THE AMERICAN LEGION

Fiscal Year 2007

VIEWS AND ESTIMATES

FOR THE

Department of Veterans Affairs

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THE AMERICAN LEGION

Statement of
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Before a
Joint Session of
The Veterans Affairs Committees
United States Congress

On The Legislative Priorities
of The American Legion

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Messrs. Chairmen and Members of the Committees:

As The American Legion's newly elected National Commander, I thank you for this opportunity to present the views of its 2.7 million members on issues under the jurisdiction of your Committees. At the conclusion of The American Legion's Eighty-Seventh National Convention in Honolulu, Hawaii, over 3,100 delegates adopted 42 organizational resolutions with 36 having legislative intent. These organizational mandates will add to the legislative portfolio of The American Legion for the remainder of the 109th Congress.

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

WHO IS A VETERAN?

"To those who have defended it, freedom has a flavor the protected will never enjoy."

- Anonymous on a bunker at Khe Sahn, Republic of Vietnam

For the purposes of title 38, United States Code, Veterans' Benefits, the basic definition of the word "veteran" is a person who served in the active military, naval or air service and who was discharged or released therefrom under conditions other than dishonorable. Some 25.6 million persons met this definition in 2002 and of those, 19.1 million meet a further definition of "veterans of any war" because they served in the active military, naval or air service during a period of war. This distinction is important because there are significant advantages specifically accruing only to veterans with wartime service. "Conditions other than dishonorable," "active military, naval or air service" and "period of war" are all defined in the law. Prior to 1980, there were no minimum length of service requirements. To be eligible for some VA benefits, an individual who enlisted in the military service for the first time on or after September 8, 1980, is now required to complete a minimum period of service, either twenty-four months of continuous active duty or the "full period for which [the veteran] was called or ordered to active duty." There is no minimum time period that a former service member must have served to apply for and receive an award of service-connected compensation. There are no other definitions of the term "veteran" to be found in title 38 of the United States Code.

Messrs. Chairmen, as you are well aware, the past year has seen a marked departure from the cordial bipartisanship that has characterized veterans' affairs in the past. Certain rhetoric has been used in the 109th Congress to attempt to create an artificial distinction among veterans; the so–called "core constituency" of veterans eligible for VA medical care. Predicated on the Priority Groups schedule enacted by Congress with the Veterans Healthcare Eligibility Reform Act of 1996, we now have "deserving", "undeserving" and even "no–shame" and "whiny" veterans. Veterans who were granted eligibility for medical care by Congress are now accused of seeking a "free ride" and causing "real" veterans to wait for care. This rhetoric must stop.

Honorable military service, whether for a single enlistment or for a thirty–year career, is not merely another period of employment in an individual's personal history. Whether one's service involved the horrors of combat in some foreign land or was spent here in the U.S. answering the nation's call to arms bestows on the individual legal and moral statuses that must not be denigrated.

With young American service members continuing to answer the nation's call to arms in every corner of the globe, we must now, more than ever, work together to honor their sacrifices. Those men and women who return from battle with career-ending injuries and life changing memories will turn to VA for their health care; health care they have

earned through their service to this country. VA must be funded at levels that will ensure that all enrolled eligible veterans receive quality health care in a timely manner.

With that in mind and on behalf of The American Legion, I offer the following budgetary recommendations for the Department of Veterans Affairs for FY 2007:

BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS

FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2007

Program	Current Funding	President's Budget Request for FY 06	House Passed HR 2528	Senate Approp Committee HR 2528	Legion's FY 2007 Request
Medical Care Including:	$31.4 billion	$30.7 billion	$28.4 billion	$ 30.9 billion	$33.5 billion
• *Medical Services*	*$21.6 billion*	*$22.4 billion*	*$21 billion*	*$23.3 billion*	
• *Medical Administration*	*$4.4 billion*	*$4.4 billion*	*$4.1 billion*	*$2.9 billion*	
• *Information Technology*				*$1.5 billion*	
• *Medical Facilities*	*$3.9 billion*	*$3.9 billion*	*$3.3 billion*	*$3.3 billion*	
Medical Care Collections	($1.9 billion)	($2.5 billion)	($2.1 billion)	($2.1 billion)	$2.1 billion*
Emergency Supplemental	$1.5 billion				
Medical & Prosthetics Research	$447 million	$438 million	$393 billion	$412 million	$469 million
Construction					
• Major	$397 million	$353 million	$607 million	$607 million	$343 million
- CARES	$400 million		*($532 million included)*		$1 billion
• Minor	$196 million	$160 million	$209 million	$209 million	$274 million
State Extended Care Facilities	$104 million	$0	$25 million	$104 million	$250 million
State Veterans' Cemeteries	$32 million	$32 million	$32 million	$32 million	$44 million
NCA Operations	$147 million	$156 million	$156 million	$156 million	$174 million
General Administration	$1.3 billion	$1.2 billion	$1.4 billion	$1.8 billion	$1.9 billion

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

VETERANS HEALTH CARE

MANDATORY FUNDING FOR VETERANS HEALTH CARE

A new generation of young Americans is once again deployed around the world, answering our nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for the freedom, liberty and security of us all. Also like those who fought before them, today's veterans deserve the due respect of a grateful nation when they return home.

Unfortunately, without urgent changes in health care funding, new veterans will soon discover their battles are not over. They will be forced to fight for the life of a health care system that was designed specifically for their unique needs. Just as the veterans of the 20th century did, they will be forced to fight for the care they each are eligible to receive.

The American Legion believes that the solution to the Veterans Health Administration (VHA) recurring fiscal difficulties will only be achieved when its funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA's health care budget competes with other agencies and programs for Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

Under mandatory funding, however, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care benefits of enrolled veterans.

The American Legion is pleased to support legislation pending in the 109th Congress that would establish a system of capitation-based funding for VHA by combining the total enrolled veteran population with the number of non-veterans who received services from VHA, then dividing that number into 120 percent of the current VHA budget or to another amount, depending on the bill. This baseline per-capita amount is then adjusted for medical inflation each year and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for VHA for each succeeding fiscal year. This new funding system would provide all of VHA's Medical Services funding, except funding of the State Extended Care Facilities Construction Grant Program, which would be separately authorized. Annual funding would be without fiscal year limitation, meaning that any savings VHA realized in a fiscal year would be retained rather than returned to the Treasury, providing VHA with incentives to develop efficiencies and creating a pool of funds for enhanced services, needed capital improvements, expanded research and development and other purposes.

The Veterans Health Administration is now struggling to maintain its global preeminence in 21st century health care with funding methods that were developed in the 19th century. No other modern health care organization could be expected to survive under such a system. The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans.

MEDICAL CARE COLLECTIONS FUND

The Balanced Budget Act of 1997, Public Law 105-33, established the VA Medical Care Collections Fund (MCCF), requiring that amounts collected or recovered from third party payers after June 30, 1997 be deposited into this fund. The MCCF is a depository for collections from third party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the government. In fiscal year 2004, VHA collected $1.7 billion, a significant increase over the $540 million collected in fiscal year

2001. The fiscal year 2005 budget estimate projects $1.9 billion in MCCF collections and the VA fiscal year 2006 budget request calls for $2.1 billion to supplement appropriations, a 10.8 percent increase over fiscal year 2005. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans.

Government Accountability Office (GAO) reports have described continuing problems in VHA's ability to capture insurance data in a timely and correct manner and raised concerns about VHA's ability to maximize its third-party collections. At three medical centers visited, GAO found inability to verify insurance, accepting partial payment as full, inconsistent compliance with collections follow-up, insufficient documentation by VA physicians, insufficient automation and a shortage of qualified billing coders were key deficiencies contributing to the shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used as operating funds. Instead, in developing a budget proposal, the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect on VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion opposes offsetting annual VA discretionary funding by the MCCF recovery.

