

Testimony of



Legislative Priorities
&
Policy Initiatives *for the*
117th Congress Second Session

Presented by

Jack McManus
National President

Before the
House and Senate
Veterans Affairs Committees

March 2, 2022

Good afternoon Chairmen Tester and Takano, Ranking Members Bost and Moran, and distinguished members of your respective committees. On behalf of our members and their families, I want to thank each member of both committees for all that you do to transform support for veterans to real programs, initiatives, and benefits. I am pleased to appear before you today to present highlights of the legislative agenda and policy initiatives of Vietnam Veterans of America for the second session of the 117th Congress.

Vietnam Veterans of America is a national Vietnam Veterans organization chartered by the U.S. Congress and approved by President Reagan on May 23, 1986, as a nonprofit organization to: promote the well-being of American Vietnam Veterans; foster the improvement of the condition of Vietnam veterans; promote the social welfare (including educational, economic, social, physical, and cultural improvement) in the United States by encouraging the growth and development, readjustment, self-respect, self-confidence and usefulness of Vietnam veterans and other veterans.

The themes of our advocacy reinforce what we have always stood for as an organization: First, that we tell the truth to power as best we can determine the truth, and that we as individuals and as an organization act openly and honestly in all of our affairs. Second, we demand that our government *always* tell us the truth and that veterans be treated justly and with respect. Third, VVA demands accountability for the *effectiveness* as well as the efficiency of each government program charged with helping veterans and their families.

VVA believes that the key test of the effectiveness of a program is that each program designed to help meet the vital needs of veterans should have as its goal-helping veteran's return to the greatest degree possible of self-sufficiency or wellness of the whole person. Each program should be making progress toward that goal, using the principles of the Government Performance and Accountability Act as the guide, and should be doing so in the most cost-efficient and cost-effective manner possible.

We stand by our motto; Never Again will one Generation of Veterans Abandon Another.

THE FULLEST POSSIBLE ACCOUNTING of America's POW/MIAs has long been our solemn priority. VVA continues to press for answers regarding those Americans still listed as killed in action, body not recovered, in the Southeast Asia theatre of operations. We must insist that Congress fund the Defense POW/MIA Accounting Agency (DPAA) with

what is required to investigate potential crash and burial sites, and to recover and identify remains. This is the 29th year of our Veterans Initiative Program. We continue to assist our former enemy in locating their unrecovered loved ones by providing fate-clarifying information such as maps of mass burial sites, ID cards, photos, and more. As we continue to work veteran-to-veteran with our former enemy, we have strengthened the trust between American and Vietnamese veterans, and have encouraged the continued cooperation by Vietnamese authorities with DOD search teams.

VETERANS AND TOXIC EXPOSURES

From Vietnam to the present-day, members of the U.S. military have been exposed to numerous toxic elements, both at home and abroad, that have killed more people than our enemies. What has made the situation more disgraceful is the fact that our government hid the negative aspects of these toxic substances from everyone serving in these areas, and fought their resulting claims with VA for many years.

VVA appreciates the HVAC/SVAC Committee Chairmen's commitment to introducing comprehensive legislation to remove the many hurdles that veterans are facing in submitting and claiming justifiable benefits for health conditions they face related to their service in the military, whether it was in the jungles of Vietnam, the sands of the Persian Gulf, or the burn pits of Afghanistan. Too many veterans wait years to see those claims successfully processed and dispersed, and some even die awaiting the adjudication of their claims.

Two current bills -- H.R 3967, *Honor our PACT Act* introduced by Mark Takano (D-CA-41) and S. 3003, *Cost of War Act*, introduced by Jon Tester (D-MT), Chairman, Senate Veterans Affairs Committee -- focus on enacting bipartisan legislation that would streamline access to healthcare benefits for veterans who served, regardless of disability status. VVA fully supports the framework for both bills; however, we do have some concerns regarding the legislation, which are related to veterans presumed to have been exposed to herbicide (e.g., Agent Orange).

VVA agrees that the standard in the new presumptive determination "framework" should be "positive association," but with the caveat that the following provision from 38 U.S.C 1116, related to herbicide/Agent Orange, should be applied to all toxic wound cohorts under *The Honoring Our PACT Act/Cost of War Act*: "An association ... shall be

considered to be positive for the purposes of this section if the credible evidence for the association is equal to or outweighs the credible evidence against the association.”

As it currently stands, about future determinations of potential new presumptive conditions, the highly complex *Honoring Our PACT Act/Cost of War Act* leaves veterans with qualifying service in the Republic of Vietnam or Korea significantly worse off than under the “framework” specified in current law. The bill’s repeal-and-replace of the existing herbicide (Agent Orange) presumptive determination “framework” would instead use a “framework” that is much more restrictive than current law. Thus, the *Honoring Our PACT Act /Cost of War* “framework” is much less likely than the current law “framework” to result in VA adding additional presumptive conditions. Therefore, this repeal-and-replace of the current law “framework” – with its clear adverse impact on Vietnam War and other herbicide-exposed veterans – is a non-starter that VVA strongly opposes.

Moreover, the *Honoring Our PACT Act/Cost of War* expansions relative to Gulf War presumptive claims have value, some more than others. In particular, the provision that would extend geographic service eligibility to qualifying veterans with service in Afghanistan, Israel, Egypt, Turkey, Syria, or Jordan is much needed and long overdue. VVA supports Gulf War provisions of the legislation; however, it is important to note that VA’s exceedingly high denial rates of Gulf War presumptive claims perpetuate the misery being experienced by countless tens of thousands of Gulf War veterans.

Therefore, unless and until VA’s presumptive Gulf War claims adjudication policies, procedures, training, and unacceptably high denial of approval rates are remedied, then expansions of eligibility for these presumptive conditions will be nearly meaningless. We would also like to remind the Committee that the pre-pandemic pledge to hold a roundtable aimed at developing solutions for these longstanding Gulf War issues has yet to be fulfilled.

Lastly, the *Honoring Our PACT Act/Cost of War Act* would favorably expand the list of named presumptive conditions for herbicide exposure (Agent Orange) to covered veterans. The expansion would add two additional presumptive conditions: hypertension and MGUS. VVA strongly supports the addition of presumptive conditions. We note, however, that for at least 15 years, VA’s own research has shown significantly increased hypertension among herbicide-exposed veterans. Even given the existing “framework” for adding new herbicide presumptive conditions, VA failed to do so. This should serve as a powerful cautionary tale to the overly optimistic proponents for creating a new, one-size-fits-all (but does not) “framework” that leaves VA in the driver’s seat. In this legislation, we most strongly support the provisions that add named presumptive conditions.

PUBLIC LAW 114-315 SUBTITLE C, THE TOXIC EXPOSURE RESEARCH ACT

The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 in Subtitle C, Section 632, required the Secretary of Veterans Affairs to “seek to enter into an agreement with the National Academy of Medicine under which the National Academy of Medicine conducts an assessment on scientific research relating to the descendants of individuals with toxic exposure.”¹ In other words, the National Academy of Medicine would be tasked with conducting the assessment, which would include a review of scientific literature on descendants of individuals exposed to toxins, an assessment of areas that require additional study, “an assessment of the scope and methodology required to conduct *adequate scientific research*” on the impact of this exposure, the establishment of categories to be used for evidentiary classification of exposure, and the “*identification of a research entity or entities*” that possess subject matter expertise and the ability to conduct research on toxic exposure issues. (Emphasis added).² Then, according to § 632(d)(1):

Not later than 90 days after receiving the results of the assessment and determination under subsection (c), the Secretary shall submit to the Committee on Veterans Affairs of the House of Representatives a certification of the understanding of the Secretary, based on such results and determination, regarding the feasibility of conducting further research regarding health conditions of descendants of veterans with toxic exposure that is expressed by such results and determination.³

The VA Secretary certified that the establishment of a Health Monitoring Research Program (HMRP) to study the generational health effects of serving in the Gulf is not feasible.⁴ In certifying infeasibility, Secretary McDonough cited a report from a VA Working Group tasked with assessing the viability of conducting the HMRP.⁵ The Working Group first convened on January 31, 2020, and its report relied on a 2018 report from the National Academies of Science, Engineering and Medicine (NASEM).⁶ The

¹ Pub. L. 114-315 § 632(a)(1).

² Id. at §632(b).

³ Id. at § 632(d)(1).

⁴ Letter to Senator Moran from VA Secretary McDonough, dated July 21, 2021 (hereinafter Letter to Sen. Moran)

⁵ Id.; see *Report of the Intergenerational Effects of Military Exposures Work Group to the Secretary of Veterans Affairs In response to Public Law 114-315, sec. 632 (d)* (May 2021) (hereinafter Working Group report).

⁶ NASEM, *Gulf War and Health, Vol. 11: Generational Health Effects of Serving in the Gulf War* (Nov. 2018) (hereinafter “NASEM report”)

Working Group only met on 13 occasions, adjourning for the last time on October 14, 2020 – seven months prior to finally publishing its report.⁷ It is important to note that the assessment conducted by VA Working Group could not be sanctioned under §§632(a)(1) or (a)(2), as only the National Academy of Medicine or an organization that is not part of the Federal Government were authorized to conduct the assessment; i.e. the Working Group report cannot be used to supplant the conclusions and recommendations of the NASEM report. Irrespective of this fact, the VA Secretary was delinquent in submitting his certification following the publication of the 2018 NASEM Report.⁸ Instead, he chose to paraphrase conclusions from the Working Group’s report, and in his certification, Secretary McDonough stated that barriers to successful operation of an HMRP:

[i]nclude lack of a national health record and a national birth defects database from which to draw data, inability to meet administrative, infrastructure requirements, and scientific evidence that does not support a link between in-service toxic exposures and adverse intergenerational health outcomes.⁹

It is evident that the VA Secretary did not follow Section 632 of the *Toxic Exposure Research Act* as identified in Public Law 114-315, and we are asking Ranking Member Jerry Moran (R-KS), the champion of this law, to hold an oversight committee hearing, with the VA Secretary as the star witness, to investigate what metrics he used that empowered him to not follow the law.

