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Annual Legislative Presentation
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Chairman Filner, Chairman Akaka and members of the Committee, I appreciate the opportunity to present the legislative priorities for 2008 of Paralyzed Veterans of America. Since its founding, Paralyzed Veterans has developed a worthy record of accomplishment, of which we are extremely proud. Again, this year, I come before you with our views on the current state of veterans' programs and services and recommendations for continued improvement in the services and benefits provided to veterans.

Background

Paralyzed Veterans was founded in 1946 by a small group of returning World War II veterans, all of whom had experienced catastrophic spinal cord injury and who were consigned to various military hospitals throughout the country. Realizing that neither the medical profession nor government had ever confronted the needs of such a population, the returning veterans decided to become their own advocates and to do so through a national organization.

From the outset the founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing individuals with a spinal cord injury, be they medical, social, or economic. Paralyzed Veterans' founders were determined to create an organization that would be governed by the members, themselves, and address their own unique needs. Being told that their life expectancy could be measured in weeks or months, these individuals set as their primary goal actions that would maximize the quality of life and opportunity for all veterans and individuals with spinal cord injury - it remains so today.
To achieve its goal over the years, Paralyzed Veterans has established ongoing programs of research, sports, service representation to secure our members and other veterans' benefits, advocacy in promoting the rights of all citizens with disabilities, architecture promoting accessibility, and communications to educate the public about individuals with spinal cord injury. We have also developed long-standing partnerships with other veterans' service organizations. Paralyzed Veterans, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, co-author The Independent Budget-a comprehensive budget and policy document that has been published for 22 years.

Today, Paralyzed Veterans is the only congressionally chartered veterans' service organization dedicated solely to the benefit and representation of veterans with spinal cord injury or disease.

FY 2009 VA HEALTH CARE BUDGET

Of utmost importance to PVA and our membership is the VA health care system. Unfortunately, due to political wrangling over the FY 2008 federal budget, the VA did not receive its full appropriation until January. We were very disappointed that the VA was forced to endure this situation for the 13th time in the last 14 years. This was particularly disappointing in light of the fact that the Administration guaranteed that the bill would be signed into law and because the bill was completed before the start of the fiscal year on October 1.

The appropriations bill was eventually enacted, but it included budgetary gimmicks that The Independent Budget has long opposed. While the maximum appropriation available to the VA would match or exceed our recommendations, the vast majority of this increase was contingent upon the Administration making an emergency funding request for this additional money. Fortunately, the Administration recognized the importance of this critical funding and requested it from Congress. This emergency request provided the VA with $3.7 billion more than the Administration requested for FY 2008.

PVA's budget recommendations are part of the joint policy statements contained in this year's Independent Budget. They are the combined recommendations of AMVETS, Disabled American Veterans, PVA and Veterans of Foreign Wars. This year, PVA and our fellow Veterans Service Organizations (VSOs) are proud to mark the 22nd year of this joint effort presenting budget and policy direction to the Congress and the Administration for all benefits and services provided to the veterans of this nation.

For FY 2009, the Administration requests $41.2 billion for veterans' health care. This included approximately $2.5 billion from medical care collections. Although this represents another step forward in achieving adequate funding for the VA, it still falls short of the recommendations of The Independent Budget. For FY 2009, The Independent Budget recommends approximately $42.8 billion for total medical care budget authority, an increase of $3.7 billion over the FY 2008 operating budget level established by P.L. 110-161, the Omnibus Appropriations bill, and approximately $1.6 billion above the Administration's FY 2009 request.

PVA is also seriously concerned that the Administration's request slashes funding for Medical and Prosthetic Research. For Medical and Prosthetic Research, The Independent Budget is recommending $555 million. This represents a $75 million increase over the FY 2008 appropriated level established in the Omnibus Appropriations Act and $113 million over the Administration's request for FY 2009. We were particularly pleased that Congress recognized the critical need for funding in the Medical and Prosthetic Research account by providing funding to match The Independent Budget last year. We urge Congress to again overrule the Administration's request, one that will seriously erode VA's crucial biomedical research programs. Research is a vital part of veterans' health care, and an essential mission for our national health care system. I doubt any group of veterans understands the importance of research more than PVA members.