MEDICARE

As do all citizens, veterans pay into the Medicare system without choice throughout their working lives. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system they cannot use their Medicare benefits at any VA health care facility. VA cannot bill Medicare for the treatment of allowable Medicare eligible veterans' nonservice-connected medical conditions. This prohibition constitutes a multibillion dollar annual subsidy to the Medicare Trust Fund The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the treatment of nonservice-connected medical conditions of allowable enrolled Medicare-eligible veterans.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES

VA's Capital Asset Realignment for Enhanced Service (CARES) has entered into the final steps of the process - implementation and integration. The CARES decision released in May 2004 directed the Veterans Health Administration (VHA) to conduct 18 feasibility studies at those health care delivery sites where final decisions could not be made due to inaccurate and incomplete information. The 18 studies fall into two broad categories: 1) studies of sites where no specific decisions have been made to date for the delivery of health care, i.e., do we decide to merge these facilities or not; and 2) studies of sites where the Secretary's decision defines the healthcare solution to be implemented, i.e., how to best use or re-use the campus as a capital planning decision. VHA contracted Pricewaterhouse Cooper (PwC) to identify and determine the best approach to provide veterans with health care services equal to or better than is currently provided and evaluate in terms of access, quality, and cost effectiveness, while maximizing any potential re-use of all or portions of the current real property inventory. The entire process was scheduled for 13 months with a completion date of no later than February 2006.

One of the components of the CARES Phase II process was stakeholder input. In order to ensure the concept was not lost during the ongoing studies, Local Advisory Panels (LAPs) were set up at each of the study sites. The membership of the LAPs consist of key stakeholders including community leaders, veterans groups, VA affiliated medical schools and VA representation. The LAPs are to hold four public meetings to gather and share stakeholder input during the yearlong studies. Ideally, PwC and LAPs will work together to develop options that PwC will eventually present to the Secretary. The American Legion was concerned when the first meetings had to be pushed back from March to the end of April. This could only mean that the final decision was going to be delayed. VA was

already behind their established timeline. When the first meetings were finally held, The American Legion was present at every single one. We will ensure our presence at all of the LAPs throughout the process. The American Legion intends to hold accountable those who are entrusted to provide the best health care services to the most deserving population – the nation's veterans.

The implementation of the CARES decision promises to be long . VA has estimated that it will require $1 billion per year for the next six years, with continuing substantial infrastructure investments into the future. The American Legion is opposed to CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for services such as long-term care, and Homeland Security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process. Without that oversight, plans and promised services may be overlooked.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. This inadequacy has become even more apparent in light of the congressionally imposed moratorium on construction funding during the CARES process. The American Legion is both relieved and encouraged to see that the first two years worth of VA designated high-priority projects include critically needed seismic corrections to nine vulnerable structures in California and Puerto Rico. The American Legion has consistently expressed its concern that veterans are being treated in unsafe facilities. There are over 60 patient care and other related use buildings in danger of collapse or heavy damage in the event of an earthquake. The sorely needed seismic corrections, along with the necessary ambulatory care and patient safety projects, will require a significant increase in funding to address VHA's current major construction requirements. We believe these designated seismic projects, other seismic corrections and life safety upgrades, should be dealt with first on an emergency basis.

VA's list of priority projects for fiscal years 2004 (18 projects) and 2005 (12 projects) will cost an estimated $1.85 billion and $635 million, respectively. Of this, $1 billion is from major construction and CARES appropriations, including $400 million in transfer authority from medical care accounts. The American Legion opposes the use of medical care appropriations for construction and urges Congress to separately and fully fund these projects.

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

Minor Construction

VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase over the previous funding level is crucial. We question the transfer of prior-year minor construction funds into CARES. During our site visits to all VHA medical centers over the past three years, we noted a recurrent theme in which facilities managers are routinely forced to divert funds from other priorities to repair roofs, replace boilers and upgrade utilities and life safety and other critical systems. The American Legion believes that these funds should be used for the purposes for which they were intended and that the "transfer authority" does not include monies designated for patient care.

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

THE AGING OF AMERICA'S VETERANS

A landmark July 1984 study, *Caring for the Older Veteran*, predicted that a "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA Long Term Care (LTC) system if not properly planned for. The most recent available data from VA, 2000 Census-based VETPOP2001Adjusted, show there were 25.6 million veterans in 2002. Of that number, 9.76 million, or 37 percent are aged 65 or older. According to the *2003 National Survey of Veteran Enrollees' Health and Reliance on VA* enrolled in VA healthcare 14 percent of the veteran population was under the age of 45, 39 percent were between the ages of 45 and 64, and 47 percent of veterans were 65 years or older. Compared to the 2001 Survey, in which the age distribution was 21 percent, 41 percent and 39 percent, respectively, it is clear that the "demographic imperative" predicted by the 1984 study is now upon us.

The study cited an "imminent need to provide a coherent and comprehensive approach to long-term care for veterans." Twenty–one years hence, the coherent and comprehensive approach called for has yet to materialize. The American Legion supports pending legislation that will require VA to publish a Long Term Care Strategic Plan within six months of enactment.

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

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

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

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

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

State Extended Care Facility Construction Grants Program

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

Under the provisions of title 38, United States Code, VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 109 SVHs in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans homes. Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system. The American Legion opposes attempts to place moratoria on new SVH construction grants and we find the $25 million appropriated in H.R. 2528 for fiscal year 2006 unacceptable. State authorizing legislation has been enacted and state funds have been committed. The West Los Angeles State Veterans Home, alone, is a $125 million project. Delaying this and other projects will result in cost overruns from increasing building materials costs and may lead states to cancel these much–needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans Homes. The American Legion also supports the provision of prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients, along with the payment of authorized per diem to State Veterans Homes. Additionally, VA should allow for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans Home.

The American Legion recommends $250 Million for the State Extended Care Facility Construction Grants Program in FY 2007.

MEDICAL SCHOOL AFFILIATIONS

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

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

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

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service has a history of productivity in advancing medical knowledge and improving health care not only for veterans, but all Americans. VA research has led to the creation of the cardiac

pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Most recently, VA research has shown that an experimental vaccine against shingles prevented about 51 percent of cases of shingles, a painful nerve and skin infection, and dramatically reduced its severity and complications in vaccinated persons who got shingles. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The American Legion supports adequate funding for VA research activities, including basic biomedical research as well as bench-to-bedside projects. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans - such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $ 469 million for Medical & Prosthetics Research in FY 2007.

ENVIRONMENTAL EXPOSURES

Agent Orange

One of the top priorities of The American Legion has been to ensure that long overdue major epidemiological studies of Vietnam veterans who were exposed to the herbicide Agent Orange are carried out. In the early 1980's Congress held hearings on the need for such epidemiological studies. The Veterans' Health Programs Extension and Improvement Act of 1979, Pub. L. 96-151 directed VA to conduct a study of long-term adverse health effects in veterans who served in Vietnam as a result of exposure to herbicides. When VA was unable to do the job, the responsibility was passed to the Centers for Disease Control (CDC). In 1986, CDC also abandoned the project, asserting that a study could not be conducted based on available records.

The American Legion did not give up. Now, three separate panels of the National Academy of Sciences have agreed with The American Legion and concluded that CDC was wrong and that epidemiological studies based on DoD records are possible.

The Institute of Medicine (IOM) report, entitled *Characterizing Exposure of Veterans to Agent Orange and Other Herbicides Used in Vietnam*, is based on the research carried out conducted by a Columbia University team. Headed by principal investigator Dr. Jeanne Mager Stellman, the team has developed a powerful method for characterizing exposure to herbicides in Vietnam. The American Legion is proud to have collaborated in this research effort. In its final report on the study, the IOM urgently recommends that epidemiological studies be undertaken now that an accepted exposure methodology is available. The American Legion strongly endorses that report.

Additionally, The American Legion is extremely concerned about the timely disclosure and release of all information by DoD on the use and testing of herbicides in locations other than Vietnam during the war. Over the years, The American Legion has represented veterans who claim to have been exposed to herbicides in places other than Vietnam. Without official acknowledgement by the government of the use of herbicides, proving such exposure is virtually impossible. Information has come to light in the last few years leaving no doubt that Agent Orange, and other herbicides contaminated with dioxin, were released in locations other than Vietnam. This information is slowly being disclosed by DoD and provided to VA.

