S. HRG. 108–874

PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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C O N T E N T S

TUESDAY, JUNE 22, 2004

SENATORS

WITNESSES

APPENDIX

PENDING LEGISLATION

TUESDAY, JUNE 22, 2004

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

The Committee met, pursuant to notice, at 2:53 p.m., in room SD–628, Dirksen Senate Office Building, Hon. Arlen Specter, Chairman of the Committee, presiding.

Present: Senators Specter, Bunning, Graham of Florida, and Rockefeller.

OPENING STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Chairman SPECTER. Good afternoon, ladies and gentlemen. The hearing of the Committee on Veterans' Affairs will now proceed. We are joined by three of our colleagues today, and in order of seniority, we will hear from Senator Kent Conrad.

STATEMENT OF HON. KENT CONRAD, U.S. SENATOR FROM NORTH DAKOTA

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

I appreciate this opportunity and appreciate the Committee giving some time to consider the legislation that I have proposed. I want to especially thank Senator Graham and Senator Rockefeller for co-sponsoring this legislation. Let me indicate that the legislation has been endorsed by the Disabled American Veterans and AMVETS.

Mr. Chairman, let me just cut to the chase and ask unanimous consent that my full statement be made part of the record.

Chairman SPECTER. Without objection, it will be made part of the record.

Senator CONRAD. Mr. Chairman, this bill is about looking at the question of access to health care facilities for our Nation's veterans. Last year, I held a hearing, and it was under the Budget Committee jurisdiction, to discuss in my home State veterans funding. What we heard at that hearing consistently and repeatedly was that the major problem facing veterans was an inability to get scheduled at an appropriate time, sometimes for primary care, but most of the problem was for specialty care. One veteran after another shared with us having to wait months to even get an appointment for specialty care and when they did get it, having to travel very long distances to get seen.

In my State, it is not at all unusual for people to have to travel 400 miles to Fargo, North Dakota, to the VA center there to get care. In some cases, we had veterans telling us that they were told that they had to go to California to get specialty care, 1,000 miles from North Dakota. There has got to be a better way.

And what I am proposing is a pilot program to look at this question and to see if we cannot do a better job of providing access to the 64,000 veterans in my State and the millions of veterans around the country. I recently learned of an instance where a Vietnam veteran from the Williston area of North Dakota was told he needed gastric bypass procedure. He is the veteran who was referred to a facility in California.

In another case, a veteran told me he was forced to travel to Iowa for cancer treatment, a trip which involved extraordinary expenses for him and his family. I am very aware of the limitations in the VA budget to address these challenges. However, the waiting times for some in specialty care I think go beyond the pale.

In view of these concerns, I introduced legislation that seeks ways to dramatically reduce waiting times for veterans. My bill would require the VA to undertake a 2-year pilot program in three VISNs to study the implementation cost and impact on VA services of several recent directives by the Secretary relating to the scheduling of medical appointments.

Under the demonstration project, veterans would wait no longer than 30 days for an appointment for primary care evaluation, hospitalization, including specialty care, or outpatient care. Both new enrollees and established patients would be eligible. If the VA facility is unable to provide the medical care within a 30-day period, the Department would make arrangements for the care at another facility.

Finally, my bill also requires the VA to report the waiting periods for appointments at facilities, including a breakdown of waiting periods by specialty.

Mr. Chairman, again, I want to thank you very much for accommodating me here today. Thanks for giving me this opportunity. I hope you will take a close look at this bill. I think we have got to address this question of waiting times and do it in a way that allows us to analyze what the cost would be if we were to look at this on a system-wide basis.

I understand we have got precious dollars here, and we are under enormous pressure. But I think we need to do a careful examination of what we are doing now and to run a pilot to see if we could not improve it and make a difference.

I thank the Chairman.

[The prepared statement of Senator Conrad follows:]

PREPARED STATEMENT OF HON. KENT CONRAD,
U.S. SENATOR FROM NORTH DAKOTA

Mr. Chairman, Senator Graham, thank you for scheduling this hearing on the Veterans Specialty Care Act, S. 2063. I recently introduced this legislation in response to concerns that I have heard over and over from veterans over serious delays in scheduling medical appointments at VA facilities.

Before we begin, let me also express my appreciation to Senators Graham, Akaka, Dorgan, Johnson and Rockefeller for their strong support as co-sponsors of my bill.

I also want to thank the Disabled American Veterans and AMVETS for their guidance and support in the preparation of this legislation.

Last fall, as Ranking Member of the Senate Budget Committee, I scheduled a hearing in my hometown of Bismarck, North Dakota to review funding for the Department of Veterans Affairs (VA) and to listen to the concerns of veterans regarding VA medical care.

In my home State of North Dakota, more than 50 percent of veterans live in rural areas that are far from VA medical facilities. At my hearing, I heard testimony from veterans who spoke about limited access and delays they face to get medical treatment at VA health centers.

Over the past few years, as the Committee is aware, there have been numerous reports of veterans having to wait considerable periods for both primary and specialty care at VA medical facilities across the Nation.

Within the past year there has been some progress in reducing the waiting list for medical appointments, particularly for primary care. The expansion of community based outpatient clinics (CBOCs) in Grafton, Bismarck and Minot has helped reduce these waiting periods.

Unfortunately, the same cannot be said of specialty care. Again, this is of special concern to me and the more than 64,000 veterans that I represent in my State because of the great distances that so many of them are forced to travel for the care they need.

North Dakota veterans continue to tell me their own stories of waiting months for specialty care appointments such as eye care, orthopedics and cardiology. And once the appointments are made, the distance that veterans in North Dakota have to travel to get to the nearest VA Medical Center is staggering. Veterans in the western part of North Dakota must travel more than 400 miles to get to the VA Medical Center in Fargo to get their care. And in many cases, the distance is greater.

I recently learned of an instance where a Vietnam veteran from the Williston area of North Dakota, was told he needed a gastric bypass procedure. News of needing this major procedure would be unsettling enough, but this veteran, who proudly served our Nation, was then informed that the only VA facility available to provide the surgery was more than a thousand miles away in California. In another case, a veteran told me that he was forced to travel to Iowa for cancer treatment, a trip that involved considerable expense for him and his family.

Mr. Chairman, I am very much aware of the limitations on VA funding and of the challenges that they face in recruiting qualified medical specialists. However, the issue of waiting periods for specialty care remains an issue of concern, especially for veterans in our most rural areas of the country.

In view of these concerns, I introduced legislation earlier this year that seeks ways to dramatically reduce waiting times for veterans. We owe veterans timely health care. That's the goal of my legislation. My bill would require the VA to undertake a 2-year pilot program in three VISNs to study the implementation, cost and impact on VA services of several recent directives by VA Secretary Principi relating to the scheduling of medical appointments.

Under the demonstration project, veterans would wait no longer than 30 days for an appointment for primary care evaluation, hospitalization including specialty care or outpatient care. Both new enrollees and established patients would be eligible. If the VA facility is unable to provide the medical care within the 30 day period, the Department would make arrangements for the care at another VA facility or non-VA facility. Every effort, however, would be made to provide the medical care for the veteran through the VA healthcare network.

Finally, because of concerns raised by the General Accounting Office and by the VA's Office of the Inspector General regarding the accuracy of VA data on appointment periods, the bill requires the VA to report on waiting periods for health care appointments, primary care and specialty care services. The VA would also be required to report on the waiting periods for appointments by VA facility and VISN, including a breakdown of waiting periods by specialty. This detailed report would be submitted to Congress by FY07 with recommendations for addressing the waiting periods.

Mr. Chairman, thank you again for giving me the opportunity to share my views on this legislation. I hope that the Committee will authorize the Department of Veterans Affairs to undertake a demonstration to help reduce the travel times and waiting periods for care at VA medical facilities. Such an initiative would greatly help our veterans living in rural areas.

Let me also express my appreciation to you and the Members of the Committee for all that you do to ensure that our Nation's veterans receive the benefits that they have earned. Your work is so important not only for those who have served,

but also for our veterans returning from Iraq, Afghanistan and from other peacekeeping deployments around the globe who will need the services of the VA.

Mr. Chairman, I ask unanimous consent that the full text of my remarks along with the letters of endorsement from the Disabled American Veterans and the AMVETS be included in the hearing record.

Chairman SPECTER. Thank you very much, Senator Conrad.

Senator Corzine.

STATEMENT OF HON. JON S. CORZINE,
U.S. SENATOR FROM NEW JERSEY

Senator CORZINE. Thank you, Chairman Specter.

I am under the impression that my colleague from New York is senior.

Senator CLINTON. Go ahead.

Senator CORZINE. I thank the Chairman and Ranking Member Graham and Members of the Committee for the opportunity to testify on two important pieces of legislation which I have introduced, and I will summarize these. I have a complete statement I would submit for the record.

Chairman SPECTER. Your full statement will be made a part of the record.

Senator CORZINE. Thank you.

The two pieces of legislation I talk about are one to increase the VA home loan program, the size of the loan program, and to improve low-income veterans' access to VA health care services. Along with Senator Murkowski, I have proposed that we increase the VA home loan guarantee to comport with Freddie Mac's conforming loan limit which applies in the conventional market, and I understand the Chairman has a piece of his legislation that deals with the overall comprehensive veterans' legislation that has a recommendation very similar to my own which would increase the loan limit up to $333,000 and match up with Freddie Mac's loan limit.

The only difference between the Chairman's recommendation and mine is that I would also tie this to Freddie Mac's automatic cost-of-living adjustment, indexing it as we go forward. I think it is very important that the VA limit now is $240,000 roughly; it does not really coincide with a number of high cost areas of the country. I would just cite the Newark Metropolitan Statistical Area has an average home price of $331,000, and $240,000 just does not comport with that, and so, I would hope that we could make this adjustment.

This has the additional benefit of actually producing $42 million of revenue for the Treasury, so it is self-financing as well as being constructive for our veterans; I think an important, positive step to a successful program that already exists.

Along with Senator Clinton, who will also speak to the same issue that gets at how the VA defines low-income veterans, we have introduced Senate Bill 1014. This bill would replace the national income threshold for consideration in Priority Group 5, which is currently $24,000, for all parts of the country. It is a uniform, one-shoe-fits-all with regional thresholds defined by the Department of Housing and Urban Development, kind of curious in and of itself.

This simple but far-reaching proposal would help low-income veterans across the country afford quality health care and ensure that Veterans Integrated Services Networks or VISN's receive adequate funding to care for their distinct veteran populations.

This is really just trying to fit the application of health care services for the poor, taking into account the significantly different cost of living elements in different regional differences. This has been studied by Rand and the General Accounting Office, which recommend that there be a geographical means test, something which is supported by studies and data, and I understand that the Veterans Administration made some adjustments to the medical center reimbursement formula, but most of those who have looked at this believe that we need to work on this baseline number, and I would recommend this as a very potent step to service our poor, our low-income veterans in high-cost areas and very much ask for the support of the Committee.

Appreciate it very much.

[The prepared statement of Senator Corzine follows:]

PREPARED STATEMENT OF HON. JON S. CORZINE,
U.S. SENATOR FROM NEW JERSEY

Thank you, Chairman Specter, Ranking Member Graham, and Members of the Committee for giving me the opportunity to testify today on two important pieces of legislation I have introduced. These bills seek to enable more veterans to utilize the successful VA home loan program and to improve low-income veterans' access to VA health care services.

Senate bill 2522, which I introduced last week with support of Senator Murkowski, would increase the VA home loan guaranty to comport with the Freddie Mac conforming loan limit, which applies to the conventional mortgage market. I would also note that the House Veterans' Affairs Committee recently marked up comparable legislation.

Today, potential homebuyers may borrow up to $333,700 for a conventional mortgage. Veterans participating in the VA home loan program, however, may only borrow up to $240,000. While a loan of this size is sufficient to assist many veterans in purchasing a home, it is insufficient for many other veterans, particularly those living in high cost areas, like my State of New Jersey. In most places in my State, the cost of purchasing a home exceeds $240,000. For example, the median home sale price in the Newark metropolitan statistical area (MSA) in 2003, was $331,200.

Mr. Chairman, I believe that you have introduced comprehensive veterans' legislation that includes a provision similar to my bill. Your legislation would increase the VA home loan guaranty to $83,425, which would allow veterans to borrow up to $333,700, as the practice among lenders is to loan up to 4 times the amount of the guaranty.

Mr. Chairman, my legislation takes this increase one step farther by tying it to the Freddie Mac limit, which increases annually to account for inflation. Indexing the guaranty to this limit, therefore, would ensure that guaranty and available mortgage limits rise with housing inflation.

Mr. Chairman and Mr. Ranking Member, I would add that according to the Congressional Budget Office (CBO), S. 2522 would actually raise approximately $42 million a year, through increased user fees associated with the VA home loan program.

This legislation is simple, it's cost effective, and it would assist our veterans, who have traded years of traditional employment to serve our country, purchase a home. I hope that the Committee will work to pass this legislation.

I have also introduced Senate bill 1014, with the support of Senator Clinton, to change the way the Veteran's Administration defines low-income veterans by taking into account variations in the cost of living in different parts the country.

This bill would replace the national income threshold for consideration in Priority Group 5—currently $24,000 for all parts of the country—with regional thresholds defined by the Department of Housing and Urban Development. This simple but far-reaching proposal would help low-income veterans across the country afford quality health care and ensure that Veterans Integrated Service Networks or VISNs receive adequate funding to care for their distinct veteran populations.

In New Jersey, HUD's fiscal year 2004 standards for classification as "low-income" exceed $24,000 per year in every single county. And some areas exceed the VA baseline by more than 50 percent. If Congress is serious about designating some veterans as "low-income" and adjusting their benefits accordingly, it seems to me that we should make that designation in a meaningful way that accounts for regional differences in the cost of living.

Indeed, studies by both the RAND Institute and the General Accounting Office recommend a geographic means test like the one provided in this legislation to ensure the proper allocation of resources under VERA.

I understand that the Veterans Administration has made some adjustments to the medical center reimbursement formula, and I support any changes that provide proper access to healthcare for high-cost and low-cost areas alike. However, codifying a regional means adjustment would go a long way to protect low-income veterans in the ways that Congress intended.

Our Nation's veterans have made great sacrifices in defense of American freedom and values, and we owe them a tremendous debt of gratitude. These bills would improve existing homeownership and health care initiatives that have served millions of veterans so that all America's veterans, including those living in high cost areas, may participate in these programs.

Chairman SPECTER. Thank you very much, Senator Corzine.

I may have miscalculated. I calculate that Senator Clinton was elected in 2000. I calculate Senator Clinton from the Moynihan seat, and Senator Corzine was elected also in 2000 from the Lautenberg seat.

Senator CORZINE. Yes, sir.

Chairman SPECTER. The first Lautenberg seat.

[Laughter.]

Chairman SPECTER. So your seniority is the same, 2000. But Senator Clinton is from a bigger State.

Senator CORZINE. Bigger State.

Senator CLINTON. But in the interests of comity, Mr. Chairman, we like to get along with our little neighbor.

[Laughter.]

Chairman SPECTER. I should have recognized Senator Clinton first which I now do nunc pro tunc.

STATEMENT OF HON. HILLARY RODHAM CLINTON, U.S. SENATOR FROM NEW YORK

Senator CLINTON. Thank you, Mr. Chairman. I also would ask unanimous consent that my entire statement be submitted for the record.

Chairman SPECTER. Without objection.

Senator CLINTON. Mr. Chairman, Senator Corzine and I have introduced S. 1014 because of the need to recalculate the level of low income that makes veterans eligible for certain services. This is an important piece of legislation for our region of the country. I assume it would also affect directly the Chairman's State as well, because the overall level of appropriations for veterans' health care is one issue, and I join with Senator Conrad's concern about waiting periods, but the equitable allocation of this health care funding across geographic regions and the potential disenrollment of low-income veterans is especially pressing in our part of the country.

This addresses the issue of regional inequality and the treatment of Category 7 veterans in the VA's funding distribution formula. And as Senator Corzine said, the GAO showed the regional disparities are quite dramatic. And the study conducted by the GAO found that the formula adopted approximately 8 years ago by the VA to

distribute Federal health dollars to veterans' health care networks unfairly penalized Northeastern and Midwestern States.

Veterans' hospitals in those two regions lost approximately $921 million under the formula, and from 1996 to 2001, the New York-New Jersey network of facilities witnessed a 10 percent decline in funding for veterans health facilities. And as this Committee well knows, in 1997, the Congress implemented the Veterans Equitable Resource Allocation System, known as VERA. Unfortunately, the VERA formula was created in a way that failed to take into account regional differences in the cost of living.

Now, when the distinction between Category 7 and Category 8 veterans was established, it was thought that Priority 7 veterans would be able to afford private insurance on which the facilities could rely on payment for care. However, because of the high cost of living in certain parts of our country, particularly in the Northeast, which we represent, even Priority 7 veterans, who by definition, are above the VA's low-income threshold, often cannot afford to help defray their cost of care through private insurance.

This oversight in the VERA formula dangerously shortchanges regions such as New York and New Jersey, Pennsylvania, the Midwest and elsewhere. We know that we have a higher cost of living. I mean, just simply heating your house during our cold winter months takes a significant proportion of a lot of our veterans' disposable income. And I am hoping that we can get favorable action on S. 1014 to replace the national income threshold currently at about $24,000, with regional thresholds, defined, as Senator Corzine said, by the Department of Housing and Urban Development.

Now, recently—and I applaud this action—Secretary Principi has directed the VA to include Category 7 veterans in the VERA funding formula. However, we should not subject the vagaries of these funding formulas to a particular VA secretary, so to take what Secretary Principi has done through Senate Bill 1014, we would put it into law, and we would therefore guard against any risks that a future VA Secretary would change direction.

So I hope that we are able to provide this change in the formula that really will create more equitable funding for the veterans that we represent in the Northeast and the Midwest.

Finally, Mr. Chairman, I want to also bring to the Committee's attention S. 2133, to name the Department of Veterans Affairs Medical Center in the Bronx as the James J. Peters Department of Veterans Affairs Medical Center. Mr. Peters was a unique American individual who made enormous contributions to the advancement of health care for spinal cord injured veterans, and he exemplified the sacrifice of America's veterans.

When he passed away on September 6, 2002, he had been serving as the Executive Director of the Eastern Paralyzed Veterans Association for over 31 years. There is widespread support for honoring Mr. Peters by making this change in the name of the VA Center in the Bronx, and so, I appreciate the Committee's attention to that piece of legislation as well.

Thank you, Mr. Chairman.

[The prepared statement of Senator Clinton follows:]

PREPARED STATEMENT OF HON. HILLARY RODHAM CLINTON,
U.S. SENATOR FROM NEW YORK

I would like to thank the Chairman, Senator Specter of Pennsylvania, and the Ranking Member, Senator Graham of Florida, and the rest of the distinguished Members of the Committee, for their willingness to hold a hearing that includes S. 1014, the veterans funding legislation that I introduced with Senator Corzine in May 2003, as well as S. 2133, to name the Department of Veterans Affairs medical center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center.

In Washington, we often measure our dedication to the men and women in uniform by how we support soldiers on active duty. While that support is vital, the Members of this Committee know full well that just as important a measure of our dedication is how we take care of our veterans after they have served. The experience of war is often just the beginning of their struggle.

We owe to our veterans more than just words. We owe to them, as legislators, our active support. I have, along many of our Senate colleagues, worked to maintain, enhance, and guarantee an adequate level of health care funding for the Department of Veterans' Affairs. As American troops serve in harm's way in Iraq, Afghanistan, and so many other parts of the world, this should be time when we do more for our veterans not less. Our mere presence overseas will result in more veterans, many with life-long medical needs. To repay America's veterans for their sacrifice, I believe we should find a way to fully fund their health care. That is why I am so pleased that the Committee today will also address Senator Johnson's bill, S. 50, the Veterans Health Care Funding Guarantee Act. I am a co-sponsor of that legislation, and am hopeful that today's hearing will demonstrate the unequivocal need for full and mandatory funding for veterans' health care.

S. 1014

It is a pleasure for me to sit beside Senator Corzine, my partner on S. 1014. It builds upon legislation that Senator Corzine and I first introduced in the 107th Congress in June 2002. S. 1014 focuses on one of the paramount challenges Congress faces. That issue is veterans' health care funding. As you know, the overall level of appropriations for veterans' health care is but one of several important facets of veterans' health care funding. S. 1014 zeroes in on two other important aspects, which are the equitable allocation of veterans health care funding across geographic regions and the potential disenrollment of low-income veterans.

Senator Corzine and I introduced this legislation to address the issue of regional inequity in the treatment of category 7 veterans in the VA's funding distribution formula. A study showing this inequity was published by the U.S. General Accounting Office (GAO). The GAO study (GAO–02–338) is entitled "VA Health Care, Allocation Changes Would Better Align Resources with Workload." This study found that the formula adopted approximately 8 years ago by the VA to distribute Federal health care dollars to veterans' health care networks unfairly penalizes Northeast and Midwest States. According to the GAO report, veterans' hospitals in the Northeast and Midwest lost approximately $921 million under the formula. From 1996 to 2001, the New York-New Jersey network of facilities witnessed a 10 percent decline in funding for veterans' health facilities.

As you know, in 1997, Congress implemented the Veterans Equitable Resource Allocation system, or VERA, distributed medical care funding provided by the VA. The funding formula was established to better take into account the costs associated with various veteran populations. To allocate money to the Veterans' Integrated Service Networks (VISNs), VERA divides veterans into priority groups based on income and other factors. Veterans who have no service-connected disability and whose incomes fall below about $24,000 are considered low-income, and hospitals and other treating facilities are therefore reimbursed by the VA for their treatment.

Unfortunately, the VERA formula that was created until recently failed to take into account regional differences in the cost of living, a significant metric in determining veteran healthcare costs. When the distinction between category 7 and category 8 veterans was established, it was thought that priority 7 veterans would be able to afford private insurance on which the facilities could rely for payment for care the facilities provided. However, because of the high cost of living in some areas of the United States, even priority 7 veterans who, by definition, are above the VA's low-income threshold, often cannot afford private insurance. This oversight in the VERA formula dangerously shortchanged regions, such as New York, with high costs of living and often elevated healthcare expenses. Under that veterans' health funding formula, New York got the short end of the stick—losing tens of mil-

lions of dollars. Unfairly penalizing States in the Northeast and Midwest, like New York, resulted in cutbacks in health services for veterans.

S. 1014 replaces the national income threshold for classification as low-income veteran—currently about $24,000 for all parts of the country—with regional thresholds defined by the Department of Housing and Urban Development. The adjustment implemented by S. 1014 would help ensure that low-income veterans across the country have access to quality health care and help ensure that Veterans Integrated Service Networks (VISNs) receive adequate funding to care for their distinct veterans populations. Secretary Principi's decision to include category 7 veterans in the VERA funding formula deserves praise because it meets this serious challenge. S. 1014 would help guard against a different decision in future, and would help to eliminate any doubt as to the low-income status of these veterans.

In addition, S. 1014 would meet another long-term challenge for Category 7 veterans that has arisen in the wake of the Secretary's decision to freeze enrollment of veterans in priority group 8. Delineating low-income veterans in priority group 5 from the "near poor" veterans in priority group 7 puts priority group 7 veterans at risk of disenrollment from the VA health care system, as VA budgets are likely, in the absence of mandatory funding, to continue to be strained in future years. I am deeply concerned that if VA health care continues to be under-funded, the Secretary will decide to disenroll current priority group 8 veterans in a misguided effort to cut costs. From that decision it is easy to picture the Secretary's next cost-cutting step being a freeze on enrollment or the disenrollment of priority group 7 veterans. Disenrollment would mean that veterans who cannot otherwise afford health care could be entirely cut out of the system, leaving them uninsured and unable to receive care at a VA facility.

Moving veterans who fall below the HUD threshold and who are now in priority 7 into priority group 5 would help insulate them from enrollment restrictions and help guarantee them continued access to quality health care. Additionally, the Secretary's recent decision to include these veterans in the VERA funding distribution formula has removed the potential fiscal impact that reclassifying these veterans into priority group 5 may have had, thus removing the sole reason for opposition. For these reasons, I urge the Committee's approval of S. 1014.

S. 2133

The second piece of legislation I would like to discuss is S. 2133, to name the Department of Veterans Affairs medical center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center.

I consider it an honor to have been given the opportunity to sponsor this legislation because James J. Peters was a uniquely American individual who made enormous contributions to the advancement of health care for spinal cord injured veterans, as well as other veterans and non-veterans alike. Jim Peters exemplified both the sacrifice of America's veterans and the unquenchable spirit of service that characterizes so many of our veterans after they leave military service.

Jim Peters passed away on Friday, September 6, 2002, after serving as the Executive Director of the Eastern Paralyzed Veterans Association for over 31 years. There is simply no better way to honor this man, who worked tirelessly to improve the lives of his fellow paralyzed veterans then to rename in his honor the home of the VA Spinal Cord Injury Center that he toiled to build.

In September 1969, Mr. Peters began his life-long career at the Eastern Paralyzed Veterans Association as Deputy Executive Director. The next year, *Life* magazine published a story about the deplorable conditions facing paralyzed Vietnam veterans at the old Bronx Veterans Administration Hospital. Jim had worked with the *Life* staff, coordinating photos and suggesting patients for interviews. The resulting article forced the VA to build a new Bronx Veterans Affairs Medical Center (VAMC) and to establish a stand-alone national Spinal Cord Injury Service that still exists today and has set the benchmark for SCI care to both veterans and non-veterans with spinal cord injury.

Jim devoted his life's work to the improvement of health care for spinal cord injured veterans. Through his efforts, Eastern Paralyzed Veterans Association joined with local institutions, including the Mount Sinai Medical Center and the New York Medical College, to provide advanced methods of treatment to paralyzed veterans in the metropolitan area. On the national level, Mr. Peters worked tirelessly and successfully to have spinal cord medicine designated an official sub-specialty by the American Board of Physical Medicine and Rehabilitation. He was also instrumental in establishing a professorship in spinal cord medicine at Stanford University, and in revitalizing the American Paraplegia Society, the national organization of physicians who provide care to persons with spinal cord injury. Jim was also the founder

of the American Association of Spinal Cord Injury Nurses, and the American Association of Spinal Cord Injury Psychologists and Social Workers.

Jim Peters also had a passionate commitment to spinal cord research. Through his leadership, Eastern Paralyzed Veterans Association once more joined with Paralyzed Veterans of America to build the PVA/EPVA Center for Neuroscience and Regeneration Research of Yale University, located at the West Haven VA Medical Center. At this facility, basic research is conducted toward a cure for spinal cord injury and multiple sclerosis. He also helped to establish the Spinal Cord Damage Research Center at the Bronx VA Medical Center, the facility we are seeking to rename in his honor, where scientists investigate the impact of spinal cord injury on other body systems. During Peters' tenure at Eastern Paralyzed Veterans Association, the Association provided $4.6 million to fund projects through the Spinal Cord Research Foundation.

Additionally, Mr. Peters served on many national and local bodies involved in veterans and spinal cord health care. He was appointed by President Carter and reappointed by President Reagan to a Select Commission on Spinal Cord Injury. He served as special consultant to several chief medical directors in the Department of Veterans Affairs. Under VA Secretary Jesse Brown, Jim was appointed to a Task Force for Improved SCI Care. He also served on the Board of Directors of the Alliance for Aging Research. In New York, Peters was a member of the State Disability Prevention Council and the State Spinal Cord Injury Research Commission.

Clearly, Jim's life was dedicated to improving the lives of his fellow paralyzed veterans. Tangible evidence of his dedication is the VA Spinal Cord Injury centers of excellence and the Bronx VAMC.

The outpouring of support that this legislation has received from veterans service organizations (VSOs) and others is truly staggering. Together with this statement, I am submitting letters of endorsement from the following national VSOs or their New York State or regional organizations: American Veterans (AMVETS), Blinded Veterans Association, Catholic War Veterans of the United States of America, Disabled American Veterans, Jewish War Veterans of the United States, Military Order of the Purple Heart, Paralyzed Veterans of America, Veterans of Foreign Wars, Veterans of the Vietnam War, and Vietnam Veterans of America. In addition, I am submitting a letter from The American Legion, Department of New York, stating that the department does not, as a matter of record, endorse naming Federal facilities, but does not oppose renaming the Bronx VAMC for James J. Peters, "honoring his commitment to veterans."

Other organizations supporting my legislation include: New York State Council of Veterans Organizations, Legislative Representatives; The Mount Sinai Hospital (affiliated with the Bronx VAMC); National Amputation Foundation; No Greater Love; and United Veterans Beacon House.

Conclusion

In conclusion, I would like to State that I believe providing fully for our veterans health care needs is a moral obligation. The Committee's approval of S. 1014 would be an important step toward the correction of regional inequities and would help protect near poor veterans from disenrollment. Likewise, the Committee's approval of S. 2133 would be an important step toward honoring James J. Peters, a truly extraordinary veterans advocate who is linked so closely with the Bronx VAMC's delivery of quality medical care to the region's veterans. I thank the Committee for including S. 1014 and S. 2133 in the hearing today, and for allowing me the opportunity to submit this statement.

Chairman SPECTER. Thank you very much, Senator Clinton.

We have a long list of witnesses, and Senator Stevens has scheduled a full markup of the Department of Defense appropriations bill at 3:30.

I am going to waive my opening statement and go right to the witnesses. Does anyone—Senator Graham, as Ranking, do you care to make an opening statement?

STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

Senator GRAHAM OF FLORIDA. Thank you, Mr. Chairman. I do not. I would like to put a statement in the record, and I would like

to recognize the special significance of today. Today is the 60th anniversary of the signing by President Franklin Delano Roosevelt of what became known as the GI Bill of Rights.

I do not think there have been many pieces of legislation in the over 200 year history of this country that have had such a transformational effect as the opportunity for millions of young Americans who had served their Nation at wartime to then return and secure a college education and provide to this country the human power which has been responsible for our phenomenal growth and prosperity since the end of World War II.

So I would just like to recognize this significant anniversary and to commend those wise enough to develop this program and those wise enough to take advantage of it.

Chairman SPECTER. Does anybody else wish to make an opening statement?

Senator BUNNING. I have one for the record.

Chairman SPECTER. All will be made a part of the record, including mine.

[The prepared statements of Senators Specter, Graham, Bunning and Rockefeller follow:]

PREPARED STATEMENT OF HON. ALAN SPECTER, CHAIRMAN, U.S. SENATOR FROM PENNSYLVANIA

Good afternoon, ladies and gentlemen.

The purpose of the Committee's hearing this afternoon is to develop a record on a number of legislative proposals that are pending before the Committee.

The range of subjects covered by the bills that are on today's agenda is extensive and eclectic, and we will hear from a number of witnesses. Because we have many bills to consider, and we have many witnesses to hear—and because time is, as always, short—I will not make an extended statement. I will just hit on a few highlights and, after giving the Committee's other members an opportunity to comment briefly, I will then turn to the witnesses who are with us this afternoon.

First, I note that the Committee is pleased to have two United States Senators before it. Welcome, Senators Conrad and Corzine. These two distinguished witnesses will be the first to testify, and they will offer testimony on bills before the Committee that they have introduced: Senator Conrad will comment on S. 2063, relating to a proposed pilot project to speed the scheduling of medical appointments at VA hospitals and clinics; and Senator Corzine will testify on S. 2522, a bill to increase the amount of home loan mortgages that VA is authorized to guarantee. We look forward to the testimony of these distinguished witnesses.

Our other witnesses will also comment on these two bills—and on numerous other bills on the agenda that cover a broad range of important policy issues. Among the legislative changes proposed in bills before the Committee are these:

- Proposed increases in Montgomery GI Bill benefits that I (and Senator Miller of Georgia) have introduced;
- A bill that I have introduced to provide VA-purchased prescription drugs to all Medicare-eligible veterans—and thus give elderly veterans access to the significant discounts on needed medications that VA is able to negotiate;
- A bill to provide that, henceforth, VA-provided medical care will be funded by mandatory, as distinguished from discretionary, budget accounts; and
- Bills supported by the Administration to provide cost-of-living increases in VA compensation benefits; to revamp VA's physician pay system; and to provide VA-financed neo-natal care to in cases where VA is providing (or paying for) a veteran-mother's maternity care.

We look forward to the oral and written testimony of the witnesses that will appear today on these—and other—issues. And the Committee will, of course, very much take those views into account as it develops its markup agenda. I hope to be able to proceed with a markup in the relatively near future.

PREPARED STATEMENT OF HON. BOB GRAHAM, RANKING MEMBER,
U.S. SENATOR FROM THE STATE OF FLORIDA

Thank you, Mr. Chairman, for holding this hearing today. We certainly have a full legislative agenda before us today, so I will be brief.

Before turning to the agenda, however, I would like to note the milestone in American history that we have reached today. Sixty years ago today, President Roosevelt signed the Servicemen's Readjustment Act of 1944 into law. Better known as the "G.I. Bill," it changed the Nation by enabling millions of veterans to purchase homes and receive a college education. It is appropriate that on this anniversary we are discussing my "Montgomery G.I. Bill for the 21st Century" that continues the intent of the original "G.I. Bill" by increasing the ability of our veterans to acquire higher education and purchase homes into today's competitive housing market.

I am pleased that legislation for mandatory funding is receiving some attention today, as it assures sufficient funding for health care in the same manner that the GI Bill assures sufficient funding for veterans' education and housing needs. Veterans groups—like many of us—have become frustrated with the yearly battle for VA health care funding. Continuing Resolutions have unfortunately become the norm. This funding uncertainty has veterans caught in the middle, health care providers held hostage, and VA managers unable to plan for the following year. Without a budget resolution as a starting point again, it appears we are headed down a similar track.

The issue of entitlements is undoubtedly controversial. From a budgetary point of view, the significance of such programs as Medicare and Social Security is that costs cannot generally be controlled in the short term. From a policy perspective, entitlements generate a reliable funding stream. Yet the mandatory funding proposals under consideration seek to create a global entitlement for the program, rather than an individual entitlement. I am interested in learning more about the net effect of this choice. What we know for sure is that we cannot continue to put the financial vise on a health system that requires people to deliver services.

Also on the agenda today is the Chairman's legislation to obviate the need for VA doctors to re-diagnose patients who seek affordable prescription drugs. Today, ten million Medicare beneficiaries are also eligible for VA health care. Requiring the government to pay twice to issue prescriptions—once under Medicare and then again under VA—is a waste of taxpayer dollars.

It is no secret to anyone on Capitol Hill that VA is able to obtain discounts for prescription drugs which are unparalleled in the marketplace. I fully support the premise of this legislation as it will allow millions of Medicare-eligible veterans to have access to VA's drug benefit—a benefit which is borne out of strong negotiations with drug manufacturers.

When it comes to the future of veterans' health care and benefits, we know we have some challenging policy decisions ahead of us. These issues require full and open discussions, and I look forward to them.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. JIM BUNNING,
U.S. SENATOR FROM KENTUCKY

Thank you, Mr. Chairman, for holding this hearing during this very busy week. I appreciate you placing my bill on the agenda.

We have a full agenda and a good number of witnesses, so I will keep my remarks short and limit them to my bill.

Recently, the final CARES decision was announced, and in Kentucky we are pleased with the results. VA wisely decided not to close either of our Lexington hospitals and to replace the aging hospital in Louisville. Nearly a dozen new clinics are planned as well.

While I have representatives from the VA in the audience, let me say I support those recommendations and I encourage the VA to move as quickly as possible—especially on opening new clinics.

Veterans throughout Kentucky are very excited about the new hospital coming to Louisville. But a new hospital is not all that is needed in the area. Jefferson County is the largest county in the Commonwealth, but there is not a nursing home for veterans nearby and the area needs more space for homeless veterans.

My bill—S. 2296—will help the Kentucky Department of Veterans Affairs address those needs. Once the new hospital is open, the Kentucky VA wants to modify the

old hospital to provide nursing home care, adult day care, and homeless services for the more than 100,000 veterans in the area.

My bill requires VA to offer the existing VA Medical Center campus to Kentucky once the new hospital is opened. The Commonwealth will have 1 year to negotiate a lease or purchase of the facility before it can be offered to any other buyers.

This is not a great change from current law, but it shows a Federal commitment to keep this historic building available to serve veterans. It will also strengthen the hand of the Commander of the Kentucky VA in securing State funds to open and run this much-needed facility.

Again, Mr. Chairman, thank you for the opportunity to talk about my bill.

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

Chairman Specter and Senator Graham, I want to thank you for your leadership and commitment to veterans. I appreciate your holding this hearing to review a long list of pending legislation which is very important for veterans, especially health care.

Since I am a co-sponsor of S. 50 the Veterans' Health Care Funding Guarantee Act, I am particularly grateful that this important bill is under consideration at today's hearing.

This legislation is designed to ensure that our VA health care system gets the funding it needs and deserves in a timely fashion. Each year, we have tended to have a major battle over the amount of funding for VA health care, and we are debating it again. In addition to the amount of funding, I am equally concerned about how VA health care funds get caught in annual budget fights, and delayed. Our VA medical directors are supposed to get their budgets on October 1st every year. This year, the budget was delayed until January 22nd. The year before, it was February 13th. A delay of four or more months is harsh and harmful—and unnecessary.

The Veterans' Health care Funding Guarantee Act would address both concerns. It would provide the amount of funding needed to service our veterans in a timely manner. It would protect VA health care funding from becoming a pawn in partisan fights, and most importantly ensure that every year, VA health care funding is guaranteed.

