certainly applaud everything that they do. But I can tell you when I talk to Jim Stanko up in Steamboat, Colorado and he tells me about their efforts in terms of trying to serve that whole northwestern part of Colorado and taking the vets down into Grand Junction, that it would be helpful if they did have some financial assistance. I know that there are many things that we will do and that you are currently doing with the non-profit community and with the private sector to bring assistance to them, but I think just a little bit of money here can go a long way. This is not asking for a lot, but I think these kinds of grants can help incentivize the good work that is already going on and even make it better. So I would appreciate it if you would keep an open mind and hopefully support the legislation.

Let me quickly, speak on 1189 on long-term care. When Dr. Perlin and I had this conversation here a month or so ago we talked about the creation of this long-term strategic plan. The legislation I have introduced, 1189, will simply put a deadline in place when we would have that plan put together 6 months out, 180 days out. I think for all of us who have worked in many different kinds of processes and different kinds of situations, there is nothing like a deadline to get to the result. So I would also appreciate it if this is something that you would support.

Secretary NICHOLSON. Again, Senator, because of the time constraints, we have not fully completed our review of it or our analysis so we do not have a position. We do appreciate the spirit of it. We are now gathering actuarial data. We have some new tools with which to do that that we have not had in the past. And we have an ongoing CARES process, the 18 locations are still being studied, and we will plan to synergize this new actuarial data with what we learn in those 18 cases and certainly plan to come back to you with that.

Senator SALAZAR. I would appreciate it. I think at the end of the day there are constraints that we will all face that we may not be able to get to our ideals because of fiscal constraints. But I think having that kind of long-term plan that gives us the cost-benefit analysis of the different options would be helpful to us as we struggle with the issue of long-term care with respect to our veterans.

I know my time is up but there was another piece of legislation that we——

Chairman CRAIG. Why don't you complete so that we will have your three pieces?

Senator SALAZAR. Thank you very much, Senator Craig.

That is the legislation numbered 1190 with respect to blinded vets. I called it the Blinded Veterans Continuum of Care Act of 2005. It essentially would put in an additional effort for us to address the major problems that our blinded vets face here in our Nation. I know you have not had an opportunity yet to review that legislation but I also think that it is a very important piece of legislation that would address the very specific and very difficult challenges that are faced by our over 100,000 blinded veterans in our Nation.

Secretary NICHOLSON. Again, I appreciate your concern about blind veterans. It is certainly shared. We are analyzing your legislation. I do want you to know that we have, in 99 of our medical centers, a visual impairment team right now. We are incentivizing some of our other facilities to do outpatient blind rehabilitation care, which is a change. For some more reason the incentive ran the other way, which was to admit them, make them an inpatient. That cut down capacity because it was limited by beds. That is not necessary that we are changing that to incentivize seeing them as outpatients. We also are recruiting some additional blind rehabilitative specialists. This is a very narrow specialty, and that will, I think, result in us having enhanced ability in the relatively few places that we do not yet have it.

So we are doing quite a lot there. We will respond to you in a more specific way with respect to your legislation. We, generally I would say, Senator Salazar, think that it might be overly specific. We do not think we need that specificity. But we share the principle.

Senator SALAZAR. I would appreciate your taking a thoughtful look and having an open mind. I do know that where we have these programs for blinded vets within the system they are working very well. My own sense is that this bill would help us do an even better job and I would very much appreciate you taking a look at it. Again I am going to ask you for your support.

Chairman CRAIG. Ken, thank you very much.

Let me state again for the record the administration has not yet been prepared to give full testimony on some of these for purposes of OMB clearance and all of that. I wanted to accelerate the process, and that is why these items are on the agenda today. I do not think it should be viewed as somebody did not do their homework. That is not the case at all here, whether it is on our side of the issue or the administration's side of the issue. I wanted to get these pieces of legislation active in the process.

We will have another hearing in 2 weeks on the balance of the legislative package of members that brought it before us, and that will be a similar environment at that time for that purpose, to make all of this active for consideration, and/or for combination as we do markup and other pieces, move forward. As we know, sometimes they may not be stand-alones. We might be able to effectively combine pieces to share in, so I think it was important to say that for the record of the committee.

Senator Murray.

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

As I said in my opening statement, I represent thousands of returning guardsmen from Iraq and Afghanistan in my State, and I am very concerned about the fact that we do not have current mental health capability to serve our current veterans, let alone these men and women who are returning. As you just said, you have been over there, you know that there is going to be a high rate of need for help with those men and women who are returning for mental health, PTSD. Both Chairman Craig's and Senator Akaka's bills expand mental health resources, and in your testimony you mentioned Chairman Craig's mental health provisions as extremely beneficial.

Given your support of those provisions, do you believe that there are other efforts that should be pursued to increase mental health access for our veterans, especially those who are just coming back now from Iraq and Afghanistan?

Secretary NICHOLSON. We are continually looking at that, trying to assess it and make sure that we have what we need because of the priorities, and also because what we have learned about this in the Vietnam experience particularly in that there seems to be a latent period for many of these——

Senator MURRAY. I think particularly for guardsmen and women because they come home, they just want to get out. They answer the questions and go out to their communities far away from a regular military facility, and that is when they start having problems and do not have access.

Secretary NICHOLSON. Well, we are trying to mitigate that with an outreach effort that we have going. We have teams going to the points of deployment, that is, deployment back, in mobilization I guess I should say, and we actually have people in Germany. We have these seamless transition teams that also have members of the military on them. This was one of the things that we talked about in Iraq, was using the chain of command more to make sure that the young trooper down in the squads knew and was listening, because they get pretty focused on going home and getting back, that they are eligible for certain VA benefits, and inform them as

to how they can access them. So we are making very robust efforts to inform them.

Senator MURRAY. Is there anything we can do as part of any of these initiatives to help prevent veterans with PTSD from stopping to seek care?

Secretary NICHOLSON. To help them do what?

Senator MURRAY. The veterans who stop seeking care, is there anything we can do? Because many of them choose not to continue to get care, and then develop larger problems later.

Secretary NICHOLSON. I think that is a really good question, and it has broader implications in my opinion than maybe even you intend, because of the benefit side of the VA as well, because people who end up being permanently impaired from a mental condition, just like a physical condition, are entitled to benefits and compensation. What we are looking at is to make sure that these individuals do go to therapy, and will subject themselves. We have not implemented this, I do not want it to sound like it is a done thing, but it is something we are looking at, so that they go to rehabilitation therapy and they get into a program before we make a final adjudication of their final condition. So their incentive is there, and I think that is going to help.

Senator MURRAY. Interesting, OK.

As I mentioned earlier, few of these programs will become a reality without adequate funding for veterans funding. And we know that when adjusted for inflation the VA is spending 25 percent less per patient than it did in fiscal year 2000. Veterans are having to wait 3 years for surgery today. In my home State at the American Lake Facility, you can only get an appointment if you are 50 percent or more service connected disability, and in Puget Sound, as of January, there was an $11 million deficit that is forcing a lot of our VA hospitals not to fill some vacant positions. Every indication is that we do not have enough funding for our current services.

It is just not right and it is not what the veterans are promised. As you know, I am very concerned about it. We are now talking about adding some new programs, programs I strongly support, but I am unsure that they will ever get off the ground if we do not have adequate funding for them.

So I would just like to ask you, Mr. Secretary, if we were to pass some or all of today's bills into law, would you request additional funding to make Chairman Craig's mental health problems—provisions and other provisions a reality?

[Laughter.]

Senator MURRAY. What did I say?

Chairman CRAIG. My mental health problems.

[Laughter.]

Senator MURRAY. No. He is from Idaho, my next door neighbor State. I apologize.

Chairman CRAIG. It is not unusual. I have been accused. Please proceed.

Senator MURRAY. His mental health provisions in his bill. Thank you.

Secretary NICHOLSON. We do not think it will cost much to fix Chairman Craig.

[Laughter.]

Secretary NICHOLSON. When I took this job, you know, the President's charge to me was to take care of our veterans, so my answer to that is that when and if I am convinced that we do not have what we need to fulfill our mission, I will be part of requesting more resources to do that.

Senator MURRAY. Specifically, if I were to introduce an amendment in the Military Construction and Veteran Affairs Subcommittee to increase funding for VA's mental health programs that are included in today's bills, would you support those?

Secretary NICHOLSON. I could not answer that right now, Senator. I would have to have a lot more information about your bill and how it would fit with what we are doing. As we have said, we have an additional 100 million in this budget for 2006 for mental health and that goes on top of—Dr. Perlin, we are spending on mental health specifically, what?

Dr. PERLIN. Yes, Mr. Secretary. For patients with definition of mental illness as statutorily defined, it is $2.2 billion. When you look at all expenses for just mental health it is in excess of $3 billion. When you look at all health care for patients with mental illness, it is in excess of $10 billion. And the 2005 budget, as the Secretary has indicated, will increase by 100 and in 2006 again by 100 million.

Senator MURRAY. Let me ask you. The House Military Quality of Life and VA passed onto the House floor 2 weeks ago, and it set aside 2.2 billion for specialty mental health care. Do you support that level of funding?

Secretary NICHOLSON. What we think we have at an adequate level right now is what we have submitted in the 2006 budget, which is that increase of 100 billion.

Senator MURRAY. It is hard to understand. If we are to pass Chairman Craig's bill, I assume you realize that we will need increased funding, correct?

Secretary NICHOLSON. No, I am not sure. I am not sure of that.

Senator MURRAY. I find it difficult to understand how we increase services. We already are behind how we pay for that.

So I hope that, Mr. Chairman, as part of our discussion, we talk about how we are going to pay for the increased services. We have more people returning from Iraq and Afghanistan. They are going to need these services. We cannot just expect the already long lines to incorporate all these people into them and not have a real challenge out there, and I think we have to discuss the funding of this.

Chairman CRAIG. Senator Murray, I appreciate that line of questioning, and I think that if 1182 become law, you and I and Secretary Nicholson are going to sit down and spread it out and look at it and see how it gets implemented, plain and simple. And if it cannot be implemented at current resources, then we will look for new ones, because I think we all show—I think our sensitivity to this issue is real and important, and we will move it forward.

Senator MURRAY. I just do not want promises out there that we are not keeping when we do not fund them.

Chairman CRAIG. I hear you. Thank you.

Senator Thune has left us. Let me ask a couple more questions of this panel before we move to our next panel.

I recently had the opportunity, Mr. Secretary, to review in more detail S. 614, Senator Specter's Prescription Drug Assistance Act. Arlen is not here this morning to speak for himself or the legislation, but I understand that VA was opposed to this legislation last year and is again this year, basically on the grounds that we do not know how such a program would interact with other prescription drug programs. However, I would like to begin to study exactly how those interactions might take place and see whether it might not be an interesting approach to managing some of our outpatient population.

I guess my question of the Department is, is the Department willing to spend a little more time and effort this year to analyze a drug-only benefit and how it might work with the new Medicare drug program or private prescription drug coverage, how all of those might interact in this particular case?

Secretary NICHOLSON. Mr. Chairman, as you know, this has been looked at before, and our view is that this will not do what I think is a well-intentioned goal. There are several parts to it. Number 1, it would not be cost neutral, and it would end up becoming cost prohibitive to patients if it was going to be put on a pay as a cost which is also in the legislation.

The reasons are that we have these huge facilities that are needed to support issuing pharmaceutical prescriptions. They are called CMOPs, Consolidate Mail of Pharmaceuticals, huge facilities. I think we have six of them throughout the United States. I visited one in Chicago recently. They are very expensive capital items. This would need tremendous IT support. There would be many more pharmacists needed, labor intensive, and probably most nettlesome is the fact that we would have to have a much broader inventory of pharmaceuticals on hand because the formulary that the VA follows in the tests that have been done of this, have not been followed by the prescribing physicians. So that when the veteran comes with his prescription, in many cases, a high incidence, cannot fill it because we do not use those kinds of drugs. We have generally similar but not the same in our formulary. Because we have a set formulary we have been able to buy pharmaceuticals at a very attractive price, deeply discounted, and that is in large measure because of this fixed formulary. In fact, I was just looking at a number I had here on a note, that in that pilot program, 47 percent of those prescriptions did not follow our formulary.

This also, we think, could threaten this VA's favored pricing structure that we now have. Another problem that we have—and Dr. Perlin could speak to this better than I—but the VA likes to think of itself as providing comprehensive health care to its patients, and in a holistic approach, so that if a person has problems, we want to know about it, we have the electronic health record that is imputed into and available all over the world literally, so a doc that is seeing one of these veterans wherever he or she is, can see what is going on and then they can prescribe. Where if we got into becoming just an issuer of pharmaceuticals we would lose that comprehensive care that we have with our patients.

So on balance, we think it is problematic.

Chairman CRAIG. Well, we will leave the question at that.

Let me turn to Senator Akaka for any additional questions he may have.

Senator AKAKA. Thank you, Mr. Chairman.

Mr. Secretary and Dr. Perlin, I direct this question to both of you. I recently introduced legislation regarding health care access issues in Hawaii. While I understand that, again, you had not had enough time to officially comment on the substance of this bill, I would like to know why on a more general level the clinics in my State are not in compliance with the Millennium Bill requirements that relate to non-institutional long-term care such as home care. We have very few nursing home beds in my State. Nearly all of the veterans in those beds are highly service-connected, so the relief you are seeking by way of the chairman's bill would not free up resources for home care. Can you please address this question, Mr. Secretary and Dr. Perlin?

Secretary NICHOLSON. Yes, sir. Thank you, Senator. I am going to ask Dr. Perlin to respond to this. He has some specific objective numbers about the situation in your State in the various locations.

Dr. PERLIN. Thank you, Senator Akaka for the question. I want to get back with you with a full report on the numbers, but I have that interest in making sure that veterans of Hawaii get the appropriate care. Understand in terms of long-term care, that we have 60 beds at the center for aging on Oahu, which serves veterans throughout the system and is actually, to the best of my understanding, operation within the provisions of the Millennium Act.

Senator AKAKA. I think you understand the problem that we are looking at.

Mr. Secretary, in your statement you indicated that at the end of the 2-year period afforded to combat veterans for easy access, a veteran could continue receiving VA care, but would be placed on the appropriate priority group. That was your statement. Does this not imply that in fact a veteran who had been receiving care for those 2 years could effectively be out of the system if they did not have an adjudicated service connected disability and they had modest income?

Secretary NICHOLSON. Yes. Senator Akaka, we have looked at that. We would like to have more time to do that. We understand the spirit of your legislation and its intent. Let me make a few points about it.

No. 1, any veteran, any reserve component, active duty person that is in the theater who comes back is eligible for full VA medical access for 2 years without being charged the medical care co-payment. If they have any service connected impairment, their care will continue right on, indefinitely, as you know, for life. And once they are enrolled they become a Category 6, and at that point they receive cost free care for any disorder attributable to that combat theater experience.

If the 2 years is up and they are in an ongoing treatment, that will continue indefinitely. And then they all, after 2 years, may continue to receive VA care as enrolled veterans. So in short then, we really right now, subject to thinking about this some more, do not see a need for this legislation.

Senator AKAKA. First, I want to commend Senator Salazar for his long-term care legislation. Along those lines, Secretary Nicholson,

I am curious as to how VA arrived at the conclusion that the institutional long-term care bed census requirement should be eliminated when we have yet to see the long-term care strategic plan. Do we need to know how many beds are necessary before we start to eliminate beds?

Secretary NICHOLSON. That is a fair question, Senator Akaka, and we had some discussion about this earlier. We think the guiding principle here should be the need, not some objective number, but what do we need? And we are working on that. We are studying 18 more locations in the CARES process right now, and we have some new actuarial tools that are going to help us make long-term care projections, that we are synergizing into the results of that second round of CARES study.

But to the point, to the principle, we are trying to redirect long-term health care so that the beneficiaries, the patients can get it either in their home or closer to where they live or have lived, nearer their family, their friends, their church, people they are used to. And that is not new. That has been an ongoing process which has driven down the number of bed occupancy in our long-term facilities, and it is working very well, using also the new opportunities of telemedicine. So when we get this new CARES round 2 finished, I think we will be in a good position to make some projections.

