

**HONORING OUR PROMISE TO  
ADDRESS COMPREHENSIVE TOXICS ACT OF 2021**

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**HEARING**

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE**

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

—————  
MARCH 29, 2022  
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# HONORING OUR PROMISE TO ADDRESS COMPREHENSIVE TOXICS ACT OF 2021

TUESDAY, MARCH 29, 2022

U.S. SENATE,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, DC.*

The Committee met, pursuant to notice, at 3:33 p.m., in Room SR-418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Sanders, Brown, Blumenthal, Hirono, Manchin, Sinema, Hassan, Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blackburn, and Tuberville.

## OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. I want to call the Senate Veterans' Affairs Committee meeting to order, and I want to thank you all for joining us today to discuss the Honoring Our Promise to Address Comprehensive Toxics Act of 2021, which is also known as the PACT Act.

Before I get started, I want to recognize a veteran who testified before this Committee this time last year about his experience with burn pit exposure. That gentleman's name, as you might remember, was Will Thompson.

Will, sadly, passed away in December. He served his country for 23 years in the Army on active duty and as a West Virginia National Guardsman. After Will's second tour in Iraq, he developed pulmonary fibrosis from his exposure to burn pits, which eventually led to a double lung transplant.

In his remaining years, Will spent much of his time advocating for his fellow veterans who were exposed to burn pits. Our country owes Will Thompson and his family a debt of gratitude, a debt that can never be repaid. We should keep his service and his sacrifice in mind today and every day.

When I introduced the COST of War Act last year, I knew we were laying down a marker for what comprehensive toxic exposure legislation should look like in order to take care of veterans like Will. Since then, we have seen a lot of progress. VA created a new process that has added a dozen new presumptives. And, Mr. Secretary, I want to thank you for that.

To put that in perspective, over the previous eight years, only four conditions were added, and three of those—bladder cancer, hypothyroidism, and Parkinsonism—were added because of an amendment that I had on the 2021 National Defense Authorization Act which forced the previous administration to do so.

So it is my view that we cannot just rely on the Executive Branch. I believe Congress has to have a responsibility to do its job on behalf of our veterans. And that is why I am thankful that following the introduction of the COST of War Act our House colleagues introduced similar legislation with the introduction of the PACT Act. That legislation achieved a historic bipartisan vote of 256 to 174 and elicited a strong statement of support from the Biden administration. This proves that we have bipartisan support for comprehensive reform, and it is reflective of the hard work of Chairman Takano and all the VSOs and the many improvements that Chairman Takano made to that bill prior to its passage.

Now as we consider the reforms in this bill, we should be very clear about our goals. We are here to right the wrongs of decades of inattentiveness, inaction, and failure by the U.S. Government.

And as I said in the outset, our comprehensive approach to reform I believe is the only way to get this right. That approach must include an expansion of health care to more toxic-exposed veterans. It must include the establishment of a new process at VA for determining additional presumptive conditions, a process that is more transparent, timely, and more fair to our veterans. And it should provide long overdue benefits to the thousands of veterans who have been living with the effects of toxic exposure for way too long despite their nation's failure to acknowledge that reality.

Yes, there is no one on the Committee that does not know that this is going to cost some money, but today, right now, our veterans are the ones that are paying that cost. I do not believe they can wait any longer.

Today, we are going to hear testimony from Secretary McDonough and veterans service organizations about how we can do just that and do it in a way that does not punish the nearly 10 million veterans that are already in the VA system. Look, by working together, we can get this done. And after gathering the feedback and technical assistance from our witnesses today, we will have what we need to move forward without further delay.

With that, I turn it over to my friend and Ranking Member, Senator Moran.

#### **OPENING STATEMENT OF SENATOR MORAN**

Senator MORAN. Mr. Chairman, thank you, and I join you in expressing my condolences to Will Thompson's family and saddened by his passing.

I would also like to recognize today that it is National Vietnam Veterans Day and to all of our Vietnam veterans, welcome home. No generation understands the challenges and hardships of toxic exposure better than our Vietnam veterans, and we greatly value your continued service in this area, particularly as Congress continues to respond to this challenge to fix our system on which so many veterans depend.

Over the last 30 years, Congress and the VA have relied on the National Academy of Sciences, Engineering, and Medicine to review literature associated with toxic exposure. Within 29 scientific reports—that is what this is—more than 473 conditions have been reviewed, and only 35 conditions have been added to a list of pre-

sumed service-connected diseases by VA through the recommendations of the Academies.

In the 20 years since 9/11, 3.5 million veterans have been potentially exposed to burn pits, but approximately 70 percent of the burn pit claims have been denied. In the past two years, nearly every veterans service organization has testified before this Committee and emphasized the importance of fixing the process the VA uses to provide health care and benefits to toxic-exposed veterans.

In response, I have been working; me and my colleagues have been working with Senator Tester, the Chairman, stakeholders, and veterans across the country to build a transparent, comprehensive, and enduring solution. Senator Tester and I are working together to create a fair, transparent, and responsive process for toxic-exposed veterans beginning with the Health Care for Burn Pit Veterans Act, which passed unanimously out of the Senate. This was also co-sponsored by every member of this Committee. When the President signs this bill into law—and he has asked the House to also pass this legislation. When the President signs this bill into law, sick veterans who are suffering from the effects of toxic substances will be immediately eligible for lifesaving health care without any further delay.

The House has chosen not to take up that piece of legislation, at least yet, and decided to send us the bill that we are reviewing today, the PACT Act. While the PACT Act includes the critical Health Care for Burn Pit Veterans Act, signaling again broad support for the legislation, it also includes provisions that perhaps will stretch the VA beyond its operational capacity, effectively providing no guarantee that veterans will be able to access the benefits promised.

This bill needs to be amended. I think that is generally known and agreed to. I think stakeholders know that. I think Secretary McDonough has said as much in his testimony.

As we work to improve this legislation to make certain the VA can—and let me point out that this piece of legislation, at least the Senate version of it, has passed this Committee unanimously with the agreement that we would take the time to work to make the changes that we believed were necessary.

As we work to improve this legislation to make certain the VA can continue to meet the needs of veterans, I again would ask the House to pass the Health Care for Burn Pit Veterans Act so the VA can immediately provide more toxic-exposed veterans health care.

Last Congress, this Committee approved the TEAM Act, which I co-sponsored, to provide a lasting presumptive framework. That bill was developed with more than 30 VSOs as a veteran-centric solution. We must draw on that framework and the VSOs' collaborative commitment to get the policy right to improve the bill before us today.

The VA developed a pilot program last year to evaluate and implement presumptions for service connections, resulting in the establishment of several presumptions for respiratory ailments. However, the VA has yet to provide this Committee with its methodology from this pilot that has led to 12 new presumptions. I look forward to examining in depth this program today to help inform

this Committee on how to create a law that will withstand the test of time while mitigating disruptions in the VA's work for caring for all of our veterans. Whether statutory or regulatory, reform must establish a threshold for scientific evidence, and the decision-making process must be transparent for all who are involved in the care of veterans.

For decades, for decades, the VA has relied upon a partnership with the National Academy of Sciences, Engineering, and Medicine to help make determinations within the presumption decision-making process. As a trusted source of scientific evidence, the Academies were charged with reviewing and describing how presumptions have been made in the past and making recommendations for an improved scientific framework that could be used in the future for determining if a presumption should be made.

I requested that the Academies submit for the record their 2008 report—it is entitled “Improving the Presumptive Decision-Making Process for Veterans”—so this Committee can utilize those recommendations while addressing this legislation.

[The requested information appears on page 131 of the Appendix.]

As part of our discussion, Secretary McDonough, I look forward to hearing how the VA has utilized and built upon the nascent recommendations.

I look forward to today's testimony and exchanges and as well as our continued partnership with the Chairman and with members of this Committee, each stakeholder as well, to craft a responsive and enduring system that will work for veterans both today and tomorrow.

Mr. Chairman, I thank you, and I yield back.

Chairman TESTER. Thank you. Today's hearing is going to consist of two panels. The second panel is going to be three VSOs. But first, we are going to hear from the first panel, which consists of Secretary Denis McDonough for the VA, and we are going to hear his views on the PACT Act and the impact this legislation would have on VA services if it is enacted as written.

You have the floor, Secretary McDonough.

## PANEL I

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### STATEMENT OF THE HONORABLE DENIS MCDONOUGH

Secretary MCDONOUGH. Mr. Chairman, Ranking Member Moran, and distinguished members of the Committee, good afternoon. I am grateful to be here this afternoon to testify on this important bill.

We support the bill for many reasons, but the first is that it helps VA accomplish a priority goal, getting more veterans into VA care because study after study shows that vets in VA care do better.

Addressing toxic exposure is also a top priority of this Administration, which is why we fundamentally changed how we address veterans' unique health and benefit needs. We have increased funding toward research, expanded our outreach and our training. We redesigned the presumptive decision-making process and leveraged

our interagency partners to improve access and accelerate outcomes for veterans.

President Biden is the first President to proactively address exposure for vets who have been fighting these wars in this region for 30 years. So it is no surprise that toxic exposure figures prominently in yesterday's budget submission, investing in toxic exposure medical research at \$20 million more than in fiscal year '22, which is just the VA portion of the interagency effort, increasing funding of new disability claims related to three presumptives introduced last year, and among much more, funding new hires to process those claims.

Today is, as Senator Moran said, National Vietnam War Veterans Day, a day to welcome home our courageous Vietnam era vets. Earlier, I walked the Wall with them and their families, and I am reminded that we honor them by fundamentally changing, improving, and expediting how we establish presumptions for vets who over the last three decades have fought wars in that geography from Somalia in the Southwest to Uzbekistan in the Northeast and all those difficult places in between, including Iraq and Afghanistan.

Here is why. When someone signs up to serve our country in the military, we make them a simple promise that if they serve us we will serve them.

While vets fought overseas, many breathed in toxic fumes and particulate matter. Some developed conditions that impacted or took their lives like, sadly, Will Thompson, long after the final shots were fired.

Marine Veteran Sergeant Johnny Green fought in Desert Storm, inhaling fumes from diesel fires and burning wells, particulates and thick dust kicked up by dust storms. In country images of him are disconcerting, even alarming, obscured by smoke he and his sniper team operated in. When he got home, he was diagnosed with rhinitis, with nasal polyps, and suffered debilitating sinus infections, putting him down for weeks at a time.

He is far from alone, and his condition is in many ways not as extreme as others. Toxic exposure is a life and death issue for too many vets, like Sergeant Green, who did their jobs for us. So now it is our turn to do our jobs for them.

We have made progress, expediting the presumptive process, re-evaluating the cumbersome model VA has traditionally used that Senator Moran just talked about, piloting a new model, taking all available science and vet claim data into account with one goal in mind, getting vets timely access to the benefits they have earned, and adding new presumptions of service connection for asthma, rhinitis, and sinusitis.

When Sergeant Johnny Green heard about those, he filed a claim, and VA granted him a 30 percent disability rating. So far, nearly 12,000 vets and their survivors are getting benefits they are owed for these conditions.

We are examining at the moment, constrictive bronchiolitis, lung cancer, brain cancer, and as you heard in the State of the Union, we have initiated rulemaking to add presumption for several rare respiratory cancers.

And we are reshaping our airborne hazards and burn pit exposure registry to streamline the questionnaire, make the experience more veteran-centric, to encourage vets participation. We are going to make sure every vet participating in the registry who wants an in-person clinical evaluation will get it. We are leveraging this platform to do everything we can to learn as much as we can about their experience, both while serving and since.

We have more to do. We need to ensure that the presumptive process created by this bill allows VA and future Secretaries to act with transparency, efficiency, and public participation for the benefit of veterans, not create additional administrative burdens that slow down presumptive decision-making, which I believe Title II as currently drafted will do.

We need our pilot program, our pilot model, to work so there is a sturdy, proven process that gets veterans and vets in the decades ahead the benefits they deserve as fast as possible.

Finally, facility space is critical to caring for vets, and the PACT Act, thankfully, will bring millions more into our care. Yet, of 31 large medical facility leases in the proposed budget, 21 have been pending for years. Everybody on this Committee, most recently, Senator Hirono, has wrestled with this CBO-related problem. So in the PACT Act, we urge you to provide VA authority to move out on those 31 leases and on future leases so we can be genuinely responsive to vets' needs.

So with President Biden leading the way and with your help, that is where we are headed because too many vets have waited too long for these benefits. Together, we will make sure that they do not have to wait any longer. And I look forward to your questions.

[The prepared statement of Secretary McDonough appears on page 45 of the Appendix.]

Chairman TESTER. Thank you, Mr. Secretary. As I said last year, this Committee thought it was critical to give VA time to design, implement, and test its pilot process for creating additional presumptive conditions. That internal analysis concludes in April. At the end of the day, any new presumptive process established in legislation needs to be proven and needs to work for both the veterans and the VA. With the VA's assistance, the House rewrote the process originally in the PACT Act to reflect the progress of the pilot.

What lessons has the VA learned from this pilot process, and does the current language in the PACT Act successfully incorporate those lessons?

Secretary MCDONOUGH. Thanks very much, Mr. Chairman. We have learned quite a bit. Most importantly, my commitment to you—and this is directly responsive to Senator Moran's question in his opening comments—is that, as you indicated, our internal pilot will conclude and come to me forthwith within days. We will take the following weeks to get—we are not going to grade our own homework. We are going to get a review of that from outside of the Department. Upon completion of that, which I anticipate is yet this spring, we will submit the whole thing to you to see, and you can see both what we have proposed and what the outside review of what we have proposed finds.