I support the Veterans' Health Care Guaranteed Funding Act. This bill would ensure that every October 1st, funding for VA health care would be secure and the level of funding adjusted for inflation. It is not an individual entitlement, but it is a meaningful assurance that we will have adequate funding for VA health care. All of our national veterans groups have endorsed this plan, and it is a much needed change.

The veterans who served bravely in our military to guarantee our freedom and security deserved guaranteed funding for their VA health care system. It is that simple.

Chairman SPECTER. We turn now to our first witness, Deputy Secretary of Veterans Affairs, the Hon. Gordon H. Mansfield.

Welcome, Mr. Secretary.

STATEMENT OF HON. GORDON H. MANSFIELD, DEPUTY SECRETARY OF VETERANS AFFAIRS, UNITED STATES DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TIM McCLAIN, GENERAL COUNSEL; JACK NICHOLSON, UNDER SECRETARY FOR MEMORIAL AFFAIRS; DR. MICHAEL KUSSMAN, ACTING DEPUTY UNDER SECRETARY FOR HEALTH; AND BOB EPLEY, ASSOCIATE DEPUTY UNDER SECRETARY FOR BENEFITS

Mr. MANSFIELD. Thank you, Mr. Chairman for inviting the Department's testimony on the many bills being considered today.

With me today are General Counsel Tim McClain; Under Secretary for Memorial Affairs, Jack Nicholson; Acting Deputy Under Secretary for Health, Dr. Michael Kussman; and Associate Deputy Under Secretary for Benefits, Bob Epley.

Understanding the time element, I would request that my formal statement be admitted for the record, and I would summarize our testimony briefly.

And to summarize, I would mention that we support enactment of S. 2483, your compensation COLA bill; S. 2484, our physician and dentist pay bill that you kindly introduced at our request; and provisions in S. 2485 to allow the VA to dispose of excess real property directly and to retain the proceeds for future property dispositions and nonrecurring capital projects and to permit NCA to lease its underutilized property.

We also support a number of provisions in S. 2486 which would, No. 1, exempt veterans' education benefits from consideration in determining their eligibility for Department of Education loans and grants; No. 2, modify the rules regarding the so-called hybrid arms home loans that we guarantee; No. 3, waive requirements for home loan fees for separating servicemembers who will qualify for disability compensation; No. 4, exempt veterans for paying co-payments for VA hospice care; and finally, make permanent our authority to provide sexual trauma care and counseling.

In addition, we support S. 2417, authorizing limited VA health care for the newborns of women veterans receiving VA-furnished maternity and delivery care, and we favor, in concept, the various bills to increase the limitation on the size of home loans VA can guarantee, but we need to finish analyzing a recent program review before we can officially endorse a new limit. And we ask that you introduce and favorably consider a draft bill that we sent over only recently to make a number of other improvements in our benefits programs.

Mr. Chairman, we cannot lend our support to provisions in S. 2486 reviving the adjustable rate mortgage guarantee, due to the historically high foreclosure rates; S. 1150, the prescription drug bill; S. 1014, a bill to move all Category 7 vets to Category 5; S. 2063, regarding health care appointment scheduling; and S. 1059, the proposed new benefit for certain HIV-infected veterans and family members.

We do not yet have cleared views and estimates on some of the other proposals on today's agenda, and we will supply them when they are available.

Mr. Chairman, thank you again for inviting our testimony. We will be happy to answer your questions.

[The prepared statement of Mr. Mansfield follows:]

PREPARED STATEMENT OF HON. GORDON H. MANSFIELD, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Good Afternoon Mr. Chairman and Members of the Committee: Thank you for inviting me here today to present the Administration's views on a number of bills that would primarily affect Department of Veterans Affairs (VA) programs of veterans benefits and services.

S. 2483—Compensation Cost-of-Living Adjustment

Mr. Chairman, I will begin by addressing S. 2483. This bill would increase administratively the rates of disability compensation for veterans with service-connected disabilities and of dependency and indemnity compensation for certain survivors of veterans, effective December 1, 2004. As provided in the President's fiscal year (FY) 2005 budget request, the rate of increase would be the same as the cost-of-living adjustment (COLA) that will be provided under current law to Social Security re-

cipients, which is currently estimated to be 2.4 percent. We believe this proposed COLA is necessary and appropriate to protect the affected benefits from the eroding effects of inflation. Therefore we support S. 2483.

Because revised economic assumptions for fiscal year 2005 were released on June 15, 2004, we cannot yet provide accurate cost estimates for fiscal year 2005 and for the period fiscal year 2005 through fiscal year 2014. We will provide a cost estimate to the Committee as soon as it is available.

S. 2484—Physicians/Dentists Special Pay

Mr. Chairman, we very much appreciate your having introduced, by request, S. 2484. S. 2484 is an important VA proposal to overhaul physician and dentist pay to greatly enhance VA's ability to recruit and retain high quality physicians and dentists, particularly high-cost medical specialists, to treat the Nation's veterans. It would completely revise the VA physician and dentist pay system to allow VA to adjust physician and dentist compensation levels according to market forces. The system's simplicity and flexibility would ensure that VA physician and dentist compensation levels and practices do not become outdated over time due to statutory limits.

The VA compensation structure for physicians and dentists has not changed since 1991. The current system is extremely complex, comprising seven or eight different special pay components in addition to basic pay. The system offers insufficient flexibility to respond to the changing competitive market for many of the medical specialties, especially for the highest paid medical subspecialties. VA is unable to offer competitive positions for critical subspecialties, such as Anesthesiology, Radiology, Cardiology, Urology, Gastroenterology, Oncology, and Orthopedic Surgery. National shortages of qualified physicians in these specialties have driven compensation levels dramatically upward. In these shortage specialties, VA total compensation lags behind the private or academic sectors by 35 percent or more. Although Congress did increase the amounts of special pay for dentists in 2000, those increases did not bring VA pay up to the levels in private dental practice. The effects of noncompetitive pay and benefits are reflected in dramatic increases in VA's reliance on expensive scarce medical specialist contracts and fee-basis care.

S. 2484 would establish a three-tiered system of base pay, market pay, and performance-based pay. The first tier, a uniform base pay band, would apply to all positions in VHA without grade distinctions. The proposed range is Chief grade, step 10 of the VA Physician/Dentist Schedule to Level V of the Executive Schedule, from roughly $110,000 to $125,000. This change would dramatically simplify hiring and employment and facilitate reassignments and position changes. Placement in this band would be based on the individual's qualifications. The second tier, the market pay band, would be determined according to geographic area, specialty, assignment, personal qualifications and individual experience. It would be indexed to the salaries of similarly qualified non-Department physicians, dentists, and health-care executives. The flexibility of this tier would allow VA to keep pace with the market, both on upward and downward trends. The third tier would be linked to performance, and would be paid for discrete achievements in quality, productivity, and support of corporate goals. VA facilities would be able to authorize performance pay of up to $10,000 for physicians and dentists below the Chief of Staff (CoS) level. VA would benchmark the sum of all three bands to the 50th percentile of the Association of American Medical Colleges (AAMC) Associate Professor compensation (for physicians) and 75 percent of American Dental Association (ADA) net private practice income (for dentists).

Flexible Schedules for Registered Nurses

S. 2484 also includes provisions to help make VA more competitive in its ongoing efforts to recruit and retain registered nurses and other health care personnel. I am especially pleased that the bill would permit enhanced flexibility in scheduling tours of duty for registered nurses. Such flexibility would permit our facilities to offer our registered nurses schedule options comparable to those often available at private and other non-VA hospitals and medical centers. In prior testimony before this Committee, we have noted the projected increase in the number of aging veterans and increased enrollment in the VA health care system by veterans of all ages over the next several years and the projected national shortage of registered nurses. VA's health care providers are its most important resource in delivering high-quality, compassionate care to our Nation's veterans. VA's nurses are critical front-line components of the VA health care team. We must be able to recruit and retain well-qualified nurses. The ability to offer compensation, employment benefits and working conditions comparable to those available in their communities is critical to our ability to recruit and retain nurses, particularly in highly competitive labor markets

and for hard-to-fill specialty assignments. Thanks to the efforts of this Committee and the House Veterans' Affairs Committee, VA has been able to offer generally competitive pay for nurses in most markets. Enactment of S. 2484 would permit VA to continue meeting the increasing challenge of recruiting and retaining sufficient nurses and other health care professionals to meet its patient care needs.

S. 2485—Enhanced-Use Lease Program Improvements

This bill contains provisions designed to improve VA's enhanced-use lease program under 38 U.S.C. §§ 8161 et seq. We acknowledge the need to reform the enhanced-use (EU) leasing process to make it more efficient, as recommended by the Capital Asset Realignment for Enhanced Services (CARES) Commission's February 2004 report to the Secretary, and we appreciate the Committee's interest in this subject. We note that such interest already has led to inclusion of many of this bill's provisions in legislation enacted as Public Law 108–170 (i.e., requiring only one notice to Congress of VA's intent to enter into an EU lease, reducing the congressional notice and review period before executing such lease from 90 to 45 days, reducing by the same number of days the congressional notice and review period regarding a planned disposal of EU leased property, giving the Secretary sole discretion and control of such property disposal by eliminating GSA involvement in the process, and authorizing use of EU lease proceeds to reimburse VA appropriations for expenses incurred in developing additional EU leases). That legislation, together with other initiatives we are pursuing, will help us to significantly reduce the time required to consummate these lease transactions.

Mr. Chairman, we also appreciate the provisions that recognize our EU lease projects can and do involve initiatives not only of the Veterans Health Administration, but also of the Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA). In this regard, section 3 would authorize EU leases implementing VBA and NCA business plans providing for applying lease consideration to programs and activities of those Administrations. Further, it would direct that net proceeds from VBA or NCA EU leases be credited to applicable appropriations of the affected Administration. We are studying the budgetary impact of the latter provision and, following executive-branch review, will advise the Committee of our views.

Finally, should a Capital Asset Fund be established (as proposed under this bill), we would support having the proceeds from a disposal of EU lease property deposited into such fund as provided by this bill.

Disposal of VA Property

S. 2485 would authorize VA to dispose of its excess real property by sale, transfer or exchange to a Federal agency, a State or political subdivision of a State or to any public or private entity and to retain the proceeds generated by the disposals. Under the proposal, the disposal of real property would be exempt from GSA's requirements in 40 U.S.C. §§ 521–522 and 541–545 and those in the McKinney-Vento Homeless Assistance Act (which provides that unused or underutilized Federal real property may be used to assist the homeless). VA would receive compensation equal to the fair market value of the property, and the proceeds would be deposited in a Capital Asset Fund (the "Fund"), as provided for by this legislation. The bill would also terminate the Nursing Home Revolving Fund and deposit funds therein into the Fund.

Amounts in the Fund would have to be used for the costs of actual or planned disposals of real estate, including demolition, environmental cleanup, necessary improvements to facilitate the sales, transfers or exchanges, and administrative expenses. They could also be used for non-recurring VA capital projects.

We support S. 2485 because it would eliminate an existing disincentive to the disposal of Departmental real property. Currently, VA must report all transfers of real property valued in excess of $50,000 (to another Federal agency or to a State or a political subdivision of a State for fair market value) in its annual budget document. This is administratively burdensome. Further, absent extension of current appropriations law allowing proceeds from the disposal of excessed property to be deposited in the Medical Care Collections Fund, provisions in title 38, United States Code, require such proceeds to be deposited into the Nursing Home Revolving Fund. S. 2485 would enhance VA's ability to manage Departmental capital resources, while promoting efficiencies and cost savings. However, we suggest the proposal be amended to provide that VA receive consideration not less than the fair market value of the disposed property to maximize the Government's return.

Limits on Disposal Authority

S. 2485 would also limit VA's authority to dispose of real property in excess of the major medical facility project dollar limitation unless the disposal has been in the budget justification documents for the current fiscal year. The bill would also require VA to receive consideration equal to the fair market value of the property. Proceeds from disposals would be similarly deposited in the Fund.

VA supports this proposal. However, we again recommend that the bill language be amended to require VA receive consideration that is not less than the fair market value of the property.

Advance Planning Funding for Major Medical Facilities

S. 2485 would also exempt projects that have already been authorized by law from current statutory notice and wait requirements that apply to certain major medical facility projects. It would also do so for such projects that are included in the President's budget. VA supports this proposal.

National Cemetery Administration Property

We are pleased that S. 2485 also includes VA's proposal to permit the leasing of unused or underutilized real property that is administered by the National Cemetery Administration. These leases would be limited to a maximum term of 10 years. Leases to a public or non-profit organization would not be required to be advertised. Consideration for these leases could be monetary or, in whole or in part, maintenance, protection or restoration of the leased property. Proceeds would be deposited in a special account in the Treasury, The National Cemetery Administration Facilities Operation Fund (the "NCA Fund"), and available until expended. The NCA Fund would consist of amounts appropriated by law, the proceeds from the leases of land or buildings or agricultural licenses, and any other amounts authorized by law. Again, we appreciate your inclusion of this VA proposal in the bill and strongly urge its enactment.

S. 2486—Omnibus Education, Housing, Health Care, and other Benefits

Mr. Chairman, with one exception, we do not yet have cleared positions or cost estimates on the education benefit provisions in S. 2486. We will supply those for the record.

Title I—Education Provisions

S. 2486 would increase to $2,000 dollars the maximum amount of contribution an individual may make under the Montgomery GI Bill (MGIB)-Active Duty Program to augment the monthly amount of basic educational assistance he or she may receive under that program.

Under current law, servicemembers who elect to participate in the MGIB agree to have their basic pay reduced by $1200 (i.e., $100 per month for the first 12 months of active service) to establish entitlement under that program. Participants are allowed to increase the monthly rate of MGIB educational benefits they will receive after service by making contributions beyond the initial $1200 basic pay reduction, at any time prior to leaving service but not more frequently than monthly, in an amount up to an additional $600 in multiples of $20. The monthly rate of basic educational assistance is thereby increased by $5 per month for each $20 so contributed, yielding an additional $150 in benefits per month for the maximum $600 in-service contribution, or an additional $5,400 for the full 36 months of MGIB entitlement.

If this proposal were enacted, the maximum in-service contribution would increase to $2,000 yielding $18,000 of MGIB benefits.

Pilot Program to Assess Feasibility of Extending the Delimiting Period for Using Chapter 30 MGIB Education Benefits

S. 2486 would also require VA to establish a 4-year pilot program to determine the feasibility and advisability of extending the delimiting period for using chapter 30 MGIB education benefits an additional 2 years for certain individuals whose delimiting period otherwise would expire before they had used all of their remaining MGIB entitlement.

Under current law, an individual's entitlement to education benefits, with certain exceptions, expires at the end of the 10-year period beginning on the date of such individual's last discharge or release from active duty.

The bill would grant a 2-year delimiting date extension to individuals who have remaining entitlement at the end of their 10-year delimiting period and apply for the extension while accepted, enrolled or otherwise participating, as determined by

VA, in the following instruction or training: (a) education leading to employment in a high technology industry as described in chapter 30, (b) a full-time program of apprenticeship or other on-job training as approved in chapter 36, (c) a cooperative program as defined in chapter 34, (d) a licensing or certification test approved under chapter 36, or (e) SAA-approved training or education leading to a professional or vocational objective, as identified by VA regulation.

Individuals eligible to receive an extension of their delimiting dates would be authorized educational and vocational counseling under chapter 36 in connection with the use of the entitlement under this section. However, individuals could not use their entitlement during the 2-year period for general education leading to a standard college degree unless it would result in an associate degree necessary to obtain a professional or vocational objective or for college preparatory courses. Individuals participating in the pilot program could not receive supplemental educational assistance under chapter 30 or a work-study allowance.

The pilot program would begin 6 months after the date of enactment of this section and terminate 4 years later. Individuals granted the 2-year delimiting date extension during the pilot program would be able to complete that 2-year extension even if the program terminated during the extension.

Exemption of VA Education Benefits

The bill contains a VA proposal to exempt VA education benefits provided under chapters 30, 32, 35, and 36 of title 38 and under chapter 1606 of title 10, United States Code, from inclusion as income or assets for the purpose of determining eligibility for, or the amount of, student assistance under any program administered by the Secretary of Education.

Currently, the Higher Education Act of 1965 (20 U.S.C. §§ 1070 et seq.) requires that VA education benefits be counted as a resource when determining a veteran's or a beneficiary's entitlement to certain unsubsidized loans and campus-based aid.

We believe strongly that Department of Education benefits should not have the effect of penalizing persons whose VA benefits have been earned through service in our Nation's Armed Forces. Rather, except for the campus-based aid programs, those benefits should be made fully available, without reduction, to such VA beneficiaries. A more limited application of this concept is appropriate for campus-based aid. Under this section, the amount of such aid (determined without considering VA education benefits) together with the VA education benefits and any Federal Pell Grant funds awarded could not exceed the individual's cost of attendance.

Mr. Chairman, we appreciate your inclusion of this proposal in your bill and strongly urge its enactment. However, the Department of Education has indicated that this proposal would work best if the legislation amended the Higher Education Act itself. We would be pleased to work with your Committee staff to modify this proposal.

Reservists—MGIB Program

S. 2486 would require the VA Secretary to collect $1200 from certain Reservists who wish to participate in the chapter 30 MGIB program before such individuals begin to receive educational assistance benefits under that program.

Title II of S. 2486 and S. 2522—Housing Benefits

Title II of S. 2486 would make several amendments to the VA housing loan program authorized by chapter 37 of title 38, United States Code.

Maximum Loan Guaranty

Both S. 2486 and S. 2522 would increase the maximum VA housing loan guaranty, which is currently $60,000. S. 2486 proposes to increase the guaranty to $83,425. S. 2522 would index the maximum guaranty to 25 percent of the Federal Home Loan Mortgage Corporation (also known as "Freddie Mac") single family conforming loan limit. Because the current Freddie Mac conforming limit is $333,700, S. 2522 would also increase the VA guaranty to $83,425. However, under S. 2522, the VA guaranty would be automatically adjusted annually in tandem with the Freddie Mac loan limit.

Neither the law nor regulations sets a maximum principal amount for a VA guaranteed home loan, so long as the total loan amount does not exceed the reasonable value of the property securing the loan, and the veteran's present and anticipated income is sufficient to afford the loan payments. As a practical matter, requirements set by secondary market institutions limit the maximum VA loan to four times the guaranty. The current maximum guaranty of $60,000 effectively limits VA housing loans to $240,000. Increasing the maximum guaranty to $83,425 would have the effect of increasing the maximum amount lenders are willing to finance to $333,700.

If the guaranty were indexed as proposed by S. 2522, in future years the effective maximum VA loan would remain at the Freddie Mac conforming limit.

VA is currently reviewing the results of an independent program evaluation of the VA Home Loan program. The maximum home loan guaranty was an element of this evaluation. We support the concept of increasing the guaranty level but reserve our opinion on this proposal until we can complete our analysis of the contractor's final report.

VA estimates that increasing the guaranty to $83,425 as proposed by S. 2486 would produce a loan-subsidy savings to the Veterans Housing Benefit Program Fund of approximately $23.3 million in fiscal year 2005, and a 10-year savings of approximately $82.4 million. Indexing the guaranty as proposed by S. 2522 would produce similar savings.

Adjustable Rate Mortgage (ARM) Program

S. 2486 would revive and make permanent the Adjustable Rate Mortgage (ARM) program authorized by section 3707 of title 38, United States Code. Originally enacted in 1992, section 3707 authorized a 3-year demonstration program for VA to carry out an ARM program similar to the one administered by the Department of Housing and Urban Development under section 251 of the National Housing Act.

Due to concerns about the high cost of ARMs, the Congress allowed section 3707 to sunset on September 30, 1995. Similar concerns prevent VA from supporting enactment of this proposal. VA's past experience was that such ARMs had a 50 percent increased risk of default over fixed-rate VA guaranteed home loans.

We estimate that enactment of this provision would increase loan subsidy costs by $4.0 million in Fiscal Year 2005, and have a 10-year cost of $261.3 million.

Hybrid ARM Demonstration Program

S. 2486 would also make permanent the Hybrid ARM demonstration program authorized by section 3707A of title 38. Unlike traditional ARMs authorized by section 3707, which have an annual interest rate adjustment, Hybrid ARMs bear a fixed rate of interest for an initial period of at least 3 years. Thereafter, the interest rate is adjusted annually.

The current Hybrid ARM program was authorized for 2 years and will sunset September 30, 2005. VA only began guaranteeing Hybrid ARMS in the current fiscal year. These loans will not have an interest rate adjustment until late calendar year 2006 or early 2007 at the earliest. We do not believe VA has had sufficient experience to judge the viability of the Hybrid ARM program or assess its performance. Accordingly, we do not favor making this program permanent at this time. Rather, we suggest that the current Hybrid ARM demonstration program be extended by 4 years, i.e., through Fiscal Year 2009, to allow VA time to assess this new program.

This bill would modify the rules for interest rate adjustments on VA hybrid ARMs. Under current law, annual adjustments are limited to 1 percentage point, and the interest rate may never exceed 5 percentage points above the initial interest rate.

S. 2486 would limit the initial interest rate adjustment to 1 percentage point if the interest rate had remained fixed for 3 or fewer years. The bill would also provide that the maximum interest rate increase over the life of the loan would be set by VA. S. 2486 does not provide for any limit on individual annual interest rate adjustments after the initial one. Although we have no objection to providing more flexibility in interest rate adjustments, we do not favor the language of this proposal as drafted.

The initial interest rate for VA Hybrid ARMs must remain fixed for at least 3 years. As a practical matter, virtually no hybrid ARMs have the initial fixed interest rate period of exactly 3 years. Interest rate adjustments are normally made at the beginning of a month. To ease pooling of loans in the secondary market, it is very likely that VA hybrid ARMs closed by a particular lender over a period of several months would all have the same initial adjustment date. An initial fixed interest rate term such as 3 years, 2 months, and 18 days would be common. Therefore, limiting the initial adjustment to 1 percentage point only if the interest rate was fixed for 3 or fewer years is virtually meaningless. Further, this section makes no mention of a limit on the initial adjustment if the fixed rate period exceeds 3 years.

We also believe the statute should limit the size of annual adjustments, or clearly provide that VA has the authority to set such limits by regulation. We would be pleased to work with your Committee staff to modify this proposal. VA estimates that enactment of this proposal would have a 10-year cost of approximately $24.8 million.

Waiver of VA Loan Fee

S. 2486 would waive collection of the VA loan fee from veterans who are rated as eligible to receive compensation as a result of a pre-discharge disability examination. Currently, section 3729 of title 38, United States Code, imposes a fee on most persons who obtain or assume a loan guaranteed or made by VA. The fee is waived, however, for veterans who are receiving compensation or who, but for the receipt of retirement pay, would be entitled to compensation, and for surviving spouses of a veteran who died from a service-connected disability.

We believe waiving the fee for a veteran or service member who has been rated eligible for compensation but who purchases a home before payment of the benefit has begun is a logical extension of existing law. Therefore, VA supports enactment of this proposal. We estimate the associated costs of its enactment would be insignificant.

Title III—Medical and Other Amendments

Title III of S. 2486 contains a number of amendments to various medical and other program authorities.

Technical Amendments to Title 5 of the United States Code

S. 2486 would also make technical amendments to title 5, United States Code, to afford veterans with preference status the right to certain administrative and judicial redress in cases where an agency has allegedly violated their rights under a statute or regulation relating to veterans' preference. Although in principle we support this proposal inasmuch as it would generally enhance veterans' employment related rights, we defer to the views of the Office of Personnel Management.

Co-Payment Exemption for Hospice Care

S. 2486 would exempt veterans receiving hospice care under VA's extended care services program from the requirement to agree to pay co-payments. We support section 311 but recommend that its scope be broadened to include hospice care provided in any treatment setting. Currently, veterans receiving hospice care through the Department may be subject to a co-payment, which can vary depending upon the type of VA facility or setting in which the care is given.

Permanent Authority for Sexual Trauma Care and Counseling Program

This bill would also permanently authorize VA's sexual trauma care and counseling program. We strongly support this proposal, noting that it is identical to a legislative proposal we submitted to Congress in 2003. Making this particular treatment authority permanent is essential. The number of veterans seeking VA counseling and treatment for military sexual trauma continues to increase. Likewise, the number of women who serve in the Armed Forces, the Reserves, and the National Guard continues to grow. VA must be able to provide needed sexual trauma counseling and related health care to these current and future veterans without any lapse in program authority. We estimate there would be no additional costs associated with enactment of this section.

Extensions of Certain Reporting Requirements

S. 2486 would extend through July 1, 2009, the biennial reporting requirement of the Advisory Committee on Former Prisoners of War. It would also extend through December 31, 2009, the reporting requirements of VA's Special Medical Advisory Group. VA supports these proposals.

Amendment to VA Definition of Minority Veterans

Finally, S. 2486 would amend VA's definition of minority veterans in section 544 of title 38, United States Code, to comport with the Office of Management and Budget's (OMB) revised Standards for the Classification of Federal Data of Race and Ethnicity (1997). We support this proposal, which is identical to one submitted by the Department last year. The proposal is needed to bring the definitions applicable to minority veterans in line with those used in the Census 2000. The proposed changes would not change minority veterans' eligibility or entitlement to existing or future benefits.

S. 2417—Newborn Care

S. 2417 would authorize VA to provide care to newborn children of women veterans for whom VA furnishes maternity and delivery care. To receive this benefit, the mother must be enrolled in the VA health care system. Currently, VA has no

authority to provide care to newborns, although VA provides maternity benefits as part of its medical benefits package.

We strongly support this bill, which is identical to a legislative proposal we submitted to Congress in 2003. After childbirth, some veterans may need this limited benefit to give them time to apply for medical assistance. Offering this care would also be consistent with the normal pregnancy and delivery coverage in the community. The modest cost of the proposal was included in the President's Budget submitted earlier this year.

S. 1153—Prescription Benefit for Medicare-Eligible Veterans

Mr. Chairman, I will next address S. 1153, a bill that you introduced to provide all Medicare-eligible veterans with a new prescription drug benefit through the VA. As we know, the availability of prescription drugs to our seniors has been an extremely important issue for America, and one that was debated extensively last year by the Congress.

Your bill would provide Medicare-eligible veterans with a compensable service-connected disability this new benefit 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. The bill would require that these veterans make an irrevocable election of drug or health benefits for each calendar year. The costs for this bill could be defrayed by any combination of annual enrollment fees, co-payments, and charges for the actual cost of the medication.

In December 2003, the President signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 to add a prescription drug benefit to Medicare. Starting in 2006, seniors without coverage will be able to join a Medicare-approved plan that will cut their yearly drug costs roughly in half, in exchange for a monthly premium of about $35. Under this new law, every Medicare beneficiary will be able to choose from at least two drug coverage options, and Medicare-approved prescription drug plans also will also be able to offer their enrollees supplemental insurance to further enhance their coverage. It is not clear how the expanded VA benefit proposed in S. 1153 would interact with this new Medicare benefit, and we are concerned that this proposal could have significant effects on other public and private health care programs by jeopardizing the current discount prices VA receives on pharmaceuticals. While we appreciate your novel approach and share your concern that veterans and all Americans have access to affordable prescription drugs, we cannot support this bill.

S. 50—Guaranteed Level of Funding for VHA

S. 50 would establish, by formula, the annual level of funding for all programs, activities, and functions (except for grants to States for the construction or acquisition of State homes for veterans) of the Veterans Health Administration (VHA) for fiscal year 2005 and fiscal years thereafter. The formula contains detailed terms by which to calculate the requisite annual funding level.

We recognize the appeal of such an approach. However, it could very well prove to be an unworkable mechanism for funding a dynamic health care system like VA's.

As you know, health care evolves continually to reflect advances in State of the art technologies (including pharmaceuticals) and medical practice. It is very difficult to estimate both the costs and savings that may result from such changes. Moreover, patients' health status, demographics, and usage rates are all subject to variable trends that are difficult to predict. A formula, such as that proposed in S. 50, could not take changes in such trends into account. As such, there is no certainty that the funding dictated by the proposed formula would be adequate or appropriate to meet the demands that will be placed on VA's health care system in the upcoming years.

Moreover, if the demand for care that such an approach creates would overwhelm VA's capacity to provide care in-house, we could transform into more of a payer than provider of veterans' health care. That would not bode well for our long-term prospects of remaining an independent system uniquely capable and structured to respond to the specialized needs of veterans of military service.

Use of an automatic funding mechanism would also diminish the valuable opportunity that Members of the Congress and the executive branch now have to identify and directly address the health care needs of veterans through the funding process. It may also diminish the Department's strong incentive to improve program operations and efficiency.

Finally, references to "guaranteed funding" may give the public the false impression that VA would be fully funded to enroll all veterans and to furnish care for

all their needs. We do not believe this proposal would ensure open enrollment. VA would still be required to make an annual enrollment decision, and that decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula.

Be assured we share the desire by many in Congress to ensure stable funding for VA's health care system. However, until there is a more complete understanding of all consequences that could flow from this approach, both intended and unintended, we are unable to lend our support.

S. 2327—State Home Per Diem Payment—Relation to Medicaid

For many years, a number of State homes have accepted both VA per diem payments for the care of veterans and Medicaid payments for those veterans without reducing the Medicaid payments by the amount of per diem payments. The Department of Health and Human Services (HHS) has determined that this practice violates its rules and is investigating whether to seek reimbursement. S. 2327 appears aimed at rectifying this situation by deeming that VA State home per diem payments "shall not be considered a liability of a third party, or otherwise be utilized to offset or reduce any other payment made to assist veterans." Because this bill would primarily impact the Medicaid program, we defer to the views of HHS on the matter.

S. 1014—Changes to VERA allocations

S. 1014 would amend the Department's statutory enrollment system by creating two groups within enrollment priority category (5). The first group would be those veterans currently in category (5), veterans whose income falls below VA's national "means test" income threshold. The second group would include those veterans currently in priority category (7), veterans whose incomes are above VA's national "means test" level but below VA's geographic "means test" threshold. The second group would remain subject to co-payment requirements that currently apply to veterans in priority category (7). Finally, the bill would also re-designate priority category (8) as priority category (7).

We understand that the bill's sponsors introduced this measure to ensure that VA facilities in locations with a high cost of living receive an appropriate level of funding under VA's Veterans Equitable Resource Allocation System (VERA). When the sponsors introduced the bill over a year ago, the VERA system allocated funds to VISNs based upon the number of veterans treated in the facility who were in VA enrollment priority categories (1–6), and did not allocate basic care funds for those veterans in priority categories (7) and (8). The sponsors may believe that facilities located in high-cost areas of the country tend to treat a greater number of category (7) enrollees than do facilities in lower-cost areas because veterans in the former locations generally have higher incomes. Priority category (7) takes into account the cost-of-living by use of a geographic "means test" that varies depending on the cost-of-living in each geographic area. Because the VERA system was not providing basic care funding for priority category (7) veterans, the sponsors apparently believed high-cost areas of the country receive less funding than needed when compared to lower-cost areas of the country. To rectify that perceived problem, S. 1014 would combine the current category (5) with category (7), thereby ensuring that the VERA allocation system provides funding for all veterans with income below a geographically adjusted means test.

S. 1014 is unnecessary and we oppose its enactment. Since the introduction of the bill, VA has changed the VERA allocation system to provide funding for both priority category (7) veterans and category (8) veterans, completely negating any need for this legislation. The VERA model also takes into consideration the actual costs for providing care to those in categories (7) and (8), as well as categories (1) through (6), and provides funding accordingly.

S. 2063—Access to Care Demonstration Project

S. 2063 would require VA to carry out a 2-year demonstration project to study the feasibility and advisability of requiring VA to schedule appointments within specified timeframes and take into consideration whether a veteran has a service-connected disability rated at least 50 percent, or is receiving care for a service-connected disability. In 2000, VA established a goal—referred to as the 30–30–20—under which veterans would be able to schedule initial non-urgent primary care appointments and non-urgent appointments with a specialist with 30 days, and would be seen within 20 minutes of their appointment times. The demonstration project would require VA to meet this goal in three Veterans Integrated Service Networks (VISNS)—one urban, one rural, and one highly rural. Veterans covered by the project would include any veteran residing in the covered network. Under the

project, each appointment would be scheduled in a VA facility unless the cost of doing so exceeds the cost of scheduling in a non-Department facility to an unreasonable degree, or unless scheduling in a non-VA facility is required for medical or other reasons, in which event VA would have to contract for the care. The bill also includes an annual reporting requirement on the waiting times of veterans for appointments. Information regarding the demonstration would be included in the 2007 annual report.

We strongly oppose S. 2063. It has the potential to dramatically increase demand for VA care and overwhelm our ability to provide care in VA facilities participating in the demonstration project.

In 2000, our goal was to achieve a national average waiting time of 30 days or less for both primary care and specialty clinics. The current May 2004 data reveal that 95.7 percent of appointments for primary care were within 30 days and 94.2 percent of appointments for specialty care were within 30 days of the desired date. At this time, however, we do not believe any of our VISNs would be able to comply with the 30-day standard for all appointments that would be required under the demonstration project. Thus, if the bill were enacted, every VA facility in the covered networks would be forced to offer any veteran desiring a primary care visit the opportunity to receive that care in the private sector on a contractual basis if VA cannot provide the care in a VA facility within the mandated time-frame. Providing contract care for all veterans waiting 30 days or more for an appointment would be more expensive than providing that care in VA facilities. We believe that huge numbers of veterans who now choose to receive their primary care in the private sector would likely avail themselves of this new benefit in the demonstrationsites. This enhanced demand would have the effect of draining appropriated funds out of VA-operated facilities to pay for contract care. These additional costs would threaten our ability to provide services to our core constituency—service-connected and indigent veterans.

Mr. Chairman, the appointment goals set in 2000 included a goal of increasing the percentage of veterans who report seeing a provider within 20 minutes to 78 percent over the 3 years, and to 82 percent over 6 years. By referencing this strategic goal, the bill appears to direct that we create a standard for the length of time a veteran would have to wait to see a provider on the day an appointment is scheduled, and require contracting for care when we are unable to comply with the standard. The rationale for this is unclear. Unanticipated delays while waiting to see the provider are commonplace in the health care arena. For example, if a provider is unexpectedly delayed while treating a patient with an earlier appointment, or while responding to an emergency, another patient may have to wait 40 minutes instead of 20 minutes. We would not ordinarily turn a patient away or reschedule the appointment time on the basis of such an unanticipated delay. It is not clear how this day-of-service standard would or could be implemented or satisfactorily monitored in a demonstration project. Waiting times on the day of appointment are better addressed through performance measures than through a standard arbitrarily designated in law or regulation.

We would encounter several additional problems implementing the demonstration project. These would include difficult issues with patient medical records caused by the fragmentation of care between VA and the private sector, and problems associated with having the non-VA providers access VA patient records and make referrals. Implementation would compromise the continuity of care for a vulnerable veteran population, and create problems coordinating ancillary follow-up care. The bill also assumes that needed care can be obtained in the community within 30 days; however, there are shortages in certain specialty care areas in the private sector that mirror VA's difficulty in hiring. Further, some geographic areas do not have certain specialty providers, while in other areas the available specialists are already under contract with VA. The bill sets a 30-day timeframe for receiving a primary or specialty appointment and provides no flexibility or latitude for patient or provider preference in determining when an appointment is needed. It is more appropriate to use the patient or provider's desired appointment date for determining whether timeframe goals are met.

As you know, VA has, in recent years, faced unprecedented new demand for services, and has been forced to place many veterans on wait lists. However, we have made remarkable progress in reducing the number of veterans on the wait list and improving waiting times. This is in part attributable to our emphasis on performance measures, the Advanced Clinic Access initiative and redirecting resources to hire additional providers. VHA will continue employing these strategies.

VA has established strategic goals to achieve the level of timeliness indicated in the bill, and we have implemented strategies to reach those goals. Enacting the

demonstration project proposed in S. 2063 would make achievement of those goals more difficult.

S. 1509—Payment of a Monetary Benefit to Persons who Contract HIV or AIDS from a Transfusion

S. 1509 would provide a $100,000 gratuity to veterans, their spouses, and their children who contract HIV or AIDS following a blood transfusion or organ transplant received in treatment of a service-connected disability. The gratuity would be available to individuals who can provide medical evidence acceptable to the Secretary of Veterans Affairs indicating a reasonable certainty that the transmission of HIV resulted from such treatment. The bill would provide that, if an individual entitled to the gratuity is deceased at the time of payment, payment will be made to the individual's survivors. The survivors of an eligible individual who dies before applying for the gratuity may apply on behalf of the deceased individual, and the deceased individual's gratuity may then be paid to the survivors in the same manner as if the deceased individual had applied for the gratuity and died before payment was made.

There are already mechanisms in place under title 38, United States Code, for provision of disability compensation to veterans who suffer disabilities as a result of contracting HIV or AIDS from VA treatment for a service-connected disability and dependency and indemnity compensation to the survivors of such veterans. Further, VA currently pays additional compensation to service-disabled veterans whose spouses require regular aid and attendance. Such benefits could be payable to veterans whose spouses contract AIDS through contact with the veteran. Also under current law, if the Government is responsible for transmission of HIV through its negligence, the Federal Tort Claims Act provides an available remedy for injured veterans, family members, and survivors. State law affords similar remedies against non-VA providers. The availability of these remedies renders unnecessary the relief contemplated by this bill. Also, the bill contains no provision for offset of the contemplated gratuity against any compensation or award received under title 38 or the Federal Tort Claims Act for the same injury. Thus, the bill would result in duplicate payments for the same harm.