Mr. Chairman, during the January 2022 roundtable discussion, VSOs unanimously agreed that VA should conduct a multigenerational study on the effects of toxic exposure on the children of servicemembers. We do not need another study, but we would appreciate your support in ensuring that the already agreed-upon study is conducted, and that VA reconsider their denial of further study in the much-needed intergenerational research, in compliance with the law in section 632 of P.L. 114-315.

⁷ Supra, footnote 5.

⁸ Supra, footnote 3.

⁹ Letter to Sen. Moran

TOXIC WOUNDS REGISTRIES ACT OF 2021

This leads us to argue for legislation that will establish real registries to cover deployments during which troops were likely to have been exposed to airborne toxic hazards. Sadly, VA's Agent Orange Registry is little more than a mailing list. VA's Hepatitis C Registry, on the other hand, could serve as a template for subsequent and future registries. Toxic Wounds Registries would enable epidemiological research by linking a veteran's medical records, in Electronic Health Records, to their military history, encoded with their location and time of service.

Thus, if a veteran in Plano, Texas, comes down with a malady they feel evolved from a particular exposure, and their battle buddy living in Topeka, Kansas, is afflicted with the very same condition, VA techs would be able to access the appropriate registry to locate others with whom they served, no matter where they might be living.

With the proper database, VA techs could easily isolate trends in medical conditions related to certain geographic sites and times of service. This relatively simple tool would enhance both treatment of identified conditions, and potentially even prevention, or at least early identification and intervention of possible life-threatening maladies. For the record, we must insist that you in Congress ensure that this capability be incorporated into VA modernizations plans for the Information Technology system.

We are now seeking "champions" from both sides of the aisle and in both houses of Congress to introduce and enact *The Toxic Wounds Registries Act of 2022*. This legislation would direct the Secretary of Veterans Affairs to establish a master registry that would incorporate registries that have built-in linkages between medical records and date/place of service for:

- Exposure to Agent Orange during and in the aftermath of the Vietnam War;
- Exposure to toxicants relating to deployment during the 1991 Persian Gulf War;
- Exposure to toxicants from a deployment during Operations Enduring Freedom, Iraqi Freedom and New Dawn, and the Global War on Terror;
- Exposure to toxicants during a deployment to Bosnia, Somalia, or the Philippines;
- and

- Exposure to toxicants while stationed at a military installation contaminated by toxic substances overseas and/or here in CONUS.

This legislation would authorize the VA Secretary to enter into an agreement with the National Academy of Medicine to review published, peer-reviewed scientific research, and suggest future research on the health effects of the toxic exposures identified in those registries; and it would require those conclusions to inform the Secretary's selection of future research to be conducted and/or funded by VA.

It also would establish a presumption of service connection for the purpose of veterans' disability and survivor benefits, for any illness, that the VA Secretary determines warrants such presumption because of a positive association with exposure to a toxicant noted in the master registry. With a final caveat that the illness became manifest, within a time period determined by actual scientific evidence, conferred by act of the Secretary of Veterans Affairs, in a veteran who experienced such exposure while serving on active duty in the Armed Forces.

AGENT ORANGE EXPOSURE FAIRNESS ACT S. 332 AND H.R. 566

Many of our members have health problems commonly associated with herbicide exposure and have endured lengthy legal struggles to prove that these problems are service-related. Those diseases include chloracne, porphyria cutanea tarda, and acute and subacute peripheral neuropathy, which currently must have been manifest within a period of one year following service in order to be considered service-connected, i.e., presumptive.

P.L. 116-315, the *Johnny Isakson and David P. Roe, Veterans Health Care and Benefits Improvements Act of 2020*, signed into law on January 5, 2021. The law included provision in S.332 introduced by Senator Richard Blumenthal (D-CT); and H.R. 566, introduced by Congressman Joe Courtney (D-CT-2nd); that GAO must submit a report in 240 days regarding removing the one-year cutoff date of chloracne, acute/subacute peripheral neuropathy, and cutanea trada after the bill became law to the House/Senate Veterans Affairs Committee, also the VA has 120 days to comply to the decision. Chairman Takano/Tester as of today nevertheless, the report to this committee is past due, and we do not want see this provision in the law get lost in the bureaucracy of the federal government. Our membership call upon the leaders of both committee to

inquire in writing to GAO leadership, on the status of the briefing and report as required by the law in Section 2011 supporting our disabled veterans and their families.

THAILAND VETERANS

Thousands of men and women served our country faithfully in Thailand in toxic environments. Surviving Thailand veterans, whose health is deteriorating due to toxic pollutants' exposures, are now having their claims denied because they need to document that they were near the perimeter of the base.

However, VA does not define a perimeter. Is it a two-foot diameter extending out from the toxic pollutants' central site? Alternatively, is it a fifty-foot diameter? VA also fails to take into consideration when adjudicating these claims any possibility that the toxic dioxin became airborne. Sadly, many Thailand veterans have died from toxic exposure, and their widows have been denied compensation. The country has failed not only the servicemember; it has failed the families of the fallen.

VVA supports the passage of S.657, introduced by Senator John Boozman (R-AR), and H.R. 2269, introduced by Congressman Bruce Westerman (R-AR-4th). These bills, when enacted into law, would require VA to ensure, if it creates a presumption of service-connection between the occurrence of a disease and exposure to an herbicide agent while serving in the Armed Forces between January 9, 1962, and June 30, 1976, at a military base in Thailand, such presumption must also apply to exposure at any military base in Thailand, regardless of where on the base the veteran was located or what military job specialty the veteran performed.

S.657 has been in SVAC since April 28, 2021, and H.R. 2269 has been in the HVAC subcommittee on DAMA committee since June 22, 2021, and have seen no movement.

VVA urges Congress take further action on these bills immediately.

HYPERTENSION: THE DATA IS THERE

In November 2016, Veterans Health Administration researchers, at the request of former VA Secretary Eric Shinseki, finalized their research on the association between herbicide exposure and high blood pressure among 4,000 U.S. Army Chemical Corps veterans. They found a detectable link between service-related occupational exposure to herbicides and high blood pressure (hypertension) risk among U.S. Army Chemical Corps (ACC) veterans, a group of Veterans assigned to do chemical operations during the Vietnam War.¹⁰

Dr. Karl Kelsey, Professor of Epidemiology, Pathology, and Laboratory Medicine at Brown University and a member of NASEM, testified before the Senate Veterans Affairs Committee on March 10, 2021, on the 2018 finding in the *Veterans and Agent Orange Update #11*, which also found sufficient evidence of an association between toxic exposure and both hypertension and monoclonal gammopathy of undetermined significance (MGUS).¹¹

The Agent Orange Act of 1991 specifies the timeline the VA Secretary is to follow having received the latest findings of NASEM as delineated in *Veterans and Agent Orange Update*. This has patently not been followed after the National Academy of Medicine 2018 *Agent Orange Update* found a positive association between exposure to dioxin and myriad health conditions related to hypertension. We are heartened that after years of hurdles and delays, Secretary McDonough has acknowledged these studies on the association between hypertension and military service.

Senator Tester, Chairman, Senate Veterans Affairs Committee, introduced S.810 the *Fair Care for Vietnam Veterans Act of 2021*, in the Senate, and Representatives Josh Harder (D-CA-10th) and Pete Stauber (R-MN-8th) introduced companion bill H.R. 1972 in the house. This bipartisan, bicameral legislation has the potential to restore equity to all Vietnam veterans who were exposed to Agent Orange. This bill would add hypertension and monoclonal gammopathy of unspecified significance (MGUS) as presumptive diseases of

¹⁰ <https://www.va.gov/HEALTH/NewsFeatures/2016/November/Research-on-Vietnam-Veterans-and-Blood-Pressure.asp>

¹¹ <https://www.nationalacademies.org/ocga/testimony-before-congress/the-national-academies-report-veterans-and-agent-orange-update-11>

Agent Orange exposure, and would, in due course, provide access to VA benefits and healthcare for hundreds of thousands of Vietnam veterans.

Vietnam veterans have waited far too long for access to VA healthcare and other benefits earned through their service to our nation. We ask for immediate action by Congress and the President of the United States to direct the VA Secretary to focus on the facts and follow their own research data to add hypertension to the list of health conditions VA recognizes as service-connected for Vietnam veterans, based on exposure to Agent Orange or other herbicides.

H.R. 1972 has been in HVAC subcommittee on DAMA since June 16, 2021, and S.810 since April 28, 2021; both have seen no movement. VVA urges Congress take action on these bills immediately.

VETERANS BENEFITS

VA PRESUMPTIVE DECISION-MAKING PILOT MODEL

The Department of Veterans Affairs announced on November 11, 2021, that it was piloting a comprehensive military exposure model to consider possible relationships of in-service environmental hazards to medical conditions. The stated goal of this new model was to lower the burden of proof for veterans impacted by exposure and to speed up the delivery of needed healthcare and benefits. The lack of transparency regarding this pilot program by Veterans Benefits Administration and VA has been staggering. Why? Because Stakeholders and Veterans Services Organizations were never allowed to provide input into this proposed plot model prior to release to the veterans community.

The pilot model erodes rather than streamlines the benefits and services to which veterans are entitled. It proposes a “New Standard” that undermines the entire established and hard-won presumptive association’s framework and moves it to causation – a much higher standard of proof. VVA is extremely concerned by the deliberate lack of mention of “association” between toxic exposure and medical maladies, and by the emphasis, instead, on causation. It appears that the VA is attempting to negate the VCCA and other advances. This crucial shift in the proposed change of presumptive standards to standards based on

causation will have highly detrimental effects on claims, especially on those for secondary conditions.

