BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

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BVA NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE HOUSE AND SENATE COMMITTEES ON VETERANS AFFAIRS

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INTRODUCTION

Chairman Sanders, Chairman Miller, Ranking Members Senator Burr and Michaud, and other Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this invitation to present our legislative priorities for 2014. BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. On March 28 of this year, the Association will turn 69 years old.

As greater numbers of wounded service members and veterans from Operation Enduring Freedom, Afghanistan (OEF) and Operation Iraq Freedom (OIF) enroll in the VA health care system after 12 years of conflict in the Middle East, an increasing number of visually impaired veterans are being added to the current database of the combat wounded from all previous wars.

BENEFICIARY TRAVEL FOR BLINDED VETERANS: S. 633 AND H.R. 1284

Veterans who are currently ineligible for travel benefits under Title 38, Section 111 of U.S.C. are not covered for the cost of public transportation or personal travel expenses to one of the 13 Blind Rehabilitation Centers (BRCs), thus adding to the financial burdens of disabled, low-income veterans. Those who must currently shoulder this hardship, which often involves airfare, are discouraged by these costs. The average age of veterans attending a BRC is 67 because of the high prevalence of degenerative eye diseases in this age group. BVA urges that these travel costs be covered by the Veterans Integrated Service Network (VISN) from which the veteran is referred and that such costs not be an added burden for the disabled blinded veteran in obtaining the crucial rehabilitation training needed to gain independence through a BRC. BVA therefore requests passage of legislation in the second session of the 113th Congress, ensuring that the Veterans Health Administration (VHA) cover such travel costs by changing Title 38 Section 111 to require VA to provide transportation costs by air, train, bus, or other methods. The legislation should specify that the transportation would be to a special rehabilitation program serving blinded veterans or the spinal cord injured and that it would be for either inpatient or HOPTEL program medical care.

BVA again thanks Senator Jon Tester for introducing S. 633 and also expresses appreciation to Congresswoman Julia Brownley for introducing H.R. 1284, the companion House bill. The legislation would assist low-income and disabled veterans by removing the financially burdensome travel expenses needed to access vital care that improve independence and quality of life. BVA points out that at both the Senate VA Committee hearing May 9, 2013 and the House VA Subcommittee on Health hearing June 24, 2013, the VA witness, along with VSO witnesses, testified in favor of this legislation.

It makes little sense to have developed, over the past decade, outstanding blind rehabilitation services with high quality inpatient and outpatient specialized training, only to tell catastrophically disabled blinded or spinal cord injured veterans that they must pay their own travel expenses. To put this dilemma in perspective, a large number of our constituents are living below the poverty line. None, of course, can drive themselves. VA utilization data revealed that

one in three veterans enrolled in VA health care was defined as a rural resident or a highly rural resident. The data also points to the fact that blinded veterans in rural regions have significant financial barriers to traveling without utilization of public transportation.

To elaborate on the challenges of travel without financial assistance, the data found that for most health characteristics examined, enrolled rural and highly rural veterans were similar to the general population of enrolled veterans. The analysis also confirmed that rural veterans are a slightly older and a more economically disadvantaged population than their urban counterparts. Twenty-seven percent of rural and highly rural veterans were between 55 and 64. Similarly, approximately 25 percent of all enrolled veterans fell into this age group.[1] In FY 2007, rural veterans had a median household income of $19,632, four percent lower than the household income of urban veterans ($20,400).[2] The median income of highly rural veterans showed a larger gap at $18,528, adding significant barriers to paying for air travel or other public transportation to enter a VA BRC or other rehabilitation program.

More than 70 percent of highly rural veterans have to drive more than four hours to receive tertiary care from VA. The FY 2015 VSO Independent Budget reports from current VA research that among all VA health care users, 36 percent (more than 2.2 million) reside in rural areas, including 76,955 from "highly rural areas" as defined by VA in 2012.

States and private agencies are not the answer either since they do not usually operate blind services in rural regions. In fact, almost all private blind outpatient agency services are located in large urban cities, making them impossible to access for rural elderly blinded veterans for daily outpatient rehabilitation training. With current economic problems that bring state budgets clearly in view, we expect further cuts to these social services. Such cuts would prohibit state agencies from funding disabled veteran travel to a VA blind center across state borders to other regions. If a low-income veteran needs blind rehabilitation training to learn the skills to live independently at home, the benefit of a $350 airline ticket to get to a BRC will far outweigh its cost to the nation. We again ask Congress to provide this small change in Beneficiary Travel eligibility and pass H.R. 1284 and S. 633 before the end of this session.