Although not proposed to have a direct impact on veterans' health-care funding, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug co-payments from $8 to $15 and an indexed enrollment fee based on veterans' incomes.

These proposals will simply add more financial strain to many veterans, including PVA members and other veterans with catastrophic disabilities. Although the VA once again chose not to overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1 million veterans will choose not to enroll. It is astounding that this Administration continues to recommend policies that would push veterans away from the best health-care system in America.

I need to take a moment to explain exactly why PVA particularly objects to the proposal. I would also like to explain why we believe this recommendation, if approved, will have a negative impact on many veterans with catastrophic disabilities whose main health care resource is the VA health-care system.

In 1985, Congress approved legislation that opened the VA health-care system up to all veterans. In 1996, Congress again revised that legislation with a system of rankings establishing priority ratings for enrollment. Within that context, PVA worked hard to ensure that those veterans with catastrophic disabilities, no matter if those disabilities were service-connected or non-service connected, would have a higher enrollment category. If the primary mission of the VA health-care system is to provide for the service disabled, the indigent and those with special needs, catastrophically disabled veterans certainly fit in the latter priority ranking. VA had an obligation to provide care for these veterans. The specialized services, including spinal cord injury care, unique to VA, should be there to serve them.

To protect their enrollment status, veterans with catastrophic disabilities were allowed to enroll in Category Four regardless of their incomes and even though their disabilities were non-service connected. However, unlike other Category Four veterans, if they would otherwise have been in Category Seven or Eight, they would still be required to pay all fees and co-payments, just as others in those categories do now for every service they receive from VA.

PVA believes this is unjust. VA recognizes their unique specialized status on the one hand by providing specialized service for them in accordance with its mission to provide for special needs. On the other hand, the system then makes them pay for those services.

Unfortunately, these veterans are not casual users of VA health-care services. Because of the nature of their disabilities they require extensive care and a lifetime of services. Private insurers and providers don't offer the kind of sustaining care for spinal cord injury found at the VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of what VA can provide. In most instances, VA is the only and the best resource for a veteran with a spinal cord injury, yet, these veterans, supposedly placed in a priority enrollment category, have to pay fees and co-payments for every service they receive as though they had no priority at all.

The Administration's legislative proposals for an indexed annual enrollment fee of $250 to $750 and increases in prescription drug co-payments from $8 to $15 would have a severe negative impact on these veterans. They quite simply create an even higher burden thereby penalizing these veterans for seeking access to the only source of health care that truly meets their needs. We strongly urge Congress to correct this financial penalty. If a veteran is a Category Four

because of a catastrophic disability, treat that veteran like all other Category Fours and exempt him or her from fees and co-payments.

As you know, the whole community of national veterans' service organizations strongly supports an improved funding mechanism for VA health care. We continue to support removing the VA health care budget from the discretionary process and making it mandatory. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

Congress could change VA's medical care appropriation to an advance appropriation which would provide approval one year in advance, thereby guaranteeing its timeliness and predictability. Furthermore, by adding transparency to VA's health care enrollee projection model, we can focus the debate on the most actuarially-sound projection of veterans' health care costs to ensure sufficiency. Under this proposal, Congress would retain its discretion to approve appropriations; retain all of its oversight authority; and most importantly, there would be no PAYGO problems.

THE DOLE-SHALALA AND VETERANS' DISABILITY BENEFITS COMMISSION REPORTS

PVA views the release of the Dole-Shalala Commission and Veterans' Disability Benefits Commission (VDBC) reports as positive steps in ensuring that the needs of the men and women returning from Iraq and Afghanistan are addressed. We believe that two basic benchmarks must be established when assessing the recommendations included in both reports. First, no current benefit or service for today's veterans should be diminished, including the reduction of resources for those benefits or services, to achieve the recommendations. Second, there should be no distinction made between combat and non-combat related disabilities or where the disabling event occurred. Unfortunately, the Dole-Shalala Commission report seems to ignore the second benchmark while also allowing for the possibility that the first benchmark might or might not occur. As such, we believe the Veterans' Disability Benefits Commission report will more appropriately address the needs of today's and tomorrow's veterans as it affirms these two benchmarks.

