STATEMENT OF
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BEFORE THE
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HOUSE COMMITTEE ON VETERANS' AFFAIRS

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Good Morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) health programs and services. Joining me today from VA's Office of General Counsel is Staff Attorney Jennifer Gray.

H.R. 4720 Medal of Honor Priority Care Act

This bill would place Medal of Honor recipients in VA's health care system in enrollment priority group (PG) 1 under the Veteran health care enrollment tiers established by the Congress. VA supports efforts to ensure responsive and appropriate health care for Medal of Honor recipients. However, we believe some clarifications on the intent of the bill may be helpful. Enrollment PGs were established to manage the enrollment of Veterans. Placing enrolled Medal of Honor recipients in PG 1, solely based on their Medal of Honor status, would not provide any additional benefits to that population. If the intent of this legislation is to ensure Medal of Honor recipients do not incur VA copayments, VA would be glad to provide technical assistance to accomplish that purpose, as explained below.

VA copayments are not directly related to PG status. The authoritative statutes governing copayments can be found at 38 U.S.C. § 1710 (inpatient/outpatient care), § 1710B (long-term care) and § 1722A (prescription drugs). The Medal of Honor recipients have been recognized as extraordinarily courageous Veterans who served their country without regard for their own safety or well-being. VA would support legislation designed to recognize their service and ensure that they can receive cost-free care to maintain their health and well-being.

Most Medal of Honor recipients have service-connected disabilities and are already enrolled as PG 1 Veterans who are not subject to copayments based on their service-connected disabilities. For the remaining limited numbers who are in PG 2 or 3, amending the statutory authorities governing copayments, rather than moving them to PG 1, will allow them to be copayment exempt, affording them the same benefits as other special categories of Veterans such as catastrophically disabled Veterans, former prisoners of war, and Purple Heart recipients.

A change to make Medal of Honor recipients copayment exempt would require some system changes to the Veterans Health Information Systems and Technology Architecture (VistA) and the enrollment system, but they would be relatively minor. Since these system changes would be combined with other funded projects, the cost would be insignificant. The Medal of Honor recipient population is extremely small and exempting them from copayments would not have any significant impact on our medical care collection fund.

H.R. 4977 Creating Options for Veterans Expedited Recovery Act ("COVER Act")

The bill would establish a commission to examine the efficacy of the evidence-based therapy model used by the Secretary of Veterans Affairs (Secretary) for treating mental health illnesses and identify areas to improve wellness-based outcomes, conduct patient-centered surveys, and examine available research on complementary and alternative treatment therapies for mental health issues.

More specifically, section 2 would establish a Veterans Expedited Recovery Commission (the "Commission") that would be charged with:

- Examining the efficacy of VA's evidence-based therapy model in the treatment of mental health illnesses and identifying areas to improve wellness-based outcomes;
- Conducting a detailed patient-centered survey within each of the Veterans Integrated Service Networks (VISN) of Veterans seeking mental health services;
- Conducting research on the benefits of complementary alternative treatment therapies for mental health issues, as specified by the bill; and
- Studying the potential increase in VA's approval of disability claims for mental health conditions of Veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

Section 3 would set forth the manner of appointing members. In general, it would require the Commission to be composed of 10 members, each of whom has recognized

standing and distinction within the medical community; a background in treating mental health; and experience working with the military and Veteran population. The President of the United States would be required to designate the chairman from among the members. Members would serve for the life of the Commission, and any vacancy would be required to be filled in the same manner as the original appointment. The measure would require these appointments to be made not later than 90 days after enactment.

Section 4 would require the Commission to hold its first meeting not later than 30 days after a majority of members are appointed and regular meetings thereafter. To perform its duties, this measure would, among other things, authorize the Commission to take testimony and receive evidence; secure needed information directly from any Federal Department or Agency; and consult and contract with private and public sector entities. It would also authorize a Federal Department or Agency, upon request, to detail personnel (on a reimbursable basis) to assist the Commission but require the Administrator of General Services to provide (on a reimbursable basis) administrative support services requested and required by the Commission.