The bottom line, in my view, about our presumptive—new presumptive process is that we have to put the veteran at the center of the process and we have to increase the sources of science available for us to make the decisions that we need to make.

As to whether Title II reflects those lessons, I do not believe it does. I think Title II needs to be reworked. I have communicated as much to members of the House. I am not sure they agree, but you know, this would be one place where I think we could profitably do some work on the existing bill.

Chairman TESTER. So the internal analysis—well, let us start here. Do you have in mind who is going to review it?

Secretary MCDONOUGH. Yes. I mean, so one group that should review it in my view is the Office of Science and Technology Policy in the White House. It has access to, and deep connections with, the kind of full academic, scientific community.

Chairman TESTER. And if you said this, maybe I missed it. When do you anticipate it being presented to the Committee?

Secretary MCDONOUGH. I would say before the end of spring.

Chairman TESTER. Okay.

Secretary MCDONOUGH. So now is the end of March.

Chairman TESTER. June 21, all right.

Secretary MCDONOUGH. Well, yes. In Minnesota, we think spring goes till like August, but . . .

Chairman TESTER. All right. And then do you anticipate that the information in that analysis will be instructive on any of the work that needs to be done on Title II?

Secretary MCDONOUGH. I do. The thing that concerns me about Title II is kind of the addition of—additional hurdles that we would have go to through. As I read Title II, and maybe as you read in our submission and the testimony, I think actually the steps that we have taken heretofore had Title II been the law of the land we would not have been able to have taken those.

Chairman TESTER. Yes.

Secretary MCDONOUGH. I am not saying that we have done enough. I am just saying that what we have done would have been made more difficult by Title II if it were statute when we first arrived.

Chairman TESTER. Okay. I will ask you to be quick on this because you have only got about a minute. First of all, I want to thank you in making your staff available to Congress. We appreciate that very much.

And as we have already said, your testimony reflects additional changes that need to be made. From your perspective, what are the two or three most critical improvements that can make this legislation better for our veterans?

Secretary MCDONOUGH. Well, I stand by what I have said on Title II. And then I come back to the comment I made in the opening, which is that each of us—and I put in that all of you have wrestled with this leasing requirement that we have. We are the only agency in the Federal Government that requires full congressional authorization of each lease, and then how CBO scores those slows them way down. We are now 21 leases behind.

Chairman TESTER. Yes.

Secretary MCDONOUGH. Take P.G. County right next to us or Beaufort, South Carolina, two facilities, each about 8,000 square feet today. They have to go—demand for care in those communities requires a 75,000 square foot to 8,000 square foot facility. We have been waiting in one case since 2019 and in the other since 2020 for the authorization to go to those bigger facilities. We have got the people. We have got ideas about how to build, how to structure the site. We just cannot get into the building, and we have got to fix that.

Chairman TESTER. Okay. Thank you.

Senator Moran.

Senator MORAN. Thank you, Chairman.

Mr. Secretary, this is a bit of a follow-up on what Chairman Tester was asking you, but maybe I can get more definitive answers, and maybe I cannot because we are still waiting for the completion of the pilot program.

Secretary MCDONOUGH. Yes.

Senator MORAN. Does your pilot include recommendations from NASEM's 2008 report, the one I mentioned in my opening comments?

Secretary MCDONOUGH. I made note of that as I was listening to your report—to your opening comments. I do not know, but I will get you an answer by the end of the day today.

Senator MORAN. And does the PACT mirror what you were doing in the pilot, and where does it diverge? And perhaps that is again what you were answering for Chairman Tester.

Secretary MCDONOUGH. I think in Title II of the PACT I think what—this is kind of classic balance of power stuff, I think. And I think that the House is trying to force our hand to try to do things. And I think they are trying to build institutional capacity around us to try to force us to be more transparent in what we do and then report to a new commission about what we are doing, get the commission to agree to what we are doing, and then proceed.

So I get what they are trying to do in Title II, which is to try to get us to move quicker. But I think the tools they have used to try to force us to do that actually would slow us down in an instance where in this Administration the President is pushing pretty hard for us to move. And so that is the first thing on what they do there.

I think, though, the spirit of what Title II intends is consistent with what I have read about what you and the Chairman are working in your process, which is let us get the veteran at the center of this presumptive process, let us be very clear and forthright about the process by which we make decisions so everybody's expectations can be clearly managed, and then let us communicate transparently when we make decisions pursuant to those agreements—to those efforts.

So we have a way to do that. We are going to—as with all of this, while Congress deliberates, we are pressing forward. We will press forward with a plan that we have to put into the Federal Register everything we do under our process so that people can see, including in any given year what do we intend to review, what timeline, and what they should then expect, which is why, for example, we have made public that this year we are going to review not just



constrictive bronchiolitis, which I talked about, but brain cancer and lung cancer. And we anticipate making those decisions and making them publically this year.

Senator MORAN. You said something that is forefront in my mind, and you said something about slowing down. One of my significant concerns about not getting this right is the consequence of slowing down services not only for toxic-exposed veterans—

Secretary MCDONOUGH. Yes.

Senator MORAN [continuing]. But for other veterans as well. What does this Committee and this legislation need to be paying attention to that does not diminish the timeframe in which a toxic-exposed veteran will receive benefits and health care? And one of the things I might add is while we are doing this it would be useful to have those veterans receive health care, which is the legislation—

Secretary MCDONOUGH. I agree with that.

Senator MORAN [continuing]. That this Committee—I will let you say that again.

Secretary MCDONOUGH. I agree with that, and more importantly, the President agrees with that and has said that publically about your bill.

Senator MORAN. That, to me, is we want to do this in a way that does not prevent people who are toxic-exposed from getting the health care benefits that they need today. We want to make sure the legislation is written in a way that does not cause a veteran who is toxically exposed and entitled to benefits to be delayed in receiving those. But I also want to make certain we do not do things in this legislation that reduces the timeframe in which other veterans, unrelated to toxic exposure, can receive care and benefits from the VA.

What would you—how would you respond to that, those concerns, and what would you suggest that needs to be done if you agree with my concerns—

Secretary MCDONOUGH. Yes.

Senator MORAN [continuing]. To avoid that?

Secretary MCDONOUGH. Yes. So I think they are legit concerns. I share the concerns.

I think there is a couple of very near-term things we can do. One is get our two Under Secretaries, one for Health and one for Benefits, confirmed. And we are really grateful for how quickly you are moving on them.

Two is enact the President's budget, and as I privately did, I publically thank you all again for the omnibus which gives us very important investments.

The budget submission for this year includes opportunities to continue to modernize the presumptive making process, and I will come back to that in a second.

What should you look at? Look, we have an estimate—and this is an estimate—that says under the PACT Act, over the next three fiscal years, there will be about 1.52 million claims filed if there is no inclusion of hypertension. If there is an inclusion of hypertension, we anticipate or we assess 2.5 million claims filed. We process in any given year about a million and a half claims.

So we have to—so just using those as rough estimates, and those are assessments, I will walk through like an algebra problem in a second.

But, one thing to think about is we have experience now with these three presumptives that the President enacted last year as quickly as he could upon coming into office. We have some water under that dam—or over that dam, under that bridge. And that gives us at least a sense of how much—how many claims are being filed relative to how many we assessed. So that would be another thing to look at in the context of this assessment.

Lastly, we think that there are prudent things we should do and we are doing, and I will lay out three of them in particular. One is we are hiring. We are hiring about 2,100 extra people right now. And we have been—at VBA, we have been talking about this. Right now, we have hired about 70 percent of those people. Of those 70 percent are about 1,472-ish claims processors. That is about 90 percent of the claims processors we want for that number.

So we are moving. There is still a bit of a training tail on that, but that will give you a sense of it. So that is one, is we should hire more, and we will probably have to hire more if this is enacted.

Two, we should use the teams that we have more aggressively, which we are doing with mandatory overtime.

Second, we should try to normalize this process in some way, shortening steps where we can prudently do so. So the requirement for, for example, additional exams I think is superfluous in many cases. So we should get that out.

Third, we should also automate the process where we can. We have been updating you on this as well. There is technology that we can use to go get these records. You have invested in us, in our ability to digitize records, which we have done to the tune of a million additional records in the last year or so. So we should continue to prepare to do that, and we are developing the algorithms to allow us to do that. Our most recent addition to that is asthma late last week. We have now run five claims through that process. I am not saying that this is the be-all and end-all, but it is an important step.

Those are the things we should look at, and I think there is meter sticks to measure this out there, both our assessed number of claims and then actual claims looking back on the three presumptives we have been working.

Senator MORAN. Mr. Secretary, thank you. In Kansas, we believe that spring can never come fast enough.

Chairman TESTER. Senator Sanders.

#### **SENATOR BERNARD SANDERS**

Senator SANDERS. Thank you very much, Mr. Chairman, and let me thank you for your important work on this legislation, as well as Senator Moran.

Secretary McDonough, thank you for the great work that you have been doing, and we thank the President for the kind of budget that he is presenting to protect our veterans.

It goes without saying that I will support the strongest possible legislation that we can come up with, but I wanted to ask the Sec-

retary, maybe the members, a question here, something that I really do not understand. And I was through this with Agent Orange as well, and now we are dealing with burn pits.

Hypothetically, let us say that Senator Brown and Senator Tester served in the same vicinity at the same time, and they both came down with the same illness. And after lengthy bureaucratic analysis, it was presumed that Senator Tester in fact was exposed to the toxin, Senator Brown was not, but they both were suffering from the same illness.

So after spending thousands and thousands of dollars discussing both cases and whether or not they were exposed, we have concluded you will get the medical care you need, but you will not. You have the same illness. That does not make a whole lot of sense to me.

At the end of the day—and I know not everybody in this room agrees with me—health care happens to be a human right for all Americans, in my view, and especially for people who put their lives on the line, such as our veterans. So I think that instead of spending a huge amount of money in the Federal bureaucracy to determine whether in fact somebody was exposed to toxins from a burn pit, exposed to Agent Orange, maybe we just say that if you were a veteran who put your life on the line to defend this country you are going to get all of the health care that you need.

Will that cost more money? It will. Is it the right thing to do? Yes. But the money that we will be spending will go toward health care, not to a huge bureaucracy to determine whether or not you were exposed or not. If you got two guys who were ill, we want to take care of them as human beings and as veterans.

Mr. Secretary, what do you think?

Secretary MCDONOUGH. Look, I think that, as I said, one of the things that particularly attracts me to the bill and attracts this Administration to the bill before us is that it expands the number of veterans who could get care.

Senator SANDERS. Right.

Secretary MCDONOUGH. Get into our care. So I think that is an attractive thing. We have that as a goal.

I will say that we do spend a large number—we spend a large amount of money on health care. We are growing at a pretty rapid pace every year.

Senator SANDERS. But we spend money on health care, to be sure, but we also spend a huge amount of money on the bureaucracy to determine whether somebody is eligible or not.

Secretary MCDONOUGH. Agree. Agree. And so this is why I think the President has put us—has directed us to make sure that we have the vet at the center of these determinations, that we are making sure that we are making the decisions in the interest of the veteran, and that we are setting up a—we are trying to design a presumptive process that gets to “yes, if,” rather than “no.” And that is what we are trying to build in this model.

Senator SANDERS. No, I appreciate that. But I think I would hope that we could all agree that if we are spending a dollar on VA health care spend it on health care, not a bureaucracy to determine whether or not the veteran, in fact, was exposed or not exposed. That seems to me a real waste of money.

And in that regard, I just want to remind people I am going to—have introduced legislation which deals with another absurd issue. And that is, for example, if you live in San Francisco as opposed to Los Angeles, the eligibility requirement for VA health care is significant because San Francisco presumably has a higher cost of living than does L.A. And that exists in all of our zip codes. It exists in Montana. It exists in Vermont. You could live across the—you and I could live across the street from each other. I am eligible; you are not. Does that make real sense?

So you have got a telephone book full of different eligibility requirements. We should simplify that and make sure, to quote the Secretary, the more veterans—I think the goal is to get more veterans into the VA. That is one way to do that.

The other point I would like to make on a subject, a different subject, we will be holding a roundtable on Wednesday on dental care. I think all of the service organizations understand that dental care is health care, that we should expand VA health care to include dental care. That is going to be this Wednesday, and I would hope that members are able to attend.

Thank you very much, Mr. Secretary.

Secretary MCDONOUGH. Thank you, Senator.

Chairman TESTER. Senator BOOZMAN.

#### SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you very much for being here. I enjoyed visiting with you earlier today about the budget.

And we also do want to give a big shout-out to our Vietnam vets and all that they represent on this day. And it is interesting, you know, that we have the hearing today. I do not know if it was designed that way, but certainly what we are dealing with now is much like Agent Orange and the difficulties that our veterans went through then and also the long period of time that it took to actually get that acknowledgment.

What we do not want to do—and I have had the opportunity of serving on the House veterans committee and now the Senate veterans committee. What we do not want to do is repeat the same implementation. So I think as I look around the Committee I know that we are committed to getting this done. What we do not want to do is have a situation where we create a backlog that it literally took years and years and years, years, you know, to make it such that the veterans actually got their benefits.

So I would like to ask, in the legislation, there is really no outline as to how you—in other words, we pass the legislation. You know, we are in good shape. We start dealing with the problem. As far as the implementation of the problem, it is really not in here.