In April 2001, officials from DoD briefed VA on the use of Agent Orange along the Korean demilitarized zone (DMZ) from April 1968 through July 1969. It was applied through hand spraying and by hand distribution of pelletized herbicides to defoliate the fields of fire between the front line defensive positions and the south barrier fence. The size of the treated area was a strip 151 miles long and up to 350 yards from the fence to north of the civilian control line. According to available records, the effects of the spraying were sometimes observed as far as 200

meters downwind. Original estimates projected as many as 80,000 troops were possibly exposed during this period. This number was later reduced to 12,056. DoD identified the units that were stationed along the DMZ during the period in which the spraying took place. This information was given to VA's Compensation and Pension Service, which in turn provided it to all 58 regional offices. VA Central Office has instructed its Regional Offices to concede exposure for veterans who served in the identified units during the period the spraying took place.

In January 2003, DoD provided VA with an inventory of documents containing brief descriptions of records of herbicides used at specific times and geographic locations outside of Vietnam. The information, unlike the information on the Korean DMZ, does not contain units' involved or individual identifying information. Also, according to VA, this information is incomplete, reflecting only 70 to 85 percent of herbicide use, testing and disposal locations outside of Vietnam. VA requested that DoD provide it with information regarding the units involved with herbicide operations or other information that may be useful to place veterans at sites where herbicide operations or testing was conducted.

Obtaining the most accurate information available concerning possible exposure is extremely important for the adjudication of herbicide-related disability claims of veterans claiming exposure outside of Vietnam. For herbicide-related disability claims, veterans who served in Vietnam during the period of January 9, 1962 to May 7, 1975 are presumed by law to have been exposed to Agent Orange. Veterans claiming exposure to herbicides outside of Vietnam are required to submit proof of exposure. This is why it is crucial that all information pertaining to herbicide use, testing, and disposal in locations other than Vietnam be released to VA in a timely manner. Congressional oversight is needed to ensure that additional information identifying involved personnel or units for the locations already known by VA is released by DoD as well as all relevant information pertaining to other locations that have yet to be identified. Locating this information and providing it to VA must be a priority.

Gulf War Illness

Hallmark legislation was enacted in 1994 to ensure compensation for Gulf War veterans suffering from unexplained illnesses. Although the Persian Gulf War Veterans' Benefits Act Veterans' Benefits Improvements Act of 1994, Pub. L. 103-446, looked good on paper, a 75 percent denial rate was the reality for sick Gulf War veterans seeking VA service connection for Gulf War-related undiagnosed illness. As a result, The American Legion supported legislation to amend title 38 with the goal of correcting this problem.

Despite the enactment of the Veterans Education and Benefits Expansion Act of 2001, Pub.L. 107-103, clarifying and expanding the definition of undiagnosed illness by including medically unexplained chronic multi-symptom illness, such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome, the denial rate for these claims remains very high. The restrictive nature of VA's final rule, published in the Federal Register on June 10, 2003, implementing Pub. L. 107-103 will likely reinforce this pattern. We urge both the House and Senate Veterans' Affairs Committees to conduct oversight of the Gulf War-related provisions of Pub. L. 107-103.

In January 2003, the Secretary of Veterans Affairs requested that the IOM review medical and scientific literature on the long-term health effects of sarin published since its initial report on sarin in September 2000. In its 2000 report, the IOM concluded that there was insufficient evidence to determine if an association exists between exposure to sarin, at levels too low to cause acute symptoms, and subsequent long-term adverse health effects. The IOM recommended that studies using laboratory animals be conducted to explore long-term health effects of acute short-term sarin exposure at levels that do not cause immediate acute symptoms. Subsequent to the September 2000 report, studies conducted by the U.S. Army Medical Research Institute of Chemical Defense found that low-level sarin exposure causes long-term health effects in animals. On August 20, 2004, IOM completed its review of all available peer-reviewed literature. Once again, IOM was unable to rule-out low level sarin exposure as a possible cause of long-term adverse health effects in Gulf War veterans. As in its 2000 report, IOM concluded that there is still insufficient/inadequate evidence to determine whether an association does or does not exist between sarin, at levels too low to cause immediate acute symptoms, and subsequent long-term adverse health effects.

Recent revelations involving the number of military personnel potentially exposed to sarin following the demolition

of an Iraqi munitions storage complex in Khamisiyah, Iraq, in March 1991, makes this research imperative. On June 1, 2004, the Government Accountability Office (GAO) confirmed its June 2003 preliminary findings in a final report titled: *Gulf War Illnesses: DOD'S Conclusions about U.S. Troops' Exposure Cannot Be Adequately Supported*. Due to the unreliability of DoD plume modeling, GAO determined that DoD's conclusions about the number of troops exposed are highly questionable. DoD models estimated that approximately 100,000 military personnel were potentially exposed to low-levels of nerve agent. According to GAO, as many as 350,000 U.S. military personnel may have been exposed to nerve agents in Iraq. GAO also concluded that given the weak data, further modeling efforts would not be any more accurate or helpful.

In July 2005, IOM released its study on mortality in Khamisiyah veterans, titled *Mortality in US Army Gulf War Veterans Exposed to 1991 Khamisiyah Chemical Munitions Destruction*. The researchers, comparing the mortality of exposed veterans with unexposed veterans, found no significant difference, with one exception—exposed veterans exhibited an increased risk of brain cancer deaths. The 2000 plume model was used to identify both groups of veterans. While researchers note that sarin and cyclosarin are not known carcinogens, this finding may be an indication that low level sarin exposure can produce long-term adverse health effects in Gulf War veterans.

GAO's investigation clearly invalidates DoD's modeling efforts as well as the usefulness of any future efforts, and suggests the number of troops exposed to nerve agents is likely much greater than estimated by DoD, and that an increase in brain cancer deaths has been identified as unique among those presumed to be exposed during the demolition at Khamisiyah. The American Legion urges that a presumption of exposure be granted for every service member in the region at the time of the demolition.

In 2003, VA and DoD released a study on amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) a fatal neurodegenerative disease affecting nerve cells in the brain, brain stem, or the spinal cord. Researchers found that deployed Gulf War veterans are twice as likely as their non-deployed counterparts to develop ALS. The Secretary of VA responded to this finding by offering Gulf War ALS cases expeditious adjudication—on a direct service connection basis. VA determined that it would be premature at this time to create a regulatory presumption for service connection for Gulf War veterans with ALS. A one-year presumptive period is assigned for this disease.

ALS is characterized by the loss of the ability to speak, swallow, chew and breath, and muscle weakening to the point of paralysis. Initial onset of the disease varies in time and degree. Symptoms may be mild, or the condition may appear dormant with little or no progression for years. Indicators may be so mild – that they may be disregarded or misdiagnosed. Since Gulf War veterans are twice as likely to develop ALS and symptoms may have delayed manifestation, legislation is needed to protect Gulf War veterans who may become ill with this disease in the future. ALS needs to be added to the presumptive list of illness for Gulf War veterans and the presumptive period needs to be extended to seven years following discharge from active duty.

Atomic Veterans

Since the 1980s, claims by atomic veterans exposed to ionizing radiation for a radiogenic disease, for conditions not among those listed in title 38, U.S.C. § 1112 (c)(2), have required an assessment to be made by the Defense Threat Reduction Agency (DTRA) as to nature and amount of the veteran's radiation dosing. Under this guideline, when dose estimates provided are reported as a range of doses to which a veteran may have been exposed, exposure at the highest level of the dose range is presumed. From a practical standpoint, VA routinely denied the claims by many atomic veterans on the basis of dose estimates indicating minimal or very low-level radiation exposure.

As a result of the court decision in *National Association of Radiation Survivors v. VA* and studies by GAO and others of the U.S.'s nuclear weapons test program, the accuracy and reliability of the assumptions underlying DTRA's dose estimate procedures have come into question. On May 8, 2003, the National Research Council's Committee to Review the DTRA Dose Reconstruction Program released its report. It confirmed the complaints of thousands of atomic veterans that DTRA's dose estimates have often been based on arbitrary assumptions resulting in underestimation of the actual radiation exposures. Based on a sampling of DTRA cases, it was found that existing

documentation of the individual's dose reconstruction, in a large number of cases, was unsatisfactory and evidence of any quality control was absent. The committee concluded their report with a number of recommendations that would improve the dose reconstruction process of DTRA and VA's adjudication of radiation claims.