Section 5 would establish detailed interim, periodic, and final congressional reporting requirements.

Section 6 would provide for the Commission's termination 30 days after the submission of its final report.

While VA supports the intent of H.R. 4977 to examine the efficacy of VA treatment of mental disorders, we do not support the manner in which this bill would carry out that goal for the reasons discussed below. In addition, VA's current programs and reviews, as explained below have substantial overlap with many elements of the work the Commission would do. Finally, the charge of the Commission to examine the efficacy of "VA's evidence-based therapy model" in the treatment of mental health illnesses we believe may be based on a flawed premise, as no single evidence-based therapy model exists by which to treat all mental health issues in Veterans who use VA health care.

Treatment is guided, in part, by the *PTSD Practice Guideline (Guideline)* that was jointly developed by VA and the Department of Defense (DoD) in 2010. The bill's charge to examine the efficacy of VA treatments would partially duplicate the *Guideline* as well as a report issued by the Institute of Medicine, entitled "Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment," issued in June of 2014. Creating such a Commission would also duplicate the efforts of the Institute of Medicine committee that is currently evaluating VA's mental health services. See "Evaluation of the Department of Veterans Affairs Mental Health Services." http://www.iom.edu/activities/Veterans/vamentalhealthservices.aspx

As to the mandated patient-centered survey to be conducted by the Commission, such a charge would be unnecessarily burdensome to Veterans because some of the required information is already available in research programs and program evaluation studies. Other mandated information will be collected as part of VA data collection

initiatives currently in development. Data collection should be refined so as to not burden Veterans by collecting information that is already available within VA or soon will be.

VA research into the benefits of complementary and alternative medicine (CAM) is also already underway. VA is establishing the Integrative Health Coordinating Center (IHCC) within the Office of Patient-Centered Care and Cultural Transformation. Integrative Health reflects the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of ***all*** appropriate therapeutic approaches, health care professionals, and disciplines to achieve optimal health and healing. Integrative Health is inclusive of CAM. The IHCC is charged to work with VA Mental Health Services, the Office of Research and Development, and other Veterans Health Administration (VHA) program offices to examine the evidence and potential benefits of incorporating complementary and alternative treatments. VA is actively partnering with the National Institutes of Health's National Center for Complementary and Alternative Medicine to study complementary and integrative health approaches. Thus, VA is already engaged in robust efforts on CAM.

The bill's requirement that the Committee conduct research on the benefits of CAM techniques is partially duplicative of the activity of the PTSD Practice Guideline Committee, which is currently preparing to update the *Guideline*. VA continues to review the emerging literature in other ways too, such as its Evidence Synthesis

Program, which issued a review of the evidence on Complementary and Alternative Medicine for PTSD. (See *Efficacy of Complementary and Alternative Medicine Therapies for Posttraumatic Stress Disorder: Evidence-based Synthesis Program.* Investigators: Jennifer L Strauss, PhD, Remy Coeytaux, MD, PhD, Jennifer McDuffie, PhD, Avishek Nagi, MS, and John W Williams, Jr, MD, MHSc. Evidence-based Synthesis Program (ESP) Center, Durham Veterans Affairs Healthcare System. Washington (DC): Department of Veterans Affairs; 2011 Aug.)

Should a Commission be established, there are additional details of H.R. 4977 that we see as problematic. Specifically, the bill requires that members of the Commission include individuals who are of recognized standing and distinction within the medical, integrative medicine, and CAM community with a background in evaluating the efficacy of conventional and CAM mental health treatments (versus those with a background in treating mental health issues). These are relevant qualities, but evaluating the efficacy of any treatment is a research endeavor. As such, scientific experts are needed both to evaluate potential merit of studies in peer review and to conduct safe rigorous trials that will enhance the state of understanding. We would recommend that expertise on the Commission be expanded to include those charged with survey development, population sampling for representativeness, and data collection/analysis, to effectively meet the stated charge.