So right now, the veterans' backlog is what? 250,000 or so?

Secretary MCDONOUGH. Yes. Right now, it is 243,000, down from its most recent peak of 264,000 last October.

Senator BOOZMAN. And it is safe to say right now you have got hardworking men and women that literally are working overtime to keep it at that level.

Secretary MCDONOUGH. We do. In fact, we just earlier today passed the 800,000th claim adjudicated this year, this fiscal year, the earliest we have ever done that. By the same token, we have

also received—so that is 17 percent higher than a year ago at this time.

Senator BOOZMAN. Right.

Secretary MCDONOUGH. We have also received, you know, 1 percent more claims this year than we did a year ago.

Senator BOOZMAN. Right.

Secretary MCDONOUGH. So we are just barely keeping up.

Senator BOOZMAN. And the claims now are more complicated.

Secretary MCDONOUGH. Some. Not always. But, yes, they can be for sure.

Senator BOOZMAN. Generally. And we anticipate working hard, getting this done, another 500,000 or so a year? Is that in the ballpark?

Secretary MCDONOUGH. Yes. I mean, as I said, over three fiscal years we think a range of 1.5 to 2.5 million claims.

Senator BOOZMAN. Right. So, a lot of claims. And you mentioned that we are hiring more people. What kind of people do we need to hire, though? And again, I am not saying this in the sense of not—I just want to be prepared as we go down this path—

Secretary MCDONOUGH. Yes.

Senator BOOZMAN [continuing]. That we make sure that we are able to deliver—

Secretary MCDONOUGH. Yes.

Senator BOOZMAN [continuing]. What we are doing. Yes, I mean, that is what planning is all about.

Secretary MCDONOUGH. I think it is a very—absolutely fair question. And so I talked through what I consider the prudent steps we are taking now to get ready. That does not mean that is all we would need. We do need to do more, but let me just talk for a minute about the hiring specifically.

Senator BOOZMAN. Okay.

Secretary MCDONOUGH. A particular challenge—well, this is where the experience of those 2,000 hires I think is meaningful as you all think about your bill. We actually advertised those openings. We got very positive response in terms of number of applications per opening, meaning that they are highly sought after positions, that allow us to run a very competitive process to fill those positions. I think that is useful.

I will get you the specifics in terms of how many applicants for the openings. Again, I think that will give you some—

Senator BOOZMAN. Right.

Secretary MCDONOUGH. I hope it gives you some confidence that we are thinking about this clearly and carefully.

The next question is identifying and hiring the person is step one. The training tail that comes with that person is step two. So there is probably—let us estimate a six- to eight-month training tail on each individual person. So we believe that those hires we have in the chair now who are training will be profitably adding to our ability to crank out additional claims come the fall.

So that underscores how complex it is, but I hope it gives you some confidence that we are thinking about it, soup to nuts.

Senator BOOZMAN. No, I understand. And yet, I think the reality is that kind of gets us out of the hole that we are currently in but

does not do any for planning in the sense, you know, making the system where it works better.

Secretary MCDONOUGH. Yes.

Senator BOOZMAN. But it really does not address the future.

Secretary MCDONOUGH. I think that is particularly true about overtime.

Senator BOOZMAN. Right.

Secretary MCDONOUGH. But I do not know that it is necessarily true about the hiring because we are adding a lot of fire power to the arsenal that will more than get us out of the hole.

But then, yes, we will be adding more on top, which is then that is where the claims modernization process itself becomes really important. Automation becomes really important. And then the steps that we are taking now, for example, to digitize records so we do not have to go into some dusty closet and pull out paper—

Senator BOOZMAN. Right.

Secretary MCDONOUGH [continuing]. Every time one of our veterans applies or files a claim. That is work we are doing now that will pay benefits in years ahead.

Senator BOOZMAN. Right. Well, we look forward to working with you so we can really, you know, hash out a system to make it such that it works. So thank you very much.

Secretary MCDONOUGH. Thank you very much.

Mr. Chairman, I just learned by virtue of modern communication that our lead researcher on the internal process did, in fact, use the 2008 NASEM report. We will get you specifics on what from the report we used as we implemented our proposed changes.

Senator TESTER. Thank you. Senator Brown.

#### **SENATOR SHERROD BROWN**

Senator BROWN. Thank you, Mr. Chairman.

Secretary, thanks for your terrific work as a public servant and what you said at the beginning, the promise, you serve us, we serve you. A whole lot of veterans, as you know, and as you have said to us personally, privately, and publically, do not think they always get the fair shot that they should. And I think none of us question—whether we are from South Dakota or Connecticut or Kansas, none of us question the public spiritedness of the great, great majority of VA employees in places like Chillicothe and Cincinnati and Dayton and Cleveland.

But it just—when you think about—I mean, ever since I started, met the first Agent Orange veteran, I do not know how many decades ago. It is just hard not to believe that the military, and in those days the chemical companies, knew what Agent Orange was doing to the men and women exposed. And it is hard to believe that the military did not know more about what these burn pits were doing when they are burning batteries and tires and medical waste.

We have with us today—there is a couple of people I want to—Heath Robinson's family is with us. Danielle and her daughter, Brielle, are here. Brielle's grandmother, Susan, who is one of the great activists in this country in bringing to our attention.

And to yours, Mr. McDonough, you did not need a lot of—you already were there, Mr. Secretary. But the heartbreak and the sadness of all this.

And they are joined by Tim Hauser today from—thank you for joining us. A Gulf War veteran from 30 years ago. He told me today he knew—from Twinsburg, Ohio. He knew within weeks of returning that something was different in his respiratory system.

So it just does not seem—I mean, I know you want to make this clean and direct. I know this is going to be really expensive. I do not know the hearts of everybody on this Committee, but I do believe they all think that we have a duty, no matter the cost, to take care of this.

So, a couple of questions. For Title I, you said it would cost about \$534 million for personnel and equipment. Elaborate how that would be spent on medical professionals. I mean, I heard what Senator Sanders said. I do not disagree with that. But, IT systems, administrative support. How do you spend that, delivering service?

Secretary MCDONOUGH. I think that is both just a people prospect, which is hiring clinicians and continuing to hire clinicians. You know, the subject of other hearings that we have had here and ongoing concerns and efforts, concerns you have about efforts that we are up to. So it is hiring people. It is also making sure that we have facilities into which we can make sure if we really do get a million and a half to two million additional enrollees who are coming to us for care, that we have facilities in which we can treat them.

And so it is all straight medical account care management, right, which is if we have more patients we need more investment to care for those patients.

Senator BROWN. Thank you. Senator Boozman had—I am going to follow up on his question about the backlog. And we have all—I mean, I assume everybody on this Committee has done various kinds of listening sessions, roundtables, and veterans do not quite understand. If they were in a specific place and they have one of these conditions, shouldn't it be a more straightforward process? So walk us through why the backlog will jump so high.

Secretary MCDONOUGH. Well, remember that the whole purpose of presumptives is to address one of the issues that Senator Sanders talked about, which is if Senator Brown and Senator Tester are both deployed in roughly similar areas, they both develop a similar condition, but somehow the process—the science is so difficult to prove, that one proves out—your case proves out differently than his. The idea of a presumptive is to sweep in or lower the threshold of evidence in places where the science in the aggregate is strong but the science in the particular is difficult.

And so one of the reasons—so it is true that any veteran could file a claim about his or her condition today and that claim would get adjudicated, but we would have to work through each of the portions of the claim. If we establish—if having established, for example, presumption of service-connection for asthma, or for rhinitis in the case of the Marine I discussed, the evidentiary threshold for him reduces, but it does not go away, right, because we still have other things we need to prove out given the statute under which we operate.

And so I think it can be—look, I think we can be frustrated. Look, our team is unbelievable, cranking through 800,000 claims already this year. Our scientists, some of the best scientists in the country. They are trying to follow the statute, follow the law. They are trying to do the right thing. But as we do that, that can be frustrating for vets.

And if we get to the presumptives, that does not erase the entire process. It erases one big piece of a three-part test. So working those other two parts ends up being time consuming.

More importantly, though, the attention around the issue will remind people, like these great Ohioans that you just talked about, that, hey, they have a claim before the United States Government, so they will come forward.

My last point on this is I do urge the Committee to take a look both here looking forward on the numbers, what we assess, but also let us look at the experience here back to last May 2021, when the President announced the first three presumptives and how did that process track our assessments. You know, what can we learn about that for the newest—new presumptions going forward?

I hope that is responsive to the question, Senator.

Senator BROWN. Good. Thank you. Thanks.

Chairman TESTER. Senator Tillis.

#### **SENATOR THOM TILLIS**

Senator TILLIS. Thank you, Mr. Chairman.

Secretary McDonough, thank you for being here and, as I have said before, thank you for being so responsive when I have reached out to you and you reaching out to me. I appreciate the working relationship.

You know, I first got involved with toxic exposures probably six or eight months into my first term here back in 2015, with the Camp Lejeune presumptions, and that was a constant battle in that case. And actually that battle transcended over administrations and a couple of VA Secretaries. It was a frustrating process. And a part of that was using data outside of the VA to get to a fair decision on presumptives.

I have reintroduced the TEAM Act again because I think we have got to get it right and we have got to make sure that we do things that are, you know, that are scientific, transparent, and enduring with respect to how we go about moving forward, getting as many presumptions as possible. How important do you think it is to have that scientific, transparent, enduring framework in anything that we pass out of the Congress?

Secretary MCDONOUGH. I think it is really important, Senator. Thanks. I echo your very generous comments about our working relationship. I appreciate that very much. People very important to me live in your State, too, by the way.

It is very important for a lot of different reasons. This is why the President has stood up, first time ever, this interagency process in the White House. I happen to know a little bit about that. The best interagency processes are run from the White House, chaired by the White House, but they yank everybody to the table. So we have Labor, HHS, Defense, and many of the specialized subagencies in each of those around the table, sharing science from outside VA.



We have met now seven times. That is increasing the aperture for additional information to us.

And having that then, as you say in the TEAM Act, fall in on a well-established, transparent framework so people like many of the people in the room today, suffering as they are, can have some transparency around, and some expectations for, what is going to come out of a process. So I think it is really important.

Senator TILLIS. Thank you. The PACT Act, I believe at least in a couple of cases, would legislate a number of presumptions that may or may not have a factual basis for support. And I think there are somewhere on the order of 400 some diseases in addition to the 23 included diseases in the PACT Act.

So is it wise for us to take that step or just to make sure that we have—that you all are enabled to have the processes that you can expedite. If these 23 are—maybe they should be viewed first. But does it make sense for us to legislate presumptions or just to provide a framework that we expect you all to work through on a timely basis?

Secretary MCDONOUGH. Well, we—as the President has made very clear, we support the PACT Act. We think that a big piece of it is those presumptives. I think working through those—you know, I am not in a position to say, we think this makes sense, this does not. But I think as a group I think we should work through those consistent with the way we have been having those discussions. We have had those discussions with the House. We should continue to have them with you.

I think that as a general matter, in the past—and I think this is particularly true with Agent Orange—congressional impetus as it were really forced action from VA. So I think there is historically—and maybe today of all days especially, as Senator Boozman underscored, is probably a day to recognize that legislated presumptions play an important role.

That said, we are putting together a framework that I think works, I hope works. I hope we can convince you it works. And I think I would like to see that enacted as well.

Senator TILLIS. Yes, yes. I am just mainly concerned with the other diseases, some 400 diseases, that we do not either through resources or focus shift our attention away from these that may have merit in being moved ahead of the line.

Secretary MCDONOUGH. Yes.

Senator TILLIS. So it is more managing the process and priorities to make sure we are helping as many veterans as possible as quickly as possible.

Secretary MCDONOUGH. That is why we started where we did. We are starting on—you know, if you line up the presumptions we have done, we started with as wide a capture as we could. Sinusitis, rhinitis, asthma, these are not the most debilitating conditions. Many conditions, including some that people in the room today are suffering from, are much more heart-wrenching, but we try to cast a wide net.

The question then is constrictive bronchiolitis, same, very broadly impactful across the force, and then these rare cancers, which are rare but they are extraordinarily devastating.

So we are trying to mix how we get as many vets in our care as we can with who are the vets, as both Senator Sanders and Senator Moran have said, who need the most timely care. We are trying to balance both of those.

Senator TILLIS. The final question just relates to the presumptions in the PACT Act. Why not go ahead? We are going to take time. We are going to try and get to a consensus and get it passed.

Secretary McDONOUGH. Yes.

Senator TILLIS. But you have authority to implement all those presumptions now. Do you intend to do that before we actually move forward with the legislation?

Secretary McDONOUGH. Yes. So we have been very clear about what we intend to do this year. As I said, we have initiated rule-making on the nine rare respiratory cancers. We are looking at brain cancer, lung cancer, and constrictive bronchiolitis. We published—we have talked about that publically. We have made clear what we are going to do this year. We have tried to put rough timelines around them. And then we will make those records of those decisions available to everybody through the Federal Register. So that is what we are going to do this year.

As to whether we just go ahead and do all the ones that are in the PACT Act, you know, I want very much to work through all of those. My own view is the founders probably would have had a view on that, which is if we are going to expand—if I am going to expand our budget, basically \$300 billion over the next 10, my guess is that there is a role for Article I in that and a role for Article II in that.

