LEGISLATIVE HEARING ON H.R. 1197, H.R. 3008, H.R. 3795, H.R. 4274, H.R. 5155, H.R. 5448, H.R. 5454, H.R. 5709, H.R. 5954, H.R. 5985, AND H.R. 6032

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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THURSDAY, JUNE 12, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND
MEMORIAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:10 p.m., in Room 340, Cannon House Office Building, Hon. John J. Hall [Chairman of the Subcommittee] presiding.

Present: Representatives Hall, Lamborn, Turner and Bilirakis.

Also present: Representatives Filner, Space and Brown of South Carolina.

Mr. FILNER [presiding]. The Subcommittee on Disability Assistance and Memorial Affairs of the House Veterans' Affairs Committee is called to order. Unfortunately, if you have heard the bells, we have three votes. Just for my colleagues, these are the last votes of the day, so we will be back in about a half hour. I apologize that with so many bills, we have to hold you. We apologize, but we will be back right after the votes.

Mr. THOMPSON. Mr. Chairman, would you entertain a question?

Mr. FILNER. Yes, sir.

Mr. THOMPSON. Would it be possible for Mr. Rehberg and I to make our statement before we recess?

Mr. FILNER. Yes, sir. With unanimous consent.

Mr. LAMBORN. Absolutely.

Mr. FILNER. So ordered. Thank you for the intelligent suggestion.

Mr. THOMPSON. Thank you, Mr. Chairman. Each of us has an airplane to catch to get home. So we appreciate it. Thank you.

Mr. FILNER. Mr. Thompson will be recognized to talk on his bill, which is part of a whole theme we are considering today, and that is justice for veterans who have been lost through the cracks.

Thank you, Mr. Thompson; thank you, Mr. Rehberg; thank you, Ms. Shea-Porter, for your commitment to our veterans.

STATEMENTS OF HON. MICHAEL THOMPSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; AND HON. DENNY R. REHBERG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA

STATEMENT OF HON. MICHAEL THOMPSON

Mr. THOMPSON. Thank you, Mr. Chairman and Members. The bill that we have would grant presumption of a service connection for veterans who have been exposed to dangerous chemicals or biological agents as part of a test called Project 112 and Project SHAD (Shipboard Hazard and Defense). These were Cold war-era chemical and biological warfare tests that were conducted on U.S. military personnel without their knowledge. These ran from about 1962 to 1974, and these tests exposed about 6,000 servicemembers to dangerous live agents such as VX nerve agent, Sarin gas, and E. coli (Escherichia coli).

And as I said, for the most part these military personnel were unaware they were being used in this test. And for nearly 30 years the Department of Defense denied that these tests ever took place.

I have today with me, and you will hear from him later, Jack Alderson, who is a constituent of mine, who brought this issue to my attention in 1998. He is a former tugboat commander, and he participated in these tests. He was the guy in Project SHAD, and he will tell you how Project SHAD veterans are routinely rejected by the VA for medical care and for disability benefits.

You are also going to hear from Dr. Salerno from the Institute of Medicine (IOM), who will testify that the study that they did found no connection between these substances and health problems with the SHAD veterans. I just want to be on record as stating that that study that she is going to talk about is terribly flawed.

I want to submit for the record, if I could, I think with unanimous consent, the letter that Mr. Rehberg and I sent regarding the flaws in this study. And I think that is important.

They took 5 years to do this study. They still have work to do, and these veterans can't wait any longer.

I also want to submit for the record a bibliography that outlines all the citations. And I have them here, the Subcommittee is welcome to them. Every blue tab on this sheet indicates a scientific reporting of how these chemicals that the IOM studied said didn't have any connection do, in fact, have a connection. And I would like—I am willing to do just the bibliography, but I will leave the whole package with you.

And thank you again for your help on this measure. And just to reiterate, these veterans did everything they were asked for from our country. They were exposed to dangerous chemicals. They are sick. They are suffering as a result of this, and they need our help. They can't wait another 5 years, they can't wait another 40 years. They were literally lied to for 40 years as to whether or not this project, this testing, took place and the effect it has had on them. And I appreciate this Committee's willingness to finally address the problems that they are having. Thank you.

[The prepared statement of Congressman Thompson, and the attached letter and bibliography, appear on p. 51.]

Mr. FILNER. Thank you, Mr. Thompson. And your leadership on this for so many years is greatly appreciated. I think we are finally going to get justice for these veterans.

Mr. Rehberg, thank you for your participation, with Mr. Thompson on this critical legislation.

STATEMENT OF HON. DENNY R. REHBERG

Mr. REHBERG. Thank you, Mr. Chairman and Members of the Subcommittee. And I would really and sincerely like to thank Mike Thompson, who has been a tireless advocate on this issue. It has been my pleasure to work with him to bring these tests to light and fight to get Project 112/SHAD veterans the benefits they deserve.

When I was first elected to the House of Representatives in 2001, I was approached by Billings resident John Olsen. John told me a disturbing tale of a government refusing to be accountable for its actions, a long line of healthcare problems, and a lack of care.

In the early Cold war era, as Mike had mentioned, the Department of Defense and other Federal agencies conducted these series of tests. They used VX nerve gas, Sarin nerve gas, and E. Coli, and they were tested on unknowing military personnel. John is one of those victims. Over the years he has battled several health problems, including skin cancer, prostate cancer, and an adrenal tumor the size of a fist.

Even worse, for more than 40 years the existence of these tests had been denied by the Department of Defense, despite reports from participating veterans like John that they were being stricken with unusual diseases. During that time, many of these veterans suffered and died while their government looked the other way.

Finally, in 2001 the DoD did acknowledge that the tests took place; however, the Veterans Administration still wouldn't provide these veterans with health benefits and compensation for their diseases. Instead, the VA commissioned the study.

We have problems with the study, as was mentioned before. While working on this issue, I have been alarmed by the deficiency of the program for notifying Project SHAD veterans of their exposure. Due to pressure from the Congress, initial search efforts began in 2000; however, they were and continue to be inadequate, bordering on negligence. Since 2003, the Department of Defense has stopped actively searching for individuals who were potentially exposed to chemical or biological substances during Project 112. At the same time, the Department of Defense reported it had identified 5,842 servicemen and women, and estimated another 350 civilians were exposed.

It is a true tragedy that our government, after exposing these servicemen and women to a witches' brew of chemicals, cannot be bothered to find and notify them of such. As I mentioned earlier, the Department of Defense did identify around 350 civilians that were potentially exposed; however, to date no effort has even been made to notify these civilians.

This legislation will help set a standard of oversight for the Federal Government's treatment of our soldiers. We can't sweep the suffering of these veterans under the rug. We can fix the problem created 40 years ago, and this legislation will do that.

Again, thank you for allowing me this opportunity. With unanimous consent, I would like to have John Olsen's testimony submitted for the record, as well as the U.S Government Accountability (GAO) Highlights that suggest DoD and VA need to improve efforts to identify and notify individuals potentially exposed during chemical and biological tests. It is not a pretty report. It needs to be in the record. And they need to do the right thing.

Thank you for your support of this legislation.

[The prepared statement of Congressman Rehberg, and the GAO Highlights, appear on p. 54.]

Mr. FILNER. So ordered on the submission of the testimony and reports.

[The prepared statement of Mr. Olsen appears on p. 108, and the other reports will be retained in the Committee files.]

Mr. Wu and Ms. Shea-Porter, we are going to take a 20-minute recess to get our three votes in, and then we will be back. I am sure you will join us, and we will hear your testimony first when we return.

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

Mr. FILNER. Thank you very much, Mr. Thompson, Mr. Rehberg. We will provide that justice.

We are recessed.

[Recess.]

OPENING STATEMENT OF HON. JOHN J. HALL

Mr. HALL [presiding]. Good afternoon. The Veterans' Affairs Disability Assistance and Memorial Affairs Subcommittee legislative hearing will now come back to order. I would ask everybody to rise for the Pledge of Allegiance.

[Pledge of Allegiance recited.]

Thank you for your patience while we were across the street voting.

First of all, I would like to thank all the witnesses for coming, and apologize for my missing the earlier part of the session when the Chairman of the full Committee, Mr. Filner, graciously filled in for me.

Mr. Lamborn, our Ranking Member, will be back shortly, and at that point he will give his statement.

We will try to move things along as quickly as possible as we consider the 11 bills, 2 of which have already been spoken on, H.R. 1197, H.R. 3008, H.R. 3795, H.R. 4274, H.R. 5155, H.R. 5448, H.R. 5454, H.R. 5709, H.R. 5954, H.R. 5985, and H.R. 6032. I left the titles out to keep it shorter, but we will hear them as we approach each bill.

As a preliminary, it has already been granted, but I ask unanimous consent that Mr. Filner, Mr. Brown, and Mr. Space be invited to sit at the dais, which they have already done. Without objection, they will be allowed to continue.

I know the many issues addressed in these bills are of utmost importance to many of you in attendance today who, like me, have constituents or loved ones who are directly impacted by the problems they seek to solve.

Speaking of witnesses, I welcome you all who are here today, including my fellow Members of Congress, I must express, however,

my disappointment that the DoD did not find it "efficient" to provide a witness to testify, particularly on legislation that has clear DoD implications. Moreover, this notice came late last week, after testimony was due, and after the DoD had originally indicated that it intended to provide a witness.

I hope to avoid this unnecessary wrangling in the future. Our veterans should be important enough to every Federal agency involved to send someone to testify. The nexus between the DoD and VA are undeniable. Invitations to testify should not be rebuffed by the DoD when we are attempting to examine issues that overlap on jurisdiction and responsibility. I do note for the record that yesterday DoD provided a written statement for the record. This fact aside, Congress deserves the right to question the appropriate DoD personnel in person, not just in writing; not to mention that our men and women who have given their all in service to our country deserve the right to have their elected officials question the executive branch. This is how our system of checks and balances must work to ensure our democratic way of governing remains intact.

After our Ranking Member, Mr. Lamborn, returns we will recognize him for his opening statement. And right now I would like to recognize the Chair of the full Veterans' Affairs Committee to speak on a bill of his, Mr. Filner.

[The prepared statement of Chairman Hall appears on p. 50.]

Mr. FILNER. Thank you, Mr. Chairman. You have a big list of bills. Thank you and Mr. Lamborn for taking up all of these bills. I think there is a common theme of long-delayed justice for veterans in all these, so I thank you for doing this.

In addition, you talk about how sad it is that the Department of Defense did not send a witness. They did send a witness to yesterday's full Committee hearing, at which the Principal Deputy Under Secretary of Defense for Personnel Readiness said, when confronted with the facts that several hundred thousand of our Iraqi veterans and deployed troops have PTSD—he said, no, they have symptoms of PTSD. And this is a quote: Only a few have PTSD. And so that is what you get when you get them here. An incredible, display of irresponsibility from the executive branch.

Mr. HALL. Creative diagnosis.

STATEMENT OF HON. BOB FILNER, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FILNER. So even when you get them here, they say really strange things.

I want to thank you for this panel today. I want to talk about two bills: H.R. 3795, the "You Were There, You Get Care Act," which would help radiation-exposed veterans of the Gulf War and subsequent conflicts; and, H.R. 6032, which would grant a presumption of service-connection for Parkinson's disease for Vietnam veterans.

I might say, since I see the national president of the Vietnam Veterans Association here, we plan, at the full Committee level, working with Mr. Hall, to actually take the theme of "You Were There, You Get Care Act" for all of the Agent Orange claims for Vietnam Veterans. I don't care if your boots were not on the

ground; you were in the blue water off the shore, you were in the blue skies above Vietnam, it is way past time for us to take care of all of those veterans, and we hope we can do that.

Depleted uranium (DU), which is the subject of the first bill, is an incredibly effective weapon, but its residue has a half life of 4 billion years, and evidence indicates that it is a carcinogen. We know that many health problems can result from exposure to depleted uranium, and we know that if veterans have been exposed, we have a responsibility to care for them.

The bill "You Were There, You Get Care" would ensure that veterans who served in the 1991 Gulf War and subsequent conflicts will be rated service-connected disabled for any illnesses currently covered by the Radiation Exposure Compensation Act, or RECA, passed by this Congress in 1990. The bill will provide payments to individuals who contract cancer and other serious diseases as a result of their exposure to radiation from above-ground tests of nuclear weapons or from employment in underground uranium mines, as well as any other diseases found by the VA Secretary to result from depleted uranium exposure.

If this bill is enacted, veterans serving in the Gulf War 1991 or those providing clean-up or servicing of vehicles or equipment that had been in the Persian Gulf would be considered exposed. If they become ill, this bill would ensure that the illnesses would be deemed service-connected, and VA healthcare and compensation would be provided.

Second, approximately 20 million gallons of herbicides were used in Vietnam between 1962 and 1971 to remove foliage and vegetation that provided cover for enemy forces during the Vietnam War. Following their military service in Vietnam, some veterans reported a variety of health problems and concerns due to exposure to Agent Orange or other herbicides and pesticides.

My second bill, H.R. 6032 would establish a presumption of service-connection for Parkinson's disease due to exposure to Agent Orange for Vietnam veterans.

I was in Minnesota in Mr. Walz's district, last year, and the Vietnam veterans group there gave me a list of hundreds and hundreds of Vietnam veterans who had gotten Parkinson's in their early fifties, way earlier than, the general population typically becomes afflicted with this disease. It is clear there is some connection here.

Although the Department of Veterans Affairs has developed a comprehensive program to respond to the Agent Orange-related medical problems, there is a lengthy list of diseases that are service-connected under title 38, section 1116, which is updated as evidence examined by the Institute of Medicine (IOM) dictates, however, the list does not include Parkinson's disease. Recently, the IOM's report indicated that the evidence is insufficient to establish an association between Parkinson's disease and the herbicides. But recently, two studies presented to the Committee from Stanford University and the Iowa Agricultural Health Study update of 2007 seem to indicate that Vietnam veterans are more than two-and-a-half times more at risk for contracting Parkinson's than the general population, and connect Agent Orange to an increased likelihood of contracting the disease.

I believe there is an association between the degenerative effects of Parkinson's and Agent Orange, and I urge the IOM to consider the findings of those studies. At the very least, as pointed out by Chairman Hall, we need to examine the disconnect between modern medicine and the current provisions under section 1110, which only allow service-connection for chronic conditions that manifest within 1 year of service. Modern science clearly establishes that the symptoms of these many degenerative diseases can take decades to onset.

So, I also look forward to exploring these discrepancies and the issue of insecticide exposure during military spray operations to control mosquitoes and to stop casualty rates due to malaria, but then, have other unintended harmful effects.

Mr. Chairman, both these bills, H.R. 3795 and H.R. 6032, would make a bold statement if enacted: When our men and women volunteer for service or are drafted, they can count on their government to compensate them and to care for them if their service leads to illness.

I thank the Chair.

Mr. HALL. Thank you, Mr. Filner. You make a logical and forceful argument for these bills.

Just to explain procedure, I am going to ask our Ranking Member, the Honorable Mr. Lamborn, first for his opening statement, and then the Members who are on the dais who have legislation before us, and then the Members at the witness table. So first Mr. Lamborn, you are now recognized.

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman, and for yielding. I thank you and your staff for scheduling this hearing today.

This afternoon we are considering several pieces of legislation, all of which are of interest and potential value. While I do have some policy concerns regarding a number of the provisions, I am primarily struck by the mandatory offsets that would be necessary to pass many of these bills under PAYGO rules.

Mr. Chairman, as you know from the PAYGO problems with H.R. 5892, it is always a challenge to find offsets within our jurisdiction, and that is something we need to keep in mind as we examine these bills today.

The main policy concern I wish to express is that some of the provisions before us are similar to section 101 of H.R. 5892 in that they would redefine "combat with the enemy" as it pertains to section 1154 of title 38. Mr. Chairman, my concerns with these types of provisions are not new to you or other Members of this Subcommittee, and I will not reiterate them here except to point out that a loose definition of "combat" would diminish the immeasurable sacrifice and service of those who actually did face combat. While I understand and appreciate the effort to address problems regarding the VA claims backlog, I believe that they are generally the result from procedural problems, and we should address the problems accordingly.

On another note, I look forward to the testimony of the representatives from the Institute of Medicine, IOM, who will hopefully enlighten the Subcommittee about the process involved in es-

tablishing a presumption of service connection for certain illnesses and disabilities. Experts at VA and IOM have years of experience in dealing with these issues, and I think it is important for Congress to avail itself of their expertise whenever possible.

Mr. Chairman, I again extend my thanks to you and your staff for holding this hearing, and I look forward to hearing the testimony of our colleagues and the other witnesses today. I yield back.

[The prepared statement of Congressman Lamborn appears on p. 50.]

Mr. HALL. Thank you, Mr. Lamborn.

The Chair recognizes Mr. Space for testimony on his legislation.

STATEMENTS OF HON. ZACHARY T. SPACE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO; HON. GUS M. BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA; HON. CAROL SHEA–PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE; HON. DAVID WU, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON; AND HON. THOMAS H. ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

STATEMENT OF HON. ZACHARY T. SPACE

Mr. SPACE. Thank you, Chairman Hall, and thank you, Ranking Member Lamborn, as well as the Members of the Subcommittee, for providing me with the opportunity to speak in favor of H.R. 5709, the "Veterans Disability Fairness Act."

At the end of last year, the Oversight and Investigations Subcommittee held a hearing on an Institute for Defense Analysis (IDA) report regarding the average disability payments received by veterans in each State. The hearing revealed that the VA's current data is lacking, and that regional cultures may be partly to blame for similarly disabled veterans receiving different ratings, and thus different disability payments.

I introduced legislation specifically geared to correct these discrepancies. "The Veterans Disability Fairness Act" requires the VA to collect and monitor regional data on disability ratings. It requires the VA Secretary to conduct reviews and audits of the rating system. It requires the VA to submit a report on an annual basis to Congress to track the progress of the program. And it requires VA raters to take ownership of their ratings by assigning identification codes to all adjudications. The performance of specific raters will be then evaluated periodically for consistency and accuracy.

The current short-changing in ratings is not reflective of our heroes' service, and there is no reason that a veteran from one State should receive less than veterans in other States. This legislation is an important step in addressing these issues and in providing needed oversight.

Additionally, H.R. 5709 supplements this Subcommittee's work on Chairman Hall's 5892, the "Veterans Disability Benefits Claims Modernization Act." Section 106 of that bill calls for an annual assessment of the quality assurance program that examines data from regional offices (ROs), the accuracy of evaluated claims, and creates automated, categorizable data to better identify trends. My

bill will require accountability by enabling the specific identification of potentially problematic claims raters who may knowingly manipulate claims. Alternatively, this legislation will protect those claims raters who are doing their jobs with integrity.

This bill is incredibly important to the veterans of Ohio. Our State was ranked dead last in average disability payments, and I cannot stand for this. According to the IDA report, the national average disability payment is $8,890. Ohio's average is $7,556. New Mexico, which had the highest in the country, is on average $12,395 annually. You can see that that is a significant discrepancy. And I believe that we must act to restore parity to the disability payment system to ensure that each veteran receives the full benefit of what he or she was promised. Senator Sherrod Brown, also of Ohio, and also a Member of the Senate Veterans' Affairs Committee, agrees, and he has introduced identical companion legislation in the Senate.

I would like to thank you once again, Chairman Hall, along with Members of the Subcommittee for their consideration of H.R. 5709, and I am grateful for the opportunity to present this important piece of legislation. Thanks.

[The prepared statement of Congressman Space appears on p. 56.]

Mr. HALL. Thank you, Mr. Space. We will give it every consideration, and the other panels will, I am sure, have comments to make on your bill, as well as the others before us today.

The Chair would now recognize Mr. Bilirakis for 5 minutes to testify on his bill.

STATEMENT OF HON. GUS M. BILIRAKIS

Mr. BILIRAKIS. Thank you so much.

I would like to start by thanking you, Chairman Hall and Ranking Member Lamborn, for including my legislation, H.R. 1197, on today's hearing agenda. "The Prisoners of War Benefit Act" is a bill that my father, Congressman Mike Bilirakis, first introduced several Congresses ago. He was able to make some progress on this legislation before he retired in 2006, and I am pleased to be continuing his efforts on this important issue in the 110th Congress.

"The Prisoners of War Benefits Act" is intended to improve the benefits currently available to former POWs. In 1981, Congress established several service-connected presumptions for certain medical conditions that affect former prisoners of war. However, because of a very high level of research certainty, 95 percent was required before establishing presumptive status, many other medical problems common in POWs have been excluded.

My legislation establishes service-connected presumptions for two additional medical conditions, Type 2 diabetes and osteoporosis. My staff has worked with the American Ex-Prisoners of War to identify these conditions as having strong evidence of a relationship between the POW experience and the onset of the disease.

Congress has passed legislation giving the Department of Veterans Affairs specific standards for determining whether the addition of new presumptive diseases for Vietnam and Gulf War vets is warranted. These standards require a positive association for the adoption of a presumptive condition. However, Congress has not es-

tablished a process for VA to add to the list of former POW presumptive diseases established in 1981.

In 2001, the VA Advisory Committee on Former Prisoners of War recommended the burden for establishing POW presumptions be adjusted to match the standards used for other beneficiary groups. Therefore, H.R. 1197 includes a provision to establish a process by which the VA could determine future presumptive conditions for former POWs when there is a positive association between the experience of being a prisoner of war and the occurrence of a disease or condition. Under my legislation, the VA's Secretary would have to review the recommendations of the Advisory Committee on Foreign Prisoners of War and all other sound medical and scientific evidence, attachment, and analysis available when making this determination.

Under current law, to be eligible for disability compensation for certain conditions presumed to be service-connected for former POWs, a veteran must have been held in captivity for 30 or more days. At the time when some of the original POW presumptions were enacted, short-term prisoners of war were unusual. Prisoners of war from more recent conflicts have been confined for shorter periods of time. H.R. 1197 would remove the 30-day minimum requirement, making all former POWs eligible, regardless of how long they were held captive. This provision is based on the recommendations of the VA's Advisory Committee on Former Prisoners of War, which concluded in 2001 that this 30-day requirement should be repealed.

The 108th Congress did enact a partial repeal of the 30-day minimum requirements as part of the Veterans Benefits Act of 2003. Specifically, this law eliminated the requirement that a POW be held for 30 days or more to qualify for presumptions of service connection for certain disabilities. Although I am pleased the Congress took this initial step, I believe that more can be done in this regard, and urge my colleagues to support H.R. 1197 for this reason.

Before I close, Mr. Chairman, I would like to mention how pleased I am that we have also included H.R. 5454 to today's agenda. H.R. 5454, I believe sponsored by Representative Brown, which I have cosponsored as well, would establish a presumption of service connection for amyotrophic lateral sclerosis (ALS). I have heard from some of my constituents whose loved ones suffer from this devastating disease. They firmly believe there is a link between their loved one's military service and their developing ALS.

In closing, Mr. Chairman, I want to thank you once again for including my bill in today's hearing. I hope that you and our other Members, our other colleagues on the Subcommittee, will support H.R. 1197 and H.R. 5454. I look forward to hearing the testimony from today's witnesses.

Thank you, Mr. Chairman. I appreciate it.

[The prepared statement of Congressman Bilirakis appears on p. 59.]

Mr. HALL. Mr. Bilirakis, thank you very much for your eloquent testimony on behalf of those bills, and we will hear testimony from our other panels soon about them.

But first we will turn to our fellow Members of Congress, starting with the Honorable gentlelady from New Hampshire, Ms. Carol Shea-Porter, speaking on her bill, H.R. 5155.

STATEMENT OF HON. CAROL SHEA–PORTER

Ms. SHEA-PORTER. Thank you, Chairman Hall and Ranking Member Lamborn, for taking up my bill, H.R. 5155, the "Combat Veterans Debt Elimination Act." I am honored to testify before you today on behalf of our servicemembers and their families. Our soldiers, sailors, airmen, Marines and Coast Guardsmen are on the frontline of this generations' struggle against terrorism. Our Nation's bravest have answered the call, and in towns and villages around the world they are stepping into the breach to secure freedom, preserve liberty, and provide relief.

Tragically, some die in service to our country. Mourning our fallen is a difficult and somber reminder that we are in a state of persistent conflict. For some families, though, the mourning process has been interrupted by an unfortunate bureaucratic procedure. Under Title 38 of the U.S. Code, the Veterans Administration is required to collect certain debts from the estates of servicemembers killed in combat. That procedure is wrong, and this bill is its best and only remedy. These collections, while not common, are unacceptable, and I believe an unintended consequence of a poorly drafted policy.

This fix is simple, appropriate, and necessary. When our servicemembers give their last full measure of devotion, their sacrifice should have had no price tag. No debt is larger than the one we owe to our Nation's heroes and their families. "The Combat Veterans Debt Elimination Act" ends the Title 38 requirement, and today we take the first step toward making this right.

It is my firm belief that the VA and I agree on the intent of my legislation, and I expect that they will share those views later in this hearing. I am committed to working with the VA and with the Committee to ensure it provides a proper remedy to this problem without delay. Our interests and our goals here are the same. Together we can agree to right this wrong and prevent further attempts to collect these small, insignificant debts that amount to little more than a rounding error, roughly 50 cents to every $30 million spent by the Federal Government, a mere pittance unless you are one of these family members.

This country has made a promise to our servicemembers to honor their sacrifice and to care for their families while they do the work of our Nation. This Committee and this Congress have made tremendous steps toward fulfilling these promises. Today we continue that forward progress.

I thank you again for this opportunity to testify before the Subcommittee.

Mr. HALL. Thank you, Ms. Shea-Porter. I appreciate your thoughtful presentation about this very worthy piece of legislation.

Next the Chair recognizes the Honorable gentleman from Oregon, Mr. Wu.

STATEMENT OF HON. DAVID WU

Mr. WU. Thank you, Chairman Hall, and Ranking Member Lamborn and distinguished Members of the Subcommittee, for the opportunity to testify today on behalf of my bill, H.R. 3008, the "Rural Veterans Services Outreach and Training Act."

A few years ago I was made aware of a problem that directly affects millions of individuals who have defended our country. Due to budget cuts in many areas, including my home State of Oregon, county veterans service officers are not being funded at adequate levels. County veterans service officers provide veterans with advice, support, casework service, and other services about their VA benefits. There is a singular need for these services in our rural communities.

There are approximately three million veterans living in rural areas in the United States. A 2004 report published in the American Journal of Public Health shows that veterans in rural areas are in poorer health than their urban and suburban counterparts. Without access to casework services, these veterans go without all the benefits they need, deserve, and have earned.

Some may argue that veterans in rural areas can simply drive to the nearest VA regional office, but for many veterans and their caregivers, this is impractical. According to the National Rural Health Association, the average distance a rural veteran must travel to get care is 63 miles. For someone who has endured the trauma of a battlefield injury and begun the long, arduous process of rehabilitation, this is often simply too much to ask.

Without access to a county veterans service officer, veterans must rely solely on customer service representatives over the telephone or the Internet in order to access their VA services. But anyone who has ever encountered an automated phone system knows how frustrating and discouraging this can be.

Veterans who have suffered physical, emotional, or psychological injuries should not be forced to navigate the VA bureaucracy alone because they do not live near a VA Regional Office. Our veterans deserve better, have earned better, and will get better under this bill.

County veterans service officers provide rural communities with more than just their expertise. I believe our veterans are best served by their fellow community members. Community members understand a veteran's needs as they relate to his or her community, job, and family and associated circumstances. Armed with this attachment, county veterans service officers can best advocate for the veterans they serve.

With this in mind, I introduced the "Rural Veterans Services Outreach and Training Act," which seeks to improve outreach and assistance to veterans and their families residing in rural areas. This bill establishes a competitive grant program at the Department of Veterans Affairs to help eligible States hire and train county veterans service officers for their own rural communities. The Rural Veterans Outreach and Training Act targets grant money to the communities that need it the most. This legislation requires that grants will be used only to supplement non-Federal funding sources, not supplant them.

We have an obligation to ensure that veterans, wherever they reside, have access to the services they have earned and deserve. Our men and women in uniform give so much in service to our country, and I believe we should act accordingly to ensure that they have access to local assistance to find the help they need. Again, I appreciate the Subcommittee's consideration of the Rural Veterans Services Outreach and Training Act, and on behalf of a grateful Nation and veterans everywhere, I look forward to working with you on this important legislation.

[The prepared statement of Congressman Wu appears on p. 60.]

Mr. HALL. Thank you, Mr. Wu.

As one who represents a district that is in New York, which people think of as concrete and skyscrapers, but nonetheless has within it Orange County, the black dirt farmers and vast stretches of rural landscape stretching toward the Delaware River, I can identify, and my veterans can identify, with the problems you described.

We will now turn to Mr. Allen for testimony on his legislation.

STATEMENT OF HON. THOMAS ALLEN

Mr. ALLEN. Thank you, Chairman Hall and Ranking Member Lamborn, for holding this hearing. I am grateful for the opportunity to testify on my bill, which is H.R. 5448, the "Full Faith in Veterans Act."

What we now know as post traumatic stress disorder, or PTSD, is not a new phenomenon. The enormous stress of military service has long been recognized as the source of disabling psychological and emotional illness for many veterans. Unfortunately, as I have learned from Maine veterans, proving that PTSD is connected to service can be very difficult, and denial of service connection leaves these veterans without access to VA health benefits or disability compensation.

The goal of my bill is to ensure that every veteran whose PTSD resulted from their service receives treatment and, if appropriate, disability compensation. Too often veterans with legitimate claims are met with skepticism and red tape. The story of one of my constituents highlights this problem.

Terry Belanger is an Army veteran from Biddeford, Maine. During his service from 1969 to 1970, his supply vehicle came under enemy fire, he reports, practically every night. Close friends were killed in combat, another died in a stabbing. He witnessed the torture of Viet Cong officers, and he saw the truck ahead of his strike a mine. On one mission a young Vietnamese girl suddenly appeared in front of his truck, and his vehicle ran over the little girl, apparently killing her. Because his convoy was under fire, he could not stop. Terry's nightmares about this incident resurfaced years ago, after he nearly struck another child who darted in front of his car.

When he returned from Vietnam, Terry was diagnosed by healthcare professionals as suffering from severe PTSD resulting from his service in Vietnam. In 1989, he filed a claim with the VA for service-connected PTSD. The claim was denied due to, and I am going to quote, lack of credible attachment of supporting stressors. For years Terry tried to get the Army to search for documents that

would prove that these stressors had occurred. In 1993, the National Personnel Records Center basically told Terry to forget it because the requested records, quote, would rarely show specific details about a unit's activities and movements. They say the agency, quote, was unable to perform the extensive research requested due to staffing and budget limitations.

But Terry continued the fight. Finally, in 2005, the National Archives found documents that verified that Terry's unit was in combat for months, but it took another 3 years for the VA to actually approve his claim, which they finally did a few weeks ago, 19 years after the claim was first filed.

Under current law, the veteran bears the burden of producing documents to prove the trauma occurred. How is Terry Belanger supposed to find the records if the government couldn't? In these cases, when no records can be found to substantiate the claim, a veteran can also submit two buddy statements as evidence their claimed stressor actually occurred, but this is no easy task. Many veterans magazines contain ads like this one in the April 2008 issue of VFW magazine. The ad reads, 173rd Airborne Support Battalion, An Khe, Vietnam, 1968–69, seeking anyone who attended Airborne Jungle School when one of the instructors was accidentally shot by one of the other instructors next to me. Anyone there when the school and mess hall were shelled and three people were killed. Need substantiation for PTSD claim. William E. Young, Jr.

Veterans should not have to take out classified ads in order to have their claims for PTSD approved by the VA. In Terry's case, doctors confirmed he had PTSD. His nightmares and flashbacks referred to his time in Vietnam. His government trusted him when he served his country. Why should we distrust him now?

Under my bill, if a veteran is diagnosed by a certified mental health professional as suffering from PTSD relating to the veteran's military service, the VA must accept this finding as sufficient proof of service connection. The VA can rebut this finding of service connection by clear and convincing evidence to the contrary. The bill would ensure that the VA does a better job at diagnosing and treating this debilitating disorder.

A broad array of veterans groups, including Veterans for Common Sense, Swords to Plowshares, and the Maine departments of the American Legion, AMVETS, the DAV, and the Veterans of Foreign Wars, along with Maine's Bureau of Veterans Services support my bill.

For too long America has neglected our responsibilities to the men and women who carry the emotional scars that military service sometimes brings. Terry Belanger's wife wrote, "This wonderful man left part of his soul in Vietnam." I hope and pray that with care and support, Terry and other veterans suffering from PTSD will be restored to full and productive lives. The Full Faith in Veterans Act can help achieve this goal.

I thank the Subcommittee for the opportunity to testify, and would be happy to answer any questions.

[The prepared statement of Congressman Allen and attachments appear on p. 61.]

Mr. HALL. Thank you, Mr. Allen.

I sympathize and agree wholeheartedly with the intent and the content of your bill. In terms of this presumptive stressor, which includes, among other things, PTSD, it may go beyond and be more thorough than the Disability Claims Modernization Act, H.R. 5892, which we approved out of the Subcommittee and the full Committee a few weeks ago.

The most dramatic case that my staff and I encountered was a World War II veteran who came to us 60 years after he had been swimming in the Pacific Ocean for the second time, after two ships were blown out from under him in World War II. He had started trying in his seventies to get some kind of help for his emotional problems with the flashbacks and the depression and the inability to lead a normal life. Fortunately, he lived long enough that we were able to get him a correct diagnosis. The VA had diagnosed him as schizophrenic with a preexisting condition, meaning when he signed up at age 18, he must have been schizophrenic, but they didn't notice it. We got that turned into 100 percent PTSD classification just last year.

So it is true this applies to any war; especially the wars in Afghanistan and Iraq, where the enemy is not in front of you and your support team behind you. It is sort of everybody is everywhere. And as in Vietnam, it is difficult to tell those who were working with you, be they translators or logistical people, from those, for instance in Iraq, who may turn on you with a bomb or a weapon at any time.

So the stress—whether it is immediate or post traumatic stress—is real, and I congratulate you and commend you for your legislation.

I am going to hold off on questions myself. Other Members of the Committee, would you like to question this panel? If not, we will excuse you. I know you have trains and planes and other modes of transportation to catch. I thank you so much for your legislation. We will be hearing testimony on it from our next panels.

Congressman Wu, Congressman Allen, thank you very much.

Mr. ALLEN. Thank you, Mr. Chairman.

Mr. HALL. We will ask our second panel, Judith Salerno, M.D., M.S., Executive Director of the Institute of Medicine, National Academy of Sciences; Sidath Viranga Panangala, Analyst of Veterans Policy for the Congressional Research Service; Christine Scott, Specialist, Social Policy, Congressional Research Services (CRS); and Douglas Weimer, Legislative Attorney for the Congressional Research Services, Library of Congress.

Thank you for joining us. Thank you for your patience. As usual, your written statement is entered into the record. So feel free to shorten it if you want, or embellish upon it if that is what you prefer.

We will begin with Ms. Salerno. You are recognized for 5 minutes.

STATEMENTS OF JUDITH A. SALERNO, M.D., MS, EXECUTIVE OFFICER, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES; AND SIDATH VIRANGA PANANGALA, ANALYST IN VETERANS POLICY, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS; ACCOMPANIED BY CHRISTINE SCOTT, SPECIALIST IN SOCIAL POLICY, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS; AND DOUGLAS WEIMER, LEGISLATIVE ATTORNEY, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS

STATEMENT OF JUDITH A. SALERNO, M.D., MS

Dr. SALERNO. Good afternoon, Chairman Hall and Members of the Subcommittee. My name is Dr. Judith Salerno, and I am the Executive Officer of the Institute of Medicine. I am also honored to have served veterans for nine years while in the Veterans Health Administration.

I am here today to address topics that are pertinent to several of the bills that are being discussed, the topics covered in seven reports that are authored by Committees of experts convened by the Institute of Medicine. The reports are part of a long history of the IOM applying its expertise to assist the Department of Veterans Affairs by evaluating scientific evidence in a fair and unbiased manner, and drawing conclusions regarding health effects associated with exposures experienced by our Nation's veterans.

My written testimony provides greater detail on all of the studies that I will summarize today. The first three studies I will discuss are Congressionally mandated, and ask the IOM to examine health outcomes related to exposures during the Vietnam and Gulf wars. H.R. 3795 would add a presumption of radiation exposure for the purposes of service connection for veterans of Gulf war and subsequent conflicts in that theater. The bill also calls for an independent study to determine diseases that may have resulted from these exposures.

H.R. 6032 would provide presumption of service connection for Parkinson's disease for Vietnam veterans exposed to herbicides. IOM expert Committees concluded that there was no evidence to either support or rule out an association with numerous health outcomes related to depleted uranium and, in the case of Parkinson's, for exposure to herbicides which were used in Vietnam. The IOM is currently conducting an update of its 2000 report on DU. It is expected to be released this fall. And the Parkinson's update is due in 2009.

With regard to H.R. 5454, the IOM expert committee examined the available scientific literature on ALS and veterans, and that report was released in 2006. Only five studies on the topic were identified. The Committee found that there was limited or suggestive evidence of an association between military service and the development of ALS.

The next three reports generally covered disability and compensation issues. H.R. 1197 addresses issues related to the establishment of presumptions of service connection. A 2008 IOM report proposes an alternative scientific framework for making decisions regarding service compensation. Its findings and recommendations

were previously delivered to the Subcommittee in February, and in the interests of time, I won't repeat these findings here.

H.R. 5448 includes provisions for VA to update the rating criteria used to evaluate PTSD for compensation purposes, and to create a training and certification program for VA employees who perform the ratings.

Last year an IOM Committee identified areas where changing current practice could result in more consistent and accurate ratings for disability associated with PTSD. The Committee found that the current criteria are overly general for the assessment of PTSD, and recommended that new criteria be developed and applied specifically to PTSD symptoms, and that these be grounded in the standards set out in the Diagnostic and Statistical Manual of Mental Disorders IV, which is used by most mental health professionals.

The Committee also recommended that VA establish a certification program specifically for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification.

H.R. 5709 would require annual reviews of the accuracy and consistency of decisions on disability compensation. This report recommended periodic evaluations of the accuracy, validity, and interrater reliability of ratings across all 58 VA field offices and body impairment categories.

The main finding of this report, however, was that the VA's schedule for rating disabilities is badly out of date, and recommended that VA update the ratings schedule using current medical knowledge.

Finally, H.R. 5954 would establish a mechanism for determining presumptive service connection for diseases that could be related to participation in Project 112, which includes Project SHAD. The 2007 report on Project SHAD found no clear evidence that specific long-term health effects were associated with the participation in Project SHAD; however, because of the limitations of the studies, in response rates, and the size of the study, the report's finding should not be viewed as clear evidence that there are no possible long-term health effects related to SHAD involvement.

The Institute of Medicine is pleased to have assisted VA and Congress with its expert evaluations. We hope that we have contributed to improving care for our Nation's veterans. Thank you for the opportunity to address the Subcommittee. I would be happy to take any questions.

[The prepared statement of Dr. Salerno appears on p. 67.]

Mr. HALL. Thank you so much for your testimony, Ms. Salerno.

Next, Mr. Sidath Viranga Panangala. Is that close to the pronunciation?

Mr. PANANGALA. You are right.

Mr. HALL. You are recognized for 5 minutes, sir.

STATEMENT OF SIDATH VIRANGA PANANGALA

Mr. PANANGALA. Thank you, Chairman Hall, Ranking Member Lamborn, and Members of the Subcommittee. My name is Sidath Panangala from the Congressional Research Service. I am accompanied today by Christine Scott and Douglas Weimer, both from CRS. We are honored to appear before the Subcommittee today.

As requested by the Subcommittee, my testimony will highlight major legislative milestones in the establishment of presumptions of service connection for veterans benefits. A copy of my full statement is submitted for the record.

CRS takes no position on any legislation that is under discussion today. In general, a veteran is entitled to compensation for disabilities incurred or activated during Active military, naval, or air service.

Currently, there are five ways to establish a disability is service-connected. First, there is direct evidence that the injury or disease was incurred while in military service.

Second, in the case of a preexisting injury or disease, there is evidence that it was aggravated while in service.

Third, through proximity to a service-connected condition; by example, veteran developing cardiovascular disease due to a service-connected amputation of the lower leg.

Fourth, the injury or disease is caused by VA medical care or vocational rehabilitation.

And finally, a service connection may be established by creating a presumption, either through statutory or administrative action, that a particular disease or diseases were incurred or aggravated by military service. Such presumptions, which are the focus of this testimony, relieve the veteran of having to prove that a particular disease was caused by exposure to a physical, chemical or biologic agent during his service.

The legislative history of veterans' disease presumptions dates back to 1921, when Congress established a presumption of service connection with an amendment to the War Risk Insurance Act. This established presumption of service connection for tuberculosis and neuropsychiatric diseases, which today is known as psychosis, occurring within 2 years of separation from Active military service.

In the following years, additions to the presumption lists were made by regulation, Executive Order, and legislation. The next major legislative change occurred with the enactment of Public Law 91–376 in 1970. This law established a presumption of service connection for seven categories of diseases and conditions for any veteran held as a prisoner of war.

It should be noted that up until this time, all statutory presumptions had a presumptive period in which a disease or illness needed to have manifested itself. Typically this was about 1 year after separation from Active service.

In the past 20 years, Congress has on three separate occasions created presumptive programs for three distinct groups of veterans, so-called atomic veterans, who were exposed to radiation from atomic above-ground nuclear tests and atomic bombs detonated in Japan; Vietnam veterans; and Gulf war veterans.

In 1988, the Radiation-Exposed Veterans' Compensation Act established a presumption of service connection for 13 specified types of cancers. That list was subsequently expanded first by legislation, later through VA administrative action, to 21 cancers.

In 1991, the Agent Orange Act established for Vietnam veterans a presumption of service connection for diseases associated with exposure to Agent Orange and other herbicides. For the first time, this act required the VA to contract with the Institute of Medicine

to conduct every 2 years a scientific review of the evidence linking certain medical conditions to herbicide exposure. The VA was instructed to use IOM's findings and other evidence to issue regulations establishing a presumption for any disease for which there is scientific evidence of an association with the herbicide exposure.

In 1998, Congress enacted the Persian Gulf War Veterans Act and the Veterans Programs Enhancement Act. Similar to the Agent Orange presumptive program, these laws mandated regular and thorough reviews of the scientific and medical literature relevant to the health of Gulf War veterans by IOM.

Next, as requested, I would briefly mention the IOM study on presumptive disability decisionmaking. In 2006, the Veterans Disability Benefits Commission requested IOM to provide a framework on how future presumptions should be made based on scientific principles. In 2007, IOM recommended the establishment of a permanent advisory Committee and a scientific review board. According to IOM, and I quote, the advisory Committee would consider and give priority to the exposures and health conditions proposed for possible presumptive evaluation, while the science review board, an independent body, would evaluate the strength of the evidence based on causation that links a health condition to military exposure, end of quote.

Next, the independent science review board's report and recommendations would go to the VA for its consideration and implementation.

In conclusion, since 1921, Congress has established numerous presumptions of service connection for a variety of health conditions affecting veterans. Establishing these presumptions, Congress and others have sought to balance the dual obligations of the VA to provide care for veterans who have been harmed by their service, and to do so in a manner that is equitable, scientifically sound, and accountable.

This concludes my statement. I will be happy to answer any questions you may have. Thank you.

[The prepared statement of Mr. Panangala appears on p. 70.]

Mr. HALL. Thank you so much, Sidath. I appreciate your testimony. I just want to note that we are entering the attachments of the IOM studies referred to into the record, graphs and figures and so on that you were referring to, as part of the official record of this proceeding.

Without objection, so ordered.

[The attachments of the IOM study appear on p. 118.]

Mr. HALL. Christine Scott, you are now recognized for 5 minutes.

Ms. SCOTT. Mr. Panangala presented testimony. We are here to help answer questions.

Mr. HALL. Would you like to say anything?

No. That is fine.

Mr. Weimer.

Mr. WEIMER. Thank you, Mr. Chairman. My comments were delivered by Mr. Panangala.

Mr. HALL. Thank you so much. They are in the record, and I appreciate you being here and submitting them.

So we will now have, hopefully, a brief round of questions.

Ms. Salerno, thank you again for joining us. The IOM's report, "Improving the Presumptive Disability Decision-Making Process for Veterans," outlines a new paradigm for determining presumptions of disability compensation.

Could you please elaborate on this new system, highlighting the differences with the current method? And please talk about the proposed science review board process.

Ms. SALERNO. Yes.

The idea was to have a process which was clear and transparent. There seems to be—when charges come to the IOM or various committees to evaluate information, the charges vary as to how one should weigh criteria. With this new framework, there would be, first, an advisory panel, advisory to the VA, which would take into consideration all the views of stakeholders and evaluate the priorities for which conditions should be under consideration for presumption.

Then the task would go to a scientific review board, which would evaluate, based on the best available scientific knowledge at the time, the process and make recommendations to VA.

The VA would then take that information to the Secretary of Veterans Affairs, and based on clear and transparent criteria for what would be the threshold for presumption, would make a decision and put it into policy. So all along the way the process would be different.

Mr. HALL. Thank you.

Congressman Thompson introduced his joint letter, dated February 15, 2008, addressed to Dr. Rick Erdtmann of the IOM, detailing their issues with the IOM study.

Were you aware of this letter, and can you give me an update on where the IOM stands on review and/or reopening of the 2007 study on the long-term health effects of participation in Project SHAD?

Ms. SALERNO. Yes, sir, I would be happy to.

We did receive the letter and we looked at the five issues that were raised in the Congressman's letter. And we take their concerns very seriously, and we think they raise some very critical points for us to consider.

So we have been open to thinking about how to discuss these issues that were raised, and we have decided that we would provide additional analyses of the data based on their concerns and questions. And we have done that.

Now, these findings from the reevaluation of the data are being sent to an independent panel of national experts who have not been involved previously with any of the Project SHAD studies for an independent peer review. And then we will provide this information to the Congressman, and we hope it will address all of their concerns.

Mr. HALL. With regard to point three of the letter, can you tell me what the potential impact on the results of the study was of omitting the health records of deceased Project SHAD participants, and is it possible that it skewed any of the results?

Ms. SALERNO. I have to see what point three is.

Yes. The deceased for whom we didn't have any other information other than that they had died were, in the initial evaluation,

not included except to note that they had passed away. It was a very small number relative to the over 5,500 veterans who were exposed and included in the study. It was literally a handful.

Attempts were made to obtain additional information on them, and we would be happy to consider additional information on these few veterans if and when they become available.

Mr. HALL. Thank you. I think it is an interesting and valid question that Mr. Thompson and Mr. Rehberg were asking: If the cause-of-death information is available for those individuals, whether it is possible to measure what impact that information would have had on the outcome of the study.

So if you could follow up on that and let us know.

Ms. SALERNO. Be happy to.

Mr. HALL. I do not know in terms of relative size, what percentage you are talking about, but nonetheless I think it would be good to get an answer to that, if possible.

I wanted to also ask briefly, Mr. Panangala, Parkinson's disease is already listed as a chronic condition under title 38 of the U.S. Code, section 1101.

In your opinion, is a separate presumption needed?

Mr. PANANGALA. I believe the disease is in the title, but I think there is a time limit that is in the regulations and statute that you had to be diagnosed with. I believe the legislation needs to remove that time limit. That is my understanding.

I can't say that that should be done or not, but that is my understanding of it, so I cannot comment beyond that explanation.

Mr. HALL. If the 1-year presumptive window did not close for these conditions, would VA already be service-connecting those veterans affected by ALS even after a 1-year lapse after separation?

Mr. PANANGALA. Can you repeat that question?

Mr. HALL. Yes. If the 1-year presumptive window did not close, if it were not a factor in the VA's deliberations, would VA be service-connecting those veterans afflicted by ALS even after a year, post separation?

Mr. PANANGALA. That means you are asking whether VA would go ahead and establish the presumption after——

Mr. HALL. Does ALS manifest more than a year after separation or does the veteran sometimes take that long or longer to recognize the symptoms and come to VA?

Mr. PANANGALA [continuing]. I cannot comment on that because I am not an expert. But we will be happy to get back to the Subcommittee after taking a look at that issue.

[Mr. Panangala provided followup information in an October 21, 2008, Memo, which appears on p. 70.]

Mr. HALL. Thank you very much. My time has expired.

I will now recognize Ranking Member Lamborn.

Mr. LAMBORN. I have some, but I am going to save them for another panel.

Mr. HALL. In that case, Mr. Bilirakis.

Mr. BILIRAKIS. I am fine, thank you. Thank you, Mr. Chairman.

Mr. HALL. Mr. Bilirakis yields. So, you are in luck. Thank you so much for your testimony. It has been very helpful. You are now excused.

Our second panel is excused. Have a lovely afternoon. Thank you for being here with us.