Meanwhile, we do not think we should be bound to some number that has been derived because it is mechanical, it does not relate really to what is going on.

Dr. Perlin, do you have anything you would like to expand on that?

Dr. PERLIN. Thank you, Mr. Secretary. That has been our experience. As we have been able to deploy more home-based care and community care, we have actually found that we move patients to those sorts of environments. In fact, in our VA nursing home beds, we are actually artificially elevating the population, the census, by holding network directors accountable for maintaining patients to a certain number. We believe that the patients should go to the long-term care institutional or non-institutional depending on need not roll, and in fact, our VA care, we want to make sure it is always there for the very aggressive rehabilitation after hospitalization for those individuals who have special needs like spinal cord injury or mental illness, or are on a ventilator. So that our beds become a very special set of beds for those individuals which require staffing at a level and with the skills that simply would not be available in community.

It is the addition though that because patients with family members around want to be in communities—even when I say to a patient that I may have, "You know, we have a beautiful nursing home here in Washington," or when I used to see patients in Richmond, they say, "Well, we live 45 miles away, 80 miles away, and really do not want dad, mom, brother, sister, whomever, or parent, at a facility that is very distant."

So we actually know now that there we are actually requiring veterans to be in those beds simply to meet a legislative mandate, not because of need.

Senator AKAKA. Thank you very much for your responses.

Mr. Chairman, thank you.

Chairman CRAIG. Senator Akaka, thank you very much.

Mr. Secretary, Dr. Perlin, we again thank you all very much for your testimony this morning. We will look forward to your additional comments as it relates to this other legislation, and that will become a part of our record. So again, thank you very much for your presence.

Secretary NICHOLSON. Thank you, Mr. Chairman, Senator Akaka.

Chairman CRAIG. I look forward to our continuing work.

Now we will ask our second panel to come forward, please.

[Pause.]

Chairman CRAIG. If we could ask our second panel to get seated and the room to be cleared so we can proceed, please, cleared of those who are leaving or planning to leave.

Let me welcome the second panel of veterans service organizations, and introduce them. We are pleased that Donald Mooney, Assistant Director of Veterans Affairs and Rehabilitation for the American Legion is with us; Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; Carl Blake, Associate National Legislative Director, Paralyzed Veterans of America; and Richard Jones, National Legislative Director for AMVETS.

Donald, we will ask you to proceed, please.

STATEMENT OF DONALD MOONEY, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

Mr. MOONEY. Thank you, Chairman Craig, Senator Salazar. The American Legion appreciates this opportunity to express our views on the many important bills being considered today by the committee. We also appreciate the ability to supplement the written record with our views because of the late arrival of some of the draft legislation to our offices.

Chairman CRAIG. Yes. To all of you, that will stand as it did for the first panel. The record will remain open so that we can get an inclusive amount of testimony on these pieces. Thank you.

Mr. MOONEY. Thank you, sir. On the first bill we are commenting on today, is the Veterans Health Care Improvements Act of 2005. The Millennium Health Care Act of 1997 required VA to maintain its in-house nursing home bed inventory at the 1998 level. However, this capacity has significantly eroded, rather than been maintained. The President's budget request projected only 9,975 beds in fiscal year 2006, a 27 percent decrease from the Mill Bill mandate. This language was rejected in the House Military Quality of Life and Veterans Affairs Appropriations bill. Simply put, VA does not know what its future long-term capacity will need to be. The American Legion supports Senator Salazar's bill to accomplish this within 6 months.

In the meanwhile, it continues to be the position of the American Legion that VA should comply with the intent of Congress to maintain the minimum long-term nursing home capacity for those disabled veterans who are in the most intense resource groups, clini-

cally complex, special care, extensive care and special rehabilitation case mix groups, at least until a study of VA future requirements is completed.

The Nation has a special obligation to these veterans. The American Legion opposes this provision of Section 2. This section also exempts former prisoners of war for co-payments for extended care services for non-service connected disabilities. Veterans who have suffered hardships, deprivations and the indignities of captivity by an enemy government should receive the best care that we have to offer at no cost. They have already bought and paid for it. The American Legion is pleased to support this provision.

The Veterans Prescription Drugs Assistance Act of 2005, S. 614, requires VA to fill prescriptions for any condition where a Medicare eligible veteran makes an annual, irrevocable, renewable election to get his or her medications from VA. The bill takes care to make sure that the new benefit is cost neutral to VA by allowing VA to establish new schedules of annual enrollment fees, co-payments, and allowing VA to charge the full cost of medication to the veterans.

The American Legion believes that while well-intentioned, this bill has serious problems. First, it requires the Medicare eligible veteran to make a decision as to where to get his or her medications based on information that is not yet available and further complicates already unfathomable extant and pending regulation for Federal prescription drug benefits. Unforeseen and unintended consequences will be rife. For example, the new Medicare Part D drug benefit includes penalties for late enrollment. Therefore, should a veteran elect to use VA, and then elect to use Medicare Part D, the veteran would end up paying a premium for having elected to use VA first.

Secondly, despite VA's renowned buying power in the pharmaceutical markets, manufacturers will react predictably to hundreds of thousands of new beneficiaries receiving medications with pricing predicated on the Federal supply schedule for pharmaceuticals or on VA's negotiated off-schedule pricing. If history is any indication, the pharmaceutical industry will react negatively to siphoning off of more profitable non-FSS-P volume by raising prices to VA.

Lastly, this bill represents yet another windfall for the Centers for Medicare and Medicaid Services, which already subsidizes—which VA already subsidizes for the non-service connected care of Medicaid eligible veterans to the tune of billions of dollars per year.

I see the light has turned red. Mr. Chairman, this concludes my testimony. I will be happy to answer any questions. Thank you.

[The prepared statement of Mr. Mooney follows:]

PREPARED STATEMENT OF DONALD MOONEY, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion appreciates this opportunity to express our views on the many important bills being considered today by the committee. We applaud the committee for holding hearings on these vital issues. Due to the late arrival of some of the draft legislation to our offices, we are unable to comment on all of them at this time. We therefore ask permission of the committee to supplement the written record with our views as soon as we have the opportunity.

S. ——, "THE VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005"

SEC. 2. COPAYMENT EXEMPTION FOR HOSPICE CARE

This section would exempt veterans receiving end-of-life outpatient hospice care from co-payments for those services. The American Legion supported legislation in the 108th Congress, which subsequently became law, applying to inpatient care. We support the extension of this exemption to outpatient care as well as the exemption of co-payments for inpatient hospice care.

SEC. 3. NURSING HOME BED LEVELS AND EXEMPTION OF EXTENDED CARE SERVICES CO-PAYMENTS FOR FORMER PRISONERS OF WAR

The President's fiscal year 2006 VA budget request contains a legislative proposal to repeal the provision of the Millennium Act requiring VA to maintain its Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. The language in the budget request refers to this mandate as "a baseline for comparison." The Millennium Health Care Act requires VA to maintain its in-house bed inventory at the 1998 level; however, this capacity has significantly eroded rather than been maintained. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimated it had 12,239 beds in 2003 and 12,245 in 2004. The President's budget request projects only 9,975 in fiscal year 2006, a 27 percent decrease from the Millennium Act mandate. VA claims that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act.

According to VA's fiscal year 2002 Annual Accountability Report Statistical Appendix, in September 2002, there were 93,071 World War II and Korean War era veterans receiving compensation for service-connected disabilities rated 70 percent or higher. The American Legion believes that VA should comply with the intent of Congress to maintain a minimum LTC nursing home capacity for those disabled veterans who are in the most resource intensive groups; clinically complex, special care, extensive care and special rehabilitation case mix groups. The Nation has a special obligation to these veterans. They are entitled to the best care that VA has to offer and they should not be dumped onto Medicaid, as is now the trend. Providing adequate inpatient LTC capacity is good policy and good medicine. The American Legion opposes this provision of Section 3.

This section also exempts former prisoners-of-war from co-payments for extended care services for non-service-connected disabilities. Veterans who have suffered the hardships, deprivations and indignities of captivity by an enemy government or other entity should receive the best care that we have to offer at no cost. They have already bought and paid for it. The American Legion is pleased to support this provision of Section 3.

SEC. 4. AUTHORIZE VA REIMBURSEMENT FOR NON-VA-PROVIDED EMERGENCY CARE

This section will authorize VA to reimburse emergency medical care for which veterans are personally liable; either directly to the veteran, to the facility providing the emergency care or to a third party that paid for the care. To qualify, the veteran must be enrolled in VA healthcare and must have received treatment from VA within 24 months prior to the emergency care. The veteran must have insurance or other third party coverage that pays some of the costs and leaves the veteran liable for uncovered costs such as deductibles and co-payments. This section is separate from similar statute that provides similar coverage to veterans who have no insurance or who needed emergency treatment for a service-connected condition, a non-service-connected condition aggravating a service-connected one, a totally service-connected disability or who is enrolled in VA vocational rehabilitation.

The American Legion supports this section; however, we note that it does nothing to correct the problems with VA policy on non-VA emergency treatment, generally, especially as regards local ambulance transportation. This has become an issue of concern to many American Legion veterans advocates around the country.

We relate a case-specific in which a veteran rated 60 percent disabled and 100 percent individually unemployable had had bilateral knee replacements for his service-connected condition. He ambulates with the assistance of braces and a cane. On a visit to the local mall, the veteran's knees gave out and he fell forward, injuring his hands, elbows and knees. The veteran's wife called the local rescue squad because the veteran was in extreme pain. The nearest VA Medical Center was in Roseburg, Oregon, 150 miles to the north, so the decision was made to transport the veteran to the local hospital for stabilization. The VA Outpatient Clinic in White City, 15 miles away, was not staffed for emergencies or orthopedic trauma and the veteran was not seen there until several days after the incident. The attending at

the VAOPC confirmed that the veteran's left knee was fractured. The veteran requested that VA pay the charges from the local hospital, but VA denied on the basis that the injury was not emergent; that is, life-threatening, and the injury could have been handled within the VA system. This, despite the fact that, even if the VAMC was close enough to use, it was on "divert", meaning it would not receive inbound ambulances. The denial of the veteran's claim is currently on appeal.

The American Legion believes Congress should closely examine the criteria under which VA is authorized to reimburse emergency non-VA treatment versus how it actually does.

SEC. 5. AUTHORIZE VA, FOR A 14-DAY PERIOD, TO PROVIDE CARE FOR NEWBORN INFANTS OF VETERANS WHO HAVE DELIVERED IN A VA FACILITY (OR AT VA EXPENSE)

This section adds 2 weeks of neonatal care of a newborn infant that has been delivered to a veteran in a VA medical facility or at VA expense. As of March 2005, 1.7 million of the Nation's 24.7 million veterans are women. Women now account for 15 percent of active duty military personnel and are currently serving in Iraq and Afghanistan under identical conditions as male servicemembers. VA now provides a full continuum of comprehensive medical services including health promotion and disease prevention, primary care, women's gender-specific health care; e.g., hormone replacement therapy, breast and gynecological care, maternity and limited infertility (excluding in-vitro fertilization), acute medical/surgical, telephone triage, emergency and substance abuse treatment, mental health, domiciliary, rehabilitation and long-term care. Given the unknowns of military environmental exposures in the current conflicts, Congress is wise to extend this care to the newborn children of these veterans. The American Legion supports this section.

SEC. 6. ALLOW PROVIDERS OF CARE TO VIETNAM VETERANS' SPINA BIFIDA CHILDREN AND CHILDREN WITH COVERED BIRTH DEFECTS TO SEEK FROM THIRD PARTY PAYERS PAYMENT FOR THE DIFFERENCE BETWEEN AMOUNT BILLED AND AMOUNT REIMBURSED BY VA

VA will provide a Vietnam veteran's child who has been determined to suffer from spina bifida and children with covered birth defects with such health care as the VA determines is needed by the child for spina bifida or covered birth defects. Under 38 C.F.R. 17.901, VA is the "exclusive payer" for spina bifida services and services related to covered birth defects regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. The rates paid by VA for the care of children of Vietnam veterans with spina bifida and covered birth defects, in many cases, do not cover the amounts billed by non-VA providers, exposing the parents to "balance billing" for the amounts not reimbursed. This legislation would clarify that the "exclusive payer" language in 38 C.F.R. 17.901 does not preclude providers from balance billing third-party payers and relieves the parents of responsibility for VA underpayment by holding harmless the parents of beneficiary children from balance billing by providers.

Caring for a child with spina bifida and/or covered birth defects imposes economic and emotional burdens on the parent that may be compounded by medical debt incurred as a result of balance billing. The American Legion supports this provision.

SEC. 7. AUTHORIZE ON A PERMANENT BASIS GRANTS AND PER DIEM PAYMENTS TO PROVIDERS OF SERVICES TO THE HOMELESS, AND INCREASE FROM $99 MILLION TO $130 MILLION PER YEAR

Homelessness in America is a travesty, and veterans' homelessness is disgraceful. Left unattended and forgotten, these men and women, who once proudly wore the uniforms of this Nation's armed forces and defended her shores, are now wandering the streets in desperate need of medical and psychiatric attention and financial support. While there have been great strides in ending veteran homelessness there is much more that needs to be done. We must not forget them. The American Legion supports funding of the Homeless Veterans Grants and Per Diem Program at $133 million.

SEC. 8. MARRIAGE AND FAMILY THERAPY

This section adds Marriage and Family Therapy to the list of professionals authorized to practice in VA facilities. A major criticism of VA Post-Traumatic Stress Disorder Treatment programs has been the exclusion of spouses and children from the recovery process. In many cases, the residuals of the veteran's traumatic experiences impact the family members of the veteran as severely as the veteran him or herself. Education about post-traumatic stress reactions, training in coping skills,

the use of efficacious therapies such as exposure therapy, cognitive restructuring and family counseling are generally accepted as methods of care for PTSD. The addition of Marriage and Family Therapy to multi-disciplinary treatment in VA will add a needed dimension to the holistic treatment model required to successfully help the veteran and his loved ones recover from the trauma of war. The American Legion supports this provision.

SEC. 9. AUTHORIZE SENIOR EXECUTIVE SERVICE COMPENSATION TO THE DIRECTOR, VA NURSING SERVICE

The American Legion has no position on this issue.

SEC. 10. REPEAL OF COST COMPARISON STUDIES PROHIBITION

The American Legion has no position on this issue.

SEC. 11. MENTAL HEALTH/PTSD SERVICE IMPROVEMENTS

In the 2003 report of the Special Commission on Post-Traumatic Stress Disorder, released before the invasion of Iraq, it was noted that demand for VA PTSD specialized services is growing. Fifty percent of all veterans service-connected for PTSD became service-connected within the last 5 years and the population served by VA specialized PTSD outpatient programs grew by 86 percent between fiscal year 1995 and fiscal year 2001. The Commission noted that the intensity of services provided to veterans service-connected for PTSD actually fell by 9.3 percent over the 5 years preceding the report. This decline in capacity is illustrated by the fact that of the 205,996 veterans who had a VA clinic visit where PTSD was the focus of treatment, only 28 percent received it in a specialized PTSD program. The other 72 percent received treatment in some other setting, including 17 percent who were seen in a non-mental health setting. Additionally, of the 128,000 veterans seen in Vet Centers in fiscal year 2002, only 55 percent were receiving services of any kind in a VA medical center. In its 2002 report, the Commission noted that the average waiting time to enter a specialized PTSD inpatient program was 47 days with waits approaching 1 year in some facilities. The Commission concluded that VA's specialized PTSD services are so fully saturated that that they cannot absorb new patients (now, Iraq war returnees) without diluting the intensity of service provided to each veteran.

This section directs VA to: (1) Expand the number of clinical treatment teams dedicated to Post-Traumatic Stress Disorder (PTSD) in VA medical facilities (funded at $5 million in each of fiscal years 2006 and 2007); (2) expand and improve diagnosis and treatment of substance abuse ($50 million); (3) expand and improve telehealth services where veterans are remote from VA facilities ($10 million); (4) improve education of VA primary care professionals to diagnose and treat mental health issues ($1 million); expand the delivery of mental health services in VA Community Based Outpatient Clinics ($20 million) and; (5) expand and improve Mental Health Intensive Case Management Teams for veterans with serious and chronic mental illness ($5 million).