And so I think we should keep working it down on our side of the street as you guys keep deliberating on your side of the street, and I think there is lessons learned in both, where I do not think anybody should wait. As we have all—you know, Camp Lejeune or North Carolinians, Minnesotans, Montanans, Kansans. There is a lot of suffering out there, and the President has been very clear to me what I need to do to make sure that we address that.

Senator TILLIS. Thank you.

Chairman TESTER. Senator Murray.

#### **SENATOR PATTY MURRAY**

Senator MURRAY. Thank you, Mr. Chairman. And I just want to thank Senator Tester for his leadership on this issue. I know we are capable of tackling some really big challenges as a committee and that that includes making sure that our veterans that are harmed by toxic exposures in their service for our country get the care they deserve. I really hope that this hearing can bring us closer to resolving some of the open issues in order to pass the comprehensive legislation that veterans in my State of Washington and across the country really expect of us.

Mr. Secretary, good to see you here today. As we continue to shape the legislation in front of us, what does VA still need to get this done?

Secretary McDONOUGH. That is a good question. So I think there is two things in particular and then one—well, let me make a general point, and then I will answer the specific question.

Generally, I have appreciated the open channel that I have had with everybody around the room on this issue. As long as I have been Secretary, we have been having very spirited, straight-forward, I think transparent conversations. Most recently, I thought the conversation I had with Senator Moran was very, very useful to me and to us. So the first thing we need is a continued open channel.

Second, I raised two things earlier. I think we need to really go to work on Title II of this thing, and I think that some of that is incumbent on us to make sure that we get to you how we are running our pilot and how it works.

Three is I think that there is relatively simple fixes on things like this really frustrating, vexing even, issue of major medical leases for new facilities. We have 31 of those now pending. We would like to get those done so we can move into bigger facilities.

And then there is this question of the “eaches” in the conditions, and I think we should—I am not in a position now to kind of go into those, but I think we have had really good conversations heretofore. We should keep working those.

Senator MURRAY. Okay. Very good.

Secretary MCDONOUGH. And then lastly, sorry, we will need resources. The CBO says basically \$325 billion over 10. That is about 60 percent mandatory, 40 percent discretionary. Not a lot of people around here understand the difference between those. I mean, you all do, but on our end of the table. But if there is anybody who knows that very well, it is you. So we need both mandatory authority, and we need discretionary capability to make sure that we get this done in a timely way.

Senator MURRAY. Okay. Thank you. We are continuing to push VA to improve the user experience for veterans while receiving care and accessing their benefits. If Congress is able to pass some comprehensive legislation to address toxic exposures, VA is going to have to have systems in place that are easy for veterans to navigate. How can we make processing service-connected disability claims less difficult for veterans who experienced toxic exposures?

Secretary MCDONOUGH. That is an excellent question, and I think there is two things in particular I want to highlight that we are doing. I think we are taking a series of prudent steps that I think will get us in a better position to manage something as big as this.

One is the claims process modernization which includes things like digitizing records, which we are doing thanks to the AARP. We are able to use overtime to digitize a lot of records, a million in the last year or so alone. We have to—so that is one, claims modernization, and there is a whole bunch of work behind that.

The second is we have to get the veteran at the middle of this process, and so our Veterans Experience Office is developing a series of efforts to try to ensure that everything we build is built around the veteran experience.

Senator MURRAY. We are thinking about all this ahead of time. That is my point.

Secretary MCDONOUGH. That is my point, yes.

Senator MURRAY. Because the last thing we want to do is pass something and then have everybody frustrated because they cannot access it, it is not understood, as you well know.

Secretary MCDONOUGH. That is next to the last thing we want to do. That is for sure.

Senator MURRAY. Correct.

Secretary MCDONOUGH. I think the last thing we want to do is—well, anyway, I agree with you.

Senator MURRAY. I also want to ask you about health equity. Women veterans are serving in increasing numbers, and I was happy to see the President's budget actually requests—highlights women's health as a priority. But we need to make sure that women veterans' needs are the focus as we move forward on this. How is VA tracking the impact of toxic exposures on women's health, including their reproductive health and fertility?

Secretary MCDONOUGH. Thank you very much. So first of all, I am glad you pointed out the President's budget. It has a big investment, \$9.8 billion in women's health, including \$767 million. Those are basically, roughly 12 and 10 percent increases over similar numbers from last year.

We have to get up this power curve. One way we get up this power curve is providing more services and providing professionally so that women veterans want to come to us for their care.

Senator MURRAY. Right.

Secretary MCDONOUGH. As it relates to research, we are increasing our focus on impact on women's health, including gender-specific health impacts of toxic exposure. That includes on reproductive health, and it includes, for example, on impact on breast cancer and—

Senator MURRAY. Are you tracking that now?

Secretary MCDONOUGH. We are tracking that, yes. And thanks to investments from you, Senator Boozman, and others, we are increasing access to mammography in VA facilities. And by the way, this is one of the big places that our vets get authorization and referrals for care in the community.

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

Chairman TESTER. Senator Tuberville.

#### **SENATOR TOMMY TUBERVILLE**

Senator TUBERVILLE. Thank you, Mr. Chairman. Thank you for your work on this. I know since I have been here you have been knee-deep in it, so thank you for all your hard work.

And thanks to the people here that have put their life on the line for all of us here and thanks to you for being here today.

I have talked to the Secretary of Defense about this burn pit problem. And sometimes we need to use a little bit of common sense. Instead of putting people in harm's way, there could have been a lot of this that could have been avoided instead of just doing things the easy way. So hopefully in the future, we can use a little bit of common sense, but sometimes that does not go very far in government.

Secretary McDonough, thanks for being here. You know, the House passed the PACT Act. It requires the VA to establish a working group consisting of representation from DOD, HHS, EPA,

among others. The purpose of such a working group is to identify opportunities for collaborative research regarding health consequences of toxic exposure experienced during active military service. What gap do you envision such a working group, as described in the PACT Act, addressing that is not already happening through the ongoing research partnerships between the VA and other agencies?

Secretary MCDONOUGH. That is a fair question. Sir, I have not had a discussion with the House members on that part of that title in particular, but my hunch is that I think they think—I think they are trying to help us codify some of the work that we are doing. They may have also broader designs, but I am not in a position to talk to them about that.

I do think that this interagency table is a really valuable one for us because, you know, for example, there has been discussion that somehow we just invest a very small amount of our research in this. We are growing that. We are growing it still, and we will be coming back to you all to talk about some of the ideas we have in this space, including for information on—for technology on research. But we can leverage the rest of the Federal Government by having everybody around that table and making sure that we are sharing information there.

Senator TUBERVILLE. So you think it is going to help?

Secretary MCDONOUGH. I do.

Senator TUBERVILLE. Yes. You know, one piece of a potential toxic exposure legislation is how to address the current disability claims backlog in addition to the number of claims that would be added under the new legislation. Given the current backlog is upward of 244,000 and legislation such as the PACT Act could add another 1.5 million claims on top of that, what consideration is given to how the claims may be prioritized in the process? Have we thought about that?

Secretary MCDONOUGH. Yes. As a general matter, we have, you know, a system whereby a claim is addressed as it comes in, which is to say it is addressed in the order it arrives.

There are certain ways to expedite a particular claim. For example, homeless veterans' claims are expedited. In extraordinary health circumstances, a claim is prioritized. But we do not envision metering or anything.

We envision working this through the system, which is why we are trying to spend as much time as we are now in taking the prudent steps to prepare that I have talked about and why we are going to need some help with getting additional resources on the other side of this. And it is why it is so important that we get our Under Secretaries of Health and Benefits in the chairs, and I know you guys will be having hearings with them later this month.

Senator TUBERVILLE. If a post-9/11 veteran has a claim pending today but wants to apply for additional benefits after additional presumptives have been made—

Secretary MCDONOUGH. Yes.

Senator TUBERVILLE [continuing]. How would the VA handle this?

Secretary MCDONOUGH. I think it would kind of depend on where the particular claim stands, the existing claim stands, but we

would probably adjudicate the first one, then go adjudicate the subsequent additions on them. We are constantly adjudicating claims on top of existing claims for veterans.

We do not have to just—it is not a one-time—you know, today is the time for Coach Tuberville to come in to get all of his claims adjudicated. You can come in today. We will manage one, that one, through the process. As additional claims come up, you file for those, and we will work through those with you.

Senator TUBERVILLE. Thank you.

Thank you, Mr. Chair.

Chairman TESTER. Senator Blumenthal.

#### **SENATOR RICHARD BLUMENTHAL**

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you to you and the Ranking Member for your work on the PACT Act, which has been a long time in coming. It is the result of a lot of years' work on a bipartisan basis, and I think it will accomplish a great deal.

And thank you, Secretary McDonough, for your full-throated endorsement of it and to the President of the United States, who has brought leadership I think that has opened a new era in Presidential support for the VA.

Very significantly, we are recognizing National Vietnam Veterans Day which is a very important reminder of the battle. And it was a real fight to get recognition for Agent Orange. The VA had to be dragged, kicking and screaming, into the scientific real world, in fact, even to the point of defying a court order. Incredibly, the VA defied a court order to resist, it said, the cost of the presumption for Agent Orange.

So, two points. Number one, to go back to Senator Sanders's remark, when we go into a war, these kinds of health care coverage are part of the cost of that war. They are not something we think about afterward. We have to change America's state of mind. If you commit to a war, if you commit to sending any American into combat, beyond the presumption, it ought to be a matter of simple fact that we cover illnesses that that veteran has afterward.

You know, in the legal world—and I have been in litigation as a trial lawyer for quite a while—presumption is a way of ducking a question. It is literally a way of avoiding a question. Often, there is a rebuttable presumption.

What we need in health care for veterans is an un rebuttable presumption. In other words, you have the illness; it is going to be covered. And so I hope that we can change the mindset here.

And I really want to pay tribute to the team that you have, thousands of them, many of them in Connecticut, doing a great job, dedicated, hardworking, compassionate, caring, and your leadership as well.

But I think this system of presumptions is part of the problem because it locks us into a decision-making mode that is costly and cumbersome—you have used the word "cumbersome"—and time consuming. And that is the last point that I would just emphasize here.

You know, a lot of these folks who are here with us today, for them, this is personal. I have two sons who have served. Fortu-

nately, they are both fine. One was in Afghanistan in Helmand Province as a Marine Corps infantry officer; the other was a Navy SEAL.

A lot of people are going to wake up tomorrow morning and have to go through a full day wondering and worrying, and their families. So time is not on our side here nor was it on the side of the Agent Orange Vietnam veterans because they were dying, and many of them are now dying.

So I want to just suggest that the PACT Act is a great start. It is very important. It will change people's lives. But we also ought to think about a new model.

And I want to ask you specifically about the Palomares and the K2 veterans. K2. You have said on page 11 of your testimony, that there—I am quoting. “There have been concerns over several potential exposures related to service at K2, and VA will continue to seek information on K2 exposure opportunities.” I would like to see that process accelerated. I would like to see it telescoped. And, the same with Palomares.

The people—the folks in Palomares cleaned up after a plane crash with radioactive material without any protective gear. The people at K2 were at an all-Soviet base that was contaminated with oil and all kinds of other stuff—I could use other words—that the Soviets did not—you know, as is illustrated by now Ukraine, they do not give a hoot about the health of their people. And they did not care about the health of the people they stationed there, but we should because we took it over and our people were there for about four years, 2001 to 2005.

So I can—I am out of time. So I think I need the Chairman's indulgence to ask you for a commitment, but if you could commit to getting back to me with an answer.

Secretary MCDONOUGH. I will. I commit to that.

Senator BLUMENTHAL. Thank you.

Chairman TESTER. Senator Blackburn.

#### **SENATOR MARSHA BLACKBURN**

Senator BLACKBURN. Thank you, Mr. Chairman.

And, Mr. Secretary, as always, thank you for your time and for being here with us. I think you know that I have got some concerns, and the backlog is one of those. I understand we are at 240,000 on the backlog. That is correct?

Secretary MCDONOUGH. That is correct, down from about a peak of 260-some odd thousand in October, yes.

Senator BLACKBURN. And employees are showing back up to work in person?

Secretary MCDONOUGH. Yes. I mean, you know, we have—as a general matter, we have now for many years had max telework arrangements with our workforce. And I think productivity has been remarkable, including earlier this year under max telework where our claims processors claimed—adjudicated more than 7,500 claims per day for 20 days in a row for the first time in the history of VA. So I think the team is working really hard.

Senator BLACKBURN. And about how many claims per person are they able to do in a day?

Secretary MCDONOUGH. Oh, that is a good question. I do not have that metric.

Senator BLACKBURN. Could you get that for me?

Secretary MCDONOUGH. Absolutely.

Senator BLACKBURN. See, my concern is if you look at the PACT Act I am afraid it is going to be a false promise, and I know you know that is my concern because your estimate is that we would go to 1.53 million on the backlog on claims. And I do not want veterans to think we did something but then we are not able to implement it.

And I know you have got 1,700 that you are going to onboard in order to become claims adjudicators, correct?

Secretary MCDONOUGH. That is right. We have onboarded about 1,750, 1,742 exactly, as of this morning. They are in training. We have a couple more on top of that. And then if we get the PACT Act, we are going to need additional people on top of that. And obviously, we have a bunch of people who are working overtime right now, too.

Senator BLACKBURN. Right.