Further, S. 1509 would result in inequitable treatment of similarly situated veterans. Veterans who contract hepatitis or other blood-borne illness as a result of treatment for service-connected disability would be ineligible for the gratuity. Such veterans would seem to be equally deserving of compensation as those who contract HIV or AIDS.

Moreover, VA would be required to pay the gratuity even if a private health-care provider were responsible for the transfusion of tainted blood. The Federal Government generally should not assume responsibility for harm caused by private entities.

For all of these reasons, we cannot support enactment of S. 1509.

VA lacks the information needed to develop a reasonable estimate of the cost of this legislation.

S. 1745—Prisoner of War/Missing in Action National Memorial Act

S. 1745 would designate the memorial to former prisoners of war (POW) and members of the Armed Forces listed as missing in action to be constructed at the Riverside National Cemetery in Riverside, California, as the Prisoner of War/Missing in Action National Memorial. It would also prescribe that the national memorial is not a unit of the National Park System and that the designation of the memorial shall not be construed to require or permit Federal funds, other than any funds provided for as of the date of enactment of the bill, to be expended for any purpose related to the memorial.

The memorial will be comprised of a circular plaza located on the east side of the upper lake just inside the entrance to the national cemetery. The centerpiece of the memorial will be a figurative bronze statue of a Vietnam POW. Black granite panels standing on end will be placed to the rear of the circular plaza. The names of all known POW sites, including the total number of prisoners at each location, will be engraved on these panels. The POW sites will be displayed by major conflict or campaign.

The Riverside National Cemetery Memorials and Monuments Commission (Commission) is a private organization that has proposed to erect the memorial and donate it to the National Cemetery Administration (NCA). The Commission is responsible for funding and contracting issues related to this project. The Commission is currently raising funds for the construction and future maintenance of the memorial through donations. The statue for the memorial is finished and is ready for installation once the plaza is completed. NCA approved plans for the project in March 2004

and designated a location for the memorial within cemetery grounds. The Commission anticipates that construction of the plaza will commence this summer and plans to dedicate the memorial 6 months after construction begins.

The National Park Service (NPS) currently maintains and operates the National POW Museum located at the Andersonville National Historic Site in the State of Georgia. In 1970, Congress authorized the establishment of the Andersonville National Historic Site pursuant to Public Law 91–465, 84 Stat. 989, in order to "provide an understanding of the overall prisoner-of-war story of the Civil War, to interpret the role of prisoner-of-war camps in history, to commemorate the sacrifice of Americans who lost their lives in such camps, and to preserve the monuments located therein." The park and the National POW Museum currently serve as a national memorial to all American POWs. Accordingly, we recommend that NPS have an opportunity to comment on this legislation.

We have no objection to designation of a national memorial at Riverside National Cemetery, and we estimate that there would be no costs to VA associated with designation of the memorial. However, we are concerned that the bill would restrict use of Federal funds to maintain the memorial in the event that private funds are not adequate for this purpose. It would also apparently preclude VA from expending any Federal funds for future maintenance of the memorial under any circumstances. Although the Commission is raising funds to cover the future costs to operate and maintain the memorial, should the donating organization become unable to meet the future costs associated with maintenance and repair of the memorial, VA would be prohibited from using Federal funds to provide such maintenance or repairs.

Without authority to use Federal funds for the care and maintenance of the memorial, we do not support this legislation.

S. 2099—Selected Reservists Entitled to Montgomery GI Bill Benefits

S. 2099 would entitle Selected Reservists who, on or after September 11, 2001, serve on active duty in the Armed Forces for not less than 2 years in any 5-year period, and who meet the other eligibility criteria, to basic educational assistance under the chapter 30 Montgomery GI Bill program. The 2-year period required for eligibility would not have to be continuous service, but could be an aggregate of one or more periods of service. These MGIB participants would receive 1 month of educational assistance benefits for each month of active duty served after September 11, 2001, as part of the 2-year eligibility criteria. The amount of the benefit paid would be the same as that of an individual whose entitlement is based on an obligated active duty period of 2 years, currently $800 monthly for a program of education pursued on a full-time basis. The Secretaries of the various military components of the Armed Forces are charged with informing Selected Reservists of the availability of the benefits provided by this bill.

Mr. Chairman, the Department has already implemented provisions of chapter 30 MGIB education benefits in a manner that recognizes benefits for Reservists called or ordered to active duty and who serve a continuous period of active duty aggregating 2 years or more, provided they otherwise meet the MGIB eligibility criteria. However, we do not yet have a cleared position or cost estimate on this specific proposal, but will supply those to the Committee as soon as possible.

S. 2296—Option for Commonwealth of Kentucky for Certain Property

Mr. Chairman, S. 2296 would grant the Commonwealth of Kentucky a first option should the VA decide to convey, lease or otherwise dispose of the Louisville, KY Veterans Affairs Medical Center. This bill would require the VA to negotiate with the Commonwealth of Kentucky and restrict for 1 year the Department from negotiating with any other party.

Let me note first of all that because VA does not presently have direct disposal authority, we do not currently have the authority to negotiate with the Commonwealth. However, as discussed earlier in my statement, we do support being given such disposal authority. Having said that, we, nonetheless, oppose this legislation because we believe it could prevent VA from achieving maximum value from disposal of the property should the property no longer be needed by VA. Achieving best value in a property transaction involves market timing and competition, and this proposal would remove both of these considerations.

S. 2133—Designation of Bronx VAMC

This bill would designate the Bronx VAMC as the "James J. Peters Department of Veterans Affairs Medical Center." We defer to Congress in the naming of Federal property.

Veterans Programs Improvement Act of 2004

Mr. Chairman, we also request the Committee's favorable consideration of a draft bill we submitted only very recently. In addition to providing for a compensation COLA (identical to that in your bill, S. 2483) it would: o extend full-time and family Servicemembers' Group Life Insurance coverage to certain additional reservists; o authorize VA to provide memorial headstones or markers when the remains of veterans' minor children are unavailable for burial in State or national veterans cemeteries; o authorize use of chapter 34 and chapter 35 benefits to defray the costs of certain high-tech courses; and o allow eligible veterans who are employable, but are determined to be in need of chapter 31 employment services only, to receive Vocational Rehabilitation Employment Adjustment Allowances.

Other Bills

Mr. Chairman, we do not yet have cleared positions or cost estimates on S. 2524, a proposal to establish a War-Related Blast Injury Center, or S. 2534, a bill to improve veterans education and housing benefits. We will supply those for the record.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Committee may have.

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

Turning to S. 1153, the proposed Veterans Prescription Drug Assistance Act, this would provide for a discount for veterans. And a couple of illustrations show the enormous cost factor. The Veterans Administration cost for 30 10-milligram tablets of Zocor, a cholesterol-lowering drug, the VA pays $7.80, and the retail price is $75.59. Lisinopril, a popular high blood pressure medication, costs the VA $2.11, and the retail price quoted at CVS is $23.09.

This legislation would provide that veterans eligible for Medicare would be able to have the benefit of VA-negotiated lower prices, allowing the VA to add on administrative costs, and the veterans would not have to be under care of the Veterans Administration in order to qualify for these lower costs. Do you not think that is a pretty good bill?

Mr. MANSFIELD. Mr. Chairman, I understand and agree with the concept of attempting to serve veterans better, but I think there are some institutional problems that we have talked about before, and that includes the fact that the VA medical community believes that we should be not just taking parts of the care, but we should be providing the whole care, and there are some concerns from the medical community about whether we would be adequately treating the patient if all we do is take care of their prescription requirements.

There are certain requirements on a periodic basis to find out what the effects of the drugs may be, to have tests and to find out, you know, what the effect of the prescription is on the person, and I think the medical doctors feel that they would rather have the care of the whole person rather than just one part.

Chairman SPECTER. Well, when the veteran comes with a prescription from a doctor, what is the problem? If the veteran is not getting any care at all, what is the problem on the question if when the veteran comes with a prescription from a doctor?

Mr. MANSFIELD. Sir, let me ask Dr. Kussman to help me answer that.

Dr. KUSSMAN. Mr. Chairman, I certainly reemphasize what the Deputy Secretary said, that we understand that you want to expand the ability to provide as much care as we can to veterans. We traditionally assume the full care of the patients, whether they come with a private prescription or not. And just filling the pre-

scription would not allow us to be sure whether this was an appropriate thing for us to do as part of the health care delivery system.

Chairman SPECTER. Well, the problem is that the VA currently has a closed enrollment, does it not?

Mr. MANSFIELD. Yes, sir, we do not accept new enrollments of Category 8s; that is correct.

Chairman SPECTER. So the veteran does not have the option of enrolling to have the benefit of the treatment and the lower cost.

There has been considerable controversy over the Medicare prescription drug bill as to a provision that does not permit the Federal Government to negotiate with the pharmaceutical companies to get the lowest negotiable price. The Veterans Administration does negotiate with the pharmaceutical companies, does it not, to get the prices illustrative of the ones I just cited?

Mr. MANSFIELD. Yes, Mr. Chairman, it does in fact, but I would point out that we are limited to 3 or 4 percent of the total product delivery system of the pharmaceutical industry, and that is an element that is involved in what the pricing is.

Chairman SPECTER. Do you not think that it would be a good idea to let the Government negotiate for the benefit of Medicare-eligible veterans—to get the lowest price for seniors?

Mr. MANSFIELD. Are you asking the Deputy Secretary of Veterans Affairs or Gordon Mansfield?

[Laughter.]

Mr. MANSFIELD. As the Deputy Secretary, I would make the point that it—as the Deputy Secretary——

Chairman SPECTER. Well, let me—wait a second. You asked me a question. I am going to answer your question. I am sorry to go over time, but I want an answer. Answer it both ways: first from Gordon Mansfield, then from the Deputy Secretary.

Mr. MANSFIELD. As the Deputy Secretary of Veterans Affairs, I would make the point that it might well have an effect on what our pricing is, and it might well cause a rise in the price that we have if you expanded the amount of the product that was subject to the negotiation. That is what I have seen in economic reports.

Chairman SPECTER. Senator Graham.

Senator GRAHAM OF FLORIDA. Well, I would like to pursue that question in a defensive manner.

Recently, before the Finance Committee, Secretary of HHS Thompson was asked basically the same question that you were just asked but with this twist: if it has been determined that it would be inappropriate to provide negotiation on prescription drugs for Medicare beneficiaries because it would constitute Federal Government price fixing, is there going to be an effort within the administration and within the VA to reverse the policy of the VA negotiating on the same rationale?

Have you seen any movement within the VA to alter your access to the lower drug prices available through aggressive negotiation?

Mr. MANSFIELD. No, sir, I have not.

Senator GRAHAM OF FLORIDA. Your comment about your concern that there would possibly be an increase in the VA prices if all of the Medicare beneficiaries were suddenly eligible, you know, only about a third of the Medicare beneficiaries are currently estimated

to be likely candidates for the benefit, because the other two-thirds already get some kind of assistance with their prescription drugs.

Actually, the number of people who are likely to be served under Medicare are not substantially greater than the number who are being served under the VA. Would that make you feel a little less apprehensive about an adverse effect on VA pricing?

Mr. MANSFIELD. I guess it would depend on what the numbers are as part of the answer, sir, yes.

Senator GRAHAM OF FLORIDA. I notice that one of the bills that you said you opposed was the mandatory funding provision, the eligibility for funding. Is that not—we are celebrating the 60th anniversary of the GI Bill. Would you not define that today as being an entitlement program?

Mr. MANSFIELD. I guess, and I do not want to parse it too much, but for example, the GI Bill education program originally started out in World War II as benefits paid to the returnees, whereas now, to sign up for it, you have to make an election, No. 1, and then, you have to pay something into it, No. 2, so I think it has evolved over time as the best way——

Senator GRAHAM OF FLORIDA. But 60 years ago when Franklin Roosevelt signed the GI Bill, would we not today entitle that as being an entitlement?

Mr. MANSFIELD. I would guess that we would, sir, yes.

Senator GRAHAM OF FLORIDA. Well, why do you feel that today, for something as basic as the health care of veterans, that idea which has served veterans so well for the past 60 years would not be a concept that would be applicable to serving the needs of veterans today with their health care?

Mr. MANSFIELD. I would have to answer it in two ways. No. 1 is there is a different set of circumstances today. In those days, we had a military that was drafted, to a large degree, to fight World War II, 16 million men and women under arms in a different situation. Today, we have a volunteer army that is much smaller, and that, I think, has an effect on what we are talking about as far as——

Senator GRAHAM OF FLORIDA. So you are saying you think that those persons who make a voluntary election to join the military are less deserving than those who are drafted into the military?

Mr. MANSFIELD. No, sir, I did not say that at all.

Senator GRAHAM OF FLORIDA. Well, what was the connection between the GI Bill of 1944 and the issue of medical benefits in 2004?

Mr. MANSFIELD. I said there were changed circumstances, and that is one of the circumstances that I see as a differential.

Senator GRAHAM OF FLORIDA. Would it not provide the kind of stability and predictability that the VA educational benefits created in 1944 if today we were to develop an entitlement program for health care benefits?

Mr. MANSFIELD. Sir, I understand the concept and the direction and the intent. One of my concerns would be the unintended consequences. If you look at the prepared statement, you would see that the argument is that we are not sure of exactly what all the intended or the unintended consequences may be. Part of it is a cost factor. Part of it is how it affects other programs. And that is

the reason that we are saying we think we would like to take more time and study this further.

Senator GRAHAM OF FLORIDA. Do you think—what constitutes more time? Thirty days? Sixty days?

Mr. MANSFIELD. No, sir, I do not think you are going to get anything during this session of Congress as an answer to that.

Senator GRAHAM OF FLORIDA. Is this the first time that the VA has been thinking about it?

Mr. MANSFIELD. No, it is not the first time, sir, but I would say that the bill has evolved over time, and then, it has changed significantly from what the first concept was. I have had the opportunity to be on what you might say both sides of this bill, having been involved with the Veterans Service Organization when the concept first arose, and I have seen it evolve, change and grow from the original concept. So I think we still have to examine what the effects may be and continue to study it.

Senator GRAHAM OF FLORIDA. Well, Mr. Chairman, my time is up. I would just say that exactly the same arguments were being made in a room like this in 1942 and 1943 relative to extending these very extensive educational benefits to the GIs of that era. It seems to me that we ought to build on that plan, not feel as if we have to go back to the drawing boards in order to develop a mandatory funding for health care.

Chairman SPECTER. Those arguments were probably made in this room.

Senator GRAHAM OF FLORIDA. Might well have been in this room.

Chairman SPECTER. And Strom rejected them.

[Laughter.]

Chairman SPECTER. Senator Bunning.

Senator BUNNING. Thank you, Mr. Chairman.

I would like to pursue something a little different, if you do not mind. It is my understanding that VA is currently studying a new hospital for Louisville, Kentucky. Would you please give me an update on the status of that study and when the hospital may be open or any kind of construction may be beginning?

Mr. MANSFIELD. Sir, my understanding is that the Secretary has directed that that study be conducted and completed by the end of this calendar year and that the design of the study is currently under discussion and I think being finalized and should shortly go out to the field.

Senator BUNNING. I want to see that the existing hospital remain in service to the veterans. Obviously, we have an existing hospital in Jefferson County, in Louisville, Kentucky. The Kentucky Department of Veterans Affairs is interested in acquiring the old hospital to provide nursing home care, adult day care, and homeless services for veterans.

That is why my bill that I have put in requires the VA to negotiate with the Commonwealth before anyone else. I know the Veterans Administration does not support this concept, but I hope they have read the entire bill where in the bill, we specifically State that you must get fair compensation.

Now, the timing of that compensation, obviously, would be determined by the Veterans Administration if, in fact, they get permission for equal value being determined for the building. That is in

my bill. You have argued or the Veterans Administration, not you specifically, have argued that you do not want to be tied down for a year.

Well, the timing may exist that you want to hold the building for more than a year. You may think you can get more out of it. We do not tie your hands as far as that goes. So I think you ought to reexamine the Veterans Administration's position definitely in regard to the bill that I put in so that the VA and the Department of Veterans Affairs in Kentucky at least has a chance to utilize that current facility for the purposes I discussed.

Please take a look at the bill in regards to that, because Veterans Affairs Department in Kentucky wants a chance to revitalize that building, use it for the veterans. There are almost 100,000 veterans in that immediate area, Jefferson County, Bullitt County, Shelby County and Oldham County. So it would behoove you to look at that bill and maybe reexamine the Veterans Administration's stance on that bill, because it gives you flexibility——

[Sound of breaking glass from the audience]

Senator BUNNING. ——My God. I did not mean to cause that stir, Mr. Chairman.

Chairman SPECTER. Senator Bunning, with just a break in the examination, if you please. OK, is anybody hurt? Anybody need any medical attention? Would the people in the area where the glass broke move away? Fortunately, there is a doctor on the premises if anybody needs any help.

[Laughter.]

Mr. MANSFIELD. Yes, right here.

Dr. KUSSMAN. She tells me she is fine.

Chairman SPECTER. Dr. Kussman, would you step outside with the young lady for just a minute and be sure she is OK?

Senator Bunning, with the break, I have to excuse myself to go to——

Senator BUNNING. I am just clearing up, and I have to——

Chairman SPECTER. I have got three more seconds. I just wanted to say, if you want to chair, Senator Graham is prepared to chair in my absence. I will return.

Senator BUNNING. Please let Senator Graham, because I have another meeting at 3:30.

I am finished. Thank you very much, gentlemen.

Mr. MANSFIELD. Senator, I will commit to you that we will look at it again and get back to you as soon as possible.

Senator BUNNING. Thank you.

Chairman SPECTER. Thank you, Senator Bunning.

As I said, I am going to have to excuse myself for a few moments to make a quorum in the Department of Defense appropriation bill, and I shall return.

Thank you very much, Senator Graham.

Senator GRAHAM OF FLORIDA. [Presiding]. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Secretary Mansfield, you made a couple of interesting statements, and I have known you in both of your capacities. And you really are not allowed to use your private capacity as an excuse for your public capacity or vice versa.

You, when you were in your private capacity, were a very strong, unyielding advocate, which I applauded. You just made a very interesting statement. You said, well, we cannot do whatever it was that was being discussed because we do not know what the effects would be on the other parts of the veterans health care, we cannot really do, and then, you backed this up, Doctor, we cannot really do one particular add-on until we have a whole health care, the whole health care of the veteran.

Now, you are perfectly aware of the budget and the budget constraints, and therefore, I assume that you are perfectly aware that what you really said was we are against this, because we are not ever going to have the wholly necessary care of the veteran, and so, you are not willing to make incremental steps along the way. Am I wrong about that?

Mr. MANSFIELD. I think you are, sir.

Senator ROCKEFELLER. Would you explain that?

Mr. MANSFIELD. And I appreciate the point that you are making and take it to heart. I thought I was answering the question by saying that I recognize that this effort started out with one concept——

Senator ROCKEFELLER. No, no, I am not talking about that. You made a separate—before that came up, you made an answer in which you said we cannot support this because we do not have the budget for all of the health care needs of the veterans, and therefore, we cannot pick and choose one particular health care——

Mr. MANSFIELD. I am sorry; referencing the pharmacy bill, sir? I am sorry.

Senator ROCKEFELLER. Yes.

Mr. MANSFIELD. I am sorry. I think the answer that I gave was that I believe that the medical community would rather treat the whole person rather than just be involved in delivering the one part of the benefit, which is the pharmacy benefit.

Senator ROCKEFELLER. I have no argument with that, Mr. Mansfield, but I hope you understand the disingenuous nature of your answer, because you know perfectly well that there is not going to be a budget, or there has not been a budget under either Republican or Democratic administrations that take care of all of the health care needs of the veteran. So what you are saying is that you want to put us on permanent hold and not take individual initiatives? I was on the conference committee back in 1993 which settled on this volume discount purchasing power of prescription drugs and find myself at a loss at your unwillingness to make an incremental adjustment until you have what doctors want to do, and that is to treat the entire needs of the veteran when you know perfectly well the budget is not there to do that.

Mr. MANSFIELD. Well, you know, there are other examples of this that we have used before, and for example, do we want to—well, I am sorry; I understand the concern that you are raising.

Senator ROCKEFELLER. I understand the concern I am raising, too, but I want to know what your response to it is.

Mr. MANSFIELD. Well, I did not intend to be disingenuous. I intended to make the argument that the medical community, the VA medical community feels that they should not just be treating this one part; that they would rather have the——

Senator ROCKEFELLER. Not just treating this one part called prescription drugs, which is the most sought-after part of virtually all of health care unless you are dealing with some kind of spinal cord injury of some sort which many people do it, you know, much, much less all the people who are estimating that 70 percent of all of the veterans returning from this war that we are involved in will be facing post-traumatic stress disorder.

The Veterans Administration is not in a position to treat that either. Are you going to make an effort toward that? I mean, I use the word disingenuous, because I meant the word disingenuous, because you are saying until we can do the whole thing, we are not going to do anything. That is what you were saying.

Mr. MANSFIELD. I think that is what the answer is, then.

Senator ROCKEFELLER. I will go to my second question, and I will do it quickly: when Secretary Principi was here, I asked him the question that I always ask the top brass of the Veterans Administration. I have been on this Committee for 20 years, and he answered the question, but I am going to ask you the question. If you are deputy, that means that you are fighting for veterans' health care and for the necessary funds to be able to do that. It is a limited budget. It is set in statutory form. It cannot be exceeded. It cannot borrow. We all know that.

So the only way—and I have done this myself, and I took on a vice president and backed off a vice president into allowing higher numbers into the budget. What I asked Secretary Principi, are you willing to go face-to-face with President Bush about the veterans health care budget, and he said he was, and I believe him, because I think he would do it. That is the way I feel about Tony.

I know you pretty well, too. I want to know have you made any effort to fight for a higher level of veterans care? HUD is not your business. Small Business Administration is not your business. Your business is veterans. Have you made an effort to take on folks at OMB or others at the White House for a higher level of funding for veterans' health care?

Mr. MANSFIELD. We are approaching that time in the cycle when it will happen.

Senator ROCKEFELLER. No, the time in the cycle when it should happen is when the budget is submitted.

Mr. MANSFIELD. Well, we are in the process of going through that cycle right now.

Senator ROCKEFELLER. Are you going to do that?

Mr. MANSFIELD. Yes, sir, I will.

Senator ROCKEFELLER. Thank you.

Senator GRAHAM OF FLORIDA. After the budget hearings, which I believe were held in February, there were a number of questions that were submitted on specific aspects of the budget. I understand that as of today, we have not received the answers to those questions. Do you have an idea when we might do so?

Mr. MANSFIELD. Sir, I will check and get back to you as soon as possible with some definite times.

Senator GRAHAM OF FLORIDA. I recently chaired a hearing of this Committee held at Bay Pines in Florida. One of the major issues was the new computer system, the Core FLS System. There were substantial problems identified at that time in the basic architec-

ture of the system, the training that has been provided to the personnel who were going to be responsible for the system. There was also a request that there would be an assessment of this. I believe it was going to be done by Carnegie Mellon.

Could you tell us what the status of the Core FLS System is, what steps are being taken to deal with the problems that were identified and what is the recommendation of how to proceed, and when will we get this external evaluation?

Mr. MANSFIELD. Sir, the Core FLS System is supposed to be designed to handle our requirements in accounting, finance, logistics and covers all parts of the VA, so the implementation was partially with NCA, the Cemetery Administration, partly with VBA and partly with VHA.

The VHA part went into Bay Pines as the chosen site to test it. The Bay Pines site was not prepared in the sense that their operating inventory system would match up with the program that was accepted, and that is where the problem in the program came up. In addition to that, I would agree with you that the training that was designed was inadequate and was not carried out properly.

Right now, we are in the process of stabilizing and ensuring that the hospital operations at Bay Pines can go forward in a manner that the patient care is the first responsibility and taken care of, and that is happening to date. The group you mentioned is in the process of doing a review and will report to the Secretary.

We have also had the Inspector General doing a review, and I believe his report is due out within a couple of days or at least the draft report, which means we have to look at it and then make any comments we may have about what the draft report is, and that is the situation we are in, sir.

Senator GRAHAM OF FLORIDA. When do you expect the Carnegie Mellon evaluation to be available?

Mr. MANSFIELD. Sir, I am not sure if the final report is going to be available for less than 60 days, but I know that the IG report and also the House Appropriations Committee investigators have also been involved in it at the Chairman's direction, and I believe that their report will be in before that 60-day period. But the final report that the Secretary is going to be making his final decisions on would be the Carnegie Mellon report.

Senator GRAHAM OF FLORIDA. Well, as you probably know, the Chairman of the House Appropriations Committee, with Bay Pines inside his Congressional district, has indicated that if he does not get satisfaction, he is going to defund this Core FLS System. So I would suggest that there ought to be a sense of urgency to get the kinds of answers to the questions came up at the hearing that we held at Bay Pines, of which Congressman Young, based on his representation of the community in which Bay Pines is located, knows well.

Mr. MANSFIELD. I am aware of his interest and in touch with his office.

Senator GRAHAM OF FLORIDA. Senator Rockefeller, any further questions?

Senator ROCKEFELLER. No, sir.

Senator GRAHAM OF FLORIDA. Thank you very much.

Mr. MANSFIELD. Thank you, Mr. Chairman.

Senator GRAHAM OF FLORIDA. While they are coming forward, I would like to introduce the members of the third panel, representing veterans service organizations: Mr. Donald L. Mooney, the Assistant Director for Resource Development, Veterans Affairs and Rehabilitation Commission, the American Legion; Mr. Paul A. Hayden, Deputy Director, National Legislative Service, Veterans of Foreign Wars; Mr. Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans; Mr. Carl Blake, Associate Legislative Director of the Paralyzed Veterans of America; and Mr. Richard Jones, the National Legislative Director of AMVETS.

Thank you very much for your being here. If I could call on you in the order in which you were identified for an opening statement.

Mr. Mooney.

STATEMENT OF DONALD L. MOONEY, ASSISTANT DIRECTOR FOR RESOURCE DEVELOPMENT, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. MOONEY. Thank you, Senator Graham. Thank you for this opportunity to present the American Legion's views on the many bills being considered by the Committee today. In view of the time restrictions, I will limit my comments to the three bills we feel are most important. Our written testimony covering all of the bills has been submitted for the record.

S. 50, the Veterans Health Care Funding Guarantee Act of 2003, establishes, beginning in fiscal year 2006, a system of capitation-based funding for the Veterans Health Administration by combining the total enrolled veteran population with the number of non-veterans served by VHA then dividing that number into 120 percent of the fiscal year 2000 VHA budget.

The resulting baseline per capita amount is then adjusted for medical inflation annually and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for the VHA for the succeeding fiscal year.

Mr. Chairman, VHA is now struggling to meet demand and to maintain its national preeminence in the 21st Century with discretionary funding methods that were developed in the 19th Century. No other modern health care organization could be expected to survive under such a system. The American Legion believes that the time has come to fund VHA based on its capitated veteran enrollment and eliminate the uncertainty of discretionary funding. The American Legion is pleased to support S. 50.

S. 1014 amends 38 USC to require the Secretary of Veterans Affairs, in the management of health care services for veterans, to place certain low-income veterans in higher health care priority categories. This bill expands eligibility for inclusion of veterans in priority group to include those veterans whose incomes do not exceed 80 percent of the median income for the geographical area in which they reside.

Currently, this is the statutory definition of priority group 7. This bill essentially eliminates priority group 8 by raising priority group 7s to group 5 and redesignating priority group 8 as 7. The American Legion has no objection to this bill in concept. It is unclear to the American Legion, however, what effect this bill will

have on the former priority group 8 veterans without additional funding to pay for the new influx of enrollees it will create.

It is likely that the Secretary of Veterans Affairs may be again forced to suspend enrollment of former priority group 8 veterans, now priority group 7 under S. 1014.

The American Legion is concerned that this law could raise hopes of priority group 8 veterans now ineligible for enrollment, only to have a new barrier erected. This whipsaw effect is eroding the confidence of veterans in the VA health care system, and it should be avoided.

S. 2484, the Department of Veterans Affairs Health Care Personnel Enhancement Act, establishes a new system of compensation designed to recruit and retain highly qualified doctors and dentists within the VA health care system. The new pay system is benchmarked to represent salaries of non-VA positions, dentists and health care clinician executives by health care market and includes performance incentives.

The American Legion has long held the position that VA pay for doctors and dentists is woefully inadequate and has led to the exodus from VHA of scarce specialists such as gastroenterologists, ophthalmologists, anesthesiologists and radiologists to more lucrative private practice.

We believe the time has come for Congress to correct the situation and pay salaries that will attract qualified physicians and dentists to work in veterans' health care. The American Legion supports this bill. Under this bill, however, VA-employed physicians and dentists holding dual appointments with affiliated medical schools and dental schools may no longer receive compensation in any form from the affiliate, although waivers may be granted on a case-by-case basis.

This provision is worrisome to the American Legion. The VA medical school affiliation system has played an important role in bringing VHA to its position of excellence in health care. This provision will force dual appointees to choose loyalties and could negatively impact its highly successful symbiotic relationship and could conceivably cause research-oriented physicians to leave VA for their affiliates that generally pay more. The American Legion believes a way should be found to avoid this unintended consequence.

Mr. Chairman, that concludes my testimony. Thank you.

[The prepared statement of Mr. Mooney follows:]

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

Mr. Chairman and Members of the Committee: Thank you for this opportunity to present The American Legion's view on the many issues being considered by the Committee today. The American Legion commends the Committee for holding a hearing to discuss these important and timely issues.

S. 50—The Veterans Health Care Funding Guarantee Act of 2003

This bill establishes in fiscal year 2006, a system of capitation-based funding for the Veterans Health Administration (VHA). It combines the total enrolled veteran population with the number of non-veterans who received services from VHA, then divides that number into 120 percent of the fiscal year 2003 VHA budget. This baseline per-capita amount is then adjusted for medical inflation each year and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for VHA for each succeeding fiscal year. This system would provide all of VHA's funding, except funding of the State Veterans Homes Construction

Grant Program, which would be separately authorized. Annual funding would be without fiscal year limitation; any savings VHA realized in a fiscal year would be retained rather than returned to the Treasury. This would provide VHA with incentives to develop efficiencies and creating a pool of funds for enhanced services, needed capital improvements, expanded research and development and other purposes.

S. 50 also repeals Section 8104 of title 38, United States Code that currently requires Congressional approval of major medical facility construction in excess of $4 million. Instead, VA would be required to report any design and development costs over $500,000 for major medical facilities construction to the Senate and House Veterans' Affairs Committees, then wait thirty days before proceeding with a project. The American Legion is supportive of legislation that will create a reliable and consistent funding stream for veterans' health care programs, but believes that some level of congressional oversight of VA construction activities should remain.

S. 1014—A Bill to Amend Title 38, United States Code, to Require the Secretary of Veterans Affairs in the Management of Healthcare Services for Veterans to Place Certain Low-Income Veterans in a Higher Healthcare Priority Category

This bill expands eligibility for inclusion of veterans in Priority Group 5 to include those veterans whose incomes do not exceed 80 percent of the median income for the geographical area in which they reside. Currently, this is the statutory definition of Priority Group 7. This bill essentially eliminates Priority Group 8 by raising Priority Group 7 veterans to Priority Group 5 and re-designates Priority Group 8 as 7.

It is unclear to The American Legion what effect this bill will have on former Priority 8 veterans without additional funding to pay for the influx of enrollees it might create. It is likely that the Secretary of Veterans Affairs may again be forced to suspend enrollment of former Priority Group 8 veterans; now Priority Group 7 under S. 1014.

FY 2002 saw the growth of Priority Group 7 and 8 veterans seeking health care at local VA medical facilities. This unprecedented increase in enrollees into the VA health care system resulted in over 300,000 veterans being placed on waiting lists regardless of their assigned Priority Group. Fiscal year 2003 saw the suspension of enrollment of newly created Priority 8 veterans due to this unforeseen growth. The American Legion is concerned that this law could raise the hopes of Priority Group veterans now ineligible for enrollment in VA health care, only to have a new barrier erected.

As a Nation at war, The American Legion advocates for adequate VA funding in fiscal year 2005 to meet the increased health care needs of America's veterans.

S. 1153—The Veterans Prescription Drugs Assistance Act

S. 1153 amends title 38, United States Code, by adding Section 1710C. Veterans who have prescriptions from their private physicians would be able to obtain such drugs or medicines from the Department of Veterans Affairs (VA). Under this new provision, VA would fill the prescriptions of those veterans in receipt of special monthly compensation. Further, any Medicare-eligible veteran may elect to receive their prescription drugs and medicines from VA. However, those Medicare-eligible veterans, who make such an election, will not be eligible for VA medical care or services during the calendar year covered by the election, unless they have a compensable service-connected disability. They are also required to pay one or more of the following: an annual enrollment fee; a co-payments for each 30-day supply of medicine; or an amount equal to VA's cost for such medicines and drugs.

Title 38, USC, section 1712(d), currently provides that VA shall furnish drugs and medicines prescribed by a duly licensed physician to veterans who are in receipt of special monthly compensation or special monthly pension by reason of being housebound or in need of aid and attendance. Less seriously disabled veterans, receiving VA medical care on an outpatient basis, are provided drugs and medicines only when prescribed by a VA physician or health care provider. The majority of these veterans are in Priority Groups 7 and 8.

Priority Group 8 veterans, who are currently enrolled and elect the option proposed in section 1710C (b)(1), are not guaranteed that after 1 year, they will be accepted back into the system or have the ability to re-enroll. Without that assurance, they will be locked out of the system indefinitely.

There are currently 26 million veterans and 40 percent of them, or 10 million, are eligible for Medicare. If they all choose to get their prescriptions filled by VA, will the VA be able to handle the workload? VA enjoys an edge in buying pharmaceuticals and wields significant clout in the marketplace. That may end if their de-

mand becomes too high. If that happens, the reasonable prices afforded to veterans may be lost.

Due to quality and safety issues, The American Legion does not support VA filling outside prescriptions without the veteran being seen by a VA physician first. The American Legion believes that while this legislation may help to reduce the backlog, the carving out of individual benefits of veterans' health care programs should be avoided.

S. 1509—The Eric and Brian Simon Act of 2003

S. 1509 authorizes a gratuity of $100,000 to be paid to any veteran who becomes infected with Human Immunodeficiency Virus (HIV) or has Acquired Immune Deficiency Syndrome (AIDS) as a result of treatment of a service-connected condition. The gratuity is also paid to the spouse, former spouse and children who become HIV positive as a result of the veteran's infection and the gratuity may be paid to the survivors of a deceased veteran.

The American Legion has no objection to this legislation.

S. 1745—The Prisoner of War/Missing in Action National Memorial Act

This bill establishes a National Prisoner of War/Missing in Action Memorial in Riverside, California. The American Legion has no official position on this initiative but is appreciative of the Congress in recognizing the dedication and sacrifice of these servicemembers.

S. 2063—A Bill to Require the Secretary of Veterans Affairs to Carry Out a Demonstration Project on Priorities in the Scheduling of Appointments of Veterans for Healthcare Through the Department of Veterans Affairs, and for Other Purposes

S. 2063 directs the Veterans Health Administration (VHA) to carry out a 2-year demonstration project to assess the feasibility and advisability of priority medical appointment scheduling of veterans who are 50 percent or greater service-connected disabled or who require treatment of a service-connected condition.

The American Legion has no official opinion on this legislation; however, we object to VHA's ongoing characterization of this group of veterans as its "core population." In the fiscal year 2004 budget request, President Bush and Secretary of Veterans Affairs Principi clearly State their objective: "a continued focus on the health care needs of VA's core groups of veterans—those with service-connected disabilities, the indigent, and those with special needs." However, the term "core groups of veterans" does not appear in Title 38, United States Code. In testimony before the House Veterans' Affairs Committee on June 17, 2003, American Legion National Adjutant Robert W. Spanogle stated that there are no "core veterans"—a veteran is a veteran. The "traditional" veterans treated in VA medical facilities were any veteran needing medical care. In the 1980's, "budgetary constraints" created distinctions through means-testing; before then any veteran was welcomed in a VA medical facility.

It should be noted that VA recently published a final rule at 69 Fed. Reg. 34074, 34076 [June 18, 2004] in which 38 C.F.R. § 17.49 was amended to reflect the additional prioritization of veterans above and beyond that authorized by 38 U.S.C. § 1705.

S. 2099—A Bill to Amend Title 38, United States Code, to Provide Educational Assistance Under the Montgomery GI Bill for Members of the Selected Reserve Who Aggregate More Than 2 Years of Active Duty Service in any 5 Year Period, and for Other Purposes

S. 2099 amends title 38, United States Code, to provide entitlement to educational assistance under the Montgomery GI Bill for members of the Selected Reserve who aggregate more than 2 years of active duty service in any 5 year period. This legislation would help to ensure that educational benefits afforded members of the Selected Reserve are indeed parallel to the level of commitment of these dedicated troops.

S. 2099 is a positive first step in ensuring that benefits earned by members of the Selected Reserve reflect the sacrifices of these citizen soldiers. The American Legion fully supports the provisions contained in S. 2099 and we commend Senators Miller and DeWine for recognizing the need to update the educational benefits in Title 38 to adequately recognize the increased reliance on members of the Selected Reserve.