VVA is also concerned with the language on Page 3 of the report stating why the change is called for now—because of expired provisions in 38 U.S.C. § 1116 (Agent Orange) and 38 U.S.C. § 1118 (Gulf War), which govern the use of the National Academies of Sciences, Engineering and Medicine (NASEM) reports. We are certain, based on the research in those reports, that hypertension should be included in the presumption decision model. NASEM clearly provided VA with ample scientific data, as reported in the *Veterans Agent Orange Update 11*, which found sufficient evidence of association for hypertension and MGUS. The VHA's own research study conducted in 2016 at the request of former VA Secretary Shinseki, further verified the findings of the NASEM reports. The VA Secretary, however, failed to add these two conditions to the list of presumptive.

Chairman Takano, Chairman Tester, the VVA stands ready to work with HVAC/SVAC to ensure that this pilot project meets the greatest needs of our disabled veterans and their families.

REINSTATE 48-HOUR REVIEW PROCESS

For many years, prior to issuing a decision, VA regional offices would allow VSOs 48 hours to review any drafted decisions in order to identify errors. This was a critical program that VVA utilized to correct numerous mistakes, thereby improving the accuracy of VA decisions, lessening the burden on the appeal system, and preventing substantial heartache for the claimant. While the VBA is pursuing the establishment of a system for electronic notification and has launched a Claims Accuracy Review (CAR) program, we believe it falls short of our desire to see upfront correction of errors. The CAR program is a reactive remedy to replace what was a proactive system of accountability. VVA strongly advocates in favor of re-establishing this important proactive program.

OVERHAUL THE BVA QUALITY REVIEW PROGRAM

In a collaborative effort between legal scholars and the former Chief of the BVA's Office of Quality Assurance, the first comprehensive study was conducted to measure the

effectiveness of the BVA's Quality Review (QR) program.¹² The 2019 study concluded that the BVA's QR program "had no appreciable effect on reducing appeals or reversals." Furthermore, "for both original and CAVC-remanded appeals, the QR program did little to stem the backlog of appeals sent back to the BVA for multiple rounds of decisions." Most troubling, the study's authors were able to "demonstrate that this inefficacy is likely by design, as meeting the performance measure of 'accuracy' was at cross-purposes with error correction."

To VVA's knowledge, the BVA's Chairman of the Board has not proposed or implemented any changes to QR in response to these stark revelations. BVA issued 4,740 decisions in January and February 2020, combined, for cases in the *Veterans Appeals Modernization and Improvement Act* (abbreviated as "AMA" by VA) system.¹³ According to information provided to VVA in a FOIA request, the BVA's QR program reviewed only 195 decisions in the same period, or 4.1 percent.

QR identified 54 errors and assigned an accuracy rate of 72.6 percent for January and 87.4 percent for February, well below BVA's stated goal of 95 percent, and all of this took place more than a year after AMA was implemented.¹⁴ Notably, where a decision has multiple errors, "that case is only counted once in the number of cases with errors column," thus the true accuracy rate should be even lower. According to the Chairman's 2021 annual report, the Board's accuracy rate remains "approximately 92.06 percent for legacy decisions and approximately 87.48 percent for AMA decisions." This 2021 statement unequivocally contradicts the 2020 QR findings cited above.

Although VVA fully supports BVA's goal of issuing decisions in a timely manner, we feel it is critical that quality not fall by the wayside. Failure to improve quality causes significant waste of public funds in litigation expenses and, most importantly, impermissibly delays or denies justice to our nation's veterans and their families. Therefore, VVA urges VA first to commission a study that evaluates how best to overhaul BVA's QR system, and then to implement the proposed changes in a timely manner.

¹² Daniel E. Ho, et. Al., "Quality Review of Mass Adjudication: A Randomized Natural Experiment at the Board of Veterans Appeals, 2003–16," *The Journal of Law, Economics, and Organization* 35, no. 2 (July 2019): 239–288, <https://doi.org/10.1093/jleo/ewz001>

¹³ <https://www.benefits.va.gov/REPORTS/ama/>

¹⁴ BVA provided data from August 2019 through March 30, 2020. The highest accuracy rate in this period was 87.4% (February 2020).

PROVIDE OVERSIGHT FOR COMPENSATION AND PENSION (C&P) CONTRACTORS

Although VA has been required by law, for decades, to provide veterans with free, competent medical examinations to support their claims for disability benefits, it has never succeeded in implementing a system to ensure compliance with CAVC standards.

Initially performed by the Veterans Health Administration (VHA), these exams have been outsourced to contractors such as QTC and LHI at progressively greater rates over time. VA has as a stated goal the full privatization of the C&P examination process within the next few years.

While these contractors have been adept at managing the scheduling aspect of the process, VVA has observed no meaningful efforts to ensure that medical professionals hired by them provide an “adequate” examination. This term has been clearly defined by the CAVC in a long series of precedential decisions, yet VVA advocates continue to see hundreds of verifiably inadequate exam reports produced each year.

Invariably, these inadequate examinations are relied upon by VA adjudicators (who are prohibited from making medical determinations), resulting in the improper denial of benefits. VVA exhorts VA to implement a robust accountability system that ensures public funds are only used to procure adequate examinations for our veterans and their survivors.

The BEST for Vets Act (S. 2329), sponsored by Senator Rubio, would work to provide more accountability by requiring that only healthcare professionals who are fully licensed and not barred from practice may furnish medical disability examinations under VA’s pilot program. These professionals would include physicians, physician’s assistants, nurse practitioners, audiologists, and psychologists.

S.89 ENSURING SURVIVOR BENEFITS DURING COVID-19 ACT OF 2021

The country mourns the loss of over 19,000+ men and women who served in combat due to the COVID-19 pandemic and the number may well have risen before my testimony. VVA has received numerous complaints that survivors are being denied DIC benefits because their loved one’s death certificate does not indicate that the veteran died of a service-connected disability due to complications from COVID-19; or that the veteran’s disability was a contributing factor. This highly unsatisfactory situation indicates a dire

and pressing need to educate all healthcare professionals who provide care to, or conduct autopsies on veterans, on the critical importance of registering service-connected factors in the medical records of all veterans. We should make the process easier, not more complicated for survivors and dependents.

Consequently, one particularly important bill that VVA supports is *S.89, Ensuring Survivor Benefits during COVID-19 Act of 2021*. Introduced by Kyrsten Sinema (D-AZ), this legislation requires the VA Secretary to secure medical opinions for veterans with service-connected disabilities who die from COVID-19, to determine whether those disabilities were the principal or contributory cause of death. Our Veterans Service Officers in the field had noticed a trend in benefits for spouses and/or dependents being denied for Dependency Indemnity Compensation (DIC) because VA was attributing the veteran's death strictly to the virus. This bill must include efforts to inform the public, as well as professionals in the medical examiner/coroners' offices, about the consequential necessity to fully complete a death certificate.

These earned benefits have been out-of-reach for too many families for too long. S.89 has been held at the house desk since July 24, 2021. VVA must insist that Congress take further action on this bill immediately.

DEPENDENT INDEMNITY COMPENSATION (DIC)

It is inherently unfair that a surviving spouse of a veteran, in the normal circumstance, to qualify for Dependent Indemnity Compensation (DIC) must have had the loved one receiving 100 percent total and permanent disability for ten or more years. More ever, the veteran death was validated as dying of an injury or disease related to military service, because such a circumstance frequently places this survivor in a disadvantageous financial position and an undeserved financial crisis.

Section 1318(b)(1) of Title 38 of the United States Code provides Dependency and Indemnity Compensation (DIC) benefits for survivors of deceased veterans who were rated totally disabled for ten or more years. However, the financial status of the surviving spouse is compromised due to the care often required for the very disabled veteran by the spouse. The veteran's spouse, acting as a caregiver, must in many instances limit, give up, or put a hold on a career and other activities. As a result, the family unit suffers an immediate income loss upon the death of the veteran, which can lead to an undeserved financial crisis

from which it may not recover, especially if the surviving spouse is no longer of working age.

VVA is willing to work with both committees to introduce legislation, which reduces the rule for the DIC qualification period to a more reasonable period. Ideally, the new legislation would call for a qualification period of five years, starting with payments at 50 percent of the maximum amount, to be increased by 10 percent per year until the maximum payment is achieved, for each year the veteran has been rated at 100 percent permanent disability.

HEALTHCARE

CAREGIVERS EXPANSION

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) provides a wide range of benefits, including monthly stipends, reimbursement for travel costs, medical coverage, training, counseling, and respite-care caregivers for veterans who were severely injured during service to their country. Since implementation, the program has assisted thousands of disabled veterans and their families during their long road to recovery and independence.

The Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, only provided these services to post-9/11 veterans, but with the passage of the *VA MISSION Act* in 2018, P.L. 115-182, and the new law allowed changes to the already established PCAFC. On October 1, 2020, family caregivers of veterans who were seriously injured in the line of duty on or before May 7, 1975, and who have a single or combined service-connected disability rating by VA of 70 percent or higher, regardless of whether it resulted from an injury, illness, or disease, became eligible for this program.

VVA applauded the expansion of this long-overdue caregiver benefit, which will enhance the quality of life for Vietnam veterans and their families. However, Veterans Health Administration has reported that most of these older and sicker veterans are being denied access to the PCAFC program because they do not meet the new eligibility requirements of the program.

VVA was hopeful that this new program would not repeat the mistakes that were made in 2018 and 2019, as foreseen by Senator Patty Murray (D-WA), and that are now being

repeated again in 2022. Unfortunately, reports indicate that access to the program has been denied to bilateral and triple Post-9/11 amputees with the only explanation being, “You don’t qualify.” This situation is both shameful and shocking; how can you deny a veteran, gravely injured in service to this country, who will need care and treatment for the rest of his or her life, the benefits he or she has earned? Is funding the only reason for the harsh treatment of our severely disabled veterans?

VVA has heard from frustrated members across the United States, and when we ask them to please contact their member of Congress to assist them, their response is that nobody in Congress is listening. If Congress was listening, our vets say, they could have stopped the bleeding months ago, when VA’s September 30, 2021, press release was issued, indicating a reassessment of VA PCAFC requirements for legacy participants.