The American Legion was encouraged by the mandate for a study of the dose reconstruction program; nonetheless, we are concerned that the dose reconstruction program may still not be able to provide the type of information that is needed for atomic veterans to receive fair and proper decisions from VA. Congress should not ignore the National Research Council's findings and other reports, that dose estimates furnished VA by DTRA over the past fifty years have been flawed and have prejudiced the adjudication of the claims of tens of thousands of atomic veterans. It remains practically impossible for atomic veterans or their survivors to effectively challenge a DTRA dose estimate.

The American Legion believes that the dose reconstruction program should not continue. We urge the enactment of legislation to eliminate this provision in the claim of a veteran with a recognized radiogenic disease who was exposed to ionizing radiation during military service.

Project 112 / Project SHAD

In June 2003, DoD completed its nearly three year investigation of Project 112, an extensive series of land based tests conducted between 1962 and 1973 to determine the vulnerability of U.S. military personnel to biological and chemical warfare attacks, and Operation Shipboard Hazard and Defense (SHAD), the shipboard portion of Project 112. On August 14, 2003, DoD submitted its report on the completion of its investigation on Project 112/SHAD to Congress.

The American Legion reiterates our concerns over the completion of the active investigation despite the promise that DoD's Deployment Health Support Directorate will continue to respond to questions and concerns regarding Project 112/SHAD and will investigate any new information brought to its attention in the future. DoD noted early in its investigation that some Project 112/SHAD files had been destroyed. DoD also noted that the term SHAD was not universally used to categorize the tests and it does not appear that DoD can guarantee that there were not other tests referred to by other names that were part of the same series.

According to DoD, only 50 of 134 planned tests were actually conducted. DoD identified 5,842 participants and forwarded the names to VA. When located, VA informs the veterans by letter of the test they participated in and encourages them to visit a VA medical facility if they have any health concerns. Many veterans received multiple letters due to their participation in more than one test.

In 2002, VA requested IOM to conduct an epidemiological study to determine if veterans are suffering from long-term health problems related to their participation in Project 112/SHAD. This study is scheduled for completion in September 2005. In the meantime, ill veterans claiming service connection for disabilities they believe are related to their involvement in Project 112/SHAD are being denied compensation benefits.

In the time it takes VA to locate and notify Project 112/SHAD participants identified by DoD, the number of ill veterans seeking health care and compensation from VA will increase. DoD may have ended its investigation but the ramifications of Project 112/SHAD will remain indefinitely. Thus, it is extremely important that Congress continue its oversight of this issue to ensure that Project 112/SHAD veterans are not abandoned.

Mustard Gas Exposure

In March 2005, the VA initiated a national outreach effort to locate veterans who had been exposed to mustard gas and Lewisite as participants in chemical warfare testing programs while in the military. The purpose of the testing programs was to evaluate the effectiveness of various types of protective clothing, ointments and equipment that could be used to protect American soldiers on the battlefield. Some participants were exposed during full-body exposure wearing various degrees of protective gear and some were tested by having a droplet of the agent applied to their forearms. For this recent initiative, VA is targeting veterans who have been newly identified by DoD for their participation in the testing, most of which had participated in programs conducted during WWII. DoD estimated 4,500 service members had been exposed.

Since the most recent VA outreach effort was announced, The American Legion has been contacted by veterans who contend that the number of participants identified was understated by tens of thousands, and that participation in these clandestine chemical programs extended decades beyond the World War II era. As with Project 112/ SHAD, investigators did not always maintain thorough records of the events, adverse health effects were not always annotated in the service members' medical records, and participants were warned not to speak of the program. Without adequate documentation of their participation, participants may not be able to prove that their current ailments are related to the testing. It is important that DoD commit to investigating these claims as they arise to see if they have merit. It is also important that VA commit to locating those identified by DoD in a timely manner, as many of them are WWII era veterans. Congressional oversight may be necessary to ensure that these veterans are granted the consideration they deserve.

Hepatitis C

Hepatitis C is an ongoing national health crisis. According to VA, the rate of veterans with Hepatitis C is at least three times higher than the rate of the general population, with Vietnam veterans, in particular, being a high-risk group. This problem is presenting a major challenge for VHA. Delaying or withholding Hepatitis C testing and treatment can lead to cirrhosis of the liver, liver cancer, liver failure and death among veterans. This would place further demands on the already overburdened VHA system. VHA should have the resources necessary to identify and treat all veterans at risk for or who have hepatitis C.

Even though VHA has scaled back many of its Hepatitis C initiatives, it is continuing internal education efforts directed at VHA health care providers and patients. It is continuing to develop data from ongoing screening of veterans' health records. To the extent possible, VHA is utilizing the latest treatment modalities, which has shown promising results. There are also a number of recently initiated research projects underway to learn more about the risk factors associated with this virus.

The American Legion believes that, in addition to its budgetary responsibilities, Congress has a legislative role in responding to the Hepatitis C challenge.

HOMELESS VETERANS

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

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

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

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

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

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

Homeless Providers Grant and Per Diem Program Reauthorization

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

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

BLINDED VETERANS

There are currently over 38,000 blind veterans enrolled in the VA health care system. Additionally, demographic data suggests that in the United States, there are over 135,000 veterans with low vision problems. Due to staffing shortages, over 1,500 blind veterans will wait months to get into one of the ten blind rehabilitative centers. VA currently employs twenty-six Blind Rehabilitative Outpatient Specialists (BROS) to provide services in twenty medical centers. The training BROS provide is critical to the continuum of care for blind veterans.

The Department of Defense (DoD) medical system does not have blind rehabilitative services and therefore depends on VA to provide the services needed for these soldiers. There is only one BROS for the Washington/Baltimore VAMC who covers both Walter Reed Army Medical Center and Bethesda Naval Medical Center. Additionally, of the four Poly Trauma Centers VA has established to treat injured soldiers returning from OEF/OIF, only Palo Alto has a BROS.

Given the critical skills that a BROS teaches to help blind veterans and their families adjust to such a devastating injury, clearly VA must recruit more of these specialists.

COMPENSATION AND PENSION

VETERANS BENEFITS ADMINISTRATION

There are currently almost 2.6 million veterans receiving disability compensation and VA reports that this number is increasing at a rate of 5,000 to 7,000 per month. In fiscal year 2005, VA expects its 57 Veterans Benefits Administration (VBA) regional offices to receive approximately 800,000 new and reopened benefits claims. A majority of these claims involve multiple issues that are legally and medically complex and time consuming to adjudicate. Whether a case is complex or simple, these offices are expected to develop and adjudicate veterans' and survivors' claims in a fair, legally proper and timely manner.

Claims Backlog

In September 2003, VA reduced its claims backlog to 253,000, just short of former Secretary Principi's promised target level of 250,000 cases. Claims processing times were also trending down toward the 100-day goal and the error rate was improving. From VBA's perspective, these results showed that regional office service had improved dramatically. Part of Secretary Principi's promise was, once the backlog goal had been achieved, VBA would be able to shift time and attention to improving the quality of claims adjudication. Unfortunately, experience has once again shown that "faster is not always better."

Since judicial review of veterans' claims was enacted in 1988, of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC), the remand rate historically has been about fifty percent. In a series of precedent setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, the courts have invalidated a number of longstanding VA policies and regulations because they were not consistent with statute.

These court decisions immediately added thousands of cases to regional office pending workloads, since they require the review and reworking of tens of thousands of completed and pending claims. As of August 6, 2005, there were more than 352,000 rating cases pending in the VBA system. Of these cases, 70,356 (20%) have been pending for more than 180 days.

Lack of Quality Decision Making in VBA

The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VBA has lost much of its institutional knowledge base over the past four years, due to the retirement of many of its 30-plus year employees. As a result, staffing at most regional offices is now made up mostly of trainees, with less than five years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their initial training.