FUNDING VHA BLIND REHABILITATION SERVICE (BRS)

Integrated among OIF and OEF veterans with eye injuries is an aging veteran population that can be characterized by a growing prevalence of age-related degenerative visual impairments. During FY 2012, there were 50,304 blinded veterans enrolled in BRS with care.[3] VA research studies estimate that there are 156,854 legally blinded veterans. Epidemiological projections indicate that there are another 1,160,407 low-vision impaired veterans in the United States with visual acuity of 20/70 or worse.[4] VA currently operates thirteen comprehensive residential BRCs across the country. The first blind center was established at the VA Hospital at Hines, Illinois, in 1948. Nine additional Blind RCs have been established and strategically placed within the VA

[1] Department of Veterans Affairs, Office of Rural Health, "Demographic Characteristics of Rural Veterans," **Issue Brief** (Summer 2009).
[2] **VSO IB 2015** Beneficiary Travel, p. 93.
[3] Blind Rehabilitation Services, BR Data (VHA, October 14, 2010).
[4] **VHA Blind Rehabilitation Service Report** August 23, 2012.

system. The sites include VA Medical Centers in Palo Alto, California (1967); West Haven, Connecticut (1969); American Lake, Washington (1971); Waco, Texas (1974); Birmingham, Alabama (1982); San Juan, Puerto Rico (1990); Tucson, Arizona (1994); Augusta, Georgia (1996); and West Palm Beach, Florida (2000). In late 2011, centers in Biloxi, Mississippi, and Cleveland, Ohio were opened. The Major Charles R. Soltes, Jr. Blind Rehabilitation Center in Long Beach, California, opened in 2012.

BVA is growing increasingly concerned over longer waiting times and growing lists of blinded veterans to enter some of the BRC's as some medical centers have vacant staff positions resulting in a reduction in the BRC beds that are open for veterans. After more than 63 years of existence and steady progress, while BRCs still provide the most ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans, the VISN networks and medical center directors at some sites are claiming that there is no funding for retiring staff members who retire or who transfer to another facility. These BRCs are therefore lacking the staffing to help blinded veterans acquire the essential adaptive skills to overcome the many social and physical challenges of blindness. This result has occurred despite a VA press release in March that claimed that "….with a medical care budget of $54.6 billion, VA is positioned to provide care to 6.5 million veterans in the fiscal year beginning Oct. 1."

The VHA BRS Director, we feel, must have more VHA central control over the blind center personnel resources and funding levels. The risk is a downward spiral of further staffing vacancies, empty BRC beds, and more veterans waiting longer for the rehabilitation services needed in order to become sufficiently independent to remain living at home. BVA has worked diligently with members of these committees to ensure that the annual VA appropriations were increased to meet the needs of blinded veterans' programs. The total BRS funding levels have risen from $94 million in 2007 to a budget of just under $126.4 million FY 2011. In FY 2012 there was another increase in the appropriations, this time by 8.4 million to nearly $135 million. In FY 2013 the figure reached more than $142 million.

Despite these higher funding levels, BVA is discovering staffing shortages at some of the blind centers, the worst of which is at Waco, Texas. The BRC there has a waiting list of more than 86 blinded veterans. There are only seven staff members on duty, including the BRC director. The result is that 50 percent of the beds have been empty for 15 months. An additional consequence of this crisis is that blinded veterans on dialysis in Texas are being told they are not able to receive BRC training and the Waco facility refuses to transfer them to other sites outside of the VISN.

Some other blind centers report similar problems. When BVA has had meetings at various sites, senior directors and assistant directors tell us they have no funding for the vacant positions. BVA would like the Congressional Oversight Subcommittee to ask where the BRS funding is being used. BVA is told that the funding doesn't get sent to the BRC, despite the fact that, going back eight years, medical centers should be reimbursed $29,737 for every blinded veteran admitted to a BRC under the Veterans Equity Resource Allocation (VERA). If blinded veterans continue on waiting lists that continue to grow, VHA and VISN Networks must explain why. These centers need directed funding to bring staffing levels up to required levels. VISN directors should not be allowed to divert funds designated by VERA for rehabilitation admissions from the blind centers to other general medical operations. There should be no bed closing or hiring freezes on critical

blind center staff positions. VHA must maintain the current bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of passage of Public Law 104-262.