These improvements come at a time when VA is experiencing an upswing in demand for mental health services by veterans of Operations Iraqi Freedom and Enduring Freedom. The American Legion has long advocated the reinstatement of mental health and substance abuse capacity that was severely curtailed in the 1990's and we support this section of this bill. However, we have concerns that by earmarking the $95 million the bill would appropriate in fiscal years 2006 and 2007, VA will be forced to further ration other programs and services. VA's fiscal year 2006 appropriation already falls well short of what VA needs to maintain currents levels of service and access. The American Legion believes the Congress should authorize additional funding to cover the costs of implementing this section.

SEC. 12. DATA SHARING IMPROVEMENTS

This section authorizes the exchange of protected health information between VA and the Department of Defense (DoD) on patients receiving treatment from VA and any person who may receive treatment from VA including "current and former members" of the Armed Services. This language is vague and seems to propose that VA become the repository of all medical records of "all current and former" members of the Armed Services. This would place an extreme burden on VA and require it to take over some of the functions of the National Archives' National Personnel Records Center (NPRC) that currently manages the service medical and personnel records of millions of former servicemembers at its facility in Saint Louis. When VA requires the medical records of an individual, usually for compensation and pension claims purposes, it requests them from NPRC. For soldiers separated or released

from active duty after October 1994, their health records already go directly to the Department of Veterans Affairs' Record Management Center (VA RMC), also in St. Louis. Additionally, VA and DoD currently have a number of ongoing information exchange initiatives in development in their efforts to meet the Seamless Transition mandates of Congress. The American Legion defers comment on this section and requests the committee to provide clarification.

SEC. 13. EXPANSION OF NATIONAL GUARD OUTREACH AND ASSESSMENT

This section directs VA to collaborate with State National Guard officials and expand the total number of VA employees dedicated to outreach under the VA's Rehabilitation Counseling Service's Global War on Terrorism Outreach Program. The American Legion supports this section.

Many of our servicemembers returning home from duty on Operations Iraqi Freedom and Enduring Freedom are not being properly advised of the benefits and services available to them from the Department of Veterans Affairs and other Federal and State agencies. This is especially true of Reserve and National Guard units that are demobilized at hometown Reserve Centers and National Guard armories, rather than at active duty demobilization centers. To assist in making sure that these servicemembers are aware of the services and benefits they have earned through their honorable service in the Global War on Terrorism, The American Legion has developed a Welcome Home brochure. This brochure outlines the basic entitlements and benefits available from VA and provides contact phone numbers and Internet web sites from which servicemembers may obtain more information. The American Legion intends to distribute this document to demobilization centers, Reserve Centers, National Guard armories and Transition Assistance Programs nationwide.

SEC. 14. EXPANSION OF TELE-HEALTH SERVICES

This section directs VA to install tele-medicine technology in a larger number of Veterans Readjustment Counseling Services facilities (Vet Centers) and to report to Congress its plan to do so in fiscal years 2005 through 2007. The American Legion supports this section and further believes that Vet Centers in highly rural and isolated areas should receive priority for this technology.

SEC. 15. MENTAL HEALTH DATA SOURCES REPORT

This section requires VA to submit a report to the Congress on the mental health data maintained by VA, including a list of the sources of such data, and assessment of the advantages and disadvantages of the current data and recommendations for improving the collection, use and location of such data. The American Legion has no position on this issue.

S. ——, "THE BLINDED VETERANS CONTINUITY OF CARE ACT OF 2005"

In this bill, Congress has found that approximately 1,500 veterans are on waiting lists for admission to VA blind rehabilitation programs nationally and that this situation is due largely to shortages of blind rehabilitation specialists in VA facilities. This legislation directs VA to establish blind rehabilitation specialist positions at VA facilities having 150 or more currently enrolled legally blinded veterans and prioritizes implementation by fiscal year starting with VA facilities having the highest numbers of blind veterans. The bill further appropriates $5 million a year for each of fiscal years 2006 through 2010 for implementation. The American Legion supports this initiative; however, we have concerns that by earmarking the $5 million the bill would appropriate in fiscal years 2006 through 2010, VA will be forced to further ration other programs and services. VA's fiscal year 2006 appropriation already falls well short of what VA needs to maintain currents levels of service and access. The American Legion believes the Congress should authorize supplementary funding to cover the costs of implementing this section.

S. ——, "TO REQUIRE THE SECRETARY OF VETERANS AFFAIRS TO PUBLISH A STRATEGIC PLAN FOR LONG-TERM CARE, AND FOR OTHER PURPOSES"

The American Legion supports this bill, however, due to restraints of time the American Legion requests the committee to allow us to submit our views as an addendum to the written record.

S. ——, "TO ESTABLISH A GRANT PROGRAM TO PROVIDE INNOVATIVE TRANSPORTATION OPTIONS TO VETERANS IN REMOTE RURAL AREAS."

The American Legion supports this bill; however, due to restraints of time The American Legion requests the committee to allow us to submit our views as an addendum to the written record.

S. ——, "THE MENTAL HEALTH CAPACITY ACT OF 2005."

The American Legion supports this bill; however, due to restraints of time The American Legion requests the committee to allow us to submit our views as an addendum to the written record.

S. ——, "THE NEIGHBORING ISLANDS VETERANS HEALTH CARE IMPROVEMENTS ACT."

The American Legion has consistently supported the establishment of VA facilities to serve veterans in remote and underserved areas. The American Legion supports this bill; however, due to restraints of time The American Legion requests the committee to allow us to submit our views as an addendum to the written record.

S. 481, "TO EXTEND COMBAT VETERANS' POST-DISCHARGE 2-YEAR PERIOD OF ELIGIBILITY FOR VA HEALTH CARE TO 5 YEARS"

The American Legion supports this bill; however, due to restraints of time The American Legion requests the committee to allow us to submit our views as an addendum to the written record.

S. 614, "THE VETERANS PRESCRIPTION DRUGS ASSISTANCE ACT OF 2005"

This bill mandates VA to provide prescription medications to Medicare-eligible veterans who are receiving disability compensation, nonservice-connected pension, aid and attendance or are housebound. VA must fill prescriptions written by "a duly licensed physician" for any condition under this legislation. Veterans receiving nonservice-connected pension who are also receiving aid and attendance may continue to receive this benefit even if their incomes exceed maximum income limitations by not more than $1,000.00. Under current law, such veterans would lose eligibility for any VA care or services once their incomes exceed the maximum income limitation.

This bill also requires VA to fill prescriptions written by "duly licensed physician[s]" for any condition where the Medicare-eligible veteran makes an annual, irrevocable, renewable election to get his or her medications from VA. VA is required to provide the veteran making the election with information about the benefits, costs and consequences prior to permitting the election. The bill takes care to make sure that the new benefit is cost-neutral to VA by allowing VA to establish new schedules of annual enrollment fees, co-payments and allowing VA to charge the full cost of medications to veterans. VA is also authorized to provide immunizations to Medicare-eligible veterans, provided that the vaccines required are furnished to VA by the Department of Health and Human Services at no charge.

Mr. Chairman, The American Legion believes that while well-intentioned, this bill has serious problems.

First, it requires the Medicare-eligible veteran to make a decision as to where to get his or her medications based on information that is not yet available and it further complicates already unfathomable extant and pending regulation and criteria for Federal prescription drug benefits. Unforeseen and unintended consequences will be rife; for example, the new Medicare Part D drug benefit includes penalties for late enrollment, therefore, should a veteran elect to use VA, then later elect to use Medicare Part D, the veteran could end up paying a premium for having elected to use VA first. If enacted, implementation of this benefit should be delayed for several years to allow the entire Federal drug benefit landscape to stabilize.

Second, despite VA's renowned buying-power in pharmaceutical markets, it is unclear how manufacturers will react to hundreds of thousands of new beneficiaries receiving medications with pricing predicated on the Federal Supply Schedule for Pharmaceuticals (FSS-P) or VA's negotiated off-schedule pricing. If history is any indication, the pharmaceutical industry will react negatively to any siphoning-off of more profitable non-FSS-P volume with predictable effects on VA's drug costs.

Last, this bill represents yet another windfall for the Center for Medicare and Medicaid Services (CMS), which VA already subsidizes for the nonservice-connected care of Medicare-eligible veterans to the tune of billions of dollars per year. The requirement that VA recover all its costs for filling prescriptions through enrollment fees, new co-payment schedules and direct cost billing relieves CMS of fiscal exposure for this population of beneficiaries and places it on the backs of veterans. VA

should be authorized to recover incurred costs not covered by existing co-payments in this new benefit from CMS.

The American Legion has consistently opposed enrollment fees for VA eligibility, including any prescription-only benefit. We restate that position today and express adamant opposition to the introduction of new co-payment schedules not already in law. Additionally, The American Legion has opposed the filling of prescriptions written by non-VA providers. VA Consolidated Mail Outpatient Pharmacies (CMOPs) are already running at over-capacity and would require significant additional infrastructure to meet the demand imposed by this bill.

S. 716, "THE VET CENTER ENHANCEMENT ACT OF 2005"

The American Legion supports this bill; however, due to restraints of time The American Legion requests the committee to allow us to submit our views as an addendum to the written record.

S. ——; "THE SHELTERING ALL VETERANS EVERYWHERE ACT"

This bill authorizes funding of the VA Grants and Per Diem Program at the full rate for domiciliary care and appropriates $200 million per fiscal year for fiscal years 2006 through 2011, expands eligibility for veterans at imminent risk of homelessness and appropriates an additional $50 million for that purpose for those years expands outreach to at-risk veterans, including those separating from active duty. It further extends authorization for treatment and rehabilitation for seriously mentally ill and homeless veterans and permanently reinstates VA authority to transfer properties obtained through foreclosure of VA home mortgages wherein VA may sell, donate, lease, or lease with option those properties to nonprofit organizations, States or localities for use in sheltering homeless veterans. The bill reauthorizes $5 million per year for fiscal years 2005 through 2011, funds the Homeless Veterans Service Provider Technical Assistance program at $1 million for the same period, expands eligibility for dental care for homeless veterans, requires an annual report to Congress from VA on the status of its assistance to homeless veterans and extends the life of the VA Advisory Committee on Homeless Veterans.

The current Administration has vowed to end the scourge of homelessness within 10 years. The clock is running on this commitment, yet words far exceed deeds. On any given night in this Nation, there are as many as 300,000 homeless veterans with as many as 600,000 homeless during the year. While less than 9 percent of the Nation's population are veterans, 34 percent of the nation's homeless are veterans and 75 percent are wartime veterans. This bill is the first major proposal in years to fund veterans homelessness programs at levels that have a potential to make a real impact and The American Legion vigorously supports it. The American Legion has concerns that by earmarking the funding required by this bill from existing appropriations, VA will be forced to further ration other programs and services. VA's fiscal year 2006 appropriation already falls well short of what VA needs to maintain currents levels of service and access. The American Legion believes Congress should authorize additional funding to cover the costs of implementing this forward-thinking legislation.

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

Chairman CRAIG. Don, thank you very much, and again, your full statement will be part of the record and any additional comments you wish to make on these individual pieces of legislation will also become a part of the record.

Now let me go to Dennis Cullinan, Director, National Legislative Service, Veterans of Foreign Wars.

Dennis.

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

Mr. CULLINAN. Thank you very much, Mr. Chairman, and on behalf of the men and women of Veterans of Foreign Wars, I want to thank you for inviting us to participate in today's most important hearing.

For the purposes of today's hearing, I am just going to extract briefly from our written statement.

With respect to the Veterans Health Care Act of 2005, Section 3, while we support exempting former POWs from co-pays for extended care services, we must oppose the provision that would eliminate the VA's statutory requirement to maintain 1998 staffing and service levels of the extended care facilities.

With respect to Section 5, this section would allow newborn children of mothers who have been receiving maternity care to receive 14 days of care at VA facilities. We strongly support this provision because it closes a loophole and is fair to the mother and to the family.

Currently, no direct health care coverage is provided to the children's families, and they must find outside health care insurance to help pay for the child's treatment. The 14-day window this bill provides allows the parents of the child to secure additional health care coverage, whether through a private company or through Medicaid, and would ease VA's ability to find a local hospital to accommodate the family.

Next I will address S. 481. The VFW supports Senator Akaka's bill that would give separating service members who have served in a combat zone an additional 3 years of access to the VA health care system. Extending this limit to 5 years give these men and women an important safety net, and can also give them peace of mind as they return from the stress of combat, safe in the knowledge that their health care safety net will be there should they need it or should they fall ill as a result of their service.

With respect to S. 716, the Vet Center Enhancement Act, the VFW applauds the introduction of this legislation that would enhance services provides to vet centers, to clarify and improve the provision of bereavement counseling by the Department of Veterans Affairs.

This legislation will allow VA to hire 50 more OIF and OEF veterans to help reach out to the newly transitioning veterans adjusting back to civilian life. And we must ask who better to explain services and help ease their transition than someone who has served alongside them, who can relate to their experiences, and has already navigated VA's many benefit programs. This legislation will also go one step further to help surviving family members who have suffered the loss of a loved one by clarifying who can use the benefit from vet center bereavement counseling services.

The VFW feels that we have an obligation to help make the transitioning period for returning service members and the readjustment period for survivors, those killed in battle, as smooth and as problem free as possible.

Thank you, Mr. Chairman. That concludes my statement.

[The prepared statement of Mr. Cullinan follows:]

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

Mr. Chairman and Members of the Committee:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our Auxiliaries, I would like to thank you for inviting us to today's hearing on veterans' health care legislation.

With the changes in the Appropriations committee, much of our focus to this point has been on the proper of level of funding for the Department of Veterans Affairs (VA), especially the amount going toward the Veterans Health Administration (VHA).

But, it is also important to focus on the actual programs receiving that funding, how effectively they treat veterans, and whether there are any necessary corrections or additions.

And the bills under consideration today do just that.

DRAFT BILL, THE VETERANS HEALTH CARE ACT OF 2005

Section 2: VFW supports this provision, which would exempt hospice care from services that require co-payments.

Section 3: While we support exempting former POWs from co-payments for extended care services, we must oppose the provision that would eliminate VA's statutory requirement to maintain 1998 staffing and service levels of extended care facilities.

Although VA has failed to live up to this target, eliminating this provision would get rid of a very important target. VA must live up to its obligations, not shirk from them.

With the Administration's budget proposal, there was much discussion about VA's long-term care programs. If changes, such as this, are to be made, then VFW feels that there must be a larger discussion about the role of VA in long-term care.

But, for now, our membership strongly supports maintaining the current spectrum of VA long-term care services. We cannot support this statutory reduction in service.

Section 4: We agree with this section, which would close the loopholes in the reimbursement process for veterans seeking emergency care. Too frequently, because of these complex regulations that the veteran, or non-VA hospitals, might not be aware of, veterans are unnecessarily being charged for their emergency care.

This problem is especially evident for our rural veterans, who, when emergencies occur, cannot take the time to make the trip to VA; they must go to the closest hospital.

VA must ensure that all veterans are treated fairly and that they not be unfairly punished or harmed because of their need for emergency care.

Section 5: This section would allow newborn children of mothers who have been receiving maternity care to receive 14 days of care at VA facilities. We support this provision, because it closes a loophole, and is fair to the mother and family.

Currently, no direct health care coverage is provided to the children and families must find outside health insurance to help pay for the child's treatment. The 14-day window this bill provides allows the parents of the child to secure health care coverage, whether through a private company or through Medicaid, and would ease VA's ability to find a local hospital to accommodate the family.

This would give the families an important peace of mind allowing them to focus on the joys of becoming parents. It makes a small change in the law to do what is right for veterans.

Section 6: VFW also agrees with this section, which would allow health care providers to seek reimbursement for extra expenses not covered by VA for treatment of children with spina bifida of certain Vietnam veterans.

This provision is important because of the complex nature of their health care problems, and the difficult and frequent treatment these children require. Making payment easier will encourage more facilities to provide the kinds of treatment these children need by eliminating an economic hurdle.