As to the bill's requirement for VA to study the potential increase in VA's approval of disability claims for mental health conditions of Veterans who served in Operation

Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, VA could not support the measure without clarification on the purpose of the requirement. We are unclear on what the authors of the bill are suggesting and whether it would cause a potential *increase* in disability claims. VA's aim throughout all its medical care and research is the fullest possible recovery of the Veterans' health, which would have the effect of reducing disability claims.

With respect to the mandated plan by the Secretary, we believe the suggested timeframe is not reasonable given the requirements of the legislation.

VA estimates the costs associated with enactment of H.R. 4977 to be $718,019 over Fiscal Years (FYs) 2015-2016, the total period covered by the legislation. This estimate does not include, however, contract-related costs required for the Commission to discharge its duties. Clarification of certain terms in the legislation and development of a scope of work are needed before contract-related costs and other costs associated with section 2(b)(4) can be estimated and included in our cost projections.

In addition to these views, we note that the Department of Justice (DOJ) has advised of legal concerns about provisions in this bill.

H.R. 5059 Clay Hunt Suicide Prevention for American Veterans Act

Mental health care and suicide prevention are among VA's highest priorities, and we appreciate that the Congress continues to raise awareness of these important issues.

VA agrees with many of the goals of the bill, and as expressed below, existing efforts of the Department are aligned with those goals. VA would welcome discussion with the Committee to examine how some provisions could be adjusted to complement VA's ongoing multi-faceted efforts.

Turning to the specifics of the bill, Section 2 of H.R. 5059 would require VA and DoD to each have an independent third party conduct annual evaluations of the mental health care and suicide prevention programs that are carried out by the respective Departments.

VA supports the intent of this provision to further suicide prevention but has recommendations to improve its effectiveness to combat Veteran suicide, including addressing issues where there is duplication of robust activity that is ongoing at VA.

VA does not believe that requiring an additional ongoing evaluation effort is necessary for its mental health and suicide prevention programs, as they are regularly reviewed by external accrediting bodies including the Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) as well as many internal review processes. In addition, VA already has robust evaluation efforts focused on mental health care and suicide prevention. For example, in prior years the Congress mandated programs such as the North East Program Evaluation Center (NEPEC), Serious Mental Illness Treatment, Resource and Evaluation Center (SMITREC), and the Program Evaluation Resource Center (PERC). These internal resources allow for timely reports

from subject matter experts in evaluation who are familiar with the complexities of using and analyzing VA's administrative data. Additionally, VA complies with current the Congressionally-mandated reporting requirements, which include posting of information online, pursuant to PL 112-239 (FY 2013 NDAA), section 726. Section 726 requirements overlap with some of the areas mentioned in section 2 of the proposed bill to report on the annual evaluation of VA mental health programs to the Congress and the public. Section 726 calls for the establishment of a contract with the National Academy of Sciences (NAS) to conduct an assessment and provide an analysis and recommendations on the state of VA mental health services. VA has actually already embarked on such a project with NAS that is closely aligned with this requirement. For suicide prevention, VA has been increasing our understanding of suicide among Veterans by developing data sharing agreements with all 50 U.S. states and several U.S. territories. The initial VA Suicide Data Report issued in February 2013 was the first effort to analyze these more complete and timely data points and provide a more comprehensive understanding of Veteran suicide to inform VA's suicide prevention efforts. The February 2013 report contained data and analysis from 21 states.

In an effort to understand the picture of Veteran suicide more completely, VA has advanced development of a VA/DoD Suicide Data Repository (SDR). The January 2014 update to the VA Suicide Data Report is the first analysis using the SDR information. This update also incorporates more recent data from the National Death Index and provides information about suicide rates, which the initial VA Suicide Data Report issued in February 2013, did not.