Concern over adequate staffing in VBA to handle its demanding workload was addressed by VA's Office of the Inspector General (IG) in a report released in May of this year. The IG specifically recommended, "in view of growing demand, the need for quality and timely decisions, and the ongoing training requirements, reevaluate human resources and ensure that the VBA field organization is adequately staffed and equipped to meet mission requirements." Additionally, the chairman of the newly established Veterans' Disability Benefits Commission questioned the Under Secretary for Benefits about the adequacy of current staffing levels during a Commission meeting this past July. The Undersecretary conceded that the number of personnel has decreased slightly over the last three years. The Chairman requested that he provide a fact paper on how many employees are needed to adequately deal with VA's growing claims backlog.

The American Legion's visits to regional offices have found that, frequently, there have been too few supervisors or

inexperienced supervisors to provide trainees necessary mentoring, training, and quality assurance. In addition, at many stations, ongoing training for the new hires as well as the more experienced staff would be postponed or suspended, so as to focus maximum effort on production. Despite the fact that VBA's policy of "production first" has resulted in many more veterans getting faster action on their claims, the downside has been that tens of thousands of cases have been prematurely and arbitrarily denied. Sixty-five percent of VA raters and Decision Review Officers (DRO) surveyed by the IG, in conjunction with its May 2005 report, admitted that they did not have enough time to provide timely and quality decisions. In fact, 57 percent indicated that they had difficulty meeting production standards if they took time to adequately develop claims and thoroughly review the evidence before making a decision. As a consequence, the appeals burden at the regional offices, the Board of Veterans' Appeals (Board or BVA) and the Appeals Management Center (AMC) continues to grow. What must also be kept in mind is that there is a disabled veteran, most often with a family, behind each one of these appeals, who has been fighting the VA system for a year, two years, or more to get what he or she feels they are rightfully entitled to.

Appeals Management Center

In an effort to address the large remand backlog in the Department of Veterans Affairs appellate system, the Secretary of Veterans Affairs, in February 2002, issued a final regulation permitting the BVA to develop or cure procedural defects without remanding the appeal to the agency of original jurisdiction (AOJ). The BVA subsequently created the Evidence Development Unit to assist reducing remands. In May 2003, the United States Court of Appeals for the Federal Circuit invalidated the portion of the regulation authorizing the BVA to develop rather than remand cases. The Secretary then directed that remands be centralized within the Veterans Benefits Administration. The result of the centralization was to create the Appeals Management Center (AMC) to develop and adjudicate BVA remands.

The AMC, the purpose of which is to provide more expeditious action on remands and also to relieve the regional offices of the workload burden associated with remands, basically functions as a national regional office for this type of case. However, VBA's goal of providing expeditious action on remands has faced serious roadblocks from the very beginning of the AMC's existence. When the AMC, located at the Washington, D.C. Regional Office, opened its doors in late 2003, it assumed responsibility for more than 16,000 remands, approximately 9,000 of which were previously under the control of the BVA's Evidence Development Unit. All BVA remands, except for approximately four percent, are now being sent directly to the AMC.

In late 2004, VBA, inundated with an overwhelming AMC backlog, established AMC Resource Centers (RC) at its regional offices in St. Petersburg (FL), Cleveland (OH), and Huntington (WV) as a "temporary measure" to assist with the approximately 25,000 remands pending in the AMC system at that time. Although the number of overall AMC remands has been reduced slightly since the establishment of the RCs, the AMC backlog is still extremely large and, as a result, resource centers will continue to receive work, mostly cases that have been "fully developed" and considered "ready to rate," from the AMC until the backlog is at a manageable level. As of July 11, 2005, there were 19,699 remands pending in the AMC system, 14,046 of which are located at the AMC in Washington, D.C. with the rest distributed among the three RCs.

While the AMC is an admirable attempt by VBA to improve service to veterans, it has had an unmanageable backlog from the very beginning and it is doubtful whether it will ever be able to gain any real control over this problem. Moreover, it does nothing to address the problems underlying the continued rise in the number of appeals and remands by the Board of Veterans' Appeals. In our view, the very necessity of the AMC's existence begs the question – why hasn't VBA mandated the regional offices to correct their own mistakes?

This new super regional office is now responsible for correcting errors that the regional offices were unwilling or unable to do. However, the AMC has no authority to prevent the same type of error, which prompted the appeal and remand, from occurring again. It is worth noting that regional offices did not receive any work credit for remand actions. This should have been an incentive for local management to try and improve decision-making and avoid appeals and potential remands. Experience has shown just the opposite.

Since production work on new claims were the highest priority and there was no work credit for remands, many regional offices simply ignored their appellate workload with remands pending for two and three years. Now, there is still no clear incentive for the regional offices to improve quality. They are continuing to forward new cases to the Board where a large percent are being remanded to the AMC. VBA must ensure that the regional offices are held accountable for the poor quality of initial decision-making and development of appeals and not allow them to shift the workload onto the Board of Veterans' Appeals and, ultimately, the AMC.

Board of Veterans' Appeals

The BVA is a separate entity within VA. Its responsibility is to render a final decision on the propriety of a regional office decision. If the Board determines a final decision cannot be made on a case due to inadequate or incomplete development, including lack of due process, it has the authority to remand the case back to agency of original jurisdiction, which now includes the AMC, for additional required development and readjudication.

Regional office appeals and dispositions by the Board are a direct reflection of the level of claimant satisfaction or dissatisfaction with and confidence or lack thereof in the fairness and propriety of regional office adjudication. It is, therefore, painfully obvious that the level of dissatisfaction is substantial and growing, in view of the increasing number of new appeals coming into the system.

As of August 6, 2005, there were more than 154,000 cases in appellate status in the regional offices with over 131,000 requiring some type of further adjudicative action. More than 28,000 appeals are currently pending at the BVA. At the present time, it is taking almost 400 days for the regional offices to complete action on a pending appeal and forward it to the Board after the substantive appeal (VA Form 9) is filed. Of equal concern is the fact that, in the first ten months of FY 2005, the Board issued 28,657 decisions and, of these, the regional offices' decisions have been affirmed or upheld in only 37 percent of the cases. The Board overturned the regional offices' decisions completely in approximately 20 percent of the cases and remanded 40 percent appeals to the AMC for additional development and readjudication. The quality of regional office adjudication is totally unacceptable. It represents a tremendous waste of Federal government resources – time, effort, and taxpayers' money.

To ensure VA and VBA are meeting their responsibilities; The American Legion strongly urges Congress to scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

Veterans' Disability Benefits Commission

The purpose of the Commission, mandated by the Defense Authorization Act of 2004, Pub. L. 108-136, is to carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. The Commission is required by law to be comprised of thirteen members, including a chairman. The Speaker of the House, House Minority Leader, Senate Majority Leader and Senate Minority Leader were responsible for nominating two appointments each while the President controlled five nominations. Seven commissioners are required to be a recipients of at least one of the following awards for valor: the Medal of Honor, the Distinguished Service Cross, the Navy Cross, the Air Force Cross or the Silver Star. Five of the current members have these wards, including two who have the Medal of Honor. Although VA will play a supporting role in its work, the Commission is an independent body and VA will not have any control over it or its report to Congress.

Pub. L. 108-136 requires the Commission to submit a report, on its study, to the President and Congress within 15 months after the date of its first meeting. Cognizant of the enormous task ahead, Chairman James T. Scott stated, during the Commission's first public meetings May 9-10, 2005, that he would, most likely, request an extension of the 15-month report deadline. The Chairman also noted that the Commission will conduct much of its work via e-mail and conference calls, but will meet as often as required in a public setting to receive information it will need to complete its study.

Under current law, a chronic disability is considered "service-connected" if it was incurred or aggravated while on active duty and not due to willful misconduct, regardless of the cause of the condition. The establishment of the Commission was the result of a legislative compromise that initially intended to allow full concurrent receipt of VA disability compensation and military longevity retirement by restricting disability compensation only for injuries or diseases that were caused or aggravated during the actual performance of one's military duties. The strict performance of duty standard was eventually dropped and the legislation was adopted with a 10-year phase in of concurrent receipt for those service-connected military retirees rated 50-100 percent. As a caveat, a provision was included to establish a commission to review the entire VA disability claims process. Key members of Congress and other government officials have publicly expressed their desire to use the Commission as a vehicle to institute radical changes in the VA disability system that would negatively impact and restrict entitlement to benefits for a large number of veterans.