Improved access to health care is nothing but a good thing for these veterans and their families.

Section 7: While we support the increased grants for homeless veterans contained in this section, we feel that the funding level in Senator Obama's draft bill, which we discuss later, to be more appropriate.

Section 8: The VFW does not take a position on this section, so long as the changes in qualification do not mean impaired access to marriage and family counseling. As we are seeing, today's long and frequent deployments are creating an increased need for these kinds of services.

Section 9: The VFW has no position on this section.

Section 10: The VFW takes no position on this provision.

Section 11: We are pleased with this section, which improves and expands VA's ability to provide mental health care services. It includes $95 million in funding to improve treatment for PTSD and substance abuse problems. It also makes access

to health care more efficient by pursuing tele-health initiatives, and expanding the number of clinical treatment teams.

With the difficulties of the unique nature of combat our men and women are facing, these mental health services will take on an increasingly important role. While much of our concern has focused on those with physical wounds, just as much effort must be focused on the unseen psychological wounds, which can linger and manifest themselves in many other problems for years.

Giving veterans easier access and de-stigmatizing the treatment of these issues prevents future difficulties from arising, and helps the veteran transition smoothly back into society.

Section 12: The VFW supports this provision, which would eliminate any bureaucratic barriers toward VA-DoD health care sharing, by allowing the two departments to fully share any protected health information for their patients.

The seamless transition between these two departments has long been a VFW goal. We hope that this provision would lead us one step closer toward that goal.

Section 13: We are pleased to support this section which improves outreach to National Guard members to inform them of their benefits and rights with VA.

We have frequently heard that the information they receive upon returning is confusing. We hope that expanding this program would alleviate some of the confusion surrounding their benefits status, and would enable those who need assistance to find a VA program that meets their needs.

Section 14: The VFW would also support this provision, which improves health care by increasing the number of Readjustment Counseling Centers which can provide tele-health services with VHA facilities.

We believe that expanding veterans' access to health care facilities with this simple technology would be beneficial and help these veterans get treatment for illnesses and disabilities. Improved access means that more veterans can receive care, often with less of a burden. That is undoubtedly a good thing.

Section 15: We have no position on this section.

S. 481

The VFW supports S. 481, Senator Akaka's bill that would give separating servicemembers, who have served in a combat zone, an additional 3 years of access to the VA health care system.

Public Law 105–627 provided Gulf War veterans, as well as those who serve in any future combat zones, 2 years of eligibility for VA health care. This was part of a larger package of improvements for Persian Gulf veterans in response to the health problems many of them faced. Given the uncertainty surrounding the health of many of them, and the difficulties of diagnosis that many of them faced, they were granted continued access to VA health care so that these problems could be monitored, or any new symptoms could be treated.

Unfortunately, because of the prohibition on new category 8 veterans, many of these veterans will have their access to health care completely curtailed. In the past, they could have continued to access the system.

Extending these veterans' eligibility is especially important when you factor in the difficulty VA has with disability claims processing, and the role that VA disability now has in health care eligibility. With disability claims taking many months to process, veterans who may ultimately prove to be disabled will slip through the cracks and denied their earned health care because of an overly bureaucratic process. That is clearly not right, and it does not do what is right for America's veterans.

Extending this limit to 5 years gives these men and women an important safety net, and can also give them peace of mind as they return from the stresses of combat, safe in the knowledge that their health care safety net will be there, should they need it, or should they fall ill as a result of that service.

S. 614 THE VETERANS PRESCRIPTION DRUG ASSISTANCE ACT

This legislation would permit Medicare-eligible veterans to receive an out-patient medication benefit from the VA provided that they forgo medical care and services from VA during the year they choose such benefit.

By way of background, the Veterans' Health Care Eligibility Reform Act of 1996 provides all veterans enrolled in Categories 1–8 full access to all of the health services described in VA's Medical Benefits Package, which includes prescription drugs.

The Final Report of the President's Task Force To Improve Health Care Delivery for Our Nation's Veterans, released in May, 2003, noted that "According to a November 2002 [Government Accountability Office (GAO)] report, of the $3 billion VA spent on outpatient pharmacy drugs in fiscal year 2001, 13 percent of the total cost, or $418 million, was for former Priority Group 7 veterans." Other surveys have also

suggested that former Priority Group 7 veterans are significantly affecting VA's pharmacy workload, and anecdotal evidence suggests that many of these veterans are coming to VA only for prescription drugs. The GAO study reported that in fiscal year 1999, 400,000 of the former Priority Group 7 veterans had 11 million prescriptions filled. "In fiscal year 2001, the number of veterans in this group seeking prescription drugs increased to 800,000 and the number of prescriptions filled grew to 26 million."

These numbers are alarming when one considers that many of these veterans come to VA with prescriptions from their private physicians already written and in-hand only to find out that they cannot get their prescription filled until they see a VA physician. The VA Inspector General noted "frequent comments in patient medical records reflecting the frustration of veterans in having to go through VA's extended process of scheduling exams and tests and then spending sometimes the entire day at the medical center solely, from their perspective, to have their prescriptions filled or refilled."

In addition, the VA Inspector General also found once veterans received appointments with VA physicians, these VA physicians "routinely review and approve the orders of the private physicians—[and] exams frequently duplicate tests and exams that have already been performed by the patient's private physician and are conducted to allow the VA physician to support filing a prescription that the patient brought from his/her private physician."

Given the current situation and the opportunity to potentially mitigate the impact of long waiting times and produce cost savings by streamlining an inefficient and overly bureaucratic process, the VFW supports the creation of an out-patient prescription benefit that would free up VA health care appointments and potentially reduce the backlog. In addition, we support providing an outpatient medication benefit to Medicare-eligible Category 8 veterans who are currently precluded from enrolling in VA health care.

VFW, however, does not support the language that requires veterans to forgo their earned VA health care in favor of Medicare. Veterans are unique in that they have an entitlement to Medicare by way of financial contribution and have also earned the right to VA health care through virtue of their service to this Nation. They must not be forced to give up their rights to either. VFW will continue to fight for adequate appropriations to allow all veterans access to VA's full Medical Benefits Package.

S. 716, THE VET CENTER ENHANCEMENT ACT OF 2005

VFW applauds the introduction of S. 716, The Vet Center Enhancement Act of 2005, legislation that would amend title 38, U.S.C. to enhance services provided by vet centers, to clarify and improve the provision of bereavement counseling by the Department of Veterans Affairs, and for other purposes.

In February 2004, the Department of Veterans Affairs (VA) authorized the Vet Center program to hire 50 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans to provide outreach to their returning comrades. As time passes and more and more veterans of OIF and OEF as well as those serving all over the globe in the War on Terror return home with both physical and mental battle scars, the need for enhanced services provided by VA is critical. Community based Vet Centers provide a safe haven and offer a wide-variety of readjustment services designed to assist transitioning veterans. Currently, 60 percent are staffed by veterans who have served in combat. This legislation will allow VA to hire 50 more OIF and OEF veterans to help reach out to those newly transitioning veterans adjusting back to civilian life. Who better to explain services and help ease their transition than someone who served along side them, can relate to their experiences, and has already navigated VA's many benefit programs?

This legislation will also go one step further to help surviving family members who have suffered the loss of a loved one by clarifying who can use and benefit from vet center bereavement counseling services. The VFW feels that we have an obligation to help make the transitioning period for returning servicemembers and the readjustment period for survivors of those killed in battle as smooth and as problem-free as possible.

DRAFT BILL, SAVE REAUTHORIZATION ACT

The VFW offers our support for Senator Obama's draft bill which would expand and improve upon VA's homelessness programs.

VA estimates that there are approximately 250,000 homeless veterans. That is a national tragedy. These men and women have served this country, and now find themselves in an unfortunate situation. We must not leave these men and women

behind. This bill greatly helps our homeless veterans, and is a positive step toward ending this national problem.

The legislation includes provisions that would provide $200 million in funding for the homeless providers grant and per diem programs annually through fiscal year 2011, and $50 million per year for the Homeless Veterans Reintegration Program.

The programs it would extend are of great benefit to homeless veterans, helping them to make the sometimes-difficult transition back into society. We applaud this legislation and thank the committee for considering it.

We received two draft bills from Senator Akaka's office, which, we were not able to review in time. We would be happy to offer our comments for the record, after we've had sufficient time to review them.

This concludes my statement, Mr. Chairman. I would be happy to answer any questions that you, or the Members of this committee, may have.

Chairman CRAIG. Thank you very much. Your full statement will be a part of the record.

Now, Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans. Welcome before the committee.

STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Mr. Chairman, Members of the committee, on behalf of the members of the Disabled American Veterans and its auxiliary, we wish to express our appreciation for this opportunity to present our views on the bills and draft bills on today's agenda.

For the sake of brevity, I will limit my oral remarks to highlight notable provisions of the bills, and ask the committee to refer to my written testimony for additional information.

The DAV supports Section 2 of the Veterans Health Care Act of 2005, which would prohibit collection of co-payments from veterans receiving hospice care furnished by VA. As you may already know, Public Law 108–422 does not exempt veterans from co-pay for hospice care, provided in other VA settings such as hospital inpatient as well as in the home.

Similarly, DAV supports the provisions in Section 3 that would exempt former POWs from inpatient long-term care service co-payments.

As part of the independent budget the DAV strongly opposes the provision of Section 3 that would eliminate VA's requirement to maintain nursing bed capacity. This provision recognizes and strengthens the importance of the Veterans Health Administration specialized services and reflects the vulnerability of these high-cost services in an under funded system, especially at a time when the projected workload of VA chronic care services will continue to rise in the future.

Section 4 would allow VA to reimburse a veteran for any remaining expenses for having received emergency treatment at a private facility. Now, DAV does have a resolution to support this legislation. However, we do object to the eligibility limitations for reimbursement of emergency services on veterans enrolled in a VA health care system.

DAV Resolution 47 calls for adequate funding and permanency of all veterans employment and training programs, including homeless programs. Therefore, we support Section 7 of this bill. However, we do note that any improvements and expansions gained would be lost in the following years due to rising costs such as in-

flation which affects the reimbursement rate, which increases annually.

DAV Resolution 175 calls for the appeal of all co-payments for veterans' medical services and prescriptions. Accordingly, we do oppose the co-payment provision in S. 614, the Veterans Prescription Drug Assistance Act.

The proposed legislation which would require VA to publish a long-term care strategic plan to address the significant needs of sick and disabled veterans for chronic care, DAV has a resolution calling for legislation to establish a comprehensive program of extended care services for veterans. However, as part of the IB, the DAV is opposed to the provision in the bill which requires the strategic plan to include specific plans to utilize Medicare, Medicaid and private insurance companies to expand care. Specifically, under tight budget constraints, this provision would allow a shift in VA's responsibility to veterans and reduces internal capacity to care for America's aging veterans.

I see my time has run out. I do appreciate again the opportunity to testify and welcome any questions you may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

On behalf of the members of the Disabled American Veterans (DAV) and its Auxiliary, I wish to express my appreciation for this opportunity to present the views of our organization on the bills and draft bills on today's agenda. As always, we appreciate this committee's efforts to improve benefits and services for disabled veterans. With a few exceptions, the provisions of these bills are beneficial and justified.

DRAFT LEGISLATION VETERANS HEALTH CARE ACT OF 2005

Public Law 108–422, Section 204, only exempted veterans from extended care co-payments for VA hospice care services provided in a nursing home setting. However, hospice care is provided in other settings such as hospital inpatient, and in the home. Section 2 of this legislation would prohibit the collection of co-payments from veterans receiving hospice care furnished by the Department of Veterans Affairs (VA) in any setting. The DAV testified in support of the same provision in S. 2486 last year, and the DAV fully supports Section 2 in this draft bill.

Similarly, the DAV supports the provision in Section 3 that would exempt former POWs from inpatient long-term care service co-payments. The DAV has a resolution calling for the repeal of all co-payments for veterans' medical services and prescriptions. We commend this committee for recognizing the tremendous undue burden placed on veterans in need of end-of-life care that provides dying patients and their loved ones with comfort, compassion, and dignity. Furthermore, veterans in no other group as a whole have borne a greater burden on behalf of our Nation and deserve more in return than our former POWs. Many suffered unimaginable horrors from torture, humiliation, other physical and psychological trauma and abuse, deprivation, isolation, and malnutrition. In addition to the effects of physical and mental trauma, many suffered from diseases caused by unsanitary conditions and inadequate diets. Many, perhaps, never fully recover from a life experience that is far more traumatic than most in society ever have to endure. To the extent we can provide former POWs benefits that address their special needs or afford some general recompense in proportion to their suffering and sacrifices, we should never hesitate to do so.

Section 3 has another provision that, if passed, would eliminate the required nursing bed capacity to be no less than the level during fiscal year 1998. As part of The Independent Budget (IB), the DAV strongly opposes the provision in Section 3 that would eliminate VA's requirement to maintain nursing bed capacity. This provision recognizes and strengthens the importance of the Veterans Health Administration's (VHA's) specialized services and reflects the vulnerability of these high-cost services in an under funded system. The projected workload for VA chronic care services will

continue to rise in the future. To address this burgeoning demand VA has testified that it will increase capacity in its non-institutional long-term care program. However, the Government Accountability Office's (GAO) review of this program found high variations in the availability of six VA non-institutional long-term care programs. Until it can be verified that these non-institutional programs are increased and functioning at a level of satisfaction to veterans who would need these services, it seems an unwise decision to relieve VA from the requirement that it protect the vulnerability of its institutional long-term care capacity.

Section 4 would allow the VA to reimburse a veteran for any remaining expenses from having received emergency treatment at a private facility. The DAV has a resolution to support legislation to authorize enrolled veterans to receive emergency medical care in private medical facilities at VA's expense when VA facilities are not reasonably available. However, we object to the eligibility limitations for reimbursement of emergency services on veterans enrolled in the VA health care system. Due to the existing eligibility criteria for VA reimbursement of emergency treatment, many veterans do not seek emergency treatment in non-VA facilities. When they do, they are charged for emergency care as a result of denial of payment by VA for such care based on the existing eligibility criteria. For example, the eligibility criteria indicate veterans must not only be enrolled in the VA health-care system, but they also must have been seen by a VA health-care professional within the previous 24 months. As part of the ill, the DAV believes all enrolled veterans should be eligible for emergency medical services at any medical facility. It is outrageous to penalize a veteran for seeking emergency care when he or she is experiencing symptoms that manifest a life-threatening condition.

Section 5 of this bill would authorize care for newborn children of enrolled women veterans following delivery. Women Veteran Coordinators have complained that it is very difficult to secure a contract for care for a woman veteran for the delivery of a baby without securing a contract for initial post-delivery newborn care. Private hospitals are reluctant to accept a sole contract for care for the mother and risk financial responsibility for the care of the newborn infant following delivery. The promise of comprehensive health care services includes prenatal care and delivery. Health care professionals consider the initial newborn care immediately following delivery as part and parcel of the delivery itself this legislation would authorize VA to pay for the initial care of the newborn infant for 14 days after the date of birth or until the mother is discharged from the hospital, which ever is the shorter period. DAV has no resolution from our membership on this issue; however, its purpose is beneficial. We have no objection to the committee's favorable consideration of this section of the measure.

Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of veterans, Congress authorized special programs including medical treatment to these children. Section 6 of this bill addresses the disparity between billed charges for medical services rendered and payments received by non-VA health care providers for treating children of Vietnam veterans who are suffering from the effects of exposure to Agent Orange. While protecting the veteran and family against the difference between the amount billed and the amount paid by VA, this provision would allow non-VA health care providers to seek third party payments to compensate for the difference. Having no mandate from our membership on this issue, we do not have a position on this section.

Section 7 would authorize increased appropriations for homeless providers' grants to $130 million beginning in fiscal year 2006. DAV Resolution No. 047 calls for adequate funding and permanency for all veterans' employment and training programs, including homeless programs. We thank the committee for recognizing the value and importance of this program, which serves a vulnerable portion of the veteran population; however, we note that any improvements and expansions gained would be lost in the following years due to rising costs such as inflation and the annual increase of reimbursement rates.