VA does support, with some modification, the bill's requirement for review of the Department's suicide prevention programs, and looks forward to discussion of this important element of the bill. A Joint VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide was released in 2013. VA recommends that a one-time evaluation of the suicide prevention program be conducted to support implementation of these guidelines. VA believes it can benefit from a one-time, targeted evaluation of this effort.

Section 3 would require DoD to review the characterization of the terms of discharge from the Armed Forces of individuals with mental health disorders that may have affected their terms of discharge. VA defers to DoD on this section.

VA supports the intent of section 4. This section would require VA to: (1) provide Veterans information regarding all of the mental health care services available in the VISN where the Veteran is seeking such services, including the name and contact of each social work office, mental health clinic, and a list of appropriate staff; (2) update the information every 90 days; and (3) include information about the website in outreach efforts.

This requirement generally aligns with the goals and efforts currently underway for ensuring that Veterans can easily locate information about VA mental health services on the Internet. Each VISN and facility maintains their own website. National policy could be reviewed and updated to meet the requirements of this section, ensuring that

appropriate information on mental health services is available and updated on those websites. VA recommends conducting an assessment of available tools for locating information about mental health services, including seeking input from Veterans in order to determine the most useful framework through which VA can provide such information. This requirement should also be considered in the context of the Secretary's goal of creating one phone number and one website for all VA services. VA would welcome discussion with the Committee on how the goals of this section can be furthered.

VA supports the intent of section 5 but notes that the measure would be in some respects redundant of current efforts. Also, we recommend technical edits to improve its value to Veterans. Section 5(a) would require the establishment of formal strategic relationships between VA, DoD, the Reserve Components at the state level, and the local VISN, medical facilities, and other local VA offices, particularly with respect to facilitating mental health referrals, timely mental health services, communication concerning Servicemembers who are "at risk" for behavioral health reasons, and the transfer of documentation for line of duty and fitness of duty determinations.

VA has been working with the National Guard Director of Psychological Health at a national level to develop and establish a Memorandum of Understanding that would address referral issues at a national level. Additionally, VHA's Outreach Collaboration Office Liaison National Guard Reserve has established a formal systematic communication mechanism for the purpose of disseminating information between DoD

and VA with the goal of ensuring that the National Guard and Reserve population receives information on VA health care, benefits, and services. Consistent dialogue with leadership within the Reserve Service will continue to improve and ensure that pertinent information is shared with the Reserve community. Finally, VHA encourages VA Medical Centers to include National Guard and Reserve personnel from their state in their local VA mental health summit. With regard to sharing of information regarding "at risk" Servicemembers, fitness for duty, and line of duty determinations, there are mechanisms already in place for sharing of medical information with appropriate DoD personnel that include sharing of mental health information. Thus, VA strongly encourages (and engages in) collaboration and coordination with National Guard and Reserves to best meet the needs of Reserve Component members, establishing formal agreements at the state and local level. The bill as drafted, therefore, could create redundant efforts.

Section 5(b) sets forth a requirement for a Government Accountability Office (GAO) report on transition of care for posttraumatic stress disorder or traumatic brain injury, particularly focused on psychotropic medications. VA does not oppose this provision. Section 6 would establish a pilot program for the repayment of educational loans for mental health professionals. VA supports the aims of section 6, but we believe the recent enactment of significant changes to VA's education-debt repayment programs (in section 302 of Public Law 113-146 and section 408 of Public Law 113-175) make some parts of section 6 obsolete. We would welcome discussion of this provision with the Committee in light of these developments.

Section 7 would add a new subsection (f) to 38 U.S.C. § 3317; directing VA to carry out a program that would increase the amount VA may contribute under the "Yellow Ribbon G.I. Education Enhancement Program" (Yellow Ribbon Program) for Veterans pursuing an advanced degree in mental health. Currently, the Yellow Ribbon Program is available to Veterans, spouses of Veterans using transferred entitlement, and all children using transferred entitlement, who are receiving Post-9/11 GI Bill benefits at the 100 percent level and attending school at a private institution of higher learning (IHL) or as an out-of-state student at a public institution of higher learning.