Our third panel is called to the table. Les Jackson, Executive Director of American Ex-Prisoners of War; Steve Smithson, Deputy Director of Veterans Affairs and Rehabilitation Commission of the American Legion; John Rowan, National President, Vietnam Veterans of America (VVA); Lieutenant Commander Jack Alderson, USN, Retired, Ferndale, California; Jeff Faull, McEwersville, Pennsylvania, a disabled veteran, on behalf of the ALS Association; David Woods, Director of Veterans Affairs of Scott County, Iowa.

We will take a moment while people get into their places. As usual, without objection, we will enter the written testimony into the record—without objection, so ordered—so other witnesses may feel free to shorten or lengthen their testimony as you like.

Whichever it is, there is a five-minute clock. You will see the lights go from green to red, as usual.

Thank you for joining us. Thank you for your patience with our having to run across the street and vote.

Mr. HALL. We will start by recognizing Les Jackson, Executive Director from the American Ex-Prisoners of War.

Mr. Jackson.

STATEMENTS OF LES JACKSON, EXECUTIVE DIRECTOR, AMERICAN EX-PRISONERS OF WAR; ACCOMPANIED BY REV. JACK MATHISON; STEVE SMITHSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA; LIEUTENANT COMMANDER JACK B. ALDERSON, USNR (RET.), FERNDALE, CA; JEFF FAULL, MCEWERSILLE, PA (DISABLED VETERAN), ON BEHALF OF THE ALS ASSOCIATION; DAVID WOODS, DIRECTOR, VETERANS AFFAIRS OF SCOTT COUNTY, IOWA

STATEMENT OF LES JACKSON

Mr. JACKSON. Mr. Chairman, I recently returned from the Blind Rehabilitation Center, operated by the Veterans Administration in Connecticut. I am unable to read my testimony, and I have asked another former prisoner of war, Reverend Jack Mathison, if he would read the statement that the American Ex-Prisoners of Wars has prepared for this statement.

Mr. MATHISON. Chairman Hall, distinguished Members of the Subcommittee on Disability Assistance and Memorial Affairs, and guests. Thank you for inviting us to participate in your legislative hearing on several bills now pending in the House Committee on Veterans' Affairs. We will confine our remarks to House Committee bill H.R. 1197, the "Improved Veterans Benefits for Former Prisoners of War."

Ninety-nine percent of former prisoners of war are from World War II and Korea and are now living in their sunset years. We are grateful that Congress has, through the years, provided benefits for former prisoners of war where it has been determined that the causal effect of an injury or illness is from the captive experience.

For more than 50 years, the National Academy of Sciences has been conducting scientific research to identify medical conditions

that, beyond any doubt, are the direct consequences of the brutal conditions of captivity. There are two medical conditions cited that still deserve presumptive status. These are osteoporosis and diabetes. Osteoporosis is bone loss attributed to starvation during captivity. Similarly, diabetes is the result of prolonged stress and permanent damage to the body's basic defense system as a result of months and years of grossly inadequate diet as a prisoner of war.

These two proposed presumptives have, again, been introduced by Representative Gus Bilirakis, Republican of Florida. We are deeply thankful to him and strongly urge your Subcommittee's support by codifying these two conditions into law without further delay.

Also very important to former prisoners of war and their survivors is House bill 156 to amend 38 U.S. Code to provide for the payment of Dependents Indemnity Compensation (DIC) to survivors of former POWs who died before September 30, 1999, with the same eligibility as applied to payment of DIC to survivors of former POWs who die after that date. This will be of great financial aid to the surviving spouses of POWs.

We thank you for giving us this opportunity.

[The prepared statement of Mr. Jackson appears on p. 74.]

Mr. HALL. Thank you, sir, for your testimony and for your service. Mr. Jackson, thank you for your service to our country.

We now recognize Mr. Smithson for 5 minutes.

STATEMENT OF STEVE SMITHSON

Mr. SMITHSON. Good afternoon, Mr. Chairman and Members of the Subcommittee. I appreciate the opportunity to appear before you this afternoon to offer the American Legion's views on the various bills being considered by the Subcommittee today.

The American Legion is generally pleased with the intent of these bills. Due to the time constraints this afternoon, I am going to limit my oral remarks to just a few of the bills being considered.

H.R. 5985, the "Compensation for Combat Veterans Act," the purpose of this bill is to amend title 38, United States Code, to clarify the service treatable as service-engaged in combat with the enemy for utilization of nonofficial evidence for proof of service connection in combat-related disease or injury.

A bill with similar intent, H.R. 5892, was recently passed by the Committee. Both title I of H.R. 5892 and this bill seek to define "engaged in combat with the enemy" under title 38, United States Code, section 1154(b) in a manner that is consistent with the realities of combat in today's world. The American Legion supports the intent of these bills.

Given the evolving nature of modern warfare as reflected in the enemy's unconventional tactics in Iraq and Afghanistan, the American Legion is of the opinion that it not only makes sense to clarify the definition of "engaged in combat with the enemy" under 38 U.S.C. 1154(b) in order to adapt to the new realities of modern war. It is essential that we do so not just for those serving now, but for those who have served in the past and those who will serve in the future.

H.R. 1198, the "Prisoner of War Benefits Act of 2007," the American Legion supports this legislation. It represents a solid step to-

ward ensuring that former POWs receive the compensation and medical care to which they are clearly entitled. However, in addition to those diseases that will be presumed service-connected, the American Legion recommends that the list also include chronic pulmonary disease where there is a history of forced labor in mines during captivity, and generalized osteoarthritis as differentiated from the currently listed disability of post traumatic osteoarthritis.

H.R. 5155, the "Combat Veterans Debt Elimination Act of 2008," although we agree with the intent of this bill, the legislation contains limitations and restrictions we do not support. The American Legion supports prohibiting the collection of debts in the case of any veteran who dies as a result of service-connected disability, not just those who die of a service-connected disability incurred or aggravated while serving in a theater of combat operations or in combat against a hostile force during a period of hostility.

A veteran's death due to a service-connected disability not related to combat is no less tragic for the veteran's family than a death due to a combat-related service-connected condition, and we see no justification in making such a distinction.

This bill also leaves it up to the discretion of the Secretary of Veterans Affairs to determine if termination of collection of the debt is in the best interest of the United States. It does not set forth any standards or criteria in determining whether or not termination of collection is in the country's best interest.

Unfortunately, such vagueness will likely result in a restrictive interpretation, which will, in turn, limit the beneficial impact that was obviously intended. The American Legion has concerns over the exclusion from the prohibition of collection of debts involving housing and small business benefit programs.

H.R. 5454: This bill, if enacted, would establish presumptive service connection of ALS for veterans who develop the disease to the degree of 10 percent of more disabling anytime after military service. The American Legion fully supports this legislation. The very nature of ALS warrants an indefinite presumptive period, as delayed diagnosis and even misdiagnosis is common with this terrible disease.

The timeliness and appropriateness of this bill is further supported by research and other evidence in the last several years, including a November, 2006, IOM report that has indicated that those who served in the military are at greater risk of developing ALS than those who never served in the military.

The last bill I will discuss this afternoon, H.R. 5954: The American Legion fully supports this bill, as it will put in place the process for establishing presumption of service connection for diseases that have been scientifically associated with exposure to the various agents and chemicals used in Project 112.

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

[The prepared statement of Mr. Smithson appears on p. 74.]

Mr. HALL. Thank you very much, Mr. Smithson. We will get back to you with questions shortly.

Next, we will recognize Mr. John Rowan, National President of the Vietnam Veterans of America.

STATEMENT OF JOHN ROWAN

Mr. ROWAN. Good afternoon, Mr. Chairman, Chairman Hall, Mr. Lamborn, Mr. Bilirakis. You folks have been busy, to say the least.

We have a formal statement that I would submit for the record which comments on all of the legislation in more depth. But there are a couple we just wanted to touch base on. You will also hear more from our colleagues at this table about H.R. 5944, the SHAD and 112 Project legislation.

VVA was very much out front on this very early on, and we worked Mr. Alderson and Mr. LaChapelle and others and had the Subcommittee of the VVA to go after this whole SHAD-Project 112 thing. We applaud Representatives Thompson and Rehberg for introducing and fighting for this legislation.

If we have a caveat on any of this piece of legislation, it is the issue of the date 1963. We believe that we should go much sooner or earlier—or later, depending how you look it at. Prior to 1963, there were all kinds of other programs going on, and the DoD is finally starting to dig into this and letting us know all of these different programs that exposed people to all kinds of different things in addition to the SHAD and 112, the incidents. So we think that those veterans also are entitled to compensation for anything that may occur from their being exposed to all kinds of interesting chemical, biological, and other kind of agents.

We also support H.R. 3008, about giving more help for rural veterans. One of our concerns, however, is, we would like to see the veterans service organizations, including the possibility of receiving those grants to help assist providing claims compensation and other kinds of programs out in the field. Many of our organizations have service officers who are out there, as well as the State and county folks, and many of them are out in the rural areas, and we would like to see, possibly including the VSOs, possibly be getting some of that grant money to help us do that.

The more service officers, the better, in my opinion. We never have enough of them out there at all. Far too many people lose their opportunity to get fully compensated for their service.

H.R. 3070, an interesting bill. We are interested in how you came up with $234 as a dollar figure. We think that was kind of interesting, and kind of low. We are really concerned about a lot of these compensation issues and a lot of the dollar amounts, quite honestly.

DIC is another one, frankly, that needs to be looked at in where we go. Of course, the whole DIC-Survivor Benefit Plan (SBP) breakdown, people lose money because they are getting a pension benefit, which makes no sense.

Basically, we primarily support all of these bills. We have nuances on each one of them, or most of them anyway.

H.R. 5448, we are glad to see the elimination of this onerous requirement to prove stressors. For those of us who have been out in the field and had to file claims with veterans, I can tell you, having done that for a couple of years myself after I had retired back in 2002, it was very disheartening to have to sit in front and talk to a veteran who had gone through a year in Vietnam, did all kinds of strange and horrible things, but couldn't get him any compensa-

tion for his PTSD because he didn't have the right badge and the right award.

Today, of course, we now know the most dangerous job in Iraq probably is being a truck driver. There were many truck drivers back in the days of Vietnam, as well, and people like that who had to go out in the field and were engaged in combat, were fired upon, had all kinds of things; but because they didn't get the right designation or didn't get the right badge because they didn't have the right military occupational skills MOS or occupational thing, that they didn't get considered the right stressor. Then we have to go through a whole song and dance and try to prove that stressor.

So we applaud the Subcommittee on its activity, its actions, its trying to catch up on things. I agree with the Chairman, Mr. Filner, a lot of the bills are long overdue justice.

Thank you.

[The prepared statement of Mr. Rowan appears on p. 78.]

Mr. HALL. Thank you, Mr. Rowan.

Lieutenant Commander Alderson, you are now recognized for 5 minutes.

STATEMENT OF LIEUTENANT COMMANDER JACK B. ALDERSON, USNR (RET.)

Commander ALDERSON. Thank you, Mr. Chairman, Ranking Member Lamborn, and distinguished Members of the Subcommittee. My name is Jack Alderson, I live in Ferndale, California. I am a retired U.S. Navy Reserve Lieutenant Commander.

While on active duty, I was ordered to Project SHAD technical staff as officer in charge of the five Army Light Tugs. I was part of the technical staff for approximately 3 years, and was involved in tests at Shady Grove, Big Tom, Half Note, and Folded Arrow; these tested biological weapons. The only ones that DoD has admitted to so far—and there were many—were Q fever and tularemia. Simulants used in the same conjunction were Bacillus Globigii, Serratia marcescens, and E. coli, all of which are known as hazardous to human health.

We decontaminated the vessels using agents such as HTH, (chlorine), ethylene oxide, formalin, and betapropiolactone, all of which are highly carcinogenic.

Each Army tug was manned by a Navy crew captained by a U.S. Navy lieutenant. The crews were hand-picked and had a security clearance of final secret. The mission of the tech staff, consisting of laboratory, ordnance personal and crews of the tugs, was to test at sea chemical and biological weapons. While in SHAD, I was involved in the training, planning and execution of tug operations.

The written testimony describes test operations, including clean-up utilizing the named highly carcinogenic chemicals. Here, I stress, we know that the weapons and simulants penetrated the tugs. SHAD training used the simulants and chemical decontamination agents often in training; in other words, we were exposed to health hazards almost continuously, and what we used as training was what the other vessels that were involved in 112 and so forth considered as being in a test.

When departing SHAD, we were forcefully debriefed to say nothing about our time in SHAD. With that secrecy, it was not until

the early nineties that I became cognizant of the health problems of SHAD personnel. When health problems occurred and the SHAD personnel went to the VA, they were shown the door. Many went to their veteran service officers but were admonished that the U.S. Government would not treat service personnel that way.

Let me give you three examples. Lieutenant Ken Frazier, who happens to also be Congressman Thompson's constituent, skippered the 2085. He received the letter from VA and twice traveled to the VA facility in Oregon with it in hand. He was turned away both times, as they didn't know anything about SHAD. Ken died of cancer of the esophagus and lungs in 2004. Ken's widow is worried about her health and her daughter's health.

Larry Pilkinton was a hospital corpsman with 15 years commendable service. He had a final secret and interim top secret clearance. He was bit by serin while loading bomblets on the Big Island. He was transferred from Tripler to Oak Knoll Naval Hospital, where he was discharged as having prior mental problems before enlisting in the U.S. service. Larry received no help from the VA, and died May 29, 2007. His widow has no benefits.

Homer Tack was a sailor in Copperhead on board the USS Power. He has very serious pulmonary problems. Recently, his VA tests and private tests have shown the seriousness of the problem. It has been over 200 days since the tests were given, and still no decision by VA.

We were ordered to SHAD to test chemical and biological weapons and then clean up with after the test. The cleanup was done with harsh carcinogenic chemicals.

DoD, for security reasons, has not disclosed all weapons tested in SHAD. In fact, in the Shady Grove fact sheet they do not even list the decontamination agents that I have listed here. I have just named them and can attest to what they were because I was involved in the utilization and the testing.

Without full disclosure of the biological and chemicals use in SHAD operations, the VA cannot equate problems of health and SHAD exposure. The veterans seriously need H.R. 5954 to assist in helping with their problems acquired during their very unique service to our Nation.

Thank you.

[The prepared statement of Lieutenant Commander Alderson appears on p. 83.]

Mr. HALL. Lieutenant Commander, thank you so much for your testimony and your service to our country and your service to your fellow veterans, especially those who were exposed during these tests.

Next, we will recognize Jeff Faull, disabled veteran, on behalf of The ALS Association.

STATEMENT OF JEFF FAULL

Mr. FAULL. Good afternoon, Chairman Hall, Ranking Member Lamborn, Members of the Subcommittee.

As you said, my name is Jeff Faull. I am from a small town in northeastern Pennsylvania, McEwensville. I appreciate the opportunity to speak with you this morning on behalf of the ALS Association and the veterans living with ALS. I hope that by sharing

my experience with you today, you will gain a better understanding of how this disease impacts vets across country, and why H.R. 5454 is so urgently needed.

Before I begin, I would like to thank Congressman Henry Brown and Congressman David Price for their leadership in introducing this vital legislation. Veterans with ALS across the country are truly grateful for their efforts.

I joined the Navy in 1992 at the age of 24, and served two tours of duty as a nuclear electronics technician, including 4 years aboard the USS Theodore Roosevelt. During that time I participated in Operation Southern Watch Deliberate Force, Allied Force, and Noble Anvil. Prior to my assignment aboard the Roosevelt, I was stationed at Knolls Power Laboratory Kesselring Site in West Milton, New York, located not too far from your district, Mr. Chairman.

I left the Navy in 2000 to spend more time with my wife, Tammy, and our daughters Tiffany and Breanna. Like many other veterans, I never thought that my service in the military would cause health problems years after I left the service. I never thought that I would have to fight to obtain benefits from the VA. I never thought I would be sitting here today before you with a diagnosis of ALS, or Lou Gehrig's disease.

For me and thousands of veterans across the country, the reality is that years or even decades after serving the country we are being diagnosed with ALS, and we are fighting for benefits at the same time we are fighting this disease.

I was diagnosed with ALS just over a year ago in February, 2007, at the age of 38, about 20 years younger than the typical person with ALS. At the time, I had no idea what ALS was. Amyotrophic lateral sclerosis meant nothing to me, as I am sure it means nothing to thousands of others when they are first diagnosed, but I can assure you it is a whole different story when the doctor looks at you and says, "Unfortunately, you don't have cancer." That is when you begin to understand how serious ALS really is.

ALS is a rapidly progressive and invariably fatal neurological disease that attacks the neurons responsible for controlling voluntary muscles. To put it simply, this disease will rob me of my ability to walk, talk, move, and breathe. There is little I can do to slow the progression, as there is no effective treatment and no cure. The disease is usually fatal in about 2 to 5 years. In fact, of the more than 2,000 veterans who are enrolled in the VA ALS registry over the past 4 years, less than 900 are still with us today.

I first noticed the symptoms of ALS as early as 1999 when I experienced cramps and twitching in my left hand and arm. As time passed, I began to develop weakness, then loss of muscle mass, which eventually led to my diagnosis last year. Since the diagnosis, the weakness and atrophy have spread and gotten worse. Both hands and arms are now weak, walking is becoming more difficult; and as you can hear, my speech is beginning to be affected. I keep a pair of slip-joint pliers in the kitchen to open things. My wife, Tammy, who is with me here today, normally makes sure that things like cereal boxes are open for me. Otherwise, I have to ask for help from my daughters.

Although they have no problems helping their old man, it is not how I pictured spending my time with them. I can't make the walk to see Breanna play soccer. I don't have the arm strength to shoot basketball with Tiffany. I will more than likely be in a wheelchair when it comes time to teach them to drive.

These are the treasures this disease steals from thousands of veterans every year before it takes our lives. In fact, I understand that recent research, which has not yet been published, suggested ALS is occurring at even greater rates in those serving in the conflict in Iraq.

Past studies have shown, a Harvard study, that all veterans, regardless of time and place of service, are almost twice as likely to develop ALS. What is alarming about this information and the evidence from prior research is that we are seeing ALS at an age when we generally do not see the disease. I was 38 when I was diagnosed. Most people diagnosed are in their fifties, sixties, or seventies.

What will we see 10, 15, 20 years in the future as the men and women serving today leave the military? It is clear that regardless of when and where someone served the military, they are at a greater risk of dying from this disease than if they had not served in the military.

Despite the evidence showing that all U.S. military veterans are at greater risk of ALS, the VA has not created a presumption of service connection for all veterans with ALS. Thousands of veterans continue to be left behind, and hundreds of thousands serving in the military today, including in Iraq and Afghanistan, continue to be at a greater risk of dying from this disease.

The VA will respond that any veteran with ALS can be service-connected on the basis of specific evidence supporting their case. As someone who has been denied service connection and knows countless others who have, as well, I can tell you that this response demonstrates a lack of understanding of this disease.

The reality is that the majority of veterans with ALS who do not fall under the current limited presumptions are forced to fight for their benefits, and we are usually denied. I have been attempting to establish service connection for over a year now and have submitted reams of scientific and medical evidence, including letters supporting my claim from my neurologist. Yet, that evidence has fallen on deaf ears.

Part of the problem we face is the nature of the disease itself. ALS is an insidious disease. First, the symptoms, such as the ones I experienced while on active duty, are so benign, they often go unreported. How many of us in this room have experienced muscle cramps and twitching and thought nothing of it? They are symptoms of ALS. Yet, they are not documented in our service medical records simply because we did not think them a big deal at the time. How many of us on active duty actually thought we would succumb to muscle twitching?

In addition, it can be years from discharge until the onset of symptoms or between onset and diagnosis, while after the 1 year presumptive period has ended and there is no simple way to diagnosis ALS, no single test you can take that says you have ALS.

Rather, there is a diagnosis of exclusion, ruling out every other possible diagnosis.

The bottom line is that if you are not diagnosed while on active duty and did not serve in the Gulf, the VA likely will not consider ALS to be service-connected, despite the studies and the fact that the VA and DoD both recognize ALS is a high priority of research. In addition to the studies that I have referenced, there are multiple peer-reviewed studies linking ALS to many of the things our military personnel are exposed to on a regular basis. These include ionizing and nonionizing radiation, fuels, solvents, lead, vapors, and vaccinations.

My question as a veteran with ALS trying to establish a connection is, what additional proof must I provide? How many more studies are needed? How many veterans have to develop ALS and die from it before the VA takes action?

I can only hope this quick glance into my life with ALS and attempts for service connection grant you the understanding to see the importance of establishing a presumption of service connection for all veterans with ALS, which is exactly what H.R. 5454 will do.

We have to fight for our lives. We should not also have to fight for the benefits the evidence shows we deserve.

Abraham Lincoln's statement, which was later adopted by the VA as their motto states, "To care for him who shall have borne the battle and for his widow, and his orphan." I, and the other veterans with this horrible disease, appreciate your time and effort to ensure that that statement is more than words. I urge you to support H.R. 5454 and help ensure that no veteran with ALS is ever left behind.

Thank you again for your time and the opportunity to speak with you.

[The prepared statement of Mr. Faull appears on p. 85.]

Mr. HALL. Thank you very much, Mr. Faull. Thank you for your service to our country. Thank you to your family for your sacrifice as well.

How many more studies are needed?

Mr. FAULL. That question I have now the evidence shows——

Mr. HALL. It's a rhetorical question, you have enough studies.

I am thinking about a Bob Dylan line about how many years must a mountain exist before it is washed to the sea. But we won't go into that at this time.

Our next witness is David Woods, the Director of the Veterans Affairs for Scott County, Iowa.

Mr. Woods, you are recognized for 5 minutes.

STATEMENT OF DAVID WOODS

Mr. WOODS. Mr. Chairman, thank you for allowing me to be here today to discuss Congressman Braley's bill on the compensation for combat veterans.

I am the Director of Veterans Affairs for Scott County in Iowa. I am also a Vietnam veteran. I have been awarded the combat infantry badge (CIB), the Purple Heart and the Silver Star. I was wounded June 12, 1970. Happy anniversary. So I have a feeling for just what our veterans are going through today.

My job as a veterans service officer in Scott County is to listen to these veterans, get them their medical help and the compensation that is due them. I also help them through the Veterans Administration, the tangle of paperwork that they have to go through, and make sure that they understand what they are entitled to for their benefits.

Having witnessed, through my combat experiences, I understand and am able to talk to these veterans, and they will sit there and tell me things that they have never told their families, their wives, or anyone else. Because I have been in combat, they can talk to me about it.

I have had veterans come into my office, and after asking them where were you at, when were you in a certain area, what unit were you with, or who was wounded or killed by you, they look at you and stare off into space because they have no idea. They forgot that stuff.

Now, how about the Vietnam veterans who have been trying to forget about his time 40 years ago? The cases of PTSD have risen because of the Iraq-Afghanistan war. After 40 years of him trying to forget where he was at or what he was doing, and then now asking him to try to remember where he was at on a certain date or where he was at, what people were injured by him, it is just impossible. They look at you and they have no idea because they have been trying to forget this horrible memory for years.

For our Iraq-Afghanistan veterans, there are times when that military police or engineer or even a cook might be pulled from his job and sent on convoy duty. Many times when that change happens, it is not documented in their files. Then, when he is sent on that job, he might not be working with his own unit or his combat buddies. Then, if they receive incoming rounds, it is not documented because it is an everyday occurrence for a lot of them over there.

I have had National Guard veterans come into my office and apply for compensation, because they have come in and we have applied through the VA, they have been turned down by the VA mainly because his part of the unit has come back to the country; another part of his National Guard unit might still be overseas, and those records are still over there. So then that veteran has to go out there and, as mentioned before, find a buddy from his combat unit that witnessed something and write it up. Then we have to put it through the VA to have them accept it. This is not right.

I have had an Iraqi veteran with TBI, traumatic brain injury, file for compensation, but because he had no CIB, Purple Heart, or other combat medal, he was turned down by the VA for his compensation. His DD 214, his discharge papers show that he was in Iraq, listing the date and unit, but nothing else. When we filed the compensation claim, that veteran was treated at the Iowa City VAMC medical center. He was found to have TBI and he was awarded his compensation.

If you were to ask a combat medic what his job was, he would tell you that he was to keep that injured soldier alive and let the people in the background do the paperwork. If you were to look at my medical report, it says that I was injured in the left arm and the neck. Neither happened to me when I was hit. That medic did

not carry a file for every soldier that is out in the field; that is not his job. So there is no way of knowing just what a soldier went through or where he was hit, or whatever, a lot of times until later on. It is still not possible today to keep these records.

Case in point: I had a World War II veteran come into my office wanting to get his Purple Heart, which he had never received. His records were burned up in the big fire in St. Louis. He just kind of thought nothing of it, but his family wanted the Purple Heart.

He came into my office. We filed the paperwork with the VA. They said, nope, can't find anything at all on him. So I did some phone calls, found out that I could write a letter to the Unit Records section down in St. Louis. We did that.

The gentleman got his paperwork from the Unit Records section. He brought it into my office. I read it, and he said, What do you think, Woody? I said, You're dead in the water, because it had him down in the medical records for an illness, not being wounded over in Germany. As far as the buddy statement, his tank crew members were all killed when he was hit and injured. So his Purple Heart, I did not get.

I have had a Vietnam veteran come into my office to apply for compensation for Agent Orange type 2 diabetes. That veteran was a deepwater Navy veteran. And when we applied for the compensation, of course, the VA came back with the *Haas v. Nickelsen* case, saying he was never in Vietnam. I asked the veteran if he had contact with any of his fellow Navy personnel, and the next day he came into my office with two e-mail addresses.

I sent off an e-mail to the gentleman. I got an answer back the very next day. The gentleman was the third ranking officer on his ship. His ship was permanently stationed right off of the tip of South Vietnam. The third officer sent me the letter saying it was common knowledge that replacement sailors would fly into Vietnam, take 2 days to truck down to the southern part of Vietnam, be boated out to the ship, and then, really to add insult to the VA and the Navy records, the same gentleman told me that every 2 to 3 months they would go onto an island off of South Vietnam and have volley ball and R&R.

So definitely this gentleman was in country and definitely he should have been connected for his type 2 diabetes. We are still waiting from the VA on that case.

These are just a fraction of the compensation claims that we are fighting with the VA.

These last wars are not like World War I and World War II where you knew who your enemy was or where the frontlines were. Now we have no lines or enemies in a certain uniform. There are not many safe areas for our veterans of today, who can actually relax. It doesn't take much incoming to put stress and pressure on our veterans, and that is what we are finding out today.

Thank you for letting me speak to you today.

[The prepared statement of Mr. Woods appears on p. 87.]

Mr. HALL. Thank you, Mr. Woods.

Without objection, I will ask Mr. Bilirakis if he would like to start off our questioning at this time.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. Thank you, gentlemen, for testifying today, and thank you for your service.

Mr. Jackson, do you have an estimate on how many former prisoners of war are living today?

Mr. JACKSON. It seems to me that it is 2,000.

No, 20,000

Mr. BILIRAKIS. About 20,000. What is the average age, would you say?

Mr. JACKSON. I have been the average age for a long time, of our group, which is, today I am 87 years old.

Mr. BILIRAKIS. Eighty-seven.

How many would you estimate would benefit from this bill, H.R. 1197?

Mr. JACKSON. I honestly don't know. But I know that they are out there.

Mr. BILIRAKIS. Okay. Thank you very much.

Does anyone else want to answer those questions? Okay. Thank you very much. We will do the research. I appreciate it, Mr. Jackson. Thank you.

No further questions.

Mr. HALL. Thank you, Mr. Bilirakis. I would like to ask Mr. Jackson, I know that adding osteoporosis and type 2 diabetes have been priority presumptive conditions that your organization has wanted to add to the list, and that you are awaiting passage of S. 1315, which contains a provision to add osteoporosis for those afflicted with PTSD to this list.

Are you aware of any other conditions that you think deserve presumptive status for former POWs?

Mr. JACKSON. No, sir, I am not.

Mr. HALL. The VA's testimony states that it is unaware of studies that associate type 2 diabetes or osteoporosis with POW internment. What evidence is your organization aware of that they are not, which would show the connection to be more likely?

Mr. JACKSON. The National Sciences Foundation has done studies on it and presented them yearly for many years.

Mr. HALL. We will make sure we pass it along to the VA.

Mr. Smithson, pertaining to H.R. 3008, in your mind, what distinguishes rural veterans from veterans in metropolitan areas that would make this legislation necessary?

Mr. SMITHSON. I'm sorry. Can you repeat that question?

Mr. HALL. What distinguishes rural veterans from veterans in metropolitan areas, which would make H.R. 3008 necessary?

Mr. SMITHSON. They often have a lack of resources, access to information. They may be far away from a VA facility. They may also not have access to service officers. A lot of rural areas have limited resources as far as county service officers and even veterans service organization service officers.

Mr. HALL. I would imagine the cost of gasoline is probably complicating things, too

Mr. SMITHSON. Probably, yes.

Mr. HALL. Mr. Rowan, it sounds like VVA has had an involved history of advocating for SHAD veterans. What is your response to the IOM testimony that claims there is no clear evidence that asso-

ciates Project SHAD participants with ill health effects? Does VVA have any additional data, a database of veterans who report being sick because of SHAD, and how would you suggest rewording the clause so that it better specifies the meaning of biological and chemical?

Mr. ROWAN. Actually, my friend, Mr. Alderson here, can probably answer those questions a lot better because they are much more familiar with it. Other than to say it was not only the fact of what they used and what the experiments were, but the cleanup was probably as dangerous as the original experiment because the caustic chemicals were just as bad.

He has done a whole lot more study on this. One of interesting things, apparently DoD is starting to catalogue all these folks who have been exposed to all of these different programs. We can find out who they were.

Mr. HALL. Let me take the suggestion and ask the same question of Lieutenant Commander Alderson.

Commander ALDERSON. Yes, sir. One of the things that was disappointing to us is that they found that our crews of our LTs—each LT only had a crew of 10, with a lieutenant as commanding officer, for a crew of 11.

But they did not count the laboratory people or the gunners mates who were loading and mixing the weapons, that were loading them onto the Marine aircraft that were coming over and escorting us. Those, we felt, were also part of the Project SHAD technical staff. But if you leave it just to the tug crews, you come down with this minor number.

If you take the whole Project SHAD technical staff from the beginning to the end, with normal rotation because this is a permanent change of duty station, I would guess that there was somewhere between 400 and 500 veterans.

They also didn't have a ship that they could compare the LTs to. I gave them the name of the U.S. *Koka*, which was a small Navy tug that operated out of the same area that we did on the docks there in Pearl Harbor.

Mr. HALL. Commander Alderson, given your direct experience with Project SHAD, what would you like to see done in the way of followup to give veterans like yourself, who are suffering as a result of exposure to various elements used during these experiments, some measure of justice, although delayed justice?

Commander ALDERSON. First of all, I would like to make sure that our health is taken care of. In cases where we are talking about, like Mrs. Pilkinton, she has no widow benefits, and she is definitely a widow of SHAD because we were there when Larry got bit.

I would like to see those things happen. I would like to have—when studies of our operations done and our exposures examined, I would like to have Commander Norman LaChapelle and myself, people who were involved in the planning, operation, and execution of the tests, be part of the panel, at least be closely consulted with what actually occurred.

I think one of the problems that is with the IOM study is that they never had a clear idea of what we did and how we did it. When they tested the rest of the United States Navy ships, they

did not ask the crew what their job was, and the signal men on the flying bridge certainly had more exposure than the radar operator in the combat information center, who is in a temperature, dust and humidity-controlled atmosphere, or the guy in the firing flat in the boiler room, in the heat. He is standing under the heavy-duty air flowing down, not only to give him something to cool off and breathe, but that air goes in and fires the boiler. So he is under a tremendous amount of exposure.

This is one of the major errors of trying to equate what that exposure was during the tests.

Mr. HALL. Speaking as a sailor who has had a number of power and sailcraft—smaller ones, I am sure—at one time we had a diesel leak from one of the tanks that sprang a leak, and it took forever to get the odor out of the hull. No matter how many times you scrubbed it with different agents, it seemed as if it permeated the fiberglass, to some degree.

I am sure the same is true of these agents that you were being tested with.

Commander ALDERSON. I said that Mrs. Frazier was worried about her health and her daughter's health. When we were out on the test, using hot weapons, that was different. When we were working out of Pearl, and we were training on a daily basis using some of the same chemicals to clean up with and so forth, there were no washing machines on the tugs. When Ken came in, he took off his uniforms and so forth, and Leah washed his clothes with hers and her daughters.

Mr. HALL. And they were all exposed to lower levels of the same contaminant?

Commander ALDERSON. Yes, sir.

Mr. HALL. Or weapon. Thank you very much for your testimony and for your service and your patience. I am sorry. I guess this is one of those times when somebody should apologize to you on behalf of your government. So I will presume to do that. I get e-mails from some of the test vets on a pretty regular basis, from all kinds of tests that can't be talked about because they are so highly-classified or secret, when I hear secret it kind of has a bad ring to it.

But anyway, I would like to ask Mr. Faull, a 1-year time period does not seem to take into account the nature of ALS, since the disease is difficult to diagnose and can in fact go undiagnosed for some period of time. It is also a disease that may manifest itself years after discharge, well after younger veterans leave the service. Do you think the VA's current policy is adequate?

Mr. FAULL. No. As I said, I have been trying to establish service-connection for over a year now. You heard some of the testimony today talking of buddy letters, et cetera. I have given those. I have given the scientific proof. And as I said, deaf ears.

Mr. HALL. You mentioned the Harvard study and the World Health Organization (WHO) guidelines. How are these different from the IOM study?

Mr. FAULL. The IOM study was a review of all the studies done to date. I think as we heard earlier, it was five. And that looked at all of those studies and said that ALS, as—the military as related to the development of ALS, it is an increased risk. The WHO

studies, the guidelines were utilized at least in my case for the vaccinations, and came back as a possible cause of ALS.

Mr. HALL. Thank you. Thanks again for your service and your sacrifice. Last, I would like to ask Mr. Woods, in your statement you identified two problems as a service officer, the first being with records that are still with the units on deployment or when documentation simply did not occur. I have also heard that getting documentation can be difficult when records are classified. So what do you do as a service officer when such problems exist? Second, in your opinion does VA give the veteran the benefit of the doubt as required by statute?

Mr. WOODS. I would like to answer that last question first. No. They definitely do not give the veteran the doubt at all. It should be that they should believe the veteran more, but they say, hey, by our records here we don't show it, so they shoot the veteran down. For me, I have learned now that I can go ahead and contact, like I said, the unit records section. Since the records were burned up in the personnel files, the unit records are still pretty much intact. Also by using the buddy statements, that is an important thing to use anymore. Sometimes the VA will accept the buddy statement.

I have had a case where a gentleman came in, complained about a back injury. He jumped into a trench during incoming rounds, he had a gentleman land on his back, injured his back, had a couple of aspirin for it later on. Well, later on in life it bothered him more, and he remembered about the gentleman jumping on his back. The VA has no records of it because it was just, you know, a medic would give him some aspirins and that was it. We were able to actually track down the two veterans that were in on the case of jumping on the gentleman's back. I sent the information to the VA, along with the Social Security number, and we got a letter back from the VA saying, well, we need more information. What unit was he with? Because he came over with a Guard unit, actually, from over in Vietnam. So we had to send more information in. And it is hard to get them to accept that.

Mr. HALL. Thank you, sir. My time is long expired. I will now recognize our Ranking Member, Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman. First of all, I want to thank you, Lieutenant Commander Alderson and Mr. Faull, for your service to our country. This question is for Mr. Rowan and Mr. Smithson. Understanding that we have some bills here that can be very beneficial to veterans, we still have to address the PAYGO issue. How do you suggest that we address PAYGO for bills, these bills, or bills like this? Help us with this situation.

Mr. ROWAN. One of my concerns about this whole PAYGO business, and we hear this not only in this, we have been hearing it in the GI Bill issue as well, we don't hear PAYGO when we hear how much we have to spend in Iraq every day. We never hear that. Why? Because it is part of a war. Well, I hate to say it, but we are all part of a war. We may be coming 20 years after the war or 30 years after the war, but we are all part of the war. And so I think that I get a little concerned about PAYGO just as a political issue here being utilized when it comes to veterans benefits. That is number one.

Number two is oftentimes the veterans benefits, unlike every nickel that is being spent in Iraq, will actually come back to help the society. It is given to the veteran. I mean, the veteran isn't going to run off and just make that money disappear. He is going to probably use it to pay for the gas that got increased last month or whatever, to pay for their life. By the time we end up getting these veterans these benefits it is oftentimes, and Mr. Woods can tell you, so far after the fact, when people have usually been beaten down into destitution, that this is barely compensating to keep them alive. And yet that money still gets recirculated back in their community and ends up having some sort of impact.

Having spent a lot of life in government, I can tell you the economists tell you every nickel you give out ends up coming back about 16 times in various ways in the economy, which is why we give all these benefits away to corporations and things to do things, build things, and move people into their community. And I think that the veterans benefits, just again as a practical thing, is part of warfare. And if we are not willing to pay for it, don't send us anywhere.

Mr. SMITHSON. I would just like to echo that. It is part of the cost of war. And several of these bills, it is about doing the right thing. And for example, H.R. 51—what is it, H.R. 5985, recognizing the change in warfare today, in that for example the conflicts in Iraq and Afghanistan that anybody over there in those two theaters are exposed to combat no matter what they are doing. And changing the law to recognize that is the right thing. And changing that is a cost of war.

So I understand your concerns about how to pay for it, but doing the right thing is doing the right thing. And there is always enough money to send troops into harm's way, but it seems when it comes time to pay for it after the fact we are always concerned about that. And again, doing the right thing is doing the right thing.

Mr. LAMBORN. And for the record, I didn't vote for the PAYGO rule. However, it is something that we are allegedly following, so I just had to ask that question, or these bills won't be able to go forward. So, thank you for your answer.

I yield back, Mr. Chairman.

Mr. HALL. Thank you, Mr. Lamborn. For the record, I would say that once upon a time the conservative approach would have been to pay for the war rather than have a war on borrowed money, and also pay for the veterans benefits. So we should probably be consistent and either pay for them both, all of it, or borrow all of it. But at any rate, I agree that we cannot consider the veterans to be separate from the war itself in terms of its urgency and its worthiness of funding.

Mr. Rowan, you wanted to comment on that?

Mr. ROWAN. Yeah, I just wanted to add one other thing with regards to the gentleman with regards to the ALS. There are many instances where we see problems with disease that doesn't necessarily manifest itself until many years after the fact. I mean, I still get a laugh every time I read the fact when we talk about the presumptives of Agent Orange, and we had chloracne, but it has a year time. Well, my year after Vietnam actually I did, I had all kinds of chloracne, but I didn't know what the heck it was until 20 years later. So we get all of these crazy things.

I have often seen, and we even had some adjudicated cases on it, and we actually won a case on a guy who had heart disease. And we proved that even though his diabetes came later, was diagnosed later, we actually proved he was probably prediabetic, which led to his heart condition, and got the heart condition as a secondary to the diabetes.

So you got all of these things that take so long to do. And so I applaud the efforts to try to, especially ALS and Parkinson's, add them to the list.

Mr. HALL. Thank you so much, Mr. Rowan, and thank you to our entire panel. We could have a long discussion about this, but given the lateness of the hour and the fact that there is another panel waiting, we will save that for another time. You are excused, and thank you very much for your testimony and your service to our country.

And we will ask our fourth panel to join us at the table. Bradley G. Mayes is the Director of Compensation and Pension Service for the Veterans Benefits Administration (VBA), accompanied by Bradley B. Flohr, Assistant Director for Policy, Compensation and Pension Service of the VBA, and Richard Hipolit, Assistant General Counsel of the U.S. Department of Veterans Affairs.

Thank you, gentlemen, for your patience, and it is good to see you again. Welcome. Of course without objection your entire statement is entered into the record and feel free to deviate, elaborate, or edit as you wish. Mr. Mayes, you are recognized for five minutes.

STATEMENT BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY BRADLEY B. FLOHR, ASSISTANT DIRECTOR FOR POLICY COMPENSATION AND PENSION SERVICES, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND RICHARD HIPOLIT, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MAYES. Thank you, Mr. Chairman, Ranking Member Lamborn. Before I get started, I did want to recognize the members of the previous panel and thank them for their service and for helping educate me, Commander Alderson and certainly Mr. Faull. We can't know what Mr. Faull is going through, clearly.

I am pleased to be here today to provide the Department of Veterans Affairs' views on pending benefits legislation. Accompanying me is Brad Flohr, Assistant Director for Policy in the Compensation and Pension Service, and Mr. Richard Hipolit, Assistant General Counsel.

We are still reviewing H.R. 5448, and will provide views on that bill in a subsequent views letter.

[The VA failed to provide Administration views for H.R. 5448 and H.R. 3795.]

I would like to begin by sharing our views on H.R. 5155, the "Combat Veterans Debt Elimination Act of 2008." I believe that was introduced by Congresswoman Shea-Porter. This is the only

bill I will be testifying on today which the administration is able to support.

This bill would prohibit VA from collecting all or part of a debt owed to the United States under any program under the laws administered by VA who dies as a result of a service-connected disability incurred or aggravated while serving in a theater of combat operations in a war after the Persian Gulf War or in combat during a period of hostilities after 9/11.

Regarding H.R. 3008, the "Rural Veterans Caregiver Compensation Act," VA does support the intent of this proposed legislation. However, we oppose the bill because we believe it would duplicate some ongoing efforts by the Veterans Health Administration's Office of Rural Health to address the healthcare needs of veterans in rural areas, as well as other outreach activities that we are conducting for vets in those rural areas. And further, it would divert existing resources away from direct service delivery, since there is no provision to fund this grant program of up to $1 million per State, as I read the bill.

H.R. 4274, the "Gold Star Parents Annuity Act of 2007," would provide a monthly benefit of $125 to parents of servicemembers who lost their lives while on active duty in military operations described by 10 U.S.C. section 1126(a). If more than one parent is eligible for the benefit, it would be divided equally among the eligible parents. VA honors the sacrifice of those who have lost their lives in the service of their country, and we recognize and honor the supreme sacrifice of Gold Star parents who have lost a son or daughter serving in the Armed Forces. However, we don't support the bill because we don't believe you can put a monetary value of this sort of a loss to servicemembers' life. And we already do provide a monthly benefit to certain qualifying parents based on need, our Parents Dependency and Indemnity Compensation (DIC) Program. Further, if parents are designated as the beneficiary of a deceased servicemember, then they are potentially entitled to DoD's death gratuity and Servicemembers Group Life Insurance. And these combined have the potential to add up to $500,000. Clearly, however, no amount of money can compensate for the sudden loss of a son or daughter.

Regarding H.R. 5709, the "Veterans Disability Fairness Act," the VA does not support this proposed legislation because we have already put in place measures that address most of the subjects covered in the bill. We are conducting quality reviews on a statistically valid sample of claims across ROs, Regional Offices. We began routinely monitoring the most frequently rated diagnostic codes this year, this fiscal year, to assess consistency of service connection determinations and degree of disability assigned for various disabilities across Regional Offices, across jurisdictions. And we conduct regular site visits. And locally, we pull random samples of cases that are adjudicated by employees responsible for deciding veterans claims in the administration of the local performance management plan.

H.R. 5985, the "Compensation for Combat Veterans Act," would require VA to treat certain veterans as having engaged in combat with the enemy for purposes of 38 U.S.C. 1154(b), thus permitting the use of lay or other evidence for proof of service occurrence of

a combat-related disease or injury. The veterans who would qualify for this treatment are veterans who during active service with a U.S. military, naval or air organization during a period of war, campaign or expedition, served in a combat zone for purposes of section 112 of the Internal Revenue Code 1986, or a predecessor provision of law. In essence, the bill would equate that service in a combat zone with the current stipulation of engaging in combat with the enemy.

We don't support the bill. The current regs relax the evidentiary requirements a combat veteran must meet to prove service occurrence or aggravation, and that language makes it clear that its purpose is to liberalize the method of proof for claims based on injuries incurred or aggravated while engaged in combat with the enemy. This provision recognizes the unique circumstances of combat which are not favorable for documentation of injury or illness because treatment for such injury or illness may be administered in the field. Supporting evidence is often difficult to obtain when a veteran later files a claim for disability compensation for a combat-related disability, hence the provision, as we heard earlier from the testimony. But this bill contemplates that all veterans in a combat zone are faced with the same difficulty in documenting treatment for injury or illness. However, it doesn't appear that the same difficulty does exist for servicemembers who, although serving in a combat zone, have access to a medical facility for treatment and whose treatment would be documented in service treatment records.

The remaining bills, H.R. 1197, and I won't read the titles to be expedient, but H.R. 1197, H.R. 3795, H.R. 5454, H.R. 5954, and H.R. 6032 all propose to modify existing presumptive provisions that are already in place, with the exception of H.R. 5954, which is the presumption to exposure to biological, chemical, or other toxic agents as part of Project 112. That bill contemplates creating a new presumption for veterans who participated in that project.

Beginning with the latter bill, H.R. 5954, I would like to begin by correcting my written statement for the record. In my written statement I indicated that DoD estimates about 6,000 veterans may have been involved in Project 112/SHAD and to date DoD has provided VA with the names of approximately 5,000 veterans who participated in tests. VA has actually received the names of 6,440 military personnel who participated in tests related to Project 112/SHAD. Of this number, 385 could not be matched to a numeric identifier such as a Social Security number or service number and 733 were known to have been deceased. We sent notification letters to all veterans that we were able to identify, informing them that they had been identified by DoD as a Project SHAD participant. And we do continue to work with DoD; however, we are not aware of any additional test participants.

[Additional Administration views from VA for H.R. 5954 appear on p. 121.]

Regarding presumptives in general, in conclusion, the VA has a process in place to review the scientific and medical evidence biennially for those veterans who were potentially exposed to herbicides in Vietnam or hazardous agents in the Persian Gulf War. Further, the VA has continuously added additional presumptive disabilities

to the list of conditions related to internment as prisoner of war, most recently the addition of atherosclerotic heart disease and stroke and its complications. VA is not aware of any scientific or medical literature or study linking diabetes mellitus and/or osteoporosis to POW service; however, we will look at the previous testimony and pull those studies to look at them.

We are unaware of any scientific or medical evidence linking exposure to depleted uranium and the radiogenic diseases already included as diseases associated with radiation exposure. Nor are we aware of evidence linking any disease to participation in Project 112/SHAD.

And finally, the IOM, the Institute of Medicine of the National Academies has consistently determined that there is insufficient evidence to associate Parkinson's disease with herbicide exposure. And ALS, again the evidence doesn't appear to be sufficient to establish a presumptive condition at this time.

That concludes my testimony, Mr. Chairman, Ranking Member Lamborn, and I would be pleased to answer any questions on these topics.

[The prepared statement of Mr. Mayes appears on p. 89.]

Mr. HALL. Thank you, Mr. Mayes. For scheduling reasons I am going to yield to or recognize our Ranking Member, Mr. Lamborn, first for questions.

Mr. LAMBORN. Thank you, Mr. Chairman, for taking me out of order. Mr. Mayes, do veterans who cannot show a service connection with PTSD, but need and want treatment for PTSD, whatever its source might have been, do they still receive treatment? And could you explain what their status is?

Mr. MAYES. Yes. Currently, veterans returning from Iraq and Afghanistan are entitled to receive treatment for 5 years.

Mr. HIPOLIT. I believe that is correct.

Mr. MAYES. So it is 5 years after expiration of their term of service. So it is comprehensive healthcare through the Veterans Health Administration.

Mr. LAMBORN. Okay. How would that apply, or would it apply to a Vietnam veteran who was in Vietnam in the sixties or seventies?

Mr. MAYES. Well, I am on the benefits side. I am a little bit outside of my lane. So in order to be completely correct, that is a question I would like to take back for the record and provide you a more thorough response. But I will say this, I know that if a veteran presents, for example, to a clinic or a counseling center and they are in distress they are not turned away.

[The following information from VA was subsequently received:]

Question: What happens if a Vietnam-era veteran who has not filed a disability claim for PTSD came to VA seeking care for PTSD symptoms?

Response: A veteran who comes to VA with a need for medical care would be assessed based on the nature of his or her needs and urgency. If the veteran needs treatment, a VA medical center or clinic can provide care by enrolling the veteran for care if he or she is in an appropriate priority group or, even if not, if he or she has urgent or emergent clinical needs. If the veteran does not meet priority requirements, the veteran could be referred to a Vet Center if he or she was a war zone veteran. If not a war zone veteran, the veteran could be referred to community mental health resources. Any of these options would lead to diagnostic assessment and possible service-connection for PTSD, which would then make the veteran eligible for VA care.

Mr. LAMBORN. Thank you. Mr. Chairman, I yield back.

Mr. HALL. Thank you, Mr. Lamborn. Mr. Mayes, would you for starters just comment on some of the cases that you heard about today from our previous panel?