Section 8 would allow VA to employ marriage and family therapists and require VA to submit a report to both the House and Senate Veterans' Affairs committees. The report would include the actual and projected workloads for providing marriage and family counseling related to posttraumatic stress disorder (PTSD) treatment, an assessment of the effectiveness of this treatment, and any recommendations for improvement. DAV has no position on these provisions since our membership has not provided us with a mandate on this issue.

Section 9 of this bill would authorize Senior Executive Service compensation to VA's Nursing Service Director. The DAV supports this provision of the bill in keeping with DAV Resolution No. 199, which seeks the enactment of legislation providing for competitive salary and pay levels for VA physicians, pharmacists, dentists, and nurses.

Section 10 would eliminate the prohibition to utilize funds appropriated for veterans medical care toward any cost comparison study between VA services and similar commercial services. The DAV does not have a resolution on this issue; however, due to the perennially inadequate level of medical care funding, we are concerned this provision would have a deleterious affect on VA's ability to deliver needed medical care to sick and disabled veterans in a timely manner.

VA supplies one-third of all care provided for this Nation's chronically mentally ill and have developed broad-reaching programs to meet the psycho-social needs of homeless veterans. Without these specialized services many veterans who are homeless or suffer severe mental illness or substance use problems would return to the street, end up in jail, or rely on more expensive and less comprehensive State-sponsored programs. The private sector is ill-equipped to provide these kinds of specialized services VA patients frequently need. Section 11 of this bill would expand VA's mental health services. To increase the number of PTSD Clinical Teams (PCTs), Mental Health Intensive Case Management teams (MBICMs), substance abuse treatment, improve mental health education and training programs for providers, increase access to VA's mental health services through tele-health initiatives, and increase the availability of mental health services in Community-Based Outpatient Clinics (CBOCs), $95 million would be authorized. With the authorization of additional funds for these programs, the DAV supports these provisions that would enhance VA's ability to provide mental health services.

On May 19, 2005, a hearing was conducted by the House Veterans' Affairs committee on seamless transition. GAO provided testimony, which indicates the Department of Defense (DoD) and VA have been working on a data sharing agreement for over 2 years, but have not reached an agreement. GAO cited differences between the two agencies in their interpretation of the Health Insurance Portability and Accountability Act of 1996 (HIP AA) and the HIP AA privacy rule, which governs the sharing of individually identifiable health data. Section 12 seeks to address this impasse by allowing both agencies to exchange protected health information despite any other provision of law. This would enable VA to locate, identify, and follow up with servicemembers who are injured while on active duty and may be eligible for VA benefits and services.

VA has indicated, of the nearly 86,000 veterans from Operation Enduring Freedom (OEF) and Iraqi Freedom (OIF) that have sought medical care from VA, over half are from the National Guard and Reserve. Moreover, over 9,000 veterans from Operation Enduring Freedom and Iraqi Freedom suffer from PTSD, and over 2,000 have sought care in Vet Centers. Outreach to National Guard and Reserves is now considered a form of psychosocial intervention and provides direct access to Vet Centers by providing information to individuals about the availability of specialized services they may require and may be entitled. Section 13 would expand VA's outreach to the National Guard and Reserve component of the military by increasing the number of employees in the Readjustment Counseling Service's Global War on Terrorism Outreach Program, requiring that information on VA benefits and services be made available to returning Guardsmen, and an appropriate needs assessment be conducted on all VA benefits and services. In addition, this section would allow for collaboration between VA and appropriate State National Guard officials to facilitate this outreach program. Section 14 would require VA to submit a plan to both the House and Senate Veterans' Affairs committees to increase the number of Vet Centers capable of providing tele-mental health for fiscal years 2005 through 2007. According to VA, the Veterans Readjustment Counseling Service maintains 206 Vet Centers, of which there are currently 20 Vet Centers across 14 Veterans Integrated Service Networks (VISNs) that have linkages to provide tele-mental health services. The DAV does not have a resolution on these issues; however, the purpose of this provision appears beneficial and we look forward to favorable consideration by this committee.

Section 15 would require the Secretary of Veterans Affairs to submit a report to both the House and Senate Veterans' Affairs Committees with data regarding the source of VA's mental health data, such as the locations of facilities maintaining such data. Additionally, the report is to include an assessment of the information and recommendations for improving data collection, use, and repository locations. The DAV does not have a resolution on this issue; however, the provisions appear beneficial.

S. 481

This bill would extend the eligibility period for veterans who served in combat during or after the Persian Gulf War, from 2 years following discharge or release from active military service to 5 years, to receive VA medical care. The DAV has

no resolution pertaining to the bill. However, because it would benefit recently discharged veterans and their family members, the DAV has no objection to its favorable consideration.

S. 614

In addition to allowing Medicare-eligible veterans to elect to receive from VA outpatient prescription medication prescribed by a physician, the Veterans Prescription Drugs Assistance Act, would direct VA to collect co-payments and/or an enrollment fee to furnish prescription medications for veterans in receipt of compensation and increased pension. Furthermore, the bill would require VA to inform each veteran considering an election to receive VA medication under these provisions of the terms of the election.

As this committee may be aware, veterans service organizations acquiesced to the use of co-payments which were only imposed upon veterans under urgent circumstances and as a temporary necessity to contribute to reduction of the Federal budget deficit. Accordingly, the Omnibus Budget Reconciliation Act of 1990 established VA's authority to charge co-payments to veterans for prescription medication and medical services with a sunset date of September 30, 1991. However, since 1997, Congress and the Administration have used the amount estimated that VA might collect from veterans to offset appropriations for VA. Most recently, on September 20, 2003, Public Law 108–7 eliminated the sunset provision making co-payments permanent without debate through hearings and other authorizing committee processes.

DAV Resolution No. 175 calls for the repeal of all co-payments for veterans' medical services and prescriptions. Accordingly, we oppose the co-payment provisions of this bill, which would require a veteran to pay an annual enrollment fee and the full cost of prescription medication VA would otherwise pay. Such provisions move VA farther down the road of shifting the costs of care onto the backs of sick and disabled veterans. Moreover, this provision is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans by a grateful Nation. We believe that providing our Nation's veterans with high quality health care is a continuing cost of national defense and should be our first priority, without cost to veterans.

S. 716

The Vet Center Enhancement Act of 2005 requires that VA employ, in career conditional status, up to an additional 50 veterans of Operations Enduring Freedom or Iraqi Freedom to provide outreach to veterans on the availability of readjustment counseling and related mental health services at Vet Centers. The bill also eliminates any limitation on duration of employment of veterans for the aforementioned program. Moreover, VA's authority to provide bereavement counseling at Vet Centers would be revised to include parents of military servicemembers who die while serving on active military duty. For fiscal year 2006, $180 million would be authorized to be appropriated for the Readjustment Counseling Service Program. The DAV has no official mandate from our membership on this measure. However, its purpose is beneficial, and we do not object to its favorable consideration.

Draft Bill to be entitled the, "Sheltering All Veterans Everywhere Act" or the "SAVE Reauthorization Act of 2005".—This bill would improve or reauthorize the following programs servicing the needs of homeless veterans.

Homeless Providers Grant and Per Diem Program.—The Homeless Providers Grant and Per Diem (GPD) Program provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans. This provision would reauthorize the GPD program through fiscal year 2011 at $200 million annually. GPD is set to expire September 30, 2006. The current annual authorization level for the program is $99 million.

Homeless Veterans' Reintegration Program.—The Homeless Veterans' Reintegration Program (HVRP) is an employment services program established to help homeless veterans reintegrate into the labor force and attain financial independence. HVRP assists homeless veterans via grants to State and local Workforce Investment Boards, commercial agencies, and non-profit organizations, including faith-based and community-based organizations. Qualified agencies directly assist homeless veterans with job placement, training, counseling, and resume preparation. This provision would reauthorize the HVRP through fiscal year 2011 at $50 million annually.

VA Outreach Services.—The VA would be required to provide information concerning homelessness, including risk factors, awareness, and contact information for preventative assistance, to members of the Armed Forces separating from active duty.

Grant Program for Homeless Veterans With Special Needs.—The grant program authorizes VA to make grants to assistance providers to assist homeless veterans with special needs, including women (with and without children), frail elderly, terminally ill, or chronically mentally ill. The special needs program has enabled VA and GPD providers to devote attention to underserved subpopulation within the homeless veteran population. It is currently authorized through fiscal year 2005 at $5 million annually. This bill would continue the program at current levels through 2011.

Dental Care.—This provision would expand eligibility for dental care by eliminating the criteria that veterans must be receiving treatment in an approved homeless program for a period of 60 consecutive days prior to becoming eligible for dental treatment.

Authorization of appropriations for the Homeless Veterans Service Provider Technical Assistance Program.—This program authorizes VA to make competitive grants to qualified organizations that provide technical assistance to nonprofit groups that provide assistance to homeless veterans. It is necessary because community-based and faith-based organizations serving homeless veterans lack the technical expertise to acquire grants via the complex set of funding and service delivery streams associated with housing and supportive services. This bill would reauthorize the program through 2011 at $1 million annually.

Annual Report.—This provision would require VA to report on homeless veteran coordination efforts with other Federal departments and agencies, including the Department of Defense, Department of Health and Human Services, Department of Housing and Urban Development, Department of Justice, Department of Labor, Interagency Council on Homelessness, and the Social Security Administration.

Advisory Committee.—This provision would add the Executive Director of the Interagency Council on Homelessness (ICH) to the Advisory Committee on Homeless Veterans.

Study on Military Sexual Trauma and Homelessness.—This provision would authorize a study on the relationship between military sexual trauma and homelessness. The VA Secretary's Advisory Committee on Women Veterans recommended in 2004 that a study be conducted on the possible correlation between military sexual trauma and homelessness among veterans and effective service models for assembling various treatment modalities and environments.

The DAV supports this draft legislation and encourages the committee to consider it favorably. The DAV is very supportive of HVRP and other homeless veterans' initiatives. It is an unfortunate and sad fact that many veterans, for various reasons, have been unable to make their way in the society they swore to defend. Such veterans exist without decent shelter, adequate nutrition, or medical care. Services provided by homeless veterans can mean the difference between a veteran living on the streets or living in transitional housing until they are capable of providing for themselves. As a member of the National Coalition for Homeless Veterans (NCHV), the DAV supports the testimony and recommendations submitted by the Coalition, which include all of the provisions of this bill.

In addition to legislative advocacy on behalf of homeless veterans, it is important to note that the DAV takes an active role in seeking to prevent and end homelessness among our Nation's veterans. The DAV Homeless Veterans Initiative, which is supported by our Charitable Service Trust and Colorado Trust, promotes the development of supportive housing and services to help homeless veterans become productive, self-sufficient members of society. Since 1989, DAV allocations for homeless projects have exceeded $2 million.

DRAFT BILL TO BE ENTITLED, THE "BLINDED VETERANS CONTINUUM OF CARE ACT OF 2005"

According to VA, of the 160,000 veterans eligible for Blind Rehabilitation Services, over 38,000 are currently enrolled to receive services. The impact of blindness is individualized and includes both the older veteran whose vision gradually worsens due to macular degeneration or diabetes and the serviceperson who is rendered totally blind by traumatic injury. Each of these veterans requires individualized, specialized care and treatment suited to the cause of blindness, physical and medical condition, age, ability to cope with frustrating situations, learning ability, and the overall needs and lifestyle of the veteran. The Blinded Veterans Continuum of Care Act of 2005 would require VA to establish Blind Rehabilitation Outpatient Specialists (BROS) at designated VA medical facilities with Visual Impairment Service Teams (VIST) or with more than 150 enrolled veterans who are legally blind.

The IB places special emphasis on VA's specialized programs such as the Blind Rehabilitation Service (BRS), which is known worldwide for its excellence in deliv-

ering comprehensive blind rehabilitation to our Nation's blinded and severely visually impaired veterans. Favorable consideration of this bill by this committee would preserve VA's mission and role as a provider of blind rehabilitation services, as well as benefit the approximately 120 servicemembers from Operations Enduring Freedom and Iraqi Freedom who suffer from visual impairments.

DRAFT BILL TO REQUIRE VA TO PUBLISH A LONG-TERM CARE STRATEGIC PLAN

The proposed legislation would require VA to publish a long-term care strategic plan to address the significant need of sick and disabled veterans for chronic care in both institutional and non-institutional settings. According to VA, the veteran population is projected to decline to 20 million by 2010, but over the same time period those age 75 and older will increase from 4.5 to 4.7 million and those 85 and older will nearly triple from 510,000 to over 1.3 million. Older veterans, particularly those over 85, are especially likely to have multiple, complex chronic diseases requiring comprehensive health care including long-term care services. Of equal importance is the fact that current VA patients are not only older in comparison to the general population, but they are much more likely to be disabled and unable to work, generally have lower incomes, and lack health insurance.

With a constrained budget, an increasing and aging veteran population, and the high cost of providing inpatient long-term care, VA is struggling with the issue of long-term care. An attempt was made to address long-term care through the Capital Asset Realignment for Enhanced Services (CARES) initiative. GAO's May 2003 report, "VA LONG-TERM CARE: Service Gaps and Facility Restrictions Limit Veterans' Access to Non-Institutional Care" (GAO03–487), confirmed veterans' access to non-institutional long-term care services is limited and highly variable across the Nation.

Extensive gaps in service exist due in part to restrictions based on veterans' levels of service-connected disability that are inconsistent with existing eligibility standards. GAO cites VA headquarters as the source of such disparity as a result of not providing clear and adequate guidance on making non-institutional long-term care services available. Furthermore, VA headquarters has failed to emphasize non-institutional long-term care as a priority, and has failed to develop a performance measure to ensure the provision of these services consistently across VA facilities.

The DAV has a resolution calling for legislation to establish a comprehensive program of extended care service for veterans in need of such care for a service-connected disability. However, as part of the IB, the DAV is opposed to the provision in the bill, which requires the strategic plan to include specific plans to utilize Medicare, Medicaid, and private insurance companies to expand care. Under tight budget constraints, this provision would allow a shift in VA's responsibility to veterans and reduce its internal capacity to care for America's aging veterans. Care for aging veterans should not be shifted to private providers because it is more convenient or more cost-effective to do so. VA nursing home care is an integral part of VA's health care benefit package and is an entitlement to certain eligible veterans, and these individuals should not be forced to accept other forms of nursing home care because VA has reduced its capacity.

DRAFT BILL TO ESTABLISH A GRANT PROGRAM TO PROVIDE TRANSPORTATION TO MEDICAL CARE FOR RURAL VETERANS

VA currently operates 100 outpatient clinics in 27 States that are located in areas considered as rural or highly rural. Veterans residing in such areas experience difficulty in accessing adequate health care in a timely manner, which in turn reduces the continuity and quality of care provided to existing enrollees in the VA health care system. Because so many sick and disabled veterans lack transportation to and from VA medical facilities for needed treatment, the DAV operates a nationwide Transportation Network. This program continues to show tremendous growth as an indispensable resource for veterans. Across the Nation, DAV Hospital Service Coordinators operate 183 active programs. They have recruited 9,657 volunteer drivers who logged 26,429,512 miles last year, taking over 725,084 veterans to and from VA medical facilities. Since 1987, our volunteer drivers have driven 8,958,755 veterans more than 338 million miles to and from their VA medical appointments.

This proposed legislation would establish a grant program administered by VA to provide innovative transportation options to veterans in remote rural areas. DAV's mission of service reflected in the commitment of men and women in our Transportation Network to assist veterans who have no other means of getting to their VA medical appointment, coupled with a mandate from our membership calling for timely access to quality health care and medical services; we support this bill and urge favorable consideration by the committee.

Due to the timeliness in receiving the remaining three draft bills scheduled for today's agenda, the DAV is unable to provide position on these measures at this time. However, we request the opportunity to submit our written testimony for the record at a later time.

On behalf of the DAV, I want to thank the committee for its consideration of these important legislative matters and for the opportunity to present our views. We sincerely appreciate your continuing support of veterans.

Chairman CRAIG. Adrian, thank you very much and your full statement will be a part of the record.

Next Carl Blake, Associate National Legislative Director, Paralyzed Veterans of America. Thank you.