We also caution that private agencies for the blind do not have the necessary full specialized nursing, physical therapy, pain management, audiology and speech pathology, pharmacy services, radiology support services, and subspecialty surgery specialists, to provide the clinical care necessary for the newly complex psychological trauma of the war wounded. Also, most private agencies are all outpatient centers in major cities that could not be accessed by our rural blinded veterans. In many rural states there are no private inpatient blind training centers, leaving the VA BRCs as the only option.

BVA requests that all private agencies be required to demonstrate the peer reviewed quality outcome measurements that are a standard part of VHA BRS. They must also be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Blind Instructors should be certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). No private agency should be used for newly war blinded service members or veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, and joint peer-reviewed vision research.

DoD-VA VISION CENTER EXCELLENCE

The establishment of the DoD-VA Vision Center Excellence (VCE) for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries (authorized by the Fiscal Year 2008 National Defense Authorization Act, Public Law 100-180, Section 1623) becomes even more vital as VHA records reveal that 130,340 OIF/OEF/OND (Operation New Dawn) veterans with eye conditions entered the VA system for care from October 2001 through March 30, 2013.[5]

The Hearing Center of Excellence (HCE) and Extremity and Amputation Center of Excellence (EACE) were also mandated in the FY 2009 National Defense Authorization Act (Public Law 110-417). HCE is aware of 255,000 individuals with hearing loss. Congress clearly established these three Centers of Excellence with the intention that they have joint leadership. Their purpose was to improve the care of wounded or injured service members and veterans affected by combat eye, hearing, and limb amputee trauma. They should also improve clinical coordination between DoD and VA for the treatment of wounded service members suffering from these specialized kinds of injuries. These centers are also tasked with developing joint clinical, bidirectional registries containing up-to-date information on the diagnosis and treatment of injuries, current activities in the areas of vision research, and the examination of long-term outcomes for these injuries. Unfortunately, these registries are still not fully functional even after being mandated more than four years ago. While VCE on the DoD side has already entered more than 20,000 of the eye injured into the Defense and Veterans Eye Injury and Vision Registry

[5] VHA Office Public Health, **OIF/OEF/OND Quarterly Enrollment Report**, October 2001 to March 30, 2013 Unique Eye Condition ICD-9 Codes.

(DVEIVR), VA has entered but a single veteran's record! Worse, we found that VHA is trying to develop its own Veterans Eye Injury Registry and Audiology Registry.

Despite a legislative mandate and Secretary William Gates' inclusion of these three centers as a top priority back in the February 2010 Quadrennial Defense Report (QDR), bureaucratic problems, limited oversight, debates over legal governance, and very limited VA budgets or staffing have all hindered significant progress toward the full establishment of the VCE, HCE, and EACE. Adding to VCE problems is the fact that the agency did not have an active duty Director for nearly one year following the departure of its former director on March 31, 2013. VCE's VA Deputy Director was both the Acting and Deputy Director for approximately 11 months. At the same time, DoD was represented at VCE by ten other full-time staff members and another 88 DoD contracted individuals. VHA, on the other hand, had a total of just two part-time VA staff members on board during the same time period. Of note as well is that HCE is also still lacking full-time VA personnel, thus hampering its key missions and the meeting of its mandated objectives.

BVA maintains that there were no surprises when the DoD Armed Forces Surveillance Center report of May 2011, **Eye Injuries, Active Component, U.S. Armed Forces, 2000-2010**, found that during an 11-year surveillance period there were 186,555 eye injuries worldwide. The data came from Military Treatment Facilities (MTFs).[6] VA also knew from published VA research papers that of the OEF/OIF/OND veterans diagnosed with Traumatic Brain Injury (TBI), some 75 percent of them experience short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems. The total number of OIF/OEF veterans with TBI visual disturbances was 37,376.[7] Some moderate to severe eye-injured OIF and OEF service members have not been centrally tracked, making the implementation of DVEIVR extremely critical to the improvement of coordination of care. The registry is also vital in ensuring access to the full continuum of VA Eye Care Services, Blind Rehabilitation Service (BRS), and Low-Vision outpatient programs that these committees have helped establish over the years.