The program provides payment for up to half of the tuition and fee charges that are not covered by the Post-9/11 GI Bill, if the institution enters into an agreement with VA to pay or waive an equal amount of the charges that exceed Post-9/11 GI Bill coverage.

Under proposed new subsection (f), VA would provide payment for 66 percent of the tuition and fee charges that are not covered under the Post-9/11 GI Bill. The IHL concerned would provide 34 percent of any of the remaining costs for tuition and fees. The Veteran would need to be eligible for the Yellow Ribbon Program, hold a bachelor's degree, and be pursuing an advanced degree with the intention of seeking employment as a mental health professional with VA. However, VA could not require the Veteran to enter into any binding agreement with respect to such intention.

Pursuant to proposed 38 U.S.C. 3317(f)(5), the Secretary would be authorized (in accordance with 38 U.S.C. 7406) to establish residencies and internships at VA medical

facilities for Veterans participating in the program. If VA employs a Veteran as a mental health professional following such participation, VA would, to the maximum extent practicable, ensure the Veteran is employed in a rural area or an area that VA determines is in greatest need of mental health professionals. In addition, the Veteran would have to be employed in a position that directly relates to the treatment of Veterans rather than a research position.

For purposes of proposed subsection 3317(f), an advanced degree in mental health would be defined as a master's, doctoral, or other graduate or professional degree that ensures the Veteran could be employed as a psychiatrist, psychologist, mental health nurse, nurse assistant, physician assistant, pharmacist, social worker, licensed professional mental health counselor, licensed marriage and family therapist, addiction therapist, occupational therapist, recreational therapist, vocational rehabilitation therapist, health science specialist, health technician, or any other position the Secretary determines appropriate.

Section 7 of the bill would also amend current section 3319 of title 38 to prohibit the use of transferred entitlement under the new program. If enacted, the amendments made by section 7 would apply to a quarter, semester, or term that begins on or after July 1, 2015.

VA supports legislation that would provide training and employment opportunities for Veterans; however, the Department has some concerns with this section of the bill. VA

is not certain a change in the way VA and IHLs share contributions for specific degrees and programs would be beneficial. Under its current structure, the Yellow Ribbon Program is a remarkably successful program with nearly 2,000 participating institutions. During FY 2013, 51,619 students were beneficiaries of the program.

In order to implement section 7, VA would have to identify Post-9/11 GI Bill Veterans who are currently pursuing an advanced degree in mental health, determine their eligibility for the new program, and verify that each Veteran intends to seek employment with VA. This would create a significant administrative burden as the Long Term Solution (LTS), the system used to process Post-9/11 GI Bill payments, does not have the capability to issue varying Yellow Ribbon payments based on the type of program being pursued. Subject to the availability of funding, VA would need one year from the date of enactment to make programming changes to the LTS to support implementation of this section. In addition to LTS changes, the amendments made by section 7 would also require changes to the Comparison Tool, VA Online Certification of Enrollment (VA ONCE) and Web Enabled Approval Management (WEAMS) computer systems. Otherwise, manual processes would be required, which would result in a decrease in timeliness and accuracy for processing GI Bill claims.

Further, the amendments made by section 7 would authorize VA to establish residencies and internships at VA medical facilities for Veterans participating in the program. VHA has already established training programs in mental health disciplines in many locations. These programs lead to a degree, licensure, certification, or

registration. The process to develop training programs requires relationships with accredited educational sponsors and suitable infrastructure for the training program, including space, qualified faculty preceptors, information technology (IT) equipment, staff support, and a sufficient number of patients to satisfy the needs of the educational program. Therefore, establishing residencies and internships must occur in settings with appropriate infrastructure and collaborative educational partnerships.

Benefit costs associated with this section are estimated to be $1.7 million in FY 2016, $9.6 million over 5 years, and $22.1 million over 10 years. Although no direct administrative or personnel costs to VA are associated with this bill, the Veterans Benefits Administration is working with VA's Office of Information and Technology to determine the IT cost estimates required to effectively implement section 7 for system changes to the LTS, Comparison Tool, VA ONCE, and WEAMS.