Concerned about the questionable history surrounding the creation of the Commission and the impact its recommendations will undoubtedly have on VA's disability compensation program, American Legion staff, prior to the Commission's first meeting, met with representatives from the other major veteran service organizations (VSOs) to discuss our mutual concerns and strategies for monitoring and responding to the Commission. The VSO community's testimony during the Commission's first meetings earlier this year contained a consistent theme: the veteran community strongly opposes any changes to the current VA compensation program that would limit or otherwise restrict a veteran's entitlement to benefits. In response to the concerns expressed by the VSOs and others, Chairman Scott stated that the Commission did not have a preconceived agenda and its recommendations will be based on a "thorough and objective analysis of the full range of programs that are intended to meet the needs of veterans."

The Under Secretary for Benefits testified before the Commission on July 22, 2005. The American Legion has serious concerns with portions of his testimony and will address these concerns with the Secretary of Veterans Affairs.

VA IG Report on Variances in Disability Compensation Payments

On December 3, 2004, a Chicago Sun-Times article revealed that Illinois veterans, on the average, received lower compensation payments than veterans in almost all other states. The article noted that federal authorities indicated that the Chicago Regional Office (RO) adjudicators and raters "have interpreted [VA rules regarding the payment of compensation benefits] more harshly than those [raters and adjudicators in other VA regional offices] elsewhere. . ." This, noted the Chicago Sun-Times, unfairly punishes veterans solely on the basis of where they live.

As a result of the December article, members of the Illinois Congressional delegation and other lawmakers requested that the VA Secretary investigate this issue. The Secretary subsequently ordered the VA Office of the Inspector General to investigate why there are differences in the average monthly VA disability compensation payments made to veterans living in different states. The IG conducted an investigation and issued a report on May 19, 2005.

The IG concluded that there were sixteen possible factors that could cause compensation payment disparities. In its analysis, the IG determined that there were ten factors that the VA could not control and there were six factors over which the VA could exert some control.

According to the IG, the factors that the VA cannot control are: power of attorney representation, enlisted versus officer, military retirees versus non-military retirees, participation of veterans receiving benefits, period of service, branch of service, dependents, special monthly compensation, age, and the average number of disabilities. The six factors that the IG indicated the VA has some control over are: pending claims, brokered claims, appeal rates, transferred cases, grant rates and rater experience.

The IG stated that some disabilities are inherently more susceptible to variations in rating determinations. The IG indicated that the Rating Schedule because it is a 60-year-old model, might also cause some inconsistencies. The IG identified post-traumatic stress disorder (PTSD) evaluations, total disability based on PTSD (including individual unemployability or IU), and all veterans rated with IU as rating decisions susceptible to variations.

The IG focused on mental disabilities for several reasons: mental disabilities have a high variability compared to the other parts of the body systems evaluated by the Rating Schedule; mental disabilities have the highest average evaluation (58 percent); and PTSD, which is a mental disability, is one of the fastest growing service-connected disabilities.

The eight specific recommendations of the IG are listed below:

1. Conduct a study to detect and correct unacceptable payment patterns.
2. Work with the Veterans' Disability Benefits Commission to clarify and revise the Rating Schedule.
3. Conduct a review of rating practices for certain disabilities such as PTSD and IU.
4. Expand national VA quality review to include review of PTSD evaluations for consistency, and to determine if the stressor was fully documented.
5. Coordinate with the Veterans Health Administration to improve the quality of medical examinations.
6. Ensure that VA regional offices are adequately staffed and equipped.
7. Consider establishing a lump-sum payment option in lieu of recurring monthly payments for veterans with disability evaluations of 20 percent or less.
8. Analyze differences in claim submission patterns to determine if certain veteran sub-populations, such as World War II veterans or veterans living in certain areas, have been underserved and perform outreach based on the results of the analysis.

For years The American Legion, and other veterans service organizations (VSOs) have stated that the driving force behind most VA adjudications is the need for VA to process as many claims as possible in the fastest possible time. This emphasis on quantity and speed of adjudication results in premature adjudications, improper denials of benefits, and inconsistent decisions.

The IG report confirms much of what we have been saying about the VA claims adjudication process. Essentially, the IG acknowledges that because VA often does not take the time to obtain all relevant evidence and information, there is a good chance that these claims are not properly adjudicated. The IG, to its credit, quoted raters and DROs who indicated that VA management is much more concerned with quantity than quality. Some VA adjudicators stated that awards and bonuses are centered on production. The IG report did not mention that in most claims where the VA does not obtain all relevant information, the claim is denied or under evaluated.

The tone of the IG report is disconcerting. The IG implies that where VA fails to develop claims properly, there are only improper grants of benefits. The IG ignores the fact that many deserving veterans have their claims denied or under evaluated because VA, in a rush to claim work credit, failed to, or refused to, comply with the duties to assist and notify. The IG admits that VA often makes errors but fails to consider or discuss whether these errors could result in the unlawful denial of benefits or the undervaluation of service-connected disabilities.

This negative tone exists throughout the IG report. For example, when discussing the differences between adjudications in New Mexico and Illinois, the IG noted that New Mexico had the highest average annual VA disability compensation payments at $11,206. The IG indicated that the high New Mexico payments "may be a cause for concern." However, the IG did not express any concern about the low paying ROs. Apparently, the possibility that some veterans may be underpaid or unfairly denied does not bother the IG.

The IG attacked the current rating schedule as "a 1945 model that does not reflect modern concepts of disability." The IG, however, did not define the phrase "modern concepts of disability" and did not explain why the current rating schedule would cause inconsistent payments.

According to the IG, representation by a VSO was the single most important factor in determining the amount of compensation payments made to veterans. The IG reported that, on the average, veterans who are represented by a VSO group receive $6,225 more per year than those veterans without representatives. This is a telling statistic. The VA runs a disability benefits program that is required to be non-adversarial and *ex parte*. The huge disparity between non-represented veterans and represented veterans supports the conclusion that the VA claims adjudication system is more adversarial than the VA or IG would care to admit.

In spite of the inescapable fact that there is a serious quality problem within the ROs that unfairly deprives many deserving veterans of VA benefits, the IG did not mention or even allude to this situation. This omission is a disservice to veterans and casts doubt on most of the IG conclusions. In response to IG recommendation No. 3, VBA announced that it would review all PTSD claims (100 percent schedular and IU) granted from FY 99 through FY 04. Approximately 75,000 cases will be part of this enormous review. VBA, however, did not see fit to review improper and/or premature denials of service connection and the under-evaluation of many service-connected conditions. VA's predictable response to the IG report is not balanced or responsible and puts the VA in an adversarial position against those who are in receipt of VA compensation benefits. It should be noted that in the past many VA reviews of benefits had a chilling effect. For example, when VA Central Office asked to review all grants of IU in the early 1980s, grants of IU decreased dramatically. We are concerned that VA will overreact in a similar fashion when it conducts case reviews based on the IG report.

In conclusion, The American Legion offers the following recommendations:

1. **The VA should implement an independent quality review program with teeth. The quality review managers and employees should be supervised by someone outside of VBA, such as the VA General Counsel or even the VA Secretary so that the people checking the quality of RO actions are not put into conflict with their supervisors and will not be subject to undue influence by VA managers.**
2. **The VA should make certain that the VA employees who perform their quality reviews are experts in veterans' law.**
3. **VA managers, DROs and raters should be rewarded for excellent quality performance and held accountable for quality problems. Poor quality should result in a restriction on bonuses and promotions.**
4. **Both the VA and interested VSO groups (if they are willing) should initiate outreach efforts to veterans in states where there are fewer claims filed than the national average. The VA and the VSO organizations should conduct separate outreach programs.**
5. **The VA should not evaluate any mental condition without an acceptable Global Assessment of Functioning evaluation.**

Filipino Veterans

The American Legion believes that the time has come to extend full recognition and benefits to all veterans, American or Filipino, who were part of the defense of the Philippine Islands during World War II. VA, in VETPOP2001 revised, estimated that there were 60,000 surviving Filipino veterans who are classified as Philippine Commonwealth Army, Recognized Guerrilla and New Philippine Scouts veterans, of whom 45,000 reside permanently in the Philippines and 15,000 reside permanently in the U.S.