We also emphasize the overall direct and indirect cost impact of these eye injuries from OIF and OEF. In May 2012, the National Alliance for Eye and Vision Research (NAEVR) released a first-ever study entitled **Cost of Military Eye Injury and Blindness**, prepared by Kevin Frick, Ph.D. (Johns Hopkins Bloomberg School of Public Health). Based on published data from 2000 to 2010 and recognizing a wide range of injuries from superficial to bilateral blindness, as well as visual dysfunction from TBI, the annual incident cost has been $2.3 billion. This figure yields a total cost to the economy of $25.1 billion over this time period, a large portion of which is the present value of future costs such as VA disability and Social Security benefits, lost wages, and family caregiver assistance.[8]

BVA appreciates the letter of inquiry that Congressman Benishek and Congresswoman Kuster, along with 15 other bipartisan members of this Committee and the House Armed Services

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[6] DoD Armed Forces Health Surveillance Center, **Medical Surveillance Monthly Report** (MSMR), Volume 18, No. 5, Eye Injuries, Active Component, U.S. Armed Forces 2000-2010 pp. 2-7, May 2011.

[7] VHA Office of Public Health: Report of Epidemiological Medical Encounters Disorders Eye, ICD-9 Code OIF/OEF/OND October 2001 to end of the 3rd quarter June 30, 2012.

[8] National Alliance for Eye Vision Research, "Decade of Vision 2010-2020: Value of Defense–Related Vision Research: Peer Reviewed Vision Trauma Research Program in Defense," Fall 2012.

Committee, sent to both Secretary of Defense Chuck Hagel and Secretary Eric Shinseki on July 22, 2013. The letter asked four key questions regarding the resources, staffing, budgets, and progress on the joint mandated trauma registries for VCE and HCE. Secretary Hagel responded on December 5 in a letter and, although Secretary Shinseki sent a reply in January to Congresswoman Duckworth, his letter did not answer the funding question for FY 2014 and 2015 that the inquiry had proposed. While DoD has provided more than $9.5 million and ten full time staff, VA has provided less than $1 million per year for three years and only two VA staff. BVA requests that this Committee hold hearings with senior witnesses from both the Navy Surgeon General's Office and senior VHA representatives to answer these questions and to explain the lack of VA resources for the past four years. Similar, the organization requests that VHA provide future plans on addressing these long-standing problems.

DEFENSE VISION TRAUMA RESEARCH PROGRAM (VTRP), FY 2015

BVA, along with other Veterans Service Organizations, is again supporting the programmatic request to continue directed funding in FY 2015 for the **Vision Trauma Research Program (VTRP)** within **Peer Reviewed Medical Research (PRMR)** for the extramural translational battlefield vision research line item. The request is again for $10 million for FY 2015, which is the same as it was for FY 2013 and FY 2014. This programmatic line item, which is managed by DoD's Telemedicine and Advanced Technology Research Center (TATRC), was initially created by Congress in FY 2008 defense appropriations and funded at $4 million. In FY 2010, funding was $3.75 million, in FY 2011 $4 million, and in FY 2012 $3.2 million, making eye injuries one of the lowest funded of all deployment injuries in the Congressionally Directed Medical Research Program (CDMRP) until 2013. BVA greatly appreciated the bipartisan efforts of Congressman Walz, Congressman Moran (Jim), Congressman Frelinghuysen, and other members who made possible the $10 million funding for both FY 2013 and FY 2014. Defense-related vision trauma research warrants a more vigorous investment as the numbers of veterans with blast-related vision complications continues to grow. Finding new battlefield treatments is imperative to prevent these complications and preserve vision in the front-line field hospitals.

Today, battlefield conditions have resulted in a high percentage of penetrating eye injuries and TBI-related visual system dysfunction among those wounded/evacuated due to IED blast forces. With the continued presence of the U.S. in Afghanistan, coupled with other global threats, eye injuries will continue to be a challenge. Serious combat eye trauma from OIF and OEF was the second most common injury and trails only hearing loss, according to an Office of VA Research and Development article published in October 2008. The article reported 4,970 moderate-to-severe penetrating combat eye injuries.[9] The VHA Office of Public Health reported that from October 2001 to the end of the second quarter of FY 2013 that the total number of OIF and OEF veterans enrolled in VA was 130,340. Among those injuries were 12,473 retinal and choroid hemorrhage injuries (including retinal detachment), 3,144 optic nerve injuries, 8,162 corneal injuries, and 16,180 with traumatic cataracts.[10]

Not unlike the existing specialized research programs on burns, prosthetics, PTSD, and spinal cord injuries, a more vigorously funded PRMR-Vision extramural research program will enable

[9] Ibid, Armed Forces Surveillance Center MSMR, May 2011, Eye Injuries Active Duty Force 2000-2010.
[10] VHA Office Public Health OIF/OEF/OND Enrollment October 2001-March 30, 2013 Report.

the exploration of new and promising research opportunities that directly meet battlefield needs. In light of the data above, research within defense appropriations must be increased for VTRP within CDMRP.