Perhaps Congress believed it would only affect aging veterans, but post-9/11 vets are being denied access as well. When the veteran then turns to VA for assistance, they are told to file an appeal. As Ron Nessler, a three-tour, severely disabled Vietnam vet, testifies, “You can’t file an appeal without complete paperwork.” Therefore, Ron attempted to submit everything he had, but was eventually denied access to the benefits. When he asked why, he was verbally told that he did not meet the new regulatory requirements, but he did not receive any written explanation of exactly how he fell short of those requirements. Ron’s story has been repeated over and over again by our membership, and when VVA asked the VA Secretary why veterans were not receiving adequate notification of why their claims were being denied, he had no response.

Over 19,500 veterans and families are enrolled in the PCAFC legacy program, said VA Caregiver Support Program Executive Director Colleen M. Richardson, Psy.D, in a September 30, 2021, VA press release. It further stated that one-third, or 6,700, of those veterans and families would be denied benefits because they did not meet the statutory 70 percent service-connected disability requirement, or the statutory ADL requirement of the new rule. This is, simply put, a travesty, because there is a third stage of the program waiting to begin this year, and what will happen to those aging veterans if Congress sits back and does nothing? May I remind you, these are your constituents, the ones you praise and take pictures of every Veterans’ Day or at candidate’s forums when you promise to take care of them, as long as you can count on their vote? Representatives and Senators, our Veterans need you now to honor that promise; use your legislative power and bring a

halt to reassessment. This was never the intent of the PCAFC program, and is certainly no way to honor our veterans. Deny, deny until they die.

AGING VETERANS POPULATION IN RURAL AMERICA

A disproportionate share of veterans lives in rural America. According to the National Center for Veterans Analysis and Statistics and the U.S. Department of Veterans Affairs, Office of Rural Health (VA-ORH), of the nearly 20 million veterans in the U.S., 4.7 million live in rural America. Fifty-eight percent, or 2.7 million of these rural vets are enrolled in the Veterans Affairs (VA) healthcare system; of those rural, VA-enrolled veterans, 55 percent are 65 years, and older, and 56 percent are affected by a service-related condition.

These statistics are particularly important because veterans living in rural areas may have difficulty accessing health services for reasons similar to other rural residents. Some rural veterans also face poverty, homelessness, and substance use disorder, which can exacerbate their health issues.

In most cases, majorities of veterans are unaware of the benefits, services, and facilities available to them through VA, and it may be even more difficult for rural veterans and their caregivers to access healthcare and other services due to rural delivery challenges. These include, but are not limited to hospital closures due to financial instability; less available housing; fewer education, employment, and transportation options; greater geographic and distance barriers in terms of regular access to VA facilities; and lack of access to broadband services.

According to the official journal of the Catholic Health Association of the United States, *Health Progress*, May 2013 issue:

“It is no long[er] possible to view rural veterans as a homogenous group. Changes in enlistment patterns are creating a more diverse population of rural veterans that includes a growing number of women, an aging cohort of veterans and a younger cohort of Gulf War and Iraq War veterans with potentially longer-term consequences from their combat service. These changes are challenging traditional veteran services systems to revise their programs and community providers to broaden their capacity to address the evolving needs of rural veterans.

To best meet our obligations to those who have served our country, it is critical to focus on opportunities to expand access to accessible, culturally sensitive primary care, behavioral health, specialty care and other support services; improve

coordination and co-management of veterans between community and VA-based service systems; increase the availability of community-based services; explore the use of technology and transportation programs to expand access to care; expand veteran outreach programs; improve the cultural competence of community providers; and enhance our understanding of the needs of the most vulnerable rural veterans.”¹⁵

We at VVA fully concur with this assessment. Consequently, we must remind you to consider that aging Vietnam veterans and their families are registered voters who reside in each of your committee member’s districts or states, whether urban or rural, and as your constituents must become a priority as both committees promote policy and issues according to the U.S. Census bureau. We have attached maps (Attachment 1) to our testimony identifying how many Vietnam veterans over the age of 65 are your constituents, and contribute to the economic stabilization of the communities they live in.

VHA VETERAN-DIRECTED CARE PROGRAM – GERIATRICS AND EXTENDED CARE

The Veteran-Directed Care Program (VDC) is operated by the Veterans Health Administration (VHA), in collaboration with the Administration for Community Living (ACL), and as a part of Health and Human Services (HHS). VDC is a self-directed program to which primary care providers or VA social workers refer veterans. The individual veteran who qualifies and has access to the program manages a VA-funded service budget, which they use to: hire their own employees including family, friends, and other individuals; and purchase other goods and services to support living safely and independently in their own homes and communities. VDC is modeled after self-directed services available in all fifty states via Medicaid State Plans and Waivers, and heavily supported by the Centers for Medicare and Medicaid Services (CMS). VA purchases VDC from Aging & Disability Network Agencies (ADNAs), which are part of ACL’s no-wrong-door initiative. The VDC provider supports the qualifying veteran with managing their budget and all employer responsibilities, and provides case management to ensure their goals for community living are being met.

¹⁵ John A. Gale, M.S. and Hilda R. Heady, MSW, ACSW, “Rural Vets: Their Barriers, Problems, Needs,” *Health Progress* (May-June 2013): <https://www.chausa.org/publications/health-progress/archives/issues/may-june-2013/rural-vets-their-barriers-problems-needs>

As of November 2021, 70 VAMCs operate VDC programs, in partnership with 150 VDC providers who serve 3,750 enrolled veterans. The average veteran in VDC manages a monthly budget of approximately \$2,408, 97% of which is typically spent on personal care services provided by the veteran's direct employees. Veterans in this program typically hire 1.5 workers, approximately half of whom are family members. In addition to personal care services provided by employees, veterans frequently use their VDC budget to pay for transportation to and from medical appointments, as well as for home modifications or the purchase or rental of medical equipment that supports the Veteran's personal care needs, and is not already provided by VA or another source, such as Medicare.

Several studies conducted by VHA, VAMCs, and non-VA researchers have demonstrated the value of VDC and other self-directed services. A recent national evaluation of VDC conducted by VA HS&RD found that veterans enrolled in VDC had fewer incidents of potentially avoidable healthcare facility use, compared to similar patients receiving other purchased care services. These benefits were more pronounced among rural VDC recipients than urban VDC recipients were. This finding supports similar reports from VAMCs who have found VDC substantially affects their ability to delay and even avoid nursing home placement for veterans with significant functional needs.

Because of the positive impact, VDC can have for veterans, their families, their caregivers and VA, VHA has announced funding to expand VDC to all VAMCs over the next five years. Beginning in early 2022, VHA will provide two years of funding for VAMCs without a VDC program to include staffing to hire a VDC Program Manager. Funding will also be provided to support the cost of 20 veterans per VAMC. VHA has identified and will support 14 new VAMCs in 2022, as they develop and implement new VDC Programs.

VVA fully supports the expansion of VDC, administered by the VHA Geriatrics and Extended-Care program, which will be evidently beneficial to many veterans, especially those who may be turned down due to ineligibility for the PCAFC. If qualified for VDC, all veterans will be allowed to manage their own healthcare needs, regardless of age or disability.

SERVING VETERANS WITH LONG-TERM PTSD

It should come as a surprise to no one that VA employs far too few mental health clinicians. This is true for myriad reasons, not the least of which are the hiring hoops clinicians must negotiate, which can take six, eight, ten months, or even longer before they can be officially employed by VA. As a result, in a shortsighted attempt to satisfy the needs of the moment, VA is leaving in the lurch too many vets afflicted with chronic, long-term PTSD. Indeed, VA is not addressing, let alone fixing, a situation its own bureaucrats have created. The question is: Will you in Congress use your standing to support these veterans? VA is currently still operating with critical shortages of staff that have, unfortunately, been exacerbated by a chronic and acute shortage of vitally needed mental health clinicians across the United States. If we are going to make progress on reducing the number of suicides among veterans of every age, the first step is to fill long vacant positions and to return to full staffing as quickly as possible.

VVA is also advocating for continuing care groups led by a clinician to be reinstated by VA to support either those veterans who are considering treatment for PTSD or related mental health issues, or those who need some help in maintaining the gains made after having gone through evidenced-based treatment. We are also asking the Department of Veterans Affairs to help those veterans who may have received a less than honorable discharge due to symptoms of PTSD, to begin the process of having their discharge considered for upgrade.

VVA would like to thank Representative Cindy Axne (D-IA-3rd) and Senator Tester for successfully advancing the *Sergeant Ketchum Rural Veterans Mental Health Act*, which became Public Law 117-21 last June. This bill requires VA to establish and maintain three new centers of the Rural Access Network for Growth Enhancement (RANGE) Program, which serves veterans in rural areas who are experiencing mental illness. While this change does not necessarily increase the overall number of clinicians, it does increase access for vulnerable veterans.

VETERAN SUICIDE

According to VA's *National Veteran Suicide Prevention Annual Report* of September 2021, the number and rate of suicide deaths rose from 2001 to 2018 across the U.S.

population. Yet the U.S. population, as well as the veteran population, experienced a decrease in the suicide count and rate from 2018 to 2019. Furthermore, in retrospect and with updated data, the veteran suicide count was noted to have decreased in 2018 — one year ahead of the U.S. population suicide decrease.¹⁶

Two out of three veteran suicides are over 55 years of age. Fourteen of 20 do not get care at a VA healthcare facility. Former Ranking Member of HVAC, Dr. Phil Roe (R-TN) was quoted as saying that more and more millions of dollars are being expended in an attempt to make an impact on the number of veterans who die by their own hand, yet the numbers do not seem to lessen. Mountains of studies, funded by millions of VA and DOD dollars, seemed only to develop recommendations revolving around the need to learn why veterans commit suicide . . . by funding yet more studies.

The whys may be unique for each individual who attempts to take their life, but they are no mystery: demons borne of the horrors of war, horrors they have experienced. Return from a war zone to a society that does not know, or understand, what they went through too often leads to drinking and/or drugging to ease the pain. In addition to these self-medicating behaviors, too many returned veterans experience fiscal uncertainties, failed relationships, and the loss of hope.