Secretary MCDONOUGH. And doing it—I just—look, I want to brag on this team. I think they are working really hard—

Senator BLACKBURN. Okay. Well—

Secretary MCDONOUGH [continuing]. And doing it pretty well.

Senator BLACKBURN. I appreciate that. But see, even if you onboard the 1,700—

Secretary MCDONOUGH. Yes.

Senator BLACKBURN [continuing]. Then it takes two years to really get them up to speed.

Secretary MCDONOUGH. Well, I think probably about nine months, but . . .

Senator BLACKBURN. Nine months?

Secretary MCDONOUGH. Yes.

Senator BLACKBURN. All right.

Secretary MCDONOUGH. But the broad point you are making is a fair one, absolutely.

Senator BLACKBURN. And this is of tremendous concern to me. So if we were to do the PACT Act and if you have to get these people onboarded, and then you are going to need additional individuals onboarding, then my concern is how long it is going to take for them to even be able to get any benefit at all from this program. Already today, we have got cases that have been out there for months without being—

Secretary MCDONOUGH. Yes, in Tennessee.

Senator BLACKBURN. In Tennessee.

Secretary MCDONOUGH. Yes.

Senator BLACKBURN. Without getting answers. And our VSOs complain about the slow pace of the VA in getting back to them with answers.

Secretary MCDONOUGH. Yes.

Senator BLACKBURN. So I am very concerned about how long it is going to take for the VA to respond if they say: “Well, we do not have the proper infrastructure. We do not have the proper training. We do not have the appropriate number of personnel.”

Secretary MCDONOUGH. Right.



Senator BLACKBURN. Then you are going to have veterans and their spouses who are going to be more frustrated than ever, and I am quite concerned about this.

And the Chairman knows, and Senator Moran knows, I have said many times I think that the only way we would be able to do this and to meet the standard of care is allowing community care right off the bat so that that promise made is a promise fulfilled because at this point you do not have the capacity to meet the need. Correct?

Secretary McDONOUGH. Yes. So thanks very much for the question. I mean, you know, we have been talking about the capacity and what we would need to meet it over the course of this. I have not looked at the final version of the PACT Act to understand when implementation dates are and all that kind of stuff. This is all stuff that this is your business, not mine, but these are all things that surely would factor into our ability to be prepared.

But we are taking a series of very important steps to get ready. There will be more that we need to do. There is no question about it.

And look, let us be very clear that enrolled veterans have legal rights under the MISSION Act once they are enrolled irrespective of when they became enrolled and for, you know, the basis on how they became enrolled.

And those are the timelines and the distance metrics that you all have laid out. We will have that conversation over the course—as we have been talking, over the course of this spring and summer as we report to you under the MISSION Act on how community care is going, including how a veteran who gets care in the community—how we are getting record of that visit back—

Senator BLACKBURN. Right.

Secretary McDONOUGH [continuing]. So we can help manage that vet's health and wellness. So I think there is a lot to chew on here.

I have not met a person yet who thinks that a vet who comes to—is enrolled with us, by virtue of an expansion made available through the PACT Act, should not have access to community care. I think that would be the law of the land, of course.

Senator BLACKBURN. Well, of course, I am out of time. We want to make certain that a promise made is a promise kept.

Secretary McDONOUGH. Fair enough.

Senator BLACKBURN. So we are looking very closely at this. Thank you.

Thanks, Mr. Chairman.

Chairman TESTER. Senator Hirono.

#### **SENATOR MAZIE HIRONO**

Senator HIRONO. Thank you, Mr. Chairman. I would like to go on record—first of all, thank you for having this hearing because it is a long time coming to address the impact of toxic exposure on our veterans. And I have heard some of my colleagues say that this is just going to be way too expensive. I think it is way too expensive because we in Congress have not addressed this matter for years on end.

So thank you, Mr. Secretary, for being here. And I thank all of the veterans and the individuals who represent veterans organizations for your advocacy in this matter.

And in fact, I agree that the VA's capacity to implement the PACT Act, assuming that we pass it—and thank you for your support, Mr. Secretary—needs to be addressed, the capacity to implement. But at the same time, I thought that the effect of the PACT Act is to enable more veterans to access VA care, which is one of the major goals that you have, Mr. Secretary. So at large, that is what the PACT Act's effect should be.

Secretary MCDONOUGH. Yes.

Senator HIRONO. And we are going to have to figure out—you know, give you the resources to implement it.

I think one of the most difficult aspects of what we require of veterans to make the service connection evident is they bear the burden of proof, and whoever has the burden of proof has a really high burden. For example, unless there is a presumption that a medical condition is service-related, the individual servicemember—or maybe you can get a group of servicemembers. Nonetheless, let us say that the individual has to prove that his or her medical condition was service-related.

So what does this mean? What kind of evidence is an individual servicemember supposed to provide to meet his or her burden of proof that the condition was service-related?

Secretary MCDONOUGH. Well, so obviously this is kind of the lifeblood of the Veterans Benefits Administration, and so, you know, we have a whole list of available, you know, proof points and evidentiary points that vets can work. We obviously work very closely. And you know, it would be a useful question to ask to the next panel, the VSOs, who are great partners to us in making sure that their members are in a position to come forward with well-built, well-developed, strongly supported claims.

And so there is a variety of ways to do that, Senator.

Senator HIRONO. Yes.

Secretary MCDONOUGH. But again, the presumptives do play a very important role—

Senator HIRONO. Yes.

Secretary MCDONOUGH [continuing]. In expediting that. It does not dot every "I" and cross every "T," but it does establish an important condition for the vet.

Senator HIRONO. I agree. But without the presumption, the burden of proof on the veteran is pretty high, requiring things, information such as all the years that the person may have been exposed to a toxic condition. A lot of this is information that even the DOD does not apparently keep. In fact, one of the questions I had asked in an earlier SASC hearing was what aspects of military health concerns with the work environment do they even track. For example, do they track what exposure to a 10-acre burn pit meant? I would not even know that.

It seems that the DOD—so their response to my question was that they really do not do the kind of health surveillance, evidence tracking that they should be doing so that the servicemember, the veteran, has some basis on which to make his or her claim that this is service-related. So that is something that I hope that you

can prevail upon the DOD. They should pay attention to the conditions in which our servicemembers are in, not to mention that they are not even given any protective gear when they are in these conditions.

And you probably are not the person that I should be hitting over the head with. It should be Secretary Austin perhaps. But really, you know, I hope that you are working—

Secretary MCDONOUGH. We are.

Senator HIRONO [continuing]. Closely with DOD—

Secretary MCDONOUGH. We are.

Senator HIRONO [continuing]. To have DOD follow and track this kind of evidence so that we can get veterans into VA care.

So I do thank you for all of the advocacy—

Secretary MCDONOUGH. Thank you.

Senator HIRONO [continuing]. And the work that you are already doing in so many areas. As far as I am concerned, you are to be commended.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Hassan.

#### **SENATOR MARGARET WOOD HASSAN**

Senator HASSAN. Thank you, Mr. Chairman, and thank you and Ranking Member Moran for this hearing.

To all the Vietnam veterans here today and watching, welcome home, and thank you to Secretary McDonough for testifying today.

I want to start by noting that I support the Honoring Our PACT Act, and I look forward to working with Chairman Tester and Ranking Member Moran to strengthen this legislation so that veterans exposed to toxic substances can get the health care and benefits that they need and they have earned. We have to work quickly to get this done for veterans in my State and all around the country. I am going to ask a couple of questions about that effort. I have three questions, but I wanted to start with a slightly more general topic.

I am concerned that the VA's recent recommendations to the Asset and Infrastructure Review Commission could reduce access to care for veterans in New Hampshire, including veterans exposed to toxic substances. New Hampshire is one of the only States in the country that lacks a full-service VA medical facility. I sent you a letter this month with the other Senators from New Hampshire and Vermont, asking the VA to forego any actions that would limit veterans' ability to get care at VA facilities in our States.

When we spoke a few months ago in this Committee, you supported VA facility upgrades in New Hampshire, including expanding ambulatory, surgical facilities in our State, but the VA's recommendations to the AIR Commission risk moving in the opposite direction. Can you please speak to the importance of preserving access to VA care and VA facilities and what you will do to ensure that AIR Commission will recognize that and avoid making changes to reduce VA care in States?

Secretary MCDONOUGH. Yes. As a general matter, I think I would say three things. One, this is the start of this process, not the end of it.

Senator HASSAN. Yes.

Secretary MCDONOUGH. So I think as you and I have discussed, the role of the Commission here will be very important.

Senator HASSAN. Yes.

Secretary MCDONOUGH. And then the President has an independent decision to make about the Commission and what it thinks about our work, one.

Two, as a general matter, across the country and in New Hampshire specifically, we tried to ensure that our recommendations increased access rather than decreased it, but I think this is something we ought to keep debating, and surely you ought to make sure the Commission takes a hard look at.

Senator HASSAN. Well, I—

Secretary MCDONOUGH. Three—

Senator HASSAN. Oh, go ahead.

Secretary MCDONOUGH [continuing]. As it relates to our conversation in this Committee, as I was looking at the New Hampshire recommendations, I was expressly thinking of the conversation I had with you at that moment because I did make a commitment to you. And I think if you look closely at our plan about Manchester, for example, I think there is a full range of options available to VA going forward that not only honor the kinds of access questions that you raise—

Senator HASSAN. Yes.

Secretary MCDONOUGH [continuing]. Including expansion of surgical and ambulatory care in that facility—

Senator HASSAN. Right.

Secretary MCDONOUGH [continuing]. But also an opportunity for us to increase partnership with other providers in the State.

Senator HASSAN. Right.

Secretary MCDONOUGH. And so we are a very important part of the health infrastructure in your State, and I am proud of that. And I anticipate these AIR Commission recommendations will increase that role, but I think we should continue to hammer this out because it is really important.

Senator HASSAN. Yes. And it is really important. Obviously, I am committed to it to make sure that our veterans—

Secretary MCDONOUGH. Absolutely.

Senator HASSAN [continuing]. In New Hampshire can get the care they deserve, they have earned, in our State. So I look forward to continuing to work with you on that.

Now let me see if I can get to the other two questions. Melanie Spears is a Granite State veteran. She deployed to Afghanistan in 2012. After more than a year of VA visits due to pain in her abdomen, she was diagnosed just last month with cancer. Veterans exposed to toxic substances need health care, but they also need VA personnel to identify their conditions early on.

The Honoring Our PACT Act includes a provision that requires the VA to provide training to VA health care personnel so they can identify, treat, and assess veterans exposed to toxic substances. In November, the VA also noted that it would expand training for VA and non-VA providers to help better treat veterans with toxic exposures. Can you please speak to how more training would help VA health care personnel better treat veterans exposed to toxic substances?

Secretary MCDONOUGH. Yes. I mean, I have a belief that because we are as familiar as we are with—not perfectly so, but I think we are much more culturally competent on the kinds of exposures and challenges, conditions that veterans are subject to. So I actually think that we do a pretty good job of that training now. We could always do better, but in all cases we have a much greater where-withal of capability to understand what our vets have been through. So additional training of the type that we announced in November will make us that much more capable, and I think at the end of the day, I hope, we can convince veterans that that is a reason that they should come to us for their care when they have that option.

Senator HASSAN. And I appreciate that. I will note that I think that there are some holes in the training guidelines that are being suggested, and I would like to follow up with you on that.

Secretary MCDONOUGH. Please do.

Senator HASSAN. And the last thing—Mr. Chair, I realize I am out of time. We have talked before about the importance of primary care physicians having questionnaires that they use to help screen veterans for toxic exposure. I am pleased that provisions that address that that we had put into our legislation are included in the PACT Act, but I would like to find out if you are starting to develop that questionnaire because I do not think you have to wait for the PACT Act to pass—

Secretary MCDONOUGH. Yes.

Senator HASSAN [continuing]. And I would like to work with all of you on that.

Secretary MCDONOUGH. Yes, let us do it, and let us talk about it. The Burn Pit Registry is also a place where the questionnaire itself is so burdensome as to ultimately be not very helpful.

Senator HASSAN. Okay.

Secretary MCDONOUGH. And so this is another place where a questionnaire of the type that you are advocating can be useful as well as the commitment I made in my testimony today that those vets who participate in our Burn Pit Registry, who want a full clinical examination, should get it. And so that is an execution challenge. That is one that we think is really important for the obvious reason that you lay out.

Senator HASSAN. Thank you and thank you, Mr. Chair, for your indulgence.

Chairman TESTER. Senator Manchin.

#### SENATOR JOE MANCHIN

Senator MANCHIN. Chairman Tester and Ranking Member Moran, I want to thank you for the kind consideration. I want to thank you for holding this hearing and for all the work that you all have done to find a consensus on this issue, and it is extremely important.

I have always said that the military and our veterans is what holds our country together. It rallies all of us, Democrats and Republicans, and that is the best thing that I can tell you that we do here is when you all come and tell us the concerns you have and how we can be of help. It is our duty to take care of all the brave men and women who have selflessly fought to defend the Nation.

Many of our veterans in West Virginia and across America who are exposed to open air burn pits are now facing health complications without health care coverage and benefits, and millions have been exposed to toxic materials, and that number is only rising. Our Committee is unique in taking care of the veterans, and it is not a partisan issue. It is simply our responsibility. So I know that we can find a solution and we will get this done.

I also appreciate, Secretary, you being here and to share with us your thoughts, recommendations for Honoring Our PACT Act and how we can get our veterans the care they need as soon as possible.