STATEMENT OF CARL BLAKE, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Chairman Craig. PVA would like to thank you for the opportunity to testify today on the proposed legislation. I will limit my remarks to just a select few of the legislative proposals.

PVA strongly opposes the provision of the Veterans Health Care Improvements Act that would repeal section 1710(b), subsection B of title 38. This section ensures that the VA maintains bed and staffing levels at the same level established by Public Law 106–117 of the Veterans Millennium Health Care and Benefits Act. Despite an aging veteran population and passage of Public Law 106–117, the VA's average daily census has continued to decline since 1998 and is projected to reach a new low of 9,795 for fiscal year 2006. We feel that the VA is ignoring the law by providing services to fewer and fewer veterans in the nursing home care program.

PVA opposes section 10, which would allow the VA to use money appropriated for health care to be used to conduct cost comparison studies between the provision of care by the VA and private and other types of contractors. Now is not the time to allow the VA to draw much-needed health care dollars when the medical system is already struggling to meet the demands being placed on the system. Furthermore, we do not believe that the contracted care is more cost effective and cost efficient than that provided by the VA, and we certainly do not believe that that care will be as high quality as that provided by the VA.

S. 614 would allow a Medicare eligible veteran to receive medications from the VA on an outpatient basis. These veterans will not otherwise be eligible for Medicare services from the VA. PVA has expressed concerns in the past about similar expansions of prescription drug benefits. We believe that opening up the VA pharmacy system in the way that this legislation does could ultimately change the basic primary mission of the VA, which is to provide health care to sick and disabled veterans. The VA does not need to become the veterans' drug store at this time.

As a participating member of the National Coalition of Homeless Veterans, PVA also supports the provisions of the Sheltering All Veterans Everywhere Act.

PVA supports the proposed legislation introduced by Senator Salazar that would require the VA to publish a strategic plan for long-term care. PVA is astounded by the fact that the VA has a proposal on the table such as the legislation being considered today to repeal the Millennium Health Care requirements, the horrific

budget proposal, even though aging veterans are a significant part of the population the VA will have to care for in the future.

Congress must make every effort to ensure that the VA develops a reasonable and effective strategic plan to provide long-term care and to ensure that the VA immediately implements that plan.

Mr. Chairman, I would like to thank you again for the opportunity to testify, and I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Chairman Craig, Ranking Member Akaka, members of the committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the "Veterans Health Care Improvements Act of 2005," the "Mental Health Capacity Enhancement Act of 2005," the "Neighbor Islands Veterans Health Care Improvements Act," S. 481, S. 614, the "Veterans Prescription Drugs Assistance Act," S. 716, the "Vet Center Enhancement Act of 2005," and the "Sheltering All Veterans Everywhere Act." As more and more veterans are entering the Department of Veterans Affairs (VA) health care system, it is important that we continue to upgrade the health care options available to them.

THE "VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005"

PVA appreciates the efforts of the committee to address the many health care issues facing veterans with this proposed legislation. PVA supports the provision of Section 3 of the bill that would exempt former prisoners of war from paying co-payments for extended care services. It is only right that we recognize the extreme hardships that these men and women faced in defense of this country.

However, we strongly oppose the provision that would repeal Section 1710B(b). This section ensures that the VA maintains bed and staffing levels at the same level established by the P.L. 106–117, the "Veterans Millennium Health Care and Benefits Act." Despite an aging veteran population and passage of P.L. 106–117, the VA has continuously failed to maintain its 1998 VA nursing home required average daily census (ADC) mandate of 13,391. VA's average daily census (ADC) for VA nursing homes has continued to decline since 1998 and is projected to decrease to a new low of 9,795 in fiscal year 2006. The VA is ignoring the law by serving fewer and fewer veterans in its nursing home care program.

PVA is deeply troubled by this move to eliminate the mandatory ADC requirement contained in the Millennium Health Care bill. This proposed change is not driven by current or future veteran nursing home care demand. In fact, the General Accounting Office (GAO) reported "the numbers of aging veterans is increasing rapidly, and those who are 85 years old and older, who have increased need for nursing home care, are expected to increase from approximately 870,000 to 1.3 million over the next decade."

PVA strongly feels that the repeal of the capacity mandate will adversely affect veterans and is a step toward allowing VA to reduce its current nursing home capacity. This is not the time for reducing VA nursing home capacity with increased veteran demand looming on the near horizon.

PVA does not oppose the provisions of Section 3 which would allow the VA to reimburse a veteran for expenses incurred while receiving emergency treatment at a non-VA medical facility. However, we have concerns about some of the eligibility criteria that determine what veterans are eligible for this reimbursement. In accordance with The Independent Budget for fiscal year 2006, we believe that the requirement that a veteran must have received care within the past 24 months should be eliminated. Furthermore, we believe that the VA should establish a policy allowing all veterans enrolled in the health care system to be eligible for emergency services at any medical facility, whether at a VA or private facility. PVA supports Section 4 of the legislation that would authorize the VA to provide care to newborn children of women veterans who are receiving maternity care. The woman veteran may be receiving care at a VA medical center or at a non-VA facility that the woman's care was contracted to.

PVA supports the authorization of the Homeless Providers Grant and Per Diem Program at a level of $130 million. This reflects a significant increase over the current authorized level of $99 million. However, as a participating member in the National Coalition of Homeless Veterans (NCHV) we would like to recommend that the

authorization level be increased to $200 million. This provision is necessary because as the per diem rate to cover the daily cost of care rises annually, there could be an actual reduction in the number of beds if the authorization level is not increased.

PVA has no position on Section 7 which established qualifications for marriage and family therapy and calls for a report on marriage and family therapy workload. PVA supports Section 8 of the bill which would authorize the VA Chief Nursing Officer to receive a salary at the Senior Executive Service level. PVA has no position on Section 9.

PVA opposes Section 10 which would allow the VA to use money appropriated for health care to be used to conduct cost-comparison studies between the provision of care by the VA and private and commercial contractors. Now is not the time to allow the VA to draw away critical health care dollars when the medical system is already struggling to meet the demand being placed on the system. Furthermore, we do not believe that contracted care is more cost-effective than the care provided by the VA, and we certainly do not believe that the VA will find the same level of high-quality care in the private sector.

PVA supports the provisions of Section 11 which would improve and expand the mental health services provided by the VA. We believe that mental health disorders and Post-Traumatic Stress Disorder (PTSD) will prove to be common problems that the men and women returning from Iraq and Afghanistan will have to face. The additional authorization for funds for these programs is also critical to ensure that the VA has the resources it needs to meet what we believe will be significant demand.

PVA supports the remaining sections of the proposed legislation. We are particularly pleased with Section 13 which would expand the number of personnel serving as readjustment counselors so that they can conduct additional outreach to National Guard members. It is important that National Guard members and Reservists not be left out as we expand the services available to those men and women who have served and are serving in the military.

S. 481

PVA fully supports this legislation which would extend the eligibility for hospital care, medical services, and nursing home care from 2 years to 5 years for a veteran who served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or in combat against a hostile force after November 11, 1998. This provision has proven especially important to the men and women who have recently served in Iraq and Afghanistan and have exited military service.

However, PVA believes that the ability of the VA to provide this essential care is threatened by the strain being placed on the veterans' health care budget. We know that the VA will continue to meet this important requirement for the young men and women who have sacrificed so much; however, at what cost will the VA meet this demand? The VA must receive adequate funding to ensure that it can provide the care to veterans who are eligible under this provision of Title 38 as well as all other veterans eligible for health care. The VA should not be placed in a position to determine which veterans will be denied care so that it might treat other veterans.

S. 614, THE "VETERANS PRESCRIPTION DRUGS ASSISTANCE ACT"

The proposed legislation would allow a Medicare-eligible veteran to receive medications from the VA on an outpatient basis. These veterans will not otherwise be eligible for medical care services from the VA. PVA has expressed concerns in the past about similar expansions of prescription drug benefits. We believe that opening up the VA pharmacy system in the way that this legislation does could ultimately change the basic primary mission of the entire VA which is to provide health care to sick and disabled veterans. The VA does not need to take on the role of the veterans' drug store.

PVA fears that if we embark upon this path of only providing certain limited health benefits to certain categories of veterans, we could very well see the erosion of the VA's mission. The VA would essentially revert back to the way it determined who received care and services prior to eligibility reform, when health care was not governed by medical needs but rather by arbitrary budget-driven classifications stratifying veterans' health care eligibility into "have" and "have not" categories.

With the VA having taken steps to drastically reduce access by denying enrollment to Category 8 veterans 2 years ago and a budget situation that could lead to even further restrictions on enrollment, now is not the time to take chances with the lives and health of veterans by dramatically, and fundamentally, changing the nature of the VA health care system. The VA would then take on the new role of managing a prescription drug plan for a whole new category of eligible veterans.

PVA opposes the provision of this legislation that would shift the cost burden of administering this program onto the backs of veterans. This is yet one more attempt to shift the responsibility for providing quality care and services away from the Federal Government. This measure would be unnecessary if Congress provided adequate funding to meet the needs of these veterans.

S. 716, THE "VET CENTER ENHANCEMENT ACT OF 2005"

PVA supports S. 716, the "Vet Center Enhancement." The Vet Centers managed by the VA provide vital readjustment services to the men and women who have placed themselves in harm's way and to their families. Vet Centers offer various types of readjustment counseling, including bereavement counseling, as well as related mental health services. The mental health services are especially important as the men and women returning from Iraq and Afghanistan seek to cope with the stress and related difficulties they faced while in combat.

This legislation would authorize the VA Secretary to hire 50 additional Operation Enduring Freedom and Operation Iraqi Freedom veterans to serve as outreach coordinators for the Vet Centers. These men and women are a valuable resource because they can closely relate to the new veterans and their families who they will be helping readjust. We also appreciate the provision that clarifies the availability of bereavement counseling to the parents of those servicemembers who have made the ultimate sacrifice. In many cases, the parents are the next of kin to the men and women who have been killed because there is no surviving spouse.

THE "SHELTERING ALL VETERANS EVERYWHERE ACT"

The VA estimates that more than 200,000 veterans are homeless on any given night, and that more than 500,000 veterans experience homelessness in a year. PVA believes that the key to overcoming homelessness among the veterans population is employment. A veteran is unable to provide for himself or herself, much less a family, without the benefit of gainful employment.

As a participating member of the NCHV, PVA supports Section 3 of this legislation. As we previously testified, increasing the authorization level for the Grant and Per Diem Program from $99 million to $200 million will ensure that the number of beds and the services provided are not reduced as the daily cost of care continues to increase.

PVA supports Section 4 of the bill that would expand the Homeless Veterans Reintegration Program to include veterans who are deemed to be at imminent risk of homelessness. PVA also supports the reauthorization of the HVRP through fiscal year 2011. The change reflects one of the goals of the NCHV. Moreover, PVA, as a member of the National Coalition for Homeless Veterans (NCHV), also supports the reauthorization of the program at a $50 million funding level. The HVRP is perhaps the most cost-effective and cost-efficient program in the Federal Government. In spite of the success of HVRP, it remains severely under-funded. Even more tragically, DOL does not request a full appropriation in its budget submission. For fiscal year 2006, the Administration only requested $22 million to support this program. Enactment of this legislation would ensure that homeless veterans who need a high level of support get it.

PVA supports Section 5 which would clarify the outreach efforts of the VA toward veterans and members of the Armed Forces to help them avoid homelessness. We also support the continuation of treatment and rehabilitation for the seriously mentally ill and homeless through 2011. PVA supports the remaining sections of the proposed legislation.

THE "VETERANS MENTAL HEALTH CARE CAPACITY ENHANCEMENT ACT OF 2005"

PVA supports the proposed legislation introduced by Senator Akaka that would improve mental health care services within the VA. We believe that quality mental health services will become vital as the rigors of combat in Iraq and Afghanistan begin to take their toll on the men and women serving there. PVA is pleased to see the strengthening of the performance measures for mental health programs outlined in Section 3. We appreciate the indexing requirement for funding specialized treatment and rehabilitation services in Section 4.

PVA also understands the need to create a joint workgroup between the VA and Department of Defense (DoD) to address the mental health problems that servicemen and women returning from overseas face. It is important that the agencies work to educate servicemembers that there is no stigma associated with treatment for a potential mental health disorder. This is particularly true of the DOD who we believe has helped perpetuate this belief in servicemembers through adverse personnel actions in the past. It is important that the DOD and VA identify the men

and women who have potential mental health problems early so that they can get the treatment that they need.

THE "NEIGHBOR ISLANDS VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005"

PVA supports the proposed legislation introduced by Senator Akaka that would improve the provision of health care and services to veterans who live in Hawaii. We recognize the unique challenges faced by veterans who live there. They do not have easy access to all of the same services available to veterans who live on the mainland. We support the requirements to build health care clinics on selected islands of Hawaii. This will ease the travel burden for those veterans seeking to get health care from the VA.

PVA supports Section 6 which authorizes the VA to conduct a study on the demand and access to specialized care and fee-basis care from the VA on the Hawaiian Islands. It is important that the VA maintains the capability to provide whatever care is needed to veterans living there.

THE "BLINDED VETERANS CONTINUUM OF CARE ACT OF 2005"

PVA shares a unique relationship with Blinded Veterans of America (BVA) and the veterans that they represent. Much like PVA members, BVA members live with a catastrophic disability every day. Blinded veterans also rely on the specialized services provided by the VA just as spinal cord injured veterans rely on the same services. PVA fully supports the "Blinded Veterans Continuum of Care Act of 2005." The establishment of specialists at designated VA medical centers to improve the ability of the VA to meet the needs of blinded veterans is essential. The nature of the fighting in Iraq and Afghanistan has led to increasing numbers of men and women with visual impairments.

LONG-TERM CARE STRATEGIC PLAN

PVA supports the proposed legislation introduced by Senator Salazar that would require the VA to publish a strategic plan for long-term care. The VA has recognized the massive needs that the Nation's oldest veterans, veterans of World War II and the Korean War, will present as they near the end of their lives. The VA has done incomparable work when it comes to studies of aging as well as the establishment of clinical approaches, research, education and new treatment models to deal with diseases of old age. VA has established 130 VA nursing home care units, and has aided the States in establishing and sustaining 128 State homes for the long-term care of elderly veterans. Despite these efforts, the VA continues to struggle to meet the long-term care needs of America's aging veterans. Furthermore, the Capital Asset Realignment for Enhanced Services (CARES) Commission originally avoided the issue all together. And now the VA is proposing to shift the burden of providing long-term care and move into a type of niche market where it provides care to only that subset physically amenable to rehabilitation.

It is imperative that the VA develop and implement a viable strategy to meet the ever-growing long-term care needs of the aging veterans' population. PVA is astounded by the fact that the VA has proposals on the table, such as the legislation considered today to repeal the Millennium Health Care bill capacity requirements and a horrific budget proposal, even though aging veterans are a significant part of the population that the VA will have to care for in the future. Congress must make every effort to ensure that the VA develops a reasonable and effective strategic plan to provide long-term care, and that the VA immediately implements that plan.

TRANSPORTATION FOR RURAL VETERANS

Although PVA recognizes the difficulties some veterans have in accessing health care within the VA, PVA believes that it is a viable system. With over 800 community-based outpatient clinics, the VA has established a good network for meeting the needs of a vastly spread veterans population.

PVA supports the legislation proposed by Senator Salazar that would establish a grant program to provide innovative transportation options to veterans who live in remote areas. This program would allow veterans to continue to access the high quality care provided at VA medical facilities without placing a financial burden for travel costs on the veteran. It will also keep veterans from venturing into the private sector to receive care that in many cases is substandard as compared to the VA.

PVA appreciates the efforts the committee is making to address the many issues facing veterans today. We would be happy to address any additional legislative proposals for the record. Thank you.

Chairman CRAIG. Carl, thank you very much. Your full statement will be a part of the record.

Now let me turn to Richard Jones, National Legislative Director for AMVETS. Richard, good to see you. Welcome.

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. JONES. Thank you, Mr. Chairman. Thank you for the opportunity to present out testimony.