Permitting vets to seek help from non-VA practitioners may help some. This will be costly, and the overall effectiveness difficult to gauge. The answers may lie in community. Increased reliance on “battle buddies” may be viable for recent veterans, but not necessarily for those who served in Vietnam a half-century ago. We want to help VA create a culture that proactively seeks out lonely, homeless, family-less, disenfranchised veterans and brings them in from the cold.

In addition, let the experts at VA, clinicians who have been dealing with veterans every day, do what they do best. According to the testimony of Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, a leading expert on achieving system-wide culture change within a health system in order to reduce suicide deaths, given before the House Veterans Affairs Committee regarding a promising initiative to disrupt suicide attempts:

¹⁶ <https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf>

In conjunction with our National Center for Patient Safety, we developed the “Mental Health Environment of Care Checklist.” Interdisciplinary inspection teams to assess the environment for hazards and determine actions that need to be taken to protect our veterans use this tool. The rate of suicide prior to the implementation of the checklist was 4.2 deaths per 100,000 admissions. It is now less than one per 100,000 admissions.

What Congress might do is enact a law that will make mandatory the insertion of this single question on every death certificate: *Did the decedent ever serve in the Armed Forces of the United States?* This simple step will enable researchers to do a more thorough medical postmortem of anyone determined to have committed suicide. This change, in turn, would add to our understanding of the whys and wherefores of a real American tragedy and allow us to get off the very expensive hamster-wheel of inconclusive research.

OTHER KEY LEGISLATIVE ISSUES

THE VETERANS ECONOMIC OPPORTUNITIES ADMINISTRATION

The most recent bill to establish the Veterans Economic Opportunity and Transition Administration is H.R. 2494/S. 1093, sponsored by Rep. Winstrup and Sen. Rubio. This bill is critical to easing transition for veterans, as this new organization would administer:

- Vocational rehabilitation and employment programs
- Educational assistance programs
- Veterans’ housing loan and related programs;
- The Transition Assistance Program; and
- The database of small business concerns owned and controlled by veterans

This bill has been in committee since May 19, 2021 and has seen no movement. VVA must insist that Congress take further action.

HOMELESS VETERANS

VVA urges the Presidential Interagency Council on Homeless to recognize homeless veterans as a Special Needs Population. Further, we appeal to Congress to require all entities and agencies, including nonprofit and governmental, that receive and utilize federal program funding dollars, to report statistics on the number of veterans they serve, their

residential status, and the services needed by those veterans. VVA strongly urges its own membership, at the chapter and state council level, to work with their state and federal legislators to enhance services to homeless veterans in their home regions, and further encourages them to recognize these veterans as a Special Needs Population. Additionally, VVA supports legislation that would incorporate a “Fair Share Dollar approach” for the federal funding of all homeless programs. Furthermore, VVA presses VA Homeless Grant and Per Diem Program (HGDP) to provide payment directly for services, rather than continuing the method of reimbursement for services that it presently provides for transitional housing. Finally, VVA staunchly supports and seeks legislation to establish Supportive Services Staffing Grants for VA-HGDP Service Center Grant awardees.

Because a long-held and oft-stated key goal of VA has been to end veteran homelessness (a promise that, realistically, never could be kept), one attempt to meet that goal that has arisen is the placement of as many homeless vets as possible in apartments, if only for the short-term. As long as VA is able to provide a continuum of care, the key to which is a plenitude of well-staffed and well-funded transitional services, this policy is sensible. The initial statistics look good; VA can rightly claim its policies are helping. The reality that must be acknowledged, however, is that there are some homeless vets who will not come in from the cold. Despite their circumstances, they still are deserving of our respect and gratitude, twin attributes that VA might better promote through a sensitive outreach campaign.

VVA was pleased to read in the *2021 Annual Homeless Assessment Report (AHAR)* to Congress that the number of veterans experiencing homelessness on a single night in January 2021 had dropped to 19,750, very different from the 49,000 reported in January 2009. Our memories of advocating for homeless veterans in earlier years was that VA had no authority to seek housing for veterans, and HUD had no authority to provide medical care for veterans. It was former VA Secretary Shinseki who saw the need and stepped in to introduce a comprehensive plan to end veteran homelessness, which included discharge planning for incarcerated veterans re-entering society, supportive services for low-income veterans and their families, and a national referral center to link veterans to local service providers. Additionally, the plan calls for expanded efforts for education, jobs, healthcare, and housing to be pursued for the re-housed veterans.

VVA believes that we were on the right track with the passage of P.L. 107-95, the *Homeless Veterans Comprehensive Assistance Act of 2001*, for which, the VVA National Homeless Committee advocated for over 10 years before passage. However, it took the on-going help of VA former and present Secretaries, as well as a COVID-19 pandemic, before we saw a significant change in the number of our most vulnerable veterans finally being settled in a place to call home. The Homeless Committee is grateful for the decrease in the number of homeless veterans; however, we will not take a victory lap until we end homelessness among all veterans. See our executive summary of the 2021 Annual Homeless Assessment Report (AHAR) in Attachment 2.

In addition to the West Los Angeles VA Campus Improvement Act of 2021, which became Public Law 117-18, in June of last year, legislative initiatives that would benefit our homeless veterans and their families include the:

- *Reaching Every Homeless Veteran Act* (H.R. 5783/S. 3094, sponsored by Rep. Mann and Sen. Moran), which would require the organization and execution of an education and outreach program to ensure housing-insecure communities are aware of available benefits;
- *Building Solutions for Veterans Experiencing Homelessness Act* (S. 2172, sponsored by Sen. Tester), which creates a grant program for substance abuse and alcohol use disorder recovery for homeless veterans, a pilot program for elderly homeless veterans, and increases funding for homeless veterans reintegration programs; and
- *Improving Housing Outcomes for Veterans Act* (H.R. 876, sponsored by Rep. Gonzalez), which informs VA medical staff regarding best practices on collaborating with HUD to combat homelessness.

MINORITY VETERANS

Over 2800 South Korean military servicemembers who fought with American troops during the Vietnam War later relocated to the U.S., and are now American citizens. These men and women served on the sea, ground, and air of the Vietnam War Theater from 1964 to 1973, alongside their American allies. Consequently, they were exposed to many perils, including Agent Orange-related illnesses and disease. Today many of these veterans are falling ill due to their Agent Orange exposure, but medical care is not currently available to them through VA healthcare system. The conventional medical community, the only option for treatment and care for these Korean-American vets, still has very little

knowledge of the effects or treatment of Agent Orange-related illnesses given the concentration of these cases in the limited population of veterans, most of whom do not use conventional medical care.

The U.S. government has been supporting the reclamation of toxic exposed land in South Vietnam. The war is long over and we have restored the economy of the new, unified Vietnam. We have embraced our former enemy, supplying technical and material aid, as well as free medical assistance to their population. Our government has abandoned our South Korean allies and fellow veterans, but has embraced and supported a former enemy, North Vietnam. Rather than abandoning them, our government should instead be supporting our fellow Korean-American combatants in a way equal to our native-born American veterans' benefits and of course, equal to or exceeding the embrace and support it provides to our former enemy, Vietnam.

Congressman Mark Takano (D-CA-41st), Chairman of the House Veteran Affairs Committee has introduced *H.R. 234, Korean American VALOR Act*; this bill would amend U.S. Code: Title 38, in order to treat certain individuals who served in Vietnam as a member of the armed forces of the Republic of Korea, as veterans of the Armed Forces of the United States for the purpose of the provision of healthcare by the Department of Veterans Affairs. To qualify, the veteran must have been granted U.S. citizenship either on or after the date on which such services in the armed forces of the Republic of Korea ended. VVA fully supports this important bill and looks forward to working with the members of both committees to secure its passage into law.

THE NEEDS of WOMEN VETERANS

As VA continues to adapt to the reality of the increasing number of women in military service, they must continue to expand their healthcare delivery to meet their needs, e.g., providing (or contracting out) prenatal care, counseling victims of military sexual trauma, and understanding the unique problems faced after facial disfigurement or loss of a limb. To meet these relatively new challenges, VA must first call for and fund research that will illuminate treatment options; VA must also seek out and hire enough female OB-GYN specialists, whom many women veterans prefer. Finally, and perhaps most importantly, VA must be a safe place where women veterans can enter without fear of being victimized by sexual harassment.

With the enactment of P.L. 116-315 *The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvements Act of 2020*, women veterans' issues are finally

being recognized. The law's provisions include the long-fought *Deborah Sampson Act*, named in honor of a colonial American, woman veteran who disguised herself as a man in order to join the Patriot Forces in the American Revolution, and subsequently became a champion for all women who served. We specifically thank Congresswoman Julia Brownley (D-CA) Chair of the Subcommittee on Health/Women Veterans Task Force and members of her staff, for a job well done, and VVA looks forward to working with Congresswoman Brownley to ensure that VA is adhering to the provisions in the law providing adequate services to women veterans.

VVA would like to acknowledge Senator Tammy Duckworth (D-IL) for championing the Protecting Moms Who Served Act P.L. 117-69 (passed November 30, 2021), which compels VA to provide community maternity care providers with training and support specific to the unique needs of pregnant and postpartum veterans, particularly regarding mental and behavioral health. VVA also supports the following bills, which would contribute to improved safety and better health outcomes for our sisters-in-arms:

- *The Servicemembers and Veterans Empowerment and Support Act* (H.R. 5666/S.3025, sponsored by Rep. Pingree and Sen. Tester), which reduces barriers for veterans to obtain treatment for military sexual trauma.
- *The DOULA for VA Act* (H.R. 2521/S. 1937, sponsored by Rep. Lawrence and Sen. Booker), which would establish a five-year pilot program to furnish doula services to pregnant veterans; and
- *The Improving VA Accountability to Prevent Sexual Harassment & Discrimination Act* (H.R. 2704, sponsored by Rep. Pappas), which would enhance VA's ability to respond to sexual harassment complaints in a timely manner, increase training, and would require annual reporting to the House and Senate Veterans Affairs Committees.