Mr. MAYES. Okay. Well, I think one of the questions that was posed earlier, if my recollection serves me correctly, was could we service-connect a condition like Mr. Faull's condition if the Lou Gehrig's disease did not manifest within the current 1-year presumptive period? And we can. What we would need, though, is medical evidence that would establish a link between the disease or the disability and military service. And really that is the premise of this program, of the VA's Disability Compensation Program, is that we have a disease or injury that is incurred in, or aggravated by, military service. What presumptives do is really they lower the threshold, the evidentiary threshold for certain disorders, disease processes where it may be difficult to get the evidence. It might be that we have scientific or medical evidence in the case of some of the other presumptives that shows a relationship between some exposure and military service. And therefore, we just go ahead and extend the presumption. But even if veterans aren't covered by the presumption or the relaxed evidentiary threshold, we can still get there, but there just has to be the nexus.

Mr. HALL. As you heard during the questioning of the IOM, there were inquiries on the proposed new paradigm for establishing presumptions outlined in its latest report. Can you inform us of the VA's views on the current manner of establishing presumptions for disability compensation and the proposed system offered by the IOM in its 2007 study? What does VA see as its role in both systems?

Mr. MAYES. First of all, the VA is interested in giving veterans their due. I want to say that up front. If there is evidence of causation, if there is evidence that a presumptive is in order, then in many cases, in the past, we have through regulations added presumptives to the list of disabilities that are subject to whatever the exposure or, for example, radiogenic diseases or Agent Orange.

So we are interested in that science, and Congress has legislated that the Institute of Medicine will look biennially at the Agent Orange presumptives and the diseases possibly associated with Agent Orange and diseases possibly associated with Gulf War service. So the way that works is that the Institute of Medicine conducts their study, they look extensively at the science and literature out there, it is peer-reviewed, they rely on peer-reviewed research, it is my understanding, and then they hand that over. We have a working group of experts, people from the Veterans Health Administration, Veterans Benefits Administration, the Office of General Counsel who review that and the recommendations. They make recommendations to a task force that is comprised of the Under Secretaries for Health, Benefits, General Counsel, and a couple of other people that are on that task force. And then they make a recommendation to the Secretary, and ultimately he makes the decision. That is the way it works now.

Mr. HALL. Okay. If I could move along.

Mr. HIPOLIT. If I could just clarify, what we are looking for in for example, the Agent Orange or Gulf War areas, is a positive association between the health outcome and the possible exposure in

service. So we don't necessarily need to prove causation in order to create a presumption. We will do it based upon a positive association, looking at the credible evidence for or against the association.

Mr. MAYES. Thank you, Dick.

Mr. HALL. Could you tell us what your position is on the new system that IOM proposed?

Mr. MAYES. I am not prepared to articulate a position at this point. That is still being considered within VA.

Mr. HALL. Okay. Whenever you have to the point of having a position, we would appreciate hearing it.

Mr. MAYES. Absolutely, Mr. Chairman.

[The following information from VA was subsequently received:]

Question: What is VA's view on the IOM's ideas for changes in the process for establishment of presumptions that were discussed in the hearing?

Response: The Institute of Medicine (IOM) published recommendations in 2008 for changes in the VA process for establishing presumptive disabilities. The IOM recommendations include creating two new advisory Committee panels. One would accept and review nominations for presumptive disabilities from veteran stakeholders. The other would be an independent scientific review board with the task of investigating the scientific basis for establishing any potential presumptive disability. This scientific panel would base its conclusions on the existence of a causal relationship between the military event and the subsequent disability, rather than on just an association between the military event and the subsequent disability.

VA views these recommendations as potentially beneficial but there are some concerns. Of primary concern is the authority of the Secretary of VA to make a final determination on establishment of a presumptive disability. Creation of these panels must be for informational purposes only and must not interfere with the Secretary's final authority. In addition, this process would have to be considered in light of Congressional legislation already enacted that mandates procedures for establishing certain presumptive disabilities. The Agent Orange Act 1991, for example, already provides a process for evaluating potential herbicide related presumptive diseases. Any implementation of the IOM recommendations must be integrated with such existing law. There is also a concern that use of these panels may prolong the actual decisionmaking process and inhibit the Secretary's ability to provide the public with a timely response.

Mr. HALL. And I would also like to just quickly ask you a couple more questions, since I am on the red light already. Since there is more up to date medical research on Parkinson's than ALS, it seems that onset does not necessarily occur in a year. So would section 1113(b) be the most appropriate provision to apply? What happens when these kinds of cases occur where the presumptive window has closed for the veteran claiming service connection for a chronic condition? Does VA deny chronic conditions simply because of the 1-year issue in section 1112?

Mr. MAYES. No. We don't deny simply because the presumptive window has closed. We can't apply the presumption of service connection because the window has closed. But we look at the evidence to try and see if there is some kind of link between the disease and military service. For example, if a clinician suggested that there were symptoms that they saw in service, and is now attributing the disease process to those symptoms, that would be an avenue that we could arrive at service connection, even if the onset is outside of the presumptive window.

Mr. HALL. It sounds to me like a legislative change to extend that 1-year window would make your job easier, because you wouldn't have to be fishing for a way to get around it in the case of a disease where frequently, if not most of the time, the disease

is not actually diagnosed or doesn't reach a point where you can definitively say what it is until after the 1 year has passed.

Mr. MAYES. Yes. It would be easier. The evidentiary——

Mr. HALL. You could spend your time getting the treatment rolling and moving on to another case instead of going and trying to get around the 1 year and find a way to get the person covered.

Mr. MAYES. Of course we have a mandate to ensure that we are compensating for diseases or disabilities due to service.

Mr. HALL. Right. And we are trying to help you do that. I appreciate that you want that, and that we are all after the same thing here.

Does VA track the number of claims it has gotten from veterans with Parkinson's, ALS, or those exposed to DU or Project 112?

Mr. MAYES. Well, yes. The claims from Project 112, yes, we do have those numbers. I don't know if I have those with me. We know how many letters we sent out to veterans. In fact, I do have that. But it was between 4,000 and 4,500. So it wasn't the full amount because we couldn't necessarily definitively identify the name that was handed us from DoD or we couldn't get an address.

[The following information from VA was subsequently received:]

Question: Does VA track claims for Parkinson's, ALS, Depleted Uranium-connected, and Project SHAD-connected claims? If so, please provide demographic information on these populations.

Response: VA tracks the number of claims filed in certain categories and other relevant information in recurring reports. However, we do not capture demographic information. Available information is provided below on the requested claim categories.

1. Parkinson's disease

As of May 2008, VA identified 968 veterans currently receiving compensation for Parkinson's disease. The following table provides the breakdown by the combined evaluation:

Comb Evaluation	Veterans
10%	26
20%	18
30%	82
40%	78
50%	67
60%	77
70%	115
80%	124
90%	93
100%	288
Total	968

2. Amyotrophic Lateral Sclerosis (ALS)

As of September 2008, VA has identified 871 unique veterans who have submitted a claim for ALS. The following table provides the breakdowns by year and decision.

Fiscal Year	Unique Veterans
FY 2004	133
FY 2005	184
FY 2006	148
FY 2007	183
FY 2008	227

3. Depleted uranium

VA does not specifically identify claims for depleted uranium.

4. Project SHAD

As of September 2008, VA has received 679 Project 112/SHAD claims; 65 are pending and 614 have been decided.

Mr. HALL. Right. Maybe you could provide us after the fact additional information on these populations, such as demographic descriptions and how many have sought treatment. I wanted to ask you the current backlog stands, as I understand it, is at about 650,000 cases, claims that are waiting to be adjudicated. How many of these are for veterans who have been diagnosed with PTSD but lack a verified stressor? And that may be something you have to get back to us on, too, but I just wanted to ask you that question.

Mr. MAYES. I don't know how many claims are pending right now today for PTSD. I do know the number of veterans who are on the rolls right now for PTSD. And that is 328—as of the end of May it was 328,923. And that compared to 1999 of only 122,070. So we know we are service connecting post traumatic stress disorder.

[The following information from VA was subsequently received:]

Question: How many PTSD claims are pending where there is no verified stressor?

Response: PTSD claims may be pending for several reasons. VA does not record the number of claims pending where the stressor has not been verified. Claims are generally pending because development is being undertaken and evidence gathered.

Mr. HALL. That is probably a good thing.

Mr. MAYES. We think so.

Mr. HALL. Not a good thing they have PTSD.

Mr. MAYES. Yes, Mr. Chairman.

Mr. HALL. But a good thing if they have it as a result of their service that they be treated and classified.

So in light of the issues we have been discussing regarding chemical exposures, the Veterans Disability Benefits Commission (VDBC) recommended that VA create a health registry for veterans who served at Fort McClellan and were potentially exposed to PCBs and other chemicals. What are your thoughts on these findings? What has VA done so far to implement this recommendation?

Mr. MAYES. I think that is one I would like to take for the record as well, because I believe it would likely be the Veterans Health Administration that would create the health registry and maintain it. So I can take that, and if you will indulge me, get back with you.

[The following information from VA was subsequently received:]

Question: What is VA's opinion on the recommendation of the October 2007 Veterans' Disability Benefits Commission report that VA initiate a registry and take other action with regards to possible PCB exposure at Fort McClellan, Alabama?

Response: While VA appreciates the recommendations and work of the Veterans' Disability Benefits Commission, VA does not support the creation of such a registry. Creating one is unlikely to improve the health or otherwise benefit those veterans who may have been stationed at a U.S. military base that also had hazardous materials onsite.

VA often hears from individuals and groups of veterans who are concerned about how their health may have been affected by exposure to environmental hazards at the U.S. military bases where they were stationed. The military uses many common hazardous materials at bases across the country. The U.S. Environmental Protection Agency (EPA) tracks nearly 1,600 hazardous waste sites across the country, and more than 170 of these are current or past military bases, including Ft. McClellan.

Moreover, a recent Department of Defense (DoD) evaluation concluded that there is little or no PCB contamination specifically at Fort McClellan that could have led to exposure of Army personnel.

However, Army personnel living off-base in the nearby town of Anniston may have been exposed to PCBs located there. That is why current scientific studies by the U.S. Department of Health and Human Services (HHS) on the health of Anniston residents, which include any veterans who may reside there today, are so important. HHS scientists are currently conducting four studies that evaluate PCB health effects for Anniston residents, including neurological health, PCB blood levels, health status of exposed children and adults, reproductive health issues, and environmental PCB levels. VA closely monitors these studies, particularly as they may turn out to relate to the health of servicemembers who may have been stationed at Fort McClellan. However, until they are completed, we have little or no data that would indicate any health problems from PCB exposure related to military service in or around Anniston.

In addition, it would be difficult to conduct meaningful health studies of veterans formerly stationed at Fort McClellan, even if it were possible to establish records of who served there during the relevant period. This is because of the difficulties of identifying and locating personnel who served in the relevant time period, finding accurate information about their actual exposures, obtaining older military medical records, and establishing a reasonable "control" or comparison group. Therefore, the ongoing HHS study provides the greatest chance of identifying a health risk from an environmental exposure.

Fortunately, veterans enrolled for VA healthcare with health problems related to PCB exposure while on active duty do not have to wait for such a study to seek healthcare and disability compensation from VA. The long-term health consequences of exposure to PCBs are very well documented. If any veteran has an illness related to PCB exposure and they can provide evidence that they were exposed during military service, they would have a good case for a related disability claim.

Fact Sheet

Polychlorinated biphenyls (PCBs) have been identified in at least 500 of the 1,598 hazardous waste sites that have been proposed for inclusion on the EPA National Priorities List (Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Toxicological Profile for Polychlorinated Biphenyls (PCBs), November 2000, www.atsdr.cdc.gov/toxprofiles/tp17.html).

An analysis of the hazardous waste sites listed by HHS Agency for Toxic Substances and Disease Registry (ATSDR) indicates that 173 sites are current or past military sites, where military personnel could have been exposed to hazardous substances. One of these 173 sites was Ft. McClellan.

A recent report from DoD's U.S. Army Center for Health Promotion and Preventive Medicine Information Paper, MCHB–TS–RAO, 13 July 2006, "Polychlorinated Biphenyls (PCB) Environmental Contamination Sources at Ft. McClellan, Alabama and Surrounding Areas") concluded that "there is little or no environmental contamination at Ft. McClellan that may have exposed Army personnel at Ft. McClellan to PCBs." However, they also pointed out that

"Army personnel who have previously resided or currently reside within the identified contaminated areas in [the town of] Anniston may have been exposed to concentrations above EPA action levels and suffer an elevated health risk equivalent to the local non-Army population." That is why the current ongoing HHS study on the health of Anniston residents is particularly relevant.

The U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry (ATSDR) has a series of four studies now underway at Anniston, and VA has been regularly in contact with the investigators for this study to monitor its progress and results.

The first is looking at neurological health among adolescents at Anniston, along with measuring blood levels of lead and PCBs. The study is also checking the health status and exposure of their parents.

The second study is looking at the health of 1,200 adults for all health outcomes, with a particular focus on type 2 diabetes, as well as PCB blood levels.

The third study is looking at reproductive health issues among women and children in Anniston.

The fourth study is monitoring for PCBs in the environment, a sort of "geo-environmental" analysis, with a focus on schools, etc.

Mr. HALL. That would be wonderful. Thank you.

Last year IOM recommended that VA improve the quality of the claims adjudication process and improve its accuracy. As we heard from IOM, accuracy was 88 percent in 2006. Do you know what it is now? And what is the target?

Mr. MAYES. Well, I believe the 88 percent number referred to the rating accuracies. So that would be the entitlement determinations. And I believe we are still at 88 percent.

Mr. HALL. Okay. Do you have a target?

Mr. MAYES. Yes, sir, we do. I believe it is 92 percent. The target is 92 percent. Now, I might add that we—Congress has been generous, and we have been able to hire over 3,000 employees. And so what we see happening is we have an influx of new employees into the work force. And we are trying to get them up to speed, but their decisions are considered just as well as those decisions made by journey level decisionmakers. So it is, I believe, having some impact.

Mr. HALL. Well, you are welcome.

Mr. MAYES. Thank you.

Mr. HALL. And we want to help, as you can tell.

Last, I wanted to say and ask, you mentioned the VDBC report and the Center for Naval Analysis (CNA) analysis on training, which was complimentary in comparison with other Federal agencies. However, you did not address the Commission's concerns with the emphasis on production over training, which is complicated by the turnover rate and the inexperience of raters. How is the VBA addressing these issues?

Mr. MAYES. Well, we frequently hear this. Brad Flohr and I both have been employees in the field. When you have veterans like we heard from today who have claims that are pending and you know they are behind you waiting for a decision, you want to push those through. I mean our employees don't like having this backlog. So there is a press to move the work. What I can say is that we manage individual performance by holding our employees accountable. We have a standard. And that standard includes both production and quality. So we do, on an individual basis at the RO, sampling. We pull cases, we review for quality. And an individual employee

can be terminated, worst case scenario can be terminated for poor quality just as well as they can be for lack of production. So they have to do both, and they want to do both.

Mr. HALL. Good. Well, thank you very much. I would like to turn to my new Ranking Member, Mr. Bilirakis, for his questions. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman. I appreciate it. Director Mayes, in your written testimony you state that the VA does not support H.R. 1197 because of the timeline for the VA to make determinations and publish regulations for establishing procedures for determining future presumptions for POWs. You said that it was untenable. You also stated the VA is not aware of any credible scientific literature to show an association between the medical conditions covered in H.R. 1197 and POW internment.

I was surprised by the VA's opposition to my legislation because the VA's previous testimony on H.R. 348 supported the bill. And my staff will give you the VA's previous testimony. In 2004, the VA testified, and I quote here, "it strongly supports enactment of section 2(c) of H.R. 348, providing that Congress can find offsetting savings. No one can reasonably doubt that the stresses and privations endured by prisoners of war take heavy tolls on their health in ways that may never be fully understood. The majority of POWs, are aging veterans of World War II who are unable to wait for science to provide definitive answers. Moreover, former POWs as a group do not benefit from relatively relaxed statutory standards, such as the positive association standard applied in the case of all Vietnam veterans because of their potential for exposure to defoliants used there. So for weighing the scientific evidence regarding associations between their service experience and later occurring diseases. There is some scientific evidence suggesting an association between the POW experience and each of the illnesses covered by the bill, which is 348 in 2004. And because these veterans are particularly deserving of special consideration, they too should be afforded the benefit of the doubt".

Since my bill is virtually identical to H.R. 348, why is the VA now opposing this language? And what has occurred to justify the change in position? That is my first question.

Mr. MAYES. The testimony that we submitted cited the reasons for the opposition. I do not know what the rationale was back in 2004. I know that was about the time I think that we actually added stroke and atherosclerotic heart disease. It might have been 2005. But I am going to go back and look, and I can provide you a more definitive answer.

Mr. BILIRAKIS. Okay. Can you please get back to me?

Mr. MAYES. Yes, sir. We will do that. We will reconcile those differences.

[The following information from VA was subsequently received:]

Question: Please explain why VA supported H.R. 348 in 2004 yet opposed a very similar bill (H.R. 1197) today. Why are the costs estimated by VA so much higher for H.R. 1197 than the previous bill?

Response: VA did support the addition of cardiovascular disease and stroke to the presumptive list for former POWs (FPOWs) in H.R. 348 and those conditions were subsequently added by amendment to statute and regulations. VA also did not oppose the addition of the other diseases mentioned in H.R. 348

although there was no strong evidence identified that would support an association between the POW experience and subsequent disease development.

H.R. 1197, however, would eliminate the requirement of any minimum internment periods. A veteran who was held 1 day or even a few hours could be service-connected for diseases that are generally associated with nutritional deficiencies associated with extreme deprivation. Additionally, VA remains unaware of any peer-reviewed studies that associate FPOW experiences with the subsequent development of Type II diabetes mellitus. Therefore, we do not support the addition of this condition to the presumptive list. Subsequent to our testimony on this legislation, however, the Secretary has become aware of studies that provide a basis for determining that an association exists between FPOWs who were held in captivity for 30 days or more and the subsequent development of osteoporosis. VA has drafted regulations to add this condition to the list of recognized presumptive conditions.

In estimating the cost for H.R. 1197, VA applied prevalence rates for osteoporosis and diabetes to more precisely identify the population of veterans and survivors that would apply for and be granted benefits. As a result, the population changed significantly from the earlier estimate. Additionally, the impact of the presumptions for POWs was revised. When providing a cost estimate for the earlier bill, we assumed the average service-connected disability payment was at the 30 percent level, resulting in a combined 50 percent disability rating. Currently the average disability payment for FPOWs is estimated to be at the 40 percent level, which we anticipate would raise the combined evaluation to 60 percent. In terms of monthly disability compensation benefit payments, a disability payment for the 50 percent combined evaluation 4 years ago was $646, while a monthly disability payment for a 60 percent combined evaluation currently is $921. The survivors benefit amount has also increased from $967 to $1091.

Mr. BILIRAKIS. Okay. And then in 2004 the VA estimated that H.R. 348, on the same subject, would cost approximately $589 million over 10 years. H.R. 348 would have established presumptions for five conditions, heart disease, stroke, liver disease, Type 2 diabetes, and osteoporosis. The VA is now submitting that H.R. 1197, which establishes presumptions for only two conditions, Type 2 diabetes and osteoporosis, will cost almost $800 million over 10 years. Although I realize it has been over 4 years since the VA's last estimate, I am puzzled by this. As I said, our bill only covers the two presumptions. So if you can get back to me on that I would appreciate it as well.

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

Mr. HALL. Thank you, Mr. Bilirakis. And we thank you for your patience, Mr. Mayes, Director Mayes, Mr. Flohr and Mr. Hipolit. Thank you for being here and for your testimony. We look forward to receiving the written responses that we have asked for. Thank you for your insight and opinions. And this hearing stands adjourned.

[Whereupon, at 5:16 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs

Good Afternoon.

The Veterans' Affairs Disability Assistance and Memorial Affairs Subcommittee Legislative Hearing will now come to order.

I would ask everyone to rise for the Pledge of Allegiance—flags are located in the front of the room.

I would first like to thank the witnesses for coming today to appear before the Disability Assistance and Memorial Affairs' Subcommittee for our fifth legislative hearing. Today we will examine 11 bills which I will identify by bill number for the sake of brevity: H.R. 1197, H.R. 3008, H.R. 3795, H.R. 4274, H.R. 5155, H.R. 5448, H.R. 5454, H.R. 5709, H.R. 5954, H.R. 5985 and H.R. 6032.

As a preliminary, I ask unanimous consent that Mr. Filner, Mr. Brown and Mr. Space be invited to sit on the dais for today's hearing. Without objection, so ordered.

I know the issues addressed in these bills are of utmost importance to many of you in attendance today, who like me, have constituents or loved ones who are directly impacted by the problems they seek to solve.

The subjects of the bills range from establishing presumptions of service-connection for certain diseases to loan forgiveness for veterans who die in combat. I look forward to hearing the informed testimony of our invited witnesses today.

Speaking of invited witnesses, I must express my disappointment that the DoD did not find it "efficient" to provide a witness to testify, particularly on legislation that has clear DoD implications. Moreover, this notice came late last week after testimony was due and after the DoD originally indicated that it intended to provide a witness. I hope to avoid this unnecessary wrangling in the future. Our veterans should be important to every implicated Federal agency. The nexus between the DoD and VA are undeniable and should not be rebuffed by the DoD when we are attempting to examine issues that overlap on jurisdiction and responsibility.

I note that yesterday the DoD did provide a written statement for the record. This fact aside, this Congress deserves the right to question the appropriate DoD personnel in person, not just in writing. Not to mention that our men and women who have given their all in service to our country deserve the right to have their elected representatives question the executive branch. This is how our system of checks and balances must work to ensure our democratic way of governing remains intact.

As I know that many of you in attendance are eager to ask questions of, or to hear answers from our knowledgeable witnesses, I will reserve the rest of my time for questioning. Since we have eleven bills under consideration today, I'll let everyone know how I intend to proceed. After Mr. Lamborn gives his opening statement, I will recognize Members of the Committee who have legislation pending before the Subcommittee today. I ask that other Members of the Subcommittee that do not have legislation pending to please submit your statements for the record.

We will then proceed to Panel I to receive testimony from our colleagues who have sponsored legislation pending before the DAMA Subcommittee. We will then proceed to panels II, III and IV each to follow by a round of questions where each Member on the dais will be offered 5 minutes to ask questions of the witnesses on that panel, in order according to the Rules of the House.

I now recognize Ranking Member Lamborn for his Opening Statement.

Prepared Statement of Hon. Doug Lamborn, Ranking Republican Member, Subcommittee on Disability Assistance and Memorial Affairs

Thank you Mr. Chairman for yielding and I thank you and your staff for holding this hearing today.

This afternoon, we are considering several pieces of legislation, all of which are of interest and potential value.

While I do have some policy concerns regarding a number of the provisions, I am primarily struck by the mandatory offsets that would be necessary to pass many of these bills under PAYGO rules.

Mr. Chairman as you know from the PAYGO problems with H.R. 5892, it is always a challenge to find offsets within our jurisdiction and that is something we need to keep in mind as we examine these bills today.

The main policy concern I wish to express is that some of the provisions before us are similar to section 101 of H.R. 5892, in that they would redefine combat with the enemy as it pertains to section 1154 of title 38.

Mr. Chairman, my concerns with these types of provisions are not new to you or other Members of the Committee and I will not reiterate them here, except to point out that a loose definition of combat would diminish the immeasurable sacrifice and service of those who actually did face combat.

While I understand and appreciate the effort to address problems regarding the VA claims backlog, I believe that they generally result from procedural issues and we should address the problems accordingly.

On another note, I look forward to the testimony of the representatives from the Institute of Medicine who will hopefully enlighten the Subcommittee about the process involved in establishing a presumption of service-connection for certain illnesses and disabilities.

Experts at VA and IOM have years of experience in dealing with these issues, and I think it is important for Congress to avail itself to their expertise whenever possible.

Mr. Chairman I extend my thanks to you and your staff for holding this hearing and I look forward to hearing the testimony of our colleagues and the other witnesses today. I yield back.

Prepared Statement of Hon. Michael Thompson,
a Representative in Congress from the State of California

Thank you, Chairman Hall and Ranking Member Lamborn, for holding this hearing. I introduced H.R. 5954 along with Congressman Denny Rehberg to allow veterans who were unknowingly used as guinea pigs in chemical and biological tests by their own government to seek medical care and compensation for their resulting illnesses. These tests—known as Project 112, which included Project SHAD, exposed at least 6,000 servicemembers without their knowledge to extremely harmful chemical and biological weapons—and we believe there are many more veterans out there that don't even know they were exposed. However, the Department of Veterans Affairs routinely rejects their claims for medical care and compensation. Our legislation will finally correct this injustice and get these men treatment they earned by honorably serving their country.

I am honored that my constituent and former tug boat commander Jack Alderson is here to testify today and share his first-hand knowledge of Project SHAD with you. Jack has been a tireless advocate for the veterans who were subjected to these tests and has kept in touch with many of them.

When I first questioned the Department of Defense (DoD) in late 1999, they told me that Project SHAD did not exist. Then I was told that the tests existed, but only simulants were used. Finally, after 3 years of investigating, the DoD finally revealed that these tests involved live agents, in some cases Vx and Sarin nerve gases and E. Coli, along with a whole host of other substances known to cause extreme illness in humans. But despite these shocking revelations, the DoD has without reason stopped looking for records of Project 112 service personnel and notifying the veterans subjected to these tests. The VA still does not recognize any long-term health consequences from exposure to these agents. As Jack Alderson will testify today, members of his crew and other affected servicemembers have since developed abnormal cancers and acute respiratory issues but are routinely rejected by the VA.

You will also hear today from Dr. Judith Salerno, Executive Director of the Institute of Medicine. In 2002, Congress directed and appropriated $3 million for the IOM to conduct a study of the health effects associated with the chemicals used during Project SHAD. Dr. Salerno will tell you that after 5 years of research, the IOM found no connection between the substances tested and the health problems of the SHAD veterans. With all due respect to IOM, I strongly believe their findings to be unsound. During the briefing on the IOM report, and utilizing the expertise of SHAD veterans Jack Alderson and John Olson, Congressman Rehberg and I identi-

fied serious deficiencies in the protocol used by IOM. For example, the health records of deceased Project SHAD veterans, who may have died as a result of health effects stemming from exposure during Project SHAD, were not examined. Such an omission could have a large impact on the results of the study. I hereby enter into the hearing record the letter sent to Dr. Rick Erdtmann of the IOM, which further outlines these issues and requests that the study be reopened. It is my understanding from the IOM that their review is ongoing and I look forward to hearing their results. But in the meantime, I want to also enter into the record a bibliography of fact sheet after fact sheet that have been prepared by other agencies and departments within U.S. Government that say exposure to these substances do in fact have long-term health consequences.

It is incumbent upon Congress to ensure that any servicemember who participated in these tests is provided with treatment if they have health problems associated with these tests. We can not wait any longer, considering many of these brave men who served their country are now sick or have even passed away. Project 112 and similar cases of chemical and biological testing on servicemembers is an issue of trust and integrity. How can we expect the current generation of soldiers to put their lives on the line knowing that harm from the enemy may not be the only danger they encounter? Jack and other crewmembers are beginning or have already experienced health problems that may be associated with these tests, and every day that we wait, I fear that these brave veterans grow sicker. Thank you for your time and consideration of this very important bill. It is imperative for us to right our government's past wrongs and help these brave veterans who unknowingly participated in these tests.

Congress of the United States
U.S. House of Representatives
Washington, DC.
February 15, 2008

Dr. Rick Erdtmann, Director
Board on Military and Veterans Health
Medical Followup Agency
Institute of Medicine of the National Academies
500 Fifth Street, N.W.
Washington, D.C. 20001

RE: Institute of Medicine (IOM) Study Long-Term Health Effects of Participation in Project SHAD

Dear Dr. Erdtmann:

In November 2007, you and Dr. Bill Page briefed us on the results of the June 2007 IOM study that had been requested by the Congress. The study looked at the long term health effects on veterans exposed during the operation of Project SHAD (Shipboard Hazard and Defense). As you know, the study failed to link Project SHAD to health problems experienced by veterans exposed during the testing project. During our briefing, and utilizing the expertise of SHAD veterans Jack Alderson and John Olson, we identified what we believe to be deficiencies in the protocol and requested that IOM reopen the study. This letter outlines the principal concerns we discussed and represents a formal request to reopen the IOM study.

1. The study acknowledges that "up to five Army light" tug boats participated in "several" Project SHAD tests, but it claims that complete personnel rosters were never found by the Department of Defense (DoD) or by IOM. According to SHAD veterans, the rosters were provided. For instance, a roster of personnel involved in the 1965 Shady Grove test, approximately 106 participants, was provided to IOM and confirmed by DoD. With the rosters identified and made available, we would expect the personnel to be considered in the study.

2. Personnel that were not exposed during Project SHAD were included in the study: a) the USS Granville S Hall (YAG 40), the Desert Test Center Command and Laboratory ship, was not exposed during Project SHAD; b) the USS George Eastman (YAG 39), participated only in some Project SHAD tests and not in others. We believe the inclusion of personnel from these two ships compromises the study results. We request that IOM examine how the inclusion of sterile personnel may have affected the results.

3. The health records of deceased Project SHAD Technical Staff, who may have died as a result of health effects stemming from exposure to Project SHAD, were not examined. We would like you to determine if the cause of death information for those individuals is available and measure what impact that information would have on the results of the study.
4. The study failed to account for the job and duty assignments of various personnel on board the ships, which resulted in different levels of exposure. Consideration should be given to the fact that personnel had different levels of exposure during training and testing to multiple weapons, experimental vaccines, trace elements, simulants, and decontamination agents. These considerations should be factored in to gain the most accurate results.
5. The description of the tests performed does not reflect the way in which the SHAD test was actually conducted. SHAD veterans must be consulted to ensure that any existing misconceptions in the IOM study are rectified.

Finally, the IOM study delineated a number of conclusions that were reached after classified material was reviewed by you and Mr. Don Burke. (See the IOM Study, p. 8–9.) SHAD veterans contest some of these conclusions, such as the conclusion regarding animal studies, as well as the one regarding vaccines. We request that these specific concerns be discussed more fully at the working group agreed to at the meeting, which will include representatives from DoD, IOM, selected SHAD veterans, and our staff.

We appreciate the briefing you provided and your willingness to review the items described above. By this letter, we formally request that IOM initiate the necessary steps to reopen the IOM study, and to work with DoD, as well as Project SHAD veterans, to address the above-referenced concerns. If you have additional questions, please contact our staff, Tracy Varghese at (202) 226–7372 or Brent Mead at (202) 225–3211.

Sincerely,

Mike Thompson
Member of Congress

Dennis Rehberg
Member of Congress

Bibliography of Facts Sheets of Chemical and Biological Agents used in Project SHAD

"Health Effects of Project SHAD Biological Agent: Bacillus Globigii," The National Academies, 2004, Contract No. IOM–2794–04–001.

"Health Effects of Project SHAD Chemical Agent: Betapropiolactone [CAS #57–57–8]," The National Academies, 2004, Contract No. IOM–2794–04–001.

"Health Effects of Project SHAD Biological Agent Coxiella Bumetii [Q–Fever]," The National Academies, 2004, Contract No. IOM–2794–04–001.

"Calcium Hypochlorite, CAS #7778–54–3; Sodium Hypochlorite, CAS #7681–52–9," Fact Sheet prepared by Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Public Health Service, April 2002.

"Calcium Hypochlorite (CaCl202)/Sodium Hypochlorite, (NaOCI), CAS 7778–54–3/7861–52–9; UN 1748/1791," Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services.

"Di(2-ethylhexyl) phthalate (DEHP), CAS #117–81–7," Fact Sheet prepared by Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Public Health Service, September 2002.

"Concise International Chemical Assessment Document 52: Diethyl Phthalate," World Health Organization, Geneva, 2003.

"Chemical Information Profile for Diethyl Phthalate [CAS No. 84–66–2]: Supporting Nomination for Toxicological Evaluation by the National Toxicology Program," National Institute of Environmental Health Sciences, National Institutes of Health, U.S. Department of Health and Human Services, November 2006.

"Diethyl Phthalate, CAS #84–66–2," Fact Sheet prepared by Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Public Health Service, September 1996.

"Bis(2-ethylhexyl) Phosphate, CAS No. 298–07–7," International Programme on Chemical Safety, October 2001.

"Escherichia coli," Centers for Disease Control, Department of Health and Human Services, March 27, 2008.

"Ethylene Oxide, CAS #75–21–8," Fact Sheet prepared by Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Public Health Service, July 1999.

"Formaldehyde, CAS #50–00–0," Fact Sheet prepared by Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Public Health Service, June 1999.

"Health Effects of Project SHAD Chemical Agent: Methyl Acetoacetate, CASD #105–45–3," The National Academies, Spring 2004, Contract No. IOM–2794–04–001.

"Health Effects of Project SHAD Biological Agent: Pasteurella [Francisella] Tularensis [Tularemia]," The National Academies, Spring 2004, Contract No. IOM–2794–04–001.

"Health Effects of Project SHAD Chemical Agent: Phosphorus-32 [Radiotoxic Effects]," The National Academies, Spring 2004, Contract No. IOM–2794–04–001.

"Q-Fever," Centers for Disease Control, Department of Health and Human Services, February 13, 2003.

"Health Effects of Project SHAD Biological Agent: Serratia Marcescens," The National Academies, 2004, Contract No. IOM–2794–04–001.

"FDA Warns Public of Contaminated Syringes," Press Release, U.S. Food and Drug Administration, January 25, 2008.

"Staphylococcal Food Poisoning," Centers for Disease Control, Department of Health and Human Services, March 29, 2006.

"Sulfur Dioxide, CAS #7446–09–5," Fact Sheet prepared by Agency for Toxic Substances and Disease Registry, U.S. Department of Health and Human Services, Public Health Service, June 1999.

"Tularemia," Centers for Disease Control, Department of Health and Human Services, October 7, 2003.

"Toxicologic Assessment of the Army's Zinc Cadmium Sulfide Dispersion Tests: Free Executive Summary," National Academy of Sciences, 1997.

Prepared Statement of Hon. Denny R. Rehberg, a Representative in Congress from the State of Montana

H.R. 5954—To grant presumption of service connection to veterans of Project 112, including Project SHAD.

Thank you Mr. Chairman and Members of the Subcommittee for allowing me to testify today on my legislation, H.R. 5954, to grant presumption of service connection to veterans of Project 112, including Project SHAD.

I would also like to thank Representative Mike Thompson, who has been a tireless advocate on this issue. It has been my pleasure to work with him to bring these tests to light and fight to get Project 112/SHAD veterans the benefits they deserve.

When I was first elected to the House of Representatives in 2001, I was approached by Billings resident John Olsen. John told me a disturbing tale of a government refusing to be accountable for its actions, a long line of healthcare problems, and a lack of care.

In the early Cold war era, the Department of Defense and other Federal agencies conducted a series of tests called Project 112. During these projects, a number of weapons containing chemical and biological agents such as VX nerve gas, Sarin Nerve Gas and E. Coli were tested on unknowing military personnel. John is one of the victims. Over the years, he has battled several health problems including skin cancer, prostate cancer, and an adrenal tumor the size of his fist.

Even worse, for more than 40 years the existence of these tests was denied by the Department of Defense (DoD), despite reports from participating veterans, like John, that they were being stricken with unusual diseases. During that time, many of these veterans suffered and died while their government looked the other way. Finally, in 2001, the DoD acknowledged that the tests took place. However, the Veterans Administration (VA) still wouldn't provide these veterans with health benefits and compensation for their diseases.

Instead, the VA commissioned a study which was conducted by the Institute of Medicine. Representative Thompson and I have questioned the validity of this study as it relates to the long term health effects on veterans of Project SHAD. Without going into too much detail, the study did not accurately portray the method in which these tests were conducted, and did not include sailors from the light tug boats participating in the tests and which my constituent John Olson served on. This was a deeply flawed study that should not be used as a basis to deny benefits to these veterans.

While working on this issue, I've been alarmed by the deficiency of the program for notifying Project SHAD veterans of their exposure. Due to pressure from Congress, initial search efforts began in 2000; however, they were and continue to be inadequate bordering on negligent.

Since 2003, the Department of Defense has stopped actively searching for individuals who were potentially exposed to chemical or biological substances during Project 112/SHAD. At that time, the Department of Defense reported it had identified 5,842 servicemen and estimated another 350 civilians were exposed during these tests.

Since the 2003 report to Congress an additional 598 veterans of these tests have been identified as potentially exposed. 394 were found in the June 2007 Institute of Medicine study, 165 were provided by various veterans' advocacy organizations, and another 39 were found through the Government Accountability Office's efforts. All told, since the Department of Defense stopped looking, 598 veterans have been identified, 10 percent of the original total. Put simply, we do not know how many more veterans may be out there.

It is a true tragedy that our government, after exposing these servicemen and women to a witch's brew of chemicals, cannot be bothered to find and notify them of such.

As I mentioned earlier, the Department of Defense did identify around 350 civilians who were potentially exposed during the course of these tests. However, to date, no effort has ever been made to notify these civilians.

H.R. 5954, in addition to the well-deserved presumption of service connection designation, would begin to draw a circle around the problem and correct it by implementing the recommendation from a February 2008 GAO report on Project SHAD. The Department of Defense must reopen its search and notification efforts, or provide an adequate cost-benefit analysis as to why not.

This legislation will help set a standard of oversight for the Federal Government's treatment of our soldiers. We can't sweep the suffering of these veterans under the rug. We can fix the problem created 40 years ago, and this legislation will do that.

Again, thank you for allowing me the opportunity to testify. And with unanimous consent I would also like to include the written statement of John Olsen for the record.

[The prepared statement of Mr. Olsen appears on p. 108.]

U.S. Government Accountability Office

Report to Congressional Requesters

"CHEMICAL AND BIOLOGICAL DEFENSE: DoD and VA Need to Improve Efforts to Identify and Notify Individuals Potentially Exposed During Chemical and Biological Tests: Chemical and Biological Defense"

February 2008, GAO–08–366

GAO Highlights

Why GAO Did This Study

Tens of thousands of military personnel and civilians were potentially exposed to chemical or biological substances through Department of Defense (DoD) tests since World War II. DoD conducted some of these tests as part of its Project 112 test program, while others were conducted as separate efforts. GAO was asked to (1) assess DoD's efforts to identify individuals who were potentially exposed during Project 112 tests, (2) evaluate DoD's current effort to identify individuals who were potentially exposed during tests conducted outside of Project 112, and (3) determine the extent to which DoD and the Department of Veterans Affairs (VA) have taken action to notify individuals who might have been exposed during chemical and biological tests. GAO analyzed documents and interviewed officials from DoD, VA, the Department of Labor, and a veterans service organization.

What GAO Found

Since 2003, DoD has stopped actively searching for individuals who were potentially exposed to chemical or biological substances during Project 112 tests, but did not provide a sound and documented basis for that decision. In 2003, DoD reported it had identified 5,842 servicemembers and estimated 350 civilians as having been potentially exposed during Project 112, and indicated that DoD would cease actively searching for additional individuals. However, in 2004, GAO reported that DoD did not exhaust all possible sources of information and recommended that DoD deter-

mine the feasibility of identifying additional individuals. In response to GAO's recommendation, DoD determined continuing an active search for individuals had reached the point of diminishing returns, and reaffirmed its decision to cease active searches. This decision was not supported by an objective analysis of the potential costs and benefits of continuing the effort, nor could DoD provide any documented criteria from which it made its determination. Since June 2003, however, non-DoD sources—including the Institute of Medicine—have identified approximately 600 additional names of individuals who were potentially exposed during Project 112. Until DoD provides a more objective analysis of the costs and benefits of actively searching for Project 112 participants, DoD's efforts may continue to be questioned.

DoD has taken action to identify individuals who were potentially exposed during tests outside of Project 112, but GAO identified four shortcomings in DoD's current effort. First, DoD's effort lacks clear and consistent objectives, scope of work, and information needs that would set the parameters for its effort. Second, DoD has not provided adequate oversight to guide this effort. Third, DoD has not fully leveraged information obtained from previous research efforts that identified exposed individuals. Fourth, DoD's effort lacks transparency since it has not kept Congress and veterans service organizations fully informed of the progress and results of its effort. Until DoD addresses these limitations, Congress, veterans, and the American public cannot be assured that DoD's current effort is reasonable and effective.

DoD and VA have had limited success in notifying individuals potentially exposed during tests both within and outside Project 112. DoD has a process to share the names of identified servicemembers with VA; however, DoD has delayed regular updates to VA because of a number of factors, such as competing priorities. Furthermore, although VA has a process for notifying potentially exposed veterans, it was not using certain available resources to obtain contact information to notify veterans or to help determine whether they were deceased. Moreover, DoD had not taken any action to notify identified civilians, focusing instead on veterans since the primary impetus for the research has been requests from VA. DoD has refrained from taking action on notifying civilians in part because it lacks specific guidance that defines the requirements to notify civilians. Until these issues are addressed, some identified veterans and civilians will remain unaware of their potential exposure.

What GAO Recommends

GAO suggests that Congress direct DoD to develop guidance to notify potentially exposed civilians. GAO also recommends that DoD and VA take steps to improve their efforts to more effectively identify and notify individuals. DoD and VA generally agreed with most of the recommendations. However, DoD did not agree with the recommendation to conduct a cost-benefit analysis regarding additional Project 112 research. As a result, GAO suggests that Congress direct DoD to conduct such an analysis.

To view the full product, including the scope and methodology, click on http://www.GAO-08-9366. For more information, contact Davi M. D'Agostino at (202) 512-5431 or dagostinod@gao.gov.

Prepared Statement of Hon. Zachary T. Space, a Representative in Congress from the State of Ohio

Thank you, Chairman Hall, Ranking Member Lamborn, and Members of the Subcommittee, for providing me with the opportunity to speak in favor of H.R. 5709, the "Veterans Disability Fairness Act."

At the end of last year, the Oversight and Investigations Subcommittee held a hearing on an Institute for Defense Analyses report regarding the average disability payments received by veterans in each state.

The hearing revealed that the VA's current data is lacking, and that "regional cultures" may be partly to blame for similarly disabled veterans receiving different ratings and thus, different disability payments. I introduced legislation specifically geared to correct these discrepancies.

The Veterans Disability Fairness Act:

- Requires the VA to collect and monitor regional data on disability ratings.
- Requires the VA Secretary to conduct reviews and audits of the rating system.
- Requires the VA to submit a report yearly to Congress to track the progress of the program; and
- Requires VA raters to take ownership of their ratings by assigning identification codes to all adjudications. The performance of specific raters will then be evaluated periodically for consistency and accuracy.

The current shortchanging in ratings is not reflective of our heroes' service, and there is no reason that a veteran from one state should receive less than veterans in other states. This legislation is an important step in addressing these issues and in providing needed oversight.

Additionally, H.R. 5709 supplements this Subcommittee's work on Chairman Hall's H.R. 5892, the Veterans Disability Benefits Claims Modernization Act. Section 106 of that bill calls for an annual assessment of the quality assurance program that examines data from regional offices, the accuracy of evaluated claims, and creates automated, categorizable data to better identify trends. My bill will require accountability by enabling the specific identification of potentially problematic claims raters who may knowingly manipulate claims. Alternatively, my legislation will protect those who are doing their jobs with integrity.

This bill is incredibly important to the veterans of Ohio; our state was ranked dead last in average disability payments, and I cannot stand for this. According to the IDA report, the national average disability payment is $8,890, and Ohio's average is $7,556. I believe we must act to restore parity to the disability payment system to ensure each veteran receives the full benefit he or she was promised. Senator Brown—a Member of the Senate Veterans' Affairs Committee—agrees and has introduced an identical companion version of my bill to the Senate.

Thank you again for your consideration of H.R. 5709. I am grateful for the opportunity to present this important piece of legislation to you.

Veterans Disability Disparity State by State Rankings [1]

1. New Mexico	12,395
2. Maine	11,734
3. Oklahoma	11,643
4. Arkansas	11,412
5. West Virginia	11,348
6. Nebraska	10,719
7. Oregon	10,677
8. Louisiana	9,815
9. Vermont	9,682
10. Kentucky	9,673
11. North Carolina	9,549
12. Arizona	9,502
13. Texas	9,484
14. Montana	9,460
15. Mississippi	9,424
16. Rhode Island	9,337
17. Washington	9,156
18. South Dakota	9,125
19. South Carolina	9,116
20. Tennessee	9,111
21. Idaho	9,063
22. Hawaii	9,047
23. Wisconsin	8,844
24. California	8,755

Veterans Disability Disparity State by State Rankings [1]—Continued

25. Alabama	8,752
26. Missouri	8,721
27. Minnesota	8,709
28. Florida	8,617
29. Nevada	8,606
30. Colorado	8,476
31. Utah	8,396
32. Wyoming	8,360
33. Iowa	8,348
34. Massachusetts	8,348
35. New Hampshire	8,317
36. Alaska	8,300
37. New York	8,278
38. Pennsylvania	8,270
39. North Dakota	8,237
40. Georgia	8,163
41. Kansas	8,052
42. New Jersey	8,032
43. Michigan	7,999
44. Illinois	7,816
45. Connecticut	7,737
46. Virginia	7,706
47. Delaware	7,679
48. Maryland	7,654
49. Indiana	7,573
50. Ohio	7,556
Overall Average	8,890

[1] Institute for Defense Analyses Analysis of Differences in Disability Compensation in the Department of Veterans Affairs Vol. 1: Final Report pg. C–15 (December 2006).

Congress of the United States
U.S. House of Representatives
Washington, DC.
July 20, 2007

President George W. Bush
1600 Pennsylvania Ave., NW
Washington, D.C. 20502

Dear Mr. President,

In visits to Veterans County Service Offices around my district, my staff hears time and again that veterans in Ohio are concerned about inconsistencies in the processing of seemingly similar disability claims. This week, the Associated Press published a story outlining the findings of the Institute for Defense Analyses' VA-commissioned study on veterans' annual disability pay from state to state. I am incredibly concerned about the report's assertion that Ohio ranks dead last.

According to the report, approximately one-third of disparities may stem from correctible factors, such as inconsistent training standards for claims evaluators and simply placing too much power in the subjective decisions of evaluators. While demographic factors also play a role in overall ratings, I believe the human component can be improved upon.

Your administration has a responsibility to ensure that the processes the VA utilizes are of the highest industry standard, and that those charged with overseeing those processes are doing so. In fact, during Secretary Nicholson's 2005 confirmation hearings, he pledged to look into the existing discrepancies. This week, as you know, he submitted his resignation without having sufficiently acted to standardize disability pay across state lines.

That's why I am writing to demand that the next Secretary of the Department of Veterans Affairs make this the highest priority. The new Secretary must ensure that veterans in Ohio and others are not being treated unjustly and unfairly relative to the rest of the country.

Mr. President, we absolutely owe it to the veterans of Ohio to get the bottom of why they are being shortchanged. I would appreciate knowing your response to this matter.

Sincerely,

Zack Space
Member of Congress

Prepared Statement of Hon. Gus M. Bilirakis, a Representative in Congress from the State of Florida

I would like to start by thanking Chairman Hall and Ranking Member Lamborn for including my legislation, H.R. 1197, on today's hearing agenda. The Prisoners of War Benefits Act is a bill that my father, former Representative Mike Bilirakis, first introduced several congresses ago. He was able to make some progress on the legislation before he retired in 2006, and I am pleased to be continuing his efforts on this important issue in the 110th Congress.

The Prisoners of War Benefits Act is intended to improve the benefits currently available to former POWs. In 1981, Congress established several service-connected presumptions for certain medical conditions that affect former prisoners of war. However because a very high level of research certainty (95 percent) was required before establishing presumptive status, many other medical problems common in POWs have been excluded.

My legislation establishes service-connected presumptions for two additional medical conditions: Type II diabetes and osteoporosis. My staff has worked with the American Ex-Prisoners-of-War to identify these conditions as having strong evidence of a relationship between the POW experience and the onset of the disease.

Congress has passed legislation giving the Department of Veterans Affairs (VA) specific standards for determining whether the addition of new presumptive diseases for Vietnam and Gulf War veterans is warranted. These standards require a positive association for the adoption of a presumptive condition. However, Congress has not established a process for VA to add to the list of former POW presumptive diseases established in 1981. In 2001, the VA Advisory Committee on Former Prisoners of War recommended that the burden for establishing POW presumptions be adjusted to match the standards used for other beneficiary groups. Therefore, H.R. 1197 includes a provision to establish a process by which the VA could determine future presumptive conditions for former POWs when there is a positive association between the experience of being a prisoner of war and the occurrence of a disease or condition. Under my legislation, the VA Secretary would have to review the recommendations of the Advisory Committee on Former Prisoners of War and all other sound medical and scientific information and analyses available when making these determinations.

Under current law, to be eligible for disability compensation for certain conditions presumed to be service-connected for former POWs, a veteran must have been held in captivity for 30 or more days.

At the time when some of the original POW presumptions were enacted, short-term prisoners of war were unusual. Prisoners of war from more recent conflicts have been confined for shorter periods of time. H.R. 1197 would remove the 30-day minimum requirement, making all former POWs eligible regardless of how long they were held captive. This provision is based on the recommendations of the VA's Advi-

sory Committee on Former Prisoners of War, which concluded in 2001 that this 30-day requirement should be repealed.