Section 8 would require DoD to submit to the Congress a "zero-based review", conducted in coordination with the Chief of the National Guard Bureau, of the staffing requirements for individual State National Guard Commands with respect to Directors of Psychological Health.

VA defers views on this section to DoD. There would be no costs to VA associated with this section.

Section 9 of H.R. 5059 would require VA to establish a pilot program focused on assisting Veterans transitioning from active duty. The pilot program would be established in at least 5 VISNs and would establish a community-oriented peer support network and a community outreach team for each medical center in those VISNs.

VA fully supports the intent of this section but views it as duplicative and redundant with work that is already being done in every VISN throughout the country. With regard to peer support, VHA has a very robust peer support program that includes outreach and community integration as a major focus. There are at least 3 peer specialists for every VA medical center and 2 for each "very large" Community Based Outpatient Clinic (CBOC) and a total of 973 peer specialists nationwide. As required by Public Law 110-387, VA has established training guidelines and has instituted a training program that results in certification of peer specialists. VA has a very active national network that includes a peer specialist and a mental health professional from each VISN. These individuals provide linkages to the peer support network throughout the country and mentorship to peer specialists in each VISN. VA's peer support teams interact a great deal with community Veterans' organizations and mental health organizations via the mental health summits that occur at each medical center as well as other activities.

In 2013, VA implemented a national requirement for each medical facility to host a mental health community summit annually. During the summits each facility invites community providers in their area to begin new partnerships or strengthen existing partnerships based on Veteran and family needs in their geographic location. In 2014,

each facility selected a community mental health point of contact to provide ready access to information about VA eligibility and available clinical services, ensure warm handoffs at critical points of transition between systems of care, and provide an ongoing liaison between VA and community partners. VA created an online map containing the name and contact information for all facility POCs by state. http://www.mentalhealth.va.gov/communityPOC.asp

Costs associated with the provisions of H.R. 5059 cannot be provided at this time.

H.R. 5484 Toxic Exposure Research Act of 2014

In general, H.R. 5484 would require the Secretary to establish a National Center (Center) charged with researching the diagnosis and treatment of health conditions of descendants of individuals who were exposed to toxic substances while serving in the Armed Forces. It would also establish an Advisory Board (the "Board") to identify these health conditions and evaluate disability claims from Veterans and Armed Forces members based on such service-related exposure and make recommendations on such claims to VA and DoD.

Section 2 would define several terms for purposes of the bill, including the term "toxic substance," which would "have the meaning given that term by the Secretary of Veterans Affairs and [would] include all substances that have been proven by peer reviewed scientific research or a preponderance of opinion in the medical community to

lead to disabilities related to the exposure of an individual to those substances while serving as a member of the Armed Forces."

Section 3 would require VA, in consultation with the Board established by section 4(a) of the bill, to select, not later than one year after the date of enactment, a VA medical center to serve as the Center for research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the Armed Forces that are related to such exposure. It would also establish selection criteria for the site and authorize the Center to conduct research on the diagnosis and treatment of health conditions of such descendants. In conducting such research, the Center would be required, at the election of the individual, to study individuals the Secretary has determined to be descendants of individuals who served as members of the Armed Forces who were exposed to a toxic substance while serving as a member of the Armed Forces; and who are afflicted with a health condition that is determined by the Board to be a health condition that results from the exposure of the member to such toxic substance.

Section 3 would also permit the Secretary of Defense or the head of a Federal Agency to make available to VA, as appropriate, records held by DoD, an Armed Force, or that Federal Agency, as appropriate, that might assist the Secretary in making the determinations required above. The measure would require the Center to reimburse the reasonable costs of travel and lodging of any individual participating in a study at the Center, plus those of any parent, guardian, spouse, or sibling who accompanies the

individual. Lastly, this provision would direct the Center to submit a report to the Congress, at least annually, that summarizes, for the preceding year, all completed research efforts and identifies those that are still on-going.