A couple things I wanted to ask you, sir. I am very pleased to see the collaboration including in Honoring Our PACT Act between the VA and the Department of Defense in the provisions of the bill on interagency research into toxic exposure, especially the important further understanding of the correlation between exposure and adverse health effects. So does the bill as it currently stands adequately divide the responsibility between the VA and DOD?

Secretary MCDONOUGH. You know what? I think that is a good question. I want to say to you "yes," but I also want to take the question to make sure that I get—come back—

Senator MANCHIN. If you can because we can make some adjustments to the bill—

Secretary MCDONOUGH. Yes.

Senator MANCHIN [continuing]. To make it work the way it should work.

Secretary MCDONOUGH. Yes.

Senator MANCHIN. I know all of our intention is to do that, but sometimes when you write a bill you have no clarity and there is an overlapping and you get nothing accomplished. So we want to make sure that that is clear.

Also, can the VA and the DOD collaborate further and get ahead of the curve to ensure that our veterans are not exposed to toxins in the course of their service going forward? Have we been able to separate and understanding the danger we are putting them in by changing how we operate in the field? And that would come back from you all—

Secretary MCDONOUGH. Yes.

Senator MANCHIN [continuing]. Giving your information to the DOD.

Secretary MCDONOUGH. Yes. Look, you have heard me say in this room before, and you have heard me say this to you privately, that I think Secretary Austin is uniquely focused, and generously so, on how to care for our vets. This is an issue that we have had conversations about. I do not want to make any kind of operational commitments or even raise operational—

Senator MANCHIN. Yes.

Secretary MCDONOUGH [continuing]. Things that I do not have a say in, but I know that DOD is very focused on this.

Senator MANCHIN. In all the agencies, we have challenges. We all mean well—

Secretary MCDONOUGH. Yes.

Senator MANCHIN [continuing]. But things go wrong at times, and you know that. When you took over, there was a—you had a tremendous backlog to work in getting us up to speed.

And I think all of you heard the story about the VA in West Virginia and the deaths we had. It is just totally mindboggling today. I cannot even—the horror that the families are going through. But I can tell you we put through great legislation to correct a lot of the things, and the whole thing is holding accountability.

Secretary MCDONOUGH. Yes.

Senator MANCHIN. So in addition to accountability, we need to make sure implementation that measures that no veterans are being left behind. So my question would be: Do you feel that Honoring Our PACT Act currently has enough standards for accountability and implementation, and if not, where could we fix any gaps? And if you have not gone in—if your staff could give us—

Secretary MCDONOUGH. Yes.

Senator MANCHIN [continuing]. The adjustments that might be needed, we need to identify that now.

Secretary MCDONOUGH. Yes.

Senator MANCHIN. Because I do not want any of you all to leave here thinking that we have got a perfect piece of legislation and we fixed everything that was wrong and we find out the language is not there to do it.

Secretary MCDONOUGH. It is a fair question, a good question. And I do not have anything specific with me today on accountability, but I will take that.

Senator MANCHIN. Well, there is different iterations of the bill.

Secretary MCDONOUGH. Of course.

Senator MANCHIN. You know, we had one on our side; they had one on their side, and this and that.

Secretary MCDONOUGH. Yes.

Senator MANCHIN. And we tried to start blending that.

Secretary MCDONOUGH. Yes.

Senator MANCHIN. And you got DOD responsibility, and you got VA responsibility, and if they are not correlated—I know you had that ability in your previous job. You had to make a lot of things happen, and I know you can make this happen, but if you need us to help write that language or make the adjustments that makes your job easier and better.

Secretary MCDONOUGH. Yes. My hunch is that we have a lot of useful accountability tools, including one that you all gave us in 2018 that would apply obviously to this going forward, but I think it is a good question. I have taken note on it, and we will make sure to get back.

Senator MANCHIN. I can assure you, as far as the bipartisan effort that we are all making right here, whatever you recommend that we could help to make this really happen because it is a big undertaking and I know we want to get it right.

Thank you, Mr. Chairman. I appreciate your patience.

Senator MANCHIN. Thanks, Senator.

Chairman TESTER. Thank you. Secretary McDonough, I believe it is about 98 minutes in. Thank you very much. I guess we are going to have to do these more often because that way people will not have a whole bunch of questions to ask you. So it is good.

Secretary MCDONOUGH. I will come; Mr. Chairman, I will come anytime you request my presence.

Chairman TESTER. I appreciate your testimony and your frankness, and you are now released.

Secretary MCDONOUGH. Good.

Chairman TESTER. And now we are going to hear from three VSOs whose members are impacted by the consequences of toxic exposure every day. I want to first introduce somebody who has been at this Committee a lot, Shane Liermann, the Deputy National Legislative Director of the Disabled American Veterans. We also have Christopher Slawinski, who is the National Executive Director of the Fleet Reserve Association. And lastly, we have Kristina Keenan, Associate Director of the National Legislative Service for the Veterans of Foreign Wars, the VFW.

In many respects, this panel is the most important panel we are going to hear from today because these three groups represent part of the men and women who have served for the last 20 years that we are talking about with toxic exposure. So I want to thank you all for being here, and I am going to turn it over to you for your opening statement, Shane.

## PANEL II

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### STATEMENT OF SHANE LIERMANN

Mr. LIERMANN. Thank you. Chairman Tester, Ranking Member Moran, and members of the Committee, on behalf of DAV's more than one million members who have wartime service related wounds, injuries, diseases, and illnesses, we thank you for the opportunity to discuss toxic exposures and the impact of Honoring Our PACT Act which DAV strongly supports. I defer to our written testimony where we discuss the bill and all of our recommendations to strengthen it.

Mr. Chairman, we thank you, the Ranking Member, and this Committee for all of your efforts and hard work on the COST of War Act and many other pieces of toxic exposure legislation.

Today is National Vietnam War Veterans Day, and we are still discussing legislation that will impact veterans exposed to Agent Orange 50 years later. We recognize the service and sacrifice of Vietnam veterans, their families, and survivors.

Mr. Chairman, we are at the precipice of a monumental event, solving the puzzle of comprehensive toxic exposure legislation for past, current, and future generations of veterans exposed to environmental hazards. As a Nation, we have responded too slowly to provide health care and benefits for toxic-exposed veterans. It took over 60 years to recognize diseases due to contaminated water at Camp Lejeune, 50 years for mustard gas exposure, 40 years for radiation exposure, and we are still adding diseases of location for Agent Orange-exposed veterans 50 years later.

There are thousands of veterans exposed to toxins and burn pits who we are already too late for, such as Ms. Ashley McNorrill. She was deployed to Iraq, where she was exposed to burn pits which she noted was only a few feet from her chow hall. After service, Ashley and her husband tried to start a family but were unable to conceive due to what they were told was endometriosis, which required a hysterectomy. After they adopted two small twin boys, she



decided to have the hysterectomy, and during the surgery it was discovered she had stage four appendiceal cancer, a rare form of the disease occurring only in one or two cases out of a million.

After years of VA claims and appeals without success, she sought out the assistance of a DAV benefits advocate in South Carolina, and then Ashley was awarded total and permanent VA disability benefits. However, shortly thereafter, she succumbed to her burn pit-related cancer and left her husband and two young sons behind. The Honoring Our PACT Act would ensure that Ashley and veterans like her would have access to health care and benefits sooner rather than later.

We recognize comprehensive toxic exposure legislation would increase VBA's workload, and we must be focused on solutions to mitigate these increases. We suggest VBA develop a plan now that considers the following mitigation strategies, to include establish a unique end product code for all new presumptives added by new toxic exposure legislation and implement a triage unit to address presumptives directly as they come into the VA. Also, they can use authority similar to pre-stabilization ratings, administrative decisions, or memorandum ratings as well.

These suggestions can be implemented under VBA's current authority. However, we recommend that they are codified. This will give VBA those same authorities for future presumptives or similar instances of increased workloads.

In addition, the PACT Act authorizes \$150 million for VBA to begin a major overhaul of IT infrastructure, including claims automation. These funds can be used to automate and implement the suggestions we have noted. We urge VA to develop a plan now that includes leveraging these existing authorities.

DAV supports waiving PAYGO for comprehensive toxic exposure legislation as it cannot truly happen otherwise. Toxic exposure legislation must be considered a cost of war and not hindered by PAYGO.

Mr. Chairman, we must take full advantage of the opportunity to enact thoughtful and meaningful toxic exposure legislation, but veterans and their families cannot afford to continue to wait for decades like past generations who were exposed to mustard gas, radiation, contaminated water, and Agent Orange. As noted historian C. Northcote Parkinson said, "Delay is the deadliest form of denial." We must act now.

Mr. Chairman, this concludes my testimony, and I am pleased to answer any questions you or the Committee may have.

[The prepared statement of Mr. Liermann appears on page 78 of the Appendix.]

Chairman TESTER. Shane Liermann, I want to thank you for the testimony for the Disabled American Veterans. Thank you very much.

Next, we have Christopher Slawinski who is with the Fleet Reserve Association. Chris, you are up.

#### **STATEMENT OF CHRISTOPHER SLAWINSKI**

Mr. SLAWINSKI. Thank you. Chairman Tester, Ranking Member Moran, and members of the Committee, my name is Chris

Slawinski; I am the National Executive Director of the Fleet Reserve Association. I served 20 years in the U.S. Navy, four years on active duty and 16 years in the Navy Reserve. I am here today to discuss veterans' toxic exposure, representing the concerns of the oldest sea service association.

For over 97 years, the FRA has served the enlisted men and women of the active, reserve, and retired communities plus veterans of the Navy, Marine Corps, and Coast Guard. The Association is congressionally chartered, recognized by the Department of Veterans Affairs, and entrusted to serve all veterans who seek help.

As one of the leading supporters of the Agent Orange Blue Water Navy bill, which was enacted in 2019, FRA is grateful for its passage and the expansion of the presumptions that were sponsored by you, Chairman Tester, in 2020. The Agent Orange legislation helps vets that served during the Vietnam War. Now Congress needs to protect those veterans who more recently served and are currently serving.

Military service for our Nation can require servicemembers go to places that may expose them to toxins that cause illnesses and diseases that may not be diagnosed for years or even decades after their service. That is why FRA is an active member of the Toxic Exposures in the American Military or TEAM coalition. The coalition wants to ensure that veterans who had exposures to burn pits and other environmental toxins gain access to VA health care benefits. We look forward to working with this Committee, the House committee, and bill sponsors to passage of a comprehensive bill on toxic exposure this year.

We understand the cost aspect of this legislation is a significant consideration. That said, the need for reform is of paramount concern to the veterans community. Too many toxic exposure claims have been denied due to a high standard of proof currently required.

In response to the President's State of the Union Address, the VA has proposed adding certain rare respiratory cancers to the list of presumed service connection disabilities in relation to military environmental exposure to particulate matter. The VA determined, through a review of scientific and medical evidence, there is a biologic plausibility between airborne hazards, specifically particulate matter, and carcinogenesis of the respiratory tract. The unique circumstances of these rare cancers warrant a presumption of service connection. Based on these findings, VA Secretary proposed a rule that will add presumptive service connection for several rare respiratory cancers for certain veterans. FRA believes this is a step in the right direction.

Prostate cancer is the number one cancer diagnosed by the Veterans Health Administration. Recent studies have reported over 500,000 veterans are living with prostate cancer and are receiving treatment within the VHA. There are over 16,000 of those with metastatic disease, and there are over 15,000 new diagnoses annually. The need to standardize treatment across VHA with the introduction of a comprehensive, systemwide prostate cancer clinical pathway should be implemented.

Studies have shown that prostate cancer develops more frequently in men exposed to Agent Orange, and the VA has established it is a presumptive condition, thus qualifying exposed veterans to full disability benefits. New data supports the link between prostate cancer and exposure to jet fuel, cadmium, and aircraft component cleaning solvents.

As I mentioned earlier, I served on active duty for the United States Navy for four years. I worked as an aviation electronics technician. My primary duties were associated with being a final checker and troubleshooter on the flight deck of the USS *Coral Sea*. Daily, I was exposed to jet fuel, exhaust, and other toxins while performing my duties for my squadron. This past September, I was diagnosed with stage four prostate cancer which has metastasized to my bones. I do not have a family history of this cancer.

I have been very fortunate to receive my treatment in the defense health care system. I can honestly say that the medical staff at Walter Reed is among the best in the world. While I am fortunate to receive this care through DHA, others are not as fortunate. That is why I am here to advocate for them today.

In closing, allow me to express the sincere appreciation of the Association's membership to all the members of the Senate Veterans' Affairs Committee and your outstanding staffs for our Nation's veterans. I await your questions.

[The prepared statement of Mr. Slawinski appears on page 88 of the Appendix.]

Chairman TESTER. Thank you, Chris. Thanks.  
Kristina Keenan, VFW.

#### STATEMENT OF KRISTINA KEENAN

Ms. KEENAN. Senators Tester and Moran and members of this Committee, on behalf of the VFW, the Veterans of Foreign Wars of the United States, and its auxiliary, thank you for the opportunity to speak on this important issue.

At a Senate Armed Services Committee hearing on toxic exposure two weeks ago, the Department of Defense was asked, how many servicemembers that deployed to Iraq and Afghanistan would have been exposed to airborne hazards and burn pits? The response, all of them.