The 108th Congress did enact a partial repeal of the 30-day minimum requirement as part of the Veterans Benefits Act of 2003 (Public Law 108–183). Specifically, this law eliminated the requirement that a POW be held for 30 days or more to qualify for presumptions of service-connection for certain disabilities. Although I am pleased that Congress took this initial step, I believe that more can be done in this regard and urge my colleagues to support H.R. 1197 for this reason.

Before I close, I would like to mention how pleased I am that we have also included H.R. 5454 on today's agenda. H.R. 5454, which I have cosponsored, would establish a presumption of service-connection for ALS. I have heard from some of my constituents whose loved ones suffer from this devastating disease. They firmly believe there is a link between their loved ones military service and their developing ALS.

In closing Mr. Chairman, I want to thank you once again for including my bill in today's hearing. I hope that you and our other colleagues on the Subcommittee will support H.R. 1197 and H.R. 5454. I look forward to hearing the testimony from today's witnesses.

Prepared Statement of Hon. David Wu,
a Representative in Congress from the State of Oregon

Chairman Hall, Ranking Member Lamborn, distinguished Members of the Subcommittee:

Thank you for the opportunity to testify today on behalf of H.R. 3008, the Rural Veterans Services Outreach and Training Act.

A few years ago, I was made aware of a problem that directly affects millions of individuals who have defended our country. Due to budget cuts in many areas—including my home state of Oregon—county veterans service officers are not being funded at adequate levels.

County veterans service officers provide veterans with advice and casework service about their VA benefits. There is a singular need for these services in our rural communities. There are approximately 3 million veterans living in rural areas in the United States. A 2004 report published in the *American Journal of Public Health* indicates that veterans in rural areas are in poorer health than their urban and suburban counterparts. Without access to casework services, these veterans go without all the benefits they need, deserve, and have earned.

Some may argue that veterans in rural areas can simply drive to the nearest VA Regional Office. But for many veterans and their caregivers, this is impractical. According to the National Rural Health Association, the average distance a rural veteran must travel to get care is 63 miles. For someone who has endured the trauma of a battlefield injury and begun the long, arduous process of rehabilitation, this is often, simply, too much to ask.

Without access to a county veterans service officer, veterans must rely solely on customer service representatives over the telephone or Internet in order to access their VA services. But anyone who has ever encountered an automated phone system knows how frustrating and discouraging this can be. Veterans who have suffered physical, emotional, or psychological injuries should not be forced to navigate the VA bureaucracy alone because they do not live near a VA Regional Office.

Our veterans deserve better, have earned better, and will get better under this bill. County veterans service officers provide rural communities with more than just their expertise. I believe our veterans are served best by their fellow community members. Community members understand a veteran's needs as they relate to his or her community, job, and family. Armed with this information, county veterans service officers can best advocate for the veterans they serve.

With this in mind, I introduced the Rural Veterans Services Outreach and Training Act, which seeks to improve outreach and assistance to veterans and their families residing in rural areas.

This bill establishes a competitive grant program at the Department of Veterans Affairs to help eligible states hire and train county veterans service officers for their rural communities.

The Rural Veterans Outreach and Training Act targets grant money to the communities that need it most. This legislation requires that grants will be used only to supplement non-Federal funding sources, not supplant them.

We have an obligation to ensure that veterans—wherever they reside—have access to the services they have earned and deserve. Our men and women in uniform

give so much in service to our country, and I believe we should act accordingly to ensure they have access to local assistance to find the help they need.

Again, I appreciate the Subcommittee's consideration of the Rural Veterans Services Outreach and Training Act. On behalf of a grateful nation and veterans everywhere, I look forward to working with you on this important legislation.

Prepared Statement of Hon. Thomas H. Allen, a Representative in Congress from the State of Maine

Thank you, Mr. Chairman, for convening this hearing on very important veterans' disability assistance bills, including my proposal, H.R. 5448, the "Full Faith in Veterans Act of 2008." I am extremely grateful for this opportunity to testify before the Subcommittee about the need for my legislation, which I introduced in February of this year.

The enormous stress of combat has long been recognized as the source of long-term, disabling psychological and emotional illness for many soldiers, sailors, marines and airmen. What we now know as post traumatic stress disorder, or PTSD, is not a new phenomenon. The wars in Iraq and Afghanistan, however, have been particularly stressful, given the unpredictability of ambushes and IED attacks, not knowing who is friend or foe, and repeated tours of duty. In addition, military and medical personnel more readily recognize the symptoms of this disorder. So it is not surprising that so many of our brave men and women return from Iraq and Afghanistan suffering from incapacitating fears, flashbacks, nightmares and other problems associated with their experiences. The Department of Veterans Affairs (VA) has diagnosed PTSD in about 67,000 Iraq and Afghanistan veterans. Because many veterans do not seek care for these problems, the true number is undoubtedly much higher.

PTSD has affected those who have served in our Armed Forces since the days it was known as "shell shock." Thousands of veterans from previous conflicts continue to struggle with the long-term effects of their service. Others have had their symptoms reemerge as a result of the extensive news coverage of the events of September 11, 2001, and the ongoing wars in Iraq and Afghanistan.

The goal of the Full Faith in Veterans Act is to improve diagnosis, compensation, and treatment for veterans with PTSD.

The primary component of the legislation seeks to ensure that every veteran whose PTSD resulted from their service receives treatment and, if appropriate, disability compensation.

Veterans for Common Sense reviewed VA documents to determine the number of Iraq and Afghanistan veterans diagnosed with PTSD—about 67,000. The organization also found the VA concluded that only about half of these veterans have a service-connected disability. This raises the question of the status for the other 30,000 or so veterans. Some veterans may not know they can file a claim or may still have a claim pending. But as I have learned from veterans in my district, proving that PTSD is service-connected can be very difficult, particularly for veterans of older conflicts. And denial of service-connection leaves these veterans without access to VA health benefits or disability compensation.

I crafted my bill after listening to Maine veterans victimized by the current system. In many cases, the law appears to be stacked against them. Instead of the support and quality healthcare they were promised, the disabling trauma they suffered during military service has been met with skepticism and red tape. I would like to share the story of one of my constituents that brings these shameful circumstances to life.

Terry Belanger is an Army veteran from Biddeford, Maine. He served in Vietnam from 1969–1970. Terry's principal duty was to serve as a light vehicle driver; his responsibilities included delivering and distributing ammunition to troops surrounding Chu Lai Air Base.

Terry's time in Vietnam was harrowing. His vehicle came under enemy fire, he reports, "practically every night." Close friends were killed in combat; another died in a stabbing over a game of cards; he witnessed the torture of Viet Cong officers, and saw the body of the driver of the truck ahead of his fly through a canvas top after the vehicle struck a mine; he slept in the mud and saw body bags being loaded on to U.S. planes. His captain was killed.

On one mission, a young Vietnamese girl suddenly appeared in front of his truck and his vehicle ran over the little girl, probably killing her. Because his convoy was under fire, he could not stop. Terry's nightmares about this incident were rekindled a few years ago after he nearly struck another child who darted in front of his car.

When he returned from Vietnam, Terry showed evidence of what several healthcare professionals have diagnosed as severe PTSD resulting from his service in Vietnam. It took him 6 months to want to hold his newborn daughter, but he didn't know why. In 1989, Terry filed a claim with the VA for service-connected PTSD. The claim was denied due to "lack of credible information of supporting stressors." Terry would spend nearly two decades fighting his own government, a government he had fought to defend. Time and again, the VA denied service-connection due to lack of evidence that his condition was linked to his military service. All the while, Terry and his family suffered, for his government would neither pay for his medical care for PTSD, nor provide him with disability benefits.

For 19 years, Terry tried to get the Army to search for documents that would prove that these traumatic events had occurred. In January 1993, the National Personnel Records Center told Terry that the records he requested "would rarely show specific details about a unit's activities and movements and that it was unable to perform the extensive research requested due to staffing and budget limitations." Finally, in 2005, the National Archives and Records Administration found over 4,500 pages that verified that Terry's unit was in combat for months, just as he had claimed. This was sufficient to establish service-connection. But because of an enormous backlog of veterans' claims, Terry had to wait another 3 years before the VA would grant his claim.

Last month, he finally received the VA's decision that it would grant his claim. Terry says that it took him 3 days to stop being angry, and he'll never understand why it took them so long to validate his claim.

It took that long because the law is unfair. The veteran, not the agency that possesses the records, has the burden of producing documents that prove the trauma occurred. How was Terry Belanger, a disabled veteran in Biddeford, Maine, supposed to find the records that the government said it didn't have the time or money to look for? His doctors confirmed he had PTSD. His nightmares and flashbacks referred to his time in Vietnam. The Army trusted him when he served his country. Why should we distrust him now, in his time of need?

Indeed, what is remarkable about Terry's case is that the records were ever uncovered. It happened only because Terry was so persistent and would not let his family down. He kept filing and appealing until finally, after 16 years, someone in the National Archives found thousands of pages that they had missed before.

Terry's story is similar to many I have heard from veterans in Maine and, I would wager, is much like the experience veterans in each of your districts have had. In many cases, no records are kept of traumatic experiences in a combat theatre. As Terry had been told earlier, military records "would rarely show specific details about a unit's activities and movements." In the case of Terry Belanger, the records were there amid millions of others. Either way, bureaucratic mismanagement or red tape is no excuse to deny veterans the healthcare and compensation they have earned.

When no records can be found to substantiate the claim, a veteran can also submit two "buddy statements" as evidence that their claimed stressor actually occurred. Again, the burden of proof is placed on the veteran to find fellow servicemembers who may remember and can corroborate the veteran's story. This is not an easy task, particularly when seeking individuals that the veteran may not have seen or spoken to for decades. One can turn to the back of many veterans' magazines and see ads submitted by veterans looking for others who can verify their claims, like these (all from the April 2008 issue of VFW magazine):

> "173rd [Airborne] Support [Battalion], An Khe, Vietnam, 1968–69—Seeking anyone who attend [sic] [Airborne] Jungle School when one of the instructors was accidentally shot by one of the other instructors next to me; anyone there when the school and mess hall were shelled and three people were killed; cooks and supply people; Sergeant Provost and Jimmy Gibson; anyone who was there when the mess hall caught on fire and we put it out; anyone who witnessed an accidental shooting on April 9, 1968, in the bunkhouse. Need substantiation for PTSD claim.—William E. Young, Jr."
>
> "222nd Personnel Services [Company], Vietnam, early 1971—Seeking anyone in a convoy traveling between Vaung Tan and Long Binh and saw Huey shot down. Need substantiation for PTSD claim.—John Westbrook"
>
> "4th [Infantry Division Artillery] Base Camp, Pleiku, Vietnam, Sept. 1969–Nov. 1970—Seeking anyone attached to camp. Need substantiation for PTSD claim.—Roger Carroll"

Veterans should not have to take out classified ads in order to have their valid claims for PTSD approved by the VA.

Under my common sense bill, if a veteran is diagnosed by a certified medical health professional as suffering from PTSD related to the veteran's military service, the VA must accept this finding as sufficient proof of service-connection. As with other disability claims, the VA must resolve every reasonable doubt in favor of the veteran. However, the VA can rebut this finding of service-connection by clear and convincing evidence to the contrary. Thus, if contrary evidence exists, and the VA produces it, the claim will not be allowed.

Under my bill, veterans like Terry Belanger would not have to wait two decades for the VA to find the relevant records. The law would also help the many veterans whose traumatic experience in the service never made it into official records. The new standards in my bill would apply to all veterans diagnosed with PTSD, not just those from the wars in Iraq and Afghanistan. It would also acknowledge the inherent dangers of military service and be applicable to all those who served our Nation in uniform, not just those who faced combat. It also accommodates cases of PTSD related to military sexual trauma that may not have happened in a combat zone.

In addition to establishing a fair system for establishing service-connection for PTSD, the bill would also ensure that the VA does a better job at diagnosing and treating this debilitating disorder.

The bill requires that VA employees who are responsible for rating disability compensation claims involving PTSD successfully complete a certification program that incorporates best practices issued by the VA's National Center on PTSD.

It directs the VA to audit the examinations that VA mental health professionals conduct for veterans who submit claims for PTSD disability compensation. This will help ensure these employees take enough time to diagnose and accurately rate the severity of the disorder.

H.R. 5448 requires that the documents mental health professionals and raters consider when evaluating or rating PTSD must include the veteran's records from VA Vet Centers, as well as written opinions of any medical professional providing mental healthcare.

The bill also directs the VA to update the schedule for rating disabilities, beginning with PTSD, traumatic brain injury, and other disabling mental health conditions.

Finally, my measure requires the VA to implement an approach for providing treatment for veterans with PTSD that combines treatment, compensation, and vocational assessment.

This bill has received support from a broad array of veterans groups, including Swords to Plowshares, Veterans for Common Sense, the Maine Veterans Coordinating Committee and Maine's Bureau of Veterans Services, along with the Maine departments of the American Legion, AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars.

For too long, America has neglected our responsibilities to the men and women who carry the emotional scars military service sometimes brings. They battled for us; now we must help them battle their demons, by treating them fairly and respectfully. Terry Belanger's wife wrote, "This wonderful man—left part of his soul in Vietnam." I hope and pray that with care and support, Terry and other veterans suffering from PTSD will be restored to full and productive lives. The Full Faith in Veterans Act can help achieve this.

Swords to Plowshares
San Francisco, CA.
March 4, 2008

Hon. Thomas H. Allen
United States House of Representatives
1127 Longworth House Office Building
Washington, DC 20515–1901

Dear Representative Allen,

I write on behalf of Swords to Plowshares to thank you for introducing the Full Faith in Veterans Act (H.R. 5448). Swords to Plowshares is a non-profit Veterans Service Organization founded by Vietnam Veterans in 1974 and dedicated to providing services and support to veterans of all eras. Our legal staff have assisted countless veterans through the complex Veterans Benefits Administration (VB A) claims process to secure compensation for Post Traumatic Stress Disorder (PTSD) incurred during service to our country.

H.R. 5448 addresses serious flaws in the adjudication of PTSD claims. Under current law, veterans must have both a PTSD diagnosis and military documentation

of the traumatic stressor which caused their PTSD, or two "buddy statements" describing the event. This process of identifying two "buddies" and eliciting their description of painful events causes undue trauma to all the veterans involved, and is triggered by a failure in military documentation for which the veteran has no control. The proposal to accept a diagnosis of PTSD by a mental healthcare professional that establishes a logical relationship between exposure to military stressors and current PTSD is a vast improvement over the current process.

We also applaud the effort to establish standards in PTSD case review through: the requirement that VBA PTSD Ratings Analysts complete a certification program incorporating best practices issued by the VA's National Center on PTSD; the requirement that VA audit their mental health examinations to ensure that sufficient time is taken to accurately diagnose and rate the severity of PTSD; and, the requirement that the Ratings Analysts consider Vet Center records and written opinions of other treating medical professionals in assessing PTSD claims.

Thank you on behalf of Swords to Plowshares for your leadership in veterans' issues and we look forward to working with you and your staff to support the Full Faith in Veterans Act.

Sincerely,

Michael Blecker
Executive Director

Veterans for Common Sense
Washington, DC.
June 10, 2008

The Honorable Thomas Allen
Member of Congress
U.S. House of Representatives
1127 Longworth House Office Building
Washington, DC 20515

Dear Representative Allen:

Veterans for Common Sense (VCS) strongly supports your new bill, "The Full Faith in Veterans Act," H.R. 5448. VCS asks Chairman John Hall and the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs to favorably report the bill at their hearing on June 12, 2008. Our VCS goal is simple: We want VA to quickly and accurately process post traumatic stress disorder claims so our veterans are not forced to wait months or years for disability benefits. We thank you for your leadership on this important issue.

The Department of Veterans Affairs' (VA) disability claims process for Iraq and Afghanistan War veterans remains broken—as shown by the fact that VA takes, on average, more than 6 months to process an initial claim, and VA takes nearly four more years to process a disability claim appeal. Among the most difficult claims to process are PTSD claims. VCS supports a presumption of a PTSD stressor based on deployment to a war zone.

VCS remains alarmed that VA denies more than half of the PTSD disability benefits filed by Iraq and Afghanistan war veterans. The latest publicly available information shows that only 37,000 Iraq and Afghanistan war veterans' VA disability claims for PTSD were approved among the 75,000 veterans diagnosed at VA hospitals with PTSD. While some cases may be pending or on appeal, VA's rejection rate is suspiciously high, and the enormous disparity warrants a prompt Congressional oversight investigation above and beyond enacting H.R. 5448.

Your bill, H.R. 5448, requires VA reports on PTSD. VCS urges Congress to pass H.R. 1354, "The Lane Evans Veterans Health and Benefits Improvement Act," a bill that requires VA to collect data and prepare reports about the human and financial costs of the Iraq and Afghanistan wars. VCS believes Congress should also ask VA how many non-Iraq and Afghanistan war veterans are diagnosed with PTSD by VA, and how many of those have approved PTSD claims. This information should shed more light on the issue of how VA handles PTSD healthcare and for claims for all our Nation's veterans.

Sincerely,

Paul Sullivan
Executive Director

"Vietnam Veterans Seek Proof Of Stress-Inducing Events"
The Hartford Courant
By Ann Marie Somma, Courant Staff Writer

May 25, 2008

A Vietnam veteran from South Carolina is searching for three scuba divers who helped him fish dead bodies out of Cam Rahn Bay in Vietnam in 1967.

An air rescue medic now living in Maine is desperately seeking anyone who remembers him killing 18 North Vietnamese during the Tet Offensive between January and March 1968.

A Brookfield vet is hoping to find someone else who saw the explosion of a F–100 fighter bomber aircraft at the Bien Hoa air base in Vietnam in 1966.

Every month, the Vietnam Veterans of America's magazine website is clogged with personal ads posted by vets around the country diagnosed with post traumatic stress disorder. They may have survived harrowing experiences in Vietnam, but the U.S. Department of Veterans Affairs won't approve their claims for disability unless they can document the exact traumatic episode that triggered the disorder.

Because the service records of so many Vietnam veterans are incomplete and inaccurate, often their only hope is to find a fellow soldier who will write to the VA confirming the traumatic event, known as an in-service stressor.

The letters are known, affectionately, as buddy letters.

Robert Chechoski, a Vietnam veteran in Bridgeport who volunteers his time to help other vets file PTSD disability claims, said the need to produce buddy letters and to prove their trauma is hurtful for those who still remember their bitter homecoming.

"They hid for 30 years. They tried to put Vietnam out of their mind. A lot worked the midnight shift, because they can't deal with people, a lot drank to forget," Chechoski said. "Then something awakens in their head, they go get counseling and help and a lot get denied by the VA."

Burning Embers

The veterans seeking buddy letters served in every branch of the military. They saw soldiers die. Their lives were threatened in ambushes, rocket attacks and shelling in villages and the jungle.

But their military records typically don't include an account of the single traumatic event they witnessed. Their DD214s, the military service records issued by the Department of Defense, are incomplete and inaccurate. Some troops left Vietnam with no records at all. Those who served in top secret government missions were, in essence, never there.

Veterans advocates say the VA's arcane standard of requiring evidence of an in-service stressor has denied thousands of veterans disability pay and continues at a time when the number of Vietnam-era veterans being treated for PTSD in the VA system is increasing.

A 2007 study by Robert Rosenheck and Alan Fontana, two Yale University researchers, found that the number of those vets being treated for PTSD increased from 91,043 in 1997 to 189,309 in 2005. Some experts believe the war in Iraq is triggering Vietnam memories, causing the spike in numbers.

Before the government officially recognized PTSD in 1980, thousands of Vietnam veterans became homeless, turned to drugs and alcohol or died. The VA now considers PTSD a disability and uses a rating system, from 10 to 100 percent, to determine how the illness has affected a veteran's quality of life, relationships and ability to earn a living. Compensation ranges from a few hundred dollars to $2,500 a month.

Chechoski, who served three tours in Vietnam and was diagnosed with PTSD in 1996, offered an explanation of the delayed effects of the disorder.

"Picture a Weber grill. You set a bag of charcoal on fire, then you douse it with a 10-gallon bucket of water. You think you got that fire out, but there is one ember that is still alive and it will ignite sooner or later," Chechoski said.

Armand Flynn's ember ignited on Sept. 11, 2001, after smoldering for more than 30 years.

The Brookfield veteran dealt with Vietnam by living a simple life. He graduated from college, married and raised three children with a career administering compensation benefits for major corporations. But he drank too much. The liquor quelled his panic attacks and insomnia.

On Sept. 11, when the hijacked planes hit the World Trade Center, Flynn flashed back to Vietnam on Oct. 6, 1966.

Flynn says he was working the flight line attached to the U.S. Air Force 6234 Tactical Fighter Wing when a plane loaded with cannons and air-to-air missiles caught fire on the runway at the Bien Hoa air base.

"I saw that pilot go by me minutes earlier, then his plane blew up like an atom bomb. There was fire and noise, stuff cooking off the plane," said Flynn, 63.

After the flashback he had a breakdown, and shortly after that he sought help at the VA in West Haven. A doctor there diagnosed him with PTSD and prescribed a cocktail of pharmaceuticals to ease his depression, panic attacks and insomnia.

The explosion is recorded in the history of Flynn's Air Force unit. But VA personnel trained to search military archives can't find a record of his service in Vietnam.

Flynn says he flew from California for duty in Vietnam in August 1966 and remained there until October before moving to his permanent assignment in Korat, Thailand. The VA says his service records place him only in Thailand.

Last year, seeking a buddy letter to prove he was at the air base, Flynn placed an announcement in the Vietnam Veterans of America magazine.

Hurbert Bradshaw in California responded to Flynn's post. He says he served with Flynn in the 6234 Tactical Fighter Wing in Vietnam and wrote the VA that Flynn was in Vietnam with him.

"I met [Flynn] in Bien Hoa, that's why I wrote the letter," Bradshaw said.

The VA denied Flynn's claim, despite the letter. He is on his third appeal.

"This has been really painful. Every time I have to appeal, I have to reconstruct the stressors, all the things that I buried are coming back, the memories, the nightmares," Flynn said.

He wonders how long he can battle the government, a quest, he said, that has strained his 37-year marriage. He no longer works and relies on VA health benefits. He attends a PTSD group therapy session at the VA every Thursday.

"Is there anything else I missed, anybody I need to contact? Maybe there is a second person? I don't know what to do," Flynn said.

Fixing The Process

Veterans groups have lobbied the VA to modernize the PTSD claims process, and there are efforts in Congress to eliminate the rule that requires proof of an in-service stressor. Now, unless a veteran received a Combat Infantryman Badge or Purple Heart, their stressor must be documented.

U.S. Rep. Tom Allen, D–Maine, introduced legislation in Congress this year that would eliminate the need for veterans to prove a stressor to receive disability compensation for PTSD.

"What these guys experienced transcends military records," Allen said. "We owe it to them. We shouldn't deny them benefits and treatments on a technicality."

Under Allen's Full Faith in Veterans Act of 2008, a diagnosis of PTSD by a mental healthcare professional who establishes a logical relationship between exposure to military stressors and current PTSD symptoms is enough to prove that the PTSD is service connected.

At a press conference earlier this year, Allen told a group of veterans that his father was the inspiration behind the bill. His father volunteered for the Navy after Pearl Harbor, working control towers on air bases in the South Pacific. The towers were bombed nightly.

But what affected Allen's father the most were the pilots who never returned from missions.

"My father never told me a lot about what happened to him during the war, but I know that when he came back he had what today would be diagnosed as PTSD," Allen said.

Allen said the VA system needs to be overhauled to deal with the impending flood of PTSD claims from those serving in Iraq and Afghanistan. A recent study conducted by the RAND Corporation found that one in every five soldiers, or 300,000 troops of the estimated 1.7 million who have been deployed to Iraq and Afghanistan, have depression and some sign of PTSD.

"There are no frontlines in Iraq, and we are going to have the lingering effects of PTSD for a long time," Allen said.

Aaron Entrekin, a Vietnam veteran from Tennessee, said he drank himself through two wives and countless jobs before seeking help at the local VA hospital. Doctors there diagnosed him with PTSD in 2001, but he hasn't found anyone to confirm his stressor.

Entrekin said he ran over a Vietnamese boy while driving a truck in a convoy heading south from Da Nang. He doesn't remember the exact year; 1970 or 1971, he guesses. But he'll never forget the boy's face.

"His dad was holding him in his arms. I see him every night in my dreams and when I close my eyes," Entrekin said. "He was trying to cry, he was bleeding out of his mouth, nose and ears."

Entrekin wanted to take the boy to the hospital.

His lieutenant ordered him to keep driving.

The U.S. Army has no record of the accident. The VA has denied his claim three times.

His announcement in the Vietnam veterans magazine in search of a buddy letter reads, "They called me Slim or Hillbilly." Entrekin hopes the nicknames will jar the memory of someone who served with him in the U.S. Army's 25th Infantry Division 18th Engineer Brigade.

"If you ain't got a Purple Heart, they don't want to help you," he said. "There are a lot of bad things that happened to people in Vietnam who didn't get a Purple Heart."

Prepared Statement of Judith A. Salerno, M.D., MS,
Executive Officer, Institute of Medicine of the National Academies

Chairman Hall asked the Institute of Medicine (IOM) of the National Academies to provide testimony regarding several bills under consideration by the Subcommittee. In response, we have prepared this testimony on issues raised in these bills that are addressed by recent IOM reports.

My name is Dr. Judith Salerno and I am the Executive Officer of the Institute of Medicine. I serve as IOM's chief operating officer and executive director of the Institute, and am responsible for managing IOM's research programs. My past work includes positions at the Department of Veterans Affairs (VA), where I directed the continuum of VA's Geriatrics and Extended Care programs across the country. I also previously served as Associate Chief of Staff at the VA Medical Center in Washington, D.C., where I coordinated clinical services for older veterans. I am honored to have had the opportunity to serve veterans for 9 years in these capacities.

The reports I will be discussing today were written by committees of experts convened under the auspices of the Institute of Medicine. IOM was created in 1970 as a component of the National Academy of Sciences, which was chartered by Congress in 1863. The National Academies' role is to provide independent, non-partisan, evidence-based advice to the Government and the Nation. As an independent voice, we neither support nor oppose the legislation under discussion at today's hearing.

I will address provisions in seven of the bills that touch on topics covered in IOM reports.

H.R. 1197: Prisoner of War Benefits Act of 2007

H.R. 1197 addresses issues related to the establishment of presumptions of service connection. The 2008 IOM report *Improving the Presumptive Disability Decision-Making Process for Veterans* describes the current process for making presumptive decisions for veterans who have health conditions arising during military service and proposes a scientific framework for making such decisions in the future. The report was requested by the Congressionally constituted Veterans' Disability Benefits Commission. Its findings and recommendations were previously delivered to the Subcommittee in testimony presented on February 26, 2008 by Jonathan M. Samet, MD, MS, and, in the interest of brevity, won't be repeated here. H.R. 3795, 5454, 5954, and 6032—which also deal with presumptions of service connection—are discussed below.

H.R. 3795: You Were There, You Get Care Act of 2007

H.R. 3795 would add a presumption of radiation exposure for the purpose of service connection for veterans of the 1991 Persian Gulf War and subsequent conflicts in that theatre. The bill also calls for an independent study to determine diseases that may result from exposure to depleted uranium.

In 1998, VA asked the IOM to convene a committee and to evaluate the scientific literature regarding potential health effects from exposure to depleted uranium. The committee's report—*Gulf War and Health: Volume 1. Depleted Uranium, Pyridostigmine Bromide, Sarin, and Vaccines*—was released in 2000. It concluded that there was inadequate or insufficient evidence to determine whether an association exists between uranium exposure and 14 health outcomes—lymphatic cancer, bone cancer, nervous system disease, reproductive or developmental dysfunction, nonmalignant respiratory disease, gastrointestinal disease, immune-mediated disease, effects on hematologic measures, genotoxic effects, cardiovascular effects, hepatic disease, dermal effects, ocular effects, and musculoskeletal effects. The committee also con-

cluded that there was limited or suggestive evidence of no association between uranium and clinically significant renal dysfunction and between uranium and lung cancer at cumulative internal doses lower than 200 mSv.

IOM is preparing an update of this report, which will include reviews of new scientific literature available since publication of the 2000 report. This update is expected to be released in the fall of 2008. In addition, the IOM has been asked by the Department of Defense to determine if it is feasible to conduct an epidemiological study of veterans who were exposed to depleted uranium while on active duty. A report addressing this question will be released later this year.

H.R. 5448: Full Faith in Veterans Act of 2008

H.R. 5448 includes provisions that instruct the VA to update the rating criteria used to evaluate Post Traumatic Stress Disorder (PTSD) for compensation purposes and to create a training and certification program for the employees who perform the ratings.

In June 2007, a committee convened by the IOM at the request of the VA completed a report entitled *PTSD Compensation and Military Service*. The committee's review identified several areas where changes in current practice might result in more consistent and accurate ratings for disability associated with PTSD. Such ratings are performed by VA raters using information gathered in a compensation and pension examination and criteria set forward in the Schedule for Rating Disabilities. Currently, the same set of criteria is used for rating all mental disorders. They emphasize symptoms from schizophrenia, mood, and anxiety disorders. The committee found that these criteria are at best a crude and overly general instrument for the assessment of PTSD disability. It recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommended that VA establish a certification program specifically for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. Rater certification should foster greater confidence in ratings decisions and in the decisionmaking process.

H.R. 5454: To amend title 38, United States Code, to establish a presumption of service connection of amyotrophic lateral sclerosis for purposes of the laws administered by the Secretary of Veterans Affairs

H.R. 5454 would establish a presumption of service connection for ALS. The available research on ALS in veterans was evaluated in an IOM study requested by the VA that resulted in the 2006 report *Amyotrophic Lateral Sclerosis in Veterans: Review of the Scientific Literature*. Only five studies on this topic were identified. The committee charged with performing the review found that there was limited or suggestive evidence of an association between military service and development of ALS. It recommended that additional studies on the relationship between military service and ALS be conducted and that, in addition, research was needed to explore what might be causing ALS among veterans: for example, involvement in traumatic events, intensive physical activity, or chemicals or other substances or activities that might be encountered during military service.

H.R. 5709: Veterans Disability Fairness Act

H.R. 5709 would require the Secretary of the Department of Veterans Affairs to perform annual reviews of the accuracy and consistency of decisions on disability compensation and take those results into account in reviewing the performance of Veterans Benefit Administration and Board of Veterans Appeals adjudicators. The June 2007 IOM report *A 21st Century System for Evaluating Veterans for Disability Benefits* found that VA's quality assurance effort has improved the accuracy of disability benefit decisions from less than 60 percent in 2000 to 88 percent in 2006, which is commendable but still leaves considerable room for improvement. This report was requested by the Veterans' Disability Benefits Commission.

The *21st Century System* report also found that VA's quality assurance system did not address consistency of decisions across VA's 58 field offices. The report recommended ongoing or periodic evaluations of inter-rater reliability as well as the accuracy and validity of ratings across field offices and impairment categories (Recommendation 5–4). The report similarly recommended periodic assessment of the inter-rater reliability of the disability examinations performed by the Veterans Health Administration, which are a key input to the disability determination process (Recommendation 5–3). It should be noted, however, that the report stated that

variability cannot be totally eliminated in evaluating most disabling conditions, because there will always be conditions with significant subjective elements such as mental disorders and back and joint pain. The report, therefore, emphasized using quality assurance results to improve the controllable elements of the decisions making system, for example, by revising guidelines, training, and/or rater qualifications and performance standards. It should also be noted that the main finding of the *21st Century System* report was that the VA Schedule for Rating Disabilities is badly out of date for certain body systems such as musculoskeletal disorders, thereby hindering raters from providing accurate assessments of veterans' disabilities. The report recommended that VA immediately update the Rating Schedule using current medical knowledge, which should itself improve the accuracy and consistency of rating decisions.

H.R. 5954: To amend title 38, United States Code, to provide veterans for presumptions of service connection for purposes of benefits under laws administered by Secretary of Veterans Affairs for diseases associated with service in the Armed Forces and exposure to biological, chemical, or other toxic agents as part of Project 112, and for other purposes.

H.R. 5954 establishes a mechanism for determining presumptive service connections for diseases that could be related to participation in Project 112, which included an effort referred to as Project SHAD. The 2007 IOM report *Long-Term Health Effects of Participation in Project SHAD (Shipboard Hazard and Defense)*, which was requested by the VA, found no clear evidence that specific long-term health effects were associated with participation in Project SHAD. The IOM study compared the health of veterans who participated in SHAD with the health of a similar group of veterans who did not participate. Although more SHAD veterans have died of heart disease, overall mortality rates among both groups of veterans were similar. Moreover, the differences in the rates of medical symptoms and conditions experienced by each group were generally slight, and the committee responsible for the report found no consistent, specific patterns of ill health among SHAD veterans. However, because of limitations in the study response rates and the size of the study, the report's findings should not be viewed as clear evidence that there are no possible long-term health effects related to SHAD involvement. Additionally, there have been very few hypotheses about specific health problems that could be related to the materials used in the SHAD tests to serve as a starting point for further investigation.

H.R. 6032: To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to provide wartime disability compensation for certain veterans with Parkinson's disease.

The IOM has convened several committees under a mandate contained in the Agent Orange Act 1991 (Public Law 102–4), charged with evaluating the scientific evidence regarding associations between diseases and exposure to dioxin and other chemical compounds in herbicides applied during the Vietnam War. These committees have produced a series of reports on the topic, the most recent of which is *Veterans and Agent Orange: Update 2006*. Their work is supported under a contract with the VA.

One health outcome examined in these reports is Parkinson's disease. The committee responsible for *Update 2006* found that the evidence is inadequate or insufficient to determine whether there is or is not an association between Parkinson's disease and exposure to the herbicides used in Vietnam and their contaminants. Several studies have reported associations of Parkinson's disease with exposure to "pesticides" or to "herbicides" in general, but none yet reviewed have established a relationship with the specific herbicides sprayed in during the war. This condition continues to be of great interest to the committee and the latest research on the topic will be a subject of the next update, which will be released in 2009.

The reports discussed here addressed a number of other topics related to veterans health and disability policy and also reached a series of other recommendations regarding these topics. The National Academies would be pleased to provide Members of the Subcommittee with hard copies of these reports upon request. The reports are also freely accessible online at the URLs listed in the references below.

Thank you for the opportunity to present this testimony before the Subcommittee today. I would be happy to address any questions you may have.

Institute of Medicine reports cited in this testimony

A 21st century System for Evaluating Veterans for Disability Benefits. (2007). http://www.nap.edu/catalog.php?record_id=11885.

Amyotrophic Lateral Sclerosis in Veterans: Review of the Scientific Literature. (2006). http://www.nap.edu/catalog.php?record_id=11757.

Gulf War and Health: Volume 1. Depleted Uranium, Pyridostigmine Bromide, Sarin, and Vaccines (2000). http://www.nap.edu/catalog.php?record_id=9953.

Improving the Presumptive Disability Decision-Making Process for Veterans. (2008). http://www.nap.edu/catalog.php?record_id=11908.

Long-Term Health Effects of Participation in Project SHAD (Shipboard Hazard and Defense). (2007). http://www.nap.edu/catalog.php?record_id=11900.

PTSD Compensation and Military Service. (2007). http://www.nap.edu/catalog.php?record_id=11870.

Veterans and Agent Orange: Update 2006. (2007). http://www.nap.edu/catalog.php?record_id=11906.

Prepared Statement of Sidath Viranga Panangala,
Analyst in Veterans Policy, Congressional Research Service
Library of Congress

Introduction

Chairman Hall, Ranking Member Lamborn, and Members of the Committee, my name is Sidath Panangala, from the Congressional Research Service (CRS). I am accompanied today by Christine Scott, Specialist in Social Policy, and Douglas Weimer, Legislative Attorney, also from CRS. We are honored to appear before the Committee. As requested by the Committee, my testimony will highlight major legislative milestones in the establishment of presumptions of service-connection for veterans' benefits. This is not an exhaustive list of legislation and regulations relating to the establishment of presumptions of service-connection.[1] CRS takes no position on any legislation that is under discussion today.

Compensation for Service-Connected Disabilities

In general, a veteran is entitled to compensation for disabilities incurred in or aggravated during active military, naval or air service.[2] Currently, there are five ways to establish that a disability is service-connected:

1. Through direct service-connection—that is, the facts, shown by evidence, establish that a particular injury or disease resulting in a disability was incurred while in service in the Armed Forces (38 CFR § 3.303);
2. Through aggravation during service—that is, a preexisting injury or disease will be considered to have been aggravated while in service in the Armed Forces (38 CFR § 3.306);
3. Through proximity—that is, a disability, which is proximately due to, or the result of a service-connected disease or injury which is considered to be service-connected (38 CFR § 3.310). For example, a veteran developing cardiovascular disease due to a service-connected amputation of a lower limb.
4. Through a finding, the disability was caused by medical care or vocational rehabilitation provided by the Department of Veterans Affairs (VA)—Disabilities caused by VA provided medical care or vocational rehabilitation are treated as if they are service-connected (38 U.S.C. § 1151).
5. Through the application of statutory presumptions—that is certain diseases as established by law or regulation are considered to have been incurred in or aggravated by service in the Armed Forces even though there is no evidence of such disease during the period of service (38 CFR § 3.307);

Today I will discuss the history of this fifth mechanism, the establishment of statutory presumptions.

What is a Presumption?

In the context of VA claims adjudication, a presumption could be seen as a procedure to relieve veterans of the burden to prove that a disability or illness was caused by a specific exposure that occurred during service in the Armed Forces. In other words, a presumption shifts the burden of proof concerning whether a disease

[1] For a detailed legislative and regulatory history of presumptions see the following: National Academy of Sciences, Institute of Medicine (IOM), *Improving the Presumptive Disability Decision-Making Process for Veterans* (2008); Zeglin, Donald, "Presumptions of Service Connection", paper prepared for the Veterans' Disability Benefits Commission (VDBC) (March, 2006); and Department of Veterans Affairs (VA), "Analysis of Presumptions of Service Connection," a report to Senate Committee on Veterans' Affairs, December 23, 1993.

[2] 38 U.S.C. § 1110.

or disability was caused or aggravated due to service, from the veteran to the VA. Often presumptions are applied to chronic diseases or illnesses that manifest after a period of time (sometimes many years) following service, and that may also occur in individuals who have never served. According to the VA's *Analysis of Presumptions of Service Connection:*

> Generally, a legal presumption is a procedural device that shifts the burden of proof by attaching certain consequences to the establishment of certain basic evidentiary facts. When the party invoking a presumption establishes the basic fact(s) giving rise to the presumption, the burden of proof shifts to the other party to prove nonexistence of the presumed fact. A presumption, as used in the law of evidence, is a direction that if fact A (e.g., manifestation within the specified period of a disease for which a presumption of service connection is available) is established, then fact B (service connection) may be taken as established, even where there is no specific evidence proving fact B (i.e., no medical evidence of a connection between the veteran's disease and the veteran's military service).[3]

Legislative History of Presumptions

The legislative history of veterans' disease presumptions dates back to 1921 when Congress, to ease the disability decisionmaking process in VA disability compensation adjudications, used its authority to establish service-connection on a presumptive basis. Given below is a synopsis of major legislation.

1920s–1940s

The first legislation that specifically established a presumption of service-connection was the amendment of August 9, 1921 (P.L. 67–47) to the War Risk Insurance Act (P.L. 63–193). This Act, among other things, established presumptions of service-connection for active pulmonary tuberculosis and neuropsychiatric disease (later known as psychosis) occurring within 2 years of separation from active duty military service. Prior to the passage of P.L. 67–47, disability compensation for World War I veterans was payable only for a disability directly related to military service. Broadly, the intent of this liberalization legislation was that "as the period beginning with the end of the war lengthened it became increasingly difficult to establish service-connection for some ailments particularly tuberculosis and neuropsychiatric disease."[4] The amendments to the War Risk Insurance Act also gave the then Veterans Bureau, authority to establish rules and regulations to carry out provisions in the Act. This allowed the agency to promulgate regulations establishing presumption of service-connection for certain diseases. As stated in VA's *Analysis of Presumptions of Service Connection:*

> Regulation No. 11 provided that chronic constitutional diseases, other than active pulmonary tuberculosis or neuropsychiatric disease, becoming manifest within 1 year following the date of separation from active service would be considered as incurred in service or aggravated by service unless there were affirmative evidence to the contrary or evidence establishing that some intercurrent disease or injury which is a recognized cause of the disorder was suffered between the date of separation from service and the onset of the chronic disease.[5]

The next major piece of legislation that established presumptions of service-connection was the World War Veterans Act of 1924 (P.L. 68–242) enacted on June 7, 1924. This Act made important changes to existing laws on presumptions related to tuberculosis and mental illness. Among other things, this Act added the following three diseases to the list of presumptive diseases: dysentery (amebic) (tropical disease added as chronic disease); paralysis agitans (now known as Parkinson's disease); encephalitis lethargica. Furthermore, this Act removed requirements that a veteran must show diagnosis by a medical examination conducted by a medical officer of the then Veterans Bureau or duly qualified physician within the presumptive period. "This provision alone brought within the purview of the legislation thou-

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[3] Department of Veterans Affairs (VA), "Analysis of Presumptions of Service Connection" a report to the Senate Committee on Veterans' Affairs, December 23, 1993, p. i.

[4] U.S. Congress, House Committee on Veterans Affairs, *The Provision of Federal Benefits for Veterans, An Historical Analysis of Major Veterans Legislation, 1862–1954*, committee print, 84th Cong., 1st sess., House Committee Print No 171, December 28, 1955 (Washington: GPO, 1955), p. 21.

[5] Department of Veterans Affairs (VA), "Analysis of Presumptions of Service Connection," a report to Senate Committee on Veterans' Affairs, December 23, 1993, p. 10.

sands of veterans who [until then] had been unable to connect their disabilities with the service so as to be eligible for compensation and [medical care]."[6]

Between the passage of the World War Veterans Act of 1924 and P.L. 80–748 several additions were made to the list of presumptive diseases through regulation and executive order. More significantly, the chronic disease category was significantly expanded through the enactment of P.L. 80–748 on June 24, 1948.

1950s–1980s

With the passage of the Veterans Benefits Act of 1957 (P.L. 85–56), Congress codified the existing list of presumptions and expanded this list by incorporating various presumptions of chronic diseases and disease categories that had been established by regulation and were in effect at that time. By the time P.L. 85–56 was enacted on June 17, 1957, there were forty chronic diseases or disease categories and seventeen tropical diseases that were presumptively service-connected. The sixties did not see any significant legislative or regulatory changes affecting presumptions of service-connection.

The next major legislative change occurred with the enactment of P.L. 91–376 in August 1970. This law established a presumption of service-connection for seven categories of diseases and conditions for any veteran held as a Prisoner of War (POW) in World War II, the Korean conflict, or the Vietnam War, and who suffered from dietary deficiencies, forced labor, or inhumane treatment in violation of the terms of the Geneva Conventions of July 27, 1929, and August 12, 1949.

In August 1981, Congress passed the Former Prisoner of War Benefits Act of 1981 (P.L. 97–37). This Act, among other things, modified the list of statutory presumptions associated with POW status and also changed the presumptive period for eligibility. The Veterans' Compensation and Program Improvements Amendments of 1984 (P.L. 98–223); the Veterans' Benefits Improvements and Healthcare Authorization Act of 1986 (P.L. 99–576); and the Veterans' Benefits and Services Act of 1988 (P.L. 100–322) expanded the list of diseases in former POWs for which a presumption of service-connection was made. Prior to the passage of the Veterans' Healthcare, Training and Small Business Loan Act of 1981 (P.L. 97–72), veterans who complained of Agent Orange-related illnesses were at the lowest priority for treatment at VA medical facilities because these conditions were not considered service-connected. P.L. 97–72 elevated Vietnam veterans' priority status for healthcare at VA facilities by recognizing a veteran's own report of exposure as sufficient proof to receive medical care unless there was evidence to the contrary.

After taking into consideration the "apprehension and concern among some Vietnam veterans and their families . . . to the alleged ill-health effects among some Vietnam veterans . . . to exposure to the dioxin in Agent Orange,"[7] Congress passed the Veterans' Dioxin and Radiation Exposure Compensation Standards Act of 1984 (P.L. 98–542). The Act required the VA to develop regulations for disability compensation for Vietnam veterans exposed to Agent Orange.[8] Veterans seeking compensation for a condition they thought to be related to herbicide exposure had to provide proof of a service-connection that established the link between the exposure and the disease onset. P.L. 98–542 also authorized disability compensation payments to Vietnam veterans for the skin condition chloracne, which is associated with herbicide exposure. This law also established a program to provide disability compensation to radiation-exposed veterans who participated in the U.S. atmospheric atomic tests or in the U.S. occupation of Hiroshima and Nagasaki, Japan.

In response to atomic veterans' complaints about the difficulty of getting compensation under P.L. 98–542, Congress in 1988 enacted the Radiation-Exposed Veterans' Compensation Act (P.L. 100–321) which established a presumption of a serv-

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[6] U.S. Congress, House Committee on Veterans Affairs, The Provision of Federal Benefits for Veterans, An Historical Analysis of Major Veterans Legislation, 1862–1954, Committee print, 84th Cong., 1st sess., House Committee Print No. 171, December 28, 1955 (Washington: GPO, 1955), p. 23.

[7] U.S. Congress, House Committee on Veterans' Affairs, Veterans' Dioxin and Radiation Exposure Compensation Standards Act. Report to Accompany H.R. 1961, 98th Congress, 2nd sess., H.Rept. 98–592.

[8] Between 1962 and 1971, the U.S. Air Force sprayed approximately 107 million pounds of herbicides in South Vietnam for the purpose of defoliation and crop destruction. The herbicides sprayed during the Vietnam era contained mixtures of 2,4-dichlorophenoxyacetic acid (2,4-D), 2,4,5-trichlorophenoxyacetic acid (2,4,5-T), picloram, and cacodylic acid. The most extensively used defoliant compound, a 50:50 combination of 2,4-D and 2,4,5–T, came to be known as "Agent Orange" because of the orange-colored band placed on each chemical storage container. For further information see CRS Report, RL34370, *Veterans Affairs: Healthcare and Benefits for Veterans Exposed to Agent Orange*, by Sidath Viranga Panangala.

ice connection for 13 specified types of cancer. That list was subsequently expanded, first by legislation, later through VA administrative action, to 21 cancers.[9]

1990s–2000

In 1991, the Agent Orange Act (P.L. 102–4) established for the first time a presumption of service connection for diseases associated with herbicide exposure. Under the Agent Orange Act, veterans seeking disability compensation for diseases they thought to be associated with herbicides no longer were required to provide proof of exposure. P.L. 102–4 authorized the VA to contract with the Institute of Medicine (IOM) of the National Academy of Sciences (NAS) to conduct a scientific review of the evidence linking certain medical conditions to herbicide exposure. For the first time the Act established a new process establishing presumptive service-connection for illnesses related to herbicide exposure. According to an article published in the *Journal of Law and Policy:* "The [IOM] process has become an essential step in ensuring that new service-connection presumptions command scientific credibility."[10]

The Veterans' Radiation Exposure Amendments of 1992 (P.L. 102–578) amended P.L. 100–321 by adding two more cancers to the presumptive list. This was based on the "Biological Effects of Ionizing Radiation V" (BEIR V) report by the National Academy of Sciences (NAS).[11] This law also repealed the disability compensation requirement that diseases suffered by radiation-exposed veterans must be manifested within 40 years of exposure.

In November 1994, Congress enacted the Persian Gulf War Veterans' Benefits Act (P.L. 103–446), allowing the VA to pay compensation benefits to veterans for Gulf War-related disabilities caused by undiagnosed illnesses. This Act also codified VA's regulatory presumptions based on exposure to herbicides for these types of cancer: Hodgkin's disease, multiple myeloma, and respiratory cancers; and porphyria cutanea tarda, a metabolic disease (must occur within 1 year of exposure).

In 1998, Congress enacted the Persian Gulf War Veterans Act of 1998 (P.L. 105–277), and the Veterans Programs Enhancement Act 1998, (P.L. 105–368). Similar to the Agent Orange presumptive program, these laws mandated regular and thorough reviews of the scientific and medical literature relevant to the health of Gulf War veterans by the IOM.

The Veterans Education and Benefits Expansion Act of 2001 (P.L. 107–103) expanded the definition of "qualifying chronic disability" to include a "medically unexplained chronic multisymptom illness (such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome) that is defined by a cluster of signs or symptoms."[12] Further more, the Veterans Benefits Act of 2003 (P.L. 108–183) provided a presumption of service-connection for cold weather injuries, traumatic arthritis, and certain psychiatric disabilities in former POWs, without regard to length of internment.