We point out that translational deployment eye injury research provides combat surgeons with new treatments that will preserve vision. A PRMR-Vision line item is a dedicated funding source for extramural research into immediate battlefield needs. This kind of eye trauma research for wounded warriors is not conducted by the National Eye Institute and is not done within VA Research and Development. This is unlike other CDMRP research for various cancer and general medical conditions in which there are many other private foundation sources. For FY 2012, more than 65 eye trauma research proposed grants were submitted for peer review but, due to the limited funding for vision trauma research, only 19 grants were funded. This is despite the identification by DoD of research gaps in both penetrating eye trauma and TBI vision dysfunction programmatic research.[11]

DoD-VA HEARING CENTER OF EXCELLENCE (HCE)

During present-day combat, a single exposure to the impulse noise of an IED can cause immediate noise-induced tinnitus and hearing damage. An impulse noise is a short burst of acoustic energy, which can be either a single burst or multiple bursts of energy. At 140+ dBA (unit of measure for decibels), the sound pressure level of an IED, damage occurs instantaneously. Many common military operations and associated noise exceeding the 140 dBA threshold occur on the battlefield, making hearing loss and tinnitus the number one injury from the wars. According to the DoD Hearing Center Excellence website, more than 335,000 OIF and OEF service members and veterans have been service connected for tinnitus and some 257,000 have various levels of documented hearing loss.[12]

Like VCE, HCE also has limited staff. Two Air Force officers are assigned in San Antonio's Wilford Hall. Today there is no full-time VHA staffing for HCE. VHA has no programmatic line item funding for HCE despite statements by senior officials in 2011 that four full-time would be provided. We point again to lack of governance from the Health Executive Council and Joint Executive Council. The Government Accountability Office Report 11-114 of January 31, 2011 found that while hearing loss is a major physical injury from the wars, the progress on starting a joint hearing registry to track and develop coordinated care between the two systems lags far behind VCE.[13] The invisible wounds of hearing and visual impairments do not seem to result in equal budgets for sensory trauma research that results for other injuries. Hearing deployment trauma research, for example, has had virtually no line item in the CDMRP for research. BVA again wishes to stress that more than 350,000 OIF/OEF/OND service members have reported tinnitus and more than 250,000 have reported hearing loss following their return from Iraq and Afghanistan. These numbers equal those reported for TBI, the signature injury of the two conflicts.

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[11] DOD "Description of Research Gap Power Point 'Inadequate War-Related Vision Trauma Research,'" Nov 2010.
[12] HCE.Gov DoD website data "Tinnitus and Hearing Loss, OIF and OEF."
[13] "Hearing Loss Prevention: Improvements to DoD Hearing Conservation Programs Could Lead to Better Outcomes" GAO-11-114 January 31, 2011.

Translated into financial costs, the Veterans Benefits Administration (VBA) paid out approximately $1.39 billion in VA disability compensation for tinnitus in 2010. At the current rate of increase, service-connected disability payments to veterans with tinnitus will cost $2.26 billion annually by 2016. The government's investment in the Hearing Center of Excellence and hearing trauma defense research, which could perhaps prevent, reduce, or even cure hearing loss in the future, pales in comparison (less than one percent of current compensation payments combined).