There are certain key components of both reports that we believe are absolutely essential to improving the VA benefits delivery system. We fully support the Dole-Shalala recommendation to establish a single medical examination with a clear delineation of the responsibilities of the Department of Defense (DOD) and VA. Currently, DOD and VA are already testing a pilot program that addresses this idea. We also support enhanced services for families including expansion of Family Medical Leave Act (FMLA). This provision would address some of the hardships experienced by service members' families as they accompany their spouse or family member through the recovery process.

Likewise, we support the VDBC recommendation to immediately increase compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of a quality-of-life measure in the Rating Schedule. Moreover, we support the VDBC recommendation to consider increasing special monthly compensation, to

address the more profound impact on quality of life of veterans who have incurred severe disabilities, such as spinal cord injury.

PVA will not support legislation that simply implements the recommendations of the Dole-Shalala report, as the negative components outweigh the positive. It is critically important that Congress take a holistic approach to fixing the veterans' benefits system, incorporating recommendations of both reports into any legislation introduced.

FAMILY AND CAREGIVER ASSISTANCE

Evidence is growing that the prevalence of mental illness is high in veterans who have served in Iraq and Afghanistan. Combat exposure coupled with long and frequent deployments are associated with an increased risk for Post Traumatic Stress Disorder (PTSD) and other forms of mental illness. In fact, the VA reports that Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans have sought care for a wide array of possible co-morbid medical and psychological conditions, including adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse.

The impact of a veteran's mental illness is far reaching and obviously has serious consequences for the individual veteran being affected, but perhaps less obvious are the serious consequences, stemming from a veteran's mental illness, that confront his or her spouse, their children and other family members. With this in mind, PVA believes that Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family and non-family caregivers of severely injured and ill veterans. The need for such comprehensive services was outlined in both the Dole-Shalala Commission report as well as the VDBC report.

Meanwhile, in the near term, we believe that Vet Centers should increase coordination with VA medical centers to accept referrals for family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation; improve reintegration of combat veterans who are returning from deployment; and provide information on identifying warning signs of suicidal ideation so veterans and their families can seek help with readjustment issues. PVA believes that an effective mental illness family counseling and education program can improve treatment outcomes for veterans, facilitate family communication, increase understanding of mental illness, and increase the use of effective problem solving and reduce family tension.

PVA has over 60 years of experience understanding the complex needs of spouses, family members, friends and personal care attendants that love and care for veterans with life long medical conditions. Additionally, because some PVA members with spinal cord injury also have a range of co-morbid mental illnesses, we know that family counseling and condition specific education is fundamental to the successful reintegration of the veteran into society. Our experience has shown that when the veteran's family unit is left out of the mental illness treatment plan, veterans with spinal cord injury who also have mental health conditions have life long reoccurring medical and social problems. However, when family VA counseling and education services are provided, veterans are more apt to become independent and productive members of society.

VHA WORKFORCE

PVA is concerned that the VA continues to experience a serious shortage of qualified, board-certified spinal cord injury (SCI) physicians, making it difficult to fill the role of chief of a Spinal Cord Injury or Dysfunction (SCI/D) service. Several major SCI/D programs are under "acting" management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged with acting chiefs assigned for indefinite time periods.

We are even more concerned about the continuing shortage of nurses, particularly in spinal cord injury units. PVA believes that the basic salary for nurses who provide bedside care to SCI veterans is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community. Recruitment and retention bonuses have been effective at several SCI centers, resulting in an improvement in the quality of care for veterans as well as the overall morale of the nursing staff. Unfortunately, these are localized efforts by the individual VA medical facilities. We believe that the Veterans Health Administration (VHA) should authorize substantial recruitment incentives and bonuses.