With passage of the National Defense Authorization Act, FY2008 (P.L. 110–181), Congress established a presumption of service-connection for purposes of VA medical care for any veteran of the Persian Gulf War who develops an active mental illness (other than psychosis) if such veteran develops such disability: (1) within 2 years after discharge or release from the active military, naval, or air service; and (2) before the end of the 2-year period beginning on the last day of the Persian Gulf War.[13]

Institute of Medicine Study on Presumptive Disability Decision-Making

Since an "increasing proportion of service-connected disability compensation is paid through a presumptive decisionmaking process,"[14] the Veterans' Disability Benefits Commission (VDBC) in 2006, requested the IOM, to provide a framework

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[9] For further information see CRS Report, RL33927, *Selected Federal Compensation Programs for Physical Injury or Death*, by Sarah A. Lister and C. Stephen Redhead.

[10] Brown, Mark, "The Role of Science in Department of Veterans Affairs Disability Compensation Policies for Environmental and Occupational Illnesses and Injuries," *Journal of Law and Policy*, vol 13, (2005).

[11] Committee on the Biological Effects of Ionizing Radiation (BEIR), National Research Council, is part of the National Academy of Sciences.

[12] Subsection 202 (a) of the Veterans Education and Benefits Expansion Act of 2001 (P.L. 107–103), December 27, 2001.

[13] The term "Persian Gulf War" means the period beginning on August 2, 1990, and ending on the date thereafter prescribed by Presidential proclamation or by law (38 U.S.C. § 101 (33)).

[14] *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century*, Report of the Veterans Disability Benefits Commission, (October 2007), p. 153. The Commission was established by the National Defense Authorization Act for FY2004 (P.L. 108–136).

on how future presumptions should be made based on scientific principles.[15] In 2007, the IOM made several recommendations—which the VDBC generally endorsed—which would, among other things, create an advisory Committee and a scientific review board. The advisory Committee "would consider, and give priority to the exposures and health conditions proposed for possible presumptive evaluation" while the "science review board, an independent body, would evaluate the strength of the evidence (based on causation) that links a health condition to a military exposure."[16] Next, the independent science review board's report and recommendations would go to VA for its consideration and implementation.[17]

Conclusion

Since 1921, Congress has established numerous presumptions of service connection for a variety of health conditions affecting veterans. In establishing these presumptions, Congress and others have sought to balance the dual obligations of the VA, to provide care for veterans who were harmed by their service, and to do so in a manner that is equitable, scientifically sound, and accountable.

Prepared Statement of Les Jackson, Executive Director, American Ex-Prisoners of War

Chairman Hall, Distinguished Members of the Subcommittee on Disability Assistance & Memorial Affairs, and Guests. Thank you for inviting us to participate in your legislative hearings on several bills now pending in the House Committee on Veterans Affairs. We will confine our remarks to H.R. 1197 Improved Veterans' Benefits for Former Prisoners of War.

Ninety nine percent of former Prisoners of War are from WWII and Korea and are now living in their sunset years. We are grateful that Congress has through the years provided benefits for former Prisoners of War where it has been determined that the causal effect of an injury or illness is from the captive experience.

For more than 50 years the National Academy of Sciences has been conducting scientific research to identify medical conditions that, beyond any doubt, are the direct consequences of the brutal conditions of captivity.

There are two medical conditions cited that still deserve presumptive status. These are osteoporosis and diabetes. Osteoporosis is bone loss attributed to starvation during captivity. Similarly, diabetes is the result of prolonged stress and permanent damage to the body's basic defense system as a result of months and years of grossly inadequate diet as a Prisoner of War.

These two proposed presumptives have again been introduced by Representative Gus Bilirakis (R–FL). We are deeply thankful to him and strongly urge your committee's support by codifying these two conditions into law without further delay.

Also, very important to former Prisoners of War and their survivors is H.R. 156, to amend 38, U.S. Code, to provide for the payment of DIC to survivors of former POWs who died before September 30, 1999, with the same eligibility as applied to payment of DIC to Survivors of former POWs who die after that date. This will be of great financial aid to the surviving spouses of POWs. Thank you.

Prepared Statement of Steve Smithson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the bills being considered by the Subcommittee today. The American Legion commends the Subcommittee for holding this hearing.

H.R. 1197, Prisoner of War Benefits Act of 2007

The purpose of this bill is to amend title 38, United States Code, (U.S.C.) to provide improved benefits for veterans who are former prisoners of war.

Specifically, this bill would repeal the current requirement in title 38 U.S.C. that an individual had to have been detained or interned for a period of not less than

[15] Ibid. p. 17.

[16] National Academy of Sciences, the Institute of Medicine (IOM), *Improving the Presumptive Disability Decision-Making Process for Veterans* (2008), p. 3.

[17] Ibid. p.18.

30 days in order to be entitled to presumptive service connection for certain Prisoner of War (POW) diseases. It would also expand the list of POW diseases presumed to be service-connected, currently set forth in title 38, U.S.C., section 1112(b), to include diabetes type 2 and osteoporosis. The legislation would also specifically authorize the Secretary of Veterans Affairs to create regulations adding or deleting diseases enumerated in section 1112(b), on the basis of sound medical and scientific evidence, to include recommendations from The Department of Veterans Affairs' (VA's) Advisory Committee on Former Prisoners of War.

The issue of the welfare and well-being of those veterans who have endured the hardship and trauma of being held as a POW has long been one of the major concerns of The American Legion. To ensure that the government of the United States fulfills its obligation to these brave men and women, The American Legion has actively supported improvements in benefits provided to these individuals and their survivors. We are pleased to support the addition of the two conditions, specified in this bill, to the list of those currently presumed to be service-connected. It is hoped this legislation will provide the impetus for continuing action to further broaden the list of presumptive diseases and disabilities, from which former POWs are known to suffer. Toward this end, we are encouraged that the bill recognizes and emphasizes the important role played by VA's Advisory Committee on Former Prisoners of War. This group of esteemed individuals, many of who, are themselves former POWs, provide the necessary mechanism and forum to evaluate scientific and medical studies on former POWs to make appropriate recommendations to the Secretary regarding needed changes in VA's outreach, benefits, and medical care program for this community of veterans.

Additionally, The American Legion has long supported the elimination of the arbitrary 30-day requirement for internment. Studies have shown there can be long-lasting, adverse health effects resulting from even a relatively short period of confinement as a prisoner of war. Such findings are especially important considering the nature of today's warfare and the rather short period of confinement most American POWs have faced during the post-Vietnam era.

This legislation represents a solid step toward ensuring former POWs receive the compensation and medical care to which they are clearly entitled. However, in addition to those diseases that would be presumed service-connected, The American Legion recommends that the list also include chronic pulmonary disease, where there is a history of forced labor in mines during captivity, and generalized osteoarthritis, as differentiated from the currently listed disability of post traumatic osteoarthritis.

H.R. 3008, Rural Veterans Services Outreach and Training Act

The purpose of this bill is to amend title 38, U.S.C., to improve services for veterans residing in rural areas. Specifically, this bill would establish a competitive grant program to provide financial assistance to state entities for veterans' affairs for the training of rural county veteran service officers in order to improve outreach and assistance to veterans, their spouses, children and parents, who may be eligible to receive benefits under the laws administered by the Secretary of Veterans Affairs, and to ensure that such individuals are fully informed about, and assisted in applying for, any benefits and programs under such laws.

Providing proper outreach and assistance to the Nation's veterans, has been, and will continue to be, a top priority of The American Legion. Although we do not have an official position, in the form of a resolution adopted by our membership, specifically addressing a grant program for such purposes, as proposed in this legislation, we would not oppose the Committee's favorable consideration of this bill.

H.R. 3070, Disabled Veterans' Caregiver Compensation Act

The purpose of this bill is to amend title 38, U.S.C., to authorize additional compensation to be paid to certain veterans in receipt of compensation for a service-connected disability rated totally disabling for whom a family member dependent on the veteran for support provides care.

As written, this bill would provide additional compensation in the amount of $234 per month to totally disabled service-connected veterans in need of regular aid and attendance only where the veteran is being taken care of by an adult family member who is dependent upon the veteran for support. It should be noted that veterans who are permanently disabled and in need of aid and attendance already receive an additional $618 per month (SMC L pays $3,145) over the 100-percent rate ($2,527). Therefore, this bill will raise the monthly benefit amount for this subset of veterans from $3,145 to $3,379.

The additional money paid to veterans, who need aid and attendance, is intended, in part, to help veterans who require aid and attendance to hire people who could provide care. Obviously, this bill contemplates that the veteran could use the addi-

tional $234 to compensate the adult family member who is taking care of the veteran. It is unclear why this additional amount would be provided as separate from the regular aid and attendance benefit because the purpose of the aid and attendance benefit is to pay for such care as addressed in this bill. It is also unclear as to how VA will determine who qualifies as a family member dependent on the veteran for support. This being the case, The American Legion would support an increase in the overall aid and attendance benefit rather than a separate payment as set forth in this bill.

H.R. 3795, You Were There, You Get Care Act of 2007

The purpose of this bill is to amend title 38, U.S.C., to provide that veterans of service in the 1991 Persian Gulf War and subsequent conflicts shall be considered to be radiation-exposed veterans for the purposes of the service connection of certain diseases and disabilities, and for other purposes.

Depleted Uranium (DU) munitions were widely used in the Southwest Asia theater of operations during the 1991 Gulf War and have been used extensively in military operations since then, including the current conflicts in Iraq and Afghanistan. As a result, there have been thousands of military personnel exposed to DU fallout from these munitions, including some with retained shell fragments due to "friendly fire" incidents. The American Legion supports the intent of this bill. The American Legion recognizes the potentially harmful effect of DU exposure. This legislation would provide for the presumption of service connection for diseases associated with such exposure for those suffering from such a disease who served in the 1991 Gulf War and any subsequent conflict where DU munitions were used. This legislation would also include service in the theater of operations of that war or conflict or involved the clean-up or servicing of vehicles or equipment that had been used in such a theater of operations.

H.R. 4274, Gold Star Parents Annuity Act of 2007

The purpose of this bill is to amend title 38, U.S.C., to provide for the payment of a monthly stipend to the surviving parents (known as Gold Star parents) of members of the Armed Forces who die during a period of war.

The American Legion does not have a position on this legislation.

H.R. 5155, Combat Veterans Debt Elimination Act of 2008

The purpose of this bill is to amend title 38, U.S.C., to prohibit the Secretary of Veterans Affairs from collecting certain debts to the United States in the case of veterans who die as a result of a service-connected disability incurred or aggravated on active duty in a combat zone, and for other purposes.

Although we agree with the intent of this bill, the legislation contains limitations and restrictions we do not support. The American Legion supports prohibiting the collection of debts in the case of any veteran who dies as a result of a service-connected disability, not just those who die of a service-connected disability incurred or aggravated while serving in a theater of combat operations or in combat against a hostile force during a period of hostilities.

A veteran's death due to a service-connected disability not related to combat is no less tragic for the veteran's family than a death due to a combat-related service-connected condition and we see no justification in making such a distinction. This bill also leaves it up to the discretion of the VA Secretary to determine if termination of collection of the debt is in the best interest of the United States and does not set forth any standards or criteria that must be met in determining whether or not termination of collection is in the best interest of the United States.

Unfortunately, such vagueness will likely result in a restrictive interpretation which will, in turn, limit the beneficial impact that was obviously intended. The American Legion also has concerns over the exclusion of debts involving housing and small business benefit programs from the prohibition of collection.

H.R. 5448, Full Faith in Veterans Act of 2008

The purpose of this bill is to amend title 38, U.S.C., to improve the disability compensation evaluation procedure of the Secretary of Veterans Affairs for veterans with post traumatic stress disorder, to improve the diagnosis and treatment of post traumatic stress disorder by the VA Secretary, and for other purposes.

The American Legion supports the intent of this bill to correct current deficiencies in the service connection and evaluation of post traumatic stress disorder.

H.R. 5454

The purpose of this bill is to amend title 38, U.S.C., to establish a presumption of service connection for amyotrophic lateral sclerosis (ALS) for the purpose of the laws administered by the VA Secretary.

ALS is an insidious disease involving degeneration of the nerve cells in the brain, the brain stem, or spinal cord. ALS is characterized by atrophy and almost always fibrillation of the muscular system of the body. Although the disease was first identified in 1869, we still do not know what causes it or how it can be prevented, effectively treated or cured. ALS in its primary stage is difficult, if not impossible, to diagnose since in this stage the condition may appear to be dormant with little or no progression of symptoms for many years, thus leading the individual and his or her doctor to believe the condition has become arrested and nothing more is done to establish its diagnostic entity.

Specifically, this bill, if enacted, would eliminate the 1-year delimiting period currently in place for the presumptive service connection of ALS, allowing for the presumptive service connection of ALS for veterans diagnosed with the disease anytime after military service. The American Legion fully supports this legislation. In fact, we have formally voiced our concerns over the inadequacy of the current 1 year presumptive period for many years.

The timeliness and appropriateness of this bill is further supported by research in the last several years that has indicated that those who have served in the military are at greater risk of developing ALS than those who never served in the military. Moreover, the Institute of Medicine, in a November 2006 report entitled *Amyotrophic Lateral Sclerosis in Veterans: Review of the Scientific Literature*, concluded that current scientific evidence supports the increased risk of ALS in military veterans.

H.R. 5709, Veterans Disability Fairness Act

The purpose of this bill is to amend title 38, U.S.C., to require the VA Secretary to carry out quality assurance activities with respect to the administration of disability compensation, and for other purposes.

The American Legion supports this bill.

H.R. 5954

The purpose of this bill is to amend title 38, U.S.C., to provide veterans for the presumptions of service connection for purposes of benefits under the laws administered by the VA Secretary for diseases associated with service in the Armed Forces and exposure to biological, chemical, or other toxic agents as part of Project 112, and for other purposes.

The American Legion fully supports this bill as it would put in place the process for establishing presumption of service connection for diseases that have been scientifically associated with exposure to the various agents and chemicals used in Project 112.

H.R. 5985, Compensation for Combat Veterans Act

The purpose of this bill is to amend title 38, U.S.C., to clarify the service treatable as service engaged in combat with the enemy for utilization of non-official evidence for proof of service connection in a combat-related disease or injury.

A bill with a similar intent (H.R. 5892) was recently passed by this Committee. Both Title I of H.R. 5892 and this bill seek to define "engaged in combat with the enemy," under title 38 U.S.C. section 1154(b), in a manner that it is consistent with the realities of combat in today's world.

The American Legion supports the intent of these bills. Unless a veteran was wounded or received a specific combat decoration or badge (such as the Combat Infantryman Badge or Combat Action Ribbon) or award for valor, it is often very difficult to establish that a veteran engaged in combat with the enemy in order to trigger the combat presumptions under title 38, U.S.C., section 1154(b). We must recognize, however, that the very meaning of the term "engaged in combat with the enemy" has taken on a whole new meaning as the nature of warfare in today's world has changed. This is especially true of service in the combat theaters of Iraq and Afghanistan.

Due to the fluidity of the battlefield and the nature of the enemy's tactics, there is no defined frontline or rear (safe) area. Military personnel in non-combat occupations and support roles are subjected to enemy attacks such as mortar fire, sniper fire, and improvised explosive devices (IEDs) just as their counterparts in combat arms-related occupational fields. Unfortunately, such incidents are rarely documented making them extremely difficult to verify.

Servicemembers who received a combat-related badge or award for valor automatically trigger the combat-related presumptions of title 38, U.S.C., section 1154(b), but a clerk riding in a Humvee, who witnessed the carnage of an IED attack on that convoy, doesn't automatically trigger such a presumption and proving that the incident happened or that he or she was involved in the incident, in order

to benefit from the presumption afforded under title 38, U.S.C., section 1154(b), can be extremely time consuming and difficult.

Given the evolving nature of modern warfare, as reflected in the enemy's unconventional tactics in Iraq and Afghanistan, The American Legion is of the opinion that it not only makes sense to clarify the definition of "engaged in combat with the enemy" under title 38, U.S.C. section 1154(b) in order to adapt to the new realities of modern warfare. It is essential that we do so, not just for those serving now, but for those who have served in the past and those who will serve in the future.

H.R. 6032

The purpose of this bill is to amend title 38, U.S.C., to direct the VA Secretary to provide wartime disability compensation for certain veterans with Parkinson's disease.

Specifically, this bill, if enacted, would establish Parkinson's Disease as a presumptive disability associated with Agent Orange/herbicide exposure in Vietnam. The American Legion strongly supports the addition to the presumptive list all conditions that have been scientifically shown to be associated with Agent Orange/herbicide exposure in accordance with provisions set forth in statute.

If Parkinson's Disease does not satisfy such criteria at this time, The American Legion recommends further research to explore the relationship between Parkinson's Disease and exposure to herbicides.

Conclusion

Thank you again, Mr. Chairman, for allowing The American Legion to present comments on these important bills. As always, The American Legion welcomes the opportunity to work closely with you and your colleagues on enactment of legislation in the best interest of America's veterans and their families.

Prepared Statement of John Rowan,
National President, Vietnam Veterans of America

Good morning, Chairman Hall, Ranking Member Lamborn, and other Members of this distinguished Subcommittee. On behalf of the members of Vietnam Veterans of America (VVA), we thank you for the opportunity to appear here today to share our views on several of the bills up for consideration. We ask that our full statement be entered in the record, and I will briefly summarize the most salient points of our statement.

We'd like to begin with **H.R. 5954**, which would provide veterans for presumptions of service connection for purposes of benefits for diseases associated with service in the Armed Forces and exposure to biological, chemical, or other toxic agents as part of Project 112.

We think some background is relevant here. Some 7 years ago, VVA first learned of the then top-secret tests done at the height of the Cold War under the rubric of Project 112. These included the SHAD tests conducted mostly in the waters of the South Pacific as well as on land in Alaska, Hawaii, and several other venues in the United States and Canada; these tests were designed to measure the lethality of biological agents and simulants for agents, e.g., *bacillus globigii* for *bacillus anthraxis*, and the ability of U.S. vessels to repel them. They also included tests of hallucinogens and other pharmacological agents, mostly but not exclusively at Edgewood Arsenal and Fort Detrick. In the former tests, sailors and other military personnel were participants, not test subjects; in the latter tests, military personnel were very definitely the test subjects. Some tests, like the SHAD tests, commenced under Project 112; others, particularly the testing at Edgewood and Detrick, began as far back as 1952.

Thanks to the efforts of Navy veterans like Jack Alderson of California, and John Olsen of Montana, and Norman LaChapelle of Tennessee (although he wasn't always from there), VVA became very interested in the possible long-term health effects of exposure to the agents and simulants that had been tested and the chemical decontaminants that had been used to "clean" ships and tugs after a test, or individual trials in a test, were completed. When we first approached the Department of Defense, we were stonewalled; eventually, DoD owned up to having planned some 134 SHAD tests and having completed 50 of them. We never learned as much as we would have liked to learn about the Edgewood and Detrick tests, in part because of the composition of our Task Force on Project 112/SHAD, which was heavily weighted with SHAD veterans.

We applauded Congressmen Mike Thompson and Denny Rehberg when they introduced H.R. 4952 in the 109th Congress. We applaud them again for introducing H.R. 5954 in this Congress. We endorse H.R. 5954, but with these caveats:

- Because chemical and biological agents are not necessarily toxic, language concerning exposure to "a biological, chemical, or other toxic agent . . ." is not quite correct. Also, if pharmacological products and hallucinogens are not embraced under "biological agents," they must be specified at the risk of inadvertently eliminating from the pool of veterans covered by this act several thousand veterans who were in fact test subjects.
- By essentially covering veterans who served from "approximately 1963," those who participated in tests prior to that year also would not be covered. This would be a miscarriage of justice, inasmuch as testing conducted during the fifties was subsumed under "112" when Secretary of Defense McNamara divvied up the functions of the Department of Defense into some 150 different functions. Covering these veterans does not represent a "fishing expedition." DoD is now maintaining a registry of Project 112 veterans (as well as registries of veterans who participated in lewisite and mustard gas testing during World War II, and veterans who were part of any other tests of chem-bio agents not embraced under Project 112).

VVA supports H.R. 5954, with the noted caveats, because it represents a simple measure of justice. Veterans whose health has been adversely affected by exposures during their military service warrant healthcare and compensation for conditions shown to be positively associated with such exposures.

H.R. 1197, The Prisoner of War Benefits Act of 2007, would repeal the currently required 30-day minimum period of internment prior to the presumption of service connection for certain diseases for purposes of the payment of veterans' disability compensation; it would add diabetes (type 2) and osteoporosis to the diseases already covered.

As with H.R. 5954, veterans (in this case former POWs) would be covered "whenever the Secretary [of Veterans Affairs] determines, on the basis of sound medical and scientific evidence, that a positive association exists" between an experience of military service and the occurrence of a disease in humans. This of course assumes that the Secretary of Veterans Affairs and that bureaucratic structure, including the notoriously anti-veteran bureaucrat's bureaucracy of Office of Management & Budget (OMB), will act in a fair and impartial manner. Often, nothing approximating veteran-friendly or even impartiality is evident. In fact the opposite is more often than not the case.

The flaw in the scenario of looking to the scientific evidence is that quite often the government will not fund the needed research, and all too often there is no reason for others to provide the resources to do such research, so the veteran is left bereft as the government either will not give the veteran access to key information citing "national security" when in fact it is only the desire to escape culpability for damage done to the long term healthcare of veterans, or they will not fund the research needed to prove the case one way or another.

VVA endorses H.R. 1197, even though we recognize that it may be difficult to secure passage because of "PAYGO" rules, unless an appropriate offset can be found. Frankly, the Secretary of Veterans Affairs should immediately seek a full review by the Institute of Medicine (IOM) reading Parkinson's disease. If it turns out that there is too little epidemiological evidence regarding veterans as determined by IOM then the Secretary should be bound to fund such independently conducted research as to be able to provide sufficient evidence that will indicate whether there is evidence of statistical association or not.

H.R. 3008, the Rural Veterans Services Outreach and Training Act, would direct the Secretary of Veterans Affairs to carry out a program to make competitive grants to provide financial assistance to state departments of veterans affairs for the training of rural county veteran service officers in order to improve outreach and assistance to veterans, as well as their spouses, children, and parents, who may be eligible to receive veterans' or veterans-related benefits and who are residing in rural counties.

It is difficult to disagree with the goals of this legislation. However, before VVA can support H.R. 3008, it needs a bit of tweaking.

Veterans service organizations, too, supply veteran service officers to assist veterans and their dependents and survivors in filing claims with the Veterans Benefits Administration. Should not the VSOs, too, therefore, benefit from the largesse of this act? To direct grants of up to $1 million annually exclusively to and for coun-

ty veteran service officers does a disservice to organizations like VVA, DAV, VFW, and the American Legion who provide effective representation to veterans.

Another weakness of this bill is that it does not recognize the reality that some state and county service officers do not provide representation before the Board of Veterans' Appeals, and other organizations, e.g., VSOs, will not take on the cases of veterans in the appeals stage. BVA representation ought to be mandatory for a county's application for funding to be granted should this bill be enacted.

We must also quibble with the definition of a county veteran service officer. What is missing from this definition is that (s)he must be accredited by the VA. Without this proviso, the law opens up the possibility that uncertified service officers can be trained and employed who do not meet VA requirements.

Last, there must be some sort of quality assurance and accountability mechanisms built into this bill to ensure that what is really needed—high quality representation by trained and dedicated individuals who will help veterans residing in rural areas know the benefits to which they are entitled and skilled help in receiving those benefits—is actually the outcome that this proposed program is likely to achieve.

If modified to meet the above criteria, then VVA would endorse such a bill.

VVA applauds the impetus behind proposals such as this as the shape of our current active duty force is the most rural we have had in a century. Almost 40 percent of this active duty force (including deployed National Guard and Reservists) come from towns of 25,000 or less, according to DoD sources. Therefore, we (collectively) must rethink the paradigm of the way in which we deliver veterans' benefits and services of all types, whether it be the size and location of national cemeteries, or medical care, or assistance in learning about and securing hard earned veterans' entitlements and services.

H.R. 3070, The Disabled Veterans' Caregiver Compensation Act, would require the Secretary of Veterans Affairs to pay monthly compensation of $234 to a veteran if and while totally disabled and in need of regular aid and attendance and while unpaid aid and attendance is provided by an adult family member who is dependent upon such veteran for support.

VVA's only question is: Why $234? Where did this figure come from? Is it subject to annual COLA increases? Despite these questions, VVA does support enactment of H.R. 3070, although we think that this monthly amount is ridiculously low, and demeans the quality of care now given by adult family members, and does not even begin to make up for income lost when a spouse or parent or other quits work or takes only part time work in order to have the time to care for the veteran.

H.R. 3795, The You Were There, You Get Care Act of 2007, presumes specified diseases, and any other disease found by the Secretary of Veterans Affairs to result from exposure to depleted uranium or the byproducts of the burn-off that occurs when a depleted uranium munition penetrates a target, among those diseases that will be presumed to be service-connected (and therefore compensable) when appearing in radiation-exposed veterans.

Perhaps the critical element in this bill is the provision for independent medical study to determine diseases that may result from exposure to depleted uranium. If, as is the case with dioxin, there is compelling medical and scientific evidence that points to a positive association between exposure and the onset of a particular disease, then an exposed veteran surely warrants care and treatment and compensation. If enactment of this bill leads to greater knowledge about the potential health effects of exposure to depleted uranium, if it can clear up some of the controversies over the claimed adverse health effects of exposure, then it is worth the time of Congress to enact it.

Keep in mind, however, that depleted uranium has been in production since the late sixties and has been tested in weaponry at such places at the Davy Crockett range in Hawaii. Is it fair to troops who may have been exposed to DU in these tests not to be covered for possible harm incurred during their service?

VVA supports H.R. 3795, but recommends expanding the group of veterans to include all who were potentially exposed, including those involved in testing this weapon.

H.R. 4274, The Gold Star Parents Annuity Act of 2007, would direct the Secretary of Defense to pay a special pension to each person who has received a Gold Star lapel button as a parent of a member of the Armed Forces who died while serving.

VVA has long supported a pension for Gold Star Mothers who, in their old age, we would like to believe would have been assisted by their son or daughter had (s)he not died during a period of war or afterward because of illness or injuries incurred during military service. Frankly, however, the starting point for date of death should be retroactive to at least include the parents of those killed in Viet-

nam, even though the payments would only begin from the date of enactment forward.

VVA at every level, local, state, and national, has a great deal of contact with these wonderful people, many of whom are active in American Gold Star Mothers organization. Many of them are clearly struggling today. We would suggest that a further modification of the proposed legislation be made so that such payments would not begin until at least age 50, unless the individual recipient can show an extreme hardship.

VVA also strongly urges the Committee to **take action to end the "widows tax,"** and to work with your colleagues in other Committees of the Congress to stop the shameful action of offsetting Dependency & Indemnity Compensation (DIC) at VA by the amounts received under the Survivor's Benefits Program (SBP) at DoD. The current "offset" is akin to reducing the amount of DIC because the servicemember had a life insurance annuity with Metropolitan Life or some other private insurance company. They paid premiums into the SBP for many years, and so it a paid for benefit, and it is outrageous to deduct that amount from the DIC. It is nothing short of an unjust "widows tax." It is way past time to rectify this injustice.

Additionally, VVA has testified many times about the crying need to increase the amount of monthly payments under DIC. It is simply an egregiously paltry amount that is paid to these dependents, and leaves many Gold Star Wives below the poverty level. This is simply just not right nor just. The founding principle of veterans' benefits is "To Care for Him who hath borne the battle, and for his widow and orphan" in the great phrase of President Abraham Lincoln. Frankly, we are just not living up to our obligation in this regard, and DIC must be significantly increased as soon as possible.

VVA applauds the motivation of Congressman Walsh and this distinguished body, but believes that it is the older parents who are in most dire need today, and deserve to be included as a priority. Further, the significant and valid needs of the surviving spouses must be addressed with at least as much urgency as the significant and valid needs of the older Gold Star parents.

H.R. 5155, The Combat Veterans Debt Elimination Act of 2008, would prohibit the Secretary of Veterans Affairs from collecting certain debts owed to the government by any veteran who dies as a result of a service-connected disability incurred or aggravated while serving in a theater of combat operations in a war after the Persian Gulf War or in combat against a hostile force after September 11, 2001, if the Secretary determines that the termination of collection is in the best interests of the United States.

It is hard not to endorse this bill. One quibble that is perhaps little more than theoretical: What if a veteran who owes the government money is called back into service, or chooses to reenlist, and then dies in a combat theatre of operations before a claim for a service-connected disability has been adjudicated by the VA? VVA believes that debt should be negated if he or she died in the line of duty, and not passed on to the veteran's survivors.

VVA also believes that given the disaster that has been made of the system of adjudicating claims that it is way past time to end the current rule of "the claim dies with the veteran." VVA recommends that if a veteran dies, and a claim has been pending for more than 90 days, that said claim automatically be turned into a DIC claim for the survivor(s), and that when finally settled, that if such a claim is successful that full benefits up until the hour of death be paid, and that the payments for DIC begin at that moment retroactively.

The veteran and their family should not be penalized for the poor leadership and stewardship of the system that is supposed to adjudicate veterans' claims, for, as General Bradley was fond of saying when he led the VA: "we are here to meet the veteran's needs, not our bureaucratic needs."

H.R. 5448, The Full Faith in Veterans Act of 2008, would direct the Secretary of Veterans Affairs to accept as sufficient proof of service-connection of post traumatic stress disorder (PTSD) alleged to have been incurred in or aggravated by active military service a diagnosis of PTSD by a mental health professional, together with a written determination that such PTSD is related to the veteran's service, if consistent with the circumstances, conditions, or hardships of such service, notwithstanding that there is no official record of such incurrence or aggravation during such service.

With all the focus on PTSD these days—Is the VA refusing in at least some locations to diagnose PTSD in cases to somehow save money? (VVA thinks this may be the case, as events at Temple VAMC in Texas have shown recently). Is there a battalion of "shirkers" out there who will fake symptoms in order to get some free money? (VVA has good reason to believe this to be a fevered delusion of one notorious "scientist" who never has any real data, but who shouts out this garbage none-

theless.) does address some pressing and timely issues. It does, however, have certain flaws.

Part of the purpose of H.R. 5448 is "to improve the diagnosis and treatment of post traumatic stress disorder by the Secretary of Veterans Affairs." Well, Dr. Peake neither diagnoses nor treats personally, but more importantly, this bill has nothing to do with diagnosis and treatment; rather, it is about service-connection. Also, while this bill addresses PTSD, it neglects other mental disabilities linked to one's military service, which may also (and often is) directly linked to military service, particularly in dangerous situations.

Furthermore, as evidence in support of this bill, VVA reminds the Committee that the Doherwend, et al. study published in August of 2006 that revisited the National Vietnam Veterans Readjustment Study (NVVRS) went back to all who claimed exposure to traumatic events in that 1986 survey/study. The researchers then tried through searching unit histories, after-action reports, newspaper and other news coverage, and other sources and tried to objectively show that the violent event did occur at the time and place self-reported by the veteran. What they found was that 91 percent of the claims could be verified as having occurred, at least there was written or printed materials that substantiated the veterans' professed exposure was either proven, was shown to be likely, or was at least proven to be plausible. Insofar as the other 10 percent or so of claims of traumatic events, the researchers stressed the fact that they could not find any substantiating records certainly did not mean that the event self-reported by the veteran did not occur. War is by its very nature messy and confusing, and often things happen that are not fully recorded, even though neat and tidy documentation is supposed to always happen according to the military's bureaucracy. Those of us who have been in a war zone know that the reality is often different.

Further, the VA Office of the Inspector General Report No. 05–00765–137, "Review of State Variances in VA Disability Compensation Payments" randomly sampled about 2,300 claims folders that had been adjudicated as being 100 percent for PTSD (many were 100 percent only when combined with individual unemployability) from a number of VA Regional Offices, in both large states and rural states. After a protracted uproar regarding charges by the OIG in press statements alleging fraud, the 2,300 files were sent to the Office of the Undersecretary for Veterans Benefits. He assembled a team that went through each claim carefully to weigh the evidence, and thoroughly asses each case. Out of the roughly 2,300, only two were found to merit full scale investigation by the IG, and these two were forwarded back to IG to further investigate. Ultimately the IG found that there were significant errors made in these two cases, but could not find any evidence of fraud or intent to fraud.

This stands as a solid testimonial to the integrity and honor of those who file PTSD claims. VVA believes that many who legitimately do suffer from PTSD have their claims denied because there are no immediate documents that the individual veteran can access to prove his or her case. (The VA has the resources and the access to secure the evidence if their "duty to assist" were not constantly being made into a mockery by the way they actually do business.)

This legislation is long overdue, and is much needed. As long as reasonable plausibility is established as to the traumatic event, and the VA is directed to use proper diagnostic tools to determine that the individual in fact has PTSD (which they often do not, due to poor training, poor leadership, poor measurement metrics, and cost cutting taking precedence over best clinical procedures), VVA supports H.R. 5448.

H.R. 5454 would establish a presumption of service connection for amyotrophic lateral sclerosis if a veteran develops a 10 percent degree of disability or more at any time. Although it is unclear from what we've read of this bill, we assume that veteran must have served during the Persian Gulf War. This being the case, VVA supports enactment of this bill.

H.R. 5709, The Veterans Disability Fairness Act, would require the Secretary of Veterans Affairs to carry out quality assurance activities with respect to the administration of disability compensation.

This bill, while well-intentioned, seems to ask for the obvious: to help ensure "the accuracy and consistency across different offices within the Department of the treatment of claims for disability compensation, including determinations with respect to disability ratings and whether a disability is service-connected." Yet anything that will help the VA achieve accuracy and consistency in this regard is to be commended. Competency based testing of all VBA employees and those accredited to represent claimants, full meaningful accountability for supervisors and managers, and generally solid leadership from the top down would go a long way toward cleaning up the mess that this system has become, as well. The lack of proper automation

of this system has been covered by all concerned so often that the yawning need for progress on this front goes without repeating.

Hence, VVA endorses H.R. 5709.

H.R. 5985, The Compensation for Combat Veterans Act, would "clarify the service treatable as service engaged in combat with the enemy for utilization of non-official evidence for proof of service-connection in a combat-related disease or injury."

While we had difficulty deciphering just what the above seems to mean, we do not have difficulty in understanding that the definition of a "combat veteran" under this act is a bit broad. While it is true that even a well-protected rear area in South Vietnam could be subject to mortar and rocket attacks and infiltration by sappers, the construct that simply to be in a combat zone means one should be treated "as having engaged in combat with the enemy" doesn't hold up. It demeans those troops who in fact do engage in combat with the enemy.

A clerk in Long Binh in 1970, while in a putative combat zone, lived in effect in a city. To give him, or her, the same status as an infantryman is simply wrong. On the other hand, we know many veterans, of both Vietnam and the current conflicts, who had military jobs that were ostensibly "non-combat" such as engineers or truck-drivers who in some case had much more direct engagement with the enemy under hostile fire than some who had an infantryman's designation. Today the military recognizes at least some of these persons with a combat action badge. However, that is not the case for those who served in Gulf War I, Vietnam, or earlier conflicts.

The notion that only those with a Combat Infantryman's Badge (CIB) have been exposed to combat, or the hazards of a combat theater of operations, is far too narrow. The notion is this bill may well be far too broad. There needs to be further development work regarding the intent of this bill, and whether there is a better way to achieve that objective. Further, at least part of what may be the intent of this bill may well be covered by H.R. 5448.

VVA cannot endorse H.R. 5985 in its present form without further work, and without better understanding the aim of this proposal, which is not immediately ascertainable.

H.R. 6032 would direct the Secretary of Veterans Affairs to provide wartime disability compensation for certain veterans with Parkinson's disease.

There is significant scientific evidence that associates the onset of this malady with one's military service in Vietnam veterans in particular, due to exposure to Agent Orange, Agent Pink, and the potpourri of other poisons in the toxic soup in which we lived and fought during the Vietnam War. VVA has no difficulty in supporting enactment of this bill.

On **H.R. 6114, The SUNSET (Simplifying and Updating National Standards to Encourage Testing of the Human Immunodeficiency Virus) ACT of 2008**, VVA takes no position.

H.R. 6122 would direct the Secretary of Veterans Affairs to develop and implement a comprehensive policy on the management of pain experienced by veterans enrolled for VA healthcare services.

It seems to us that the Veterans Health Administration already takes a pro-active interest in pain; certainly, just about every veteran who is examined by a nurse is asked about his/her level of pain. Still, while this bill seems a bit redundant with what the Department is already doing, VVA supports its enactment, particularly with regard to the VA's program of research into acute and chronic pain suffered by veterans.

VVA thanks the Subcommittee for the opportunity to comment on these bills, and will be pleased to reply to your questions.

Prepared Statement of Lieutenant Commander Jack B. Alderson, USNR (Ret.), Ferndale, CA

Chairman Hall, Ranking Member Lamborn and Distinguished Members of the Committee. My name is Jack B. Alderson, and I live in Ferndale, California. I am a retired Lieutenant Commander from the U.S. Navy Reserves and am here today to describe my experiences within the "Project SHAD Technical Staff" (PSTS).

In 1964 I was a Lieutenant on active duty in the U.S. Navy and received orders to the "Project SHAD Technical Staff", as Officer in Charge of a Division of five U.S. Army Light Tugs (LTs) at Pearl Harbor. The mission of the PSTS and the LTs were to test at sea Chemical/Biological Weapons. I was there from September 1964 until

August 1967. The LTs acted as sampling stations and read targets for disseminated weapon clouds.

Each LT was manned by a Navy crew with a U.S. Navy Lieutenant as OinC. The LTs were Army vessels with Navy crews operating under a Joint Services Command. These were not volunteers, but hand picked personnel with "Final Secret" clearance ordered to do a job. That job was done, and done well. During the 3 years I was with the PSTS LTs, they never missed a commitment, and completed all tasks assigned while maintaining a fine safety record. This was, at times, a very dangerous job with stringent safety precautions and procedures in place.

I herein stress, that we took every safety precaution within the technologies and knowledge available in the 1960's. Sometime later I became aware that some of the PSTS personnel were having health problems; namely, respiratory and cancer. A knowledgeable medical person connected with the tests stated to me that "some of the materials used to decontaminate the LTs after a test are now known to be carcinogenic". Decontamination agents used were Betapropiolactone, Formalin, Ethylene Oxide and HTH (Chlorine). Please see attachment. Further concern is here for the PSTS staff, as the FDA had not approved the inoculations administered to them. Security conditions precluded any of this being placed in our official health records. In fact, some of our health records are missing.

Upon return to Pearl Harbor the PSTS, including the Light Tugs took part in training and in tests involving simulants. Named tests included Fearless Johnny, Big Tom, Folded Arrow and others on and around the Hawaiian Islands. Some of these simulants have now been shown to have harmful affect on humans when exposed. The decontamination agents and procedures are the same as for the live weapons tests.

I also took three of the LT's on two Bird Cruises. Wherein we had on board scientists including ornithologists from the Smithsonian Institute. The purpose of the Bird Cruises was to make sure none of the indigenous birds of the central Pacific were carrying any residue of the tests.

After I left the PSTS in 1967 they continued to operate for a number of years. Some of their operations were off the California coast. I know this because I was then assigned to "Fleet Training Group San Diego" where I wrote the weekly operation order assigning operating areas and training assets. In 1968 I received a request for operating areas for the USS Herbert J Thomas (DD833) and five Army Light Tugs. Since some tugs sailors and I had trained the DD I can guess what they were doing.

My concern is for the personnel of the PSTS, who with full trust in their country, did what they were told to do and did it well. Many of these persons are dead, and many have health problems that may well have started with their participation in SHAD. Importantly, their present attending physician would not equate present health problems to something that happened many years ago.

As I stated, I became aware of the problem some years ago when I heard from the SHAD veterans that they could not get care at VA clinics and were turned away because they could not fully describe what occurred to them. At first we were told that no such testing happened. The Army said they had concerns but took no action until forced. In fact, a letter dated August 23, 2000 from Maj. General J. M. Cosumano, Assistant Deputy Chief of the Army, states that everything remains classified but only simulants were used, and protective clothing worn . . . Untrue.

During the initial efforts to expose what was happening to SHAD veterans I found I had a severe Malignant Melanoma and that brought home to me the concerns of other SHAD veterans. I now have other health concerns possibly attributable to SHAD operations.

On September 13, 2001, DoD released three sets of FACT SHEETS. One set was for "Operation Shady Grove", listing as participating units the 5 LTs.

Upon completing our training and inoculations we were considered ready to participate in test operations. We were ordered to standby to get underway on 2 January 1965. We were ready, and then told to stand down as the President has not signed the operational document. President Johnson did sign, and we were underway for Johnston Island on 21 January 1965 for "Operation Shady Grove", the testing of Biological Weapons, simulants and trace elements. This operation was under control of the Deseret Test Center, Fort Douglas Utah and personnel from Dugway Proving Ground.

The aforementioned "FACT SHEETS" are incomplete and contain erroneous information such as dates of test and not naming decontamination agents as examples.

"Operation Shady Grove" was staged from Johnston Island. Prior to commencement, the LTs were scripted for the next 6 days of operation as radio silence was imposed. The LTs would pick up the test sampling material and animals from the USS Granville S Hall (YAG 40), Granny, and proceed to their assigned position on

the grid. At twilight the monkeys were placed in cages topside, and the LT buttoned up. U.S. Marine A 4s would disseminate the agent, simulants and trace elements up-wind of the LTs and down wind of the Granny. The weapons cloud would then drift down over the grid while samples were being taken. In the morning, the exterior decontamination crew would exit the interior and decontaminate the exterior, including wrapping up the monkeys for transfer to the Granny. Even though the Light Tugs had air pressure and filtering systems, they leaked. We know this from the instruments inside the tugs. We were not worried as we were inoculated ... Right?

After 6 days of operations the LTs would return to Johnston Island for a three-day rest and repair. During this break sometimes the tugs were decontaminated on the interior. Our decontamination agents are now considered carcinogenic.

Personnel from the Deseret Test Center and Dugway have often stated that LT crew should have been in protective clothing during a test and we were not. In fact, there was none on the LTs. The exterior decontamination crew wore cotton coveralls with rubber bootie and gloves, plus a gas mask. Exterior decontamination was done by a crew of three by hand using HTH in a soapy solution. These three were the only members with gas masks. When they completed decontaminating they stripped placing every thing they wore in a metal trashcan, taping it shut and through a fitting releasing an aerosol of Ethylene Oxide onto the clothing, entering the vessel through an air lock and showering on the way. There were no washing machines on the tugs, so the next day the exterior crew donned their equipment and did it again. Ethylene Oxide ia a known Carcinogen as is HTH.

Periodically it was necessary to decontaminate the interior of the tugs. This was accomplished by using a fogging device with the fog made from Betapropiolactone and Formalin, both of which are highly carcinogenic. To make sure the fog penetrated everywhere every locker every drawer was open the only sealed item was the galley refrigerator. After a period of time the tugs were opened up and aired out. However, when we went inside the liquid was running down the bulkheads and the interior atmosphere caused our eyes to smart and some personnel received rashes. Our bunks and clothing were damp from the fog.

I understand security classifications and the sensitivity of our operation. However, these were not volunteers but service personnel ordered to do a dangerous job and they did it, and did it well, now their Nation needs to take care of them.

I thank Representative Mike Thompson who has stuck with us for a number of years even while members of the administration said there was no SHAD. Appreciation also goes to Representative Rehberg for joining in this task.

I thank you Chairman Filner, Ranking Member Buyer, and Members of the Committee, and herein respectfully request that H.R. 5954 be moved from Committee to the Floor of the House with the recommendation for approval.

If you have any questions I will try to answer them.

Prepared Statement of Jeff Faull,
McEwersille, PA (Disabled Veteran), on behalf of The ALS Association

Good afternoon Chairman Hall, Congressman Lamborn and Members of the Subcommittee. My name is Jeff Faull and I am from a small town in northeastern Pennsylvania called McEwensville. I appreciate the opportunity to speak with you this morning on behalf of The ALS Association and veterans living with ALS across the country. I hope that by sharing my experience with you today, you will gain a better understanding of how this disease impacts veterans across the country and why H.R. 5454 is so urgently needed.

Before I begin, I would like to thank Congressman Henry Brown and Congressman David Price for their leadership in introducing this vital legislation. Veterans with ALS across the country truly are grateful for their efforts.

I joined the Navy in 1992 at the age of 24 and served two tours of duty as a nuclear electronics technician (Navy Nuke), including over 4 years aboard the U.S.S. *Theodore Roosevelt*. During that time I participated in Operations Southern Watch, Deliberate Force, Allied Force and Noble Anvil. Prior to my assignment aboard the Roosevelt, I was stationed at the Knolls Power Laboratory Kesselring Site in West Milton, NY located not too far from your district Mr. Chairman.

I left the Navy in 2000 to spend more time with my wife Tammy and our two daughters Tiffany and Breanna. Like many other veterans, I never thought that my service in the military would cause health problems years after I left the service. I never thought that I would have to fight to obtain benefits from the VA and I never thought I would be sitting here before you today having been diagnosed with

ALS, or Lou Gehrig's disease. But for me and thousands of veterans across the country, the reality is that, years—and even decades—after serving our country, we are being diagnosed with ALS and we are fighting for benefits at the same time we are fighting this disease.

I was diagnosed with ALS just over a year ago in February 2007 at age 38, about 20 years younger than the typical person with ALS. At the time, I had no idea what ALS was. Amyotrophic lateral sclerosis meant nothing to me, as I'm sure it means nothing to thousands of others when they are first diagnosed. But I can assure you it's a whole different story when your doctor uses phrases such as "unfortunately, you don't have cancer." That's when you begin to understand how serious ALS really is.

ALS is a rapidly progressive, invariably fatal, neurological disease that attacks the neurons responsible for controlling voluntary muscles. To put it simply, this disease will rob me of my ability to walk, talk, move and breathe. There is little I can do to slow the progression of the disease as there is no effective treatment available for ALS, nor is there a cure. The disease is usually fatal in about two to 5 years. In fact, of the more than 2,000 veterans who have enrolled in the VA ALS registry over the past 4 years, less than 900 are still with us today.

I first noticed the symptoms of ALS as early as 1999 when I experienced cramps and twitching in my left hand and arm. As time passed, I began to develop weakness then loss of muscle mass, which eventually led to my diagnosis last year. Since my diagnosis, the weakness and atrophy which began in my left hand has not only worsened but spread. Both hands and arms are now weak, walking is becoming more difficult and, as you can hear, my speech is beginning to be affected.

I keep a pair of slip-joint pliers in the kitchen to help open things. My wife Tammy who's with me here today normally makes sure that things like cereal boxes are opened for me otherwise I have to ask for help from my daughters. Although they are more than happy to help their "old man" this is not how I pictured spending my time with my daughters. I can't make the walk to see Breanna play soccer. I don't have the arm strength to shoot a basketball with my older daughter Tiffany. I will more than likely be in a wheelchair when it comes time to teach them to drive. These are the treasures this disease steals from thousands of veterans every year. That is, before the disease takes our lives.

Several studies, including studies funded by the Department of Defense and the Department of Veterans Affairs have found that military veterans of the 1991 Gulf War are approximately twice as likely to develop ALS as those not deployed to the Gulf. As a result, the Secretary of Veterans Affairs established a presumption of service connection for those veterans with ALS who served in the SW Asia Theater of Operations from August 2, 1990 to July 31, 1991.

However, the increased risk of ALS is not confined to veterans of the Gulf War, nor is it limited to veterans who served during a time of war. Researchers at Harvard University have found that military veterans from other eras, ranging from before World War II to after Vietnam, also are nearly twice as likely to develop ALS as those who have never served in the military. The study did not even consider Gulf War veterans. Moreover the study showed that veterans were at greater risk of ALS regardless of whether they served during a time of war or peace, or whether they served at home or abroad.

The Institute of Medicine reviewed these and other studies and reported in November 2006 that existing evidence supports the increased risk of ALS for veterans. In fact, I understand that recent research, which has not yet been published, suggests that ALS is occurring at greater rates in those who are serving in the current conflict in Iraq. And what's alarming about this information, and the evidence from prior research is that we are seeing ALS in veterans at an age when we generally do not see the disease. I was 38 when I was diagnosed. Most people are diagnosed in their fifties, sixties and 70s. What will we see 10, 15, 20 years in the future as the men and women serving today leave the military?

It is clear that regardless of when or where someone served in the military, they are at a greater risk of dying from the disease than if they had not served in the military.

The Department of Defense and the VA also recognize that there is a relationship between military service and the development of ALS. In addition to Gulf War veterans, veterans who experience symptom onset or are diagnosed with ALS while on active duty or within 1 year of discharge are presumed service connected. DoD, VA and Congress also have invested funding for ALS research, including establishing the Veterans ALS Registry at the VA and creating the peer reviewed ALS Research Program at DoD, which is seeking treatments for veterans with ALS.

However, despite the evidence showing that all U.S. military veterans are at a greater risk of ALS, the VA has not created a presumption of service connection for

all veterans with ALS. Thousands of veterans continue to be left behind and hundreds of thousands serving in the military today, including in Iraq and Afghanistan, continue to be at a greater risk of dying from the disease.