VA INFORMATION TECHNOLOGY AND SECTION 508 ADA COMPLIANCE

Section 508 of the Americans with Disabilities Act requires federal agencies to ensure that all electronic and information technology developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public. The 2012 Department of Justice (DOJ) report identifies continued challenges with Section 508 implementation and management. The report makes recommendations for training, policy, and better collaboration. The DOJ Section 508 compliance survey completed in the summer of 2012, however, found widespread problems and lack of accessible electronic and information technology at federal sites.[14]

BVA has repeatedly requested in its annual resolutions that VA Information Technology be fully compliant with Section 508 of the Americans with Disabilities Act in VHA and VBA websites. We appreciate the fact that both of these committees have requested VA briefings and required updates on the status of its efforts to comply with 508 Access. This problem of lack of compliance, however, has still not been fixed within VHA and VBA. Some 184 Information Technology program barriers were found in 2012 testing.[15] Blind VA employees and BVA National Service Officers are frequently unable to access the current VA system because of its lack of ADA-compliant features. We request that Congress continue its strong oversight to ensure that VA adequately funds its Information Technology programs and that it meet timelines for fixing the inaccessible websites. We are concerned about the lack of progress being made on compliance with electronic and Information Technology program timelines. There appear to be inconsistencies in budgetary changes made by the VA Assistant Secretary for Information and Technology/Chief Information Office and actual programmatic changes. In FY 2012, BVA was pleased that Mr. Roger Baker, Assistant Secretary for VA IT, formulated these timelines for change. He made them a senior level, internal priority and dedicated more personnel to the effort. There was $10 million in 508 access program funding and contractor support was added to fix these long-standing problems. We ask Congressional members to continue strong oversight of the IT system and to insist that VA meet its obligations to comply with Section 508 in all Internet-based programs.

CONFERENCES FOR VISUAL IMPAIRMENT SERVICES TEAMS AND BLIND REHABILITATION OUTPATIENT SPECIALISTS

[14] www.ada.gov/508

[15] VSOIB FY 2014, pp. 110-111

The Visual Impairment Service Team (VIST) system now employs 123 full-time Coordinators and 38 who work part-time. VIST Coordinators nationwide serve as the critical key case managers. There are also 81 full-time Blind Rehabilitation Outpatient Specialists (BROS). As state governments slash social services budgets, additional blind and low-vision veterans could be drawn into the VA system for care. Given the demographic projections of visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility with 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA and other endorsers of the VSO Independent Budget for FY 2014 assert that in order to strengthen the ability of VHA to recruit and retain VHA health care professionals, they must have access to Continuing Medical Education conferences and updates on emerging research and professional development education to meet licensure and certification standards.

While we agree that there should be oversight to prevent wasteful spending at previously large VA conferences involving thousands of employees, we find the drastic cuts to all professional medical conferences and outright cancellation of nearly all VA medical CEU conferences to be troubling. The annual small 195-person VIST/ BROS training conference is now permanently canceled. VA has also canceled travel to non-VA sponsored professional medical association conferences for physicians. As a consequence, staff is unable to earn educational credit hours necessary to improve their duties. Further, VA internally has created complex, bureaucratic, administrative review processes involving several management layers and arbitrary limitations of attendance not to exceed 50 for any private or VA- sponsored conference.[16] Vital joint DoD and VHA medical conferences on subjects such as TBI, vision and spinal cord injury rehabilitation, prosthetics research, and audiology have been canceled. We ask Congress to revisit this issue and request a more balanced approach in order to determine what can be done to reverse it while still remaining cost effective in supporting employee professional development and training programs.

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)

The Convention on the Rights of Persons with Disabilities (CRPD) is an international disability treaty that was inspired by strong U.S. leadership in recognizing the rights of people with disabilities dating back to the passage of the Americans with Disabilities Act passage more than 20 years ago. The CRPD is a vital framework for creating legislation and policies around the world that embrace the rights and dignity of all people with disabilities. The Americans with Disabilities Act (ADA) was the model for CRPD, which echoes the values of independence, respect, and reasonable accommodation throughout the treaty.

The United States signed CRPD in 2009. On December 4, 2012 the Senate ratification unfortunately fell five votes short of the supermajority vote required. The Senate's failure to ratify the disability treaty disappointed the large number of Veteran and Military Service Organizations that had overwhelming support for ratification. BVA reiterates its continued support for the CRPD's Senate bipartisan leaders who remain committed to bringing the disability treaty up in the second session of the 113th Congress.

[16] VSOIB FY 2014 Personnel Training, pp. 156-157.

We appreciate the Republican leaders who have repeatedly asked for ratification of the CRPD Treaty. Republican leaders who support it include former President George H.W. Bush, former Senator Bob Dole, former Attorney General Dick Thornburgh, former White House Counsel C. Boyden Gray, past Senate Majority Leader Bill Frist, retired General Colin Powell, Senator John McCain, etc. This treaty will help bring American experience and expertise to the international community's efforts to bring about changes for the disabled everywhere, most especially among the 130 nations who have already ratified it.