Section 4 would, in general, require the Secretary to establish, not later than 180 days after the Act's enactment, the Board, which would, among other things, be charged with advising the Center and overseeing and assessing its work; determining which health conditions result from exposure to toxic substances; and evaluating cases of exposure of current and former service members to toxic substances related to their service in the Armed Forces. The measure would also establish specific requirements related to composition of the Board, selection of members, terms of service, and duties. It would further direct the Board to determine which health conditions in descendants of individuals exposed to toxic substances while serving in the Armed Forces resulted from such exposure, for purposes of determining the descendants' eligibility for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) health care benefits. The Board would also be required to study and evaluate claims by current and former members of the Armed Forces of service-related exposure to toxic substances.

Section 5 would authorize the Secretary of Defense to declassify documents related to any known incident in which no fewer than 100 members of the Armed Forces were exposed to a toxic substance that resulted in a least one case of a disability that a member of the medical profession has determined to be associated with that toxic

substance. It would limit such declassification to information needed to determine whether an individual was exposed to the toxic substance, the potential severity of the exposure, and any potential health conditions that may have resulted from the exposure. Declassification would not be required, however, if the Secretary of Defense "determines that declassification of those documents would materially and immediately threaten the security of the United States."

Section 6 would require the Secretary of Veterans Affairs and the Secretaries of Health and Human Services and Defense to jointly conduct a national outreach and education campaign directed toward members of the Armed Forces, Veterans, and their family members.

VA does not support H.R. 5484. Of primary concern, the bill is vague insofar as it fails to clearly define how the Board's review of "claims" would operate in relation to existing statutes and regulations governing VA's processing and adjudication of claims for benefits administered by VA. Under the provisions of the bill, the Board would study and evaluate "claims" of service-related exposures to toxic substances submitted by current and former members of the Armed Forces or certain other persons. It is unclear whether the "claims" referenced in this bill are claims for disability benefits administered by VA under title 38 of the United States Code or some other type of claim.

To the extent the bill would require the Board to decide disability compensation and pension claims for benefits administered by VA, it would raise a number of significant

procedural and practical concerns. First, the bill would conflict with the provisions of 38 U.S.C. §§ 511 and 512 requiring the Secretary or authorized officers or employees of VA to decide all claims for benefits. Further, it is unclear whether VA offices would be required to refer all benefit claims based on toxic exposure to the Board; whether the Board would be required to provide the notice, claims assistance, and other procedural protections VA is required by statute to provide to claimants; and whether decisions of the Board would be treated as decisions of a VA agency of original jurisdiction for purposes of appeal and other procedural rights. The scope of section 4(c)(3)(B) of the bill would permit claims to be submitted by any of seven specified individuals or entities. Under current law, however, VA generally recognizes only claims submitted by Veterans and eligible dependents and survivors or their authorized representatives.

To the extent the bill contemplates that the Board would consider claims for benefits authorized under title 38 based on in-service exposure to a toxic substance, its implementation would be impractical and may adversely affect claim processing. Currently, VA regional offices receive thousands of claims related to in-service exposures. Exposure claims must be researched and adjudicated based on the facts and circumstances of each case and decided on the individual merits of each case. The small Board likely would be unable to process this volume of cases within the 180-day deadline section 4(c)(3)(C) would impose for consideration and action on claims. If the Board determines that further consideration of the claim is needed, section 4(c)(3)(C)(ii) of the bill would require the Board to refer the claim to the Center

established under section 3 of the bill. VA is concerned that the procedures under this bill may result in lengthy periods during which a disability claim is awaiting adjudication.

We note that section 4(c)(3)(D)(iii) would require a report from the Board to the Secretary to include "[i]nformation on cost and attributable exposure, as defined in regulations prescribed pursuant to this Act." However, the meaning of the phrase "attributable exposure" is unclear. Although this provision would authorize rules to define this term, the meaning of the term within the context of the bill is so unclear as to provide no basis for proper regulatory interpretation.