Of the 45,000 residing in the Philippines, 41,000 do not receive any compensation or pension benefit from VA, and most are sickly, over 70 years old and live below the poverty level. Those veterans living in the Philippines currently receive only 50 cents on the dollar as compensation for their service connected conditions. Veterans of those groups who live in the United States and members of the Regular Commonwealth Army living in the Philippines receive their full entitlement.

The current policy has created a virtual caste system of first and second-class U.S. veterans in the Philippines. These veterans fought, were wounded, became ill, became prisoners of war, were subject to torture, deprivation and

starvation and many died in the service of the Armed Forces of the Unites States at the same rates as regular U.S. soldiers, sailors and Marines who were isolated on those islands during the Japanese occupation.

Filipino veterans have recently been somewhat successful in incrementally increasing benefits to parity with other U.S. veterans; however, the exclusion of these veterans from full benefits remains a fundamental unfairness in the law that has stood for too many years. As the numbers of these deserving veterans quickly dwindle, Congress has little time to redress this injustice.

GI BILL EDUCATION BENEFITS

The American Legion commends the 108th Congress for its actions to improve the current Montgomery GI Bill (MGIB). A stronger MGIB is necessary to provide the nation with the caliber of individuals needed in today's Armed Forces. The American Legion appreciates the efforts that this Congress has made to address the overall recruitment needs of the Armed Forces and to focus on the current and future educational requirements of the All-Volunteer Force.

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. We believe this is directly related to the fact that current GI Bill benefits have not kept pace with the increasing cost of education. Costs for attending the average four-year public institution as a commuter student during the 1999-2000 academic year was nearly $9,000. On October 1, 2005, the basic monthly rate of reimbursement under MGIB will be raised to $1,034 per month for a successful four-year enlistment and $840 for an individual whose initial active duty obligation was less than three years. The current educational assistance allowance for persons training full-time under the MGIB Selected Reserve is $297 per month.

The Servicemen's Readjustment Act of 1944, Pub. L. 78–346, the original GI Bill, provided millions of members of the Armed Forces an opportunity to seek higher education. Many of these individuals may not have been afforded this opportunity without the generous provisions of that act. Consequently, these former service members made a substantial contribution not only to their own careers, but also to the economic well being of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Between 1944 and 1956, when the original GI Bill ended, the total educational cost of the World War II bill was $14.5 billion. The Department of Labor estimates that the government actually made a profit, because veterans who had graduated from college generally earned higher salaries and, therefore, paid more taxes.

Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only improving their career potential, but also, making a greater contribution to their community, state, and nation.

The American Legion recommends the following improvements to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify;
- The educational cost index should be reviewed and adjusted annually;
- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package;
- Enrollment in the MGIB shall be automatic upon enlistment; however; benefits will not be awarded unless eligibility criteria have been met;

- **The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated;**
- **If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay those loans;**
- **If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB;**
- **A veteran may request an accelerated payment of all monthly educational benefits upon meeting the criteria for eligibility for MGIB financial payments, with the payment provided directly to the educational institution;**
- **Separating service members and veterans seeking a license, credential, or to start their own business must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device;**
- **Eligible veterans shall have 10 years after discharge to utilize MGIB educational benefits; and**
- **Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years after their date of separation to use MGIB educational benefits.**

HOME LOAN GUARANTY PROGRAM

VA's Home Loan Guaranty program has been in effect since 1944 and has afforded approximately 17 million veterans the opportunity to purchase homes. The Home Loan programs offers veterans a centralized, affordable and accessible method of purchasing homes in return for their service to this nation. The program has been so successful over the past years that not only has the program paid for itself but has also shown a profit in recent years. The American Legion believes that it is unfair for veterans to pay high funding fees of 2 to 3 percent, which can add approximate $3,000 to $11,000 for a first time buyer. The VA funding fee was initially enacted to defray the costs of the VA guaranteed home loan program. The current funding fee paid to VA to defray the cost of the home loan has had a negative effect on many veterans who choose not to participate in this highly beneficial program. Therefore, The American Legion strongly recommends that the VA funding fee on home loans be reduced or eliminated for all veterans whether active duty, reservist, or National Guard.

Specially Adapted Housing

The American Legion believes that with the increasing numbers of disabled veterans returning from Iraq and Afghanistan, the need for specially adapted housing is paramount. Therefore, The American Legion strongly recommends that the current $50,000 grant for specially adapted housing be increased to $55,000 and special home adaptations be increased from $10,000 to $12,300. Specially adapted housing grants are available for the installation of wheel chair ramps, chair lifts, modifications to kitchens and bathrooms and other adaptations to homes for veterans who cannot move about without the use of wheelchairs, canes or braces or who are blind and suffer the loss or loss of use of one lower extremity. Special home adaptation grants are available for veterans who are legally blind or have lost the use of both hands. Given the rising costs of construction materials and services, The American Legion is pleased to support pending legislation that would raise these allowances and allow the grants to be paid to adapt the homes of parents or siblings caring for disabled veterans.

VETERANS MEMORIALS

NATIONAL CEMETERY ADMINISTRATION

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

National Cemetery Expansion

The NCA's budget proposal totaled $459 million and 1,566 FTE for fiscal year 2006. Of the total outlay projected for FY 2006, $170.6 million is for burial benefits, $156 million is for National Cemetery operations and maintenance. The FY 2006 outlay proposal earmarks $90.3 million for major and minor construction. This reflects the cemetery construction mandated by The Veterans Millennium Health Care and Benefits Act, Pub. L. 106-117, which required NCA to establish six new National Cemeteries. The first, Fort Sill, opened in 2001 under the fast-track program, while the remaining five – Atlanta, Detroit, South Florida, Pittsburgh and Sacramento – are in various stages of development.

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

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or state cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

National Shrine Commitment

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take twenty-eight years to complete. The American Legion supports NCA's goal of completing the National Shrine Commitment in five years. This Commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the NCA to fulfill this Commitment.

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

State Cemetery Construction Grants Program

The FY 2006 budget requested $32 million for State Veterans Cemetery Grant Program. This is "no-year money" and so any monies not spent in the previous fiscal year can be carried over into the next fiscal year. This program is not intended to replace National Cemeteries, but to complement them. Grants for state-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries. Currently there are 61 operating state cemeteries in 32 states. In FY 2004, NCA supported State cemeteries provided more than 19,000 interments. NCA currently has 43 active applications for grants to build new state cemeteries and expand existing ones.

Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all states. Therefore, individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery.

The American Legion recommends $47 million for the State Cemetery Grants Program in FY 2007.

ECONOMIC OPPORTUNITY FOR VETERANS

DEPARTMENT OF LABOR

Veterans' Employment And Training Service

The American Legion's position regarding the VETS program is that this is and should remain a national program with Federal oversight and accountability. The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment. The American Legion views the VETS program as one of the best-kept secrets in the Federal government. It is comprised of many dedicated individuals who struggle to maintain a quality program without substantial funding and staffing increases.

Annually, DoD discharges approximately 250,000 service members. Recently separated service personnel are likely to seek immediate employment or are preparing to continue their formal or vocational education. In order for the VETS program to assist these veterans to achieve their goals, it needs to:

- Improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans.
- Provide employers with a labor pool of quality applicants with marketable and transferable job skills.
- Provide information on identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels.
- Eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market.
- Strive to be a proactive agent between the business and veterans' communities in order to provide greater employment opportunities for veterans.

The American Legion believes staffing levels for Disabled Veterans' Outreach Program (DVOP) specialists and Local Veterans' Employment Representatives (LVERs) should match the needs of the veteran community in each state and not be based solely on the fiscal needs of the state government. Such services will continue to be crucial as today's active duty service members, especially those returning from combat in Iraq and Afghanistan, transition into the civilian world. Education and vocational training and employment opportunities will enable these veterans to succeed in their future endeavors. Adequate funding will allow the programs to increase staffing to provide comprehensive case management job assistance to disabled and other eligible veterans.