S. 2296—A Bill to Require the Secretary of Veterans Affairs to Give the Commonwealth of Kentucky the First Option on the Louisville Department of Veterans Affairs Medical Center, Kentucky, Upon its Conveyance, Lease or Other Disposal by the Department of Veterans Affairs

The decision of the Secretary of Veterans Affairs on the Capital Asset Realignment for Enhanced Services (CARES) program for VISN 9 includes a study of the feasibility, cost-effectiveness and impact of building a replacement, state-of-the-art VA Medical Center in Louisville, Kentucky. The current facility is over crowded and provides a "poor environment of care."

The American Legion has no position on this proposal; however, reiterates the position that no facility scheduled for closure or other disposal under CARES should be closed until adequate and appropriate replacement facilities are available to serve the affected veteran population.

S. 2327—A Bill to Amend Title 38, United States Code, to Clarify That Per Diem Payments Made by the Department of Veterans Affairs for the Care of Veterans in State Homes Shall Not be Used to Offset or Reduce Other Payments Made to Assist Veterans

S. 2327 amends title 38, United States Code, to clarify that per diem payments by VA for the care of veterans in State homes shall not be used to offset or reduce other payments made to assist veterans.

The American Legion currently does not have an official position on S. 2327. The Veterans Affairs and Rehabilitation Commission within the organization is reviewing the intent of the legislation. The American Legion has a long history of advocating on behalf of improved funding for State Veterans Homes and supports future efforts to ensure long term care is available to America's aging veterans population well into the new millennium.

In addition, The American Legion remains concerned of the exclusion of long term care services from the CARES analysis that could prove detrimental in VA's ability to meet the increasing demand for long term care.

S. 2417—A Bill to Amend Title 38, United States Code, to Authorize the Secretary of Veterans Affairs to Furnish Care for Newborn Children of Women Veterans Receiving Maternity Care, and for Other Purposes

This bill amends title 38, United States Code, to authorize VHA to provide up to 14 days of neonatal care to the newborns of female veterans who deliver children in VA facilities or in non-VA facilities under contract to VA.

The United States Armed Forces is currently comprised of 11 percent female servicemembers and this figure is expected to climb in the near future. This bill is one of many accommodations that VA is undertaking to meet the needs of female veterans. The American Legion has no objection to this legislation.

S. 2483—The Veterans' Compensation Cost-of-Living Adjustment Act of 2004

This bill authorizes the annual cost-of-living increases in the rates of Disability Compensation, Clothing Allowance and Dependency and Indemnity Compensation by the same amount as the cost-of-living increases under Social Security, as well as for the publication of these new rates.

The American Legion supports this annual legislation.

S. 2484—The Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004

Section 3—Improvement and Simplification of Pay Provisions for Physicians and Dentists

This provision establishes a new system of compensation designed to recruit and retain highly qualified doctors and dentists within the VA healthcare system. The new pay system is benchmarked to representative salaries of non-VA physicians, dentists and health care clinician-executives.

Three components comprise the new system. Base pay is a uniform pay band nationwide with a minimum (Chief Grade maximum, currently $100,897) and maximum (Executive Level V, currently $128,200) that is adjustable annually by the same percentage as the GS schedule. Market pay is a variable pay band that VHA facilities may offer to a prospective physician or dentist employee that allows the facility to be more competitive in the local marketplace by geographic location, specialty, assignment, qualifications and experience.

Market pay is based on published health care workforce employment and compensation data and may be adjusted by VA in response to health care labor trends. Performance pay is linked to the attainment of organizational and personal perform-

ance goals up to $10,000 per annum. In the case of Chiefs of Staff and other clinician-executives, performance pay up to 10 percent of the total benchmark pay is authorized. Base pay for the Undersecretary for Health (USH) is set at Executive Level III, currently $145,600. The USH is also eligible for market pay.

The American Legion has long held the position that VA pay for doctors and dentist has been woefully inadequate and has led to the loss of scarce specialists, such as gastroenterologists, ophthalmologists, anesthesiologists and radiologists, to private practice. The time has come for Congress to correct this situation and pay salaries that will attract qualified physicians and dentists to work in veterans' health care. The American Legion supports this bill.

Under this bill, VA-employed physicians and dentists holding dual appointments with affiliated medical and dental schools may no longer receive compensation, in any form, from the affiliate, although waivers may be granted on a case-by-case basis. This provision is worrisome to The American Legion. The VA/Medical School affiliations system has played an important role in bringing VHA to its position of excellence in health care. This provision will force dual appointees to choose loyalties and could negatively impact this highly successful symbiotic relationship. The American Legion believes a way should be found to avoid these unintended consequences.

Section 4—Alternate Work Schedules

This establishes a variety of new alternative work schedules to attract qualified nurses to work for VA. Flexible work schedules have long been used by the private healthcare sector to attract nursing personnel. This legislation will not only attract nurses who would have opted for other positions because of scheduling issues, but will provide Medical Center directors needed flexibility in staffing. The American Legion does not oppose this provision.

Section 5—Nurse Executive Pay

This provision authorizes special pay for nurse-executives (minimum $10,000, maximum $25,000) depending upon factors such as grade of the position, scope and complexity of the position, personal qualifications, characteristics of the health care facility. Given the critical shortage of nurses in VA, generally, it is imperative that talented nurse-executives be retained. The American Legion supports this provision of S. 2484.

S. 2485—The Department of Veterans Affairs Real Property and Facilities Management Act of 2004

Section 2—Authority to Use Project Funds to Construct or Relocate Surface Parking Incidental to a Construction or Non-Recurring Maintenance Project

This authorizes the use of construction or non-recurring maintenance funds to construct or relocate surface parking lots incidental to the projects. In its visits to numerous VA healthcare facilities, The American Legion notes that the current moratorium on new parking space has resulted in congestion and inconvenience to veterans, families and employees. In some instances, facilities have resorted to contracting valet parking services to address the short-term problem. The American Legion supports measures that will create greater ease of access to VHA facilities.

Section 3—Improvements of Enhanced-Use Lease Authorities

This provision allows the Undersecretaries for Health, Benefits and Memorial Affairs to propose business plans involving enhanced use lease (EUL) of VA real property and allow VA to use EULs to obtain other facilities, space or services. It requires public hearings be held and requires reports on proposed EULs to Congress and reduces the comment period from 90 to 45 days. S 2485 further removes the requirement for involvement in EULs by the General Services Administration (GSA).

Section 4—Disposal of Real Property of the Department of Veterans Affairs

Section 4 also removes GSA from the EUL process with regard to disposal of facilities and land, establishes the Capital Asset Fund into which proceeds from EULs are to be deposited and makes an initial deposit of $10,000,000 to the fund in fiscal year 2005.

Section 5—Modification of Other Real Property Disposal Authorities

This redefines the parameters and processes required for VA to dispose of certain real property, including justification to Congress and the requirement that the net proceeds of disposal be deposited into the Capital Asset Fund.

Section 6—Termination of Nursing Home Revolving Fund

Repeals section 8116, title 38, United States Code and requires that any balance in the fund be deposited into the new Capital Asset Fund on date on enactment.

Section 7—Lease of Certain National Cemetery Administration (NCA) Property

This authorizes VA to engage in EULs of undeveloped land and underutilized buildings and establishes a National Cemetery Administration Facilities Operation Fund into which proceeds from EULs are to be deposited.

The American Legion has no position on this bill, but given the number of VHA properties slated for EUL under the CARES decision, this legislation streamlines the EUL process and establishes funds to ensure that proceeds from EULs remain within affected Administrations seems appropriate and timely.

Regarding the NCA EUL provision, The American Legion notes that NCA is in the midst of the largest expansion of the National Cemetery System since the Civil War and questions what undeveloped land owned by NCA is appropriate for EUL.

S. 2486—The Veterans' Benefits Improvement Act of 2004

S. 2486 amends title 38, United States Code, to improve and enhance education, housing, employment, medical and other benefits for veterans and to improve and extend certain authorities relating to the administration or benefits for veterans.

Title I—Educational Benefits

Increase in maximum amount of contribution for increased amount of basic educational assistance under the Montgomery GI Bill.

The American Legion does not support increasing the maximum amount of servicemember contribution for increased amount of basic educational assistance under the Montgomery GI Bill.

Pilot program on additional 2-year period for use of entitlement by participants in Montgomery GI Bill for vocational or job readiness training.

The American Legion supports providing an additional 2-year period for usage of GI Bill benefits for vocational or job readiness training.

Exclusion of veterans' educational benefits in determination of eligibility or amount of Federal educational grants or loans.

The American Legion supports the exemption of educational benefits under the GI Bill when determining eligibility for grant or loan assistance provided under title IV of the Higher Education Act of 1965.

Collection of contributions for educational assistance under the Montgomery GI Bill from Reservists called to active duty.

While The American Legion supports increased educational benefits for Reservists under the Montgomery GI Bill, that support has never included payment of $1200 by any veteran. The American Legion does not support requiring payment of $1200 by any active duty, Guard or Reserve member in order for receiving benefits under the Montgomery GI Bill.

Title II—Housing Benefits Increase in Maximum Amount of Housing Loan Guarantee

The American Legion fully supports increasing the maximum amount of housing loan guarantee currently provided to veterans.

The Montgomery GI Bill for the 21st Century Act

This draft bill amends title 38, United States Code, to extend and enhance benefits under the Montgomery GI Bill to improve housing benefits for veterans.

Section 2—Exclusion of Basic Pay Contributions for Participation in Basic Educational Assistance in Certain Computations on Student Financial Aid

The American Legion has long supported elimination of the current requirement that eligible servicemembers must contribute $1200 during their first year of enlistment in order to participate in the GI Bill benefit program. Veterans should not have to purchase this well deserved benefit.

Section 3—Opportunity for Enrollment in Basic Educational Assistance Program of Certain Individuals Who Participated or Were Eligible to Participate in Post-Vietnam Era Veterans Educational Assistance Program

While The American Legion does not have an official position on this provision, we do not oppose offering an enrollment opportunity for those veterans who are eligible to participate in post-Vietnam Era educational assistance programs.

Section 4—Commencement of 10-Year Delimiting Period for Veterans, Survivors and Dependents Who Enroll in Training Program

The American Legion fully supports a delimiting period for the use of educational benefits under the Montgomery GI Bill. The unique experiences of servicemembers often prevent them from utilizing educational benefits directly after discharge from active duty. Extending the delimiting period will help to ensure veterans can indeed take advantage of the educational benefits they have earned through their service.

Section 5—Availability of Education Benefits for Payment for National Admissions Exams and National Exams for Credit at Institutions of Higher Learning

The American Legion supports allowing eligible veterans to utilize their educational benefits, under the Montgomery GI Bill for payment of national admissions tests and national exams for credit at institutions of higher learning. In addition, The American Legion supports allowing veterans to use their educational benefits for payment of written or practical tests that may be required in the acquisition of a license, certification or credential that may be needed to obtain employment in a certain career field.

Mr. Chairman, that concludes my testimony. Again, I thank the Committee for this opportunity to appear. The American Legion looks forward to working with each of you on these important issues.

Senator GRAHAM OF FLORIDA. Thank you very much, Mr. Mooney.

Mr. Hayden.

STATEMENT OF PAUL A. HAYDEN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

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

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States and our ladies' auxiliary, I would like to thank you for the opportunity to testify at today's important hearing. It is especially fitting, as you mention, that today also marks the 60th anniversary of the day that President Roosevelt signed the GI Bill into law.

The legislation under consideration today spans a wide range of veterans' health care and benefits issues, and the VFW is pleased to offer its support to the majority of bills being considered today. Our full comments can be found in our written testimony. I would highlight our general support for S. 1153, given the current prescription drug situation within the VA.

The VFW supports the creation of an outpatient prescription benefit that would free up VA health care appointments and potentially reduce the backlog. In addition, we support providing an outpatient medication benefits to Medicare-eligible category 8 veterans who are currently precluded from enrolling in VA health care.

The VFW, however, does not support the language that requires veterans to forego 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 medical benefits package.

Turning to other veterans' benefits, the VFW fully supports S. 2486, the Veterans Benefits Improvement Act. We support all sections in Title I and II and are particularly pleased with Section 103, which would exclude veterans' educational benefits in determining the eligibility or amount of Federal education grants and loans.

A veteran's earned benefit, since the MGIB is paid for through service and sacrifice. Today's departing servicemembers deserve an equal opportunity to be considered for other forms of assistance to help them attain their dreams and goals.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions that you or Members of this Committee may have.

[The prepared statement of Mr. Hayden follows:]

PREPARED STATEMENT OF PAUL A. HAYDEN, DEPUTY 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 (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify at today's important hearing. The legislation under consideration today, spans a wide-range of issues pivotal to VFW and the entire veterans' community.

S. 50—Veterans Health Care Funding Guarantee Act of 2003

VFW strongly supports this legislation, which would dramatically and beneficially alter the way that veterans' health care is funded. For the first time, Congress would guarantee quality, timely, and accessible health care for our Nation's veterans.

Clearly, the current discretionary process fails veterans. Despite the record budget increases of the last several fiscal years, for which we are thankful, Department of Veterans Affairs (VA) funding continues to lag behind what is needed. Previous years of flat-lined budgets and increasing demand have created a significant gap between what VA needs and what Congress has been able to provide.

Another problem with the discretionary process is its irregularity. It has been several fiscal years since VA has had its budget on time. Instead, they have had to deal with flat-lined budgets at the start of every fiscal year, which adversely affects long-term and even short-term planning. The uncertainty of the process hampers VA's ability to effectively manage care for the millions of patients it treats. With a stalled budget resolution looming large again this year, it is likely that VA will not have its fiscal year 2005 budget on time either. They will continue to provide care on the already-insufficient amount of funding, while increased patient demand and the high costs of medical inflation erode this ability until Congress lives up to its full responsibility.

This growing mismatch between the demand for care and available funding has forced VA to ration health care through lengthy delays, reduced services, higher copayments, and, in some cases, veterans being turned away from hospitals completely. None of these are acceptable. Although VA has made substantial progress to reduce the appointment backlog from its all-time high of over 300,000 veterans, it is still unconscionable that there are any veterans who have to wait 6 months or more for a simple health care appointment. None of us in this room here would accept that, yet we expect those who have faithfully served this country to wait.

Enacting this legislation would go a long way toward providing the proper level of funding. For the first time, VA's resources would be based on the demand for care and the inflationary costs of providing health care. If more veterans choose VA as their health care provider, then VA receives more funding, lessening the need for health care rationing. Mandatory funding would assure that veterans receive the care they justly deserve and would eliminate diminished access as the primary method of cost control. I have attached a copy of VFW Resolution 610, which supports mandatory funding for veterans' health care.

S. 1014—To Amend Title 38, United States Code, to Require the Secretary of Veterans Affairs in the Management of Health Care Services for Veterans to Place Certain Low-Income Veterans in a Higher Health-care Priority Category

VFW supports this bill, which would place veterans who are currently in category 7 into enrollment priority category 5. This legislation recognizes that those currently in category 7 are some of the veterans who most depend on VA. They frequently are the poorest veterans and those who can least afford health care outside the VA system.

It gives these veterans better priority access to the system. Additionally, it frees them up from having to pay co-payments and other fees related to the health care they earned through their service to this Nation.

Our Nation has an obligation to care for those who most need our assistance. This legislation recognizes this obligation and provides a meaningful solution to the problems these veterans face.

S. 1153—Veterans Prescription Drugs 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 General Accounting 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 Medical Benefits Package.

S. 1509—The Eric and Brian Simon Act of 2003

VFW is appreciative of the intent of this legislation, which would award a $100,000 gratuity to veterans who contracted HIV or AIDS as a result of blood

transfusions, organ transplants, or other service-connected conditions. We cannot, however, support this legislation.

Although their condition is a tragedy and they have to suffer due to no fault of their own, their condition is not significantly different than many other diseases, illnesses or injuries that other veterans survive. Awarding them additional compensation would not be fair to other service-connected veterans, who also suffer due to no fault of their own. All disabled veterans have given a piece of their lives to this country. The sacred compact of disability compensation is intended to lessen the impact of that burden and to help make them whole. Those afflicted with HIV or AIDS are already entitled to the same treatments and compensations that any other service-connected veterans are. Providing a special gratuity to one category of veterans, but not another, is not equitable.

S. 1745—The Prisoner of War/Missing in Action National Memorial Act

VFW supports this legislation, which would designate a POW/MIA National Memorial at Riverside National Cemetery in Riverside, California. As a long-time advocate and leader in helping to locate the remains of members of our Armed Forces who are missing in action, we believe that a memorial to honor all former POWs and all those who remain unaccounted for is long overdue.

VFW's Department of California and many of the local VFW Posts in Southern California have been instrumental in helping to raise funds to build the memorial. It is only fitting and proper that a national memorial is dedicated to the bravery of those members who have sacrificed and served our Nation honorably—some never to return home.

S. 2063—To Require the Secretary of Veterans Affairs to Carry Out a Demonstration Project on Priorities in the Scheduling of Appointments of Veterans for Health Care Through the Department of Veterans Affairs, and for Other Purposes

VFW supports this legislation, which would create a demonstration project in three Veterans Integrated Service Networks to improve the scheduling of appointments for veterans in VA facilities.

The aim of the bills it to meet VA's 30–30–20 goals, which we strongly support. First, veterans must receive primary care and specialty care appointments within 30 days of scheduling and they must be seen by their health care provider within 20 minutes of the scheduled appointment. It remains just a goal as VA has had difficulty implementing it system-wide.

Although VA no longer has over 300,000 veterans waiting over 6 months for health care appointments, there are still nearly 10,000 veterans on that waiting list—a number that is still unacceptably high.

The demonstration project this bill would create would give VA the opportunity to try new business practices and to attempt unique solutions to one of VA's largest problems. We hope that VA could take any successes of the demonstration project and apply them to the whole system, improving the ability of veterans to access their earned health care.

S. 2099—To Amend Title 38, United States Code, to Provide Entitlement to Educational Assistance Under the Montgomery GI Bill for Members of the Selected Reserve Who Aggregate More than 2 Years of Active Duty Service in any 5-Year Period, and for Other Purposes

VFW supports this legislation, which would greatly improve the Montgomery GI Bill (MGIB) benefits provided to reservists. There is a significant difference between what the MGIB pays for reservists versus what it pays to those on Active Duty ($282 and $985 per month respectively). Reservists, however, can qualify for increased benefits if they complete 2 consecutive years on Active Duty.

With the recent deployment of so many Reservists around the world in the war on terrorism, significant numbers of them are accumulating time on Active Duty, but are falling just short of the 2 consecutive years required for improved benefits. This legislation would extend these benefits to any Reservists who accumulate 2 non-consecutive years of service in any 5-year period. So, for example, one who goes overseas for two 18-month deployments separated by a year of inactive service would qualify for a higher MGIB rate.

While on active duty, they would accrue 1 month of Active Duty MGIB benefits for each month of active duty service. Additionally, they would accumulate 1 month of Active Duty benefit for every 4 months of inactive service during that 5-year period. The MGIB would be payable at the rate for less-than 3 years of Active Duty service.

We believe that this is a significant step toward recognizing the valuable contributions our Reservists make as part of the Total Force Concept.

S. 2133—To Name the Department of Veterans Affairs Medical Center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center

VFW supports this bill, which would name the Bronx VA Medical Center after James J. Peters, former Executive Director of Eastern Paralyzed Veterans of America and a long-time advocate for those with spinal cord injuries.

S. 2296—To Require the Secretary of Veterans Affairs to Give the Commonwealth of Kentucky the First Option on the Louisville Department of Veterans Affairs Medical Center, Kentucky, Upon its Conveyance, Lease, or Other Disposal by the Department of Veterans Affairs

VFW would not oppose this bill, which would give the State of Kentucky the first chance to purchase or lease the Louisville Medical Center if VA decides to dispose or lease it out.

S. 2327—To Amend Title 38, United States Code, to Clarify that Per Diem Payments by the Department of Veterans Affairs for the Care of Veterans in State Homes Shall Not be Used to Offset or Reduce Other Payments made to Assist Veterans

VFW is pleased to support this bill, which would ensure that VA per diem payments that are made to State Veterans' Homes for the care of patients cannot count against any other form of payments made to those veterans.

Enacting this legislation would ensure that these veterans, who are relying on States for their long-term care, receive the full amounts of payments given to them, and by extension, States would be required to provide the full amounts to the homes. This would mean more money for the homes and better care for the veterans.

VA has a statutory obligation to provide long-term care for certain veterans residing in State homes. To do their job effectively, State homes need every resource they are due. This bill sees that these State homes receive the funding to which they are entitled.

S. 2417—To Amend Title 38, United States Code, to Authorize the Secretary of Veterans Affairs to Furnish Care for Newborn Children of Women Veterans Receiving Maternity Care

VFW supports this bill, which would allow VA to provide health care coverage to the children of women veterans for up to 14 days after the child's delivery. 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.

S. 2483—The Veterans Compensation Cost-of-Living Adjustment Act

We are pleased to support this legislation, which would increase the rates of compensation for veterans with service-connected disabilities, and the rates of dependency and indemnity compensation paid to the survivors of certain disabled veterans. This bill provides that the rate of increase paid by the VA shall be equal to percentage rates payable under Title II of the Social Security Act.

This legislation greatly benefits those who are least able to adjust their incomes to keep pace with inflation and is vital to many of whom have limited or fixed incomes.

S. 2484—The Department of Veterans Affairs Health Care Personnel Enhancement Act

This legislation reforms pay and work schedules for VA physicians, dentists, nurses, and other health-care personnel. For doctors and dentists, it reforms the pay system staring with a new base and adds market-based and incentive pays to that. Additionally, it reforms some pays for nurses and creates several programs to increase their job-schedule flexibility.

While we will not comment on the specifics of the bill, we do support it in that we believe that these proposals would improve recruitment and retention for VA's

health care workers. We must strive to ensure that VA maintains the high level of quality service and care veterans have grown to expect.

S. 2485—The Department of Veterans Affairs Real Property and Facilities Management Improvement Act

VFW offers our support for this legislation, which would make changes to the way VA manages and disposes of its properties.

In particular, we support the part of section 3 that allows the Under Secretaries of Benefits and Memorial Affairs to enter into enhance lease agreements.

Additionally, we support the creation of the Capital Asset Fund, a revolving fund that would collect the proceeds from the transfer, exchange, or conveyance of property. The funds can then be used to supplement VA construction funding, including the costs associated with the disposal and clean-up of sites.

The proposals of this bill would allow VA to reinvest funding back into its aging physical structures. CARES-related delays have severely hampered construction projects over the last few years and VA needs a significant funding boost. The revolving fund, as well as the management improvements contained in this bill would be a step in the right direction. They would not solve the funding dilemma, but they would bring us closer to a solution with the flexibilities this bill would provide to VA.

S. 2486—The Veterans Benefits Improvements Act

VFW supports this bill that will provide many additional benefits to veterans. We have reserved our comments to a few sections.

Title I—Education Benefits

We support all sections in Title I and are particularly pleased with Sec. 103, which would exclude veterans' education benefits in determining eligibility or amount of Federal educational grants and loans. A veteran's earned benefit, such as the MGIB, is paid for through service and sacrifice. Today's departing servicemembers deserve an equal opportunity to be considered for other forms of assistance to help them attain their dreams and goals.

Title II—Housing Benefits

We support Title II in its entirety and would like to comment on Section 201 and Section 204.

Section 201 would increase the maximum amount of the VA home loan guaranty from $60,000 to $83,425. As co-author of the Independent Budget, we have strongly advocated increasing this benefit as average housing costs have risen to amounts that make the maximum VA guaranty insufficient to allow veterans to use the VA home loan when purchasing a home. Today's veterans purchasing homes with a VA guaranteed mortgage are limited to a home costing a maximum of $240,000. The median price of a home in a metropolitan area today is close to $400,000, which would render the VA home loan useless in many housing markets today. This legislation will effectively expand this most important benefit.

Section 204 would repeal the loan fees collected from those servicemembers eligible to receive compensation as a result of a pre-discharge disability examination. VFW has long supported repealing all VA Home Loan fees, especially for those recently discharged young veterans entering the job market and purchasing a home for the first time. These individuals are most affected by the inequitable fees and can ill-afford such a large out of pocket expense to pay the funding fee.

S. 2522—To Amend Title 38, United States Code, to Increase the Maximum Amount of Home Loan Guaranty Available Under the Home Loan Guaranty Program

VFW is pleased to support this legislation that increases the maximum amount of VA's home loan guaranty. This bill goes a step beyond just increasing the amount of home loan guaranty by allowing for the maximum amount of the guarantee to be equal to 25 percent of the Federal Home Loan Mortgage Corporation's (Freddie Mac) conforming mortgage loan rate. As Freddie Mac rates rise, so will VA guaranty rates. We believe that this is a giant step forward in ensuring that this most important veterans' benefit keeps pace with the constantly rising costs of today's housing market.

S. 2524—To Improve the Provision of Health Care, Rehabilitation, and Related Services to Veterans Suffering From Trauma Relating to a Blast Injury

I am happy to offer VFW's support for this important legislation, which would improve treatment and care for veterans suffering from blast injuries by establishing new centers for research, education, and clinical activities on blast injuries.

The news is filled each night with images of the damage bombs and other explosive devices cause to our men and women in uniform. Sadly, many have paid the ultimate price. But a great many more have survived. Improvements in technology are helping those, who just a few years ago would have perished, to survive the blasts, but often at a cost of a limb or their hearing.

These veterans have special needs and no one can question the merits of their disability—they incurred it while on the front lines of the war on terrorism. It is up to us to live up to our obligation and to tend to their special needs and the unique challenges their disabilities present. VA really is at its best when it is tending to these special needs and creating new centers, specifically for the traumas of blast injuries is a worthy goal.

S. 2534—To Extend and Enhance Benefits Under the Montgomery GI Bill, and to Improve Housing Benefits for Veterans

VFW is pleased to support this bill, which improves MGIB and housing benefits for veterans.

Section 3 extends an additional opportunity of enrollment in the current MGIB for those Vietnam-era veterans who declined to enroll in the current program. It allows them one more chance to enroll and obtain the improved monetary benefits the MGIB provides.

We also support sections 4 and 5, which alter the period of use for certain training programs and allows the benefits to be used to pay for admissions-related tests.

While we appreciate the intent of section 2, which reduces the veterans' financial aid burden by $1,200, it does not fulfill our goal. We would prefer to see the complete elimination of the $1,200 buy-in. No other form of Federal student aid requires the recipient to pay for eligibility. The MGIB should be the same, particularly because those who are buying into the program are those who can least afford to give up a substantial portion of their income. I have attached VFW Resolution 632, which supports a repeal of the $1,200 contribution.

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

Senator GRAHAM OF FLORIDA. Thank you, Mr. Hayden.

Mr. Atizado, did I totally mess up your name?

[Laughter.]

Mr. ATIZADO. I have heard much worse, but thank you; I appreciate it.

Senator GRAHAM OF FLORIDA. Would you pronounce your name?

Mr. ATIZADO. Atizado.

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

Mr. ATIZADO. Thank you. As always, DAV is grateful for the opportunity to provide our views on legislation on today's agenda.

As we all know, access to comprehensive health care and specialized services that VA provides is essential for the health and wellbeing of many sick and disabled veterans. However, VA reports that it has now reached capacity at many of its health care facilities, and the cumulative effects of insufficient and delayed health care funding have now resulted in a rationing of medical care.

S. 2063 and S. 1014 both seek to address the issue of rationed care, and having a resolution from our membership to call on timely access to quality health care services, DAV supports S. 2063. We do believe that VA must identify and immediately correct the underlying problems that contribute to excessive long clinic waiting times, and while S. 1014 would shift veterans from one priority

group to another DAV is concerned that this measure would force VA to shift scarce resources for the care of one veteran to another, and in doing so, the priority treatment of one veteran would simply displace another.

It is no surprise that chronic under funding has forced VA to drive veterans away from the system. In fact, while budgeting for VA health care considers a co-payments provision as a cost saving measure to VA, this is due to increased revenues and fewer users. Shifting the cost of care onto the backs of sick and disabled veterans is fundamentally contrary to the spirit and principles which underlie the provision of benefits to veterans by a grateful Nation, and DAV has and will continue to oppose any co-payments provision of any bill which would affect sick and disabled veterans nationwide.

With consistent experience that funding veterans' medical care under the discretionary process has put veterans' medical care at risk, DAV believes in remedies to guarantee adequate and stable funding such as those offered under in S. 50. We do note that the former Under Secretary for Health testified that VHA must apply a 13 or 14 percent per year increase in money available to take care of just the core population of veterans.

Therefore, the current version of S. 50, DAV recommends the funding amount of fiscal year 2005 be equal to 130 percent of the amount allocated for fiscal year 2003 and that the formula utilize the Consumer Price Index for hospital and related services.

In closing, Mr. Chairman, there are many beneficial provisions included in the bills being considered today that DAV supports, which I have not mentioned for the sake of brevity. These provisions demonstrate the sincere efforts of Members and the staff of this Committee as well as other Senators who have introduced and co-sponsored some of these bills to improve veterans' programs.

We appreciate the strong support for our Nation's disabled veterans.

[The prepared statement of Mr. Atizado follows:]

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

Mr. Chairman and Members of the Committee: The agenda today includes a number of bills of importance to the more than 1 million members of the Disabled American Veterans (DAV). As always, we appreciate this Committee's efforts to improve benefits and services for disabled veterans, and we are grateful for the opportunity to provide our views on legislation affecting our members. With a few exceptions, the provisions of these bills are beneficial and justified.

S. 50—The Veterans Health Care Funding Guarantee Act of 2003

This bill would require the Treasury to make available to the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) for fiscal year 2005, 120 percent of the amount obligated during fiscal year 2002. Adjustments to the amount provided after fiscal year (FY) 2005 would be based on the number of enrolled veterans and other persons eligible but not enrolled who are provided care, multiplied by the per capita baseline amount for fiscal year 2003. In addition, the amount provided after fiscal year 2005 would be increased by the percentage increase in the Consumer Price Index.

Furthermore, this measure would repeal the provisions which prohibit the appropriation, obligation, or use of funds for any major medical facility project or lease unless specifically authorized by law. VA would no longer be required to submit to specified congressional Committees a prospectus of a proposed medical facility involving an expenditure of more than $4 million or facility lease with an average an-

nual rental of more than $600,000. Also, VA would not be required to give advanced notice to Congress of funds for a major medical facility project that would cause the total amount obligated to exceed the amount specified in the law for that project by more than 10 percent, and for any proposal of funds to be used for a purpose other than that for which such funds were appropriated.

The DAV commends this Committee for its strong advocacy for veterans in providing this forum for discourse on this extremely important matter. Around the world, servicemembers continue to defend the freedom we enjoy, some paying the ultimate sacrifice, others struggling with the scars of war. Now more than ever, with new sick and disabled veterans seeking care, it is vital that the crisis in the VA health care system be addressed. As this Committee is aware, we must fight an uphill battle year after year to get more realistic appropriations for VA, and that annual battle is getting ever more difficult in this era of limited discretionary dollars. To get funding to continue operation of their medical programs, veterans should not have to compete with all the many other interests who seek part of the limited allocation of discretionary money. Veterans and VA should not have to face the yearly uncertainty of whether there will be sufficient and timely funding provided to continue essential medical care services for disabled veterans. Veterans should not have to wait months to be treated for their illnesses. VA should not have to continue operating the largest medical care system in this country on the shoestring of annual appropriations and without any means to plan strategically for long-term efficiencies. Unfortunately, despite the President's Task Force to Improve Health Care Delivery to Our Nation's Veterans (PTF) findings of a significant mismatch between demand for VA services and available funding, it is the political will of Congress and the competing interests that determine how much funding veterans' medical care receives each year under the discretionary appropriations process.

With consistent experience that funding veterans' medical care under that process puts veterans' medical care at risk, the remedy is to guarantee adequate and stable funding through a permanent authorization that uses a reliable formula to project resource needs, such as that offered by S. 50. The Former Under Secretary for Health, Dr. Roswell, testified before the House Committee on Veterans' Affairs that VHA must apply a 13- or 14-percent per year increase in the money available to take care of just the core population of veterans. Therefore, DAV recommends the funding amount for fiscal year 2005 be equal to 130 percent of the amount obligated for fiscal year 2003, in the current bill. In addition, since VHA is a provider of health care services, we recommend that the formula utilize the Consumer Price Index for all Urban Consumers, United States City Average, Hospital and Related Services, Seasonally Adjusted. We believe such changes would allow VA to plan for and meet the growing needs of our Nation's sick and disabled veterans.

S. 1014

This bill would require VA to give priority, in the veterans' patient enrollment system for providing medical care services, to a veteran who is eligible for treatment as member of a low-income family under the United States Housing Act of 1937 for the area in which the veteran resides.

We commend the advocacy of this legislation for veterans who are forced to wait for unreasonably long periods to receive medical care and travel long distances to existing facilities operating under tremendous financial difficulty. However, DAV has concerns there may be some unintended consequences when shifting veterans in Priority Group 7 into Priority Group 5.

VA could be forced to shift scarce resources for the care of one veteran to another veteran in a different Priority Group. In doing so, the priority treatment of one veteran would simply displace another. DAV believes the crisis in the VA health care system is due to increased demand for medical services and rising costs for care combined with continued funding shortfalls. We believe adequate funding for VA health care would relieve the health care crisis and allow veterans to receive the high quality care they need in a timely manner.

S. 1153

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, S. 1153, 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 cir-

cumstances 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-payments 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. 1509

The Eric and Brian Simon Act of 2003, S. 1509, would direct VA to pay $100,000 to each veteran who contracted HIV from treatment for a service-connected disability, and $100,000 to the current and former spouse and each natural child who has contracted HIV from such veteran.

Testimony delivered by Eric Simon and his father before this Committee on March 9, 2004 clearly depicts the nature of the tragic and life-altering effects of HIV on veterans and their dependents, especially those innocently infected. DAV does not have a resolution on this issue; however, we commend this Committee for introducing this bill to assist veterans and their dependents suffering from HIV by alleviating the economic effects of this terrible disease.

S. 1745

The Prisoner of War/Missing in Action National Memorial Act, S. 1745, would designate the memorial in honor of POW/MIA veterans at Riverside National Cemetery in Riverside, California, as a national memorial. The DAV has no resolution concerning this issue; however, we would not oppose the enactment of this bill because it commemorates the extreme sacrifices POW/MIA veterans have made on behalf of our Nation.

S. 2063

To address the issue of timely access to high quality medical care, this measure would require VA to carry out a 2-year demonstration project to assess the feasibility and advisability of providing for priorities and scheduling appointments according to the VHA goal of 30–30–20, and VHA directives 2002–059 and 2003–062. VA would select three VISNs, representing an urban, rural, and highly rural area. The priority of the project is to schedule each appointment at a VA facility. VA would also be required to submit an annual report to the House and Senate Committees on Veterans' Affairs on waiting times for health care appointments.

We believe VA must identify and immediately correct the underlying problems that contribute to excessively long clinic waiting times for primary and specialty care for veterans nationwide. VA surveys show that the organization has fallen far short of the expected progression toward its "30–30–20" timeliness goals and has failed to provide equal access to primary and specialty care for its enrolled veteran population. DAV has a resolution calling for timely access to quality health care and medical services; therefore, we support this bill and urge favorable consideration by the Committee.

S. 2099

This measure would make a member of the Selected Reserve who serves on active duty for an aggregate of not less than 2 years during any 5-year period on or after September 11, 2001, eligible for basic educational assistance under the Montgomery GI Bill. In addition, VA would be required to inform members of the Selected Reserve, who are or may become entitled to basic educational assistance benefits, of their eligibility. The DAV has no mandate from its members; however, this bill appears beneficial and we would not oppose favorable consideration by this Committee.

S. 2133

This bill would rename the Department of Veterans Affairs medical center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center. The DAV has no resolution on this issue, but we do not oppose its enactment.

S. 2296

This bill would require VA to give the Commonwealth of Kentucky the first option on the Louisville Department of Veterans Affairs Medical Center upon its conveyance, lease or other disposal by the Department of Veterans Affairs. DAV does not have a resolution on this issue; however, we are concerned this measure may have a negative impact on the implementation of the Capital Assets Realignment for Enhanced Services (CARES) process. This measure circumvents CARES as a national initiative and does not ensure fair market value or guard against diminished returns to enhance services to sick and disabled veterans.

S. 2327

The VA State Veterans Home Program has proven to be a cost-effective provider of quality care services to the Nation's veterans who require domiciliary, nursing home, and hospital care. However, the current interpretation by the Centers for Medicare and Medicaid Services (CMS) treats VA per diem payments as third-party payments, and thus requires that the entire amount be offset against Medicaid payments. S. 2327 would clarify the treatment of the VA per diem payments made to State Veterans Homes and restore the benefit that residents of State Veterans Homes receive. The DAV does not have a resolution on this issue; however, we are pleased this Committee recognizes the need to ensure the viability of the VA State Veterans Home Program, and we would not oppose favorable consideration.

S. 2417

This legislation would allow VA to provide care, for up to 14 days after birth, to a newborn child of a woman veteran who is receiving maternity care furnished by the VA. DAV does not have a resolution on this matter, but would not oppose this measure.