WORK OPPORTUNITY TAX CREDIT (WOTC)

In August 2011, about three million U.S. veterans, or 14 percent of the total number worldwide, reported having a service-connected disability. Among veterans with a service-connected disability, approximately four in ten reported a disability rating of less than 30 percent while three in ten had a rating of 60 percent or higher. At that same time, 60.3 percent of veterans with a service-connected disability rating of less than 30 percent were in the labor force compared with 26.6 percent for those with a rating of 60 percent or higher.

In 1981, the first tax credit for private employers who hire veterans and other chronically unemployed workers was signed into law by President Ronald Reagan. Because higher unemployment is the lot of persons with an actual or perceived deficiency, such as a disability or a perception of having few civilian skills, these individuals have less of a chance than the average worker of being hired. In designing the present-day Work Opportunity Tax Credit (WOTC), Congress took steps to ensure that the credit functioned through the private marketplace where workers could be regular employees at regular wages and have the same opportunity as others to learn and advance. Congress also capped its contribution to the labor cost of each new hire so that the Treasury loses no more than approximately $1,100 per hire on average, according to the Joint Committee on Taxation data. This amounts to the lowest cost of any federal jobs program because the employer pays the remainder of compensation for the entire duration of the job. Congress also mandated that each worker's status as a veteran or other target group be certified by the State Workforce Agency upon valid documentation and verified by the IRS during audits. Because of these safeguards, there has never been a significant instance of fraud or abuse in WOTC.

Of the nearly 1.2 million WOTC jobs created in FY 2011, Department of Labor statistics show that veterans accounted for a total of 17,712, of which 3,117 were disabled veterans. As in past wars, recently returning veterans suffer the highest unemployment rates. For example, as of December 2012, of the 2.5 million Gulf War Era II veterans (those who served from 9/11 to the present), 1,874,000 were employed and 226,000 unemployed, with an unemployment rate of 10.8 percent. Of these unemployed, 180,000 are men with an unemployment rate of 9.9 percent and 46,000 are women with an unemployment rate of 15.7 percent. Clearly, women veterans who want to work are having serious difficulty finding jobs.

In 2011, President Obama recommended and Congress amended WOTC in the VOW To Hire Heroes Act. The legislation increased the benefits for hiring unemployed veterans, with the

largest benefit of $9,600 for hiring a disabled veteran. The 2013 employment data show improvements in the overall hiring of OIF/OEF veterans but for severely disabled veterans the data continues to show persistently high rates.

Small and medium-sized enterprises (SMEs) are not participating in WOTC because the program expired at the end of 2013. If WOTC were made permanent, promoted to SMEs, and expanded to private nonprofit employers such as hospitals and colleges, a world of well-paying jobs would open up to veterans in health care, life sciences, business services, education, and manufacturing where participation is now low. At present, SMEs cannot and will not bear the cost of changing their hiring practices to draw in veterans if the program is short-term.

CHAINED CPI'S NEGATIVE IMPACT ON DISABLED VETERANS

BVA and several other Veterans and Military Service Organizations are still opposed to continued recent proposals that a "Chained Consumer Price Index" be used for determining yearly inflationary costs instead of the usual CPI for the annual disabled veteran Cost of Living Adjustment (COLA).

The chained CPI, which many describe as a very minor change, would alter the method by which inflation is measured. It would reduce Social Security and VA disability benefits by cutting the annual COLA. It would also increase taxes by slowing the rate at which tax brackets rise.

The "Chained CPI" has been on the table in deficit reduction talks for months. BVA opposes it for the following reasons:

- **The chained CPI will be a double benefit cut for veterans who receive both Social Security and VA benefits.** More than nine million veterans, mostly elderly, receive Social Security benefits. This amounts to four in ten veterans. By contrast, in 2010, 4.1 million veterans received VA benefits. The exact number of veteran Social Security beneficiaries that also receive VA benefits is unknown but 771,000 of the veterans receiving Social Security benefits are receiving disability benefits.

- **VA benefits are already modest.** There are two principal VA benefits programs that go to veterans: disability compensation and pension benefits. The former are for veterans with service-connected disabilities, and the latter are for nonservice-connected disabled veterans or elderly veterans with income below the poverty level. In 2011, poor senior veterans received $11,830 in annual pension benefits.