In addition, section 2 of the bill would define toxic substances as "all substances that have been proven by peer reviewed scientific research or a preponderance of opinion in the medical community to lead to disabilities related to the exposure of an individual to those substances while serving as a member of the Armed Forces." This definition does not conform to accepted approaches to evaluating the body of scientific evidence as a whole to determine toxic health effects of substances. Peer reviewed journals and medical opinions vary greatly in quality and can, at times, have questionable validity or reliability; this shortcoming is not recognized by the definition in the bill. There are also issues related to the use of the term "disability." Medical professionals provide assessments of functional limitation; whereas, determinations of disability are administrative determinations.

Second, other Federal Departments and Agencies are better poised to support research on multi-generational health effects of toxic exposures. Large populations are needed

to appropriately study rare multi-generational effects. Focusing solely on military exposures – which can often be similar to many civilian exposures – would likely result in inconclusive research. In contrast, VA's approach is to monitor Veterans' health, conduct surveillance studies, and remain abreast of findings from well-conducted studies in other populations. New Veteran-centric studies are conducted when findings by the clinical care, surveillance, or clinical/scientific community have indicated the need for such studies—and when they are likely to yield new insights.

Third, the Center that would be established by H.R. 5484 would duplicate work done by the National Institute of Environmental Health Sciences, the Agency for Toxic Substances and Disease Registry, VHA (the War Related Illness and Injury Study Center, the Office of Research and Development, and the Office of Public Health), as well as other governmental and non-governmental scientific organizations. These existing organizations have for many years conducted research on the impact of environmental exposures on human health. Finally, the diagnosis and treatment of health effects from exposure to toxic agents generally does not differ whether the exposure occurred while performing in a military occupation or a civilian occupation. It is not clear whether the focus of the Center would be to determine additional unknown health outcomes from exposure or translate known health outcomes of exposure – typically best determined by research in non-military populations – to the Veteran population.

As section 5 of the bill requires actions by DoD, VA would defer to that agency for its position on this section. In addition, we note that DOJ has advised of legal concerns about provisions in this bill.

VA cannot estimate the cost of section 4 of this bill for two primary reasons. First, it is unclear how the Board's consideration of "claims" under this bill would interact with and affect VA's claims-adjudication activities. Second, the costs to VA resulting from this bill would depend largely upon the nature of the Board's recommendations concerning benefits for disabilities related to in-service exposure to toxic substances. As to the bill's other measures, VA estimates the costs associated with their enactment to be $7.7 million for FY 2015; $98.5 million over a five-year period; and $227 million over a 10-year period. In the absence of additional funds being made available and appropriated for this specific purpose, implementation of these other measures would require the diversion of significant resources from programs providing direct benefits and services to Veterans.

H.R. 5475, to amend title 38, United States Code, to improve the care provided by the Secretary of Veterans Affairs to newborn children

VA supports legislation to provide expanded coverage for the newborn through the first 14 days of life, subject to finalization of VA's cost analysis for the bill. VA currently offers maternity and newborn benefits as a part of its medical benefits package. These benefits cover recommended post-delivery inpatient and outpatient care for newborns

through the first seven days of life. This care is typically provided by non-VA care through private health care providers and institutions that are reimbursed by VA.

Additionally, it is the standard of care for further evaluations to be conducted during the first two weeks of life to check infant weight; feeding; and newborn screening results. Pending these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may need to be addressed, including monitoring stability of the home environment or providing clinical and other support if the newborn requires monitoring for neonatal abstinence syndrome (e.g. withdrawal for maternal drug use during pregnancy).

The expanded coverage for the newborn through the first 14 days of life would include coverage of inpatient and outpatient needs that may fall in the 7-14 day window.

VA is still in the process of evaluating costs for H.R. 5475.

Mr. Chairman, we appreciate the opportunity to present our views on these bills and will be glad to answer any questions.