S. 2483

As the short title of S. 2483 indicates, the Veterans' Compensation Cost-of-Living Adjustment Act of 2004 would increase the rates of disability compensation, dependency and indemnity compensation, and the clothing allowance by the percentage of annual increase in the cost of living, with rounding down of the adjusted rates to the next lower whole-dollar amount. These increases would be effective December 1, 2004.

Congress must adjust these benefit rates regularly to avoid the decrease in their value that would otherwise occur by reason of rising costs of goods and services. The DAV supports this bill. However, we continue to oppose rounding down of compensation increases.

S. 2484

The Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003, S. 2484, would revise VA physician and dentist pay provisions. VA would also be authorized to provide alternative work schedules and, upon completion of a specified alternative work schedule, would allow overtime pay for additional hours of work above and beyond the alternative work schedule.

DAV has a resolution on competitive salary and pay levels for VA physicians, pharmacists, dentists, and nurses; however, we have some concern that the current version of the bill would not provide VA the level of competitiveness needed for effective recruitment and retention. We believe this is a good first step for further discussion on VA's ability to recruit and retain an adequate number of qualified health care providers.

S. 2485

Currently, the time-consuming and cumbersome process to implement VA's authority for enhanced used lease of a property dissuades any interested parties to enter into any such agreement with VA. The Department of Veterans Affairs Real Property and Facilities Management Improvement Act of 2004, S. 2485, would improve VA's authority of enhanced used lease and disposal of real property. This bill would also eliminate VA's nursing home revolving fund and establish the capital assets fund. Any unobligated balances from the nursing home revolving fund, as well

as proceeds from the disposal of real property by transfer, exchange, or conveyance would be deposited into the capital assets fund.

While this bill seeks to streamline the process of enhanced use lease, it does not specify the uses for this fund. Without specification, such funds may be utilized to offset VA appropriations, much like how the estimated amount that VA might collect from veterans and their third-party insurers has been used to offset appropriations.

Furthermore, the pursuit of additional revenue sources through a streamlined enhanced use lease process may minimize other real property issues. Faced with scarce funding and competing patient care demands, VA management has delayed the protection and preservation of VA's historic structures for decades and has ignored its legal and moral responsibility to develop a comprehensive national program for its historic properties. Like all other real property administered by the Secretary, VA and Congress must ensure receipt of fair market value and not dispose such properties for the sake of getting rid of them.

S. 2486

Section 101 of Title I of the Veterans' Benefits Improvements Act of 2004, would allow eligible servicemembers to provide additional contributions to increase the aggregate education assistance allowance of the Montgomery GI Bill (MGIB). Section 102 of this bill would authorize VA to carry out a 4-year pilot project in which veterans would be entitled to an additional 2-year period after the expiration of the 10-year eligibility period to use MGIB education benefits. Section 103 would prohibit veterans' education benefits from being considered when determining a veteran's entitlement to Federal financial aid. Section 104 would allow members of the Selected Reserve to contribute the full amount for eligibility of MGIB benefits at any time after having served 2 consecutive years of active military service.

In its current form, the MGIB is inadequate because it has not kept pace with the significant increases in the costs of higher education. Although the DAV has no mandate from its membership on this issue, we believe these provisions have beneficial purposes and we do not oppose its enactment.

Section 201 of Title II of this bill would increase the maximum amount available to a veteran through the VA home loan guarantee from $60,000 to $83,425. The Congressional Research Service Reports show that since the program's inception, the VA has guaranteed approximately $708 billion in loans for the purchase or refinance of more than 16.6 million homes. To remain successful, the amount of guarantee must keep pace with the rising cost of homes. The Independent Budget (IB) for fiscal year 2005, which is a document co-authored by the DAV, the Veterans of Foreign Wars, Paralyzed Veterans of America, and AMVETS (American Veterans), recommended raising the home loan guaranty maximum amount. We are pleased that the Committee recognizes the need for a significant increase. In accordance with the recommendation of the IB, the DAV supports this provision.

Sections 202 and 203 would make permanent the authority for VA to guarantee adjustable rate mortgages (ARMs) and hybrid ARMs. Section 204 would allow VA to waive funding fees to active-duty servicemembers who are eligible to receive compensation resulting from a pre-discharge rating examination. DAV has no mandate on these issues and has no objection to these provisions.

Section 301 would extend administrative and judicial redress to all veterans who are eligible for Federal job preferences but who were denied the opportunity to compete for Federal employment. The DAV has no mandate on these issues, but we do not oppose this section of the bill.

DAV fully supports Section 311 of this legislation, which would prohibit the collection of co-payments from veterans receiving hospice care furnished by VA. DAV's resolution calls for the repeal of all co-payments for veterans' medical services and prescriptions. We commend this Committee for recognizing the 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.

Section 321 would extend to 2009 the authority for a biennial report by the VA Advisory Committee on Former Prisoners of War for setting forth recommendations for improvements in VA benefits afforded to former prisoners of war. In addition, the reporting requirement for the VA Special Medical Advisory Group would be extended to December 31, 2009. Although the DAV has no mandate from its membership on these issues, we believe these provisions have beneficial purposes and should be reported by the Committee.

The DAV believes women have always provided meaningful contributions to our armed services over the course of our Nation's history, most recently exemplified in Afghanistan and further by the 33,000 women who served honorably in Southwest Asia performing combat and combat support functions. Currently, many women

seeking VA health care find services difficult to obtain or personnel unprepared to understand or deal with their specific needs. Section 321 would make permanent VA's authority to provide counseling and treatment services to those who suffered sexual trauma during military service. DAV has a resolution from its membership to seek enactment of legislation mandating the provision of VA health care services to eligible women veterans to the same degree and extent that services are provided to eligible male veterans, including counseling and/or psychological services incident to sexual trauma; therefore, we fully support this provision.

Section 331 would modify the definition of minority group for the purposes of membership in the VA Advisory Committee on Minority Veterans. The DAV has no mandate on this issue, but we do not oppose favorable consideration by this Committee.

S. 2524

This measure would establish at least one War-Related Blast Injury Center within VA, to improve the provision of health care, rehabilitation, and related services to veterans suffering from trauma relating to a blast injury. In addition, it would provide comprehensive and specialized rehabilitation programs, as well as targeted education and outreach programs and research initiatives. Although the DAV has no mandate from its membership on this issue, we believe this bill has beneficial purposes and should be reported by the Committee.

S. 2534

Section 2 of the Montgomery GI Bill for the 21st Century Act would exclude the basic pay contribution by a servicemember for MGIB education benefits by subtracting $1200 from the expected family contribution when determining a veteran's entitlement to student financial aid. Section 3 would provide for an opportunity for servicemembers who participated in or were eligible for the Veterans Educational Assistance Program (VEAP) to enroll in the MGIB education program. Section 4 would commence on the first day of the program of study the 10-year delimiting period for use of MGIB education benefits.

Section 5 would make national admissions exams such as the Scholastic Aptitude Test (SAT), Graduate Record Examination (GRE), Graduate Management Admission Test (GMAT) and Law School Admission Test (LSAT), and national exams for credit at institutions of higher education, such as the Advanced Placement exam covered by MGIB. Although the DAV has no mandate from its membership on these issues, we believe these provisions have beneficial purposes and we do not oppose its enactment.

Section 6 would index the maximum VA guarantee loan amount at 100 percent of the Freddie Mac conforming loan limit. The IB, in addition to recommended raising the home loan guaranty maximum amount, also recommended that Congress provide for an automatic annual indexing of the Fannie Mae-Freddie Mac loan ceiling thereafter. We are pleased that the Committee recognizes the need for a significant increase as considered in S. 2486, along with this annual indexing to ensure the program to remain successful. In accordance with the recommendation of the IB, the DAV supports this provision for favorable consideration by this Committee.

Closing

The many beneficial provisions included in these bills demonstrate the sincere efforts of Members and staff of this Committee, as well as other Senators who introduced and co-sponsored some of these bills, to improve veterans' programs. We appreciate this strong support for our Nation's disabled veterans.

Senator GRAHAM OF FLORIDA. Thank you.

Mr. Blake.

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

Mr. BLAKE. Senator Graham, PVA would like to thank the Committee for the opportunity to testify today on the proposed legislation. Since I am sure you are well aware of PVA's position on mandatory funding, and having submitted my full written statement for the record, I will limit my remarks to S. 2485 and S. 2133.

S. 2485 would improve the authority of the VA to manage and dispose of real property and facilities. As the VA begins the manip-

ulation, sale or leasing of its infrastructure, great care must be taken to ensure that the value on equity in VA's physical property is not squandered. That equity does not belong to the VA or the Federal Government; it belongs to the veterans of the Nation for their future good.

We believe the legislation before the Committee does provide the VA with improved flexibility in leasing unused or underused properties. One major element in the legislation that I would like to address is the establishment of a capital assets fund to serve as the repository for the proceeds from the sale or lease of VA properties and then acting as the conduit of the reinvestment of those proceeds for the improvement of other VA facilities.

PVA strongly supports this provision which would allow the VA to keep the equity and the income from property it conveys, and, in the spirit of the CARES process, use those proceeds for the improvement of health care and benefit delivery for veterans.

We have two areas of caution, however. First, VA, with proper Congressional oversight, must ensure that it receives fair market value and appropriate leases for these properties. Second, Congress, in authorizing the Capital Assets Fund, must be very specific in defining what these funds can be used for. PVA has great concern, just as in the case of third party collections or any other alternative funding mechanism that VA uses that the capital assets fund might be looked at by OMB or the Congressional Budget and Appropriations Committees as an alternative to and not a supplement for regular VA health care.

We also do not want to see VA major and minor construction funding or nonrecurring maintenance budget line items offset by Capital Asset Fund disbursements either. PVA would also like to recommend that the Committee consider making historic preservation of VA structures a recipient of capital asset funding.

PVA is also pleased to support S. 2133, which would rename the VA Medical Center in the Bronx, New York as the James J. Peters Department of Veterans Affairs Medical Center. For over 30 years, Mr. Peters was a leader, a counselor and a visionary for PVA. Through his position as executive director of the Eastern Paralyzed Veterans Association, his focus was on the veterans of New York City Metropolitan Area and surrounding States. Yet his reach and achievements stretch nationwide.

The legacy of James J. Peters is one that can be measured in improved lives for tens of thousands of veterans with spinal cord injury and dysfunction and millions of other Americans with disabilities. There can be no more fitting tribute to Mr. Peters than to name the medical center after him, a medical center to which he tirelessly devoted himself.

Senator Graham, again, I would like to thank you for the opportunity to testify today, and I would be happy to answer any questions you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERCIA

Chairman Specter, Ranking Member Graham, Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the proposed legislation.

S. 50—The Veterans Health Care Funding Guarantee Act

PVA fully supports S. 50 which would remove veterans health care funding from the uncertainty of the "discretionary" budget process and make it "mandatory." Year after year, the Department of Veterans Affairs (VA) faces increasingly inadequate health-care budgets. This year was no exception as the President released his Budget Request for fiscal year 2005, a request that recommended a mere 1.2 percent increase over last year. PVA is committed to ensuring that VA health care is fully funded.

Over time, the true resource requirements for veterans' health care have not increased sufficiently to provide timely, quality care. In the past 5 fiscal years, VA appropriations have not been enacted prior to the start of the fiscal year on October 1st, and in the last 2 years, the VA health care system has had to operate under the already inadequate funding levels established for the prior year, fully one-third of the way through the new fiscal year. Because of inadequate resources, and the tardiness with which they have been provided, the VA health care system continues to struggle to meet the needs of sick and disabled veterans.

Mandatory funding would ensure funding for the VA based on the number of veterans seeking care from the system without subjecting it to current, often arbitrarily determined, discretionary budgets. It would not create an individual entitlement to health care, nor would it change the VA's mission. Mandatory funding is a comprehensive policy solution to the funding crisis faced by veterans and would keep our commitments to current, and future veterans.

S. 1014

S. 1014 would require the VA to place veterans in Priority Category 7 into new Priority 5(B). This would give Priority 7 veterans precedence over Priority 6 veterans. Priority 8 veterans would then become Priority 7 veterans due to renumbering of the categories. PVA has concerns with the provisions of S. 1014 that would shift these veterans. This represents a major change in the priority management structure for health care in the VA. Although the eligibility of these veterans is protected under the means test, they are still required to pay co-payments for services. We are sympathetic to the situation that they face.

However, PVA believes that there may be certain unforeseen consequences. First and foremost, the eligibility of veterans in other categories might be threatened, particularly veterans currently enrolled in Category 8. Furthermore, we are concerned that the VA may not be able to pay for this change while operating under the severely constrained budget that it does.

Of greater concern to PVA is the injustice to catastrophically disabled veterans, particularly PVA members, which this change would maintain. For eligibility purposes, catastrophically disabled veterans who are non-service connected are enrolled in Category 4, but they still must pay co-payments like other non-service connected veterans. PVA has testified in the past that these co-payments can become an enormous financial burden on veterans with severe disabilities due to the number and expense of prescription drugs and medical supplies that they must pay for out of their own pockets. Moving the Category 7 veterans to Category 5 to relieve the burden of co-payments does not address the unfairness of catastrophically disabled veterans continuing to make co-payments.

S. 1153—The Veterans Prescription Drug Assistance Act

PVA has expressed concerns in the past about the expansion of prescription drug benefits. We believe that any new prescription drug legislative proposals could 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 take on the role of the veterans' drug store. PVA fears that if we embark upon this path of only providing certain 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 provided 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 last year and a budget situation that can only be de-

scribed as critical, 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. 1509—The Eric and Brian Simon Act

This legislation would authorize the VA to provide a $100,000 gratuity to a veteran and his or her spouse or dependents who contract HIV or AIDS from blood transfusions related to a service-connected disability. PVA observed the moving statements provided by Douglas and Eric Simon during this Committee's hearing earlier this year. PVA has no objection to providing this benefit to families affected by this horrible disease.

S. 1745—The Prisoner of War/Missing in Action National Memorial Act

S. 1745, the "Prisoner of War/Missing in Action National Memorial Act," calls for the designation of a POW/MIA memorial located at the Riverside National Cemetery in Riverside, California. PVA has no objections to the proposed memorial. A memorial recognizing the extreme sacrifices and struggles of those held prisoner and those who have never returned home is a fitting tribute. As we have recommended in the past with respect to the authorization of national memorials, we urge the designers of this memorial to make every effort to ensure full accessibility for disabled veterans and citizens in the memorial design.

S. 2063

S. 2063 would require the VA to carry out a demonstration project on priorities in the scheduling of appointments for health care within the VA. PVA supports the standards that the VA established with VHA Directives 2002–059 (Priority for Outpatient Medical Services and Inpatient Hospital Care) and 2003–062 (Priority Scheduling for Outpatient Medical Services and Inpatient Hospital Care for Service Connected Veterans) and the 30–30–20 goal for waiting times for veterans. Timely access to care is indeed a critical concern of PVA. The number of veterans seeking health care from the VA in recent years has risen dramatically. Since 1995, the number of veterans enrolled in the VA has risen from approximately 2.9 million to more than 5 million. Despite the Secretary's decision to close enrollment of Category 8 veterans earlier this year, the numbers of enrolled veterans only continues to increase as we add new veterans from the war in Iraq and Afghanistan.

PVA opposes the provision of this legislation that allows the Secretary to contract out care to a non-Department medical facility. Veterans with specialized health care needs cannot receive the same level of care that VA specialized services provide. Likewise, contracting out to private providers will leave the VA with the difficult task of ensuring that veterans seeking treatment at non-VA facilities are receiving quality health care. PVA believes that contracting services to private facilities will set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the Federal Government to shift its responsibility of caring for the men and women who served.

PVA does support an annual report on waiting times and appointments for care and services within the VA. The information provided by this report could prove useful in determining where the VA is struggling to meet the demand of veterans seeking care and assist in developing solutions to overcome long waiting times.

S. 2099

PVA supports S. 2099, a bill which would allow members of the Selected Reserve who spend more than 2 years on active duty in any 5 year period to be entitled to Montgomery GI Bill (MGIB) benefits. This would apply to reservists called to duty after September 11, 2001. Since September 11, the National Guard and Reserves have spent lengthy periods of time on active duty. The sacrifices these individuals have made in defense of this country are no less important than those being made by our men and women on permanent active duty. It is only fair that Selected Reservists be allowed to use MGIB benefits that many of their counterparts who are on permanent active duty are eligible for.

S. 2296

S. 2296 would give the State of Kentucky the first option for conveyance, lease, or disposal of the VA medical center in Louisville, Kentucky. PVA has no position on this legislation. We would only urge the VA to ensure that it gets fair market value for the property and that disposal of the property is in the best interest of veterans and the VA.

S. 2327

PVA supports S. 2327 that would clarify that per diem payments by the VA for the care of veterans in State veterans' homes not be used to offset payments made from third parties to assist veterans. PVA understands that State homes are being pressured by Medicaid because they are receiving reimbursements from both the VA and Medicaid to care for veterans. This legislation would prevent Medicaid from denying payment to the State homes just because they are receiving funds from VA.

S. 2417

S. 2417 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 this legislation.

S. 2483—The Veterans' Compensation Cost-of-Living Adjustment Act

PVA supports S. 2483, a bill to increase the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for certain disabled veterans. We oppose again this year, as we have in the past, the provision rounding down to the nearest whole dollar compensation increases.

S. 2484—The Department of Veterans Affairs Personnel Enhancement Act

PVA believes that the subject of recruitment and retention of health care professionals deserves a hearing solely dedicated to that end. The VA health care system does not operate in a vacuum, and must be ever-cognizant of national health care trends and practices. Although the VA is part of our national health care effort, it must also compete with private and other public sector systems to ensure that veterans receive their health care from the most highly qualified and highly motivated health care professionals.

We look forward to seeing the revision that will be made to this version of the legislation, and look forward to exploring, along with this Committee, how best to recruit and retain health care professionals.

S. 2485

S. 2485 would improve the authority of the VA to manage and dispose of real property and facilities. As the VA begins the manipulation, sale or leasing of its infrastructure, facilitated in the legislation before the Committee today, great care must be taken to ensure that the value and equity in VA's physical property is not squandered. That equity does not belong to the VA or the Federal Government; it belongs to the veterans of the Nation for their future good. With any rearrangement of VA facilities great care should be taken to make certain the present as well as the future needs of veterans are fully accounted for.

With that caveat, we believe the legislation before the Committee does provide the VA with improved flexibility in leasing unused or underused properties. VA enhanced use lease authority is unique among other Federal departments and agencies. Unfortunately, however, the process has been called cumbersome and time consuming, discouraging VA administrators from wanting to expend the effort to use this route in dealing with property. Such a lengthy process also greatly discourages potential private sector entities from considering VA properties as a potential investment asset. This legislation authorizes the VA to further streamline the enhanced use leasing process to the benefit of both the VA and those in the private sector wishing to invest in VA properties.

The second major element in the legislation is the establishment of a Capital Assets Fund to serve as the repository for the proceeds from the sale or lease of VA properties and then acting as the conduit for the reinvestment of those proceeds for the improvement of other VA facilities. PVA strongly supports this provision which would allow VA to keep the equity and the income from property it conveys, and, in the spirit of the CARES process, use those proceeds for the improvement of health care and benefit delivery for veterans. We have two areas of caution, however. First, VA, with proper Congressional oversight, must ensure that it receives

fair market value and appropriate leases for these properties. Second, Congress, in authorizing the Capital Assets Fund must be very specific in defining what these funds can be used for. PVA has great concern, just as in the case of third party collections or any other alternative funding mechanism VA uses that the Capital Assets Fund might be looked upon by the Office of Management and Budget, Congressional Budget and Appropriations Committees as an alternative to, and not a supplement for regular funding for VA health care. We do not want to see VA major and minor construction funding or non recurring maintenance budget line items offset by Capital Asset Fund disbursements.

PVA would also like to recommend that the Committee consider making historic preservation of VA structures a recipient of Capital Asset Funding. The Independent Budget for fiscal year 2005 makes a very direct recommendation on the protection and preservation of VA's extensive inventory of historic structures. The CARES Commission report also recommended that the VA move to address this issue. VA owns almost 2,000 historic structures. Many are suffering from neglect and deteriorate further every year. VA has a moral responsibility to maintain these examples of the national legacy we share in caring for the American veteran. The Department is also bound by other Federal statutes requiring it to care for them as well. Other Federal departments and agencies have come to grips with this problem, finding alternative uses or divesting themselves of historic properties through leasing or sale. VA, if given the incentives, can do the same. The Capital Asset Fund is a logical source for renovation funding or stabilization for enhanced use leasing to help VA turn many of these structures from liabilities to assets.

S. 2486

S. 2486 would make improvements to many benefits programs administered by the VA, to include education, housing, employment, and medical. Title I of the proposed legislation addresses changes to VA education benefits. Section 101 would increase the maximum amount of MGIB benefits from $600 to $2000. PVA supports this provision as it will afford servicemembers better access to education opportunities. It also reflects the ever-increasing cost of advanced schooling. PVA also supports Section 102 which would authorize a pilot program to allow a veteran to use MGIB benefits for vocational or job readiness training for up to an additional 2 years beyond the delimiting date of the benefit. Vocational training gives veterans more options as they enter the civilian workforce.

Section 103 would exclude veterans' education benefits from the determination of eligibility for grants or aid provided by the Department of Education. Although some grants, such as Pell grants, already exclude VA education benefits, not all grants and education aid provide the same exclusion. PVA supports this section. PVA also supports section 104 of the legislation.

Title II of S. 2486 addresses improvements in the home loan program administered by VA. Section 201 would increase the maximum amount of the home loan guarantee from $240,000 to $333,700. This provision is in accordance with a proposal made by The Independent Budget to increase the maximum VA home loan guaranty amount. This would allow our servicemen and women who are returning from the conflicts in Iraq and Afghanistan and getting out of the military to have a fair opportunity to own a home. Too often, these men and women do not have a chance to obtain a home because of high real estate costs associated with the still booming housing market. PVA supports Section 202 and 203 which would make permanent the authority of the VA to guarantee adjustable rate mortgages (ARMS), and authorize the guarantee of hybrid adjustable rate mortgages. PVA also has no objections to Section 204.

PVA supports Section 301 of S. 2486 that would allow a veteran to file a complaint with the Secretary of Labor if his or her veterans' preference rights have been violated. PVA has worked with many of the veterans service organizations to ensure that veterans preference rights in Federal hiring are protected. We remain concerned that the Federal Government is not doing enough to recruit new veterans to the workforce. We are concerned that veterans often are hired for jobs that are not commensurate with the skills they have. PVA supports Section 311 which would prohibit the VA from collecting a co-payment from a veteran who is receiving hospice care. PVA has no objections to Section 321 or 331.

S. 2524

PVA supports S. 2524 which would improve health care, rehabilitation, and related services for veterans suffering from trauma relating to a blast injury. The VA will accomplish this by designating not less than one and not more than three centers for research, education, and clinical activities on blast injuries. Many of the young men and women who have been injured in Iraq suffer the effects of blasts

associated with improvised explosive devices being used by the enemy. These devices are causing severe trauma, both physically and mentally. The VA needs a facility that can properly care for these men and women as well as study methods to improve their care over time.

S. 2534—The Montgomery GI Bill for the 21st Century

PVA supports Section 2 of this legislation which would exclude basic pay contributions made to educational assistance programs for certain computations on student financial aid. Section 3 would open enrollment into the MGIB education program for 1 year for servicemembers who participated in or were eligible to participate in the post-Vietnam era educational assistance program, known as VEAP. PVA supports this provision. PVA also supports Section 4 which would allow the 10 year delimiting period for the use of education benefits to begin on the date that a veteran or his or her dependent begins the program of study. Currently, the 10 year period begins upon discharge from the service. Section 5 of the legislation could be very beneficial to young veterans who were unable to take these national admissions test upon graduation from high school or who could not afford to take the tests prior to military service. PVA fully supports this provision of S. 2534.

PVA supports Section 6 of S. 2524 which would increase the maximum home loan guaranty amount and index that amount annually based on the Freddie Mac conforming loan limit. As we stated with regard to Section 201 of S. 2486, we support any measure that will provide our servicemen and women a more fair opportunity to own a home. PVA, in accordance with the recommendations of The Independent Budget for fiscal year 2005, also agrees with the provision of this legislation that would allow the home loan guaranty amount to have an automatic annual adjustment. Much like many other benefit programs administered by the VA, the home loan guaranty has not been adequately adjusted to reflect the economic growth of this country.

S. 2133

S. 2133 would rename VA medical center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center. For over 30 years, Mr. Peters was a leader, a counselor, and a visionary for PVA. Through his position as Executive Director of the Eastern Paralyzed Veterans Association his focus was on the veterans of the New York City metropolitan area and surrounding States, yet his reach and achievements stretched nationwide. The legacy of James J. Peters is one that can be measured in improved lives for tens of thousands of veterans with spinal cord injury and dysfunction and millions of other Americans with disabilities. There can be no more fitting tribute to Mr. Peters than to name the medical center after him, a center to which he tirelessly devoted himself. PVA strongly supports S. 2133.

Senator GRAHAM OF FLORIDA. Thank you very much, sir.

Mr. Jones.

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. JONES. Mr. Chairman, it is a pleasure to present testimony on the legislative subjects of this hearing. Like those who have testified before, AMVETS supports S. 50, the Veterans Health Care Funding Guarantee Act. Mr. Chairman, one of the greatest Presidents in the Twentieth Century once said that it is commonsense to take a method and try it, and if it fails, frankly admit it and try another, but above all, try something.

President Franklin Delano Roosevelt's advice is a wise pathway and a ray of hope to veterans seeking access to VA health care. Too many sick and disabled veterans either cannot enroll in the current system or are waiting too long for care. The system is broken, and we need to try something new. We support the goal of S. 50.

Mr. Chairman, AMVETS supports the goal of S. 1153, the Veterans Prescription Drug Assistance Act. This legislation seeks to remedy a situation faced by older, banned priority 8 veterans. It would allow Medicare eligible veterans access to the VA system via

an outpatient medication benefit. A veteran who has been diagnosed and prescribed medication by a non-VA health provider could have his prescription filled by VA.

It would help those individuals, and additionally, it may induce some of those priority 8 veterans enrolled before the Secretary's cutoff date to return to their non-VA doctors, which would provide additional access and reduce VA patient backlogs.

S. 1509, which is the Gratuity for Veterans and Family Members with Service-Connected AIDS is a bill that we also support. The bill would right a wrong that has been committed and provide a level of assistance to people who have suffered because of no mistake and no fault of their own. This is a bill that has been known as the Brian and Eric Simons Act of 2003. It is named after the sons of Doug Simons, who received tainted blood during an operation at Fort Benning, Georgia, while serving in the Army National Guard.

These tragic victims of a Minnesota family have suffered a grief of an infection with this terrible AIDS disease and have watched their mother and their sister die. And they continue to give their father the care he requires to get through daily life. It seems clear to the members of AMVETS that Government agencies should be held accountable for the infection of these people and other veterans and their families in unfortunate, similar circumstances. They have a tragedy visited upon them through no fault of their own, and simply because of a blood supply that had not been kept safe, they suffer this painful experience. AMVETS supports this bill to bring compassionate assistance to hurting victims who have contracted this disease.

Mr. Chairman, the others are a matter of record in the written testimony. I thank you for the opportunity to testify.

[The prepared statement of Mr. Jones follows:]

PREPARED STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Chairman Specter, Ranking Member Graham, and Members of the Committee:

Thank you for the opportunity to present testimony to the Veterans' Affairs Committee on legislation subject to this legislative hearing. AMVETS is pleased to present our views regarding S. 50, the Veterans Health Care Guarantee Act; S. 1014, Healthcare Priority; S. 1153, Prescription drug bill; S. 1509 Gratuity for veterans and family members with service-connected AIDS; S. 1745 POW/MIA Memorial at Riverside National Cemetery; S. 2063, Priorities in scheduling appointments; S. 2099 Educational assistance boost for certain Reservists; S. 2296, State of Kentucky option to purchase VA property; S. 2327 Coordination of VA per diem and Medicare payments for care in State homes; S. 2417 VA provision of neo-natal care; S. 2483 Cost-of-living adjustment; S. 2484, VA physician pay; S. 2485 provisions related to VA property management; S. 2486 Miscellaneous education, home loan, and other benefits; S. 2524, on blast injury research and clinical care centers; S. 2534, relating to various education and home loan benefits program improvements.

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 60-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 argument. 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. 50—The Veterans Health Care Funding Guarantee Act

S. 50, introduced by Senator Johnson, would provide a comprehensive solution for VA's health care funding crisis. AMVETS fully supports moving VA health care from a discretionary account to a mandatory account funding method. Providing quality, timely healthcare services for sick and disabled veterans should be a top priority. Guaranteed funding would eliminate the year-to-year uncertainty about funding levels that have prevented VA from planning for and meeting the growing needs of veterans seeking care.

Mr. Chairman, one of our greatest Presidents once said, "It is common sense to take a method and try it. If it fails, admit it frankly and try another, but above all try something." President Franklin Delano Roosevelt's advice presents a wise pathway and a ray of hope to veterans seeking access to VA's healthcare system. AMVETS urges Congress to recognize that the current system of funding veterans health care is broken. It simply doesn't work. Too many sick and disabled veterans either cannot enroll in the system or wait too long for care.

AMVETS strongly supports the goal of S. 50 and firmly believes that once health care funding matches the actual average cost of care for veterans enrolled in the system, with annual indexing of inflation, VA can truly fulfill its mission.

S. 1014, a bill to amend Title 38, United States Code, to require the Secretary of Veterans Affairs in the management of health care services for veterans to place certain low-income veterans in a higher health-care priority category.

Introduced by Senator Corzine, S. 1014 would adjust the Veterans Equitable Resource Allocation to replace the national income thresholds for consideration in Priority 5 with regional thresholds that take account of differences in the cost of living across the country. The aim of this legislation is to improve the allocation of resources under VERA to ensure it better reflects the true costs of VA health care in various VISNs in the United States. AMVETS supports the goal of this bill.

S. 1153—The Veterans Prescription Drugs Assistance Act

As the Committee is all too aware, Secretary Principi took action on January 17, 2003, that banned healthcare access to an estimated 164,000 veterans who could have enrolled in 2004 and a similar number who could have enrolled this year, citing a lack of resources. Congress had allowed these so-called high-income veterans or "Priority 8s" into the VA system since 1996, but the funding to provide for them has never been adequately appropriated. 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 of veterans waiting for a doctor's appointment are waiting solely to have a prescription written and filled.

It is commonly noted that the majority of the Priority 8s entering the system have done so to access 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.

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.

Mr. Chairman, AMVETS supports the goal of this legislation. S. 1153 seeks to remedy the situation faced by older "banned" Priority 8s. It would allow Medicare-

eligible veterans access to the VA system via an outpatient medication benefit. A veteran who has been diagnosed and prescribed medication by a non-VA healthcare provider could have his prescription filled by VA. The current VA prescription cost for enrolled patients is $7.00 per prescription for a 30-day supply. At this cost, many eligible veterans could see a substantial reduction in their medication expenses. Additionally, this benefit could induce some Priority 8 veterans, enrolled before the Secretary's cutoff date, to return to their non-VA healthcare providers and thereby reduce VA patient backlogs.

Further, though we understand the rational, AMVETS remains disappointed in the ban of Priority 8 veterans taken by the Secretary January 17, 2003. We understand the funding realities faced by the Secretary, and we know this Committee and its members have fought for adequate funding for VA. However, we must never forget who Priority 8 veterans are. They are those brave Americans who answer our Nation's call and with God's grace return from service whole and able to continue their lives without disabling injury or illness. They are the soldiers, sailors, airmen or marines who stand a post or walk a patrol somewhere in Iraq or elsewhere across the globe. As we speak, these warriors may be replacing a buddy who yesterday gave the ultimate sacrifice, but today these patriots are ready take their place, voluntarily, in defense of freedom and our way of life. The members of AMVETS believe these men and women, whose future income may exceed the $24,000-a-year "high-income" threshold, which serves to deny them future healthcare eligibility, should be able to seek care at VA if they have the need following their military service. And it is the least our Nation can do for those on whom America depends to defend her liberty.

S. 1509—Gratuity for Veterans and Family Members with Service-Connected AIDS

Senator Coleman's bill, S. 1509 would right a wrong that has been committed and provide a level of assistance to people who have suffered because of no mistake of their own. Something has to be done to assure compassionate payments to veterans or families of veterans who have contracted AIDS through poorly screened blood supplies used by military and VA healthcare facilities for transfusions.

This is the bill that has been known as the Brian and Eric Simon Act of 2003. It is named after the sons of Doug Simon who received tainted blood during an operation at Fort Benning, Georgia, while serving in the Army National Guard. These tragic victims of a Minnesota family that suffered the grief of an infection with this terrible disease have watched their mother and sister die and continue to give their father the care he requires to get through daily life.

It seems clear to the members of AMVETS that government agencies should be held accountable for the infection of these people and other veterans and their families in unfortunate similar circumstances. They have had a tragedy visited upon them through no fault of their own. Simply because a blood supply had not been kept safe, this family became a victim of a painful tragedy by the failure to properly screen donors and blood supplies. AMVETS supports this bill to bring compassionate assistance to hurting victims who have contracted this disease through no fault of their own.

S. 1745—A Bill to Designate a Prisoner of War/Missing in Action National Memorial at Riverside National Cemetery in Riverside, California

S. 1745, introduced by Senator Boxer, seeks to designate the memorial under construction at Riverside National Cemetery, Riverside, California, as the Prisoner of War/Missing in Action National Memorial. AMVETS supports this legislation as a fitting tribute and honor to America's former prisoners of war. It is our hope that such a designation would continue the work to ensure that future generations understand the courage of these men and women who sacrificed so much of their freedom in defense of the liberties we hold dear. AMVETS supports the bill.

S. 2063—A Bill to Establish a Demonstration Project on Priorities in Scheduling of Appointments

S. 2063, introduced by Senator Conrad, would help reduce the time veterans must wait for a VA doctor's appointment, particularly for veterans in need of specialty care.

While progress is being made to gain more timely care for veterans currently enrolled in the VA healthcare system, reports make clear that veterans waiting months for eye care, orthopedics, back surgery and related specialty care continue their uncertainty of receiving medical attention.

Moreover, the Secretary's decision to halt enrollment of certain veterans is another clear indicator that VA cannot meet its own standard for scheduling and appointment within 30 days.

S. 2063 would establish a 2-year pilot program in three Veterans Integrated Service Networks—a highly rural VISN, a rural VISN, and an urban VISN—to improve access for veterans seeking care. It would help determine how much such standards would cost in terms of resources and impact on other VA medical services.

In effect, the bill provides a valuable tool to use for reducing waiting times and responding to the healthcare needs of veterans. Moreover, it would provide vital information on the actual resource needs necessary to ensure veterans earned benefits are provided in a timely manner.

AMVETS supports this legislation to address the concerns of our members about veterans waiting for timely care from VA.

S. 2099—Increase in Educational Assistance Under the Montgomery GI Bill for Members of the Selected Reserve Who Aggregate More Than 2 Years Active Duty Service

S. 2099, introduced by Senator Miller, would authorize a person who serves more than 2 years active duty during any 5-year period to be eligible for the educational benefits made available under Title 38, Chapter 30, of the Montgomery GI Bill.

As currently designed the Montgomery GI Bill aims to benefit active duty service. There is, however, current provision to grant educational benefits to Selected Reserves who agree to serve on active duty for 2 years followed by 4 years in Selected Reserve status.

S. 2099 would change eligibility criteria to recognize the changing mission of Reservists from a strategic reserve built on a cold war construct to an operational reserve capable of joint and expeditionary missions.

AMVETS recognizes the crucial role Reserves now play in military operations. In the four decades of the cold war, Reserves faced only two Presidential activations—once during the 1948 Berlin airlift and once again for a limited call-up during the Vietnam War.

The upward spiral of mobilization and deployment since 1990 stands in stark contrast to the previous period. Reserves have participated in the Persian Gulf War, Bosnia, Kosovo, Afghanistan, Iraq and elsewhere around the globe. While some units have been called up more often than others, overall operations have dramatically transformed the Reserves as an essential part of combat operations.

AMVETS supports the bill and welcomes the help of the Senate Veterans Affairs Committee in efforts to move its consideration forward. The bill appropriately recognizes the mission shift in Reserve. Frankly, Mr. Chairman, AMVETS view is that the Nation should not skimp on benefits dearly earned by its citizen-soldiers as they go in harm's way to defend our freedom.

S. 2296—A Bill to Authorize Conveyance, Lease or Disposal of the Louisville VA Medical Center to the State of Kentucky

S. 2296, introduced by Senator Bunning, would allow the State of Kentucky first option regarding the purchase of the Louisville VA Medical Center. AMVETS main interest in the Kentucky CARES situation is speedy completion of a replacement hospital near the University of Louisville, which requires congressional approval of funding. We have no opposition to the timely disposition of the former hospital site.