The Honoring Our PACT Act is the comprehensive solution for toxic exposures. It will provide veterans with health care and benefits and creates a presumptive framework to address any toxic exposure, past, present, and future. This is the priority of over 40 veterans service organizations, all of which support passing the PACT Act.

The PACT Act may be a House bill, but this was born in the Senate. The TEAM Act was first introduced by Senators Tillis and Hassan; the Veterans Burn Pits Exposure Recognition Act introduced by Senators Sullivan and Manchin, the SERVICE Act introduced by Senator Boozman, and the Health Care for Burn Pit Veterans Act introduced by Chairman Tester and Ranking Member Moran, these bills shaped Titles I, III, and VI of the PACT Act.

The VFW is grateful for the Senate foundations of this comprehensive legislation. We have worked closely with your offices to

get this right. We ask that the Senators who introduced or co-sponsored these bills pledge their support for passage of the PACT Act.

Regarding the cost, some Members of Congress, they say that they need to be responsible, fiscally responsible with taxpayer money and that veterans are taxpayers, too. Congress spent trillions in taxpayer dollars on the Global War on Terror. Being responsible is accurate. Servicemembers were sent into harm's way, and some came home and developed serious illnesses. We are responsible for these men and women. Providing them health care and benefits is responsible.

We are talking about veterans. Veterans. What is more responsible than taking care of the people who risk their very lives defending this country? This is a cost of war. This is responsible, and it is personal for all Americans.

Veterans here in this room, in these buildings, were exposed to hazards and toxins in service, and I am not just talking about us veterans here on this panel or sitting behind me. Senator Sullivan was exposed to open air burn pits as were Senators Duckworth, Cotton, Ernst, Graham. Senators Kelly and Peters served in areas with oil fires and chemical hazards. Senator Carper served in Vietnam, exposed to Agent Orange. Senator Blumenthal's sons, as he mentioned, were exposed to open air burn pits. And Senators Moran, Tester, Boozman, you all have staff that served in Iraq and Afghanistan. They worked and slept next to open air burn pits during their time in service.

Everyone knows a friend, a family member, a colleague, a co-worker, someone who was exposed to toxins in service to our country. We need to take care of this problem once and for all.

How many Vietnam veterans had to die before we got the legislation right? How is it that today, on National Vietnam War Veterans Day, of all days, that we are still trying to fix toxic exposure at VA?

The members of this Committee, you have the opportunity to be leaders in this historic moment. All eyes of the veteran community are on you right now. You can help pass this bill and not divert to a smaller version that leaves veterans still waiting. Every day, every week, every month that delays the PACT Act, more veterans get sick and die. Be the champions of this solution and be on the right side of history.

We, the veterans sitting before you, sitting next to you, sitting behind you, and all around this country fought for you. Now we need you to fight for us.

Thank you for the opportunity to provide my remarks. I look forward to answering any questions you may have.

[The prepared statement of Ms. Keenan appears on page 96 of the Appendix.]

Chairman TESTER. Thank you for your testimony, Kristina. I am going to stick with you for my first question. The PACT Act runs about \$325 billion over 10 according to the CBO. The COST of War Act runs currently at about \$413 billion over 10. Could you once again tell me what I should tell the people that say we simply cannot afford this kind of expenditure?

Ms. KEENAN. This is a cost of war. As I mentioned in my testimony, Congress approved trillions of dollars over the last 20 years in conflicts. We have passed large pieces of legislation for veterans in the past, MISSION Act, Choice Act, and we waived PAYGO.

For something this large, there are not enough offsets to pay for all of it. We really have to consider how we are going to pay for this. It is so big. We need to just find a way. This is a cost of war.

Chairman TESTER. Okay. This is for you, Shane, but anybody can jump in on this. There were some questions about the fact if we pass the PACT Act or the COST of War Act that services for veterans who are currently enrolled in the VA, who get services from the VA, would not get as timely a service as they would otherwise. What is your response to that?

Mr. LIERMANN. Probably about 12 years ago, maybe 13, there were over 1 million claims backlogged and pending within the VA system. And were any actions taken? Not right away. It took years of veterans to get actions done.

So are we familiar with this territory? Absolutely, we are. But I also do know that any veteran is not going to tell their fellow veterans, sorry, you do not get benefits today because I am in line and you have to wait.

Veterans are in this together. We understand that there is going to be increased workloads within VA. Well, VA has the authorities to correct that, and along with this Committee, we can find ways to make that streamlined, more efficient, so no veteran has to wait. And, we do not have to consider giving new benefits because other veterans may have to wait longer. That should never be a conscientious thought within our veterans community.

Chairman TESTER. So the President has basically endorsed us to take care of toxic exposure, and I applaud that and thank Secretary McDonough for his support of this bill.

So this is for you, Chris. Why not just let the Executive Branch do it? Why should Congress stick their fingers in this?

Mr. SLAWINSKI. The bottom line is that we have waited for administrations to basically act in the past. The Blue Water Navy bill—I joined the Fleet Reserve Association as part of their staff in 2004, and I fought side by side with Vietnam veterans for a number of years to get that bill passed. We went to the VA and talked to the Secretaries and said, “you have the administrative authority to make a change.” And they looked at us and said, “show us the science.” We showed them the science. They continued to delay. So it took an act of Congress to get it done.

We do not want to—waiting is going to kill people. We cannot wait for any administration to make a decision on whether it is the right thing or wrong thing to do. We know that Congress has got the authority to basically make sure that they can push the Administration and push the VA into the right direction to get things accomplished.

Chairman TESTER. So this goes to anyone who wants to answer it. What would you say to the people who say that if we pass the PACT Act or the COST of War Act, and we have a procedure by which the VA can determine toxic exposure and make sure that the benefits and health care are there for those folks who have been

exposed, that this would be a false promise to those folks because the VA simply does not have the capacity?

Ms. KEENAN. I am going to jump in and answer that. I think that is a good question, and I know people are concerned, but there are provisions within the bill to provide VA additional resources. The VFW and DAV, PVA together compose the independent budget VSOs, and we make budget recommendations for VA every year. So we know going forward VA is going to need some IT upgrades. They are going to need to train more personnel. The Secretary identified some of their needs. So I think Congress needs to be fully aware that VA is going to need more, but that should not slow the process.

Veterans would rather be in the queue than knocking at the door, not able to get in. They need to be able to get into the process even if it takes a little bit longer, but knowing that they have access is going to reassure veterans who need to get in.

Chairman TESTER. Senator Moran.

Senator MORAN. Chairman, thank you and thank you to our three witnesses representing many, if not all, the veterans organizations and many, if not all, the veterans.

Christopher, first of all, best wishes, best regards, hope, prayers for you and your well-being. Thank you all for your service.

Kristina, let me—this is a narrow topic within this Act, but your testimony seemed to indicate that not all of the VSOs have been included in the development of the pilot program and its decision-making process. And you mentioned how the VFW would like to work with the VA and make recommendations in that process. I have heard that complaint elsewhere as well. Any thoughts you would like for me to know, or us to know, about that? And secondly, are there any amendments to include in the PACT Act that would ensure that process—that includes a trigger from an outside entity?

Ms. KEENAN. Well, the bill does include some VSO involvement within the process. So we do appreciate that that was included. However, in the developments of VA's current pilot program, it is really critical to have veterans service organizations to provide input. And I say service organizations because the VFW, for example, has over 2,000 VA-accredited service officers. So we have got people on the ground working and assisting veterans with their claims that really know and understand the adjudication process, the realities of how long it take, some of the miscommunications that we have with them.

So to have the VFW at the table before something is fully fleshed out but to really offer our expertise is not only on this issue but all issues something that we really want to have and just to ensure that everything is—nothing is overlooked and that we are really involved in the entire process.

Senator MORAN. Thank you. Mr. Liermann, Shane, the Agent Orange Act of '91 required the Secretaries to determine whether a presumption was warranted within 60 days of a NASEM report and, if so, prescribe regulations within 60 days of making that determination. I am told that you were involved in that legislation, and it has been the law of the land since 1991. My impression is the PACT Act mandate nearly doubles that time amount that the

Secretary has to make those determinations. Can you talk about that difference and if that makes sense or that is an area that needs attention?

Mr. LIERMANN. Absolutely. Thank you. Actually, those protections and those triggers for the timeframes in the 1991 Agent Orange Act actually expired in 2015 and have not been reauthorized. So right now, there are not any and, hence, why hypertension, bladder cancer, and other conditions were never added even though they were recommended.

We think putting a timeframe—whether 60 days, 90, or 120, we want to make sure, one, we give the Secretary ample time to review and make decisions. And two, we want it to be—we want them to be held to that standard, right, because if you take a look back over the years on the number of presumptive diseases it was not always within that 60-day window. It was close. But we want to give them the opportunity to make those decisions, and we need those authorities and safeguards back.

Senator MORAN. So the actual number of days is less significant than the data and there being a requirement and also the reminder that they ought to mean something once they are put into law.

Mr. LIERMANN. Exactly, Senator. It is the trigger. Whether it is 60, 90, or 120, that trigger is the most important part.

Senator MORAN. I have never had a Secretary of the Department of Veterans Affairs, this or previous, that ever asked for a little bit of delay in a congressionally mandated timeframe. So we will hold—we will try to hold the VA accountable to those standards.

Mr. Chairman, thank you.

Chairman TESTER. I want to thank the panel very, very much. A couple things. You guys were here. You heard the Secretary field a bunch of questions. You guys know the lay of the land better than anybody because you represent the veterans that are out there, and I just want to thank you for taking time out of your schedule to be here today.

There is work to be done here, and I am glad you all three and others, 37 others just like you, are on the ground giving us input because I think it is really, really, really important.

For the folks who normally do not come to a Senate Veterans' Affairs Committee, I want to say thank you for coming today. Normally, we do not have this many people show up, and we like to have you show up. So thank you all for being here. I think it does express to this Committee how very, very concerning the issue of toxic exposure is and why we need to do something about it. And so thank you for all being here, too, and the same thing for everybody that is watching at home.

I think everybody wants us to do right by our veterans. We just need to make sure that we find the sweet spots so we are able to do that because, quite frankly, all we have to do is look at Agent Orange and see that those folks, many of them, died before there was any benefits. The reason they had the ailments that they had, I believe, was directly due to a very, very intense herbicide called Agent Orange that was made to kill plants but also killed people.

So with that said, I really look forward to working with everybody here today, the Secretary, Ranking Member Moran, to get a

comprehensive piece of legislation to the President's desk as soon as possible.

As far as recordkeeping here, we are going to keep the record open for two weeks for any additional comments and if there is any additional questions that need to be asked.

With that, thank you all for being here, and this hearing is adjourned.

[Whereupon, at 5:37 p.m., the Committee was adjourned.]



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**A P P E N D I X**

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## **Prepared Statements**

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**STATEMENT OF THE HONORABLE DENIS MCDONOUGH  
SECRETARY OF VETERANS AFFAIRS  
DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
ON  
HONORING OUR PACT ACT OF 2021**

**MARCH 29, 2022**

Chairman Tester, Ranking Member Moran, and other Members of the Committee: thank you for inviting me here today to present the Department's views on H.R. 3967, the Honoring our Promise to Address Comprehensive Toxics Act of 2021, or the Honoring our PACT Act of 2021.

I will begin my written testimony with a general discussion of VA's current approach to ensuring Veterans who have experienced environmental exposures receive the care and benefits they have earned and then provide a general discussion of each title of the Honoring our PACT Act of 2021. In discussing each title, I will provide a summary of its provisions, describe the potential impact of the bill on the timely delivery of VA health care and benefits, discuss potential costs associated with that title and other resources needed to implement the bill, and explain how the title could support ongoing research efforts. In addition, I have included an appendix to my testimony identifying technical amendments or corrections we believe need to be made to the bill.

**General Discussion**

VA has struggled for decades to address the health effects of harmful environmental exposures that occurred during military service from World War I to the post-9/11 generation. All too often, VA's historical process resulted in VA denying claims from Veterans for lack of evidence, only for VA to eventually create presumptions of service connection decades later, but often too late for many Veterans, caregivers, families, and survivors. These issues loom large for the post-9/11 Veteran cohort, numbering 3.5 million, whose exposures to burn pits, carcinogenic substances, airborne and environmental hazards, chemical warfare agents, and other toxins have been potentially linked to a broad array of maladies.

Over the past 12 months, VA has taken a number of important steps to ensure Veterans who served in Southwest Asia since 1991 and who were exposed to burn pits and other environmental hazards get the timely access to world-class care and benefits they deserve. VA is establishing a holistic approach, informed by science, for determining toxic exposure presumptions going forward. This new approach expands our focus concerning scientific evidence and considers all available data, listens to and learns from Veterans' experience, and is guided by one core principle: getting Veterans the benefits they have earned and therefore deserve. This new approach already has

resulted in real progress, including new presumptions of service connection for three respiratory conditions (asthma, rhinitis and sinusitis) for Veterans who served in Southwest Asia and certain other areas. The establishment of these new presumptions makes President Biden the first President to provide exposure benefits proactively to the Veterans who have fought our wars in the Middle East and Southwest Asia for the past 30 years, and more importantly, ensures that over 10,600 of those Veterans are now finally getting the benefits they have earned and deserve. Earlier this month, VA announced our intention to initiate rulemaking to add several rare respiratory cancers to the list of presumed service-connected diseases in relation to exposure to toxic chemicals in the air, water or soil for certain Veterans. The presumptions would make it easier for affected Veterans to obtain VA health care and other benefits. The cancers under consideration include squamous cell carcinoma of the larynx, squamous cell carcinoma of the trachea, adenocarcinoma of the trachea, salivary gland-type tumors of the trachea, adenosquamous carcinoma of the lung, large cell carcinoma of the lung, salivary gland-type tumors of the lung, sarcomatoid carcinoma of the lung, and typical and atypical carcinoid of the lung.