Throughout AMVETS' 61-year history in serving American veterans, the members of AMVETS have held to the belief that America's promises to veterans for the military service needs to be recognized and honored as our forbears intended.

Mr. Chairman, in reading our submitted testimony you will see that AMVETS agrees mostly with our colleagues in nearly every case, so let me address one point that is a bit different, and that is Senator Specter's bill, Senate Bill 614, the Veterans Prescription Drug Assistance Act.

As introduced, the legislation would allow Medicare eligible veterans to obtain prescription drugs from VA. It would provide a partial remedy to the situation faced by older Priority 8 banned veterans from the VA health care system, who were banned under the 2003 decree that halted their access to medical care. Under this legislation, a veteran who has been diagnosed and prescribed medication by a non-VA health care provider, could have a prescription filled at VA at a steeply reduced price.

As the committee knows, the Department of Veterans Affairs Secretary has banned health care access to approximately 495,000 veterans who would otherwise have been able to enroll except for the January 17, 2003, decision which closed off their health care benefits and denied them their earned benefits.

These so-called high-income veterans are outside looking in, as some have described them. They remain eligible for VA care, but neither Congress nor the administration has supported the funding necessary to ensure adequate resources for their care. It is important, we believe at AMVETS, to never forget who these so-called Priority 8 veterans are, and they are the brave Americans who answered our Nation's call, and with fortune and God's grace, they returned to this country following their service whole and able to continue their lives without disabling injury.

In today's war on terrorism it may be the priority 8 veteran who takes a post or a stand on a day following a day where another has been killed or injured. He puts his life on the line knowing he may return injured. But we do not win without these priority 8 veterans who stand the ground that we hope to liberate. These patriots serve voluntarily, and the members of AMVETS believe each of them earns access to the health care system through military service. These men and women did not fail us in our Nation's time of need, and we should not fail them.

They held in their hands for a brief period in history the determination on whether or not we would win or lose the fight for free-

dom. It is the least our Nation can do for those on whom America depends to defend her liberty. Senate Bill 614 offers veterans an opportunity to access earned benefits that might otherwise be denied them. To that extent we support the bill.

Thank you, sir, for the opportunity to present testimony today on these 10 bills.

[The prepared statement of Mr. Jones follows:]

PREPARED STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Chairman Craig, Ranking Member Akaka, and Members of the committee:

Thank you for the opportunity to present testimony to the Veterans' Affairs Committee on legislation subject to this hearing devoted to healthcare related matters. My name is Richard Jones, AMVETS national legislative director.

AMVETS is pleased to present our views on the ten bills before the committee: The Chairman's proposed legislation called the "Veterans Health Care Improvements Act of 2005"; Ranking Member Akaka's four proposals, the "Mental Health Capacity Enhancement Act of 2005", the "Neighbor Islands Veterans Health Care Improvements Act", and S. 481, a bill to extend combat veterans' post-discharge 2-year period of eligibility for VA health care to 5 years, and S. 716, the "Vet Center Enhancement Act of 2005"; Senator Specter's bill, S. 614, the "Veterans Prescription Drugs Assistance Act"; Senator Obama's bill the "Sheltering All Veterans Everywhere Act"; and Senator Salazar's bills to require VA to publish a strategic plan for long-term care; to establish a grant program to provide transportation for rural veterans; and the "Blinded Veterans Continuum of Care Act of 2005".

Mr. Chairman, AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues its proud tradition, providing not only support for veterans and the active military in procuring their earned entitlements but also an array of community services that enhance the quality of life for this Nation's citizens.

Throughout our sixty-one year history, our focus and indeed our passion have been to represent the interests of veterans as their advocates. In this regard, this committee and our organization share a common purpose—we support veterans in their efforts to receive the benefits that a grateful Nation intended them to have in recognition of their dedicated service to our country.

As a Nation, we owe veterans an enormous debt of gratitude—for their service, their patriotism, and their sacrifices. The benefits to which they are legally entitled are not the product of some social welfare program, as some might argue. Rather they are yet another cost of freedom that unfortunately is too often forgotten.

As a national veterans service organization, chartered by Congress, AMVETS is committed to assisting veterans in their times of need. For example, during the past 18 years, we, together with DAV, PVA, and VFW, have co-authored a document titled, "The Independent Budget" in which we identify the funding requirements necessary to support the Department of Veterans Affairs.

We believe that America's promises made to veterans for their military service need to be recognized and honored as our forebears intended. We believe that veteran's benefits should be provided in a timely and compassionate manner. We believe that to do less dishonors those whose service in defense of this Nation provides a central underpinning for the prosperity and freedoms we all enjoy.

We appreciate the opportunity you provide to testify on pending legislation to enhance, update, and strengthen veterans legislation.

S. 614, THE VETERANS PRESCRIPTION DRUGS ASSISTANCE ACT

Mr. Chairman, AMVETS supports the goal of this legislation. As introduced, the legislation would allow Medicare-eligible veterans to obtain prescription drugs from the Department of Veterans Affairs at the significantly discounted cost that VA, as a high-volume purchaser of prescriptions medications, is able to secure in the marketplace.

S. 614 would provide a partial remedy to the situation faced by older Priority 8s "banned" from the VA healthcare system under the 2003 decree that halted their access to medical care. Under this legislation, a veteran who has been diagnosed and prescribed medication by a non-VA healthcare provider could have a prescription filled by VA at a steeply reduced price.

As the committee knows, the Department of Veterans Affairs Secretary has banned healthcare access to an estimated 495,000 veterans who could have enrolled

for care prior to January 17, 2003, when former Veterans Affairs Secretary Anthony Principi closed off their healthcare benefits and denied them access to VA medical care.

These so-called high-income veterans or "Priority 8s" remain eligible for VA care, but neither Congress nor the administration has supported the funding necessary to ensure adequate resources for their care.

Currently, veterans are eligible to receive prescription medications from the VA only if a VA physician prescribes the medication. While insisting that a VA doctor see the patient may not seem like too great an imposition, many veterans waiting for a doctor's appointment are waiting solely to have a prescription written at VA, so it can be filled.

It is commonly noted that the majority of the Priority 8s have entered the system to gain access to the VA prescription drug program. For these veterans, once they are under the care of a VA physician, they can see dramatically reduced prescription drug costs versus the private sector. The current VA prescription cost for enrolled patients is $7.00 per prescription for a 30-day supply.

VA dispenses over 100 million prescriptions yearly to its nearly 5 million patients, and with this volume, VA can negotiate very favorable drug prices. Figures from the National Association of Chain Drug Stores claim that for 2001, VA cost per prescription was almost half the cost found in the private sector. With the ever increasing cost of prescriptions, it is little wonder Priority 8 veterans have availed themselves of this benefit after Congress allowed them access to the VA system.

It is important to understand that AMVETS remains deeply disappointed in the continuing ban of Priority 8 veterans, which began on January 17, 2003. In past years, this committee and its members have fought for adequate funding for VA, yet VA has not been adequately resourced.

It is also important to never forget who these so-called Priority 8 veterans are. These are brave Americans who answered our Nation's military call, and with fortune and God's grace they have returned from service whole and able to continue their lives without disabling injury or illness.

In today's war on terrorism, the Priority 8 veteran may be one of the soldiers, sailors, airmen or marines who stand a post or walk a patrol in Iraq or elsewhere across the globe, replacing a fellow soldier who was injured or who gave his life in defense of freedom and our way of life.

These patriots serve, voluntarily, and the members of AMVETS believe each of them has earned access to the VA healthcare system following their military service, as statute provides. For a moment in our history they held in their hands the defense of our Nation and its cherished freedoms. These men and women did not fail us in our Nation's time of need, and we should not fail them. It is the least our Nation can do for those on whom America depends to defend her liberty.

S. 716, THE "VET CENTER ENHANCEMENT ACT OF 2005"

Introduced by Ranking Member Akaka, S. 716 would enhance care and services provided through Vet Centers. The bill recognizes the need to augment these centers especially at a time when there are an increasing number of troops returning from Operation Enduring Freedom and Operation Iraqi Freedom. The legislation would also increase authorized funding for Vet Centers to $180 million from $93 million to help returning service members and surviving family members through a smoother readjustment period. AMVETS supports this legislation.

S. 481, A BILL TO EXTEND COMBAT VETERANS POST-DISCHARGE 2-YEAR PERIOD OF ELIGIBILITY FOR VA HEALTH CARE TO 5 YEARS

Introduced by Ranking Member Akaka, S. 481 would extend policies and procedures for providing free health care services and nursing home care to combat veterans for a period of 5 years beginning on the date of separation from active military service. Under current coverage, recently separated service members, including National Guard and reserve personnel, are eligible for health care for 2 years. The benefit covers all illnesses and injuries except those clearly unrelated to military service such as the common cold and injuries from accidents that occurred after discharge. Dental services are also not included. Unlike other veterans there is no burden to prove they have low-income to qualify for VA health care. This is an important change. In past conflict, veterans have reported medical problems that have been hard to explain or difficult to diagnose. Providing an extended period of eligibility, common medical problems may be better diagnosed and care more properly applied in a timely manner. AMVETS supports this legislation.

S. ——, A BILL TO REQUIRE VA TO PUBLISH A STRATEGIC PLAN FOR LONG-TERM CARE

Senator Salazar proposes legislation to direct VA to develop and publish a strategic plan for long-term care. The bill recognizes that long-term care was not included in VA's Capital Asset Realignment for Enhanced Service (CARES) process and is therefore lacking in appropriate consideration. AMVETS supports restructuring the VA system through the CARES process, but it must be done with a sharp eye for the future and with sound facilities and operations planning. With the number of veterans over the age of 85-years old and older expected to nearly double over the next decade to 1.3 million from 870,000, AMVETS supports this legislation.

S. ——, A BILL TO ESTABLISH A GRANT PROGRAM TO PROVIDE TRANSPORTATION FOR RURAL VETERANS

Senator Salazar proposes legislation to establish a grant program managed through VA to provide critically needed transportation services to veterans in rural remote areas. But there probably are hardly any States in the Union with the exception of maybe Rhode Island or Connecticut or someplace like that where we do not have at least some veterans who are somewhat isolated from VA hospitals and are having to go great lengths to get their medical care. Provision of a grant program would offer a degree of opportunity to veterans who live in these areas to access the health care benefits to which they are entitled through honorable military service. AMVETS supports this legislation.

S. ——, THE "BLINDED VETERANS CONTINUUM OF CARE ACT OF 2005"

Senator Salazar's proposed legislation would provide critical enhancements to the care provided blinded veterans. The bill would establish Blind Rehabilitation Outpatient Specialists positions at medical centers with Visual Impairment Service Teams (VISTs) with a full-time coordinator or with more than 150 currently enrolled legally blind veterans. Blind Rehabilitation Outpatient Specialists play an important role in helping blinded veterans with a number of living skills. In many cases, these blinded individuals achieve successful careers despite their blindness. Clearly however, many sensory disabled veterans have not had the same opportunities afforded them or the same veterans assistance programs. Accordingly, this legislation would pursue its goals of enhancing these types of services which combined with research, rehabilitation and re-employment can make a critical difference in the lives of blinded veterans. AMVETS supports this legislation.

S. ——, THE "NEIGHBOR ISLANDS VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005"

Senator Akaka's legislation would establish vet centers and clinics on certain islands of Hawaii. The bill would also provide staffing enhancements to assist in adjustment counseling and related mental health services for veterans. It also would establish a mental health center in Hilo for the provision of mental health care and treatment. In addition, it authorizes construction of a mental health center at Tripler Army medical center. The facilities in Hawaii are superb and AMVETS supports this legislation.

S. ——, THE "MENTAL HEALTH CARE CAPACITY ENHANCEMENT ACT OF 2005"

The proposed legislation of Senator Akaka would take a number of steps to strengthen and improve VA capacity to provide mental health care and treatment. The bill would establish patient-staff ratios and foster collaborative approaches for primary and mental health care providers. The bill would also require VA to have onsite, contract, or tele-mental health services available at not less than 90 percent of Community-Based Outpatient Clinics. In addition the bill would establish a joint VA-DoD workgroup on mental health tasked to study how to recognize signs of and to deal with mental health disorders. Under the bill, the workgroup would also consider collaborative approaches to improve the transition of servicemembers to veterans status, care, and treatment. AMVETS supports the goal of improving mental health treatments and ensuring the availability of care at outpatient clinics and throughout the VA healthcare system.

S. 1180, "SHELTERING ALL VETERANS EVERYWHERE ACT"

Senator Obama has introduced S. 1180, the Sheltering All Veterans Everywhere Act, to reauthorize the Homeless Providers Grant and Per Diem (GPD) program, the Homeless Veterans Reintegration Program (HVRP), and the Grant Program for Homeless Veterans With Special Needs. The GPD and HVRP programs sunset in 2006 and VA homeless programs expire later this year. The bill also calls for VA

to study the interrelationship between military sexual trauma and homelessness and effective service models for addressing trauma among homeless veterans. AMVETS goal is to bring a continuity of commitment to getting homeless veterans back on their feet and into the mainstream of our communities. AMVETS clearly recognizes that progress is being made, and our members support this legislation, to defeat homelessness and help veterans.

S. ——, THE "VETERANS HEALTH CARE IMPROVEMENTS ACT OF 2005"

It is critical that service men and women who have sacrificed for their country in the Armed Services be taken care of upon their return to home and community. To abandon our responsibilities would bring dishonor and send a message that the contributions of our servicemembers are not fully appreciated.

Our First President George Washington warned us to be careful about honoring our veterans, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their Nation."

The "Veterans Health Care Improvements Act of 2005," introduced by Chairman Craig, would undertake a number of changes in veterans healthcare. Section 2 of this legislation completes the exemption from hospice co-payments as enacted last year. It eliminates co-payment for veterans using outpatient hospice care as well as previously enacted co-payment for institutional hospice care. AMVETS supports this section of the bill. AMVETS also supports the elimination of co-payments for former POWs. However, we oppose the elimination of VA requirement for maintaining a certain nursing home bed level, also contained in this section. AMVETS supports improvements in the reimbursement of expenses for veterans using emergency room facilities, and we support as well Section 5 designed to care for newborn children of women veterans. It is also appropriate to enhance payer provisions for health care furnished to certain children of Vietnam veterans for Spina Bifida and associated disabilities. Section 7 authorizes appropriations for the homeless providers grant and per diem program. This is an important and competitive program. And AMVETS is pleased to support this authorization. AMVETS also supports the sections dealing with improvements in tele-health, marriage therapists, and mental health services. AMVETS also supports the bill's authorization of additional VA personal to expand National Guard outreach programs. The upward spiral of Guard deployment over the recent past dictates action to improve understanding of benefits available to those who serve in our National Guard.

This concludes AMVETS testimony. Again, thank you for the opportunity to testify on these important bills, and thank you as well for your continued support of America's veterans.

Chairman CRAIG. Gentlemen, thank all of you for being here and providing testimony and working with us as we move some of this legislation through. Each of your organizations opposes the provision in S. 1182 that would repeal the bed-level capacity requirement, but each of you has some differing reason as to why you are against the legislation, and I frankly appreciate the concerns that all have expressed.

Would each of you agree that having some defined package of long-term care options is better than a bed-level requirement? Would that be a more welcome alternative? Response?

Mr. CULLINAN. Mr. Chairman.

Chairman CRAIG. Dennis, please.

Mr. CULLINAN. If a policy were put in place that would provide access to veterans requiring long-term care, that would certainly be an improvement over the current situation. But the fact is that through the years this idea of eliminating that census has come up over and over again. It has always been primarily budget driven, and our concern is that right now in absence of some sort of defining policy providing proper access to veterans to long-term care, it would simply allow VA to divest itself of its long-term care resources, and we strongly suspect that any resources that would be

freed up through this action would not go to VA and help pay for veterans health care. It would be lost in the general treasury fund.

Chairman CRAIG. Further comment?

Mr. MOONEY. Senator, I would like to note that VA is only required statutorily to provide long-term care to veterans who are 70 percent and greater service connected disabled. Even that does not automatically mean that a veteran will be placed in a nursing home. They are assessed by a geriatric assessment team, and they are given the services that the veteran wants in the least restrictive, least costly environment.