GULF WAR VETERANS

Veterans deployed to Southwest Asia during the Gulf War in Operations Desert Shield and Desert Storm are still waiting for answers. The list of toxicants to which they were exposed include (but are not limited to):

- Oil Well fires;
- Chemical and Biological weapons, including Sarin, from the demolition of the ammunition storage depot at Khamisiyah;

- Depleted Uranium used in U.S. military tank armor and bullets;
- CARC – Chemical Agent Resistant Coating – paint on military vehicles to resist corrosion and chemical agents;
- Pesticides;
- PB – Pyridostigmine Bromide – a pre-treatment drug to protect against the nerve agent Soman; and
- Solvents, including Benzene, Cyclohexanol, Ethylene Glycol, Methylene Chloride, Methyl Ethyl Ketone, Methyl Isobutyl Ketone, Naphtha, Toluene, Tetrachloroethylene, Trichloroethylene, and Xylenes.

When those who served, who did our nation's bidding, came home and encountered illnesses they couldn't explain, and subsequently went to a VA medical center, treatments often could not mitigate their maladies or their pain.

When they sought hard-earned disability compensation, most were treated as if they were trying to get over on the government, and claims denied. It is important to note that VA's exceedingly high denial rates of Gulf War presumptive claims (78 percent for presumptive Chronic Multi-Symptom Illness CMI and 93 percent for the broken Undiagnosed Illness UDX presumptive conditions in 38 CFR §3.317) perpetuate the real and on-going misery being experienced by tens of thousands of Gulf War veterans. Therefore, until VA's presumptive Gulf War claims adjudication policies, procedures, and training all are remedied, Gulf War veterans suffering at the hands of the organization that is supposed to help them will continue.

The Agent Orange Act of 1991 mandated that VA engage the Institute of Medicine, now the National Academy of Medicine of the National Academies of Science, Engineering, and Medicine, to convene panels of experts every two years to audit the peer-reviewed scientific literature; hold public hearings; and produce their findings on levels of association, ranging from sufficient to none known at this time, on suspect health conditions related to exposure to dioxin. The Act further mandated that their findings be published in biennial updates of *Veterans and Agent Orange*.

There is a real need for Congress to reauthorize the funding for this endeavor for at least another decade and to expand its scope to embrace the potential effects of past, present, and future exposures to toxicants on veterans of all eras, specifically the 1991 Persian Gulf War and the recent conflicts in Afghanistan, Iraq, and Syria.

This congressionally mandated research, paired with publication of the panel's findings, should also include the investigation of sites in the Continental United States (CONUS) known for the presence of toxic substances. This publication would follow the format of the *Veterans and Agent Orange* updates. These sites include, but are hardly limited to: Fort McClellan in Alabama; Fort Chafee in Arkansas; Fort Detrick and Aberdeen Proving Ground in Maryland; Dugway Proving Ground in Utah; the Marine base at Camp Lejeune, North Carolina; the former Marine air base at El Toro, California; Fort Greely in Alaska; and Luke Air Force Base in Arizona.

At the very least, veterans deserve an acknowledgment that their health may have been compromised in the long term by service-related toxic exposure. These include the tens of thousands of servicemembers in the Gulf War exposed to the toxic plume from the demolitions of the Iraqi ammunition dump at Khamisiyah and the CIA's detonation of at least five other sites that remain classified; and the hundreds of thousands of veterans who have seen service in Iraq and Afghanistan, working and sometimes living for months or years next to those insidious burn pits that pockmarked their bases in the desert. Also included are those exposed to Per- and Poly-fluoroalkyl Substances, the "forever chemicals" in fire-fighting foam that are pervasive at overseas sites and at virtually all Air Force bases in CONUS.

In closing, for as long as we can remember veterans with a DD 214 (Certificate of Release or Discharge from Active Duty) have been turned away from the Department of Veterans Affairs when seeking benefits, because they cannot document every place they served. This long-accepted practice has been impactful: treating each request for benefits as an attempt to get something for nothing. Appraising our returned warriors as fakers or frauds as a first-step reaction is simply unacceptable. These benefits are an integral part of the cost of war. For example, too often have Navy veterans who spent their service in the engine room of a battleship been told that their hearing loss was a function of something else; or members of a field artillery team been informed that their hearing loss was caused by something that happened before their enlistment in the military. Of course, we acknowledge there are people that want to defraud anyone, including the Department of Veterans Affairs. What we are asking is that VA start from the premise of believing the individual veteran's story about military experience, and give it some consideration in their assessment, rather than

looking for holes and contradictions as a first reaction. Managing for fraud first and the veteran second is an upside-down approach, particularly for an agency whose stated mission is “to care for [them] who shall have borne the battle.”

Vietnam Veterans of America greatly appreciates the efforts of both committees for your bipartisan support in adding three presumptive for Gulf War veterans, and the many laws that you have enacted to improve the quality of life for our veterans and their families. We also appreciate the opportunity to testify today, and look forward to working in concert with Congress, as partners, to make inroads into many of the issues and problems you have heard about this afternoon and over the past several weeks. Moreover, we will do our best to reply to any questions or concerns you might care to put to us.

VIETNAM VETERANS OF AMERICA

Funding Statement

March 2, 2022

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

Director for Policy and Government Affairs

Vietnam Veterans of America

(301) 585-4000 extension 111

Jack McManus



Jack McManus was elected to serve as VVA National President at VVA's 20th National convention, held in November 2021, in Greensboro, North Carolina. First elected VVA national treasurer in 1995, he was re-elected to the position in 1997, and again in 2019. He previously served as the VVA Michigan State Council President for six and one-half years from 1989 to 1996, overseeing the largest state program in VVA. In 1997, he was awarded VVA's highest honor, the VVA Commendation Medal, for his extraordinary service to the organization, to all veterans, and to the community at large. The VVA New York State Council has also recognized him with its own Commendation Medal.

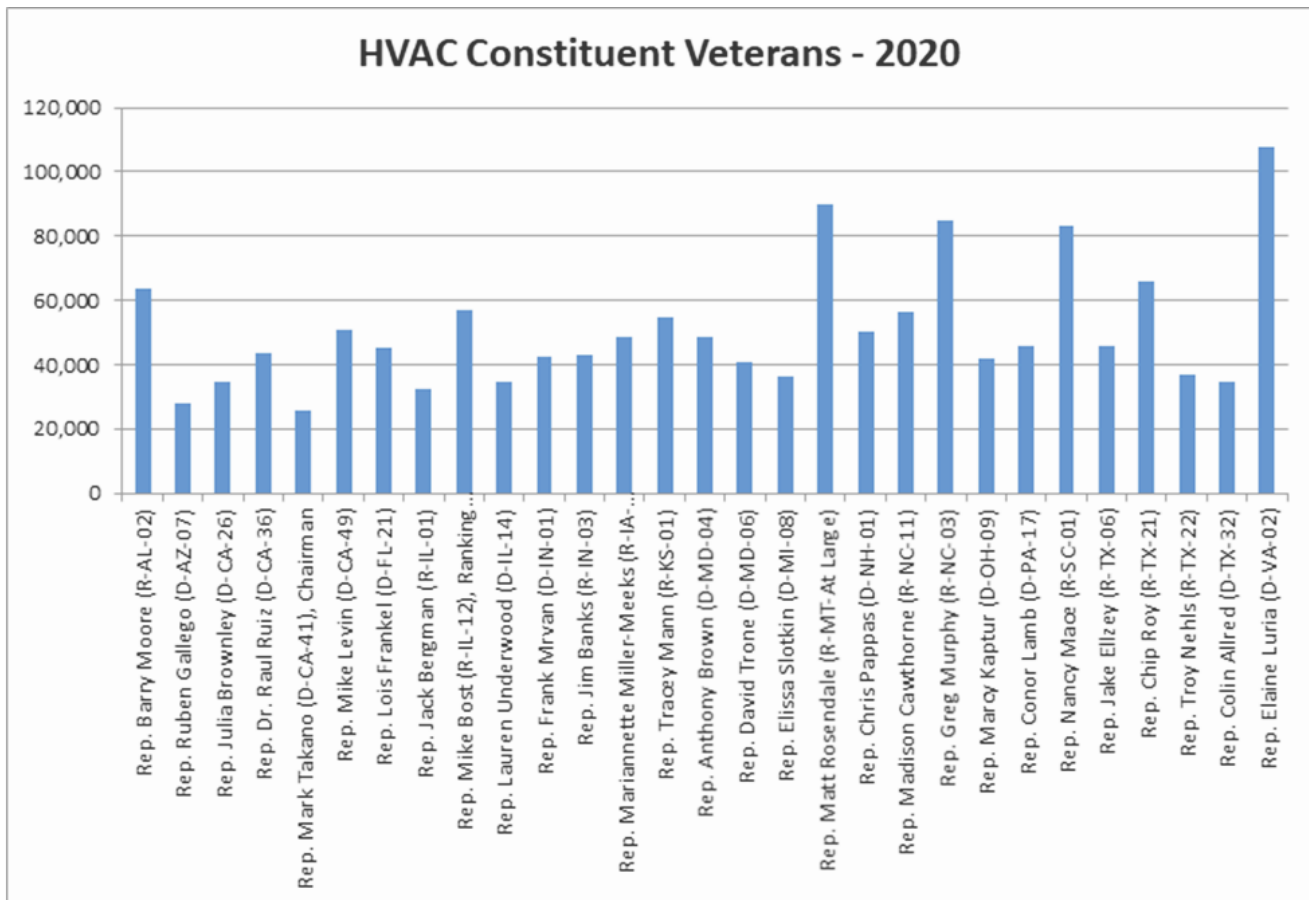
During his career as a private businessman, McManus's company employed approximately 3,500 in two service-sector businesses, with \$150 million annually in sales. In 1978, his company was recognized as the first drug-free workplace in the building service contracting industry. The company also emphasizes special hiring programs for handicapped individuals, ex-offenders, and rehabilitated substance abusers for its internal rehabilitation programs. From 1978 to 1985, McManus was the program manager for his company's contract with the Kennedy Space Center space shuttle program in Florida.