We call on Congress to conduct more oversight of the VHA in meeting its nurse staffing requirements for SCI units as outlined in VHA Directive 2005-001. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care. Furthermore, not all SCI centers are in full compliance with the regulation for the staffing ratio of professional nurses to other nursing personnel. With proper congressional oversight, these mistakes can and must be corrected.

CONSTRUCTION ISSUES

We are seriously concerned that the Administration's budget request for FY 2009 significantly reduces funding for Major and Minor Construction. The Administration's request slashes funding for Major Construction from the FY 2008 appropriations level of $1.1 billion to $582 million. The Minor Construction account is also significantly reduced from the appropriated level of $631 million to only $329 million. These funding levels do little to help the VA offset the rising tide of necessary infrastructure upgrades. Without the necessary funding to address minor construction needs, these projects will become major construction problems in short order. For FY 2009, The Independent Budget recommends approximately $1.275 billion for Major Construction and $621 million for Minor Construction. The Minor Construction recommendation includes $45 million for research facility construction needs.

We are pleased that the Administration finally heeded our advice by more adequately funding the non-recurring maintenance portion of Medical Facilities. We have long argued that cannibalizing this important account to address other shortages in the medical care accounts creates major long-term problems. With adequate non-recurring maintenance funding level, the VA can begin to properly address the massive backlog of needed infrastructure upgrades.

PVA believes that the time to address the large number of construction issues facing VA is now. Unfortunately, throughout the entire Capital Asset Realignment for Enhanced Services (CARES) process, construction needs were severely neglected. The Administration cannot continue to put off new construction or critically needed facility upgrades and maintenance. Moreover, we believe that the CARES planning model should not be completely thrown out simply because time has passed since it was originally completed. It establishes an effective blueprint that is critical for the VA to expand or contract its infrastructure where necessary.

PVA also calls on Congress to help close the current and future VA nursing home care bed gap that exists for veterans with spinal cord injury or dysfunction (SCI/D). Today, waiting lists exist for the four designated SCI/D long-term care facilities and VA's CARES SCI/D long-term care data project significant gaps in capacity for 2012 and 2022.

VA's CARES data project a VA SCI/D nursing home gap of 705 beds in 2012 and an even larger gap of 1,358 beds in 2022. This pending crisis is made even clearer when we realize that VA currently operates only four designated long-term care facilities for veterans with SCI/D and none of these facilities are located west of the Mississippi River. This lack of services in the western portion of the country is especially troublesome for a nationally distributed population. These four existing facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility in Chicago, Illinois (28 staffed beds); and Castle Point, New Jersey (16 staffed beds).

PVA was hopeful that VA's CARES initiative would bring some needed relief to this dire situation in the short run. CARES proposed adding 100 SCI/D long term care beds at four new locations. These locations were in Tampa, Florida (30 SCI/D LTC beds); Cleveland, Ohio (20 SCI/D LTC beds); Memphis, Tennessee (20 SCI/D LTC beds); and Long Beach, California (30 SCI/D LTC beds). However, the CARES proposals have proven to be slow movers. To date, only the Tampa and Cleveland sites are moving forward, and remain several years from completion. The sites at Memphis and Long Beach haven't even entered the planning phase.

EDUCATION BENEFITS AND THE MONTGOMERY GI BILL

Since the inception of the GI Bill, every generation of veterans has had a benefit to ease their transition back into civilian life, providing them an opportunity for education, and serving as an investment in the future of our nation. PVA believes that today's GI Bill is not meeting the needs of our veterans as soaring education costs are forcing veterans, particularly those men and women serving in the War on Terror to shoulder the burden of their college expenses. This is simply unacceptable.

The increasing costs of education are diminishing today's GI Bill as a veterans' education benefit. As explained in The Independent Budget for FY 2009, according to the Department of Education, the national average cost of undergraduate tuition, fees, room, and board charged to full-time students in degree-granting institutions for the 2005-06 academic school year was $17,447. A veteran in receipt of the active duty full-time GI Bill benefit for the same period received $9,306, approximately 53 percent of the total cost of education. This benefit level makes it difficult for a single veteran to attend college and prohibitive for a married veteran to support his or her family and seek an education.