S. 2327—A Bill to Clarify That VA Per Diem Payments for the Care of Veterans in State Homes Shall Not be Used to Offset or Reduce Other Payments Made to Assist Veterans

S. 2327, introduced by Senator Campbell, would ensure that VA payments to States would not be considered a liability of a third party and not otherwise be used to offset or reduce any other payment made to assist veterans. VA's per diem program, part of the Medical Care account, assists States in providing domiciliary and nursing home care for veterans through partial payment of per diem costs. VA reports that in fiscal year 2001 over 16,000 veterans on any given day were provided nursing home care in State veterans homes. The per diem program is an important program as it represents an effective way to deliver geriatric care, especially in rural areas. AMVETS supports Senator Campbell's bill as it safeguards against the potential of abuse and protects the interests of veterans who in many instances are vulnerable and dependent in many aspects of their daily lives. With OMB hungry for resources, this legislation is particularly timely, and we encourage its speedy passage.

S. 2483—The Veterans Compensation Cost-of-Living Adjustment Act of 2004

S. 2483, introduced by Chairman Specter, would provide a cost-of-living adjustment for veterans' benefits programs and help protect the veterans' benefit against the erosion effects of inflation. The principle programs affected by the adjustment would be compensation paid to disabled veterans, dependency and indemnity compensation payments made to surviving spouses, minor children and to other dependents of servicemembers who died in service or who died as a result of service-connected injuries or disabilities. AMVETS supports the adjustment. We would, however, encourage Congress to make the adjustment to totally disabled veterans more generous than the consumer-price-index as measured by the Department of Labor. We believe it is time the Nation recognizes that compensation to totally disabled veterans is too low. We need to be more generous to those who have given so much in their military service. And we believe there are a number of ways to make the adjustment within the current budget.

S. 1133, introduced by Chairman Specter, would provide a cost-of-living adjustment for veterans' benefits programs and help protect the veterans' benefit against the erosion effects of inflation. The principle programs affected by the adjustment would be compensation paid to disabled veterans, dependency and indemnity compensation payments made to surviving spouses, minor children and to other dependents of servicemembers who died in service or who died as a result of service-connected injuries or disabilities. AMVETS supports the adjustment and would encourage Congress to take one more step making the payment adjustment to totally disabled veterans more generous than the consumer-price-index as measured by the Department of Labor. It is time we recognize that the compensation to totally disabled is too low and there are a number of ways to make the adjustment within the current budget.

S. 2484—The Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003

S. 2484, introduced by Chairman Specter by request, would adjust pay provisions for doctors and dentists and better accommodate work schedules and pay for nurses within the VA healthcare system. AMVETS recognizes that the VHA is an efficient and cost-effective healthcare system. VHA makes no profit, pays no insurance premiums, and compensates its physicians, nurses and clinical staff less than private-sector healthcare systems. We also recognize that VHA must compete in the marketplace to attract high-caliber healthcare professionals to practice medicine and treat veterans seeking care at VA facilities. To attract the skilled workforce necessary to meet the needs of the system, the overall VA compensation package must be able to respond to the market. It must be flexible and ready to compete. Unfortunately the current compensation provisions have not been changed since 1991. At the same time, the system must be accountable in achieving quality and productivity. To recruit and retain quality staff, AMVETS supports the goal of this legislation.

S. 2486—A Bill to Improve and Enhance Education, Housing, Employment, Medical, and Other Benefits for Veterans to Improve and Extend Certain Authorities Relating to the Administration of Benefits for Veterans

S. 2486, introduced by Chairman Specter and Sen. Murkowski, would improve and update a number of VA education and housing programs. Section 101 would enhance the current "buy up" program that boosts the monthly Montgomery GI Bill benefit when the servicemember voluntarily contributes up to $600 in addition to the $1,200 made to secure MGIB benefits. This provision would allow the servicemember to contribute up to $2,000 to secure up to $500 per month over the period of educational entitlement. While AMVETS believes the original GI Bill should serve as a template for the veterans educational benefit, we believe this proposal would be helpful.

Section 102 of this bill would extend the eligibility period for use of the MGIB benefits, which now is 10-years following discharge. With the rapid change in the skill needs of America's workforce, AMVETS supports this provision. We believe, as the Chairman's statement says, "Providing veterans with some flexibility in the use of a benefit they have earned is a sensible approach to helping veterans obtain the skills they may need to stay competitive in a 21st century workforce."

Section 103 would change eligibility rules for a veteran's entitlement to Federal financial aid administered by the Department of Education. It would exclude from consideration MGIB benefits for forms of assistance such as unsubsidized Stafford loans and campus-based aid. AMVETS supports this provision.

Section 104 would improve the flexibility of MGIB benefits provided Reservists. Currently Reservists are eligible for MGIB benefits if they contribute $100 a month

during their first 12 months of service and serve on active duty for 2 consecutive years. Of course, this is a difficult situation for a Reservist who has no idea at the start of Reserve duty whether a 2-year consecutive service will be required. This provision would allow the Reservist to pay $1,200 at some later point in service when eligibility is established. AMVETS supports this provision.

Section 201 would increase the maximum amount of housing loan guarantee to $83,425 from $60,000. This change in guarantee will increase no-down payment VA guaranteed home loan limits from $240,000 to $333,700. Under the current formula, VA guarantees 25 percent of the available loan up to the guarantee limit.

Housing prices in certain parts of the country prevent many veterans from buying a home without a down payment. The proposed increase in the guarantee would enable many veterans to purchase a home of their choice without a down payment, which would otherwise be unavailable to them. It is our understanding that related Federal mortgage associations, including Fannie Mae, have established similar increases in their guarantee and that this legislation provides parity with the conventional loan market. AMVETS fully supports this improvement.

Section 202 and 203 of this bill would expand the range of available adjustable rate mortgage options for home loans. The current pilot program for ARMs is successful, but limited. Since this current pilot expires on September 30, 2005, it is appropriate to review the program and enhance it. AMVETS supports the expansion of options for GI home loans.

Section 204 would allow VA to waive the home-loan funding fee for active duty servicemembers who are eligible to receive compensation as a result of a pre-discharge examination, but who are not yet been discharged. With VA making pre-discharge determinations in this regard, it is appropriate that the waiver be available in advance of discharge when discharge is imminent.

AMVETS supports the provisions of the Veterans' Benefits Improvement Act of 2004.

S. 2522—A Bill to Increase the Maximum Amount of VA Home Loan Guarantee Benefits

It is AMVETS understanding that S. 2522, introduced by Sen. Corzine, would adjust annually the amount of maximum home loan guarantee available to eligible veterans by indexing the increase of the VA guarantee to the Freddie Mac conforming loan limit. Housing prices in certain parts of the country prevent many veterans using a VA home loan guarantee from buying a home without a down payment. The proposed increase in the guarantee would enable many veterans to purchase a home of their choice without a down payment, which would otherwise be unavailable to them. Because the bill takes into account fluctuations in the housing market and would more readily adjust the housing benefit to the yearly real estate market, AMVETS supports this legislation.

S. 2524—To Address Blast Injury Research and Clinical Care Centers (BIRCCs)

S. 2524, introduced by Ranking Member Graham, would establish a VA war-related Blast Injury Center to study, research and treat veterans suffering from trauma related to blast injury. Blasts from roadside bombs and artillery result in injuries to lungs, inner ear, limbs and head are common combat injuries. Veterans returning from war often must deal with these types of blast related wounds. AMVETS supports efforts to intensify expert treatment that attends to soldiers facing a lifetime of dealing with battlefield wounds.

S. 2534—The G.I. Bill for the 21st Century

S. 2534, sponsored by Ranking Member Graham, would improve home-buying and education options for America's veterans. AMVETS supports this legislation. It would ensure the VA home loan guaranty benefit is kept up to pace by increasing the maximum home-loan limit to help veterans secure an adequate loan to meet today's housing market. In addition, the bill has several education enhancements that would change the MGIB benefits. We urge the Committee to give this matter every serious consideration. AMVETS supports the goal of this bill.

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.

Senator GRAHAM OF FLORIDA. Thank you very much, sir.

I would like to ask a question relative to the mandatory funding proposal. As I understand the formula that is currently being con-

sidered, it is mandatory funding to the Veterans Administration for the purposes of financing medical care. Most mandatory funding programs, including the one whose 60th anniversary we are recognizing today as well as programs like Social Security, which is an entitlement program, Medicare, an entitlement program, the funding goes directly to the eligible beneficiary, and then, the eligible beneficiary accesses or uses the funds as he or she determines.

Why would that not be the preferred method of mandatory funding, entitlement funding, for veterans' health care?

Mr. MOONEY. Senator, we would consider the entitled entity in this case to be all veterans enrolled, with a pooled entitlement. For better or worse, capitation is the standard way of funding health care in this country now. You take all of your enrollees; you add them up; you assign an amount of money to them, and you multiply that money by the number of enrollees, and that is your budget. It is up to the health care organization how best to utilize the money. The VERA formula would work—I believe would work well under a capitated system. But the entitled entity would be the VA.

Senator GRAHAM OF FLORIDA. I guess that is the way the legislation is currently written. I am trying to understand the philosophy behind the legislation. Let us take Medicare, which is a similar program. The beneficiary is not the 39 million Americans who are currently eligible for Medicare but rather each one of the individual 39 million.

I just would like some discussion as to the relative impacts on veterans of using a Medicare type system as opposed to a system which would provide a guaranteed block of money to the Veterans Administration, and then, it would be responsible for allocation.

Mr. BLAKE. Well, Senator Graham, one concern we have is you are kind of setting up a situation where the VA becomes more of an insurer of care, not necessarily a provider of care, and you eventually erode what the VA was established for in the first place.

The concern we have is giving each individual veteran this money to receive, to get their care through this sort of insurance process is that they begin to go out in the private sector. And we begin to have concerns that a veteran cannot receive the care that he would get from the VA from the private sector. This is especially true of members of PVA or of other veterans who have severe disabilities or blinded veterans; those with post-traumatic stress disorder, all of the specialized services.

These are services that these veterans will not be able to get at a private facility. It is just a fact. And they do not necessarily know that, and they would think that maybe their best alternative is to go to a local private facility, and that is not necessarily in their best interest.

So our concern would be that over time, you would erode what the original intent of the VA was, and that was to provide care to sick and disabled veterans, and as it is set up now, to all veterans who are eligible. And this, by changing that system into an insurer, ultimately, you could see the downfall of the VA health care system as it is established currently.

Senator GRAHAM OF FLORIDA. If you provided that this entitlement could only be accessed at a VA hospital, that is, you could not

use it in the general health care community, would that make you feel more comfortable about having an individual entitlement?

Mr. ATIZADO. Well, Senator, the idea of having a pool of resources within VA for any disabled veteran to utilize at any time is probably a better stewardship of the taxpayers' money. It allows VA a wide range of flexibility as far as where to address demand where it arises. I believe that without that flexibility, having a veteran come in at any facility may produce—how should I say—undue strain on a particular area of VA's health care system.

Now, the idea of creating an individual entitlement has never been part of any iterations of any mandatory funding bills, specifically because the Secretary already has the ability to ensure that whichever veterans are enrolled into the health care system would receive care. Everybody is aware of the January 17, 2003, decision of not allowing priority group 8 veterans into the health care system, which only decries the fact that VA is under funded.

Now, if you were to actually fund VA for every single veteran, we are talking about 25 million veterans, and I do not believe that that would be the most effective way to provide our Nation's veterans with the care that they would receive and still answer to the grateful Nation that provides this service.

Senator GRAHAM OF FLORIDA. Any other comments on the issue of individual as opposed to group entitlement?

Before leaving that question, I am going to make a parochial statement, and I confess that in my State of Florida, we are one of the relatively few States where the veteran population is growing. And in addition to the permanent population growing, during times of the year such as the winter, we get large numbers of veterans who have their residence elsewhere but who come to a place like Bay Pines for veterans' medical services during the time that they are in Florida.

Would it not assure that the money that is allocated goes to the facility where service is being rendered if you had the money essentially follow the veteran?

Mr. JONES. Well, I agree with that premise, that the money should flow to where the veteran is seeking care, not where the veteran wants care but where the veteran needs care. With the circumstances you present, that is an example of a system that requires funding to maintain facilities to provide quality, timely care to the veterans in the residence catchment area.

If I have understood you correctly, more money should go to those systems that serve more veterans.

Senator GRAHAM OF FLORIDA. And is the best way to ensure that that happens not to have the money carried by the veteran, so if the veteran goes to hospital A, it gets the money, not hospital B, where he is not seeking services?

Mr. JONES. I think that the system can account for the influx and flow of veterans and can account for that in the distribution of the total available funding. I think that works fairly well.

Senator GRAHAM OF FLORIDA. Do you think that, in fact, has been the history of the VA? Have, for instance, there been——

Mr. JONES. No, it has not been, and it was in the early nineties where changes had to be made, and finally, we began to recognize the demographics of change, where veterans were moving to the

Southwest, to the South, and out of the Northeast, which, of course, presents problems as outlined earlier today by Senator Corzine and Senator Clinton with regard to Northeastern facilities.

Feels a little bit like a drama here today, Senator. You have chandeliers breaking, thunder outside.

Senator GRAHAM OF FLORIDA. I mean, there is an amusement area in Disney World that reminds me of things that have glasses that are tottering and thunder on the outside, but I do not think we are at Disney World.

Mr. JONES. No, sir.

Senator GRAHAM OF FLORIDA. That issue of individual versus group entitlement is an issue that I would like to pursue later, maybe when we have a hearing which I hope will be soon devoted exclusively to the issue of mandatory funding.

Let me ask about one other piece of legislation that we are considering here today, and that is the issue of the ability of a veteran who is receiving his primary care outside the VA system such as a person on Medicare with a local physician, but as of now, the Medicare program does not cover prescription drugs, and that is the one element of a comprehensive health care system that is not currently available to him at affordable prices.

What do you think about the proposition that a veteran who is receiving primary care from a physician who by all standards is a professional and properly licensed to provide that care and then have the VA fill the prescription drug scripts that are written for that individual?

Mr. HAYDEN. The VFW believes that veterans should be allowed to fill their private prescriptions at the VA.

Senator GRAHAM OF FLORIDA. You say they should or they should not?

Mr. HAYDEN. They should be allowed to fill their prescriptions there. And we base a lot of this—I am sure you have seen the GAO report that was produced, the duplication of services that goes on; they wait in line; they contribute to the backlog of appointment backlogs waiting to see the VA physical to basically get the same prescription prescribed to them.

So we think it would be a win-win situation for the veteran and the VA.

Senator GRAHAM OF FLORIDA. Any other comments on that?

Mr. JONES. Yes, sir, for a period of time, AMVETS felt that it was important that VA not become a drug store. We felt that providing access to non-VA-doctor prescribed medications would diminish the amount of available funding for critical medical care needs. However, it is our understanding that in fiscal year 2004, over $600 million was carried over of unspent medical care funding from fiscal year 1903. And it is projected into fiscal 1905 from fiscal 1904 that some $800 million will be carried over of unspent funding.

Funding is available presently to ensure that all veterans who are currently banned—and that is 164,000 veterans a year who are not allowed even access to VA would be able to have their prescriptions filled, and we would be able to also begin to back out those who remain within the VA system backlogging those searching for their first doctor's appointment.

The money is there; we think that this is an appropriate way to spend it. Congress has been generous, and VA ought to move forward in this area, and if they are not moving forward, sir, certainly, legislation should be out there.

Senator GRAHAM OF FLORIDA. Our Chairman has returned, and I will return the gavel to him.

Chairman SPECTER. [Presiding]. Thank you very much. Thanks very much, Senator Graham, for filling in. Just for a word of explanation, after this hearing was set, the Chairman of the Appropriations Committee listed a hearing for the Department of Defense Appropriations bill, and we had the Subcommittee markup in the morning, full Committee this afternoon, and hopefully, it goes to the floor tomorrow.

So the appropriations process understandably takes precedence over everything else, but we are able to work it out with Senator Graham filling in, so the panel has been able to proceed.

The subject which I would like to discuss with all five of you gentlemen involves the prescription drug legislation. It seems to me that the VA is able to negotiate tremendous discounts. Many of the veterans sign up for care with the VA to have the benefit of the prescription drug program. Many veterans sign up solely for that reason. The veteran ought to have the option of signing up or not, but if the veteran really does not want the medical treatment, why should he have to have it as a precondition to getting a drug benefit?

In such cases, the VA is incurring costs giving treatment to a veteran who does not want it, who probably is having treatment on the outside. And if someone has a prescription for Zocor, he is going to a doctor, not that Zocor, for example, has any great complications in terms of taking it.

Mr. Mooney, how do you size it all up? What would your conclusion be?

Mr. MOONEY. Well, Mr. Chairman, I would compare the VA health care system to Tricare. Tricare is—VA is a closed system. Their pharmacy system does not take input from outside medical providers. Tricare is a managed care operation that has thousands of retail pharmacy providers as well as their mail order pharmacies.

Every time a prescription comes in to Tricare, it goes to a computerized review system, and a data base or a profile, medications profile is built for each patient who is receiving medication. This is from, you know, prescriptions that are written by Tricare providers. That way, if there is a medication conflict or some other problem, it can be picked up on.

VA does not have that capacity. VA also does not have the capacity to—right now, their CMOPs or VA's consolidated mail order pharmacies are running pretty much at capacity, and I believe Secretary Principi testified to that effect in the House last year. They would not be able to pick up the kind of demand that this bill would anticipate without, you know, some considerable infrastructure improvements.

The American Legion, we side with the VA on this particular issue. We do not believe that the VA was designed to be a mail order pharmacy.

Chairman SPECTER. Mr. Hayden, what do you think?

Mr. HAYDEN. We believe that veterans should have access to it, Mr. Chairman. It is there for them; it is part of the medical benefits package that they get when they enroll in the system. Currently, category 8s are excluded, but you could even open it up to allow those category 8s to at least access maybe that part of the package if they are not willing to access the other part of the medical benefits package.

Chairman SPECTER. Mr. Atizado.

Mr. ATIZADO. Mr. Chairman, the members of DAV have a strong opinion with regards to a provision of the bill, which is a co-payments provision. I have mentioned that in my oral testimony earlier. But aside from that, our concern of having a prescription-only benefit in this type is that veterans would have to choose either or, such that if a veteran were to elect this benefit that they would have to—they would, in a sense, not be able to use VA medical care.

And we believe that may actually be a detriment to the veteran. Granted that it is a benefit; prescription medication is part of the therapy of a disability. We believe that disabled veterans are an inherently different population. They are older, sicker; they have more chronic conditions. Therefore, we believe that they should have the ability to utilize the VA health care system not just one part of the benefit.

Chairman SPECTER. Thank you very much.

Senator GRAHAM OF FLORIDA. So do you believe that if they are not using the whole system, they should be eligible to use the pharmaceutical or precluded from using the pharmaceutical?

Mr. ATIZADO. I believe they should be able to use the entire health care benefit package, not just one.

Senator GRAHAM OF FLORIDA. My question was a little bit different.

Mr. ATIZADO. I am sorry.

Senator GRAHAM OF FLORIDA. Suppose a veteran says I want to use the doctor that I have used for the last 30 years now that I am on Medicare, and that doctor, you know, writes a prescription. Are you saying that you think that that veteran ought to be able to take that prescription to the VA and get it filled, or because he is getting the rest of his health care through his private physician should be excluded?

Mr. ATIZADO. Well, we believe it should be up to the veteran, obviously. You should have a freedom of choice, but we oppose a preclusion of him being able to use the VA health care system.

Senator GRAHAM OF FLORIDA. Oh, yes, OK.

Chairman SPECTER. Mr. Blake.

Mr. BLAKE. Mr. Chairman, PVA's position has always remained essentially the same on this. Our biggest concern is that basically, you could see a change in the VA's mission to that of sort of a veterans' drug store. Did not realize it was not on.

Our concern is that you would possibly go back to the way health care benefits and different parts of the health care benefits package were managed prior to eligibility reform, where you have certain groups of veterans getting certain types of benefits, and it is broken up, and you create categories where you have essentially, like,

haves and have nots as far as who gets what type of benefit covered under the VA.

I also want to reiterate a point that Mr. Atizado made about the co-payments. We have had concerns about shifting the burden of costs for even just the prescription drug benefit onto veterans, which is, essentially, in our mind, is what S. 1153 does, as have other prescription drug benefits that we have seen that have been proposed.

So I would say that I would just have to mirror Mr. Atizado's comments. We have opposed S. 1153 and most of the prescription drug bills that have been proposed because of the possibility of a change in the VA's mission.

Chairman SPECTER. Mr. Jones.

Mr. JONES. AMVETS in the past has held a position similar to PVA in that we felt that the issuance of non-VA prescribed drugs would diminish available medical dollars for critical treatments of veterans. However, it is our understanding that that argument no longer really holds water.

If you take a look at the budget for fiscal 1904, you will see $600 million of carryover funds from 1903 in the medical care account. Looking at the estimated carryover into 1905, $800 million. At an average price of $13 per prescription, you could easily give all of those veterans who are seeking care but banned, 164,000 a year, access to VA without damaging VA's timely or quality care resources. So we believe that yes, veterans should have access to VA pharmacy whether their pharmaceuticals are prescribed by a VA doctor or not.

Chairman SPECTER. Well, thank you very much, gentlemen. This has been a very useful hearing. We have quite a legislative package to move, and this hearing gives us an evidentiary record basis for proceeding.

We thank you for the outstanding job you are doing in representing America's veterans, and at a time when we are at war in Iraq and Afghanistan and have troops all around the world, it is more important than ever that we focus on the ways to treat America's veterans properly.

So thank you very much.

[Whereupon, at 4:20 p.m., the hearing adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Mr. Chairman, thank you for holding this hearing on proposed legislation relating to VA health care benefits and other general benefits. I want to welcome those who have come to testify and look forward to hearing their thoughts on the various bills.

I am especially pleased that we will be considering my Veterans Nursing Home Stipend bill, S. 2327, which will clarify the treatment of the per diem payments made by the Department of Veterans Affairs (VA) to support State Veterans Homes across the country.

For several decades, Federal law has required that the VA pay a per diem amount to States to support quality care provided to eligible veterans at qualified State Veterans Homes. This VA per diem, currently about $56 per day for nursing home care and $27 per day for domiciliary care, is intended to assist States in providing the best possible care to those who served in our armed forces.

In my State of Colorado and a number of other States, the availability of the VA per diem is threatened by interpretations of Medicaid rules by the Centers for Medicare and Medicaid Services (CMS). CMS would treat the VA per diem payments as third-party payments, requiring that the entire amount be offset against Medicaid payments. This interpretation would deny residents of State Veterans Homes who receive Medicaid in these States any benefit whatsoever of the VA per diem payments.

Mr. Chairman, I believe this runs contrary to the intent of Congress in establishing the VA per diem payment system. My legislation would simply clarify that the VA per diem payments cannot not be considered to be a third-party liability under Medicaid.

Again, thanks. I look forward to the testimony this afternoon.

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

Chairman Specter, I want to thank you and Senator Graham for calling this hearing to discuss the important pieces of legislation before us.

I also want to join you in welcoming all of the panelists here today, especially the Veterans Service Organizations who provide a strong voice for their membership—those brave men and women who have served and sacrificed so honorably for our country.

As you may know, my father was a disabled World War II veteran. I grew up understanding the sacrifices our veterans make, and I've always been deeply aware of our obligations to veterans once they return home.

In college, I volunteered at the Seattle Veterans Hospital, and I'm proud to be the first woman to ever serve on this Committee.

I sought this position so I could advocate for Washington's nearly 700,000 veterans.

Today, I continue to be focused on ensuring our veterans have all of the benefits and services they have earned.

Mr. Chairman, like you, I believe it is vital that Congress take steps to ensure all members of our armed forces and their families are taken care of, especially during extended active-duty deployments, and upon their return home.

Unfortunately, that has not always been the case. Veterans who volunteered—or were drafted to serve our country—were promised healthcare and other benefits.

But, when the returned home, many found those promises were not kept. In recent years, the Administration has barred certain veterans from enrolling in the VA.

And, the President's budget request for this year would have required some veterans to pay additional fees for the services they are currently able to receive.

While this Committee and the Congress have made strides in providing the services due to our Nation's veterans, there is still much more to be done.

Mr. Chairman, I am a co-sponsor of several pieces of legislation before us today, including:

• Senator Johnson's bill, S. 50, that would make Veterans' Healthcare funding mandatory—ending the annual budget games and keeping our promise to the veterans who have served so honorably for our country.

And Senator Campbell's bill, S. 2327, which would ensure VA per diem payments to State Veterans' Homes—including those in Washington State—could be used in conjunction with Medicaid payments to enhance patient care to veterans in State homes.

I am also a co-sponsor of each of the three bills that would allow veterans to receive a larger VA home loan.

As we all know, the VA loan limit has not been increased since 2001 and the current VA loan amount of $240,000 has eroded to just 74 percent of the FHA loan limit.

We must act to ensure that veterans have access to this important program, and keep it in pace with the rising costs of decent housing in this country.

As with home costs, education costs are rising at an unprecedented pace.

Updating the Montgomery GI Bill is one of the best ways we can act to ensure our recent veterans and current servicemembers have the education options they deserve.

Currently, there are two Montgomery GI Bill programs.

One for active-duty (MGIB-AD), and one for Guard and Reservists (MGIB-SR).

Originally, the GI Bill benefits for Guard and Reserves were set at 47 percent of the active-duty benefit. But, these benefits currently lag at 29 percent of the active-duty benefit.

I have heard from members of the National Guard and Reserves who worried that they had to leave their university to go to Iraq for a year.

Several soldiers who are in the high tech field said to me "18 months away from my job means that I won't be ready to go back to my position."

That's why—back in February—I included a provision in my Guard and Reserve Enhanced Benefits Act (S. 2068) to extend and update the GI Bill benefits.

This is a critical program for the men and women called away from school and their jobs to serve our country on active duty.

I am a proud co-sponsor of each of these GI Bill enhancements before the Committee today because we should:

• Encourage participation in the program,

• Provide a competitive edge for Guard and Reserves when they return to the private sector, and

• Create incentives for the citizen-soldiers we rely so heavily on today.

Mr. Chairman, as you know, several of us have to leave shortly for an Appropriations Committee meeting on the Defense bill.

But, again, I want to commend you and Senator Graham for bringing these important pieces of legislation before the Committee today.

Your leadership will allow us to make more progress in providing our veterans the benefits they have been promised, and the benefits they've earned with their sacrifice for our country.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

The American Federation of Government Employees, AFL-CIO, which represents more than 600,000 Federal employees who serve the American people across the Nation and around the world, including roughly 150,000 employees in the Department of Veterans Affairs (VA), is honored to submit comments on legislation currently pending before the Senate Veterans Affairs Committee.

S. 2484—DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PERSONNEL ENHANCEMENT ACT OF 2003

Chairman Arlen Specter introduced S. 2484 on June 1, 2004, at the request of Secretary Prinicipi. Our union greatly appreciates that when Chairman Specter introduced S. 2484 as a courtesy to Administration he acknowledged that AFGE had

significant concerns with VA's proposed legislation and that we have offered constructive ideas to improve the VA's proposal. AFGE looks forward to working with Chairman Specter and Ranking Member Graham and members of the Committee to improve this legislation.

PHYSICIAN AND DENTIST PAY PROVISIONS

The legislation VA requested to be introduced would give the VA unreviewable discretion to set VA physicians' and dentists' pay. AFGE opposes the physician and dentist pay provisions in S. 2484, as drafted. We do not believe this pay system, as introduced, will help the VA retain and recruit needed medical providers to care for veterans.

VA claims that its proposal will simplify its current physician and dentist pay system. The legislation would establish three tiers of pay bands. The first tier, would be a nationwide base pay band ranging from $110,000 to $125,000. VA would have broad discretion to situate an individual's base pay anywhere along the base pay band. The proposed legislation does not state how the VA would make meaningful distinctions among employees to situate their base pay along the pay band.

In addition to the base pay, the VA would then have the discretion to add a second market pay tier. The legislation gives the VA total discretion to set the range for market pay, to define the market area and to then situate an individual along the variable market pay band base upon specialty, assignment, personal qualifications, and individual experience. Thus the VA would have the flexibility and discretion to set a variety of market pay bands within a geographic area to account for the other variables or to set one geographic pay band and situate the market component of a physician's pay along the band based upon non-market factors. The legislation does not require physicians to receive a minimum market pay adjustment for their locality.

In addition to variables for being situated along the base pay and market pay bands, the VA would also have a performance pay tier. VA proposes that this third tier would be linked to performance and be paid for discrete achievements in quality, productivity and support of "corporate goals." The variables for setting those goals and ensuring consistent measurement are not specified in the legislation.

The tier variable pay bands would be combined to set individual pay for each VA physician and dentist. The legislation gives VA broad flexibility to set the pay bands and to set individual salaries using the combined three tiers of pay bands. It is our understanding that if this bill remains unchanged VA intends to use the flexibility to set individual physician and dentist pay by the Medical Director based upon a recommendation from management designated professional standards board.

S. 2484, as drafted, authorizes the VA to reduce the market and performance salaries of VA physicians or dentists, and S. 2484 explicitly makes such an extreme action unreviewable by existing governmental processes designed to ensure due process and fairness in governmental personnel actions. The legislation, as drafted, does not require any independent neutral process by which a physician or dentist may seek to challenge a negative, unfair or arbitrary salary decision.

The legislation does guarantee VA physicians and dentists a nationwide across-the-board pay increase based upon the General Schedule (GS) nationwide pay increase. As currently drafted, S. 2484, would not guarantee VA physicians and dentists the GS locality pay increase.

As drafted, S. 2484, does not require the VA to recognize the value of full-time physicians and dentists through a guaranteed and consistent pay adjustment for fulltime physicians. The current pay system rewards full-time physicians for their full-time commitment to caring for veterans. Under S. 2484, a part-time VA primary care physician could make the same amount as a full-time VA primary care physician in the same medical facility.

S. 2484, as introduced, does not require the VA to encourage a stable patient-physician relationship and long-term commitment to caring for veterans through length of service pay, as in the current pay system for VA physicians and dentists.

S. 2494 also does not provide incentive pay for ongoing professional expertise and advanced credentials through guaranteed compensation for board certification, which recent research has shown is linked to improved patient outcomes. The current pay system has an automatic adjustment for board certification. Under S. 2484, the VA would no longer be required to increase a physician's pay because he or she achieved board certification in the practice of medicine.

AFGE'S RECOMMENDATIONS TO IMPROVE PHYSICIAN AND DENTIST RECRUITMENT AND RETENTION

1. Improve quality of care by promoting physician and nurse involvement in the organizational and clinical decisionmaking processes of the VA by enhancing collaboration and communication between VA administrators and front-line care providers.

Addressing VA's ability to retain and recruit needed primary care and medical specialty providers is essential if the VA is to meet the current and future demand for veterans' medical care. Our members are frustrated and deeply concerned that veterans must wait months for appointments to see VA medical providers.

Pay and benefits are key to retaining and recruiting direct care providers, but AFGE strongly believes that current working conditions must improve in order for the VA to be able to hire and retain physicians and dentists. Like other civil servants, physicians and dentists choose to work at the VA because it offers an opportunity to help people hone and develop their professional practice, and perform meaningful and challenging work. In short, it is the nature of the work, not just the size of the paycheck, which matters.

Decisions on restructuring, staffing, administrative duties, and rationing of care affect how physicians are able to practice medicine. Ensuring that front-line physicians have a voice in decisions, which involve medical practice and quality of care issues, is absolutely essential if the VA is to be the employer of choice for doctors and dentists and provide world-class health care.

For example:

• Front-line medical providers need to be part of VA's dialog on developing a staffing model for primary care, long-term care, and specialty care to ensure that the methodology accounts for time spent not only on direct patient care but administrative tasks, research, coordination of care and ongoing professional development and education.

• VA's ongoing efforts to refine a computerized medical record system would benefit from extensive feedback from the very doctors who must expend time entering data that would otherwise be spent with the patient.

• VA's efforts to implement the CORE-FLS system would also benefit from additional input and feedback from front-line staff.

Current law creates unnecessary constraints on the ability of front-line physicians and dentists to work with VA management to address the ongoing challenges the VA faces in the delivery of direct patient care.

AFGE strongly urges the Committee to revise S. 2484 to enhance the participation of front-line physicians and dentists in administrative decisions that affect their practice. Ensuring that frontline staff has a voice in decisions that involve medical practice and quality of care is absolutely essential if the VA is to provide world-class health care.

Establishing a process whereby front-line doctors and their union representatives can provide meaningful input to help shape workplace decisions that impact on patient care will boost VA's ability to hire and keep medical providers.

AFGE believes the collaborative process drafted by the Senate Veterans Affairs Committee and enacted in P.L. 108–107 offers a moderate approach to providing collaborative input from VA health care professionals in VA's policies on their advancement and promotions. Chairman Specter and Ranking Member Graham, AFGE urges you to revise S. 2484 to provide front-line doctors, nurses and their union representatives with collaborative opportunities to shape workplace decisions that affect how these professionals deliver care.

2. Balance VA flexibility and discretion in setting individual physician and dentist pay with statutorily established accountability and safeguards.

The current VA physician pay system is transparent, fair, credible, and equitable because many of the pay components are guaranteed. It also makes the system easier to administer and less subjective or vulnerable to bias or discrimination than a system which places all components of pay for each individual physician at the discretion of VA facility management or on the recommendations of a professional standards board.

Discretion in setting individual pay may give VA flexibility but it also makes the pay system vulnerable to arbitrary, inconsistent and biased salary decisions. With this vulnerability comes inconsistency, favoritism and discrimination, all which erode the core merit principle of equal pay for work of equal value. The inconsistent and biased exercise of discretion hurts morale.

According to the General Accounting Office (GAO), any Federal pay system, which attempts to implement "results-oriented pay reform", must have "effective, credible, and validated management systems that are capable of supporting pay and other

personnel decisions."[1] Although there is no evidence that GAO's own performance pay system has either improved production, quality or upheld the merit system principle of equal pay for substantially equal work, the GAO has put forth the following standards to consider both before implementing a pay system to set individual pay linked to performance and individual competencies and as safeguards for post-implementation.

- Assure that the agency's management systems can result in meaningful distinctions in individual employee performance.
- Involve affected employees, their representatives and other stakeholders in the design of the system, including having employees directly involved in validating key parts of the pay system and standards for making pay distinctions.
- Assure that key pre-decisional internal safeguards exist to help achieve the consistency, equity, non-discrimination and non-politicization of the process (e.g., reviews of pay determinations to ensure that they are merit-based, internal grievance process to address employee complaints).

Assure transparency and appropriate accountability mechanisms in connection with the process (e.g. publish results of pay decisions while protecting individual confidentiality and report periodically on internal assessments and employee survey results).[2]

When agencies lack credible and validated performance appraisal methods and lack appropriate safeguards to support individualized pay systems, the GAO found that employees and managers lose confidence in the fairness of the decisions that are made.[3]

GAO's determination about the factors that lead to failures in systems that set individualized pay based upon subjective assessment echoes the conclusions of researchers in the field of "pay for performance."

Professor Jeffrey Pfeffer, of Stanford University's School of Business, has written extensively about the misguided use of individualized pay for performance systems in the public and private sectors. Pfeffer's research shows that performance systems never achieve their desired results, yet "eat up enormous managerial resources and make everyone unhappy."

Professor Pfeffer explains that pay for performance myths are based on conceptions that human nature is uni-dimensional and unchanging. In economics, humans are assumed to be rational maximizers of their self-interest, and that means they are driven primarily, if not exclusively, by a desire to maximize their incomes. The inference from this theory, according to Pfeffer, is that "people take jobs and decide how much effort to expend in those jobs based on their expected financial return. If pay is not contingent on performance, the theory goes, individuals will not devote sufficient attention and energy to their jobs."

But do pay for performance systems work? Pfeffer answers with the following:

Despite the evident popularity of this practice, the problems with individual merit pay are numerous and well documented. It has been shown to undermine teamwork, encourage employees to focus on the short term, and lead people to link compensation to political skills and ingratiating personalities rather than to performance. Indeed, those are among the reasons why W. Edwards Deming and other quality experts have argued strongly against using such schemes.

Consider the results of several studies. One carefully designed study of a performance-contingent pay plan at 20 Social Security Administration (SSA) offices found that merit pay had no effect on office performance. Even though the merit pay plan was contingent on a number of objective indicators, such as the time taken to settle claims and the accuracy of claims processing, employees exhibited no difference in performance after the merit pay plan was introduced as part of a reform of civil service pay practices. Contrast that study with another that examined the elimination of a piece work system and its replacement by a more group-oriented compensation system at a manufacturer of exhaust system components. There, grievances decreased, product quality increased almost tenfold, and perceptions of teamwork and concern for performance all improved.[4]

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[1] GAO April 1, 2004 Testimony "Results-Oriented Cultures: Modern Performance Management Systems Are needed to Effectively Support Pay for Performance," before the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform, House of Representatives.

[2] *Id.* and May 19, 2003, letter to The Honorable Jo Ann Davis, Chairwoman, Subcommittee on Civil Service and Agency Organization, Committee on Government Reform, House of Representatives, from J. Christopher Milm, GAO Director, Strategic Issues.

[3] May 19, 2003 GAO letter, pages 4–5.

[4] "Six Dangerous Myths about Pay" by Jeffrey Pfeffer, *Harvard Business Review,* May-June 1998, v.76, no. 3, pg. 109(11).

Compensation consultants like the respected William M. Mercer Group report that just over half of employees working in firms with individual pay for performance schemes consider them "neither fair nor sensible" and believe they add little value to the company.