Title 38 U.S.C. § 4103A requires that all DVOP specialists shall be qualified veterans and that preference be given to qualified disabled veterans in appointment to DVOP specialist positions. 38 U.S.C. § 4104(a)(4) states:

> "[I]n the appointment of local veterans' employment representatives on or after July 1, 1988, preference shall be given to qualified eligible veterans or eligible persons. Preference shall be accorded first to qualified service-connected disabled veterans; then, if no such disabled veteran is available, to qualified eligible veterans; and, if no such eligible veteran is available, then to qualified eligible persons."

The American Legion believes that the military experience is essential to understanding the unique needs of the veteran and that all LVERs, as well as all DVOPs, should be veterans

The American Legion recommends a funding level of $342 million for the Veterans' Employment and Training Service in fiscal year 2007.

Make TAP/DTAP a Mandatory Program

The Department of Defense estimates that 68 percent of separating service members attend the full TAP seminars and only 35 percent of the reserve components attend. The American Legion believes this low attendance number is a disservice to all transitioning service members especially the reserve component. Presently, countless numbers of National Guard and Reserve troops have returned from the war in Iraq and Afghanistan only to encounter difficulties with their federal and civilian employers at home. In numerous cases brought to the attention of The American Legion by veterans and other sources, many of these returning service members have lost jobs, promotions, businesses, homes, cars and in a few cases become homeless. The American Legion strongly endorses the belief that service members would greatly benefit by having access to the resources and knowledge that the Transitional Assistance Program (TAP) can provide.

National Veterans Training Institute

Additionally, The American Legion recommends adequate funding for the National Veterans Training Institute (NVTI) budget. The NVTI provides standardized training for all veterans employment advocates in an array of employment and training functions.

Service Members Occupational Conversion and Training Act

The American Legion urges the reinstatement of the Service Members Occupational Conversion and Training Act (SMOCTA). SMOCTA was developed as a transitional tool designed to provide job training and employment to eligible veterans discharged after August 1, 1990. Veterans eligible for assistance under SMOCTA were those with a primary or secondary military occupational specialty that DoD has determined is not readily transferable to the civilian workforce; or those veterans with a service connected disability rating of 30 percent or greater.

Eligible veterans received valuable job training and employment services through civilian employers that built upon the knowledge and job skills the veterans acquired while serving in the military. This program not only improved employment opportunities for transitioning service members, but also enabled the federal dollars invested in education and training for active duty service members to be reinvested in the national job market by facilitating the transfer of skills from military service to the civilian workforce.

SMALL BUSINESS ADMINISTRATION

The American Legion views small businesses as the backbone of the American economy. It is the driving force behind America's past economic growth and will continue to be the major factor as we move further into the 21st century. Presently, more than nine out of every ten businesses are small firms, which produce almost one-half of the Gross National Product. Veterans benefits have always included assistance in creating and operating veteran-owned small businesses.

The impact of deployment on self-employed reservists is tragic with a reported 40% of all veteran owned businesses suffering financial losses and in some cases bankruptcies. Many small businesses have discovered they are unable to

operate and suffer some form of financial loss when key employees are activated. The Congressional Budget Office in a report "*The Effects of Reserve Call-Ups on Civilian Employers*" stated that it "expects that as many as 30,000 small businesses and 55,000 self-employed individuals may be more severely affected if their reservist employee or owner is activated" The American Legion is a strong supporter of the "Hope at Home Act of 2005", which is a bipartisan bill that would not only require the federal government to close the pay gap between their Reserves and National Guard service member's civilian and military pay but it would additionally provide tax credits up to $30,000 for small businesses with service members who are activated.

VETERANS PREFERENCE

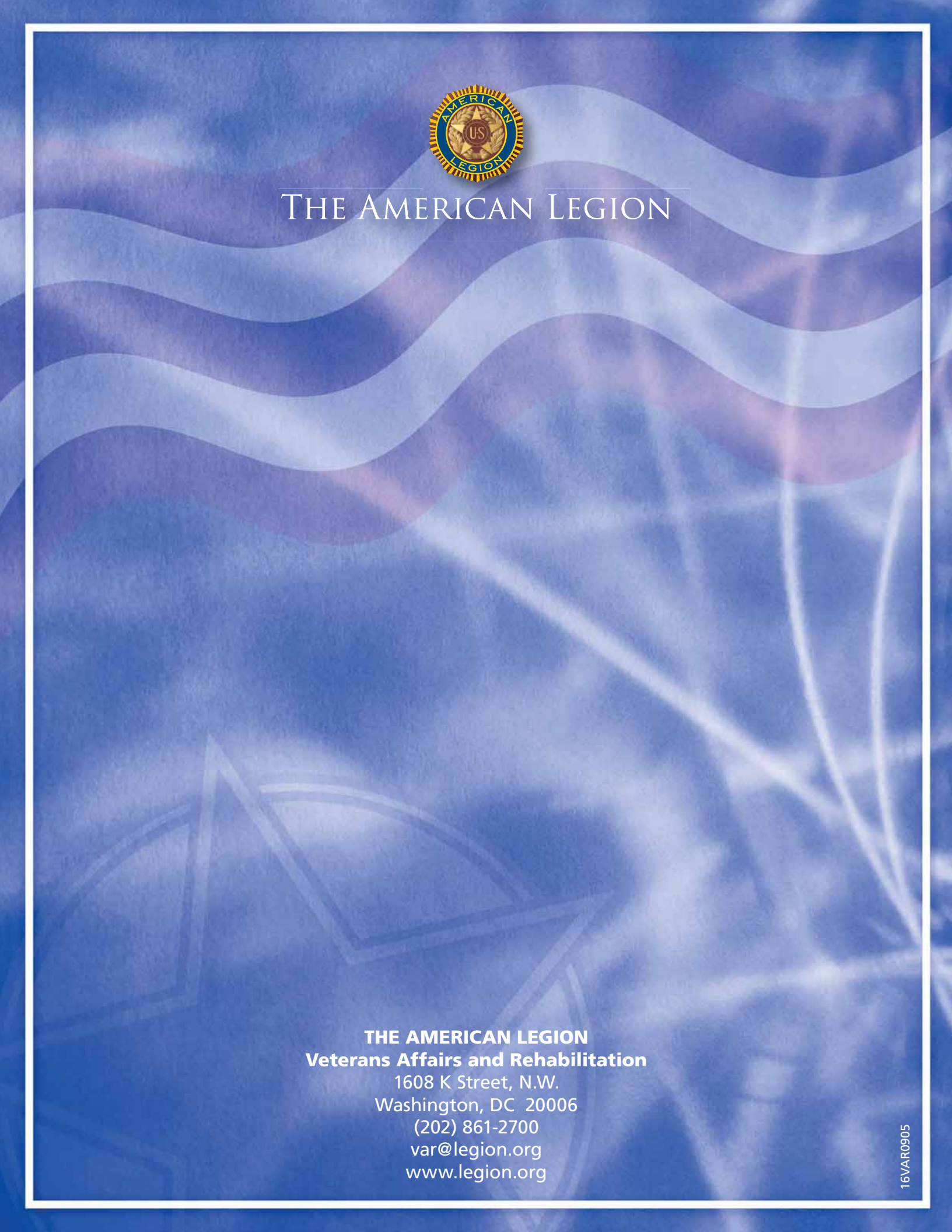
A grateful nation, following each war, has indicated its thanks to those who bore the brunt of the battle by providing certain rights and benefits, one of which has been a small advantage when seeking federal, employment; and whereas, absence from a highly competitive job market creates an unfair and unequal burden on veterans upon completion of their military services. In competing with their non-veteran peers, which this preference in federal, employment is intended to overcome in part, The American Legion suggests that the Office of Personnel Management (OPM) which has the task of monitoring compliance of veteran preferences within all federal agencies subject to title 5, United States Code, create a Office of Veterans Affairs within OPM to ensure that all veterans are getting their employment preferences.

SUMMARY

Messrs. Chairmen and Members of these Committees, The American Legion appreciates the strong relationship we have developed with both Committees. With increasing military commitments worldwide, it is important that we work together to ensure that the services and programs offered through VA are available to the new generation of American service members who will soon return home. You have the power to ensure that their sacrifices are indeed honored with the thanks of a grateful nation.

The American Legion is fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to health care, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the nation's call to arms.

Thank you for allowing me the opportunity to appear before you today.



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