The Department of Health and Human Services set the 2005 poverty line for individuals earning at or below $9,570, a two-person household $12,830, and a three-person household $16,090. A student veteran earning no additional income is living below the poverty line and struggling to afford an education. For a veteran with a family, they are dramatically below the poverty line if they are relying solely on the GI Bill to sustain them and their dependents through college.

The GI Bill has evolved from its origins as a transition benefit to become one of the primary tools that the military uses for recruitment. With each successive year of war in Iraq and Afghanistan, the military faces the increased challenge of meeting projected recruitment and retention goals. A robust education benefit would have a positive effect on military recruitment and help broaden the socio-economic makeup of the military improving the overall quality of individual recruits.

When the original GI Bill was created following World War II, millions of returning service members sought higher education. Approximately 7.8 million veterans took advantage of the newly created benefit. These veterans helped lead this country into a new era of prosperity and growth. The original GI Bill vastly expanded the middle class in America, improved the lives of veterans and profoundly affected their families and all Americans. We believe that a new and better GI Bill could do the same for this generation of veterans.

PVA calls on these Committees to favorably move S. 22 and H.R. 2702, the "Post-9/11 Veterans' Educational Assistance Act." We also hope and expect that Congress and the Administration will act quickly to enact comprehensive GI Bill reform. It would serve to strengthen DOD's recruitment efforts, provide the nation with a new generation of well-educated future leaders, and most importantly improve the lives of veterans and their families.

PROTECTION OF SPECIALIZED SERVICES

Finally, we must emphasize that specialized services are part of the core mission and responsibility of the VA. For a long time, this has included spinal cord injury care, blind rehabilitation, treatment for mental health conditions-including post-traumatic stress disorder (PTSD)-and similar conditions. We believe that traumatic brain injury (TBI) and polytrauma injuries are new areas that the VA must focus on as part of their specialized care programs.

Specialized services were initially developed to care for the unique health care needs of veterans. The VA's specialized services are incomparable resources that often cannot be duplicated in the private sector. With this in mind, we believe that the VA must be given the opportunity to show what it is capable of doing in addressing TBI and polytrauma conditions for this newest generation of veterans.

The provision of specialized services is vital to maintaining a viable VA health care system. Specialized services are part of the primary mission of the VA. The erosion of these services would lead to the degradation of the larger VA health care mission. With growing pressure to allow veterans to seek care outside of the VA, the VA faces the possibility that the critical mass of patients needed to keep all services viable could significantly decline. For example, all of the primary care support services are critical to the broader specialized care program provided to

veterans with spinal cord injury. If primary care services decline, then specialized care is also diminished.

As such, we believe the VA can apply the model that it has developed for spinal cord injury care to treatment for polytrauma and TBI. PVA believes that the hub-and-spoke model used in the VA's spinal cord injury service serves as an excellent model for how this network of polytrauma centers can be used. Second level treatment centers (spokes) refer spinal cord injured veterans directly to one of the 21 spinal cord injury centers (hubs) when a broader range of specialized care is needed.

The polytrauma center structure could function in the same fashion. The new level two polytrauma centers (spokes) being established will better assist VA to raise awareness of TBI and polytrauma issues. These increased access points will also allow VA to develop a system-wide screening tool for clinicians to use to assess TBI patients. When more comprehensive treatment is needed, a veteran can be referred to a level one polytrauma center that serves as the hub. Unfortunately, the ability of the VA to provide this critical care has been called into question. PVA recognizes that the VA's ability to provide the highest quality TBI and polytrauma care is still in its developmental stages; however, it continues to meet these veterans' needs while continuing to expand its capabilities.

CONCLUSION

PVA appreciates the opportunity to present our legislative priorities and concerns for the second session of the 110th Congress. We look forward to working with the committees to ensure that adequate resources are provided to the VA health care system to ensure that the funding gap identified by The Independent Budget is closed and so that eligible veterans can receive the care that they have earned and deserve. We also hope that the committees will take the opportunity to make meaningful improvements to the benefits that veterans rely on.

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