GAO's research on the Federal Aviation Administration's individualized pay band system found similar results. Nearly two-thirds of the FAA managers and employers interviewed by the GAO disagreed or strongly disagreed that the new pay system is fair to all employees. GAO found evidence to support concerns about FAA pay disparities in the Department of Transportation's Inspector General report.[5]

As the Committee considers S. 2484, AFGE urges that you revise the legislation to establish the following statutory safeguards and mechanisms for accountability.

- Establish a national base pay schedule that would recognize and reward fulltime dedication to caring for veterans and encourage stable patient-physician relationships and long-term commitment to caring for veterans through a guaranteed time-in-grade pay increase based upon satisfactory performance.
- Adjust the full salary of VA physicians and dentists annually with the GS across-the-board and locality pay increases.
- Prohibit negative pay adjustments.
- Involve affected VA physicians, their representatives and other stakeholders in the design, training and evaluation of the pay system, including validating and testing the reliability of any criteria used to make pay distinctions, and the selection of board members.
- Enhance the objectivity of the pay setting process by ensuring consistent pay adjustments for board certification and full-time status.
- Assure pre-decisional accountability by establishing employee access to an independent, neutral grievance process by which employees may challenge pay decisions which they regard as inconsistent, arbitrary or non-merit based.
- Assure transparency by requiring the VA to publish an annual result of pay decisions (while protecting individual confidentiality) desegregated by gender, race, ethnicity, age, area of medical specialty, and facility.
- Assure accountability through published periodic evaluations and assessments (from the Inspector General or GAO) involving employees and their representatives.

AFGE looks forward to working with the Committee to ensure that the revision of VA's physician pay system reflects the minimal statutory safeguards and accountability measures recommended by the GAO.

3. Correct the obsolete 24/7 leave policy. S. 2484, as introduced, does nothing to address an ongoing frustration for physicians and dentists over how the VA charges them for annual, sick and military leave. The current VA rules governing leave for physicians, dentists, podiatrists, optometrists and chiropractors requires that these employees be charged for annual, sick and military leave on weekends, even when their normal work schedule is Monday through Friday. This policy is based upon the VA's position that VA physicians, dentists, podiatrists, optometrists and chiropractors are on-call 24/7, regardless of their actual work schedule. Eliminating the weekend charges for annual, sick and military leave, while maintaining 30 days of annual leave for full time physicians, dentists, podiatrists, optometrists and chiropractors, would be a significant step to improving the working conditions of these medical providers at the VA. VA's own Quadrennial Report Reviewing Committee concluded "there is no longer any value in charging full-time physicians and dentists for absences on non-duty days."

AFGE has tried to work with the VA to address this issue of concern for many full-time VA physicians and dentists, unfortunately with limited success. As a result, we must urge Congress to eliminate the weekend charges of annual, sick and military leave for VA's physician medical care providers. As you revise S. 2484, we urge you to correct the problems in the VA's 24/7 leave policy.

REGISTERED NURSE ALTERNATIVE WORK SCHEDULE PROVISIONS

S. 2484, as drafted, would authorize the VA the discretion to offer Registered Nurses (RNs) the following flexible tours:

(1) three 12-hour tours (36 hours) in a workweek paid as 40 hours;

(2) seven 10-hour days/7 days off in a pay period, with pay for 80 hours;

(3) 9 months of work with 3 months off, with pay apportioned over a 12-month period.

AFGE is generally supportive of the principle of offering RNs alternative work schedules in order to recruit and retain nurses. However, we have the following con-

[5] *Human Capital Management: FAA's Reform Effort Requires a More Strategic Approach,* GAO–03–156 (February 3, 2003).

cerns with the S. 2484, as drafted, which we believe adversely impact RNs and veterans.

1. VA's legislative proposal takes no steps to ensure continued patient safety.

The Institute of Medicine (IOM) report titled "Keeping Patients Safe: Transforming the Work Environment of Nurses" recommends that, to reduce error-producing fatigue, health care organizations should establish policies designed to prevent nurses who provide direct patient care from working longer than 12 hours in a 24-hour period and in excess of 60 hours per 7-day period. [6]

VA is proposing a schedule that would have direct care RNs work seven 10-hours days consecutively or 70 hours in a 7-day period, and then have 7 days off. This provision in S. 2484, which the VA proposed to Congress before the IOM report was issued, would have the VA violate the IOM recommendation that direct care nurses should not volunteer or be required to work more than 60 hours in 7-day period.

Even though the proposal would allows facility managers to offer a 70-hour work schedule but does not require it, we believe that the VA should be the leader in creating systemic improvements in patient safety. Given the strength of the IOM recommendations that hospitals should take steps to prevent direct care nurses from working more than 60 hours in a week it would imprudent for Congress to pass legislation to give VA facility management the discretion to ignore basic patient safety standards for nurse scheduling.

Given the IOM recommendation for patient safety and RN work hours, based upon a substantive body of research on the effects of fatigue on worker performance, AFGE must oppose the alternative work schedule of 70 hours in 7-days.

Although the proposed alternative schedule of three 12-hour shifts does not technically conflict with the IOM recommendation that hospitals prevent direct care nurses from working 12 hours in a 24-hour period, we are concerned with the proposal given VA's current policy and practices. It lacks consistent practices and has an often non-existent policy to prevent RNs from working more than 12-hour shifts. Our union is concerned that direct care RNs working three 12-hour shifts, either under this alternative schedule or otherwise, will be vulnerable to working additional fatigue-producing hours and their patients' safety will be placed at risk.

As the Committee considers allowing the VA to offer work schedules that will require RNs to work to up to the maximum number of safe hours in a 24-hour period AFGE urges the Committee to ensure that the VA follow the IOM recommendations to prevent direct care nurses from working beyond 12 hours in a 24-hour period.

For the safety of veterans and to ensure the retention and recruitment of quality nursing staff, AFGE urges this Committee to require the VA to develop a policy designed to prevent direct care nurses from working longer than 12 hours in a 24-hour period whether voluntarily or by mandate. Such a prevention policy would need not prohibit RNs from being called upon to work in excess of 12 hours in a 24-hour period or in excess of 60 hours in a week during emergencies. Rather the policy would ensure that such occurrences are rare and due to true emergencies not inadequate scheduling or staffing. In order to secure a policy that is flexible for the unique situation of each hospital unit but remain a meaningful objective, it is imperative that the policy is jointly designed and jointly monitored for compliance by VA's nurse administrators and the union representatives of VA direct care nurses.

2. S. 2484, as drafted, denies RNs who agree to work the alternative schedules with existing premium pay.

VA's legislative proposal specifically exempts RNs working on the proposed alternative schedules from receiving night shift differential pay, Saturday premium pay, holiday pay, and on-call pay under 38 USC 7453. Nurses working an alternative work schedule should not be denied any current premium pay under 38 USC 7455, which are now available to part-time and full-time RNs. AFGE urges the Committee to ensure that all RNs, continue to receive all premium pay provisions under 38 USC 7453.

3. S. 2484, as drafted, may place RNs who agree to work some alternative schedules, but not other alternative schedules, in an indefinite probationary status.

RNs who work an alternative work schedule or years of part-time should not be considered on probation for an indefinite and unending period of time. RNs who work full-time and have satisfactorily completed their 2-year probation period are returned to an indefinite and unending probationary period if they convert their schedule to parttime. RNs who are not considered probationary would become probationary indefinitely if they agreed to work the 9-month alternative schedule under

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[6] The relevant pages of the IOM report are attached, including Appendix C which was prepared by Ann E. Rogers, Ph.D, RN, FAAN, of the University of Pennsylvania, concerning the research to support the recommendation on preventing direct care nurses from working more than 12 hours in a 24-hour period and more than 60 hours in a 7-day period.

S. 2484. AFGE urges the Committee to clarify the law to ensure that all RNs at the VA should have a 2-year probation requirement. Upon satisfactory completion of the hour equivalent of 2 years of full-time work—under any work schedule—RNs should no longer be considered on probation.

4. VA's legislation would limit overtime for RNs on alternative work schedules.

S. 2484, as drafted, would limit the overtime of RNs who work the alternative schedule. For example, a RN who works three 12-hour shifts would only get paid overtime after he or she worked an additional 4 or more hours. The RN would not get overtime pay for working 3 additional hours beyond a 12-hour shift.

Nurses working an alternative work schedule should receive overtime for any hours they work over their set work schedule. It is particularly important that VA pay RNs overtime as a disincentive for VA requiring RNs already working 12-hour shifts to work additional error-prone fatigue-producing hours. AFGE urges Congress to ensure that all RNs continue to receive overtime for any hours worked over their shift.

5. VA's legislative proposal, as introduced in S. 2484, shuts front-line direct care nurses and their union representatives out of the process for developing and implementing fair regulations on alternative schedules.

Should the Senate Committee include portions of the alternative schedule provision in the final version of S. 2484, RNs and their employee representatives need a collaborative role as the VA develops and implements its policy on these alternative schedules. Last year, this Committee took the lead in developing a moderate and model approach to allowing front-line professionals at the VA weigh in on key workplace decisions concerning the advancement and promotion of a significant group of VA professional health care workers. As a result of this Committee's leadership, P.L. 108–107, established a labor-management collaborative process. AFGE urges this Committee to provide for collaborative input by union representatives into the development and implementation of the policy for how each facility will determine whether or not to offer RNs these alternative schedules and how RNs will be selected to agree to work such alternative schedules.

6. VA's legislative proposal, as introduced in S. 2484, is unclear as to the full impact of working the proposed alternative schedules on annual leave, health care premiums, life insurance, etc.

The legislative provision on the alternative 9-month schedule is unclear and ambiguous with respect to leave and benefits for RNs agreeing to work this alternative schedule.

The legislation is silent as to whether RNs working this schedule will earn leave at the full-time rate while working full-time or earn it at the .75 rate for all 26 weeks. It is also not clear how nurses working a 9-month year will be charged for health care premiums during the 3 non-work months. Currently, part-time Federal employees are eligible to receive the same health care coverage as full-time employees, but part-time workers must pay a greater percentage of the premium because the Federal Government's share is prorated based on the number of hours the employee is scheduled to work each week. Would nurses on the 9-month scheduled be required to pay the full premium during the 3 months of non-work hours?

We also are concerned that the lack of clarity in the legislation for the 9-month schedule may adversely impact employees with regard to the Federal Employees' Group Life Insurance program because the entitlement to the benefit has fiscal, calendar, and leave-years requirements.

Similarly, the legislation does not explicitly state that RNs scheduled for three 12-hour shifts, or 36-hours a week, will not be required to pay a greater portion of their health care premium, even though normally a Federal employee scheduled for a 36-hour week would be required to pay an additional percentage of the health care premium.

We recognize that the Committee intends for these alternative schedules to be desirable for RNs. AFGE urges the Committee to revise S. 2484 to resolve these ambiguities to ensure that RNs who agree to work these schedules do not receive diminished benefits or entitlements and do not have to pay additional premiums to receive the same level of health care coverage.

AFGE also encourages the Committee to ensure that VA to provide RNs documentation about the impact of working an alternative schedule on a RN's FEGLI entitlements, health benefit premiums, probationary status, and leave. This official documentation should be in plain English. It should be given to RNs prior to their agreement to accept an alternative work schedule.

SECTION 7 OF S. 2484, VA'S PROPOSED ADMINISTRATIVE PROVISION

In VA's requested legislation, VA creates a new section 7427 in Title 38 that states that "The functions assigned to the Secretary and other officers of the Department of Veterans Affairs under this chapter are vested in their discretion." The need for this vague legislative provision is unclear. VA's transmittal letter provides not a single sentence on this provision.

The VA's analysis of the draft bill provides this brief description of the purpose of Section 7: "Section 7 adds an administrative provision concerning functions under chapter 74. It provides that functions of the Secretary and other Department officers under chapter 74 are vested in their discretion. The purpose of this provision is to make clear that the exercise of those functions 5 U.S.C. 701(a)(2) exempts the exercise of those functions from judicial review under the Administrative Procedures Act."

AFGE must vigorously oppose this provision. It would allow the VA to issue directives and regulations without any opportunity for aggrieved parties to seek minimal judicial review to determine if such regulations are arbitrary or capricious or not within the scope of VA's authority.

SUMMARY

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Committee. We look forward to working with Chairman Specter and Ranking Member Graham to improve S. 2484.

PREPARED STATEMENT OF THE MORTGAGE BANKERS ASSOCIATION

The Mortgage Bankers Association (MBA)[1] appreciates the opportunity to express our views to the Senate Committee on Veterans' Affairs on the provisions of two bills pending before the Committee: S. 2486, the "Veterans' Benefits Act of 2004," introduced by Chairman Aden Specter, and S. 2522, (same title), introduced by Senators Jon Corzine and Lisa Murkowski.

MBA is a strong advocate of the home financing program offered by VA's Loan Guaranty Service. Since 1949, this program has provided an important homeownership benefit to those men and women who have served their country through their service in the armed forces. The vast majority of VA guaranteed loans made each year are made by MBA members. Our members are proud of their involvement in this program.

Both bills contain provisions strongly supported by MBA. Both bills would increase the maximum VA Home Loan Guaranty amount to 25 percent of Freddie Mac's conforming loan limit, resulting in a current maximum VA loan amount of $333,700. In addition, S. 2522 would provide that the maximum VA loan amount would be indexed annually to the Freddie Mac conforming loan limit. S. 2468 would reinstate the VA 1-year adjustable rate mortgage (ARM), provide for permanent authority for the VA Hybrid ARMS, and would provide technical improvements in the 5/1, 7/1 and 10/1 Hybrid Mortgage products.

MBA supports the concept of indexing the maximum VA guarantee amount to the Freddie Mac limit because it will avoid the necessity of Congressional action to keep the VA benefit relevant as home prices change.

VA's guarantee amount has been raised only once since 1994, for an increase of approximately 18 percent, despite the fact that national home prices have appreciated over 70 percent since that time.

The indexing feature is already a part of another important Federal housing program, the Federal Housing Administration's (FHA) single family loan programs. FHA received such indexing authority in 1996, and its maximum mortgage limits have nearly doubled since that time, Freddie Mac loan limits have increased over

[1] The Mortgage Bankers Association (MBA) is the national association representing the real estate finance industry, an industry that employs more than 400,000 people in virtually every community in the country. Headquartered in Washington, D.C., the association works to ensure the continued strength of the nation's residential and commercial real estate markets; to expand homeownership prospects through increased affordability, and to extend access to affordable housing to all Americans. MBA promotes fair and ethical lending practices and fosters excellence and technical know-how among real estate finance professionals through a wide range of educational programs and technical publications. Its membership of approximately 2,700 companies includes all elements of real estate finance: mortgage companies, mortgage brokers, commercial banks, thrifts, life insurance companies and others in the mortgage lending field. For additional information, visit MBA's Website: *www.mortgagebankers.org.*

64 percent since 1994. Clearly, it is time for veterans to be treated equally with other homebuyers with regard to financing.

MBA is concerned that the lack of indexing will preclude more and more veterans from using their benefit to obtain homeownership in many expensive markets as home price appreciation outstrips the VA maximum no-downpayment loan amount. For this reason, MBA strongly supports the indexing feature of the two bills.

MBA understands that this is expected to generate additional revenue for the U.S. Government by an estimated $71.3 million over the next 10 years. The additional revenue provided by this change gives further evidence that the two bills are a prudent financial move for VA's Loan Guaranty Service. Therefore, this is not only good for veterans, but it is good for the American taxpayer.

With respect to the VA Loan Home Guaranty Program in general, MBA would suggest the following additional improvements:

AMEND THE CAP STRUCTURE ON 5/1, 7/1, 10/1 HYBRID ARMS

As of October 1, 2003, VA began guarantying hybrid Adjustable Rate Mortgages (hybrid ARMs. In the 7 months following, VA has guaranteed 35,183 3/1 hybrid ARMs, representing 16 percent of its entire production and 27 percent of its refinances for that period. VA has indicated that no 5/1, 7/1, or 10/1 ARMs have been originated during that period. Clearly there is a problem with the cap structure for these hybrid ARMS,

While authorized to guarantee 5/1, 7/1, and 10/1 hybrid ARMs, lenders are not finding these products viable because of the interest rate caps restricting these products to a 1 percent initial and annual adjustment cap and a 5 percent lifetime adjustment cap. MBA believes amending the caps for the 5/1, 7/I, and 10/1 hybrid ARMs to a 2 percent initial and annual adjustment limit and a 6 percent lifetime adjustment limit will offer sufficient flexibility for these products to be offered in the marketplace. The above cap structure is the same that MBA has urged for FHA hybrid ARMS: For veterans to gain the best pricing, MBA believes it is particularly important that the cap limits on the FHA and VA hybrid ARMs are the same so that the loans can be pooled together by Ginnie Mae. If VA adopts limits that are different than FHA, it is likely that the VA loans will lose the economies of scale of being pooled with the higher volume FHA hybrid ARMs.

REINSTATE THE 1-YEAR ARM PRODUCT

MBA also supports the reinstatement of the VA 1-year ARM product. Previously, VA was authorized to guarantee 1-year ARMs during 1994 and 1995, as a pilot program. MBA believes that it is important to offer veterans as many mortgage options as other borrowers. Over the past 10 years, underwriting polices and procedures have advanced such that 1-year ARMs can be successfully originated. FHA and the private sector have proven this.

REMOVE LEGISLATIVE MANDATE FOR APPRAISER ASSIGNMENT BY VA

Finally, MBA would suggest taking this opportunity to give the Loan Guaranty Service the authority to dissolve its panel of fee appraisers and implement a system whereby lenders can choose licensed appraisers. FHA undertook this reform more than 10 years ago and MBA believes it has led to increased efficiencies for the FHA program and lower costs for FHA borrowers. It is time for VA to have the same authority.

The current VA appraiser fee panel can be problematic for lenders and borrowers. Borrowers who submit a purchase offer on a home using VA guaranteed financing are often disadvantaged in the marketplace because of the perception that VA-guaranteed financing takes longer to complete. While this perception is largely inaccurate, MBA does believe that a policy of lender-chosen appraisers will improve the VA Loan Guarantee program and ensure the veteran borrower is competitive with other bidders.

Giving such authority to VA's Loan Guaranty Service will allow the Service to review the lender-choice policy option and offer it to lenders as a way to increase the efficiency of originating VA guaranteed loans and lower the costs to veterans. Unfortunately, under current law, VA's Loan Guaranty Service is restricted from implementing such a change.

MBA respectfully urges the passage of S. 2486, as modified with the above suggested changes, for by doing so, you are bettering the homeownership prospects for those men and women of the armed services who have served our great country.

Thank you for giving MBA an opportunity to express our views on S. 2486 and S. 2522. We would be pleased to furnish any additional needed information.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS (NAVAPD)

Thank you Mr. Chairman for allowing the National Association of VA Physicians and Dentists, (NAVAPD), the opportunity to submit written testimony to the Senate Committee on Veterans Affairs on behalf of the physicians and dentists who practice in the Veterans Health System. NAVAPD is the only national organization whose sole mission is enhancing the professional working conditions, and incentives, that increase VA physicians and dentists ability to provide accessible, high-quality health care for our Veterans.

We are here today with three messages: (1.) To thank this administration and this Congress for recognizing the need for an adjustment in the direction of competitive pay for the front line physicians and dentists who serves our nation's veterans. (2.) To support the paradigm shift in compensation that is rooted in S. 2484. A shift which, we believe, lays the groundwork for Title 38 VA physicians and dentists to keep pace with similar practitioners in the private sector, And, (3.) To support changes to the proposal that we believe will produce a statute that is simple, equitable, understandable, self-updating and more easily administered than the version that Chairman Specter introduced "by request." The proposal we support, and which has been discussed at length with staff and other affected parties has flexibility, is market responsive and maintains harmony with the American economy.

Some thirteen years ago, NAVAPD and others came before Congress asking that the compensation of VA doctors be adjusted upward because we were falling woefully behind our colleagues in the private sector. You heard us and enacted legislation that brought us more in line with the private sector. Since that bill was signed into law a dozen years ago, save for cost of living increases, VA physicians have not received one dime in increased compensation. While the time for action is long overdue, we believe that Secretary Principi and the Bush Administration are acting out of a genuine desire to provide the quality of health care our country's veteran population deserves.

The Department of Veterans Affairs is facing a critical situation in its compensation system for physicians and dentists. The VA can no longer recruit and retain highly qualified and experienced physicians and dentists, and not just in the categories where scarce medical and surgical sub-specialties are required. Many VA professionals remain employed in the VHA out of respect for, and loyalty to, the men and women "who shall have borne the battle." However, these professionals also desire opportunities to do research that cannot be done elsewhere and to educate future healthcare providers. In so doing, they build careers and provide unique care-giving knowledge for the special needs of our veterans. These professionals want to be treated fairly and be compensated commensurate with their knowledge and skill levels.

Because the Department of Veterans Affairs is not meeting these professional career goals, recruitment and retention of physicians and dentists is a critical, and worsening, problem for the Department. In addition, generational attitude shifts by many young medical professionals have redirected their focus away from institutionalized medical care, medical education, and research. This translates into a rapidly shrinking pool from which to select replacement physicians and dentists with the requisite knowledge base and specialized skills.

Historically, it has been necessary for VA physicians and dentists to come to Congress with a request for increases in compensation through the addition of "specialty pay" categories or higher "pay bands" for existing specialty pay brackets. This has meant VA physicians and dentists pay has approached private sector standards for a snapshot in time. We have then had to "wait our turn" for the next legislative opportunity. . .all the while slipping further and further behind our private sector colleagues. Now we have a proposal on the table that suggests review and parity on a regular basis, without the need to change the law of the land each time. We believe this is a prudent change in thinking that will have a positive impact on recruitment and retention of quality physicians and dentists. However, as is usually the case. . .the devil is in the details.

The Department of Veterans Affairs proposal is vague and complex and, NAVAPD believes, impossible to fairly administer. NAVAPD also believes that the Department's proposed legislation is limited in scope, is intended to benefit only a small minority of front line medical staff, provides few details regarding implementation, and has the potential to be manipulated in ways that were not originally intended. Further, the legislation proposed by the Department is not in concert with either the most recent Presidentially mandated Quadrennial Report or even the Department of Veterans Affairs' Task Force Interpretation of that Report.

The stated purpose of this legislation is to provide salaries that will be competitive with the private sector, which will in turn keep the professionals we have and attract high-quality recruits to the VHA. However, as proposed, this legislation would have a positive compensation impact on only thirty percent (30 percent) of the fourteen thousand-plus physicians and dentists currently in the VHA. And that assumes total pay would include base pay, market pay AND performance pay. It is difficult to see this as a "morale booster" for existing staff or a recruiting tool for new-hires.

It is even more difficult to see how this will help VA meet overall operational and clinical objectives. The front line medical staff is more than just "foot soldiers" in achieving these objectives. They are the face of the VA, they are the decisionmakers, the team leaders, the clinical thinkers, the quality managers, the innovators. They are very much the pilots of this highly technical, highly complex machine that is the modern health care system, managing life and death decisions, entrusted with the care and comfort of vulnerable and suffering human beings. They are under constant public scrutiny, relying upon their many years of education, training and experience, their intuition and art, and their humanity to guide their clinical actions in helping veterans and their families face the most complex, intimate and difficult choices of their lives. In this regard, quality does matter, and not just for the 20 or 30 percent of the most difficult to recruit and the highly paid sub-specialists, but perhaps of equal or greater importance, also for the journeyman VA physicians and dentists, the folks who are the heart and soul of this system and the ones who make it run day in and day out.

In addition to the goals which have already been described, and which are primarily addressed by the proposed legislation—the ability to recruit and retain extremely high-paid rare sub-specialist—we ask that you keep another objective in mind as well the importance of returning the VHA to those who have the interest of the organization most at heart, the career VA physicians and dentists.

Wasting precious taxpayer dollars through the use of expensive contracts with affiliated university or private groups to hire needed and rare sub-specialists must be significantly reduced, if not eliminated. We agree with the department that it is vexing and galling, perhaps even ludicrous, to pay more to hire these specialists on contract while losing the benefit of a loyal full time VA employee in the process. To "pretend" to not pay them higher than the prohibited salary levels by hiring them "On Contract" is a lose-lose proposition for the VA, the veterans and the taxpayers. One of the stated purposes of this legislation is to address this issue, however, it is only a part of story from our perspective.

The value and contributions of sub-specialty providers are generally well understood; but less well understood are the contributions of the full time, clinically based medical providers. These are the professionals for whom the quality of the organization matters, who are loyal not only to their patients and their colleagues, but also to their organization and the mission of the VA. We represent and are concerned about the "bread and butter" of the medical staff, the doctors who come to work each day with the intent to make their facility a better place and who are committed to working in a health care environment which is world class and second to none in their community in the standards and quality of care. The cost of neglecting this talent is never addressed in the proposed bill and in our estimation the cost is incalculable. If this item remains unaddressed when the bill is passed this asset will almost certainly gradually be lost to expensive contract services.

S. 2484 as it is currently written describes "Performance Pay" as "a variable pay band linked to a physician's or dentist's achievement of specific corporate goals and individual performance objectives." It goes on to say, "The amount payable to a physician or dentist for this component may vary based upon individual achievement, and may not exceed $10,000." The proposal later states that "no physician or dentist will be paid less the day after the implementation than he or she was being paid the day before implementation." How is it possible to determine performance pay prior to implementation? Is this provision, in fact, a "lack of performance" pay that potentially will be held over the heads of physicians and dentists like the sword of Damocles? At a minimum, this provision, as written, is vague and open to abuse. We recommend that a clear and distinct benchmark be used for evaluating the decisions of Medical Center and VISN Directors to ensure that performance pay is equitably administered across the country and not just a means for individual Directors to balance their budgets.

Additionally, this assurance of no negative pay adjustments appears to be negated by subsection 7431 (B) (d) which states, "Any decrease in pay that results from an adjustment to the market or performance component of a physician's or dentist's total compensation does not constitute an adverse action," and by the proposed language for subsection 7431, which states, "the functions of the Secretary and other

officers of the Department of Veterans Affairs under this chapter are vested in their discretion." This provision appears to remove the due process rights of physicians and dentists and is reported to be in response to the unfair termination case of Dr. Elizabeth Von Zemensky in which the courts upheld her reinstatement.

Physicians and dentists are further placed at risk of negative pay adjustments when budget pressures may force cost cutting measures. This is the result of the statutory provision that prohibits negative pay adjustments for the largest professional group in the VHA, nurses. We implore you not to allow an accounting bullseye to be placed on our backs, and adopt the same no negative pay adjustment standard for physicians and dentists in this legislation as currently exists for nurses. Similarly, we urge you to favorably consider the deletion of the aforementioned change to subsection 7431.

As we mentioned earlier, the current proposal will positively impact only thirty percent (30 percent) of the physicians and dentists in the VHA. NAVAPD is supporting a proposal that will positively effect a more significant pool of VA physicians and dentists. To this end, we support a two-tiered basic pay plan, consisting of a National Market Rate and Scale and a National Longevity Scale combined with a separate annual bonus program to reward extraordinary service.

The Market Rates and Scales will be developed, reviewed and implemented by the Secretary under specific guidelines every 2 years. These guidelines would include the use of at least two nationally recognized data sources that identify private sector physician and dentist pay by regions, as well as defined professional criteria. Individual pay would be determined locally by the director, in consultation with a local PSB, which would consist of three to five members, a majority of which must be practicing clinicians. In the 'off year' between Secretarial reviews, all physicians and dentists will receive the governmentwide cost-of-living increase, including locality adjustments, presuming satisfactory job performance. We would recommend that Base Pay be standardized at the GS 15, step 10 level for all physicians and dentists.

The Longevity Rates would consist of fifteen (15) ladder steps. For each 2 years a physician or dentist remains employed within VHA that employee would move one step (approximately 3-percent) on the ladder, presuming "satisfactory" performance at the current level. This will provide a thirty-year career pay path to assist in retaining high-quality practitioners in all practice areas.

We also recommend that a Performance Pay bonus system be implemented for higher than standard work achievement and that the range be from $1,000 to $20,000 in 1 year. This bonus pay would be reviewed and awarded annually at the local level and would not be included in any high three or retirement calculations.

If this legislation is going to be the vehicle that moves the recruitment and retention of high-quality physicians and dentists into the 21st Century then we must address the leave policies that are unintentionally punitive in their effect. While private sector practices are offering newly minted physicians and dentists between 6 and 8 weeks of annual leave, as well as paid time for continuing medical education, we have remained trapped in a system that discourages normal vacations by charging us leave for Saturday and Sunday if we take leave on the preceding Friday and the following Monday. . .regardless of whether or not we see patients or perform other duties on that Saturday and/or Sunday. We believe that the department has the authority to make the necessary adjustments to correct this situation. We have been trying to work with them for over 2 years on this issue. However, we have been unsuccessful, even though other groups have changed leave and other benefits without this type of difficulty. We now turn to you for help. Our final request of this Congress would be to statutorily remove the so-called 24/7 regulations that currently penalize Title 38 physicians and dentists in the use of their leave. This charge against annual and sick leave is even being calculated for VA physicians and dentists who are away from their VA facility on active duty in Iraq and other foreign countries. This is a significant drain on morale and it can be changed at little or no cost to the taxpayers and without "windfall" days or payments to physicians and dentists when they retire. Please include in this legislative package the directive necessary to allow us to take our thirty days of annual leave without the penalty of being charged for our non-duty days.

Mr. Chairman, we have taken the liberty of including suggested substitute language in our written testimony on these and other relevant subjects for your consideration. We believe this alternative compensation proposal will provide the roadmap necessary for VA professionals to know where our careers stand and what the future will hold for us. We hope you will factor our comments and concerns into your deliberations.

Again, thank you for the opportunity to share NAVAPD's thoughts on this critically important legislation. We would be happy to answer any questions you may have.

ELEMENTS OF THE NAVAPD PROPOSED SUBSTITUTE COMPENSATION LEGISLATION

The alternative compensation plan described below will address the tremendous pay disparities between VA physicians and dentists and those in private practice and academia. Although this plan would not match current private practice incomes, it would stem the rapid drain of these professionals from the system. The proposed compensation plan will provide assurance to Veterans that this Nation will maintain a Veterans' Health System that is second to none.

1. No physician or dentist will receive less than his or her current salary on the day following enactment of this statute.

2. There will be no written employment contracts or specified retirement dates.

3. Market pay Rates and Scales guidelines will be updated every even numbered year on November 1 and the new guidelines will become effective on the first day of the first full pay period in the subsequent January.

4. Longevity Pay shall consist of a fifteen (15) step ladder with each step representing 2 years of satisfactory VA employment, beginning at the current Grade 15 Step 10 level.

5. Total compensation will be the sum of Longevity and Market Pay.

6. Individual salaries will be determined by the local director in consultation with a local PSB.

7. The legislative language must specifically State that salaries of VA physicians and dentists will not be reduced, and that there would be no negative pay adjustments.

8. Performance/Bonus Pay will be calculated and addressed separately. One year range to be between $1,000 and $20,000 and shall not be included in any high three or retirement calculations.

9. Federal Locality Pay will be included for all Department of Veterans' Affairs physicians and dentists according to current Federal statutes for each geographic location in the computation of cost of living increases.

10. Judicial review will be maintained for all administrative levels as now dictated by Title 38 and Title 5 statutes.

11. There will be no vesting periods for any category of pay.

12. VA physicians and dentists will earn thirty days of annual leave per year. Non-duty days (weekends and holidays) will not count against that leave.

13. VA physicians and dentists will earn fifteen days of sick leave per year. Non-duty days (weekends and holidays) will not count against that leave.

14. Separate leave pools will be established to facilitate transition of non-duty days, with current leave balances being used prior to days accrued under new system.

15. All language referencing benchmarking salaries must be included in the actual legislative language, including all references to specific sources of income data.

16. This statute will become effective immediately upon enactment.

The following is a brief statement that we received from one of our rank and file members that speaks to many of the points we are addressing here that I would like to share with you:

> I'm a full-time VA employee, board certified in three specialties, with eleven years of post-graduate training before beginning my practice at the VA, where I've remained for the last 8 years. I am an Intensivist, a specialist in critical care medicine and take care of patients who are severely ill in the intensive care unit. During that time I'm on call 24 hours a day, 7 days a week. It is demanding and stressful work. When I'm attending in the ICU, 4 months out of the year, I work on average 70 hours a week, including weekends, for which I receive no additional compensation. When I'm not in the ICU, I work about 50 hours a week. I'm also a co-director of the ICU and I spend long hours working on quality and safety improvement efforts, which have helped to make our ICU among the best in our community. My VA salary, which is my only source of income, is $134,000 dollars a year, admittedly a good income. By contrast, however, according to the Medical Group Management Association (MGMA) data base, the median national income for a Critical Care Intensivist in 2001 was $203,000, the mean salary income nationally was $218,747, and for the third quartile was $277,564. In all likelihood a competitive salary in my particular market area is more than double my current income.

The VA has an asset in both its academic and clinical front line staff, which it seems, it does not fully recognize and which this bill absolutely does not recognize. The cost in loyalty, in efficiency, in quality improvement to the VA, in letting this asset remain under-recognized, and not aggressively competing to retain this asset is immeasurable and vastly exceeds that for recruitment and retention of high end, rare sub-specialists. I agree with the effort to compete for these high end sub-specialists but believe that it misses the real mark, if that is the main intent of the bill, in terms of providing real and lasting value not only to the veterans but to the health and future of the VA itself.

PREPARED STATEMENT OF VETSFIRST, A DIVISION OF UNITED SPINAL ASSOCIATION

INTRODUCTION

VetsFirst, a division of United Spinal Association (formerly the Eastern Paralyzed Veterans Association), is a nationally certified veterans service organization dedicated to enhancing the lives of veterans with spinal cord injuries or disease and ensuring their access to the supports and services they need and deserve. We applaud the Senate Committee on Veterans' Affairs for holding this hearing and providing us with the opportunity to comment on this pending legislation.

VetsFirst recognizes the importance of and is providing comments on all the bills being discussed. However, we would like to highlight four bills, in particular: S. 50, S. 1014, S. 1153 and S. 2133.

S. 50—Veterans Health Care Funding Guarantee Act

Although we support the concept of making veterans health care funding mandatory rather discretionary, VetsFirst has concerns regarding S. 50.

Although the intent of the Veterans Health Care Funding Guarantee Act is laudable, we believe that S. 50 will fall short of reaching its stated goal of fully funding health care for all veterans. First, the proposed method of calculating the mandatory rate of funding is based on an arbitrary amount that is already too low, namely the amount appropriated for veterans' health care for fiscal year 2003. Second, we believe that the amount of money needed to fully guarantee funding for all potential veterans seeking health care is extremely cost prohibitive and unrealistic in today's fiscal climate. Unfortunately, the prospect of passing a law to mandatorily fund veterans' health care at the necessary levels, we fear, is slim. We would rather that VA budgeting continue as is than have Congress adopt a poorly constructed mandatory funding scheme that will not enable VA to offer quality health care to all who seek it.

Again, VetsFirst fully supports efforts to make veterans health care funding a mandatory funding stream. We do not believe, however, that the Veterans Health Care Funding Guarantee Act is a viable and responsible vehicle for doing so.

S. 1014—A Bill to Amend Title 38, United States Code, to Require the Secretary of Veterans Affairs in the Management of Health Care Services for Veterans to Place Certain Low-Income Veterans in a Higher Health-Care Priority Group

VetsFirst strongly supports S. 1014, which would help protect low-income veterans across America.

This bill would move certain low-income veterans currently in priority group 7 to priority group 5 by establishing a true regionally-adjusted income threshold based on the Department of Housing and Urban Development's definition of "low-income." This regional adjustment recognizes that the cost of living, including the cost of medical care, can be significantly higher in large urban centers than in smaller, more rural communities.

VetsFirst strongly believes that there is little difference between a veteran making $23,000 in low cost of living areas and a veteran making $32,000 in a high cost area. For all intents and purposes both veterans are indigent and should be considered similarly by the VA. Unfortunately, VA's existing means test threshold delineates between these two veterans, placing the equally indigent high cost of living veteran in a priority group that is more susceptible to potential system disenrollment.

When it was created, priority 7 and 8 veterans were expected to be able to afford secondary private insurance from which treating facilities could collect payment for care provided. Unfortunately, because of the high cost of living in some areas of the

United States, priority 7 veterans who, by definition, fall above the VA's low-income threshold cannot afford to help defray their cost of care.

Re-categorization of priority 7 veterans into priority group 5 is urgent, particularly in light of VA's ongoing budget constraints and discussions regarding mandatory funding for veterans' health care. As VA faces ever-tightening budget constraints, the Secretary has been forced to make difficult decisions regarding priority group 8's ability to access the VA system. The Secretary has already chosen to freeze enrollment for that category of veterans. Given that VA health care will continue to be under-funded, it is our concern that the Secretary will be forced to disenroll current priority group 8 veterans. The next logical step would be to freeze or even disenroll priority group 7 veterans. This, of course, would mean that veterans who cannot otherwise afford health care would be entirely cut out of the system, leaving them uninsured. Although the Secretary may have the discretion to bar enrollment of priority group 5 veterans, it would be politically impossible to do so because they are considered a "traditional" coverage group. Moving veterans who fall below the HUD threshold into priority group 5 would protect them from possible enrollment restrictions and virtually guarantee them continued access to health care.