Originally, from New York City, Jack McManus joined the Air Force in 1965, where he served until 1969. Between 1967 and 1968, he was assigned to Operation Ranch Hand in Vietnam.

Jack received his B.A. in Business Management from New York University in 1973. He resides in North Carolina with his wife Jackie. He is a recipient of numerous business and community awards.

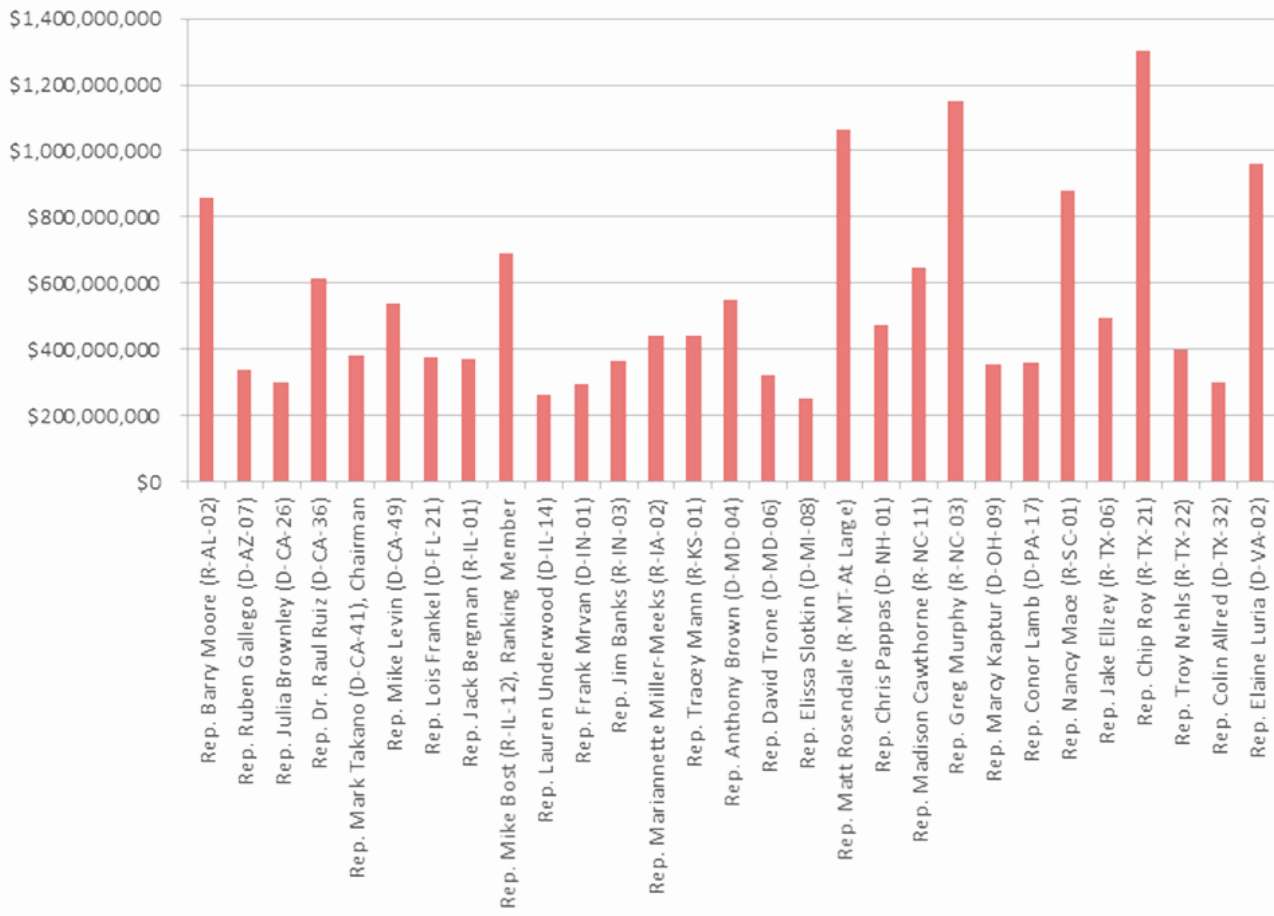
Attachment 1

House Veterans Affairs Committee Data¹⁷

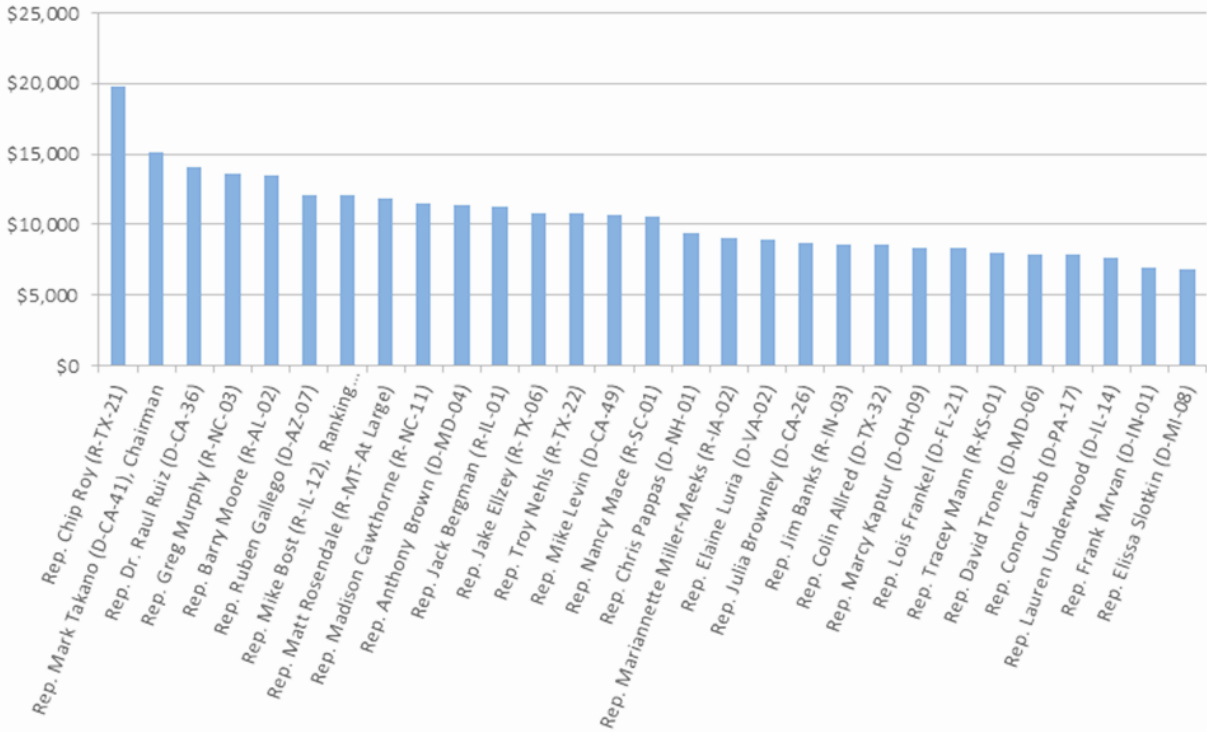


¹⁷ [National Center for Veterans Analysis and Statistics - 2020, VA \(last visited Jan. 13, 2022\).](https://www.va.gov/vetdata/Expenditures.asp)
<https://www.va.gov/vetdata/Expenditures.asp>. All amounts are based on 2020 estimates and dollar amounts are actual.

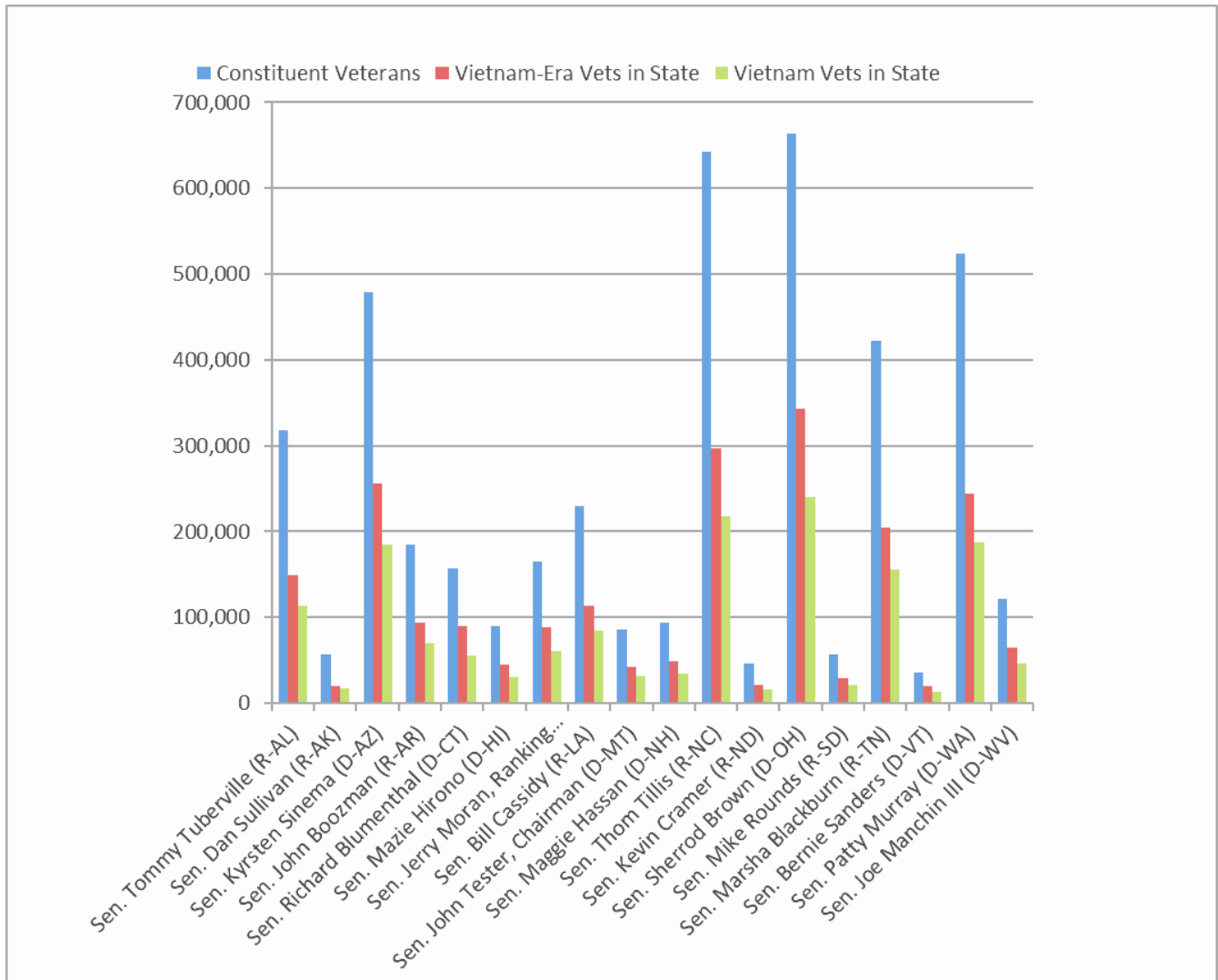
HVAC Expenditures - 2020



HVAC Dollars Spent per Veteran (by Total Expenditure)