The VA will respond that any veteran with ALS can be granted service connection on the basis of specific evidence supporting their case. As someone who has been denied service connection, and knows countless others who have as well, I can tell you that this response demonstrates a lack of understanding of the disease.

The reality is that the majority of veterans with ALS, who do not fall under the current limited presumptions, are forced to fight for their benefits. And we are usually denied. I have been attempting to establish service connection for over a year now and have submitted reams of scientific and medical evidence, including letters supporting my claim from my neurologist. Yet that evidence has fallen on deaf ears.

Part of the problem we face is the nature of the disease itself. ALS is an insidious disease. First the symptoms, such as the ones I experienced while on active duty, are so benign that they go unnoticed or unreported. How many of us in this room have experienced muscle cramps and twitching and thought nothing of it? These are symptoms of ALS, yet they are not documented in our service medical records simply because we did not think they were a big deal at the time—after all, we were in the military. How many of us on active duty actually thought that we would succumb to muscle twitching?

In addition, it can be years from discharge until the onset of symptoms or between onset and diagnosis—well after the 1 year presumptive period has ended. And there is no simple way to diagnose ALS, no single test you can take that says you have ALS. Rather it is a diagnosis of exclusion, made by ruling out every other possible diagnosis.

The bottom line is that if you were not diagnosed while on active duty and did not serve in the Gulf, the VA likely will not consider ALS to be service connected. This, despite the studies and the fact that the VA and DoD both recognize ALS to a high priority for research.

In addition to the studies that I have referenced and which are included in the ALS Association report, ALS in the Military; the Unexpected Consequences of Military Service, there are multiple peer reviewed studies linking ALS to many of the things our military personnel are exposed to on a regular basis. These include ionizing and non-ionizing radiation, fuels, solvents, lead, vapors and vaccinations. In fact, recent peer reviewed studies and World Health Organization guidelines link some of the vaccines given to our military personnel as a possible cause of ALS.

My question, as a veteran with ALS trying to establish service connection is what additional proof must I provide? How many more studies are needed? How many veterans have to develop ALS and die from it before the VA takes action?

I can only hope that this quick glance into my life with ALS and attempts with service connection grant you the understanding to see the importance of establishing a presumption of service connection for all veterans with ALS, which is exactly what H.R. 5454 would do. We have to fight for our lives. We should not also have to fight for the benefits that the evidence shows we deserve.

Abraham Lincoln's statement which was later adopted by the VA as their motto states, *"to care for him who shall have borne the battle and for his widow, and his orphan"*. I and the other veterans with this horrible disease appreciate your time and effort to ensure that statement is more than words. I urge you to support H.R. 5454 and help ensure that no veteran with ALS is ever left behind. Thank you again for your time and the opportunity to speak with you.

Prepared Statement of David Woods,
Director, Veterans Affairs of Scott County, IA

Mr. Chairman and Members of the Committee, thank you for allowing me to be here today to discuss Congressman Braley's bill, The Compensation for Combat Veterans Act. I am the Director of Veterans Affairs of Scott County in Iowa. I am also a Vietnam combat Veteran. I have been awarded the C.I.B., the Purple Heart and the Silver Star from being wounded June 12th 1970 in Nam. So I have a feeling for just what our Veterans are going through.

My job as a Veterans Service Officer for Scott County is to listen to these Veterans, get them the medical help and compensation which is due them. I also help them through the Veterans Administration tangle of paperwork and to make sure that they understand what they are entitled to. Having witnessed my combat experiences, I understand and am able to talk and relate to what these Veterans are

going through. They will tell me things that they have told nobody else, not even their wives or family.

I have had Veterans come into my office asking him where, when, and what unit were you with, who was wounded or killed near you. He just stared at me and replied that he had no idea what the date was or maybe they were working with a different unit than his own, so he had no idea who the guy was that got wounded, but the Veteran was there.

Now, how about our Vietnam Veterans who have been trying to forget his time in Vietnam, the cases of PTSD are rising since the start of the Iraq, Afghanistan Wars. After 40 years, have him try to remember when he was attacked or even the name of a buddy who was injured. I know that when most of us were in combat we did not have calendars with us and as to where we might have been, we just followed our leader's orders. Asking these questions sometimes just brings back bad memories, memories which we were trying to forget.

For our Iraq, Afghanistan Veterans, there are times when that MP or engineer or even a cook might be pulled from his job and be sent on convoy duty. Many times when that change happens, it is not documented for the files. Then when he is sent on that job, he might not be working with his own unit or his combat buddies. If they receive incoming rounds it is not documented; it's just an everyday occurrence.

I have had National Guard Veterans whom had been activated, come into my office for compensation claims, which we filed. The Veterans Administration has turned down these claims because part of the units were still on duty and all of the units' records were still over with the rest of the unit. Then we had to track down a buddy that might have witnessed what had happened to the Veteran. Now with the Guard you have to remember that they might not see that certain buddy until drill weekend, if they drill together in the same unit. Also their days also ran together and they had no idea when they were fired on. When they were in a certain village or city they at least knew that much.

I have had an Iraqi Veteran with T.B.I. (Traumatic Brain Injury) file for compensation but because he had no C.B.I or Purple Heart or other combat medal, he was turned down by the VA for his compensation. His DD 214 showed that he was in Iraq listing the date and unit, but nothing else. When we filed the compensation claim, that Veteran was tested and treated at the Iowa City VA Medical Center. He was found to have T.B.I. and he was awarded his compensation claim.

If you were to ask a combat medic just what his job was, you would be told that he was to keep that injured soldier alive and to let the people in the background do the paperwork. If you were to look at my medical report, it says that I was injured in the left arm and the neck. Neither happened to me when I was hit. That medic did not carry a file for each of us to report every little wound or knock to us. It was not possible and it's still not possible to keep track of these records.

Case in point, I had a W.W. II Veteran come into my office wanting to get his Purple Heart which he had never gotten. His records were burned up in St. Louis and he really wanted it for his family. He was injured in Germany and sent to France for his medical treatment. While in the hospital in France he was told that his Purple Heart would be given to him when he got back to his combat unit. On returning to that unit he was informed that he should have received it while in France. He just wanted to get home so he forgot about it until his kids asked about his awards. While talking to him I found out what unit he was with and when and where he was injured. I sent a message to the Unit Records section in St. Louis; when we got the response with his name on the records, it said that he was in the hospital for illness not an injury. Since the other tank members were all deceased, he was dead in the water for his Purple Heart. Just another show of great military records keeping for the Veteran.

I had a Vietnam Veteran come into my office to apply for Compensation for Agent Orange Type II Diabetes. This Veteran was a Navy deep water Veteran and when he applied for his compensation, the VA turned him down stating the "Hass vs. Nickelsen" case that he was never in Vietnam. I asked the Veteran if he had contact with any of his shipmates and the very next day he had e-mail addresses for two of his shipmates. I contacted one of the two, and it turned out that he was the third officer on the ship. His letter back to me was a statement telling that it was common knowledge that the replacements would fly into Vietnam, truck 2 days down to the tip of Nam, and then be boated out to the ship. Then to add insult to injury to the VA and the records keeping, he mentioned that every two or 3 months they would all land on an island beach off of Vietnam for volleyball and R & R. We are still waiting to hear from the VA on that case.

These are just a fraction of the Compensation Claims which we are fighting with the VA. These last wars are not like W. W. I and not like W. W. II where you knew whom the enemy was or where the frontlines were. Now we have no lines or en-

emies in a certain uniform. There are not many "safe areas" when the Veterans of today can actually relax. It doesn't take much incoming to put stress and pressure on our Veterans and that is what we are finding out today.

Thank you for letting me speak to you today.

Prepared Statement of Bradley G. Mayes, Director, Compensation and Pension Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, I am pleased to be here today to provide the Department of Veterans Affairs' (VA) views on pending benefits legislation. Accompanying me is Richard J. Hipolit, Assistant General Counsel. VA is still reviewing H.R. 5448 and will provide views on that bill in a subsequent views letter.

H.R. 1197

H.R. 1197, the "Prisoner of War Benefits Act of 2007," would: (1) repeal the current minimum 30-day internment period required for veterans who are former prisoners of war (POWs) to be entitled to presumptive service connection for the disabilities listed in 38 U.S.C. § 1112(b)(3); (2) add type-2 diabetes and osteoporosis to the list of disabilities presumed service connected for former POWs; and (3) authorize VA to administratively determine, and establish procedures for such determinations, whether to add or remove diseases from the list of POW presumptions. The bill would require VA, in making such determinations, to take into account the recommendations received from the Advisory Committee on Former Prisoners of War and, whenever that Committee recommends that a presumption of service connection be established for a disease, to make the determination not later than 60 days after receipt of the recommendation. VA would have 60 days after that to either propose regulations to implement a positive determination or publish a notice of a negative determination. Final regulations would be required not later than 90 days after any proposed regulations are issued.

VA does not support this bill for the following reasons:

The diseases already listed in section 1112 have been medically and scientifically associated with the harsh physical and psychological conditions associated with POW internment. It is unreasonable to assume that the extreme deprivation associated with the diseases listed in section 1112(b)(3) occurred during internment periods of less than 30 days, particularly those diseases associated with nutritional deprivation. These diseases include avitaminosis, chronic dysentery, helminthiasis, malnutrition, pellagra, cirrhosis of the liver, peripheral neuropathy, irritable bowel syndrome, peptic ulcer disease, atherosclerotic heart disease or hypertensive vascular disease and their complications, and stroke and its complications.

VA is not aware of any credible scientific or medical literature or study that has associated type-2 diabetes mellitus or osteoporosis with POW internment.

The timeline S. 1197 would mandate for making determinations and publishing regulations is untenable. Determination of whether any particular malady should be added to the list of diseases warranting presumptive service connection must reasonably involve a lengthy process of scientific study. Sixty days is insufficient time for the Secretary to be able to evaluate a recommendation to create a new presumption.

We estimate the benefit costs of this bill to be $61.1 million during fiscal year (FY) 2009, $440.1 million for 5 years, and $798.2 million over 10 years. The bill would minimally affect workload, so full-time employee (FTE) costs would be insignificant.

H.R. 3008

H.R. 3008, the "Rural Veterans Services Outreach and Training Act," is intended to improve outreach and assistance to veterans and their dependents who may be eligible to receive VA benefits and are residing in rural counties, through the training of rural county veteran service officers. To this end, H.R. 3008 would establish a competitive grant program to provide financial assistance to state departments of veterans affairs.

Although VA supports the intent of H.R. 3008, we oppose the bill because it would duplicate ongoing efforts by the Veterans Health Administration's Office of Rural Health (ORH) to address the health care needs of veterans in rural areas, as well as duplicate other outreach activities already conducted by VA for veterans in rural areas.

The ORH has been initiating innovative programs to improve care and services for veterans who reside in geographically isolated areas, including the following:

- *Rural Mobile Healthcare Clinic*: The ORH recently disseminated a nationwide Rural Mobile Healthcare (RMHC) Clinic Pilot Request for Proposals, to extend access to primary care and mental health services in rural areas where it is not feasible to establish a fixed access point. Although the primary focus of RMHC is to enhance the delivery of care to rural veterans, secondarily it can address outreach and collaborate with community partners. The ORH expects to complete the selection of the pilot sites by the end of summer 2008.
- *Veterans Integrated Service Networks Rural Consultants*: The use of Veterans Integrated Service Networks (VISN) Rural Consultants was mandated by section 212 of Public Law 109–461. The consultants will enhance service delivery to veterans residing in rural areas, will lead activities in building an ORH Community of Practice to facilitate information exchange and learning within and across VISNs, and support a stronger link between ORH and the VISNs. The ORH recently disseminated a nationwide Request for Proposals and intends to fund eight consultants. We expect to complete selection of consultants by the end of 2008.

VA believes the results of the RMHC Pilot Initiative and the VISN Rural Consultants program will enhance healthcare services for veterans and guide the future direction of other potential initiatives, such as those contemplated by H.R. 3008.

In addition to the abovementioned rural healthcare initiatives, the following are examples of other outreach services occurring in rural areas:

- Vet Centers provide readjustment counseling and outreach services to all veterans who served in a combat zone. Certain services are also available for their family members. The goal of the Vet Center program is to provide a broad range of counseling, outreach, and referral services to eligible veterans to help them successfully readjust to civilian life. The Vet Centers are community-based and staffed by small multi-disciplinary teams of dedicated providers, many of whom are combat-veterans themselves. The Vet Center staff routinely visits rural communities to provide outreach and direct readjustment services. The Vet Center program has initiated its own community outreach vehicle project and is in the process of selecting sites for 50 outreach vehicles. The measures outlined in H.R. 3008 would be duplicative of their efforts.
- VA is conducting a substantial amount of outreach, counseling, and education for returning Reserve and National Guard members and their families. Effective May 1, 2008, at the Secretary's request, an estimated 570,000 Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans are being contacted and given information on VA medical services and other benefits available to them.
- VA currently engages in a range of activities to educate VA staff and other agencies and organizations involved in helping veterans and dependents, such as community service providers, school officials, lenders, service organizations.
- The Healthcare for Homeless Veterans Outreach program.
- The Tribal Veteran Representative programs.
- Seamless transition programs for OEF/OIF veterans.
- Educational patient support groups

VA's outreach efforts also include activities that assist veterans generally, such as attending benefit fairs and exhibits at conferences, conventions, veteran service organization meetings, Federal boards, and townhalls, and participating in a range of Department of Defense-related activities such as Transition Assistance Program (TAP) briefings and National Guard and Reserve component conferences.

H.R. 3008 has insufficient detail to fully develop a cost estimate. The grant costs associated with this bill could range anywhere from no cost to $50 million annually. VA would incur additional costs to administer the program, but we are unable to determine FTE costs at this time.

H.R. 3795

H.R. 3795, the "You Were There, You Get Care Act of 2007," would add to the list in current law of diseases presumed to be service connected for a radiation-exposed veteran any other disease "covered" under 38 CFR § 3.309 or 3.311, as well as any other disease found by VA to result from exposure to depleted uranium or the by-products of the burn-off that occurs when a depleted uranium munition penetrates a target. H.R. 3795 would also require that a veteran who served in the Persian Gulf War or any subsequent conflict in which depleted uranium munitions were

used, if that service was in a theater of operations or involved the clean-up or servicing of vehicles or equipment that had been in such a theater of operations, be considered a "radiation-exposed veteran" for purposes of the presumptions of service connection for such veterans. The bill would require the Secretary to provide for an independent in-depth medical study to be conducted by civilian medical entities to determine other diseases that may result from exposure to depleted uranium. Upon receiving the report of the study, the Secretary would have to transmit a copy of the report to the Congressional veterans' affairs committees.

VA does not support this bill because it would create an overly broad presumption. Although the statutory provision the bill would amend provides a presumption for diseases associated with exposure to ionizing radiation, section 3.309 covers many conditions not associated with radiation exposure, such as chronic diseases, tropical diseases, diseases specific to former POWs, and diseases associated with exposure to certain herbicide agents. H.R. 3795 would extend the presumption of service connection for radiation-exposed veterans to all of these unrelated diseases.

The scope of H.R. 3795 is also extremely broad in covering veterans who served in the theater of operations in a conflict in which depleted uranium munitions were used. Depleted uranium munitions are used primarily as anti-tank rounds. The bursting radius of those rounds is much smaller than that encountered in aboveground nuclear tests. Furthermore, the provision could be read to include "in the theater of operations" servicemembers who served at sea or in airborne operations whose service occurred far from where these weapons were used. Exposure to hazards from depleted uranium would be very unlikely, if not impossible for such servicemembers.

We are developing a benefit-cost estimate for this bill and will submit it for the record. No additional FTE costs would be associated with this bill because a minimal impact on workload would be expected. We estimate that discretionary costs related to the study, based on previous contracts, would be less than $2 million.

H.R. 4274

H.R. 4274, the "Gold Star Parents Annuity Act of 2007," would provide a monthly benefit of $125 to parents of servicemembers who lost their lives while on active duty in certain military operations described by 10 U.S.C. § 1126(a). If more than one parent is eligible for the benefit, it would be divided equally among the eligible parents.

VA honors the sacrifice of the servicemembers who have lost their lives in the service of their country. VA also recognizes and honors the supreme sacrifice of Gold Star parents, who have lost a son or a daughter serving in the Armed Forces. However, VA does not support this bill because VA already provides a monthly benefit to certain qualifying parents.

Parents' dependency and indemnity compensation (DIC) is a monthly benefit that is currently paid to eligible surviving parents of a veteran who died while on active duty, or after service as a result of service-connected disability. Parents' DIC is a need-based income-support benefit.

H.R. 4274 would authorize a small benefit, which would be divided among eligible parents if there is more than one. The administrative burden of paying this benefit would be great relative to its size. Additionally, the bill would provide disparate treatment. Although it may be appropriate for the Congress to distinguish between combat-related deaths and other service-related deaths, the requirement that the servicemember have died while engaged in combat operations and on active duty fails to acknowledge that some post-service deaths, particularly in the early years following separation, can be tied directly to battle wounds and thus creates at least the appearance of disparate treatment.

Costs for this bill cannot be estimated at this time.

H.R. 5155

H.R. 5155, the "Combat Veterans Debt Elimination Act of 2008," would prohibit VA from collecting all or part of a debt owed to the United States under any program under the laws administered by VA (other than a housing or small business program under chapter 37 of title 38, United States Code) by a veteran who dies as a result of a service-connected disability incurred or aggravated while serving in a theater of combat operations in a war after the Persian Gulf War or in combat against a hostile force during a period of hostilities after September 11, 2001, if the Secretary determines that termination of collection is in the best interest of the United States. The amendments made by the bill would be effective on the date of enactment and would apply "with respect to collections of indebtedness of veterans who die on or after September 11, 2001."

VA supports the intent behind this bill, but does have a concern with the effective-date provision. That provision is unclear as to whether the prohibition on debt collection would apply retroactively to a debt already collected before the date of enactment or apply only prospectively. We recommend that the bill be amended to require VA to refund any amount of a debt of a covered veteran collected after September 11, 2001, but before the date of enactment.

We estimate that enactment of this bill, if amended as recommended, would result in additional benefit costs of $5,000 for FY 2009 and a 10-year cost of $50,000.

H.R. 5454

H.R. 5454, would establish a presumption of service connection for amyotrophic lateral sclerosis (ALS), a rare disease of unknown cause, for any veteran who develops the disease to a compensable level at any time after separation from service.

VA does not support this bill. Current evidence does not justify the establishment of a presumption for ALS. There is insufficient credible scientific evidence that ALS is caused by service or more likely to develop in veterans as opposed to the general population. Although the Institute of Medicine (IOM) found limited suggestive evidence of an association between the development of ALS and military service, the IOM clearly indicated that the disease's cause is unknown. A review of the literature cited seems to suggest that ALS is associated with vigorous people, as would be found in military service, but is not unique to the military.

We estimate benefit costs of this bill to be $23.5 million during FY 2009, $214.2 million over 5 years, and $505.8 million over 10 years. This bill would minimally affect workload, so FTE costs would be insignificant.

H.R. 5709

H.R. 5709, the "Veterans Disability Fairness Act," would require the Secretary to carry out quality assurance activities with respect to the administration of disability compensation to ensure accuracy and consistency across different VA offices with respect to whether a disability is service connected and disability ratings. The Secretary would be required to retain, monitor, and store data for each claim for disability compensation, to include: (1) the state the claimant resided in when the claim was submitted; (2) the Secretary's decision with respect to the claim; (3) the regional office and individual employee responsible for evaluating the claim; (4) the results of adjudication; and (5) such other data as the Secretary determines is appropriate for monitoring the accuracy and consistency of decisions.

H.R. 5709 would further require VA to conduct reviews and audits, at least annually, to identify and correct any adjudication inaccuracies or inconsistencies. The reviews and audits would have to include a sample large enough to draw statistically valid conclusions. Additionally, the Secretary would have to consider factors relating to consistency and accuracy when evaluating adjudication employees. The bill would require the Secretary to report to Congress, within 60 days of enactment, on the implementation of this legislation and to include information on consistency in the annual report required by 38 U.S.C. § 7734(2).

VA does not support H.R. 5709. VA already has measures in place, and is implementing additional measures, that address most of the subjects covered in H.R. 5709. VA has a robust quality assurance program. Quality reviews are conducted on a statistically valid sample of adjudicated claims. VA will begin routinely monitoring the most frequently rated diagnostic codes in FY 2008 to assess consistency of service-connection determinations and degree of disability assigned for various disabilities across regional offices. VA conducts regular site visits at VA regional offices to assess operations for consistency and accuracy. In addition, a random sample of cases adjudicated by employees responsible for adjudicating claims is reviewed for quality at the regional offices. The results of this review represent one element of employee performance.

Training is an integral part of VA's quality assurance program. The Center for Naval Analyses reviewed VA's training efforts for the Veterans' Disability Benefits Commission and was highly complimentary of VA's training efforts in testimony before the Commission. Also, in a recent assessment of the Department of Defense (DoD) Disability Evaluation System, the Government Accountability Office referred to the VA Compensation and Pension quality review program as a favorable model for adoption.

Because the bill would not affect benefit entitlement, no mandatory costs would be associated with it. There would be no additional FTE costs because the bill would not affect workload, and VA already maintains a staff to conduct quality and consistency reviews.

H.R. 5954

H.R. 5954 would: (1) establish a presumption of service connection for any diagnosed disease determined by the Secretary to have an increased incidence in veterans exposed to a biological, chemical, or other toxic agent known or presumed to be associated with service during which the veteran was directly or indirectly subjected to a chemical or biological warfare test or project under Project 112; (2) require the Secretary to determine the presumptive period during which such disease must manifest itself to warrant a presumption of service connection; (3) establish a presumption of such exposure if the veteran was subjected to a Project 112 test; and (4) require the Secretary to notify, under regulations prescribed not later than 180 days after enactment, all veterans who were potentially exposed to any biological or chemical agent, simulant, tracer, or decontaminant during Project 112 of the potential exposure.

Further, this bill would require DoD, in consultation with VA, to submit to Congress, within 1 year after enactment, a report that would: (1) document the costs, benefits, and challenges associated with continuing the search for additional Project 112 participants; (2) provide a full accounting of all information known concerning Project 112 participants; and (3) address other concerns regarding Project 112 held by the VA, veterans, or veterans service organizations.

Project 112 was a comprehensive program initiated in 1962 by DoD to protect and defend against potential chemical and biological warfare threats. Project SHAD (an acronym for Shipboard Hazard and Defense), a component of Project 112, encompassed a series of tests by DoD to determine the vulnerability of U.S. warships to attacks with chemical and biological warfare agents, and the potential risk to American forces posed by these agents. Project 112 also involved similar tests conducted on land rather than aboard ships.

VA opposes this bill. VA has already contracted for a significant long-term study concerning the health effects on SHAD participants and received the report from the IOM. The Secretary has authority to contract for an additional study if it is deemed necessary. We believe that enactment of this bill is unwarranted at this time due to the lack of credible scientific and medical evidence that adequately demonstrates any statistically significant correlation between participation in SHAD tests and the subsequent development of any disease.

DoD continues to release declassified reports about sea—and land-based tests of chemical and biological materials associated with Project 112. VA is working with DoD to obtain information regarding the tests, including who participated, duration, and agents used. DoD estimates that about 6,000 veterans may have been involved in Project 112/SHAD. To date, DoD has provided VA with the names of approximately 5,000 veterans who participated in the tests. In May 2002, VA began to contact veterans who participated in Project SHAD about medical care and benefits to which they may be entitled.

In October 2002, VA contracted with the IOM to conduct a 3-year, $3-million study of potential long-term health effects of tests conducted aboard Navy ships in the sixties. IOM's report, "Long-Term Health Effects of Participation in Project SHAD," was published in May 2007 and found no clear evidence that specific long-term health effects are associated with participation in Project SHAD.

We are in the process of estimating the costs that would be associated with enactment of this bill, and we will provide them for the record.

H.R. 5985

H.R. 5985, the "Compensation for Combat Veterans Act," would require VA to treat certain veterans as having engaged in combat with the enemy for purposes of 38 U.S.C. § 154(b), thus permitting the use of lay or other evidence for proof of service incurrence of a combat-related disease or injury. The veterans who would qualify for this treatment are veterans who, during active service with a U.S. military, naval, or air organization during a period of war, campaign, or expedition, served in a combat zone for purposes of section 112 of the Internal Revenue Code 1986, or a predecessor provision of law. In essence, this bill would equate service in a combat zone with engaging in combat with the enemy. VA does not support this bill.

Section 112(c)(2) of the Internal Revenue Code 1986 defines "combat zone" as any area that the President by executive order designates as an area in which U.S. Armed Forces are engaging or have engaged in combat. Section 112 governs the computation of gross income for tax reporting purposes based upon service and applies to all veterans who serve in a combat zone regardless of actual involvement in combat. The executive order designates which geographical areas are combat zones and the date of commencement of combat activities.

Section 1154(b) of title 38, United States Code, relaxes the evidentiary requirements a combat veteran must meet to prove service incurrence or aggravation. The language of section 1154(b) makes it clear that its purpose is to liberalize the method of proof for claims based on injuries incurred or aggravated while engaged in combat with the enemy. This provision recognizes the unique circumstances of combat, which are not favorable for documentation of injury or illness because treatment for such injury or illness may be administered in the field under exigent conditions that do not permit concurrent documentation. Supporting evidence is often difficult to obtain when a veteran later files a claim for disability compensation for a combat-related disability. This bill contemplates that all veterans in a combat zone are faced with the same difficulty in documenting treatment for injury or illness. However, the same difficulty does not exist for servicemembers who, although serving in a combat zone, have access to a medical facility for treatment and whose treatment would be documented in service treatment records. The purpose of section 1154(b) was to recognize the unique circumstance of actual combat.

We cannot estimate benefit costs that would result from enactment of this bill because there are no data available upon which to estimate the number of claims for service connection filed by veterans for disabilities incurred in a combat zone.

H.R. 6032

H.R. 6032 would establish a presumption of service connection for Parkinson's disease for any veteran who served in the Republic of Vietnam during a certain period and develops the disease to a compensable level at any time after separation from service.

VA does not support this bill. The Agent Orange Act 1991, codified at 38 U.S.C. § 1116, requires that, when the Secretary, on the basis of sound medical and scientific evidence, determines that a positive association exists between herbicide exposure and a disease, the Secretary will issue regulations providing a presumption of service connection for such disease. The Agent Orange Act further directs that the Secretary take into account reports from the National Academy of Sciences.

The IOM of the National Academy of Sciences has consistently determined that there is insufficient evidence to associate Parkinson's disease with herbicide exposure. The IOM continued this determination in its most recent report, "Veterans and Agent Orange, Update 2006." VA believes that it should recognize diseases as presumptively associated with service only if such association is adequately established by credible medical and scientific evidence. Such evidence has consistently failed to demonstrate an association between Parkinson's disease and herbicide exposure.

We are in the process of estimating the costs that would be associated with enactment of this bill and will provide them for the record.

This concludes my statement, Mr. Chairman. I would be happy to entertain any questions you or the other Members of the Subcommittee may have.

Statement of Hon. Michael L. Dominguez,
Principal Deputy Under Secretary of Defense for
Personnel and Readiness, U.S. Department of Defense

Mr. Chairman and Members of this distinguished Committee, thank you for the opportunity to provide views on draft legislation. Our comments on several of the bills are below.

H.R. 3795, *the bill provides that veterans of service in the 1991 Persian Gulf War and subsequent conflicts shall be considered to be radiation-exposed veterans for purposes of the service connection of certain diseases and disabilities.*

The Department of Defense (DoD) opposes this legislation. This bill is very broad and assumes any participation in the 1990–1991 Persian Gulf War with subsequent development of diseases, as specified in sections 3.309 and 3.311 of Title 38 of the Code of Federal Regulations (cancers and other diseases) is based on radiation exposure. It eliminates any requirement for evidence of radiation exposure. More to the point, the premise that depleted uranium causes a radiation hazard that is sufficient to cause adverse health effects in humans is unsupportable. Uranium is a very common naturally occurring heavy metal, and depleted uranium is 40 percent less radioactive than natural uranium. There is no evidence that the extremely low radiation levels emitted by depleted uranium can cause illnesses in humans. There is no evidence that natural or depleted uranium exposure causes cancer in humans.

H.R. 5454, *the bill establishes a presumption of service connection of amyotrophic lateral sclerosis (ALS) for purposes of the laws administered by the Secretary of Veterans Affairs.*

DoD opposes this legislation. The scientific evidence does not support a presumption of service connection of ALS. Although there are a couple of reports that show a possible association between ALS and military service, there is currently insufficient evidence to conclude that ALS is caused by military service. In the general population, approximately 10 percent of cases are genetic and the causes of the other 90 percent of cases are unknown. Similarly, the causes of 90 percent of ALS cases in military veterans are unknown. Several research projects are underway that will determine whether military veterans are at increased risk for developing ALS, compared with individuals who did not serve in the military.

H.R. 5954, *the bill provides veterans presumptions of service-connection for purposes of benefits under laws administered by Secretary of Veterans Affairs for diseases associated with service in the Armed Forces and exposure to biological chemical or other toxic agents as part of Project 112.*

DoD opposes this legislation. The scientific evidence does not support a presumption of service connection for any diseases associated with exposure to biological, chemical, or other toxic agents that resulted from Project 112 (also frequently called Shipboard Hazard and Detection—SHAD, although SHAD was only a component of Project 112). Project 112/SHAD was a series of tests which took place in 1962–73. The Department of Veterans Affairs requested civilian medical experts in the Institute of Medicine (IOM) to perform a comprehensive study of the possible long-term health effects of participation in Project 112. The IOM study was published in 2007 and concluded that there was no clear evidence of specific health effects that were associated with participation in Project SHAD.

In addition, having conducted an exhaustive search for information on Project 112/SHAD, DoD does not agree that additional archives searching would result in a more complete documentation. However, DoD will investigate any new information that may be presented and share that information with the Department of Veterans Affairs and the public.

H.R. 5985, *the bill clarifies the service treatable as service engaged in combat with the enemy for utilization of non-official evidence for proof of service-connection in a combat-related disease or injury.*

DoD opposes this legislation. This provision equates service in a combat zone with engaging in combat with the enemy for the purposes of establishing service connection for combat-related diseases or injuries. While supporting evidence is often difficult to obtain for disability compensation for a combat-related disability, this bill provides that all veterans in a combat zone are faced with the same difficulty in documenting treatment for injury or illness. However, the same difficulty does not exist for servicemembers who, although serving in a combat zone, have access to a medical facility for treatment and whose treatment would be documented in service treatment records.

H.R. 6032, *the bill directs the VA Secretary to provide wartime disability compensation for certain veterans with Parkinson's disease.*

DoD opposes this legislation. This legislation would provide a presumption of service connection for Parkinson's disease for veterans of the Vietnam War. From 1994 to 2006, the IOM has published seven exhaustive reports on the possible health effects of Agent Orange and other herbicides used during the Vietnam War, and another report will be published during the next year. The IOM has consistently concluded that there is insufficient evidence for a link between exposure and Parkinson's disease. Therefore, scientific evidence is lacking to support a presumption of service connection.

Statement of Hon. Bruce L. Braley, a Representative in Congress from the State of Iowa

Thank you, Chairman Hall, Ranking Member Lamborn, and Members of the Subcommittee, for considering H.R. 5985, the *Compensation for Combat Veterans Act*, at your hearing today. It is an honor to testify before you in support of this legislation.

I introduced the *Compensation for Combat Veterans Act* in May in order to address a problem faced by too many of our veterans. Today, combat veterans are required to provide official evidence that they were wounded in a specific combat incident in order to demonstrate that their injuries are service-connected. I believe that Congress should overturn this requirement, and that service in a combat zone

should be sufficient evidence to demonstrate that a veteran received their injuries in combat.

The *Compensation for Combat Veterans Act* would clarify that evidence in a veteran's record of assignment in a combat zone is sufficient for a veteran to prove their combat service when other military documents are unavailable. This bill would remove the documentation barriers that in some cases are preventing combat veterans from receiving compensation for their disabilities, or which cause unnecessary delays in providing veterans with the benefits they deserve.

A law passed in 1941 liberalized the requirements for proof of service-connection in cases involving veterans who participated in combat. Under this existing law, veterans who can establish that they participated in combat do not have to produce official military records to support their claim that their disabilities or injuries are service-connected.

However, a Department of Veterans Affairs General Counsel opinion issued in 1999 requires veterans to establish by official military records or decorations that they "personally participated in events constituting an actual fight or encounter with a military foe or instrumentality." Under this opinion, some veterans are being delayed or denied compensation for combat injuries because they are unable to produce official military documentation—like certain medals, unit reports, or news reports—proving their personal participation in a specific combat incident.

While the VA accepts certain medals as proof of combat, only a fraction of those who actually participate in combat receive a qualifying medal. In addition, making, maintaining, and transmitting records in combat zones can be difficult and chaotic, and military records usually do not document actual combat experiences.

Mr. Chairman, I believe that the last thing our wounded veterans returning home from war should have to do is engage in another battle with the VA to prove that they were wounded in a specific incident in order to receive disability benefits. How can the VA conscionably force a veteran suffering from Post-Traumatic Stress Disorder (PTSD), or from a physical injury incurred in combat, to track down official proof—proof that may not even exist, considering the poor records keeping in combat zones—of their engagement in battle? How can the VA force wounded veterans to wait indefinitely for help as the VA conducts research to determine whether the veteran's unit engaged in combat?

This requirement is just one more example of an unnecessary bureaucratic barrier, another piece of arbitrary red tape, which our wounded veterans must face. I am especially concerned with this bureaucratic hurdle because, as we saw at the Oversight and Government Reform Committee hearing at Walter Reed last year, the layers and layers of VA and DoD bureaucracy directly contributed to the systemic breakdown and the mistreatment of veterans there. Unless we start to peel away these bureaucratic layers, I'm afraid we are in danger of repeating the shame of Walter Reed and denying veterans the treatment and benefits they deserve.

Indeed, unnecessary red tape and unnecessary delays in receiving benefits continue to plague veterans all over the country, and continue to be identified by veterans and those who work with them as one of the most significant problems facing returning veterans today. The astounding number of backlogged VA benefits claims—currently over 648,000—is evidence of this problem. I am concerned that this number is only going to increase as more veterans return from the wars in Iraq and Afghanistan unless we address some of these paperwork and documentation problems. The *Compensation for Combat Veterans Act* would do just that: VA Regional Offices have estimated that the passage of this bill would speed up their claims processing by weeks.

David Woods, the Director of Veterans Affairs for Scott County, Iowa, who is testifying before the Subcommittee today, estimates that he has helped 75–100 injured veterans who have had problems proving that they were injured in specific combat incidents. This includes veterans returning from Iraq and Afghanistan, as well as Vietnam veterans experiencing PTSD triggered after several decades by the current wars. As David has said, soldiers engaged in combat are often from several different units and do not know who is there fighting along with them when a battle breaks out. Soldiers engaged in combat are focused on survival—not documenting where and when the battle is taking place.

My office has also worked with at least one veteran who has experienced this problem. This veteran came to my office last August asking for assistance with his service-connected disability claim for his wounded shoulder and other injuries. Though the VA treated his shoulder, since his medical records from Iraq are missing, the VA won't approve service-connection. This veteran has served two separate deployments in Iraq, and I believe that it is unacceptable that he is being denied the benefits that he deserves.

That is why I believe it is so important to pass the *Compensation for Combat Veterans Act*. My bill would overturn the VA General Counsel precedent opinion, and allow for utilization of non-official evidence as proof of in-service occurrence for establishing service connection of combat-related diseases and injuries. This bill would eliminate the requirement for further evidence in cases in which a veteran can demonstrate service in a recognized combat area, alleges disabilities related to their service in that combat area, and has a disease or injury consistent with the circumstances, conditions, or hardships of their service in that combat area. This bill would lower the evidentiary standards for veterans suffering from physical injuries, as well as from mental wounds like PTSD or Traumatic Brain Injury, the hidden and hallmark wounds of the wars which often do not materialize for months after a veteran has returned home.

Again, thank you for allowing me to testify in support of the *Compensation for Combat Veterans Act* today. I hope that the Subcommittee and full Veterans Affairs' Committee will act quickly to move this important legislation forward to ensure that combat veterans receive the benefits they deserve in a timely manner.

Statement of Kerry Baker,
Associate National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

On behalf of the 1.3 million members of the Disabled American Veterans (DAV), I am honored to present this testimony to address various benefits bills before the Subcommittee today. In accordance with our congressional charter, the DAV's mission is to "advance the interests, and work for the betterment, of all wounded, injured, and disabled American veterans." We are therefore pleased to support various measures insofar as they fall within that scope.

H.R. 1197

The "Prisoner of War Benefits Act of 2007" (H.R. 1197), introduced by Congressman Bilirakis in February 2007, would provide improved benefits for veterans who are former prisoners of war (POW). Specifically, H.R. 1197 would repeal the minimum period of internment for presumptive service connection for diseases associated with POW status. The bill would also add type 2 Diabetes and osteoporosis to the list of diseases presumptively associated with POW status. The DAV has a standing resolution to support the expansion of benefits for former POWs; therefore, we support this bill.

The bill also authorizes the Department of Veterans Affairs (VA) to establish additional diseases as presumptively related to a veteran's POW status. Such authorization instructs the VA to establish a new disease as presumptively related to POW experiences whenever credible evidence for the association is equal to or outweighs the credible evidence against the association. The DAV feels this criteria is very fair considering that a disease may not be considered presumptive unless evidence as a whole suggests no relationship and that such evidence is not outweighed by evidence that does suggest a relationship. The Nation's former POWs have earned no less.

H.R. 3008

The "Rural Veterans Services Outreach and Training Act" (H.R. 3008), introduced by Congressman Wu in July 2007, is meant to improve services to veterans residing in rural areas. The bill proposes to improve outreach and assistance to veterans, their dependents, and survivors through training of rural county veterans' service officers (CVSOs). The bill proposes to do this by making competitive grants to provide financial assistance to state departments of veterans affairs wherein the grants are determined by the Secretary of Veterans Affairs (Secretary) but shall not exceed $1,000,000.

The DAV is concerned that providing Departmental funds to train CVSOs may not be the best use of such funds. Nonetheless, the DAV has no resolution on this issue and we therefore take no position on the bill.

H.R. 3070

The "Disabled Veterans' Caregiver Compensation Act" (H.R. 3070), introduced by Congressman Peterson in July 2007, would authorize additional compensation, in the amount of $234.00, to be paid to certain veterans in receipt of compensation for

a service-connected disability rated totally disabling for whom a family member dependent on the veteran for support provides care. This extra compensation would be paid "[i]f and while rated totally disabled and in need of regular aid and attendance and while unpaid aid and attendance is provided by an adult family member who is dependent upon such veteran for support. . . ."

The DAV supports this bill—we applaud it. However, clarification is needed. Title 38 defines "child" and "parent" as they relate to various veterans' benefits. Title 38 does not define "dependent" for benefits administered by the Secretary. Without such a definition, at least concerning the amendments made by this bill, it will be unclear who qualifies for this benefit. For example, an adult child caring for a veteran described by this bill may qualify as an "adult family member" but still not qualify as "dependent upon such veteran" if the child were not financially dependent on the veteran. Such a child could not qualify as a dependent, even if he/she had to relinquish employment in order to care for the parent because the child may no longer qualify as a "child" for VA purposes.

We do not believe the bill's intent is to exclude those in the above scenarios, as well as others. Therefore, while we fully support the bill, we request the bill be amended to properly define who does and does not qualify for the benefit provided by the bill.

Additionally, the amount of compensation listed herein ($234) is equal to the amount of compensation listed in section 1115 payable to a veteran with a spouse in need of aid and attendance. If this figure is no coincidence, which we do not believe to be the case, we must note that $234 is the figure for 2002. We asked that the bill be amended to reflect the current year's level of compensation.

H.R. 3795

The "You Were There, You Get Care Act of 2007" (H.R. 3795), introduced by Chairman Filner in October 2007, would provide that veterans of service in the 1991 Persian Gulf War and subsequent conflicts shall be considered to be radiation-exposed veterans for purposes of service connection for certain diseases and disabilities, and for other purposes. This bill would provide presumptive service connection for any "disease that is covered under section 3.309 or 3.311 of title 38 of the Code of Federal Regulations and any other disease found by the Secretary to result from exposure to depleted uranium or the by-products of the burn-off that occurs when a depleted uranium munition penetrates a target. The DAV supports this bill.

Those veterans covered by this bill are those that served during the Persian Gulf War or any subsequent conflict in which depleted uranium munitions are used, if that service is in the theater of operations of that war or conflict or involved the clean-up or servicing of vehicles or equipment that had been in such a theater of operations. The DAV does not have a standing resolution directly on point with this bill, we do however have resolutions calling for the support of enhanced benefits for Persian Gulf War veterans suffering from diseases associated with their service. Therefore, the DAV fully supports this bill.

H.R. 4274

The "Gold Star Parents Annuity Act of 2007" (H.R. 4274), introduced by Congressman Walsh in December 2007, would provide for the payment of a monthly stipend to the surviving parents (known as "Gold Star parents") of members of the Armed Forces who die during a period of war. The DAV has no opposition to this bill.

This bill would require the Secretary to pay a monthly pension to each person who has received a gold star lapel button under section 1126 of title 10 as a parent of a person who died in a manner described in that section. The total amount of payment to a Gold Star parent would be $125. If there is more than one eligible parent, the total amount would be divided equally among the eligible parents.

While the DAV has no opposition to this bill, we do not believe that $125, or $75 dollars each for two parents is adequate. These amounts cannot begin to honor the depth of a parent's sacrifice when their child, perhaps their only child, is lost forever on a distant battlefield. Death on the battlefield is unquestionably the greatest sacrifice a servicemember can make for his or her country, but it is also the greatest sacrifice that a parent can make. Therefore, while we respect the intent of this bill and thank Mr. Walsh for its introduction, we respectfully request the monetary amount described herein be substantially increased.

H.R. 5155

The "Combat Veterans Debt Elimination Act of 2008" (H.R. 5155), introduced by Congresswoman Shea-Porter in January 2008, would prohibit the Secretary from

collecting certain debts to the United States in the case of veterans who die as a result of a service-connected disability incurred or aggravated on active duty in a combat zone. The DAV has no resolution on this issue, which is essentially outside our mission scope. Therefore, we take no position on this bill.

H.R. 5448

The "Full Faith in Veterans Act of 2008" (H.R. 5448), introduced by Congressman Allen in February 2008, would seek to improve the disability compensation evaluation procedures for veterans with post traumatic stress disorder and to improve the diagnosis and treatment of post traumatic stress disorder. The DAV has no opposition to this bill; in fact, we are on record as staunch supporters of a similar bill, H.R. 5892.

H.R. 5892 accomplishes many of the same goals as this bill and has already been moved out of Committee and into the full House. H.R. 5892 is also more comprehensive than H.R. 5448, while achieving the same goals as this bill. Because of this, and even though we do not oppose this bill, we respectfully request that any resources that Congress would otherwise spend on this bill be diverted to support the passage of H.R. 5892.

H.R. 5454

Congressman Brown introduced H.R. 5454 in February 2008. This bill would establish a presumption of service connection of amyotrophic lateral sclerosis for purposes of the laws administered by the Secretary. Essentially, this bill would amend section 1112 of title 38, United States Code, to provide for a presumption of service connection for amyotrophic lateral sclerosis when developing to a 10 percent degree of disability at any time after service. Although the DAV has no resolution on this issue, because of its positive impact on disabled veterans and their dependents, as well as the higher prevalence of this disease among the veteran population, we support this bill in full.

H.R. 5709

The "Veterans Disability Fairness Act" (H.R. 5709), introduced by Congressman Space in April 2008, would require the Secretary to carry out quality assurance activities with respect to the administration of disability compensation. In order to carry out the quality assurance program under section 7731 of title 38, United States Code, with respect to the administration of disability compensation, this bill would require the Secretary to ensure accuracy and consistency across different offices within the Department of the treatment of claims for disability compensation, including determinations with respect to disability ratings and whether a disability is service connected.

For each disability compensation claim, this bill would require the Secretary to track and monitor the following: (1) The state in which the claimant resided when the claim was submitted; (2) the decision of the Secretary with respect to the claim; (3) the regional office and individual employee of the Department responsible for evaluating the claim; (4) if the claim was adjudicated, the results of such adjudication; (5) the state of the claimant's residence; and (6) such other data as the Secretary determines is appropriate for monitoring the accuracy and consistency of decisions with respect to such claims. Once compiled, the Secretary would be required to use this information to conduct annual reviews to correct any inaccuracies or inconsistencies in disability ratings and the adjudication of claims for disability compensation. Such reviews and audits shall evaluate disability ratings and claims adjudication by regional office and by the employee responsible for each such rating or adjudication

The DAV has long advocated for enhanced quality assurance and oversight of VA's disability claims processing system. We therefore support this bill and applaud Mr. Space for its introduction.

H.R. 5954

Congressman Thompson introduced H.R. 5954 in May 2008. If enacted, this bill would provide veterans with presumptions of service connection for purposes of benefits under laws administered by the Secretary for diseases associated with service in the Armed Forces and exposure to biological, chemical, or other toxic agents as part of Project 112. This bill is one that all disabled veterans who were unknowingly harmed by military experiments and wrongfully denied disability benefits to which they were legally entitled should celebrate.

This legislation will only be successful if the Department of Defense (DoD) releases the names of all participants of these military experiments, many of which may not even be aware of their involvement. For this reason, the DAV is pleased that this bill requires the DoD to release the information vital for the success of this bill. Without such a requirement, those affected by these unthinkable experiments will continue to be locked out of a system otherwise designed to provide the help this bill delivers.

Since 2003, the DoD has stopped actively searching for individuals who were potentially exposed to chemical or biological substances during Project 112 tests, but have not provided any basis for that decision. In 2003, the DoD reported it had identified 5,842 servicemembers as having been potentially exposed during Project 112, but also indicated that it would cease searching for additional individuals. In 2004, the government Accountability Office (GAO) reported that the DoD did not exhaust all possible sources of information.

Since June 2003, however, non-DoD sources—including the Institute of Medicine—have identified approximately 600 additional names of individuals who were potentially exposed during Project 112. This fully supports the proposition that the DoD's actions were completely arbitrary. Until these issues are addressed, veterans will remain unaware of their potential exposure, and this monumental injustice of experimentation on U.S. servicemembers will continue to go unanswered. Congress must mandate that the DoD live up to its obligation of identifying every single veteran that may have had even the smallest potential of exposure. This bill is a large step in the right direction and the DAV supports it.

H.R. 5985

The "Compensation for Combat Veterans Act" (H.R. 5985), introduced by Congressman Braley in May 2008, would clarify service treatable as "service engaged in combat with the enemy" for utilization of non-official evidence as proof of service connection in a combat-related disease or injury. The DAV supports this bill; however, we suggest amendments. This legislation establishes that a veteran who "during active service . . . served in a combat zone for purposes of section 112 of the Internal Revenue Code of 1986, or a predecessor provision of law, shall be treated as having engaged in combat with the enemy in active service for purposes of that paragraph during such service in that combat zone." The legislation as currently written would allow, for example, an Iraqi War veteran who only served in Bahrain and was consequently never in danger of being exposed to combat, the same consideration as an Iraqi War veteran who served inside the combat theatre of operation.

We therefore suggest an amendment to this legislation that would still consider a class of veterans as having been exposed to combat, but suggest that those veterans with service inside the borders of the combat theatre of operation receive such consideration, such as those serving inside the borders of Iraq, Afghanistan, Vietnam, etc.

H.R. 6032

Congressman Filner introduced H.R. 6032 in May 2008. The bill would direct the Secretary to provide wartime disability compensation for veterans who served in the Republic of Vietnam and who have manifested Parkinson's disease to degree of 10 percent or more. The DAV is certainly not opposed to enhancing benefits for veterans who served in the republic of Vietnam. However, currently we are unaware of scientific evidence suggesting a positive association between Parkinson's disease and exposure to herbicides. Therefore, the DAV takes no position on this bill. If, however, such scientific evidence becomes available, or we are otherwise made aware of its existence, we will fully support this legislation.

Mr. Chairman, this concludes my testimony on behalf of DAV. We hope you will consider our recommendations.

Statement of Susan R. Frasier,
Albany, NY (Disabled Veteran), on behalf of
Fort McClellan Veterans Stakeholders Group

Thank you Mr. Chairman, for allowing us to make a brief appearance in writing for the record, and to speak on some of the breakthrough bills which appear on your docket today. Our remarks will be directed to H.R. 5954 which provides a long awaited justice to our military brothers of the Project 112 ship tests during the Cold war Era, and also to H.R. 3795 for the veterans of the Gulf War.

I am the lead activist for the Fort McClellan Veterans Stakeholders Group. We formed this group in 2003 to advance our own pursuits for legislation and justice inside the VA disability system. We are mostly medical and disability patients who have served at Fort McClellan, Alabama from 1955 to 1978. We hold the Cold war Service Medals issued under the Clinton administration from years past. We do consider ourselves to be chemical exposure victims from our service at the base, and we can speak in verification about the ordeal the current VA disability system poses to any new and incoming Veterans who identify themselves as known or suspected exposure cases, regardless of the source.