Furthermore, and as indicated earlier, VetsFirst believes that the amount of money that would be necessary to fully fund veterans' health care for every potential patient is unrealistically, and cost prohibitively, high. Thus, we believe that Congress cannot create a mandatory funding system that will provide for all priority groups of veterans. Instead, a more viable option would be to only mandate funding for the disabled and indigent—priority groups 1–5 with veterans in other groups expected to have third-party insurance to defray the cost of their care. As current priority group 7 veterans are legitimately unable to defray the cost of their care we believe that these veterans must be accounted for in any mandatory funding system and should be moved into priority group 5 to ensure that they are included in potential mandatory funding discussions.

Moving priority group 7 veterans, who fall below the HUD threshold, into priority group 5 would protect them from possible enrollment restrictions and help guarantee access to health care. Additionally, it would ensure that they are included in most viable mandatory funding discussions. For these reasons we strongly support this legislation.

S. 1153—Veterans Prescription Drugs Assistance Act

VetsFirst strongly supports S. 1153, the Veterans Prescription Drug Act of 2003. S. 1153 would allow all Medicare-eligible veterans to "opt-in" to a new program in which VA would fill their privately written prescriptions without requiring the patient to see a VA doctor, whether the veteran has enrolled in the system or not. The veteran would pay the VA's cost of the drug, which is significantly less than the cost of the drug in the private market. By opting into this program the veteran would also be required to forego his/her access to the rest of VA's care for the year and they would have to make the decision on their participation in this program on an annual basis. Medicare eligible veterans with service-connected disabilities who participate in the program would not be precluded from VA services.

This program was tailored to increase the number of options available to veterans as opposed to limiting veterans' choices. Participation in this program is discretionary and there is nothing forcing each individual veteran to give up his or her access to all of VA's services. By allowing only Medicare eligible veterans to opt into the program, Congress is ensuring that only those veterans with non-VA medical care coverage already in place (i.e., Medicare) can freeze themselves out of the system. Additionally, service-connected veterans will continue to have open access to the VA system and will now gain the opportunity to use private Medicare providers when convenient.

Finally, S. 1153 could have an additional effect on the system that would result in new priority group 8 veterans regaining the ability to enroll in the health care system. On January 17, 2003, in response to the inundation of veterans into the VA health care system, VA Secretary Anthony Principi announced that the system would immediately stop enrolling these priority group 8 veterans, closing them out from health care. This program will provide, at a minimum, cheaper prescription drugs to those veterans currently barred from the system and shorter wait times for all veterans seeking VA health care. It is our hope that as currently enrolled priority group 8 veterans opt into this program and opt out of VA health care, veterans who need the resources of the whole system, but are currently frozen out, can fill the vacated spots in the VA health care system.

S. 2133—A Bill to Name the Department of Veterans Affairs Medical Center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center

United Spinal Association strongly supports S. 2133, a bill to name the Department of Veterans Affairs medical center in the Bronx, New York, as the James J. Peters Department of Veterans Affairs Medical Center. Jim Peters served as our Executive Director for over 30 years and earned this honor thorough his unwavering support and dedication for his fellow paralyzed veteran. All who knew Jim Peters would agree that there was no greater advocate for veterans with Spinal Cord Injury (SCI). Jim devoted his life to the improvement of health care for spinal cord injured veterans and to ensuring quality health care for all who served. He was instrumental in establishing a stand-alone national Spinal Cord Injury program within the VA and, working with *Life Magazine*, was the driving force in the news stories that exposed the deplorable conditions facing spinal cord injured veterans at the old Bronx veterans hospital. This exposd triggered the decision to rebuild the Bronx Veterans Affairs Medical Center, which is now the SCI Center for Excellence in the northeast region. He consistently encouraged our members, and veterans alike, to utilize the services offered by the VA health care system, as according to him, "it far surpassed the care available anywhere else". Jim passed away at the Manhattan VAMC.

Jim Peters not only worked tirelessly to improve the spinal cord injury ward at the Bronx VAMC but also promoted partnerships with medical researchers to develop cutting-edge treatments for spinal cord injury patients. The Bronx VAMC is now the premier veterans center for spinal cord injury patients, in large part due to Jim's efforts. We see no better way of honoring his commitment than having the Bronx VAMC renamed, "The James J. Peters Department of Veterans Affairs Medical Center". It is an action that truly befits his legacy of support for his fellow injured veterans.

We have received letters of support from: Vietnam Veterans of America, The American Legion, Paralyzed Veterans of America, AMVETS, Disabled American Veterans, Blinded Veterans Association, Veterans of the Vietnam War, Jewish War Veterans, Catholic War Veterans, Veterans of Foreign Wars, Military Order of the Purple Heart, United Veterans Beacon House, National Amputation Foundation, New York State Council of Veterans Organizations, Mount Sinai, and No Greater Love.

We will now briefly comment on the remaining bills on the committee's agenda.

S. 1509—Eric and Brian Simon Act of 2003

VetsFirst supports the Eric and Brian Simon Act of 2003 (S. 1509), which would provide compensation to veterans, their spouses and children who contract HIV or AIDS as a result of a blood transfusion relating to a service-connected disability.

According to this legislation, any veteran treated with HIV contaminated blood as a result of a service-connected disability would receive $100,000 in compensation. If a spouse or child of the veteran becomes infected with HIV through transmission from the veteran, they too would receive compensation. Additionally, if an individual entitled to a gratuity under this legislation is deceased at the time of payment, payment shall be made to a surviving spouse or children. This legislation is similar to provisions created under the Veterans Benefit Act of 1997, which states that children of Vietnam veterans suffering from spina bifida are granted benefits ranging from monetary allowance, vocational training and rehabilitation, and healthcare benefits limited to the treatment of spina bifida (38 U.S.C. § 1805), so similar precedent already exists.

United Spinal recognizes the enormous cost associated with HIV/AIDS healthcare treatment and medications and would also recommend that a spouse or child infected with HIV as a result of the veteran's service-connected transfusion be given access to VA's healthcare system for the treatment of HIV/AIDS or at the very least VA's pharmaceutical benefits.

S. 1745—Prisoner of War/Missing in Action National Memorial Act

VetsFirst supports S. 1745. It is both appropriate and necessary to honor members of the Armed Forces who have been held as prisoners of war or listed as missing in action.

S. 2063—A Bill to Require the Secretary of Veterans Affairs to Carry Out a Demonstration Project on Priorities in the Scheduling of Appointments of Veterans for Health Care Through the Department of Veterans Affairs, and for Other Purposes

VetsFirst supports S. 2063, which would assess the feasibility of providing priority scheduling of appointments for service-connected veterans through a demonstration project. VetsFirst supports this legislation that will bolster the Secretary's authority to implement this appointment prioritization as he has already done (38 CFR Part 17). We support projects that look for effective ways to deliver timely access care to VA health care.

S. 2099—A Bill to Amend Title 38, United States Code, to Provide Entitlement to Educational Assistance Under the Montgomery GI Bill for Members of the Selected Reserve Who Aggregate More Than 2 Years of Active Duty Service in Any Five Year Period, and for Other Purposes

VetsFirst strongly supports this legislation that will extend educational assistance provided by the Montgomery GI bill to members of the Selected Reserve who accumulate more than 2-years of active duty service in a 5-year period. In light of recent military actions that have resulted in longer periods of service and greater conflicts, this benefit is well deserved.

S. 2296—A Bill to Require the Secretary of Veterans Affairs to Give the Commonwealth of Kentucky the First Option on the Louisville Department of Veterans Affairs Medical Center, Kentucky, Upon its Conveyance, Lease or Other Disposal by the Department of Veterans Affairs

VetsFirst supports S. 2296. We believe that the Commonwealth of Kentucky should use this space primarily for the provision of services to veterans.

S. 2327—A Bill to Amend Title 38, United States Code, to Clarify that Per Diem Payments by the Department of Veterans Affairs for the Care of Veterans in State Homes Shall Not be Used to Offset or Reduce Other Payments Made to Assist Veterans

VetsFirst supports this legislation that would prevent the offsetting of payments made to veterans in State homes based on VA's per diem payments to State homes.

S. 2417—A Bill to Amend Title 38, United States Code, to Authorize the Secretary of Veterans Affairs to Furnish Care for Newborn Children of Women Veterans Receiving Maternity Care, and for Other Purposes

United Spinal Association supports S. 2417 which would amend Title 38, United States Code, to Authorize the Secretary of Veterans Affairs (VA) to furnish care for newborn children of women veterans receiving maternity care, and for other purposes. This legislation would apply to any woman veteran who is receiving maternity care furnished by the VA up to 14 days after the birth of the child whether or not the veteran delivered the child in a VA facility or in a non-VA facility pursuant to VA's contract for the delivery services. Though most pregnancy care is focused on the pre-birth period, post delivery is also a critical time for the health of the mother and her baby. United Spinal recognizes the importance of postpartum care and therefore strongly supports this bill.

S. 2483—Veterans' Compensation Cost-of-Living Adjustment Act of 2004

VetsFirst supports this legislation to increase the rates of compensation for veterans with service-connected disabilities and the rates of Dependency and Indemnity Compensation for the survivors of certain disabled veterans.

S. 2484—Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003

VetsFirst supports the concept of S. 2484. Like all parts of the health care sector, VA is facing shortages of health care personnel. This has been one of the root causes of delays in and waiting lists for appointments with VA doctors. VA must do all it can to attract high quality doctors, nurses and other health care providers, including increasing pay rates and possibly adjusting work hours.

S. 2485—Department of Veterans Affairs Real Property and Facilities Managements Improvement Act of 2004

VetsFirst supports S. 2485. In particular, the procedures for entering into enhanced-use leases of VA property is notoriously complicated, drawn-out, and overly burdensome for all parties involved. This system is long overdue for change. Addi-

tionally, by allowing the VA to retain the proceeds of disposition of VA properties, S. 2485 would improve the financial situation of the Department. In light of the recently announced Capital Asset Realignment for Enhanced Services plan, this provision makes sense.

S. 2486—Veterans' Benefits Improvements Act of 2004

VetsFirst supports this legislation that will improve or expand education, housing, and employment benefits to veterans. We also support the waiving of co-payments for veterans receiving hospice care.

S. 2524—A Bill to Amend Title 38, United States Code, to Improve the Provision of Health Care, Rehabilitation, and Related Services to Veterans Suffering from Trauma Relating to a Blast Injury, and for Other Purposes

VetsFirst supports S. 2524, which would improve the provision of health care, rehabilitation, and related services to veterans suffering from trauma relating to a blast injury. The majority of blast injury victims (70 percent) sustain soft tissue injury, and traumatic amputations occur in approximately 11 percent of cases.[1] We support the creation of centers for research, education, and clinical activities on blast injuries, as they will allow for the proper treatment of veterans suffering from multiple traumas associated with a blast injury. Blast injuries are devastating and any improvement of services for victims of explosions is strongly supported by VetsFirst.

S. 2534—Montgomery GI Bill for the 21st Century Act

VetsFirst supports S. 2534 that will improve educational benefits under the Montgomery GI Bill.

CONCLUSION

VetsFirst applauds the committee for holding this hearing on pending legislation and its leadership on these and all issues important to the men and women who have served our country. We appreciate the opportunity to comment on this critical legislation.

[1] Elsayed NM. Toxicology of blast overpressure. Toxicology 1997;121:1–15.

The American Legion
Department of New York
112 State Street, Suite 400 · Albany, New York 12207

Charles J. Herschlag
Department Commander

Richard M. Pedro
Department Adjutant

27 April 2004

Mr. Jeremy Chwat
United Spinal Association
75-20 Astoria Blvd.
Jackson Heights, NY 11370

Via FAX: 718-803-1089

Dear Mr. Chwat:

The American Legion, Department of New York does not endorse naming federal facilities as a matter of record. However, this office is not opposed to the Eastern Paralyzed Veterans Association's desire to rename the Department of Veterans Affairs Medical Center in Bronx, NY as the "James J. Peters Department of Veterans Affairs Medical Center, honoring his commitment to veterans.

In Comradeship,

Richard M. Pedro
Department Adjutant

(Tel) 518-463-2215 (Fax) 518-427-8443 (E-Mail) info@nylegion.org (Website) www.ny.legion.org

SERVING WITH PRIDE

December 17, 2003

The Honorable Jose Serrano
U.S. House of Representatives
Washington D. C. 20515

Dear Representative Serrano,

As you know Mr. James J. Peters, who served for 30 years as the Executive Director of the Eastern Paralyzed Veterans Association, passed away after a short illness on September 6, 2002. Anyone who knew Mr. Peters knows that there was no greater advocate for veterans with Spinal Cord Injury (SCI or the entire Ba Health Care System. As such, we strongly support your legislation seeking to rename the Bronx Department of Veterans Affairs Medical cater, Located in the Bronx New Your, as the James J. Pelters VA Medical Center.

James Peters Compassionate Commitment to veterans with SCI and the VA's SCI health care system is what prompted us to endorse your legislation to rename the Department of Veterans Affairs Medical Center in Bronx, New york as the "James J. Peters Department of Veterans Affairs Medical Center". Renaming the Bronx VAMC for Jim Peters is an action that truly befits his legacy of support for his fellow injured veterans, and we, at the AMERICAN VETERANS (AMVETS) see no better way of honoring his commitment to all veterans.

Dedicated to Service

Joseph W. Lipowski
Dept. of N.Y. Exec. Director

AMVETS

Joseph W. Lipowski
NY State Executive Director
43 Mona Ct.
Depew, NY 14043
Phone: 716-684-1714
Cell: 716-713-7940
E-mail: syl12@localnet.com

BLINDED VETERANS ASSOCIATION, NEW YORK, INC.
NEW YORK REGIONAL GROUP
245 WEST HOUSTON STREET
NEW YORK, N.Y. 10014-4805
TELEPHONE (212) 807-3173
FAX (212) 807-4022

November 1, 2002

The Honorable Eliot Engel
United States House of Representatives
Washington, DC 20515

Dear Representative Engel:

As you know, Mr. James J. Peters, who served for 30 years as the Executive Director of the Eastern Paralyzed Veterans Association (EPVA), passed away after a short illness on September 6, 2002. Anyone who knew Mr. Peters knows that there was no greater advocate for veterans with Spinal Cord Injury (SCI) or the entire VA Health Care System. As such, we strongly support your legislation seeking to rename the Bronx Department of Veterans Affairs medical center, located in the Bronx, New York, as the James J. Peters VA Medical Center.

Jim devoted his life to the improvement of health care for spinal cord injured and all veterans. Through his efforts, EPVA joined with local institutions, including the Mount Sinai Medical Center to provide advanced methods of treatment to paralyzed veterans in the metropolitan area. He helped to establish the Spinal Cord Damage Research Center at the Bronx VA Medical Center, where scientists investigate the impact of spinal cord injury on other body systems. He also played an instrumental role in establishing a stand-alone national Spinal Cord Injury Service within the VA and in the decision to rebuild the Bronx Veterans Affairs Medical Center, which is the SCI Center for Excellence in the northeast region. He consistently encouraged EPVA members, and veterans alike, to utilize the

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FAX (212) 807-4022

services offered by the VA health care system, as according to him, "it far surpassed the care available anywhere else".

James Peters' compassionate commitment to veterans with SCI and the VA's SCI health care system is what prompted us to endorse your legislation to rename The Department of Veterans Affairs Medical Center in Bronx, New York, as the "James J. Peters Department of Veterans Affairs Medical Center". Renaming the Bronx VAMC for Jim Peters is an action that truly befits his legacy of support for his fellow injured veterans, and we, at the New York Regional Group of the Blinded Veterans Association, see no better way of honoring his commitment.

Sincerely,

Dennis J. O'Connell, President

Catholic War Veterans
OF THE UNITED STATES OF AMERICA, INC.
DEPARTMENT OF NEW YORK • 346 BROADWAY, SUITE 812 • NEW YORK, NY 10013
Telephone: (212) 962-0988 Fax: (212) 894-0517

July 21, 2003

The Honorable Jose Serrano
United States House of Representatives
Washington, D.C. 20515

Dear Representative Serrano:

As you Know, Mr. James J. Peters, who served for 30 years as the Executive Director of the Eastern Paralyzed Veterans Association (EPVA), passed away after a short illness on Sept. 6, 2002. Anyone who knew Mr. Peters knows that there was no greater advocate for veterans with Spinal Cord Injury or the entire VA Health Care System. As such, we strongly support your legislation seeking to rename the Bronx Department of Veterans Affairs medical center, located in the Bronx, New York, as the James J. Peters VA Medical Center.

Renaming the Bronx VAMC for Jim Peters is an action that truly befits his legacy of support for his fellow injured veterans and we, at the Catholic War Veterans, see no better way of honoring his commitment.

Sincerely

Phil Scola
Commander
N.Y. Department
Catholic War Veterans

DISABLED AMERICAN VETERANS
DEPARTMENT OF NEW YORK, INC.
200 Atlantic Avenue • Lynbrook, New York 11563 • (516) 887-7100 • Fax (516) 887-7175

October 30, 2002

The Honorable Eliot L. Engel
United States House of Representatives
Washington, D.C. 20515

Dear Representative Engel:

The Department of New York Disabled American Veterans is proud to support the naming of (Base #81) Bronx VA Medical Center after James J. Peters, Executive Director of the EPVA.

Please let us know we can further support your efforts in this regard.

Sincerely,

Sidney Siller, Sr. PDC
Department Adjutant

SS; db
cc: Gerard Kelly, Executive Director
Eastern Paralyzed Veterans Association

Jewish War Veterans, U.S.A.
Department of New York

The Militant and Patriotic Voice of American Jewry

346 Broadway, Room 817, New York, New York 10013 - Tel: (212) 349-6640
Fax.: (212) 577-2575

LEWIS B. WUNDERLICH
COMMANDER

e-mail: deptny.jwv@juno.com

November 14, 2002

The Honorable Eliot Engel
United States House of Representatives
Washington, DC 20515

Dear Representative Engel:

Mr. James J. Peters served for 30 years as the Executive Director of the Eastern Paralyzed Veterans Association (EPVA), passed away after a short illness on September 6, 2002. Anyone who knew Mr. Peters knows that there was no greater advocate for veterans with Spinal Cord Injury (SCI) in the entire VA Health Care System. As such, we strongly support your legislation seeking to rename the Bronx Department of Veterans Affairs medical center, located in the Bronx, New York, as the James J. Peters VA Medical Center.

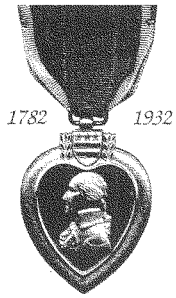
The Jewish War Veterans know that Jim devoted his life to the improvement of health care for spinal cord injured and to all veterans. Through his efforts, EPVA joined with local institutions to provide advanced methods of treatment to paralyzed veterans in the metropolitan area. He helped to establish the Spinal Cord Damage Research Center at the Bronx VA Medical Center, where scientists investigated the impact of spinal cord injury on other body systems. He also played an instrumental role in establishing a stand-alone national Spinal Cord Injury Service within the VA and in the decision to rebuild the Bronx Veterans Affairs Medical Center, which is the SCI Center for Excellence in the northeast region. He consistently encouraged EPVA members, and veterans alike, to utilize the services offered by the VA health care system.

James Peters' compassionate commitment to veterans with SCI and the VA's SCI health care system is what prompted us to endorse your legislation to rename The Department of Veterans Affairs Medical Center in the Bronx as the "James J. Peters Department of Veterans Affairs Medical Center." Renaming The Bronx VAMC for Jim Peters is an action that truly befits his legacy of support for his fellow injured veterans, and we of the Department of New York Jewish War Veterans see no better way of honoring his commitment.

Sincerely,

Lewis B. Wunderlich

Lewis B. Wunderlich
Commander



MILITARY ORDER OF THE PURPLE HEART

CHARTERED BY CONGRESS

OFFICE OF:

Tony Rivera Jr.
Region 1 Commander
1647 William Street
Fort Lee,N.J.07024

Mr. Gerard M. Kelly
Executive Director
Eastern Paralyzed Veterans Association
75-20 Astoria Boulevard
Jackson Heights, New York 11370-1177

Dear Mr. Kelly,

We suffered a great loss with passing of James Peters. He has been a staunch ally, if not a great supporter of many programs involving those who have served our great Nation. His compassioned giving transcended every level of human need.

A little over a year ago, he with out questions as to addressing a gift, which fulfilled a chance remark on my behalf. I noticed a shortage of wheelchairs at the East 23rd Street VAMC. I had spoken to the urologist in charge of that department as to her needs. She suggested one or two chairs. I approached James Peters whose help, led to the Colon-Rivera Memorial Chapter #3 of the Military Order of the Purple Heart putting together of not one or two wheelchairs, but the giving of thirty. I will never forget his beaming smile at that event.

He had the marvelous capability to cooperatively excel when the need arises to bring to fulfillment that which benefited the health of others. The EPVA under his leadership mobilized their resources by backing my Region 1, which I command, efforts to bring about a major veterans event, United We Stand on the Intrepid Sea and Air Museum. He never realized the finality of that effort as he perished from the complications of a stroke. Mr. Peters had enthusiastically set aside his accomplishment to see our efforts culminate in a major success by determining to join the MOPH local host chapter, others, and me specifically the EPVA to bring together the loose ends. He infused the EPVA through his quality of giving with the impetus to carry on as recognition of his generosity.

There is no person who can turn aside from honoring, not only the recent events, but his great dedicated accomplishments, which addressed the sufferings as relate to spinal cord injuries as well as associated pathologies. The veterans have benefited from what he had undertaken as a major calling, that of spinal injury and disabling pathologies, which impacts not only veterans but also the civilian population. His efforts, world respected, as his life's work has promoted an outstanding program, which has led to modernizing the Bronx VAMC into a major facility injures through its

incorporating of therapy, research, diagnostic skills as a leading institute. The Bronx VAMC is acknowledged by international and National authorities for outstanding uniqueness as a center for spinal injuries and associated pathologies.

I strongly recommend that his memory be rewarded by naming the aforementioned facility as The James Peter's VAMC.

Yours in Patriotism,

Tony Rivera Jr.
Region 1 Commander

Colon-Rivera Memorial Chapter 3-NYC • PO Box 401 • • Radio City Station
New York NY 10101-0401 • 212-686-7500 x3596 • 201-585-8026

Mount Sinai

L.H. Hollier, M.D.
President

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Tel: (212) 659-9090
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October 7, 2002

The Honorable Eliot Engel
United States House of Representatives
Washington, DC 20515

Dear Representative Engel:

As you know, Mr. James J. Peters, who served for 30 years as the Executive Director of the Eastern Paralyzed Veterans Association (EPVA), passed away after a short illness on September 6, 2002. Anyone who knew Mr. Peters knows that there was no greater advocate for veterans with Spinal Cord Injury (SCI) or the entire VA Health Care System. As such, we strongly support your legislation seeking to rename the Bronx Department of Veterans Affairs medical center, located in the Bronx, New York, as the James J. Peters VA Medical Center.

The Mount Sinai School of Medicine (MSSM) maintains an affiliation with the Bronx VAMC and has worked with EPVA on Spinal Cord Injury research for over 15 years. We know first hand that Jim devoted his life to the improvement of health care for spinal cord injured and all veterans. Through his efforts, EPVA joined with local institutions, including the Mount Sinai Medical Center to provide advanced methods of treatment to paralyzed veterans in the metropolitan area. He helped to establish the Spinal Cord Damage Research Center at the Bronx VA Medical Center, where scientists investigate the impact of spinal cord injury on other body systems. He also played an instrumental role in establishing a stand-alone national Spinal Cord Injury Service within the VA and in the decision to rebuild the Bronx Veterans Affairs Medical Center, which is the SCI Center for Excellence in the northeast region. He consistently encouraged EPVA members, and veterans alike, to utilize the services offered by the VA health care system, as according to him, "it far surpassed the care available anywhere else".

James Peters' compassionate commitment to veterans with SCI and the VA's SCI health care system is what prompted us to endorse your legislation to rename The Department of Veterans Affairs Medical Center in Bronx, New York, as the "James J. Peters Department of Veterans Affairs Medical Center". Renaming the Bronx VAMC for Jim Peters is an action that truly befits his legacy of support for his fellow injured veterans, and we, at the Mount Sinai School of Medicine, see no better way of honoring his commitment.

Sincerely,

Larry H. Hollier, MD
President
The Mount Sinai Hospital

National Amputation Foundation
40 Church Street
Malverne, N.Y. 11565
(516) 887-3600
(516) 887-3667 FAX
Email: amps76@aol.com

INCORPORATED
UNDER THE LAWS
OF THE
STATE OF NEW YORK

October 24, 2002

Honorable Eliot Engel
United States House of Representatives
Washington DC 20515

Re: James Peters

Dear Representative Engel:

Your proposal to rename the Department of Veterans Affairs Medical Center in the Bronx after James J. Peters has recently come to our attention. We can think of no finer tribute to Mr. Peters' years of work on behalf of spinal cord-injured veterans. The Bronx VA is a spinal cord injury center and Mr. Peters has been the executive director of the Eastern Paralyzed Veterans Association from 1971 until his untimely death in September of this year.

We wholeheartedly endorse the proposal to rename the DAV Medical Center in the Bronx the "James J. Peters Department of Veterans Affairs Medical Center".

Sincerely,

Donald A. Sioss, PP
Executive Secretary

DAS/lr
cc EPVA

All donations to the National Amputation Foundation, Inc. are deductible as charitable contributions for Federal Income tax purposes.

A FLAME OF HOPE
THROUGH DECADES
OF REMEMBRANCE

1750 NEW YORK AVENUE, NW
WASHINGTON, DC 20006
PH: 202-783-4665
FAX: 202-783-1168
E-MAIL: REMEMBRANCE@NGL.ORG
WEBSITE: WWW.NGL.ORG

NO GREATER LOVE

November 6, 2002

Mr. Gerard M. Kelly
Executive Director
Eastern Paralyzed Veterans Association
75-20 Astoria Boulevard
Jackson Heights, NY 11370-1177

Dear Gerry:

I want to add my full support in the naming of the VA Medical Center in the Bronx after the best friend any veteran ever had – James Peters

Emerson said, *"A friend may well be reckoned as a masterpiece of Nature."* Jim Peters was a genuine masterpiece of Nature.

I had the privilege of meeting Jim over 30 years ago, when I asked him if he and EPVA would support No Greater Love: the only organization solely dedicated to remembering the families, particularly the children, who lost a parent in service to our country. Among the many I had contacted, Jim Peters was the only one, at that time, who said that he would be there for them. And he remained faithful to his promise for three decades as a board member of our organization. Without his help we could not have reached out to the thousands of No Greater Love children and the families of the hostages in Iran and in Lebanon, but also those who lost loved ones by acts of terrorism, from the Marine Barracks in Beirut to the victims of 9/11.

Jim seemed perpetually determined to make more fulfilling and more joyous the lives of all with whom he came in contact. He was truly one of a kind. His strong point was with people, especially veterans. His compassion inspired all those who met him, child or adult. All of us who knew him are the better for it.

I salute his unswerving dedication in using all his energy and resources to pursue whatever was necessary, to improve the lot of veterans and the families of those who died in service to our country. Jim decided it was not enough to accept the world as it is but that each of us has an obligation to make it better. *"to tend the garden,"* as Voltaire so famously said. To me, that was at the core of his values and it really explained who he was. He was a go-getter and a go-giver. With his passing, we have all suffered a profound and immeasurable loss.

I think Albert Einstein had it right when he said: *"Try not to become a man of success, try to become a man of value."* Jim Peters was both. He was a man of success because he was a man of value.

The Bronx VA Hospital deserves to be named for a true American and the great human being that was Jim Peters.

Sincerely,

Carmella LaSpada
Founder

New York State
Council of Veterans Organizations
Legislative Representatives

P.O. Box 2562 • Empire State Plaza • Albany, NY 12220-0562

American Gold Star Mothers
American Military Retirees Assoc.
American Ex-Prisoners of War
AMVETS
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Catholic War Veterans
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Eastern Paralyzed Veterans Assoc.
Italian War Veterans
Jewish War Veterans
Korean War Veterans
Marine Corps League
Military Order of the Purple Heart
N.Y.S., County Veterans Service Officers Assoc.
Noncommissioned Officers Assoc.
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369th Veterans Assoc.
Sampson Navy WWII Veterans
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United Service & Veterans Action Council
United Auto Workers Region 9, Veterans Comm.
United Federation of Teachers, Veterans Comm.
Veterans in Government
Veterans of Foreign Wars
Veterans of Foreign Wars Auxiliary
Veterans of Overseas Service of America
Vietnam Veterans of America
Women Veterans of America

November 23, 2002

Honorable John M. Engal
United States House of Representatives
2442 Rayburn House Office Building
Washington D.C. 20515

Dear Representative Engal,

The New York State Council of Veterans Organizations is in support of renaming the Medical Center in Bronx, for a great advocate Mr. James J. Peters. He served for 30 years for the Eastern Paralyzed Veterans Association with honor. It would be a great honor having this Medical Center in his name.

Robert E. Becker, Jr.
President

PVA
PARALYZED VETERANS OF AMERICA

May 3, 2004

Honorable Hillary Rodham Clinton
United States Senate
SR-476 Russell Senate Office Building
Washington, DC 20510-3203

Dear Senator Clinton:

On behalf of the Paralyzed Veterans of America (PVA), I write in strong support for your efforts, S.2133, to name the Department of Veterans Affairs Medical Center located in the Bronx, New York the James J. Peters VA Medical Center. There can be no more fitting tribute to Mr. Peters than to name the Center after him, a Center to which he so tirelessly devoted his energies. Mr. Peters' dedication to fellow veterans, particularly veterans with spinal cord injury or dysfunction, was selfless and unrelenting; he committed his life's work to improving the VA and the quality of life it afforded veterans whether in areas of health care, research or benefits.

James Peters was a life member of PVA and he served our organization with the same zeal and passion as he served individual veterans. For over thirty years Mr. Peters was a leader, a counselor and a visionary for PVA. Through his position as Executive Director of the Eastern Paralyzed Veterans Association his focus was on the veterans of the New York City metropolitan area and surrounding States, yet his reach and achievements stretched nationwide. Veterans throughout the VA system of spinal cord injury care are the beneficiaries of his efforts to improved clinical practices and expand research initiatives. He fought for all veterans believing they had rightfully earned the very best in health care and benefits this Nation can provide.

The legacy of James J. Peters is one that can be measured in improved lives for tens of thousands of veterans with spinal cord injury and dysfunction and millions of other Americans with disabilities. His efforts on behalf of his fellow citizens were remarkable, spanning numerous aspects of daily life. His life represents the highest standards of public service and caring for his fellow veterans and citizens.

The naming of the Bronx VA Medical Center in recognition of the achievements and actions of James J. Peters is commendable and yet but a small token for a man who did so much for so many. Again, on behalf of the Paralyzed Veterans of America, thank you for your initiative and we strongly support your efforts.

Sincerely,

Delatorro L. McNeal
Executive Director

United Veterans Beacon House
1360 Fifth Avenue, BayShore, New York, 11706

631-665-1571 Fax 631-665-1578

October 29, 2002

Mr. Gerard M. Kelly
Executive Director
Eastern Paralyzed Veterans Association
75-20 Astoria Boulevard
Jackson Heights, New York 11370-1177

Dear Mr. Kelly,

The Veteran community suffered a catastrophic loss with the recent passing of Jim Peters. He was a great advocate of Veterans rights and benefits. Jim was also an advid supporter of the Veterans Administration and the medical care that it provides.

I know the staff and members of the EPVA are proud of the many accomplishments they have experienced under the leadership of Jim Peters. None stands out in my mind more than the modernization of the Bronx Veterans Hospital and the benefits reaped from the more than one billion dollars he raised for spinal cord injury research. Not only has our veterans benefited from the accomplishments of Jim Peters and EPVA but also many non-veterans as well. These accomplishments are recognized worldwide throughout many hospitals and medical learning institutions.

Jim Peters and EPVA would respond to any worthy need for veterans, such as the funding for housing for senior veterans with disabilities. The EPVA has given the services of its architect and a generous grant of five thousand dollars for the development of a new Beacon House in Levittown, New York.

I can think of no better way to honor a man that has done so much that benefited so many than to name a VA Medical Center after him. For his passion was to help his brother veteran in despair. I strongly support and recommend the Bronx V A Medical Center be renamed in honor of the work Jim Peters has done and the work being done today by the EPVA to the "JAMES J. PETERS BRONX VETERANS AFFAIRS MEDICAL CENTER".

Warmest personal regards.

Sincerely,

Frank Amalfitano

Frank Amalfitano
Executive Director

CHARTERED BY CONGRESS
An association of men and women who fought America's foreign wars on land, sea, and in the air

FOUNDED 1899
"To care for him who has borne the battle and those dependent upon him."

VETERANS OF FOREIGN WARS
OF THE UNITED STATES
DEPARTMENT OF NEW YORK, Inc.

1044 BROADWAY
ALBANY, NY 12204

TEL: (518) 463-7427
FAX: (518) 426-8904

November 21, 2003

The Honorable Jose Serrano
United States House of Representatives
Washington, DC 20515

Dear Representative Serrano,

As you know, Mr. James J. Peters, who served for 30 years as the Executive Director of the Eastern Paralyzed Veterans Association, passed away after a short illness on September 6, 2002. Anyone who knew Mr. Peters knows that there was no greater advocate for veterans with Spinal Cord Injury (SCI) or the entire VA Health Care System. As much, we strongly support your legislation seeking to rename the Bronx Department of Veterans Affairs Medical Center, located in the Bronx, New York, as the James J. Peters VA Medical Center.

Jim devoted his life to the improvement of health care for spinal cord injured and all veterans. He helped to establish the Spinal Cord Damage Research Center at the Bronx VA Medical Center, where scientists investigate the impact of spinal cord injury on other body systems. He also played an instrumental role in establishing a stand-alone national Spinal Cord Injury Service within the VA and in the decision to rebuild the Bronx Veterans Affairs Medical Center, which is the SCI Center for Excellence in the northeast region. He consistently encouraged all veterans to utilize the services offered by the VA health care system, as according to him, "it far surpassed the care available anywhere else".

James Peters' compassionate commitment to veterans with SCI and the VA's SCI health care system is what prompted us to endorse your legislation to rename the Department of Veterans Affairs Medical Center in Bronx, New York, as the "**James J. Peters Department of Veterans Affairs Medical Center**". Renaming the Bronx VAMC for Jim Peters is an action that truly befits his legacy of support for his fellow injured veterans, and we, at the Department of New York, Inc., Veterans of Foreign Wars, see no better way of honoring his commitment.

Sincerely,

Art Koch III, PSC
State Adjutant

AK/meh

cc: Harold Burke, Jr., State Commander
Karl Rohde, PSC, State Legislative Chairman
Katherine Hrvatin, Eastern Paralyzed Veterans Association

VETERANS OF THE VIETNAM WAR, INC.
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805 South Township Boulevard, Pittston, PA 18640
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1-800-VIETNAM
E-mail: vvnwnatl@epix.net Website: www.vvnw.org

"Service Without Reward - Dedication to Brotherhood"

November 1, 2002

Mr. Gerard M. Kelly
Executive Director
Eastern Paralyzed Veterans Association
75-20 Astoria Boulevard
Jackson Heights, New York 11370-1177

Dear Mr. Kelly:

Dedication, unselfishness, commitment, passion ... all words that could be used to describe James J. Peters, a true friend to veterans and non-veterans alike. His accomplishments showed his true, heartfelt commitment to doing all that he could to improve the life situations of everyone he met.

It is our sincere belief that a "man is not truly dead until he is forgotten". By renaming the Bronx Veterans Administration Medical Center the James J. Peters Bronx Veterans Administration Medical Center we would ensure that current veterans and those who come next will know of the James J. Peters legacy.

The Veterans of the Vietnam War, Inc. is honored to add our recommendation to those of other organizations in supporting this renaming effort.

With our hopes for the accomplishment of this goal, we remain,

Sincerely,

Michael Milne
National Commander

Peter Forbes
Australian Commander

Nancy Verespy
National Executive Director

Vietnam Veterans of America

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

June 15, 2004

The Honorable Hillary Rodham Clinton
United States Senate
SR-476 Russell Senate Office Building
Washington, D.C. 20510-3203

Dear Senator Clinton,

Vietnam Veterans of America (VVA) strongly endorses your bill and that of Congressman Jose Serrano that would name the VA medical center in the Bronx, the "James J. Peters Department of Veterans Affairs Medical Center."

We at VVA knew Jim Peters to be an articulate and forceful leader as executive director of the Eastern Paralyzed Veterans Association for 31 years until his death in September 2002. We knew him as a man of principle who in 1970 worked with Life magazine on a story exposing the deplorable conditions facing paralyzed Vietnam veterans at the old Bronx VA hospital. The article in Life forced the then Veterans Administration to build the new Bronx VAMC, where he helped establish the Spinal Cord Damage Research Center. He was instrumental as well in establishing a stand-alone national Spinal Cord Injury Service.

On a personal note, I'd known Jim Peters since 1979. He was a close personal friend as well as an activist who devoted his life to the improvement of health care for all veterans, particularly those with spinal cord injuries. It is entirely fitting that his commitment to veterans be acknowledged by naming the facility he helped rebuild the "James J. Peters Department of Veterans Affairs Medical Center."

Sincerely,

Thomas H. Corey
National President

cc: Katherine Catu, United Spinal Association