As I said in my testimony, VA has not conducted a comprehensive long-term care needs assessment. There have been two reports in the last 20 years that predicted this problem, and no action has been really taken on any of them, on either of them. We think before VA starts dismantling its long-term care infrastructure, especially as regards these frail elderly veterans who tend to have more problems than the average nursing home resident, we need to—the VA needs to know what their requirements will be before they start taking apart the system that exists. I think Congress in 1997, when they mandated this, had a sense of that, that they knew this wave of elderly was coming, and they told VA, you need to maintain this capacity. VA still does not know what they are going to need, and we think until they do, they should comply with the Mill Bill.

Chairman CRAIG. Carl.

Mr. BLAKE. Mr. Chairman, I want to refer to something that Mr. Mooney said about 70 percent requirement for institutional long-term care. That points out the fact that those individuals who would be getting institutional long-term care are the most severely disabled, and in most, maybe not all, but in most cases, the best care that they will get is in the institutional setting. That is not to say that we do not support the idea of non-institutional care as well. That kind of parallels a common held belief of PVA that we should do everything to help a veteran become independent or seek the best independent living possibilities for him or her.

However, I would say that it will be better if you had a combination of the two, and not to just close off what their current infrastructure is by eliminating the bed and staffing requirements. The unfortunate thing about this is we deal with the same type of issue with regards to spinal cord injury centers, and we have an agreement with the VA that the VA will maintain a certain bed and staffing level for SCI centers, and that is yet another area where they fail to meet their requirements. And every month we go out and evaluate SCI centers, and yet it is a continuing process. But I do not think we should push off the responsibility from the VA so that they can just focus solely on what appears to be a move toward non-institutional care.

Mr. JONES. Sir, thank you for the question. We look at the most recent proposal on the 2006 budget from the administration which suggests cutting per diem payments to State nursing homes, and we just wonder where are they headed?

Chairman CRAIG. Well, they are not headed there.

Mr. JONES. Well, they are not headed there because Congress has wisely seen——

Chairman CRAIG. They thought they were. Congress told them no.

Mr. JONES. Absolutely, and we are so pleased with that because it was headed in the wrong direction. We think this is wrong also. Regarding 1998 bed status for a nursing home, we face a period now where we expect to double the population of those over the age of 85 over the next period of 8 years. As we look to doubling the population over the next few years, as we look to reduced per diem payments, we need to have wisdom again and retain what Congress had put in place before. It is simply wrongheaded and wrong directional.

Chairman CRAIG. Thank you. My time is up, and I think Senator Thune is moving to depart. He has been quiet all through this, in and out, and I did want to recognize his presence.

Senator, do you have any questions of this panel?

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

Senator THUNE. Mr. Chairman, thank you to you for holding this hearing, and to the panel members for the good work that you do representing our Nation's veterans, and this is an important subject, the various pieces of pending legislation I look forward to having a vigorous debate about that, about things that we can do to improve the overall quality of health care to America's veterans.

I think it is really important, as we do that, that we do it in a very open manner. I have got a bill as well, which I would at some point like to have considered. Right now it is over at the Finance Committee because it deals with Medicare and they have jurisdiction, and the Finance Committee is very particular about their jurisdiction on these issues, but it has got a number of other provisions that I also believe would fall under this committee's jurisdiction, and some things that hopefully we will get a chance to have all of you—I know some of you have already reviewed some of those things, and get a chance to comment on as we try to put together a package, a proposal that will do a better job of addressing the health care needs of our Nation's veterans.

But my view is it is important that we get that consensus, that we put together something that will address the needs, especially as we have more veterans coming home from Operation Enduring Freedom and Operation Iraqi Freedom. We obviously owe them a great debt of gratitude and need to make sure that we are giving them access to the very best care possible.

So thank you for holding the hearing.

Thank you to your organizations, and again for the good work that you do on behalf of America's veterans, and we look forward to working with you on a consultive basis as legislation moves forward so that we can get the very best possible product put in place for our Nation's veterans.

I will look forward to discussing these issues further.

I have to go to a meeting now to talk about BRAC, which is another issue of great importance. So thank you all very much.

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

Good morning Chairman Craig and Ranking Member Akaka, Thank you for holding today's hearing on pending veterans' healthcare legislation. I look forward to a productive hearing. Before I begin I would like to welcome Secretary Nicholson and Undersecretary Perlin back to the committee. I know your schedules are busy and I thank you for taking the time to work with us in providing the best possible healthcare for America's Veterans. I would also like to welcome the representatives of the Veterans Service Organizations, who often serve as the voice of America's veterans before the committee. Thank you for your service.

Veterans' healthcare is one of the most important issues facing our country. I am glad to see this committee addressing the matter in an open bipartisan manner. My concern regarding veterans' healthcare is the reason I introduced S. 963, The Veterans' Health Care and Equitable Access Act of 2005. I believe there is a growing need to address veterans' healthcare issues and it must be done without the affects of politics as usual. All too often, the issue of veterans' healthcare is exploited for its emotional value and used for partisan purposes. Neither veterans nor this committee are served by such baseless actions.

America's men and women are returning home from Operation Enduring Freedom and Operation Iraqi Freedom and we owe them a debt of gratitude and access to the best care possible. Many of our returning veterans will have mental and physical wounds that need to be healed. I applaud Chairman Craig and Ranking Member Akaka for holding this hearing and I look forward to reviewing the pending legislation, both Democratic and Republican, whose sole aim is to fulfill America's promise to our veterans.

Thank you Mr. Chairman, I yield back.

Chairman CRAIG. Senator, thank you very much. And knowing the situation in your State with BRAC, I suspect that is a higher priority.

Senator THUNE. This is a high priority as well.

Chairman CRAIG. Yes, it is.

A couple more question of this panel. Let me tell you where I am coming from when it relates to static numbers of beds and locations and facilities. In another life, just a year ago, I chaired the Special Committee on Aging, spent a good deal of time and consistently heard from a non-vet population though, that they wanted to receive their services at home, near home, around home, not at some distant location that the compensation and/or the provider might take them. And because we have these expanding and then declining populations, and we also have mobility today in our population like we have never had it before, I thought it was reasonable and appropriate that we ought to be looking a little bit differently than we have.

And possibly to reassure your concern, we ought to get the horse in front of the cart. We ought to see what we could do and/or look at what the administration is proposing as it relates to long-term care before we propose to tear down that which we have.

But I do believe there is some sensibility to looking at ways to deliver service that our not static and locational and cannot be moved, but are tied to the veteran wherever he or she may be. And I appreciate, Carl, some of the unique care characteristics that are out there with certain veterans, that is not to say that they could not be cared for in a specialized institutional setting that is non-veteran or non-VA in its character. That does not mean that we would not provide some of that also.

Anyway, those are some of my concerns, and why I felt it was appropriate to bring this to the forefront and have a healthy debate with all of us about it.

I think one of the great frustrations we have today—and it is part of what we are examining, what the past administration of the Veterans Administration did and is still ongoing—is to look at some of these large institutional facilities today that cost hundreds if not millions of dollars a year to maintain, that are located over here and the veteran is over here, and how we do not get ourselves locked into that again. If we were to meet the true needs of long-term care veterans today in this bubble that we are in, we would be pouring an awful lot of concrete to probably have it emptied 10 years down the road or at least maybe not as necessary.

So it is my concern that we look at a variety of options of service—and I do not blame you for buying off on something you cannot see, feel or touch in your advocacy for our veterans. So I think that is where I am coming from and where I will continue to come from as we pursue this issue. I think it is an important one, because I think long-term health care is extremely important. That is why I placed the priority on it in this legislation.

Any of you wish to comment further on that general area?

Carl.

Mr. BLAKE. Senator, I would like to thank you very much.

I think some of this goes to the heart of what Senator Salazar's bill is about. I think we can make assumptions of what the VA plans to do based on budget recommendations and other things that we see going on, but until we have a clear strategic plan that has been outlined by the VA, a lot of this is just rhetoric and us voicing our concern and you doing the same, and trying to address an issue that we do not really know what the clear facts are yet.

So I think we cannot emphasize enough the need to know what the VA's strategic plan for long-term care is going to be. Once we have that in our hands, then we can proceed from there. That will not probably change the concerns that I have expressed, but at least it gives us a framework for something to work from.

Chairman CRAIG. Thank you.

Don.

Mr. MOONEY. Senator Craig, I would like to submit that the elderly health care crisis is already affecting VA in other ways. It was mentioned by Secretary Nicholson or one of the other—it might have been Dr. Perlin—that it takes a year to schedule an elective surgery in some places in VA, and part of that reason is because so many elderly veterans are using VA in the intensive care units.

Dr. Kussman once related to me that there is a bottleneck of aging veterans in VA's intensive care units, and that VA, it is well-known that veterans die in VA intensive care units at about 4 times the rate they do in a standard private sector hospital. That is how the population is affecting VA's capacity right now. So it is already here.

Chairman CRAIG. Adrian, comment?

Mr. ATIZADO. Yes, sir. Thank you. Looking back at the testimony that DAV provided on the capacity provision in the Millennium Health Care Act, I get a sense that not only—without reading our testimony but the testimony of the other organizations as well as VA, I believe that a major concern that had driven the capacity law to be passed, was a certain amount of protection, a certain amount

of responsibility that must be kept by VA. DAV is certainly sensitive to the veterans' desires as far as where they want to receive care. We do know VA has made many strides in non-institutional settings, and they continue to do so both in the lab as well as practical work.

I would say that the capacity law represents more than just the number of beds, it represents exactly that the protection of a service, a needed service that veterans will require in the near future, which has its vulnerabilities based on the environment the VA operates in, under funded system, different populations moving all over the place and the kind of care that VA can provide, both institutional and non-institutional. And I think that a certain amount of reassurance has to be had to the veteran community before we do away with this law.

Chairman CRAIG. Well, gentlemen, I appreciate that obvious concern and heartfelt comment as it relates to this type of care and the importance of it, and we will continue to pursue that and work with you and the Veterans Administration to see if we might not clarify that vision a bit.

And I think, Adrian, what you are talking about, at least it came to my mind as you were relating, if beds are a target and a symbol, and not a structure, but a level of care required to be provided, that may be a definitional term or that may in itself be a way of an indicator. My great frustration today is still getting into the business of pouring a lot of concrete and large capital expenditures, only to have them obsolete a very few years down the road in a very dynamic environment. And therefore focusing on service and delivery of service under certain criteria, and how do veterans become assured that Congress and the VA are going to provide that? How do we tag that provision in a way that is ongoing based on a certain level of requirement?

I think we have all learned some lessons, and that is that you can build a facility and you can turn the lights on, but depending on budget requirements, it might not mean you allow access through the front door. And so you sometimes have large capital expenditures setting out there, but by criteria of Congress and VA, depending on certain availabilities of resources, the door may be limited, and those who can access it, and so I am wrestling through some of these issues as we work on them with the administration and certainly with all of you to see where we get.

I want to thank you all sincerely for being here today. I appreciate it. I am going to probably submit some additional questions to you as it relates to Senate Bill 614. I can understand your frustration about it, what it may or may not mean as it relates to pharmaceutical drugs and gaining access to them, or the reaction to them. We thought it was going to be unanimous opposition. It was not quite. But I think there are some legitimate underlying concerns. The question is how do you address it and what is the impact of it on the existing service because we know that one has been relatively successful.

Thank you all very much. As I said, the record will remain open as we finalize this testimony, and the committee will stand adjourned. Thank you.

[Whereupon, at 12:05 p.m., the committee was adjourned.]

A P P E N D I X

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

Question 1. In your statement before the committee, you stated that the increased services required by the Vet Center Enhancement Act will require only an additional $8 million and that "there is no necessity or justification" for authorizing the amount of funding included in the bill. Can you please elaborate on why you feel such a small increase is needed when in 2004, Vet Centers cared for 9,597 OEF/OIF veterans, and projections for 2005 are that Vet Centers will see 12,656 OEF/OIF veterans?

Answer. The $8 million referenced above in Department of Veterans Affairs' (VA) statement to the committee was an estimate based on projections of the cost of the additional services this bill would direct.

The Vet Center program's mission is central to VA and its operation is extremely cost effective. Approximately 80 percent of the annual Vet Center program budget of $89 million for fiscal year (FY) 2005 goes directly into the care of veteran and family members. This covers the cost of 206 community-based Vet Centers and 943 staff.

In February 2004, Veterans Health Administration (VHA) authorized a staff augmentation program for the centers to enhance its ability to outreach to the veterans returning from combat operations in Operation Enduring Freedom (OEF) and Operations Iraqi Freedom (OIF). Specifically, the Vet Centers have hired and trained a cadre of up to 50 new outreach workers from among the ranks of recently separated OEF and OIF veterans at targeted Vets Centers. These 50 new staff members were hired on 3-year term appointments. Including the add-on for this initiative, the actual program operating budget for fiscal year 2005 is $94 million.

In March 2005, based upon the demonstrated success of the Global War on Terrorism (GWOT) veteran outreach initiative to locate and inform new returning veterans, VHA authorized the Vet Centers to hire an additional 50 GWOT veterans to further enhance the program's outreach capacity. Additionally, VA is in the process of converting the initial 50 GWOT veteran outreach counselors to career status. The latter action will increase the Vet Center program's annual budget by $2.5 million starting in fiscal year 2006. Including the 3-year term cost for the salaries of the second 50 GWOT new hires, this initiative will cost $5 million a year for fiscal year 2006 through fiscal year 2008. Also, in November 2004, VHA approved of a plan to establish a new four-person Vet Center in Nashville, TN. This will increase the number of Vet Centers to 207, and increase the program's recurring base by $393,000 annually. The first full year funding for the new Vet Center will be realized in fiscal year 2006.

In fiscal year 2004, the Vet Centers system-wide served 125,737 veterans and provided slightly more than one million visits to veterans and family members. For the first two quarters of fiscal year 2005, the Vet Centers system-wide served 76,567 veterans and provided more than half a million visits to veterans and family members. A continuation of this rate of service delivery for the remainder of the year will produce 153,134 veterans served and more than one million visits provided. This represents an increase in veterans seen of 21.7 percent while maintaining the same number of visits.

Following Secretarial authorization in the wake of hostilities in Afghanistan and Iraq, the Vet Centers commenced in 2003 to actively outreach and provide readjustment counseling to the new cohort of war veterans returning from OEF and OIF and their family. To date the Vet Centers have provided substantive services to over 19,500 veteran returnees from OEF and OIF. Given a continuation of the current rate of service delivery, the Vet Centers collectively will have served over 25,000 OEF/OIF veterans cumulative by the close of fiscal year 2005. For fiscal year 2005,

this amounts to over 14,000 OEF/OIF veterans served. This represents approximately 9 percent of the projected Vet Center workload for 2005.

Following Secretarial authorization in August 2003, the Vet Centers initiated a program to provide bereavement counseling to military family members whose loved ones were killed while on active duty in Afghanistan and Iraq. Since inception of the program, over 400 cases of active duty, military-related deaths have been referred to the Vet Centers for bereavement counseling, resulting in services to over 600 family members. This is a new component of the Vet Center mission.

Question 2. S. 1182, the Veterans Health Care Improvement Act of 2005, would eliminate the prohibition in Title 38, Section 8110(a)(5) against using VHA appropriated funds for cost-comparison studies in public-private competitions without specific authorization from Congress. Please explain your views on this provision.

Answer. Title 38 U.S.C. §8110(a)(5) prohibits the Department of Veterans Affairs (VA) from using health-care appropriations to fund ". . . any activity in connection with, the conduct of any study comparing the cost of the provision by private contractors with the cost of the provision by the Department of commercial or industrial products and services for the Veterans Health Administration unless such funds have been specifically appropriated for that purpose." The provision in question has had the effect of prohibiting VA from conducting cost-comparison studies to determine whether it would be more cost-effective for VA to directly furnish services, or obtain them by contract. The President's Management Agenda stipulates that agencies increase their focus on competitive sourcing and expand the number of activities subjected to cost comparisons with commercial sources. This cannot be accomplished with the prohibition in place.