We applaud, endorse, and support the victories which are represented in your bills today by H.R. 5954 and H.R. 3795. Those exposure groups have worked long and hard along side our own group, to receive this day of justice in their names. The tests of Project 112 and its loosely related counterpart, more commonly referred to out here in our Veterans arena as the Edgewood tests, were in some ways a freak of the times. We can only wonder what the military authorities were all thinking when they subjected these brave volunteers to various forces of contamination and then walked away without providing them with adequate followup reviews for medical tracking or to give them prioritized disability standing in the VA medical system.

For our Gulf War counterparts, they too have been put through an ordeal that was prolonged, unnecessary, and preventable if only the VA had a working "rapid response" system in place to activate temporary support services while their Presumptive statuses were pending.

The simple fact that it requires an act of Congress to rescue verified contamination medical patients inside the current structure of the VA disability system, speaks volumes about the ordeal that so many of us have been put through.

While we are relieved, happy, and gratified that H.R. 5954 has finally arrived for our military brothers of Project 112, we caution that the rest of the Edgewood test population still should be addressed by separate legislation, and when that happens, our group will then exert a vested interest in that outcome too.

Fort McClellan, Alabama from the years 1955 to 1978, also represents a freak of the times, and poses a new and unique situation to this legislating body of Congress. It is a situation which has never before been seen in the history of veterans disability claims. During the same and simultaneous time span of years, Fort McClellan was not only a part of the Edgewood series of open air chemical tests on the grounds of the base itself, but also, the same base was surrounded by a massive, PCB contamination zone by the nearby Monsanto chemical factory of it's day in our recreation district of downtown Anniston, Alabama. The PCB zone contaminated the air, the water, and the soil of much of the surrounding region leading up to the base, even though today's reports from the Environmental Protection Agency only addresses the modern day concerns and tests of the water and soil.

The rate of spew from the broken Monsanto air stacks, based on our computations made from the original notes of the Monsanto pollution engineers back in the day, amounted to over 2,000 tons per month released into the air back in the day. Then in addition to that, the EPA has estimated the cloud cover from that spew to have an extended overhead smog life of 10 days in lingering. This is to say that the thousands of pounds of PCB's that spewed into the air on any 1 day, also remained overhead in that same region for yet another 10 days in lingering before releasing and dispersing out into the general atmosphere away from the geographic location. Then this overhead lingering was added into by yet more spew.

Simultaneously, and without the knowledge of the nearby Monsanto disaster that was in the works, persons assigned to the Edgewood Cold war Era tests at Fort McClellan were conducting open air chemical tests on the base itself. These tests were done with inadequate attention applied to the protection of those volunteers who were actually in the tests, and with no protection whatsoever to those of us who were at other locations on the base and not involved in the tests. This was the time of the Vietnam War training maneuvers, which included Pentagon-mandated gashouse training which involved the removal of face masks inside of active (CN) and (CS) gas discharges so that we could be war certified in completion of our boot camp training.

We have contended that anyone of these exposure sources, or any combination of them in the hereafter, may be the causation of our modern day disabilities and diseases. We may actually be the very first known medical population to enter the military and VA system to declare ourselves as a "bystander" exposure population since we never knew the cause of either of these contamination scenarios.

So you can see here the similarity of concerns and experiences that we bring to the legislative table when offering up our support and sympathy to our Project 112 military brothers and our counterparts of men and women from the Gulf War.

The VA has been unresponsive to all of these exposure populations up until today, so it brings us a great sense of hope and celebration today to see with our own eyes, this day of victory and justice which is embodied in your bills of H.R. 5954 and H.R. 3795.

The Department of Veterans Affairs should undergo massive reorganization to position themselves for the future to serve and support all hazardous exposure military veterans, regardless of the source of their exposure. The current VA system is broken beyond repair and sadly, there is not even a showing of interest in repairing it whenever we have approached Washington VA officials for resolve.

The VA uses deprivation of services as the first course of action whenever they are approached by a new population of veterans who are suspecting themselves to be hazardous exposure medical patients. Without intervening legislation from Congress, their mistake will not likely be fixed. The VA has no understanding at all of the meaning of "emergency response." They will stand around in a spirit of inaction and delay, and literally allow veterans to die or have their hands forced into suicide from the prolonged suffering they endure, rather than to eat the embarrassments of correction and apology for their bureaucratic mistakes.

At the Fort McClellan contamination zone, the veterans who served there are medically matched to the nearby civilian population, and yet even with this stunning development to our advantage, the VA holds onto their delay practices, their deprivation of services, and their no assistance to our service group as medical patients.

In some ways, Project 112 and the related Edgewood tests are a symbol of what is also wrong at the VA. All of these matters are an outcome of excessive proofing requirements gone amuck. There reaches a point in most rational acts, where relentless questioning, unending verifying, and proofing above and beyond the norms of medical scenarios, (and the relentless demanding of the same), crosses a line beyond the normal limits of proper reason and travels straight over into a dark side where most of us would never go. There are people in this world who will spend all of their days questioning life itself: but that does not mean that the rest of us all have to go along for the ride.

The VA requires individual medical patients to shed themselves of their hospital standing, and become mini-agencies in their own name to prove up, answer up, comply up, and provide the tonnage of science, medical, classified, unclassified, military, unmilitary, hospital and even childhood documents just to prove that which every other rational American in this country can blatantly see with their own eyes as true. We say, that this all has to stop, in the name of saving the lives of Veterans. Proofing of disease and disability, at the level of extremes, excessiveness, and over the top—even when the same logical conclusion is as plain as day to everyone else who reviews a veterans case, is causing the premature deaths of our veterans and it is causing them to die with no service connected benefits in place at all.

Lack of information, concealment of information, and especially the absence of official NOTIFICATION to Veterans who may have been exposed to hazardous sources, wreaks havoc throughout the entire chain of process in both the VA and the Social Security systems. Veterans are first not officially notified of their exposure circumstances, and then are also burdened with elaborate and complicated "nexus theories" to succeed either in their individual disability claims or their pursuits for patient class recognition, which is known in the VA system as Presumptive Service Connected statusing.

Official notification to Veterans who have come into contact with any potential contamination source during their military service, must be integrated into all legislation and policy changes at the VA because it is crucial information that we have to pass along to our caregivers. It is vital deciding information that a practicing physician weighs upon during the moment of diagnosis for these veterans. So notification must be treated equal in importance to all other features of rescuing hazardous exposure veterans at the VA.

The VSO's do complicate this ordeal situation even further for us.

Instead of taking on the system to force the VA to reorganize themselves into an "emergency response" program to intake and serve these exposure veterans, the VSO's force veterans to endure years of process to comply with the wholly malpracticed systems which the VA currently has in place.

I have fired VSO's one by one in my own case for this very reason. Furthermore, VSO's only provide case-in-a-box assistance for claims.

Claims which are far more complicated, and not as cut and dried as the run of the mill, case-in-a-box, which are presented to them, are simply refused assistance by the VSO's due to complexity and their inability to either comprehend the details of the case, or their inability to construct fast and simple workarounds to the barriers put up by the VA. Also, if they do accept the case for VSO handling the vet-

erans are subordinated to unqualified and incompetent case people who are in over their heads and don't know it. In the end, these exposure cases in some cases, not always, remain unassisted by VSO's.

We have repeatedly gone out to VSO's to obtain help for our Fort McClellan advocacies only to have the door slammed in our faces with either a wall of silence, (much like what the VA does), or a lousy "thank you for sharing" letter to facilitate the VA's agenda of delay until death. I am almost 60 years old and mobility impaired with muscular disease and yet even identifying myself with that, VSO's have sided with the nonsense processes of the VA and not with us.

We consider ourselves to be holding matching and textbook disease patterns to be commonly recognized markers held in all other chemical exposure populations. But it is only the VA who stands around spinning its wheels on process and burdening us with delay.

Among the list of those refusing to help us as VSO's includes DAV, American Legion (Albany & Washington, DC), VFW, the WAC Veterans Association, Vietnam Veterans of America (the Womens Committee) the National Veterans Legal Services Corporation and the Veterans Pro Bono Consortium. Among those who have refused assisting us at the VA includes Dr. Mark Brown, Irene Trowell-Harris, the Center for Women Veterans, Comp & Pen, and the VA Secretary's Office himself. At the Dept. of Defense, the Office of Health Deployment sent us directly to the VA and would not talk to us any further after passing us to VA hands.

Among other things, the VA also forces medical patients to "incorporate" as nonprofit corporations just so they can obtain legislative or medical recognition as a patient group class. We say for the record that we are opposed to such practices and insist here before you today, that these larger systemic issues of the VA be mandatorily halted in the future. To say to a body of medical patients that their only hope of advancing medical assistance is to form a corporation and become a company is just plain nonsense and is contrary to the treatment advisory of licensed medical practitioners.

The Veterans Disability Benefits Commission of 2007, in their report to Congress in Chapter 5, has found in our favor as medical patients and has found against the practices of the VA. In combination with the Institute of Medicine and the Center for Naval Analysis, they have concluded that the Fort McClellan Veterans, whether involved in Edgewood tests or by their exposures to the Monsanto PCB contamination, should receive their day of legislative justice along with our counterparts represented in the bills before you today. They have also concluded that the VA's current process for Presumptive Service Connected statusing, should be wholly revised and undergo massive correction. Our Stakeholders Group did participate in the VDBC hearings and we gave our endorsements to these findings and conclusions when those topics came up for a floor vote by them. We implore upon you now to please change the VA presumptive system.

There are 2 simple questions to be answered in all of this as I present it to you today:

How much is "enough" for VA medical patients to have to endure without any assistance or services?

And also,

Why do individual medical cases have to endure excessive and over the top proofing requirements in exposure scenarios when the Dept. of Justice has already litigated cleanups on behalf of the Environmental Protection Agency for the nearby civilian population?

These are fair questions to know and I bring them to you today in the name of our Stakeholders Group.

I am not the U.S. Department of Susan R. Frasier, so why is the VA treating me as if I am a well-funded, fully staffed, and mobilized government agency without any health impairments?

The Duty To Assist clause in the 38 CFR is also a complete disaster for us. All it does is allow the VA to obtain documents which actually verifies our cases, (without us ever seeing those documents first), and then gives the VA (not the veteran) the litigating advantage to turn around and use those documents against us to further deny the cases. In other words, if there is a mistake in the papers which the VA retrieved, then the individual medical patient is blamed for that mistake.

In my own case, VARO Manhattan has sought to blame me personally for the fact that the Monsanto contamination zone in Alabama was never made publicly known until the late nineties. It is very much a matter of record that I was denied my 36 year old disability backlogged case because the Army failed to show in my hospital records that I was exposed at the Monsanto chemical zone, even though I had sent alternate information proving to the VA that the contamination was in the air during my army service.

All of official Washington appears to be unanimous in their voices that the VA systems of now are in dire need of change and correction. The VA has possessed the VDBC Commission report to Congress since October of 2007, and they have possessed Chapter 5 specifically since January 8, 2008 when I hand delivered it to the VA Secretary's Office in Washington. And yet here we are 5 months later with no assistance and no change and no legislation from the VA Secretary to this very minute.

Congress must look at the VA claims system with new eyes as if you are riding in a helicopter overhead to see the big picture.

In medical environments, there reaches a point where excessive and unnecessary process must be set aside in the name of good medicine and fair justice.

The proofing and evidencing requirements that we are burdened with as medical patients in the VA are extreme, excessive, over the top, and used only for purposes of delay and the causation of our premature deaths. It is done to literally stress and strain a genuinely sick veteran straight into his or her early grave with upset, despair, and relentless continuation in the scourge of poverty. These are inhumane practices which are done for the purpose of gaining legal advantage in a VA-sponsored disability litigation environment, and we call for its swift and decisive end. No other hazardous exposure veteran should have to endure what all of us have been forced to endure at the hands of the VA.

We send our love, our celebration, and our salutes, to our military brothers of Project 112 and to our counterparts of the Gulf War era. Their ordeal and odyssey is now over and not a minute too soon either. We share in their important victory.

We thank this Congress today, and to all who contributed to the development of H.R. 5954 and H.R. 3795 for the wisdom and rescue that both of these bills hold. We ask that you include "notification to veterans" in bills such as these in the future, to mandatorily require the VA to issue a letter and make an appropriate outreach effort to advise effected veterans that they have served in a potential contamination area. This notification is vital to the family information of those medical patients who are affected by contamination scenarios.

And we call upon Congress to continue its important work on these matters of intervention, correction, and emergency for all other remaining hazardous exposure patient groups, including the Fort McClellan Veterans, who remain hopelessly trapped in a VA system that is broken, uncaring, and unserving to all who identify themselves as potential new exposure cases.

Also Signed in Support, The Following Members of our group:

Carolyn Tyler—Wisconsin
Kathy Warren-Miller—Texas
Sandra Ashley—Washington
John Snodgrass—Alabama
Nancie Smith—Florida
Ellen O'Neill—Ohio
Carolyn Arnold—Ohio
John Kamps—Texas
Janie Lehman—Pennsylvania
William Brawley—North Carolina
Wanda Seay—California
Nancy Gower—Indiana

The remaining members of our group wish to remain anonymous.

Statement of Commander Norman C. Lachapelle, MSC, USN (Ret.), Administrator, Bureau of Environmental Health/Emergency Regional Response, Memphis and Shelby County Health Department, TN

Chairman Filner, Ranking Member Buyer and Distinguished Members of the Committee. My name is Norman C. Lachapelle and I live in Memphis, Tennessee. I am a retired Commander, Medical Service Corps, U.S. Navy and presently Administrator, Bureau of Environmental Health/Emergency Regional Response Coordinator with the Memphis and Shelby County Health Department in Tennessee.

I received orders to Project SHAD Technical Staff on board USS Granville S. Hall (YAG–40) in May 1965. My duty assignment was senior microbiologist and later technical operations officer charged with overseeing the microbiological and chemical functions in support of Deseret Test Center (DTC) SHAD tests. I served in that capacity until 1970 interrupted by a 12-month deployment in Vietnam in 1967.

In addition to the Division of five (5) light Tugs as described by the officer in charge's testimony, the technical staff of SHAD consisted of experienced Navy microbiologists, hospital corpsmen, laboratory technicians, gunners mate, meteorologists and photographers. This group was responsible for:

- Preparing and calibrating air monitoring equipment used on the five (5) Light Tugs that served as aerosol sampling platforms during open-air sea tests conducted with biological and chemical simulant released agents.
- Conducting quality control of "munitions" i.e., concentration of agent slurry used for aerosol dispersal from military jet aircraft.
- Analyzing test samples collected from Light Tugs for quantitative and qualitative microbiological evaluations.
- Preparing a summary of raw laboratory qualitative and quantitative analytical results and data submitted to DTC Test Director after the completion of each test trial. These data revealed the concentration of agents collected in the Light Tug laboratories after each test trial.

For the most part, technical staff participants were informed of the nature of the tests, standard operating procedures and trained in precautionary safety techniques using best available practices in the 1960's. In retrospect, based on my experience with DTC–SHAD sea and land base tests, more stringent safety measures should have been reinforced involving so called "harmless" simulants such as *Escherichia coli* (E-Coli) and Serratia marcescens (SM) which are now of medical concern and no longer used by military in biological aerosol testing. Most disturbing is the fact that in 1950 the Army sprayed SM off the Coast of San Francisco, and shortly afterwards patients at Stanford University Hospital began appearing with *Serratia marcescens* infections. This should have been a wake up call on the use of SM and other biologicals as simulants.

Bacillus globigii (BG) was used as a simulant in the majority of DTC tests. However, BG, as reported in the Institute of Medicine (IOM) long-term health effects of participants in Project SHAD study report, is now considered a pathogen for humans.

Of great concern was the application of beta-propiolactone (BPL) disseminated as a mist to decontaminate the interior of ships including the Light Tugs. The procedure involved sealing the vessel after the crew was evacuated and releasing the BPL from an electrical vaporizer for a period of time sufficient to destroy microorganisms. To my knowledge the concentration of BPL was not recorded or the testing of the interior spaces for residual BPL, to ensure safe re-entry. The International Agency for Research on Cancer (IARC) regards beta-propiolactone as a possible Carcinogen and cautions that a single dose of exposure is enough to pose a significant risk of cancer.

It is important to mention that high level DoD officials testified at a Senate Armed Services Hearing in 2003 that DTC test records indicated that sailors were vaccinated against *Paternella tularensis* (Tularemia) and *Coxriella burnetti* (Q-Fever) and that the Army had vaccines against those agents. Neither of these vaccines were FDA approved and considered experimental vaccines. To my knowledge, a medical followup on the health status of the SHAD participants that were inoculated was not conducted and the type and dosage of the vaccine were not entered in their medical records.

Regretfully, all information and data about SHAD tests remained classified until 2001 when DoD began sharing some declassified DTC test information with Veterans Affairs. SHAD veterans were certainly at a disadvantage during this time, i.e., over 40 years post termination of Project SHAD in not having this information available when being evaluated for proper health care. It is of great value and help for attending physicians to know as much as possible about concentrations of hazardous materials that their patients have been exposed to.

It was a privilege and honor to have served with shipmates that were unquestionably dedicated in accomplishing the dangerous and highly classified mission of SHAD.

The many Project 112/SHAD participants, who unselfishly and willingly exposed themselves to hazardous biologicals and chemicals, oftentimes with minimum personal protection, deserve the highest level of quality healthcare that this government can provide.

I join the many Project 112 and SHAD Veterans in expressing a heartfelt appreciation for all the hard and consistent work that Congressman Mike Thompson has done in our behalf and for Congressman Rehberg for joining the task.

I thank Chairman Filner, Ranking Member Buyer, and Members of the Committee, and herein respectfully request that H.R. 5954 be moved from Committee to the Floor of the House with the recommendation for approval.

Statement of John A. Scocos,
President, National Association of State Directors of Veterans Affairs, and Secretary, Wisconsin Department of Veterans Affairs

On behalf of the National Association of State Directors of Veterans Affairs, this letter is to express our strong support for the efforts of the U.S. House Committee on Veterans' Affairs and its work in advancing bills of great importance to current, past, and future generations of veterans.

We appreciate you holding this important Committee hearing on these many issues. Our positions on these bills are as follows:

H.R. 1197—Prisoner of War Benefits Act

We support an expansion of presumptive service-connection benefits, liberalizing the requisite period of internment, and updating the determination of such presumption for former prisoners of war.

H.R. 3008—Rural Veterans Services Outreach and Training Act

We support H.R. 3008 only if it is substantially amended as follows. The current language of H.R. 3008 is an excellent starting point for continuing a growing dialog on the need for expanded outreach to our Nation's veterans, though it does not yet reflect the benefits and service delivery system of the majority of the states. We strongly support the creation of a statutory definition of outreach that ensures a systematic, proactive approach, and we support the definition of outreach as contained in H.R. 3008, which appears to mirror the language contained in S. 1315 as recently passed by the U.S. Senate and now awaiting House action. We also strongly support the creation of a federal grant program to the States for the provision of outreach.

However, while we generally support the grant structure, grant amounts, and grant-making process in H.R. 3008, two areas of this bill should be amended to more closely match the variations in the veterans benefits and services delivery system that exist across the 50 states, the territories, and the District of Columbia (hereinafter referred to as "the states").

First, while we concur that there is need in many rural parts of the Nation to provide outreach to veterans in rural areas, we recognize that many of the Nation's 24 million veterans live in areas that are not rural. We recently noted with interest the VA's telephone call outreach campaign to 570,000 of the 1.7 million veterans of the wars in Iraq and Afghanistan who have not yet utilized VA services—presumably a mix of rural, suburban, and urban. Veterans of the early years in the war in Iraq may not be aware of new testing and treatment for brain injury following blast exposure, post traumatic stress disorder, treatment for the self-medicating but self-defeating effects of substance abuse that may have only recently emerged, and so on. There is much to be done with regards to providing desperately needed outreach and services to our Nation's veterans, not just in rural areas of the Nation, and H.R. 3008 brings us part way to reaching that goal.

Additionally, in the years following each war, Congress has successively expanded healthcare and other benefits programs to meet the needs of these warriors, including presumptive service-connection and healthcare enrollment and specialized treatment for various categories of veterans, including those with exposure to Agent Orange, ionizing radiation, Project 112 including Project SHAD, Gulf War illness, and for veterans who are ex-prisoners of war, purple heart recipients, veterans with service after 1998, and more. More needs to be done to reach out to these veterans as well, who are also presumably a mix of rural, suburban, and urban.

As it is currently drafted, H.R. 3008 targets the grants exclusively to outreach workers who are employees of counties. Less than half the states, including Wisconsin, have benefits and outreach workers who are county employees, most typically called county veterans service officers (CVSOs). The language of the bill as it is currently written could certainly benefit these states. However, the majority of the states employ a variety of other models to provide services and outreach to their state veterans.

In many of the states, there are service officers who are state agency employees, typically called state service officers, including Tennessee, New Mexico, and Illinois, whose Director of Veterans Affairs, Tammy Duckworth, testified before this Subcommittee a few weeks ago about her state's service state-employee service officers and the need for the creation of an outreach grant.

A number of states contract with veterans service organizations (VSOs) to provide veterans services, like Utah, or with other types of non-profits, like Massachusetts.

In some states, including in New York, municipalities and other non-county local governments provide direct veterans services and outreach.

Many states, including Oregon, have a combination of several of these outreach mechanisms.

The one thing all the states have in common is a state agency led by a director charged to serve all veterans within the geographic borders of the state. In order to effectively achieve the outreach goals outlined in this bill, it must be amended with language broad enough to cover veterans residing in all areas of the country in ways that are locally effective.

The ability of State DVAs to provide Federal outreach funds to reach veterans in the respective states, either through a grant or through a contract, should continue to be allowed as under the original bill. Therefore, use of the term "non-profits" should be retained.

To date, NASDVA has supported S. 1314, the Veterans Outreach Improvement Act and the language it contains. For the reasons noted above, NASDVA and the National Association of County Veterans Service Officers (NACVSO) agreed to recommend that the following language be included in S. 1314, which we believe more appropriately captures the totality of the Nation's infrastructure available for the provision of outreach to veterans nationwide:

> *A veterans agency of a State receiving a grant under this subsection may use the grant amount for purposes described in paragraph (1) or award all or any portion of such grant amount to local governments in such State, other public entities in such State, or private non-profit organizations in such State for such purposes.*

Of note, the term "non-profit" includes VSOs, which are incorporated under one of the non-profit provisions of 501c of the Internal Revenue Code.

H.R. 3008 is an important step in the right direction, and we appreciate the recognition of the need for more outreach and services by the bill's author, co-sponsors, and the leadership and Members of this Subcommittee in allowing today's hearing on this bill.

H.R. 3795—You Were There, You Get Care Act

We support the expansion of presumptive service-connected disability benefits to veterans who served in the Gulf War theater of operations and other military operations involving depleted uranium. We also support the independent medical study to identify other conditions in addition to those already covered under existing laws covering radiation.

H.R. 4274—Gold Star Parents Annuity Act of 2007

We support the creation of a stipend to surviving parents who are the recipient of the Gold Star lapel button.

H.R. 5155—Combat Veterans Debt Elimination Act

We support the prohibition of collections on indebtedness for military servicemembers who die of a service-connected disability incurred or aggravated on active duty in a war or combat zone.

H.R. 5448—Full Faith in Veterans Act

We support the implementation of new criteria for the service-connection of PTSD that reduces the burden of proof on the veteran and requires the consideration for the inclusion of treatment records that updates the provisions of the disability rating schedule regarding PTSD, traumatic brain injury, and other mental disorders.

H.R. 5454—Presumption of service-connection for ALS

Given the growing recognition of an inexplicable association of higher rates of amyotrophic lateral sclerosis among those with military service than those without similar service, we support the presumption of service-connection for ALS for wartime veterans.

H.R. 5954—Presumption of service-connection for Project 112 veterans

We support the presumption of service-connection for diseases associated with biological, chemical, or other toxic agents for veterans who were participants in Project 112, including Project SHAD, regardless of whether their participation was knowing or unknowing, willing or unwilling.

H.R. 5985—Compensation for Combat Veterans Act

We support the acceptance of records showing the veteran was entitled to combat zone compensation as proof of combat service of veterans for the purposes of certain veterans benefits. Given the nature of current military operations, it is highly possible that small groups of military servicemembers may be in combat operations and

entitled to combat zone compensation exclusion, which may be the only publicly available evidence of their combat zone participation.

H.R. 6032—Wartime disability compensation for certain veterans with Parkinson's disease

Given the growing recognition of an inexplicable association of higher rates of Parkinson's disease among those with military service than those without similar service, we support the presumption of service-connection for Parkinson's disease for wartime veterans.

Statement of Denise Nichols,
Vice Chairman, National Vietnam and Gulf War Veterans Coalition

National Vietnam and Gulf War Veterans Coalition
Washington, DC.
June 12, 2008

To: HVAC Subcommittee Disability Assistance

CC: House Veterans Affairs Majority Staff

Subject: Support for H.R. 3795—DU; H.R. 5954—BIOLOGICAL–CHEMICAL; H.R. 5454—ALS; H.R. 6032—PARKINSON

Dear Representative Hall,

Today your Subcommittee is marking up excellent legislation that we would like to wholeheartedly support. All the bills being brought up should be supported fully. The bills we are most interested in H.R. 3795, 5454, 6032, 5954 are long overdue! Each of these bills address urgent needs. The Gulf War veterans have a particular interest in H.R. 3795 and we are putting this on our hottest priority list! WE are already pushing more Representatives to sign on and show their support as cosponsors! We want these bills passed into law as fast as possible.

Bills H.R. 5454 and 6032 address two devastating diseases and the veterans that are diagnosed with these need direct and immediate attention. The numbers of both within the VA system are not overwhelming and of course much lower than PTSD and the current combat injured (amputations, etc) but they probably need more support long term and that is the least we can do. We need to lift the burden of continued claims battles these veterans face and these bills will certainly serve to get them through that battle more rapidly so that they can not be burdened by additional fights when they need to focus on healthcare and battling to maintain their health as their central issue. We complement the VA House Committee for bringing them the first step in long term relief to the veterans that suffer these devastating illnesses.

Bill H.R. 5954 the relief for Project Shad Veterans is long overdue. Again the number of these veterans is small as compared to all other groups and they have been forgotten for too long. We fully support this bill moving forward rapidly.

We also support

H.R. 1197—POW
H.R. 5985—COMBAT VETERAN
H.R. 5448—PTSD
H.R. 5709—QUALITY CONTROL ON CLAIMS
H.R. 5155—-DEBT RELEASE
H.R. 3008—RURAL CARE

Thank you for your efforts to make a real difference for all veterans!

Sincerely,

DENISE NICHOLS
Vice Chairman

Statement of John E. Olsen, ET–2, USN,
Billings, MT

Chairman Hall, Ranking Member Lamborn and distinguished Members of the Committee. My name is John E. Olsen and I live in Billings, Montana. I am a

former ETN–2 (64–65) and I write to describe my experiences within the "Project SHAD Technical Staff" (PSTS).

I entered the U.S. Navy in 1961 after 3 years at Montana State University, including Advanced Army ROTC. After boot camp, I was assigned to ET 'A' school for preparation as an Electronic Technician and assignment to the fleet. In 1964 I received orders to Project SHAD Technical Staff on board the USS Granville S. Hall for LT 2085. In normal transfers an enlisted person goes to the receiving station on the coast involved. In my case that should have been "RECSTA Treasure Island" in San Francisco bay. Instead, my orders were to the "Presidio" in San Francisco. A suite in a fancy barracks, and I did not see anyone else in the building while I was there. A few days here, then transported to Treasure Island and immediately bussed to the airbase to catch a MATS flight to Pearl Harbor. The morning after arrival I was picked up by car and driven to a warehouse and told to go to an office in the back and up one flight. There I was met by a Chief Petty Officer and a LT(jg), who I later learned was the Personnel Officer for PSTS. Our conversation hinged on the concept of war; whether the old style of breaking things and killing people or would we rather just take over an ill populace. I was told that "President Kennedy had personally believed this and he had chosen us to carry this concept into working order. We were the best at our primary jobs, could handle very well other jobs on board a ship, and we could pass the security clearance factor." Well, when our president wanted me for special work, who was I to say no! Of course I accepted the challenge. When the 2085 was tied up and the civilian crew had left, those of us already in Pearl went to the boat and met our skipper and chief engineer. Our skipper was a full Lieutenant and the Chief Engineer was a senior E–6 Engineman about twice my age. All this for a small boat, 107 feet in length and mostly black in color. (Army colors) It needs grey, but first we find out that we do not wear our Navy uniforms. Then we gather on the Granville S. Hall for a security briefing that informed us that we would not leave the base without an undercover escort, one of which we may, or may not, figure out but there would be someone else also covering us. We went out on shakedown cruises, training on seamanship, and for our job in research. Then we had firefighting training. We were brought as a crew into a 'classroom' setting and trained on the exposure suits and gas masks. This part of the training was filmed by an Army photo unit. Then to the G.S. Hall for shots, something special as we were only told the basics when we got them. Then decontamination of the interior of the vessel using challengers filled with betaPropilactone and formalin. I turned them on and left the area, closing the hatch behind me. After the challengers were empty they shut down and we opened the 85 and went back to our home. No one told us it was safe to re-enter the boat. We still had liquid running down the bulkheads in most of the vessel. We had sealed only the refrigerator and opened the rest of the interior to assure there were no bugs still on board. Now on to Emergency Ship handling school where an E–4 (me), an E–6 (one of our cooks), and three officers off a submarine, a Lieutenant Commander and two LTs (jg)'s made up the class taught by a Commander.

We had five LTs and six crews, we were trained for our job, but there was a President who had not been elected, but had assumed the position after the death of our beloved JFK. Volunteers were requested to keep one crew in Pearl and transfer the balance back to the fleet. I elected to stay with the unit as I had earned advancement to E–5. During the down time we put in electronic spares on each boat, cared for the vessels, and a few excursions. One was the time a Russian Trawler had need of spare parts only available in the port of Honolulu. Well, on that day, while a Geodesic Survey ship and other 'proper' ships of the line were in the harbor, we were out with one of the LT's equipped to spray agent, practicing our man overboard procedures. Grey harbor tug manned by people in civilian clothes with the ability to lay down a spray—and they had the long lenses and lots of film. Were we out there as bait of a sort, I so believe to this day?

Election up coming, let's get up to strength by bringing in the other new crews. Now we are back on our proper vessels getting ready again to go into research, to work. Most of the engineering crew had some experience with tugs but most of the ET's came from destroyers or large vessels. But our Weathermen came off a carrier or a shore installation, never anything as bouncy as a tug. The placard said "This vessel not to be operated on ocean or coastwise waters, signed, commandant U.S. Coast Guard" and seemed to have validity. I do know that one time I had a roll of 65 degrees and a pitch of 40 degrees as this was what was needed to throw the gyro out of kilter, and it did. OK, after the inauguration of LBJ we were ready to start Shady Grove. This was to take place near Johnston Island and we needed to transit to that site. We left Pearl Harbor on the 21st of January.

After arrival in Johnston Island we again deConned the interior of the vessels before doing anything else. Our air group arrived, Marine A4's and the ground crews.

The General paid a visit to each boat. Soon we were underway to run the initial test, and first series of trials to get us acquainted with the actual procedures. About a week out at sea then back into port for a couple days, then out to station again. The weatherman and I strapped the theodalite in and proceeded to do the wind balloons and information to control each evening, in code. Five or 6 days at sea then a couple days in, then back out. The testing takes much of the night, then during the day a minimum crew operates the ship to the lab ship then back to station. Minimum crew was one person on the bridge and one person in the engine room, and I had been appointed to day watch. Of course, that meant that during the tests I was asleep in the sleeping quarters, never knowing what was leaking through the filters, and going into my lungs. Our filters got everything down to 1 micron, but they were made of paper, and this was close to the ocean and there was actual seawater in the area. Salt water and paper made for paper changing its porosity, in other words, it leaked.

My morning at sea began before sunrise as I assisted the navigator in shooting the stars to determine our position after the external decon of the vessel. As the ship was opened up for day operations most of the crew went to sleep and one engineer and myself brought the vessel to the lab ship to off load the samples and get the special supplies for the next nights tests. And so it went until April when we completed "Shady Grove" and I was on my way back to Montana State University. My field of study was Electrical Engineering and Business.

By the end of my first quarter on campus I needed to get some work to keep me busy so I applied to the Electronic Research Laboratory. I started with the Digital Data Systems group where we would be working with Water Resources Research group. We developed the Snow Pack measuring devices that are put into the mountain areas of the west. And I built the prototype. After about 3 years of school, I finally earned a BS degree in Commerce (General Business).

Now to work, and a large construction company looks like the place to put my varied experience to work. After completing the field training I am offered a position in the purchasing department of Southwest Operations of Chicago Bridge and Iron Company. Since I had more law courses in school I was given the pleasant chore of contracting our company attorney, and one of the choices available was Leon Jaworski and Associates. Good thing he had a number of attorneys on staff as he was called to Washington, D.C., to head the Watergate investigation. As we expand operations I am handed the steel buying and before long become probably the largest single consumer of steel on the Gulf Coast of the United States. About 1975 I was given the added responsibility of managing the annual audit of SW operations, and this is the year we go from 'Over the Counter' to the New York Stock Exchange. About this time that I am handed one of the largest jobs I have ever had. Negotiating with and meeting the proposed supplier off and on for a few months then one morning I receive a call, then place a call to New York lasting about 10 minutes and I've spent over $10 million. I also furnished most of the steel for the last greenfield refinery built in the U.S.

Next was Chemtrol Corporation as the Purchasing Manager of this specialty insulation company. Fireproof and radiation proof insulation was important in the nuclear power field anywhere in the world. And we did it! I'm with the company only about a month when Three Mile Island happened, and this certainly put a crimp in our future. After less than a year I move to Sales Manager for an Electronics and Metrology Company. We handle everything from single meters to plant process control (Dow Freeport). We do temperature measuring of the GM first battery powered vehicles to clocks on the space shuttle. It is during this time that the first indication of possible troubles from SHAD arise. I'm 41 and have hypertension, but then I have a massive spasm of the heart muscle. The difference between a spasm and attack is a spasm leaves no damage to the heart muscle, even though it can kill just as dead. Very unusual as normal medications work only for a short time then fail as the pressure goes up higher than before. Soon I am again not getting paid so move back to Montana. The prognosis is not good.

I finally cannot afford medical care so end up with the VA hospital in Miles City, still trying to nail this down. Finally a sophisticated test shows a probable tumor within the body so I am sent to the Salt Lake VA Hospital where the tumor is confirmed. I am scheduled for surgery, but first I needed to be switched from the normal anti-Hypertensive to a quick acting variety when a timing fluke reared its ugly head. My blood pressure went up to over 300+/300+. The nurse told me I wasn't supposed to be there any longer, but I made it to the operating room and had an adrenal tumor removed. I did not feel, per what I had been told upon leaving SHAD, that I could tell the medical people that my internal fluids might be hazardous to their health. But I did survive this and went on to live without blood pressure problems for quite some time, but now have had a mild attack which took me to a cardi-

ologist some 2 weeks after the event for one stent. Skin cancer, prostate cancer, replaced hip, arthritis, COPD, and now osteoporosis and scoliosis of the lower spine for me and only some cancer in the family history make me wonder, was it SHAD.

From the age of 41 I have been unable to find work of a nature to fit my field of study, or that would pay anywhere near the amount I had earned at the electronic sales job that I had then. If that salary were brought to the present it would be in the neighborhood of $150,000, and with that I could have some funds set aside for retirement, but the best I have done since then has been below $18,000. That's not enough to leave a nest egg.

Statement of Paralyzed Veterans of America

Mr. Chairman and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), we would like to thank you for the opportunity to submit a statement for the record regarding the proposed legislation. We appreciate the fact that you continue to address the broadest range of issues with the intention of improving benefits for veterans. We particularly support any focus placed on meeting the complex needs of the newest generation of veterans, even as we continue to improve services for those who have served in the past.

H.R. 1197, THE "PRISONER OF WAR BENEFITS ACT OF 2007"

This legislation would repeal the requirement that a Prisoner of War (POW) be held captive for at least 30 days in order to receive a presumption of service-connection for the purposes of receiving benefits. This issue was first considered during the 108th Congress after American service personnel who were held captive in Iraq during the early stages of the war were released or rescued after less than 30 days of internment. These men and women had sustained severe injuries as a result of combat actions and their subsequent internment. It seems only fair that any POW, regardless of time in captivity, be recognized as being eligible for service-connected benefits. PVA supports this provision.

We likewise support the addition of the following diseases to the list of diseases presumed to be service-connected; Type II diabetes and osteoporosis. We have no objections to the requirements placed on the Secretary of VA for adding or subtracting diseases to the presumptive service-connection list. We would only caution that veterans and former POWs should be given the benefit of the doubt before any consideration is given to removing a disease from the list.

The legislation also allows a survivor of a veteran to continue to receive dependency and indemnity compensation for the death of a veteran resulting from such disease on the basis of such presumption after a disease is removed from regulations. PVA supports this provision of the legislation.

H.R. 3008, THE "RURAL VETERANS SERVICE OUTREACH AND TRAINING ACT"

The "Rural Veterans Service Outreach and Training Act" is intended to improve outreach activities performed by the VA. It does so by creating a grant program for states to help fund their rural county veteran service officers. A state is eligible to apply for a grant if it has at least one county where veterans reside, and that county does not have a service officer. State eligibility may also include a county that has a service officer working part time, or a county that has more that 1000 veterans residing in it and has a full-time county veterans service officer but can still demonstrate a need for additional services by a county service officer.

The maximum grant amount available is $1,000,000 and states will be able to apply annually. States are required to provide a 20 percent match to receive the funds and states must use the funds to increase their outreach activities and not to supplement existing programs.

We believe this program can demonstrate to new veterans, as well as veterans from past conflicts that state governments along with the federal government are making a real effort to ensure that they receive the information, services, and benefits that they have earned. PVA generally supports the provisions in this proposed legislation.

H.R. 3795, "YOU WERE THERE, YOU GET CARE ACT OF 2007"

PVA supports H.R. 3795, the "You Were There, You Get Care Act of 2007." This legislation allows for the men and women who served in the 1991 Persian Gulf War

and conflicts since that date to be considered to be radiation-exposed for the purpose of service-connection as a result of exposure to depleted uranium. However, we believe that this legislation should be expanded to include veterans who served prior to the first Gulf War. During the eighties, U.S. Army armor units located in Germany and South Korea carried armor piercing shells that were made from depleted uranium. While servicemembers understood that there were hazards associated with depleted uranium, they still spent weeks at a time in the tanks with these shells radiating uranium. As such, these veterans should also be included in this category for presumptive service connection.

H.R. 4274, THE "GOLD STAR PARENTS ANNUITY ACT OF 2007"

PVA has some serious concerns about this proposed bill. First, we question how this benefit would be applied in a situation where a veteran has a surviving spouse or dependents as well as surviving parents. We do not believe that this is an appropriate benefit if the veteran has a surviving spouse or dependents because those individuals already would be the designated beneficiaries for all survivor benefits. Payments under this bill would be nothing more than a secondary survivor benefit to the parents.

While PVA always supports benefits that recognize the sacrifices made by our servicemembers, we believe that providing $125 per month as a recognition for the death of a service man or woman is a slap in the face at best. The value of this benefit suggests that the life of the man or woman who served and died honorably is worth almost nothing. Moreover, to create a situation where separated parents might receive a $62 per month reminder of their son's or daughter's service and death is beyond comprehension. While intentions for this legislation might be good, this bill will certainly create more heartache and pain rather than honorable recognition. With these thoughts in mind, this legislation should be reconsidered.

H.R. 5155, THE "COMBAT VETERANS DEBT ELIMINATION ACT OF 2008"

PVA principally supports H.R. 5155, the "Combat Veterans Debt Elimination Act of 2008." However, we have a couple of concerns with the proposal. First, we believe that the legislation should afford the same benefit to any servicemember who might have been killed while serving in the line of duty. We do not think that a special distinction should be made between a servicemember who was killed in a combat theater and a servicemember who was killed while serving at his or her home duty station. We would ask; "What is the difference between having a tank roll over on the individual in Iraq or Afghanistan, or a tank roll over on the individual at Fort Hood, Texas?" The benefit of this legislation should be afforded to any servicemember killed while serving this nation honorably.

Second, we wonder why a special exception is made in this legislation for certain debts to be collected. As we understand the bill, the only debt that the VA will be permitted to collect upon a servicemember's death is a home loan or small business loan.

H.R. 5448, THE "FULL FAITH IN VETERANS ACT OF 2008"

PVA supports H.R. 5448, the "Full Faith in Veterans Act of 2008." This legislation will help address the high number of post traumatic stress disorder (PTSD) cases from Operation Iraq Freedom/Operation Enduring Freedom (OIF/OEF) as well as veterans from previous conflicts. As more information becomes available from the VA's Mental Health Centers of Excellence and other professional sources pertaining to the diagnosis and treatment of PTSD, this information must be available to all VA health care providers.

The latest information must also be available to the VA's Vet Centers. Vet Centers are often the only VA representation in rural areas, and most Vet Centers are the first point of contact for veterans in rural areas with PTSD, as well as other mental health conditions.

H.R. 5454, ALS

PVA supports H.R. 5454, a bill that provides a presumption of service connection for Amyotrophic Lateral Sclerosis (ALS) for any veterans that served during a period of war.

Studies published in medical neurology journals indicate a higher level of ALS among servicemembers that served in the Gulf War than any other segment of the general population. Although, at this time there is no causal effect standard for determining presumption, more research should be funded by the VA for current vet-

erans with ALS and future cases. We support this presumption of service connection for these veterans since there is currently no medical evidence to refute the increased incidence among veterans.

H.R. 5709, THE "VETERANS DISABILITY FAIRNESS ACT"

PVA supports the provisions of H.R. 5709, the "Veterans Disability Fairness Act." We hope that this legislation will correct the inconsistencies of ratings that veterans receive from different VA regional offices. We have heard testimony over the last couple of years about veterans that may receive a 70 percent rating in one location, and be rated 100 percent in another region. While we understand that no veterans' claims are the same, there is still a great deal of inconsistency in application of adjudication standards and regulations.

This legislation requires the VA to conduct reviews and audits annually to identify and correct inaccuracies or inconsistencies in disability ratings and the adjudication of claims for disability compensation. The VA can use that information to address the differences that occur nationally. To minimize the variability among regional offices, the VA must increase training, improve rater qualifications, and increase the quality review system.

In the *Veterans' Disability Benefits Commission* report, released in October 2007, the Institute of Medicine (IOM) recommended that educational and training programs for VBA raters and VHA examiners be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs. We believe this legislation begins to address this recommendation, but it could do more.

We look forward to working with the VA and Congress to improve the consistency in disability ratings for veterans throughout the system.

H.R. 5954, PRESUMPTION OF SERVICE CONNECTION FOR PROJECT 112

PVA supports H.R. 5954, a bill to provide veterans with a presumption of service connection for purpose of benefits for diseases associated with service in the Armed Forces and exposure to biological, chemical, or other toxic agents as part of Project 112.

The Department of Defense (DoD), originally denied the occurrence of tests including chemical and biological agents until a government investigation identified these tests. Project Shipboard Hazard and Defense (Project SHAD) was conducted between 1962 and 1974. Of the 20,000 veterans that may have been exposed to these chemicals, VX nerve gas, Sarin Nerve Gas and E.Coli, all known to be harmful chemicals, only 6,000 veterans have been identified. This bill will ensure that all veterans that may have incurred a disease as a result of exposure to these chemicals will receive the medical care they deserve.

Section 2 of the bill requires the DoD to release all records that will allow the VA to identify the other 14,000 veterans involved in Project 112. It is time that the DoD finally sets the record straight and comes clean about all of the activities surrounding Project 112/SHAD.

H.R. 5985, THE "COMPENSATION FOR COMBAT VETERANS ACT"

PVA fully supports H.R. 5985, the "Compensation for Combat Veterans Act." This proposed legislation is in accordance with a recommendation included in *The Independent Budget* for FY 2009. As stated in *The Independent Budget:*

> While VA recognizes the receipt of certain medals as proof of combat, only a fraction of those who participate in combat receive a qualifying medal [qualifying medals include combat badges and medals received for valor]. Further, military personnel records do not document combat experiences except for those who receive certain medals. As a result, veterans who are injured during combat or suffer a disease resulting from a combat environment are forced to try to provide evidence that does not exist or wait a year or more while the Department of Defense conducts research to determine whether a veteran's unit engaged in combat.

This legislation will clarify the status of veterans that have served in a combat zone and have suffered a disease or injury. This will eliminate the need to establish evidence for proof of service-connection. H.R. 5985, when signed into law, will save the veteran valuable time in developing their claim to submit to the VA when they seek the medical care for an injury or disease as a result of their combat service.

It is important to note that this legislation would not eliminate or alter in any way the requirement that a veteran's claim for disability have an official diagnosis or that a clear connection between that claimed disability and military service exists. It would simply relieve the burden placed on veterans who served in a combat theater of proving that the claimed disability was combat-related. As it currently exists in law, service in a combat zone or theater does not necessarily meet the threshold that the VA has established for recognizing a combat veteran. This loophole needs to be changed to benefit the veteran and we believe this legislation will accomplish that task.

H.R. 6032, PRESUMPTION OF SERVICE CONNECTION FOR PARKINSON'S DISEASE

PVA supports H.R. 6032, a bill that provides a presumption of service connection for Parkinson's disease for certain veterans who served in the Republic of Vietnam. The 109th Congress passed legislation that required the Secretary to designate six centers of excellence for Parkinson's disease research, education, and clinical activities. These facilities will have an arrangement with an accredited medical school that provides training in neurology and diagnosis and treatment of neurodegenerative diseases. Medical evidence has indicated a higher rate of Parkinson's disease among veterans that have served in Vietnam. With the passage of this legislation, a veteran that develops Parkinson's disease will be able to receive the latest treatment for this devastating condition.

Mr. Chairman, we would like to thank you again for the opportunity to submit a statement for the record. We look forward to working with the Subcommittee to ensure that the best benefits are available to all veterans.

Statement of Alan Oates,
Edinburg, VA, Member, U.S. Military Veterans with Parkinson's (USMVP)

Dear Chairman and Committee Members,

I am Alan Oates, a Vietnam Veteran. I have Parkinson's disease. I am a member of an organization called "U.S. Military Veterans with Parkinson's" (USMVP). Our organization and members haven't received any Federal Grant Funds nor do we have any contracts with the U.S. government.

Parkinson's is a degenerative, progressive disease without a cure. The physical, mental and financial burden on Vietnam Veterans suffering with this disease and their families is devastating.

Public Law 102–4 was passed to provide a better means to address Agent Orange and the health issues that Vietnam Veterans faced. Congress recognized the need for an agency outside of the VA to look at these issues. Especially since the VA's own report by Admiral Zumwalt stated that the VA's review Committee on Agent Orange was so biased to Veterans that they should be fired. The VA classified this report to keep it from the public.

However due to flaws and failed implementation of Public Law 102–4, the system created by Congress to help these Vietnam veterans has failed them. It has failed the Veteran who recently emailed me, pleading for help as his Parkinson's had left him unable to work and almost homeless—. and the Veteran who at 58 years of age was left so helplessly immobile in bed that his wife has to cauterize him twice a day. Let there be no doubt that their Parkinson's is a result of their service to their Country in Vietnam.

I have met with the staff of many of the Members on this Committee and have provided extensive documentation and justification for passing this bill. As in written testimony I am limited to ten pages total, I am only including selected exhibits.

After extensive research we have found:

- Vietnam Veterans were exposed to a large number of toxic chemicals including Agent Orange and Organophosphates.
- Evidence that connects Parkinson's disease to service in Vietnam and to exposure to various chemicals used in military operations.
- The Department of Veterans Affairs and the system established under Public Law 102–4 to look at the disease in Vietnam Veterans has failed these Veterans.

I. Vietnam Veterans were exposed to a multitude of chemicals during their military service in Vietnam. Agent Orange and Malathion (Malaoxon) are two of those.

A. Agent Orange consisted of two herbicides, 2,4–D and 2,4,5–T. The production of 2,4,5–T created the toxic dioxin, TCDD. This is considered one of the most toxic dioxins known to man.

1. The Institute of Medicine in the Agent Orange Review reports that the TCDD in Agent Orange could be up to 1,000 times more toxic than that in the same herbicide used outside of military operations (farming and home use). This is important as most studies using the 2,4,5–T herbicide are based on a less toxic form than that used in Agent Orange.

II. Malathion is an organophosphate insecticide. Organophosphates were developed by Nazi Germany in the late 1930's as a Chemical Warfare Nerve Agent. These agents impact the Central and Peripheral Nervous System.