- **A veteran with average earnings who retires at age 65 would get a benefit cut of $577 at age 75 and $1,006 at age 85**. In addition, a 100 percent service-connected, 30-year-old OIF disabled veteran will have his/her benefit reduced by $1,376 at age 45, $1,821 at age 55, and $2,260 at age 65 under chained CPI[17][1].

[17][1] www.Strengthensocialsecurity.org. Chained CPI and Veterans and Social Security Disabled, November 2012

- **For the currently elderly, disabled, nonservice-connected veterans living on Social Security, increases in annual health care inflation and increased co-payments for Medicare premiums and medications must be factored into the equation**. The resulting chained CPI reductions would force them to live below poverty levels in their remaining years of life. For 313,000 elderly veterans living on small VA pensions, for widows of veterans, and for service-connected veterans, the chained CPI is the wrong way to deal with the problem.

CONCLUSION

Once again, Chairman Sanders, Chairman Miller, and all Members, BVA thanks you for your efforts on behalf of all veterans and their families. Thank you especially for the opportunity to present BVA's legislative priorities before you today. I will now gladly answer any questions you may have concerning our testimony.

RECOMMENDATIONS

- Ensure the full establishment of the Vision Center of Excellence (VCE) and Defense Veterans Eye Injury Registry (DVEIR). Availability of joint DoD/VA staffing resources is critical for future success and VHA must provide the six staff it promised Congress it would provide. We request oversight hearings on the three DoD-VA Centers for Vision, Hearing, and Limb Extremity.
- The dedicated Vision Trauma Research Program and VTRP should become a line item in DoD's Congressionally Directed Medical Research Program, funding $10 million in FY 2015 defense appropriations.
- BVA and Paralyzed Veterans of America ask the Second Session of the 113th Congress to pass S. 633 and H.R. 1284, Beneficiary Travel to VA Blind Rehabilitation Centers (BRCs). Passage would result in amending Title 38 U.S.C. Section 111.
- Make the Work Opportunity Tax Credit (WOTC) permanent and then expand it to cover Small and Medium-sized Enterprises (SMEs) and even private nonprofit employers.
- Pass House Resolution 190 to ensure that DoD implement effective processes to share IED and blast trauma related medical research and data with VA, other federal agencies, and appropriate non-governmental organizations or entities.
- Ensure that VA implement full Americans with Disabilities Act Section 508 compliance for all VHA and VBA information technology program sites and that VA set timelines, funding levels, and staffing.
- Revisit the issue of ensuring that VHA provide vital medical educational conferences to meet the recruitment, retention, licensure, certification, and professional development standards necessary for a well-qualified VHA workforce. The conferences can be conducted in a cost effective manner that make them well worth the investment of valuable resources.
- Senate ratification of the Convention on Rights of Persons with Disabilities during this session.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS
BLINDED VETERANS ASSOCIATION

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

BVA is a 501(c)3 congressionally chartered nonprofit membership organization.

MARK A. CORNELL
BVA NATONAL PRESIDENT

BVA National President Mark A. Cornell was born in Buffalo, New York, and served for nearly 18 years in the United States Air Force. He is a recipient of the Bronze Star and Air Medal for his service Operation Desert Shield and Operation Desert Storm, performing during his service such duties as Air Force Security Police Specialist, Audio-Visual Television Production Specialist, Aerial Photographer for new test aircraft, and Combat Aerial and Ground Photographer.

While still on active duty and attending Syracuse University to pursue a career in electronic journalism, Mr. Cornell lost his much of sight as a result of a rare reaction to Lyme's Disease caused by a tick bite that went unnoticed.

Mr. Cornell has logged thousands of hours in the BVA volunteer office at the Audie L. Murphy VA Medical Center, where he has represented BVA on both the VA Volunteer Services Committee and on the VA Hospital Directors Service Program. His service also includes direct help to blind and visually impaired veterans through the VA Visual Impairment Service Team at the Medical Center, a role he hopes to keep for as long as he is able.

Mr. Cornell is active in the local Low Vision Club. He was first elected as a BVA District Director in 1999 and went on to hold national office as Treasurer, Secretary, and Vice President. He has also served as both President and Secretary of the South Texas Regional Group. He currently resides in San Antonio, Texas.