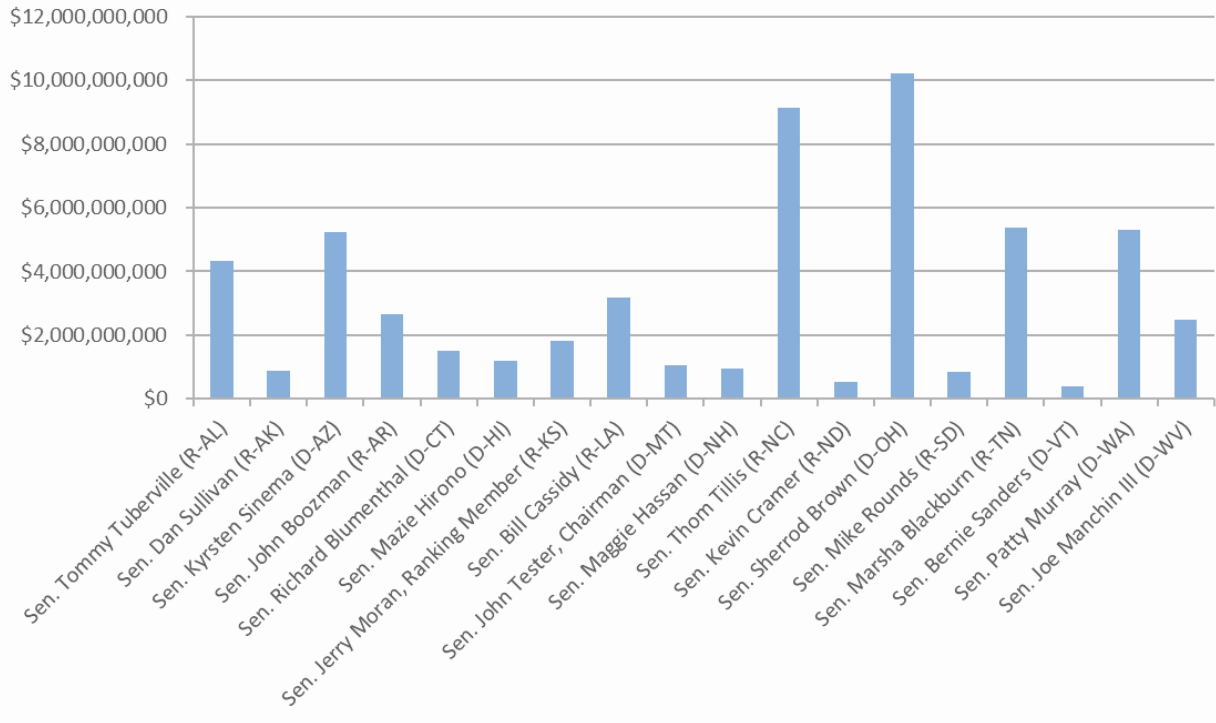


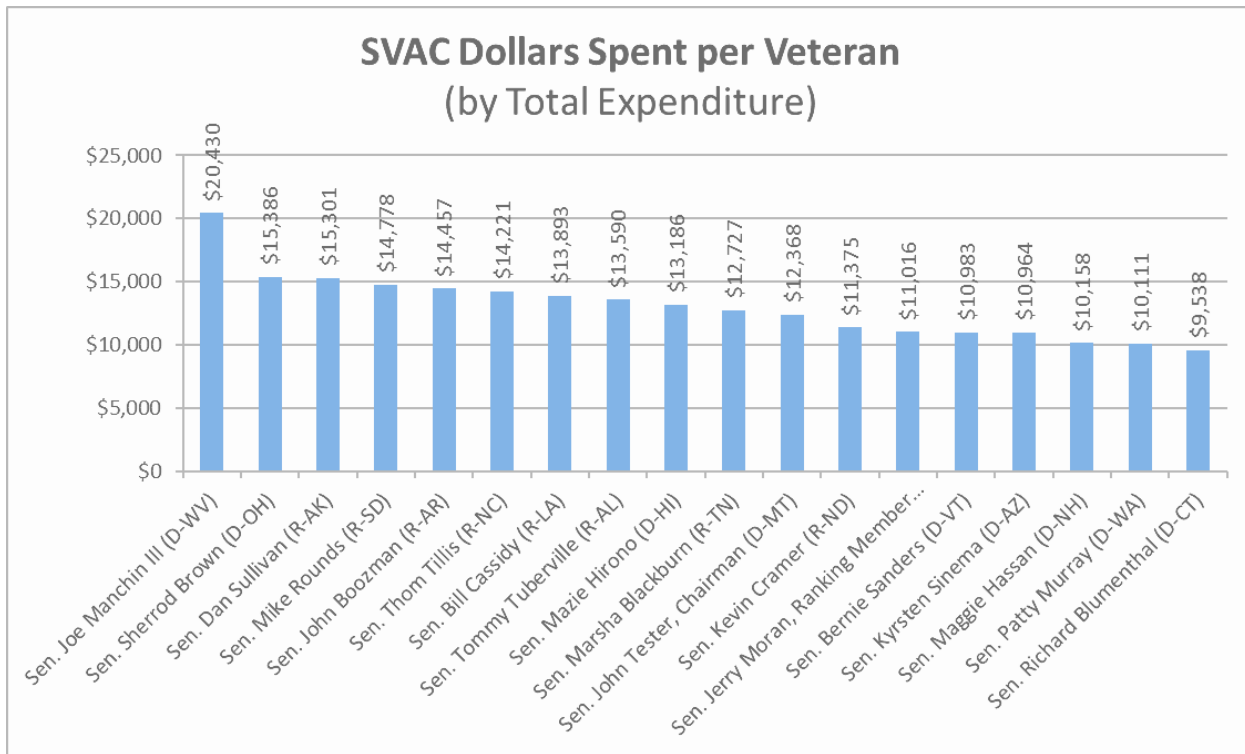
Senate Veterans Affairs Committee Data¹⁸



¹⁸ [National Center for Veterans Analysis and Statistics - 2020, VA \(last visited Jan. 13, 2022\).](https://www.va.gov/vetdata/Expenditures.asp)
<https://www.va.gov/vetdata/Expenditures.asp>. All amounts are based on 2020 estimates and dollar amounts are actual.

SVAC Expenditures by State





Attachment 2

Vietnam Veterans of America executive summary of the 2021 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S

Question Asked: How did the count for *sheltered* homeless veterans came out to approximately 19,750 for 2021?

Answer: HUD relied on PIT and HIC reporting in a year where PIT participation was low and where HIC reporting requirements were reduced, resulting in an artificial decrease in the sheltered homeless veteran estimate.

Explanation

HUD's AHAR uses Point-In-Time (PIT) and Housing Inventory Counts (HIC) at the national, state, and Continuum-of-Care (CoC) level.¹ PIT counts are "estimates of both sheltered and unsheltered homeless populations."² HICs are a count of beds used for the homeless and are provided by each CoC.³ In 2021, only 226 CoC communities conducted a PIT count "because their capacity to conduct counts was limited due to other pandemic-response efforts and the risk of transmitting COVID-19".⁴ More specifically, only 150 communities (39% of all CoC communities) provided full unsheltered counts, while another 76 communities provided a partial count (and did not include household or demographic characteristics). Additionally, shelter providers reduced their bed counts where shelters were set up in a communal or barracks fashion, but not all CoCs reported the reductions in bed counts.

The AHAR itself says that "[e]stimates of the number of veterans experiencing sheltered homelessness at a point in time in 2021 should be viewed with caution, as the number could be artificially depressed compared with non-pandemic times".⁵ Given the reduced participation in PIT by CoCs, in addition to reduced content

¹ <https://www.hudexchange.info/homelessness-assistance/ahar/#2021-reports>

² 2021 AHAR Report, p. 5.

³ 2021 AHAR Report, p. 5.

⁴ 2021 AHAR Report, p. 3.

⁵ 2021 AHAR Report, p. 38.

reporting for HICs and a cut in the number of beds available due to social-distancing requirements, the numbers for homeless sheltered veterans are likely artificially low for 2021.

Note: The raw data for PIT and HIC are supposed to be available on the HUD website, but the data for 2021 is currently missing. Per the [VA website](#), VA relies on HUD to conduct PIT counts, and explains that HUD only collects information on both *sheltered* and *unsheltered* homeless on odd-numbered years. The VA website also states that it combines the PIT count “with many other data points to make strategic decisions about programs” for homeless veterans. VVA believes that VA combines the PIT count numbers with self-reported data from veterans for an overall count of homeless veterans.