A. Operation Flyswatter exposed Vietnam Veterans to Malathion routinely every 9 days weather permitting.

B. The long storage times, high heat and exposure to sunlight cause Malathion to break down into a highly toxic Malaoxon.

III. Agent Orange and Malathion individually and in combination are scientifically associated to Parkinson's disease.

IV. Evidence of Association between Parkinson's disease and military service in Vietnam.

A. Stanford University Military Deployment Study Abstract (Exhibit A) found an increase of 2.6 times in the risk for Parkinson's disease in veterans who deployed to Vietnam compared to those who did not.

B. Dr. Chris Reid provides a nexus between service in Vietnam and Parkinson's.

V. Agent Orange Association

A. In the Iowa Agriculture Health Study Update 2007 (Exhibit B), Dr. Kamel found that 2,4,5–T (Agent Orange herbicide) was associated with an increased risk in Parkinson's disease.

B. In the BMC Neurology Study published March 28, 2008, a strong Odds Ratio was found between 2,4–D and Parkinson's disease even though the association had not reached a scientific significant level.

C. A study showing how 2,4–D can impact the portion of the brain related to dopamine productions. "Intracerebral administration of 2,4-diclorophenoxyacetic acid induces behavioral and neurochemical alterations in the rat brain. Bortolozzi A."

D. A study showing alterations in dopamine in basal ganglia by 2,4–D in neonatal exposed rats, mediated by a serotonergic modulation on the dopaminergic system.

E. A study shows that 2,4–D can damage the cytoskeleton structure of brain cells and disrupts the microtubule of neuron cells. (2,4–D Acid Disrupts the Cytoskeleton and Disorganizes thee Golgi apparatus of Cultured Neurons) Silvan B. Rosso April 5, 2000). Another study shows that when the microtubule is disrupted in a dopamine carrying cell, it causes dopamine to leak from the cell and kill the dopamine cells. (Jian Feng Microtubule: A Common Target for Parkin and Parkinson's Disease Toxins). The loss of dopamine cells causes Parkinson's disease.

F. A study (2,3,7,8–Tetracholorodibenzo-p-dioxin exposure disrupts granule neuron precursor maturation in the developing mouse cerebellum. Collins LL.) Demonstrates the ability of alter neuron cells.

VI. Organophosphates Malathion Evidence of Association

A. The BMC Neurology Study published 28 March 2008 finds scientifically significant association between Organophosphates (Malathion) and Parkinson's disease.

B. There are numerous studies showing how organophosphates are suspect in the development of Parkinson's disease.

VII. Public Law 102–4 has failed the Vietnam Veterans.

A. The law failed to address the issue that were many chemicals exposure and not just Agent Orange for Vietnam Veterans and narrowly focused on only the herbicides used in military operations.

B. The Institute of Medicine (IOM) in conducting its research for the Agent Orange Reviews is limited to researching only the Diseases as they are associated with herbicides used in Vietnam.

C. The IOM charge is to look for a scientific connection between a disease and the herbicides and not to look for a connection between a disease and Veterans service in Vietnam.

D. An example of this is in the IOM AO 2006 review as cited by the Department of Veterans Affairs in the Federal Register on presumptiveness for Peripheral Neuropathy. A study found some association with service in Vietnam but not to the chemicals of interest. The focus should be, is there evidence of an association between the disease and the Veterans service in Vietnam.

E. IOM will not look at other chemicals such as Organophosphates as their charge by law is limited to herbicides. There are many cases where other chemical exposures such as Organophosphates and solvent contribute to or cause a disease.

VIII. The Department of Veterans Affairs (DVA) has failed to implement requirements of the law.

A. Public Law 102–4 required the DVA to conduct studies that were recommended by the IOM in the Agent Orange Reviews.

1. DVA failed to conduct studies recommended by the IOM in the Agent Orange Reviews.

a. Since 1994 in each review IOM has stated the importance of seeing if there is an early onset of Parkinson's disease in exposed veterans.

b. The importance of studies comparing exposed to non exposed veterans.

B. DVA failed to collect and review the clinical data on illnesses and disease related to Agent Orange in Vietnam Veterans.

1. This is evident by the fact that the DVA has been unable to provide even the number of Vietnam War Zone Veterans they are treating for Parkinson's disease. A request was made on my behalf by Congressman Goodlatte on April 9 for information on Vietnam Veterans with Parkinson's, as of this date.

C. DVA has not provided this information. DVA failed to recognize that a finding of a biologic plausible mechanism in the IOM Agent Orange review is a causal relationship.

1. Public law 102–4 required the NAS (IOM) to look to see if there is evidence of a biologic plausible mechanism "or other" causal association.

a. By using the words "or other" Congress and the law is clear that a finding of evidence of a biologic plausible mechanism is a causal association.

2. The VA Appeal Board has found service connection for Parkinson's disease due to herbicide exposure in two cases that we have found. In one of those cases the VA admits a finding of Biologic Plausibility and the appeal court judge rules in favor of the Veteran based partly on that point.

IX. DVA is required by law to evaluate the evidence for and against presumptiveness of a disease and rule in favor of presumptiveness if the evidence for is equal to or greater than the evidence against an association. DVA must also publish its findings on presumptiveness in the Federal Register and give the scientific basis for that finding.

A. In the 2006 Agent Orange Review, IOM stated, "In pursuing the question of statistical association, the Committee recognized that an absolute conclusion about the absence of association is unattainable. As in science generally, studies of health effects associated with herbicide exposure cannot demonstrate that a purported effect is impossible or could never occur. Any instrument of observation, even the most excellent epidemiologic study, is limited in its resolving power. In a strict technical sense, therefore, the Committee could not prove the absence of an association between a health outcome and exposure to any of the compounds of interest. That contributed to the current Committee's decision to reevaluate findings on the health endpoints classified in Update 2004 as having "suggestive evidence of no association."

This is a dramatic change from the prior position of the IOM. "Studies of health effects associated with herbicide exposure cannot demonstrate that a purported effect is impossible or could never occur." Since a negative association is not technically possible the credible evidence provided by the IOM at the worst can only be viewed as neutral by DVA when evaluating a disease for presumptiveness.

X. Since a positive causal association exists, not only because of the biologic plausibility but because of other credible evidence, DVA should have already approved presumptiveness for Parkinson's disease.

The system and the DVA have failed Vietnam Veterans. We bring our issues to the Veterans' Affairs Committee and the House of Representatives (The People's House) to correct and right this injustice. We ask that the Committee do two things:

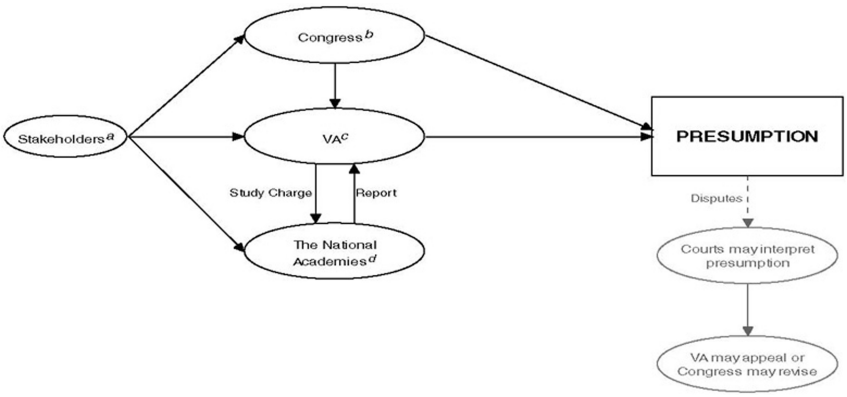
- First, pass H.R. 6032 and give these Veterans, who on the average have already suffered with this service connected disease for 6 years and individually up to 25 years, the help they so desperately need. They can not afford to wait any longer for the system to be fixed and to then address this issue.
- Second, make the necessary changes to the system to insure that they will correct the problems and issues we have addressed in this document.

Thank you for the opportunity to provide input on this important issue.

Excerpted Figures from
"Improving the Presumptive Disability
Decision-Making Process for Veterans"

Committee on Evaluation of the Presumptive Disability
Decision-Making Process for Veterans
Board on Military and Veterans Health
Jonathan M. Samet and Catherine C. Bodurow, Editors
Institute of Medicine of the National Academies

FIGURE S–1—ROLES OF THE PARTICIPANTS INVOLVED IN THE PRESUMPTIVE DISABILITY DECISION–MAKING PROCESS FOR VETERANS



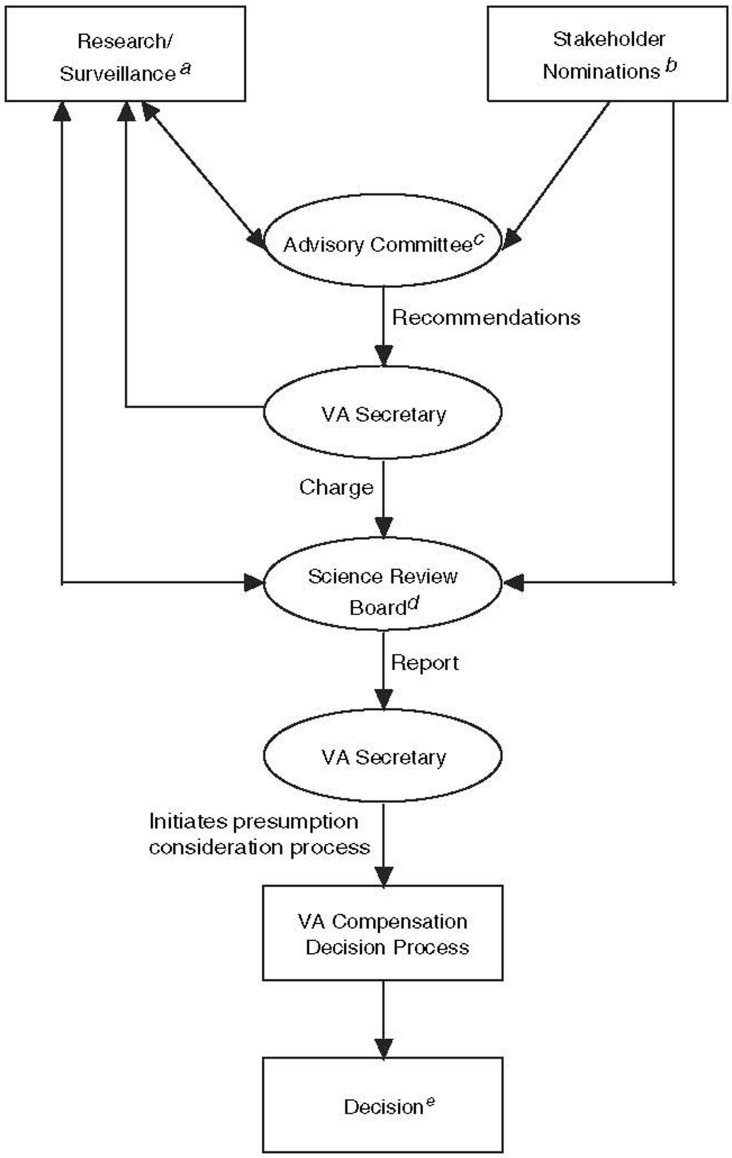
[a] Stakeholders include (but are not limited to) veterans service organizations (VSOs), veterans, advisory groups, Federal agencies, and the general public; these stakeholders provide input into the presumptive process by communicating with Congress, VA, and independent organizations (e.g., the National Academies).

[b] Congress has created many presumptions itself; in 1921, Congress also empowered the VA Secretary to create regulatory presumptions; on several occasions in the past, Congress has directed VA to contract with an independent organization (e.g., the National Academies) to conduct studies and then use the organization's report in its deliberations of granting or not granting regulatory presumptions.

[c] VA can establish regulatory presumptions; VA sometimes contracts with the National Academies to conduct studies and uses the organization's report in its deliberations of granting or not granting regulatory presumptions.

[d] The National Academies (Institute of Medicine and National Research Council) submit reports to VA based on requests and study charges from VA.

FIGURE S–2—PROPOSED FRAMEWORK FOR FUTURE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS



[a] Includes research for classified or secret activities, exposures, etc.

[b] Includes veterans, veterans service organizations (VSOs), Federal agencies, scientists, general public, etc.

[c] This committee screens stakeholders' proposals and research in support of evaluating evidence for presumptions and makes recommendations to the VA Secretary when full evidence review or additional research is appropriate.

[d] The board conducts a two-step evidence review process (see report text for further detail).

[e] Final presumptive disability compensation decisions are made by the Secretary, Department of Veterans Affairs, unless legislated by Congress.

CONGRESSIONAL RESEARCH SERVICE

MEMORANDUM	October 21, 2008
To:	House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs Attention: Kimberly Ross
From:	Sidath Viranga Panangala, Analyst in Veterans Policy, 7–0623
Subject:	Follow-up to Question Posed at the Legislative Hearing on June 12, 2008

This memorandum responds to a question posed by Chairman John Hall at the legislative hearing on June 12, 2008. During that hearing Chairman Hall asked the following question:

Does ALS [Amyotrophic Lateral Sclerosis] manifest more than a year after separation or does the veteran sometimes take that long or longer to recognize the symptoms and come to the [Department of Veterans Affairs] VA?

Studies done regarding military service and ALS are quite limited, and published literature does not provide a clear answer about the post-service timeframe over which such an association may be seen. This memorandum provides a brief summary of the Institute of Medicine (IOM) review done to examine an association between ALS and military service and discusses current VA policy establishing a presumption of service-connection for ALS.

Introduction

Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease, is a rapidly progressive medical condition that affects a person's nervous system.[1] The Institute of Medicine (IOM) of the National Academy of Sciences reports that ALS causes nerve cells in the brain and spinal cord to degenerate. This degeneration in turn causes a breakdown in communication between the nervous system and the voluntary muscles of the body, and eventually leads to muscle paralysis. Moreover, muscles responsible for breathing are affected, and respiration fails.[2] It affects about 20,000–30,000 people—of all races and ethnic backgrounds—in the United States at any given time.[3] Most people who are diagnosed with the disease die from respiratory failure within 3 to 5 years of the onset of symptoms.[4] About 10 percent of patients with ALS survive for 10 or more years.[5] It has been reported that the rate of progression of the disease varies from patient to patient.[6]

Military Service and ALS

Many returning veterans from the Persian Gulf War began reporting numerous health problems that they believed to be associated with their service in this war.[7] Among the conditions reported were symptoms associated with ALS. Given this concern among veterans that there is an increased risk of developing ALS among those who served in the Persian Gulf War, the VA asked the IOM to conduct an independent assessment of the potential relationship between military service and the later development of ALS. The IOM Committee did not address, nor was it asked to consider, the timeframe over which ALS symptoms appeared in veterans who succumbed to the disease. Based on a review of the scientific literature, the IOM Committee concluded that "there is limited and suggestive evidence of an association between military service and later development of ALS."[8]

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[1] National Institute of Neurological Disorders and Stroke, National Institutes of Health, "Amyotrophic Lateral Sclerosis Fact Sheet," September 9, 2008, [http://www.ninds.nih.gov/disorders/amyotrophiclateralsclerosis/detail_amyotrophiclateralsclerosis.htm].

[2] National Academy of Sciences, Institute of Medicine (IOM), *Amyotrophic Lateral Sclerosis in Veterans: Review of the Scientific Literature* (2006) p. 7.

[3] Ibid.

[4] Ibid.

[5] National Institute of Neurological Disorders and Stroke, National Institutes of Health, "Amyotrophic Lateral Sclerosis Fact Sheet," September 9, 2008, [http://www.ninds.nih.gov/disorders/amyotrophiclateralsclerosis/detail_amyotrophiclateralsclerosis.htm].

[6] National Academy of Sciences, Institute of Medicine (IOM), *Gulf War and Health: Health Effects of Serving in the Gulf War* vol 4. (2006), p. 153.

[7] Ibid. p. 1.

[8] National Academy of Sciences, Institute of Medicine (IOM), *Amyotrophic Lateral Sclerosis in Veterans: Review of the Scientific Literature* (2006), p.36. According to IOM, "limited and suggestive evidence" would indicate that evidence is suggestive of an association between military service and ALS in humans, but the body of evidence is limited by the inability to rule out chance and bias, including confounding factors, with confidence.

Compensation for Disabilities Associated with ALS and Military Service

In 2001, the then VA Secretary made a policy decision to give special consideration to ALS disability claims by Persian Gulf War Veterans who served during the period August 2, 1990–July 31, 1991. Under this policy veterans with ALS who served during other periods would not receive disability compensation.[9]

The VA subsequently announced in September 2008 that it would establish a presumption of service-connection for ALS for any veteran who develops the disease at any time after separation from service.[10] This would relieve the veteran of the burden to prove that ALS was caused by a specific exposure or activity that occurred during service in the Armed Forces. To be eligible for this presumptive service-connection, a veteran must have served on continuous active duty for a period of 90 days or more. The VA made this decision based on the understanding that further research is unlikely to clarify this association between ALS and military service, and there is sufficient evidence indicating a correlation between ALS and activities in military service that supports establishment of a presumption of service-connection for ALS for any veteran with that diagnosis.[11] VA also noted that it could revisit this presumption if scientific and medical advances in the future show that ALS is not associated with activities during military service.[12]

H.R. 5954, 2nd Session of 110th Congress

Presumptions of Service Connection for Purposes of Benefits under Laws Administered by Secretary of Veterans Affairs for Diseases associated with Service in the Armed Forces and Exposure to Biological, Chemical, or other Toxic Agents as part of Project 112

Issue

H.R. 5954, Presumption of Service Connection for Diseases associated with Exposure to Biological, Chemical, or other Toxic Agents as part of Project 112.

Purpose

H.R. 5954, proposes to amend subchapter 1, chapter 11, of title 38, United States Code, with the addition of a new section 1119 entitled "Presumptions of service connection for diseases associated with Project 112" that will:

- Establish a presumption of service connection for any disease determined by the Secretary to have resulted from an increased incidence of exposure to a biological, chemical, or other toxic agent during service or having been directly or indirectly subjected to a chemical or biological warfare test under Project 112.
- Require the Secretary to determine the presumptive period that such disease must have manifest to warrant entitlement of service connection.
- Establish presumption of such exposure if the veteran participated in a Project 112 test and defines what constitutes Project 112 test.
- Instruct the Secretary to notify all veterans that were potentially exposed as the result of Project 112 not later than 180 days after enactment of the legislation. The Department of Defense will be tasked to transfer the records of active duty personnel and reservists that were potentially exposed within 30 days after enactment.
- Task VA to submit a report to Congress within 1 year after enactment concerning Project 112. The report will accomplish the following: (1) Document the costs, benefits, and challenges associated with continuing the search for additional Project 112 participants; (2) provide a full accounting of all information known concerning Project 112 participants; and (3) address other concerns regarding Project 112 held by the VA, veterans, or veterans service organizations.

Program Views on Proposed Legislation

Highlights

This proposed legislation defines presumption of exposure for a Project 112 partcipant, directs the Secretary to determine what diseases are associated with such exposure and also to determine any presumptive time frame, instructs VA to

[9] Department of Veterans Affairs, "Presumption of Service Connection for Amyotrophic Lateral Sclerosis," 73 *Federal Register* 54691, September 23, 2008.
[10] Ibid.
[11] Ibid.
[12] Ibid.

contact potentially exposed veterans, and requires that VA deliver a report to Congress concerning the effects of Project 112.

Program Views

Project SHAD, an acronym for Shipboard Hazard and Defense, was part of a larger effort called Project 112 which was a comprehensive program initiated in 1962 by the Department of Defense (DoD) to protect and defend against potential chemical and biological warfare threats. Project SHAD encompassed a series of tests by DoD to determine the vulnerability of U.S. warships to attacks with chemical and biological warfare agents, and the potential risk to American forces posed by these agents. Project 112 tests involved similar tests conducted on land rather than aboard ships. Project SHAD involved servicemembers from the Navy and Army and may have involved a small number of personnel from the Marine Corps and Air Force. Servicemembers were not test subjects, but rather were involved in conducting the tests. Animals were used in some, but not most, tests.

DoD continues to release declassified reports about sea—and land—based tests of chemical and biological materials concerning Project 112. VA is working with DoD to obtain information as to the nature and availability of the tests, who participated, duration and agents used. DOD estimates that about 6,000 veterans may have been involved in Project 112/SHAD. To date, DOD has provided VA with the names of approximately 5,000 veterans who participated in the tests. VA began, in May 2002, to contact veterans who participated in Project SHAD about medical care and benefits to which they may be entitled.

In October 2002, VA contracted with the Institute of Medicine (IOM) to conduct a three-year, $3 million study of potential long-term health effects of tests conducted on board Navy ships in the sixties. IOM's report, *Long-Term Health Effects of Participation in Project SHAD*, was published in May 2007 and found no clear evidence that specific long-term health effects are associated with participation in Project SHAD.

VA opposes this legislation. We have already contracted for a significant long-term study concerning the health effects of SHAD participants and received the report from the IOM. The Secretary has authority to contract for an additional study if it is deemed necessary. We do not believe that enactment of this legislation is warranted at this time due to the lack of credible scientific and medical evidence that adequately demonstrates any statistically significant correlation between participation in SHAD tests and the subsequent development of any disease.

Costs (Mandatory and Discretionary)

Mandatory Benefit Costs

This bill provides disability compensation to veterans with diseases associated with toxic agents and disability indemnity compensation to survivors of such veterans. The Department of Defense estimates that 6,442 veterans are currently alive who were exposed to toxic agents through Project 112. Under this proposal, the Secretary would determine which diseases warrant a presumption of service connection for this population and publish decisions in regulations. The Institute of Medicine (IOM) of the National Academies released their report, "Long Term Health Effects of Participation in Project SHAD" on May 30, 2007. IOM could not clearly connect any conditions to toxic exposure in SHAD. VA therefore assumes that no conditions would be determined presumptive for service-connection based on involvement in Project 112. We are unable to provide a cost estimate for this bill without further support.

Discretionary GOE Costs

There would be no discretionary costs as this proposed legislation would have no significant impact on workload.

Contacts

For questions please contact Adrienne Foster, at 202–461–9690, C&P Service Budget Staff (211C) or Christina DiTucci, ORM Benefits Budget Division (244A), at 202–461–9928.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
June 23, 2008

Hon. Michael L. Dominguez
Principle Deputy Under Secretary of Defense
for Personnel and Readiness
U.S. Department of Defense
1300 Pentagon Defense
Washington, DC 20301

Dear Mr. Dominguez:

In reference to our House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs Legislative Hearing on H.R. 1197, H.R. 3008, H.R. 3795, H.R. 4274, H.R. 5155, H.R. 5448, H.R. 5454, H.R. 5709, H.R. 5954, H.R. 5985 and H.R. 6032 on June 12, 2008, I would appreciate it if you could answer the enclosed hearing questions as soon as possible.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for material for all Full Committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Megan Williams by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

John J. Hall
Chairman

Questions for the Record
The Honorable John J. Hall, Chairman,
Subcommittee on Disability Assistance and Memorial Affairs,
House Veterans' Affairs Committee
June 12, 2008

Legislative Hearing on H.R. 1197, H.R. 3008, H.R. 3795, H.R. 4274, H.R. 5155, H.R. 5448, H.R. 5454, H.R. 5709, H.R. 5954, H.R. 5985, and H.R. 6032

H.R. 3795

Question 1: Please inform the Committee whether Depleted Uranium (DU) is widely used by the military, for example, in anti-tank weapons, tank armor and ammunition rounds.

Answer: The United States military uses DU in armor penetrating munitions fired by Abrams tanks, Bradley Fighting Vehicles, and several aircraft systems, including the A–10. Depleted uranium also provides defensive armor for Abrams tanks. Depleted uranium is generally limited to combat situations involving enemy tanks, and, therefore, is not currently in wide use in theater. It also has some uses in the civilian community, including in stabilizers in aircraft and boats.

H.R. 3795

Question 2: Does the DoD agree that Persian Gulf War veterans were exposed to greater amounts of DU than the average citizen?

Answer: Most Persian Gulf War veterans had no greater exposure to depleted uranium (DU) than does the average U.S. citizen. The Department of Defense (DoD) and the Department of Veterans Affairs maintain DU medical management programs to assess Servicemembers and veterans for possible DU exposure. The Department classifies personnel into three possible levels of exposure, and requires DU testing for those personnel in the two groups at the highest risk of exposure. Personnel at lower risk of exposure may also undergo testing based on concerns of the

medical care provider or the patient. Thus far, DoD has tested almost 2,500 personnel serving in Operation Iraqi Freedom for DU in their urine specimens. Of these, only 10 have been positive for DU, most of whom had elevated levels associated with the presence of embedded DU fragments. However, the remainder of the 2,500 personnel tested have not shown elevation of urine uranium above the expected background level of natural uranium.

H.R. 3795

Question 3: According to an article published by the U.S. National Library of Medicine and the National Institutes of Health, American soldiers involved in "friendly fire" accidents during the 1991 Gulf War were injured with depleted-uranium-containing fragments or possibly exposed to depleted uranium via other routes such as inhalation, ingestion, and/or wound contamination. Through urine samples, it was found that most of these soldiers had above-average DU concentrations in their bodies. Those studies only pertain to "friendly fire" injuries, so these figures would likely be much higher if all veterans were taken into consideration. Given these facts, does the DoD think that there is a slight possibility that even some Gulf War Veterans were exposed to DU and hence may be at greater risk of developing cancer?

Answer: The Department generally concurs with the conclusions of the National Academy of Medicine (NAM) in its analysis of depleted uranium (DU) exposures during the 1991 Gulf War, which to a great extent have been based on decades of data arising out of industrial exposures to natural uranium. It is important to note that neither occupational exposure to natural uranium nor military exposure to DU (which is 40 percent less radioactive than natural uranium) has been shown to cause cancer in humans. Much of what is known about the exposure to and absorption of DU is derived from the scientific literature on natural uranium, which the NAM discusses at great length.

All humans are exposed daily to natural uranium through inhalation and ingestion, and excrete it in their urine. Servicemembers on the battlefield are also exposed to natural uranium. In some unusual situations, they may be exposed to DU. After studying the Servicemembers with the highest risk of exposure to DU, it has become clear that the presence of embedded DU fragments is the main factor that results in long-term DU exposure. Neither "friendly fire" victims without embedded fragments, nor other individuals with lesser exposures, have had increased uranium in their urine that would indicate levels of exposure to DU that would have an adverse health effect.

Those Servicemembers and veterans at greatest risk for possible exposure to DU are required to undergo medical evaluation by DoD or the Department of Veterans Affairs. Urine biomonitoring is the most sensitive technique for determination of excessive intake of DU, including inhalation and ingestion, and exposures in excess of occupational safety and health guidelines are readily detectable through elevation of urine uranium. About 80 veterans involved in "friendly fire" incidents have been extensively evaluated, some since 1993. Despite elevations of urine uranium levels in those personnel with remaining embedded DU fragments, no medical conditions associated with uranium exposure have been detected in any of the examined veterans during comprehensive medical evaluations.

Some individuals not involved in "friendly fire" incidents and without embedded DU fragments are undergoing urine screening for DU because of military occupations that require them to work on damaged tanks, or possibly subject them to other low-level exposures. The Department has not identified any individual in this group who has tested positive for DU in the urine, and significant DU exposures are unlikely to have occurred in the absence of DU in the urine. Based on the absence of associated disease occurring in individuals involved in "friendly fire" incidents, and the negative biomonitoring results from others possibly at risk of exposure, DoD believes that those at risk of developing uranium-associated disease are limited to the small group invited to participate in long-term medical follow-up

H.R. 3795

Question 4: Additionally, the World Health Organization lists lung tissue damage leading to a risk of lung cancer as a potential effect of inhalation of large amounts of radioactive DU, and a DU Follow-up Program conducted by the Baltimore Division of the VA Maryland Healthcare System in January of 2000 found that health effects are related not only to the presence of uranium, but also to the amount of time or duration a person is exposed. It seems that any health effects are due to the total amount of exposure, not just the effects of a single incidence.

Did the DOD take into account the duration of the exposure and the potential effects the length of time might have on servicemembers?

The Committee has been apprised of a study conducted by a Northern Arizona University biochemist in 2006 that reveals that uranium can bind to and has profound and debilitating effects on human DNA. The findings seem to establish that when cells are exposed to uranium, the uranium binds to DNA and the cells acquire mutations, triggering a whole slew of protein replication errors, some of which can lead to various cancers. Please provide a response to these findings and indicate whether the DoD concludes that this research may shed light on the possible connection between exposure to depleted uranium and Gulf War Syndrome?

Answer: The Department follows with interest the results of all relevant literature and research on the effects of uranium or depleted uranium (DU) on humans and mammalian systems. These must be interpreted based on whether they use in vivo (live animal) or in vitro (cell culture) models and what the studies are designed to measure. Medical science has evaluated health effects of natural uranium for more than 50 years and DU for more than 20 years. Because DU is a heavy metal with minimal radioactivity, it would exert a toxic effect mainly as a chemical hazard rather than radioactive hazard. A few industrial workers (not 1991 Gulf War veterans) have developed kidney disease after taking in large amounts of uranium, due to its chemical properties. However, no human cancer, including lung cancer, has been linked to exposure to either natural uranium or DU.

According to the World Health Organization, because "DU is only weakly radioactive, very large amounts of dust (on the order of grams) would have to be inhaled for the additional risk of lung cancer to be detectable in an exposed group." The Institute of Medicine concluded that there was suggestive evidence of no association between exposure to uranium and lung cancer at doses 2–10 times higher than the maximum dose estimated in the DU Capstone Study. The Army's DU Capstone Study assessed DU dust levels in scenarios in which DU munitions struck vehicles, and calculated the incremental cancer risks of occupants in those vehicles under a variety of conditions, some of which were extreme. One of these conditions was the length of time occupants remained in the vehicle. The analysis supported the view there would be little or no long-term impact on the health of personnel from inhalation of DU particulates inside tanks or other vehicles struck by DU munitions.

The Department is aware of publications by Diane Stearns and Virginia Coryell, of Northern Arizona University, in 2005 and 2006, which examined survival of Chinese hamster ovary cells exposed to a form of DU. While the results of the study suggest possible genotoxicity from the chemical effects of uranium exposure in a mammalian tissue culture system, these results must be viewed in perspective. Uranium is an element that is found everywhere in our environment, although some parts of the Earth contain higher concentrations of it in the soil. On average, more than four tons of natural uranium exists in the top foot of soil in every square mile on Earth. All humans are exposed to low levels of uranium on a daily basis, including in food, water, and the air we breathe. Everyone has about 80 milligrams of naturally occurring uranium in their body as a result of natural exposure, and excretes uranium in the urine. Most substances that we encounter have adverse effects in certain situations or concentrations, and studies of undesirable effects from excess exposures must be interpreted by comparison to usual exposures, or the norm. However, there is no way to compare the Northern Arizona University results with what would constitute a normal exposure.

Furthermore, Service members evaluated for DU exposure are measured against a norm of low levels of natural uranium, rather than the total absence of uranium. Personnel with confirmed elevations in uranium levels are referred to the DU program for long-term medical follow-up. Significant elevations in urine uranium levels are associated with the presence of embedded DU fragments, and represent continuing exposures. Even after more than 15 years of follow-up for some individuals with embedded fragments of DU, no health effects resulting from their DU exposures have been detected other than wounds caused by the DU fragments. In addition, no birth defects have been observed in any of the offspring of these veterans. From Operation Iraqi Freedom deployments, about 2,500 personnel at elevated risk of DU exposure have undergone testing, and only 10 have been confirmed positive and referred for continued follow-up.

H.R. 5454

Question 5: Please inform the Committee when the results of these research projects you mention in your Statement for the record (DAMA Subcommittee hearing, June 12, 2008) will be available.

Answer: Two of the ongoing research projects will finish in 2009:

- Harvard University—"Prospective study of Amyotrophic Lateral Sclerosis Mortality Among World War II, Korea, and Vietnam veterans;" and
- University of Cincinnati—"Biomarkers for Amyotrophic Lateral Sclerosis in Active Duty Military"

Other projects should complete in 2010.

H.R. 5454

Question 6: You admit that there are a few reports that show a possible association between ALS and military service, but you maintain that this is still insufficient evidence. So what would you consider to be sufficient evidence that would lead the DoD to conclude that there is some level of causation between military service and ALS?

Answer: The Department concurs with the conclusion of the Institute of Medicine (IOM). The IOM published a report on Amyotrophic Lateral Sclerosis (ALS) in November 2006, entitled "Amyotrophic Lateral Sclerosis in Veterans: Review of the Literature." Based on the strength of the scientific evidence, the IOM concluded that there was "limited and suggestive evidence of an association between military service and later development of ALS." This means the IOM concluded the evidence was not strong enough for causation. A causal relationship requires stronger scientific evidence than an association requires.

The IOM stated that about 5–10 percent of ALS cases in the general population are inherited, and the causes of the remaining 90–95 percent of cases are not known. Similarly, in the studies of ALS in veterans, about 10 percent of the cases were inherited, and the causes of 90 percent of the cases were not known. IOM pointed out that there have been many ALS studies in the general population that examined occupations, physical trauma, strenuous physical activity, and lifestyle factors, but there have been no consistent results.

The IOM made a recommendation to "conduct further corroborative or exploratory studies to elucidate ALS risk factors relevant to military service." There are several ongoing research studies that are evaluating the possible relationship between military service and later development of ALS. When completed, these studies will provide additional evidence on whether military veterans are at increased risk for developing ALS, compared with individuals who did not serve in the military.

H.R. 5454

Question 7: On June 12, 2008, there was testimony delivered during the DAMA Subcommittee hearing by a veteran diagnosed with ALS (Jeff Faull) who cited a study funded by the DoD that found that veterans of the 1991 Gulf War are approximately twice as likely to develop ALS as those not deployed to the Gulf. Would the DoD consider this as sufficient evidence to conclude causation between ALS and military service?

Mr. Faull also referred to a study conducted at Harvard that concluded that veterans from other eras, ranging from before World War II to after Vietnam, are also twice as likely to develop ALS as those who have never served in the military, regardless of whether the service was during time of peace or war, or at home or abroad? Moreover, the study indicated that veterans were at greater risk of becoming afflicted with ALS regardless of whether they served during a time of war or peace, or whether they served at home or abroad. Is the DoD aware of this study? If not, please inform the Committee of the DoD's opinion on the results of the aforementioned study now that it is aware.

Answer: The Department is aware of the study, "Occurrence of Amyotrophic Lateral Sclerosis, Among Gulf War Veterans," published in the medical journal, *Neurology*, in September 2003. The Institute of Medicine (IOM) published a report on ALS in November 2006, entitled "Amyotrophic Lateral Sclerosis in Veterans: Review of the Literature." On pages four and five of this report, the IOM states, "the results of a single study are not sufficient evidence to conclude causation between Amyotrophic Lateral Sclerosis (ALS) and military service." The Department of Defense (DoD) concurs with IOM's conclusion that the results of a single study are insufficient.

The Department is aware of the study conducted by Harvard University researchers, "Prospective Study of Military Service and Mortality from Amyotrophic Lateral Sclerosis," published in *Neurology* in January 2005. The Department reviewed this

study and determined that it used appropriate methods. In fact, DoD provided funding to the Harvard University researchers to perform additional research on ALS in veterans of World War II, Korea, and Vietnam.

H.R. 5954

Question 8: Has the DoD provided the Department of Veterans Affairs with all of the names of participants in the Project SHAD and Project 112 testing?

Answer: The Department of Defense (DoD) has provided the Department of Veterans Affairs (VA) with all the names of the participants in Project 112 and Project Ship Hazard and Defense (SHAD) that it has discovered to date. The Department vigorously pursues any new leads it receives on possible exposures in Project 112/SHAD. If during our investigations of these leads, we find new Project 112/SHAD exposures, DoD immediately notifies the VA.

H.R. 5954

Question 9: Please provide a response to the U.S. Government Accountability Office's claims that the DOD needs to provide a more objective analysis of the costs and benefits of actively searching for Project 112 participants and that until then your efforts are questionable? The Committee adds that the GAO also stated that the American public cannot be assured that the DoD's current effort is reasonable and effective until you address the following limitations:

a. DOD's effort lacks clear and consistent objectives, scope of work, and information needs that would set the parameters for its effort.
b. DOD has not provided adequate oversight to guide this effort.
c. DOD has not fully leveraged information obtained from previous research efforts that identified exposed individuals.
d. DOD's effort lacks transparency since it has not kept Congress and veterans service organizations fully informed of the progress and results of its effort.

Answer: In late 1991 and continuing for approximately 5 years, the Department of the Army, as the Department of Defense (DoD) executive agent, responded to several congressional inquiries on behalf of three possible Project Shipboard Hazard and Defense (SHAD) veterans. In 1992, the Army confirmed the existence of Project SHAD and provided, in relation to these specific inquiries, vessels involved, test locations, and substances used. In 1994, the Army provided unclassified or redacted documents. In 1998, renewed interest in the release of additional information on the Project 112 test program developed. In August 2000, the Department of Veterans Affairs (VA) asked DoD to provide more information on SHAD tests. At that time, VA wanted information on three tests—Autumn Gold, Copper Head, and Shady Grove—to satisfy pending claims.

In September 2000, DoD assigned responsibility for the investigation to the organization now known as Force Health Protection and Readiness (FHP&R). FHP&R personnel held weekly meetings with VA to ensure that DoD's search produced information that would be useful information to VA. This information included dates/location of tests, vessels involved, lists of agents, stimulants, tracer material, and decontaminants used. VA did not request agent concentration information. VA decided that if an illness was linked to an exposure, the veteran would receive compensation.

DoD's investigation indicated that the Desert Test Center (DTC) planned both shipboard and land based testing. Investigators quickly determined that there were a significant number of tests conducted. In all, DTC personnel planned for 134 tests and conducted 50. DoD decided that veterans of individual tests should not have to wait for a full report of the investigation. Investigators prepared fact sheets for each test and delivered the names of exposed individuals to VA as soon as they compiled and declassified the necessary information. DoD provided information on Autumn Gold, Copper Head, and Shady Grove to VA on September 13, 2001, and simultaneously posted fact sheets relating to these tests on the FHP&R web site. DoD continued this procedure (develop fact sheets on tests, identify veterans possibly exposed, post the fact sheets on the FHP&R Web site, and notify VA of the individuals exposed on those tests) until the investigation was completed.

In researching Project 112/SHAD, DoD investigators compiled over 34,000 pages of relevant material. Locations searched for documents included West DTC, Dugway Proving Grounds, Navy Historical Center, Naval Surface Warfare Center, Edgewood Chemical and Biological Center, United States Army Chemical Center and School, Defense Technical Information Center, National Archives, Office of Naval Research,

and the Office of the Secretary of Defense Historical Office. The discovery of DTC annual and semi-annual progress reports was a major breakthrough in the investigation that allowed a better understanding of the universe of tests planned. Many of these documents remain classified for national security reasons. However, without compromising national security, DoD investigators declassified portions of relevant documents and used this declassified material to build fact sheets for each test that accurately reflects the nature of Project 112 testing.

During its investigation, DoD found no test specific medical records or classified medical records. Technical reports on tests did not include personally identifiable information on the health effects of exposures. The purpose of these tests was to assess dissemination characteristics and operational countermeasures, not health effects on personnel.

Identification of Navy personnel was straightforward. Test documents identified the dates of the test and the trials associated with each test. Using these dates and the Enlisted/Officer Distribution and Verification Report (Quarterly listing of the ship's crew), ship's deck logs, and the ship's personnel diary, investigators identified personnel on-board during tests. Unfortunately, these documents are not available for the Navy tugs involved in several tests and complete information on these vessels is still lacking.

Identifying individuals on land-based tests proved more difficult. DoD investigators identified military personnel who participated in these tests from test officers' log books, temporary duty orders, country clearance measures, overtime reports, letters of commendation, and similar documents. DoD investigators were able to identify personnel on only one-third of the land-based tests.

Investigators could not totally identify three other groups of Project 112 personnel: the aircrews who loaded the spray tanks used on some SHAD tests, the pilots who flew spray missions, and members of the Project 112 technical staff.

In August 2003, we provided Congress with a complete report, detailing our efforts to identify Project 112/SHAD testing and the individuals possibly exposed during this testing. Since our 2003 report to Congress, DoD received numerous phone calls and letters from veterans relating to participation in Project 112. These veterans have shared with us temporary duty orders, letters of commendation, etc., that enabled us to identify additional Service members involved in Project 112. However, these individuals were not able to identify locations that might contain additional SHAD documents.

Additionally, the Institute of Medicine (IOM) conducted a study of the "Long-Term Health Effects of Participation in Project SHAD," publishing its report in 2007. In support of this effort, DoD provided IOM with the Project 112 Exposure database. Using the same documents used by DoD, IOM reviewed the database and identified additional personnel possibly exposed. Working with IOM, DoD validated an additional 394 SHAD participants.

The Department is currently identifying all non-Project 112/SHAD personnel possibly exposed to chemical and biological agents from World War II to the present. The DoD contractor conducting research for this effort completed a review of documents available at Dugway Proving Ground. During this review, they found no new individuals associated with Project 112 tests. They did find some additional tests for a few civilians already identified as participating in known Project 112 tests.

Having conducted an exhaustive search for information on Project 112/SHAD, DoD does not concur that any degree of searching records archives for a long ago terminated program would result in a more complete documentation of all aspects of the program. The evidence found produces an accurate picture of Project 112/SHAD. We currently know of no other investigative leads that would meaningfully supplement that picture. We instructed the current contractor looking for non-Project 112/SHAD exposures to collect the names of any individuals they discovered exposed in Project 112. FHP&R will investigate any new information that may be presented and share that information with VA and the public.

The DoD program and actions address the intent of the GAO recommendations. The GAO stated that DoD had "agreed to and has in some cases begun taking action to respond to the five recommendations." The Department updated its program goals and objectives to identify individuals who were possibly exposed during chemical and biological tests outside of Project 112. The revised statement of work, implementation plan, and concept of operations ensure consistent guidance and deliverables that are responsive to the GAO recommendations.

The Office of the Special Assistant for Chemical and Biological Defense and Chemical Demilitarization Programs oversees the current program and has established an implementation plan with the Deputy Assistant Secretary of Defense (Force Health Protection and Readiness) (DASD(FHP&R)) delineating program oversight responsibilities. The following controls are in place: monthly reporting, quar-

terly program reviews, and data reviews with key personnel from the office of the DASD(FHP&R). As recommended by GAO, the DoD program manager conducts quarterly site visits.

Under the revised statement of work, the support contractor conducts research to identify other organizations performing similar work. During quarterly reviews, the contractor presents analyses and reports on those sources that it recommends should be coordinated with and leveraged to identify additional individuals possibly exposed. As noted in DoD written comments to the draft GAO report, DoD continues to identify Project 112 participants when new leads or information is shared with us or VA from any source, including former Service members and others knowledgeable of these tests. DoD continues to develop and provide guidance to individuals possibly exposed during these tests.

The DASD(FHP&R) continually adds information to its website to update the public on DoD's current efforts. FHP&R is upgrading this Web site to include information on possible exposures outside of Project 112/SHAD. In February 2008, representatives of the DASD(FHP&R) briefed the veterans and military service organizations on our efforts and the DASD(FHP&R) will continue to brief these organizations on a periodic basis.

H.R. 5985

Question 10: If this bill is not enacted, how would the DoD suggest making, maintaining, and transmitting military records amidst the often chaotic environment in which they are created in combat?

a. What does/would the DoD do in a situation where a servicemember's combat records are lost or otherwise irretrievable?

Answer: The proposed amendment does not improve the likelihood of a fair hearing in these cases, because it proposes the addition of a provision to establish Service connection that would require information from official records. Lost records place an unfair burden on a veteran who is seeking to establish Service connection for a disease or injury. The Department provides assistance to reconstruct lost records, but this is not a guarantee that the information needed to prove Service connection will be recovered.

Current law already addresses cases where official records cannot be used to provide Service connection. Title 38, United States Code, section 1154, subsection (b) clearly establishes a different burden of proof for the veteran and the government in cases where Service connection is called into question. This is evidenced by two provisions in the subsection:

- First, the Secretary of Veterans Affairs shall accept satisfactory lay or other evidence that the disease or injury was incurred or aggravated by service, which involved the engagement of the enemy in combat as sufficient proof of Service connection. If there is no official record that the disease or injury was incurred or aggravated by such service, the Secretary shall resolve every reasonable doubt in favor of the veteran.
- Second, the criterion for a rebuttal of a claim for Service connection is the presentation of clear and convincing evidence to the contrary.

The legal framework for a reasonable evaluation of the evidence and a fair decision concerning a claim for Service connection is already established. The addition of a criterion to consider service in a combat zone to be equivalent to service, which involves engaging the enemy in combat, really does not address the issue of lost records.

H.R. 5985

Question 11: Given the changing dynamic of combat in the current OEF/OIF conflicts (where there are virtually no lines or enemies in a certain uniform and where there are not many "safe areas") please explain how the DoD identifies a combat area, i.e., an area where a servicemember would engage in combat with the enemy?

Answer: There may be several definitions of "an area where a Service member would engage in combat with the enemy," depending whether the context is operational or for other purposes. For the purpose of establishing eligibility for tax benefits under section 112 of the Internal Revenue Code, the Department identifies a potential "combat zone" as an area, both land and sea, where combat operations are either occurring or likely to occur. Once a consensus is reached on the area, the De-

partment drafts an Executive Order and recommends that the President sign the order, formally establishing the Combat Zone.

H.R. 5985

Question 12: Service Medals are typically presented on a unit basis. Please describe how the DoD defines "engaged in combat with the enemy" for the purposes of awarding service medals. How does the DoD award service medals to those service members who "engaged in combat with the enemy" apart from his/her assigned unit, i.e. truck drivers on a convoy, etc.?

Answer: The term "Department of Defense Service medals" encompasses all of the Department of Defense (DoD) Campaign, Expeditionary, and Service medals, including the Afghanistan Campaign Medal (ACM), Iraq Campaign Medal (ICM), Global War on Terrorism Expeditionary Medal, Global War on Terrorism Service Medal, Kosovo Campaign Medal, National Defense Service Medal, and many others. Many of these medals include criteria that authorize award based on a Service member being engaged in combat with the enemy. Specifically, the ACM and ICM criteria authorize award for being "engaged in combat during an armed engagement," regardless of the amount of time spent in the area of eligibility. It is the responsibility of unit commanders, many of whom are on the ground in Iraq and Afghanistan, to determine if a Service member's specific situation constitutes actual combat during an armed engagement that would warrant award of the ACM or ICM. The Department and the Services do not define "engaged in combat during an armed engagement" for the purpose of awarding the ACM and ICM in order to allow as broad an interpretation as possible.

The majority of Service members are awarded DoD Service medals, not for being engaged in combat, but for serving the required number of days in the specified area of eligibility. For those Service members who are authorized the award based on combat engagements, it is the Service member's responsibility to request award based on the "engaged in combat during an armed engagement" criteria and to notify their local chain-of-command of the qualifying combat engagement. The local commander verifies eligibility based on witness statements from other personnel present at the time of the combat engagement. The authority to authorize award of DoD Service medals has been delegated down to the local command level in order to expedite processing of such requests.

H.R. 5985

Question 13: On average, what is the waiting period for a deserving servicemember to receive a medal for military service?

a. Please describe the process for awarding service medals.
b. Are there avenues to expedite this process?

Answer: The Department of Defense (DoD) Service medals include Campaign, Expeditionary, and Service medals. Examples of DoD Service medals include the Iraq Campaign Medal (ICM), Afghanistan Campaign Medal (ACM), Global War on Terrorism Expeditionary Medal, Global War on Terrorism Service Medal, and National Defense Service Medal, to name a few. Each military department is responsible for prescribing appropriate regulations for administrative processing and awarding of DoD Service medals.

The Services do not track the waiting period for a Service member to receive a DoD Service medal. As one would expect, processes for award of Service medals vary for each Service based on its respective regulations and award systems. However, since determining eligibility is basically an administrative review to ensure eligibility criteria have been met, the timeframe between providing proof of eligibility and updating personnel records is minimal, normally less than 30 days. Award authority is delegated to the local commander in order to expedite the award process. The Department is aware of no avenue to further expedite this process nor is there evidence to suggest that there is a problem with the timely award of DoD Service medals.

H.R. 6032

Question 14: Please comment on the results of the most recent IOM Report on the possible health effects of Agent Orange and other herbicides used during the Vietnam War?

Answer: The Institute of Medicine (IOM) report "Veterans and Agent Orange Update 2006" was released in late 2007. The update fulfills the mandates of the Agent Orange Act 1991 and the Veterans Education and Benefits Expansion Act for the National Academy of Sciences, which require a comprehensive evaluation of scientific and medical information on the health effects of exposure to Agent Orange, other herbicides used in Vietnam, and the chemical components of those herbicides.

The Department of Veterans Affairs (VA) established an internal VA Work Group to formally review the report. The Department awaits the completion of VA's formal review. This update will assist in the development of VA policy related to disability determination for Vietnam veterans claiming injury from Agent Orange exposure.