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VA is piloting a new comprehensive, evidence-based, presumptive decision-making model to consider possible relationships between in-service military exposures to environmental hazards and medical conditions. VA designed the model to expand the aperture for reviewing scientific information and facilitate timelier decision making, thereby lowering the burden of proof for Veterans impacted by exposures and speeding up the delivery of health care and benefits they need. At the President's direction, VA will use this new presumptive decision-making model to assess associations between environmental exposures and constrictive bronchiolitis, rare brain cancers, and lung cancer. By April 1, 2022, I will receive the results of the model, and, from there, we will leverage the validated model to seek answers on those conditions that may be strong candidates for presumptions of service connection later this year.

### **Title-by-Title Discussion**

#### **Title I: Expansion of Health Care Eligibility**

##### *Summary*

Title I of the bill, named the Conceding Our Veterans' Exposures Now and Necessitating Training Act, or the COVENANT Act, would make various amendments to sections 101, 1703, 1710, and 7322 of title 38, United States Code (U.S.C.). These changes would add new terms and their definitions and would expand eligibility for health care and the scope of benefits in six important ways.

- First, the bill would amend VA's current requirement to provide care to any Veteran who was exposed to a toxic substance, radiation or other conditions, and instead refer simply to "toxic-exposed Veterans."
- Second, it would require VA, on a phased-in cycle, to provide hospital care, medical services and nursing home care for any illness to three new categories of Veterans:

- Those who participated in a toxic exposure risk activity while serving on active duty, active duty for training or inactive duty training;
  - Covered Veterans (as defined in a new § 1119(c), which would be added by section 302 of the bill), which would include:
    - Veterans who were assigned to a duty station in Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia, Somalia or the United Arab Emirates on or after August 2, 1990, during active service; or
    - Veterans who were assigned to a duty station in Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Syria, Yemen, Uzbekistan, the Philippines or any other country determined relevant by VA on or after September 11, 2001, during active service.
  - Veterans who were deployed in support of Operation Enduring Freedom, Operation Freedom's Sentinel, Operation Iraqi Freedom, Operation New Dawn, Operation Inherent Resolve and Resolute Support Mission.
- Third, the bill would expand access to clinically appropriate mammography screening to certain Veterans, based on their period and place of active service, who are not enrolled in VA health care by amending § 7322 of title 38.
  - Fourth, the bill would extend the window for eligibility to enroll in VA health care from 5 years to 10 years from discharge or release from active service for certain Veterans who were discharged or released from active service after September 11, 2001. It would also create a 1-year period of eligibility to enroll, beginning on October 1, 2022, for Veterans who were discharged or released between September 11, 2001, and October 1, 2013.
  - Fifth, it would clarify eligibility for health care for Veterans who served in a combat theater during a period of war after the Persian Gulf War and received the Armed Forces Expeditionary Medal, the Service Specific Expeditionary Medal, the Combat Era Specific Expeditionary Medal, the Campaign Specific Medal or any other combat theater award established by a Federal statute or an Executive order.
  - Sixth, it would allow VA to authorize emergency care under the Veterans Community Care Program (VCCP) if VA is notified of an admission of a covered Veteran within no less than 96 hours of such admission.

In addition, title I would require VA to submit to Congress:

- Plans to conduct outreach to Veterans who will become eligible for health care at least 180 days before such Veterans become eligible on the phased-in schedule;
- Within 180 days of enactment, an assessment to determine the personnel and material resources necessary to implement the expanded health care eligibility under section 103 of the bill, as well as the total number of covered Veterans who receive hospital care or medical services under chapter 17;
- Annual reports on the effect of the implementation of and the provision and management of care under section 103 of the bill on the demand for health care services, including patterns and changes in health care delivery;

- Biennial reports, in collaboration with the Department of Defense (DoD), specifying other periods and places of active service for purposes of eligibility for clinically appropriate mammography screening;
- Within 2 years of enactment, a report that compares the rates of breast cancer among members of the Armed Forces who deployed to locations during periods identified in § 7322, as amended, to members of the Armed Forces who did not deploy to those locations during those periods and to the civilian population; and
- A plan to conduct outreach to Veterans who would become eligible to enroll during the 1-year period previously described, as well as a report on the number of Veterans who enrolled during this period.

Title I also would require VA to establish information systems to assess the implementation of section 103 of the bill and use the results of the assessments to inform its annual reports to Congress.

*Impact on Care and Benefits*

We want to ensure that the expansion of eligibility required by title I does not result in the delay or disruption of care for those Veterans already receiving health care from VA. In this context, we appreciate the bill's phased-in approach to some of the expanded eligibility, as well as the flexibility to accelerate that timeline if VA can do so responsibly.

We believe there would be at least some, and potentially significant, overlap between different categories of Veterans who would become eligible under some of the different provisions in this title. This overlap could result in more Veterans becoming eligible at once on the outlined schedule than was perhaps intended. On the other hand, at least some portion of the Veterans described in this bill would already be eligible to enroll in, and may have already enrolled in, VA health care under a current authority, for example, based on service in combat (see § 1710(e)(1)(D)). Initial estimates indicate that somewhere between 60 and 75% of Veterans described in these provisions are already eligible for enrollment. While these Veterans may already be enrolled in VA care, this title could result in their placement in a higher priority group, which could reduce their financial liability for care. Among currently enrolled Veterans who would benefit from this title, VA expects this population would rely on VA for more of their care. We would like to work with Congress to ensure that the provisions related to the phased implementation are clearly understood so that VA can effectively implement this bill.

In particular, the bill includes language consistent with a legislative proposal from the Administration to expand the window for eligibility to receive care and enroll to up to 10 years from separation, as well creating a 1-year period for those who did not enroll during their previous window, for certain combat Veterans. For awareness, this Committee's Health Care for Burn Pit Veterans Act, S. 3541, would include this authority as well. These amendments will ensure Veterans have the opportunity to make informed decisions about when, where and how to receive their care. In relation to the expansion of access to clinically appropriate mammography services, female Veterans should be provided mammography in accordance with recognized medical best practices, evidence and the best available science in consultation with their



providers. All women Veterans enrolled in our system are eligible for clinically appropriate breast cancer screening; this bill would expand the number of women Veterans eligible for such screening. VA follows the American Cancer Society guidelines for breast cancer screening in average-risk women by offering screening mammography beginning at age 40, and we screen earlier for high-risk women when clinically appropriate. VA has reviewed the medical literature, and there is currently no population-based evidence that military exposures increase the risk of breast cancer and so relies on established best medical practice as our guide for care recommendations. Part of our research, though, is focused on learning more about these risks, and we are training our providers to better understand potential risks based on environmental exposures. If a woman believes she is at risk based on her service, we furnish an individualized risk assessment, and our providers discuss if early screening is indicated based on identifiable risk factors. We caution that it would not be clinically appropriate to conduct a mammogram without a clinical indication to do so, as this could lead to false positive results that could result in radiation exposure, unnecessary procedures (such as biopsies), anxiety, and other complications. We appreciate that this bill would allow VA to make these clinical determinations for more Veterans than we can today to ensure they receive appropriate, timely care. Concerning the extension of VA's current "72-hour" rule to 96 hours, we understand the intent of this effort, but we do not anticipate this extension would result in a significant change in eligibility for emergency care.

#### *Costs and Resources*

Many of the provisions in title I also are connected to provisions in other titles, such as titles II, III and IV. VA is still analyzing the interactions between these provisions and how they would affect the demand for care and benefits. As noted previously, the phased-in approach of the bill could mitigate immediate resource requirements. We estimate the cost of the extension of the window for enrollment from 5 years to 10 years, and the provision of an additional 1-year window for those previously eligible to enroll, would cost approximately \$534 million over 10 years. This estimate is inclusive of personnel and equipment. We are unable to determine at this time if additional physical infrastructure would be needed based on this expansion, as such decisions are informed by detailed build/buy analyses, but if construction is required, these cost estimates would increase. Some elements of title I, as is the case with other titles as well, would be subject to rulemaking that could affect the potential costs and resource needs for implementation. To implement this title effectively, VA believes it would need additional appropriations to support the necessary full-time employees, including health care providers, enhancements to VA's network of community providers, new or improved information technology systems and additional support staff in VA Central Office and the field to provide administrative support, guidance and oversight.

#### *Research*

While title I does not include provisions directly related to research, it could still provide new opportunities to support research related to Veterans' health and benefits. By enrolling more Veterans and providing them the care they need, we also benefit from learning more about this population's health issues and conducting further research

specific to their needs. VA can, in turn, use these findings to inform decisions about presumptions for service connection, risk factors and evidence-based treatments. These interactive effects could serve as a force multiplier to support VA in its mission of providing care and benefits to Veterans, Service members and their families.

## **Title II: Toxic Exposure Presumption Process**

### *Summary*

Title II, called the Fairly Assessing Service-related Toxic Exposure Residuals Presumptions Act, or the FASTER Presumptions Act, would create new provisions in chapter 11 of title 38, U.S.C., regarding determinations relating to presumptions of service connection based on toxic exposure.

- The new 38 U.S.C. § 1171 would establish the process by which VA could establish or modify presumptions of service connection based on toxic exposures.
- The new 38 U.S.C. § 1172 would establish a Formal Advisory Committee on Toxic Exposure.
  - VA could consult with, and seek the advice of, the Committee with respect to cases in which Veterans are suspected of having experienced a toxic exposure during active service or dependents of such Veterans.
  - The Committee would have to assess cases of toxic exposures of Veterans and their dependents by conducting ongoing surveillance and reviewing scientific literature, media reports, information from Veterans and information from Congress. These assessments would cover suspected and known toxic exposures.
  - The Committee also would be responsible for periodically assessing the accuracy of the Individual Longitudinal Exposure Record (ILER) and the data collected.
  - The Committee could develop a recommendation for formal evaluation under the new 38 U.S.C. § 1173 to conduct a review of the health effects related to an exposure if the Committee determines that the research may change the current understanding of the relationship between an exposure to an environmental hazard and adverse health outcomes in humans.
  - Based upon evidence regarding the periods and locations of exposure covered by an existing presumption, the Committee could nominate for formal evaluation under new 38 U.S.C. § 1173 modifications of the periods and locations for eligibility for benefits.
- The new 38 U.S.C. § 1173 would require VA to establish a process to conduct a formal evaluation for each recommendation of the Committee established under proposed § 1172.
  - Under this process, VA would have to conduct research regarding the health effects related to a case of toxic exposure or to evaluate evidence regarding the periods and locations of exposure covered by an existing presumption of service connection.

- Each formal evaluation would have to cover scientific evidence, claims data and other factors as VA determined appropriate.
  - The formal evaluations would have to evaluate the likelihood that a positive association existed between an illness and a toxic exposure while serving in active service and assess toxic exposures and illnesses to determine whether the evidence supported a finding of a positive association between the toxic exposure and the illness.
  - Not later than 120 days after a formal evaluation is commenced, the element of VA that conducts the evaluation would have to submit to the Secretary a recommendation with respect to establishing a presumption of service connection for the toxic exposure and illness, or modifying an existing presumption of service connection, covered by the evaluation.
- The new 38 U.S.C. § 1174 would require VA to commence issuing regulations if the Secretary determines, based on a recommendation under § 1173, that the presumption or modification is warranted or to notify the public that the presumption or modification is not warranted. If VA removed a presumption, Veterans and other beneficiaries who were receiving benefits based on that presumption would continue to receive such benefits.
  - The new 38 U.S.C. § 1175 would allow VA to modify the process under which it conducts formal evaluations under § 1173 and issues regulations under § 1174.
    - VA would have to ensure the new evaluations cover the evidence, data and factors required by § 1173(b).
    - VA would have to notify Congress and wait 180 days before implementing such changes.
    - VA also would have to seek to enter into an agreement with a non-governmental entity or a Federally funded research and development center to conduct a review of the implementation of this subchapter.
  - The new 38 U.S.C. § 1167 would require VA, whenever a law, regulation or Federal court decision established or modified a presumption of service connection, to identify all previously denied claims that were submitted to VA that might have been decided differently had the presumption been in effect at the time of the application.
    - VA would have to allow for the re-evaluation of such claims at the election of the Veteran.
    - Notwithstanding 38 U.S.C. § 5110, VA would have to provide compensation with respect to claims approved pursuant to such re-evaluation based on the date of the submission of the original claim.
    - VA also would have to conduct outreach to inform relevant Veterans they may elect to have a claim re-evaluated under this authority.
    - This section would apply to presumptions of service-connection established or modified on or after the date of enactment.

Title II also would amend 38 U.S.C. § 1116 to require VA to ensure that any determination made on or after the date of enactment regarding a presumption of

service connection based on exposure to an herbicide agent under this section would be made pursuant to the new authorities described previously.

In addition, title II would require VA to submit to Congress:

- Not less frequently than annually, a publicly available report on recommendations for research and any recommendations for legislative or administrative action from the Committee established under § 1172; VA would have to submit a publicly available report on the findings and opinions of VA with respect to the Committee's report.
- Within 2 years of enactment, a report on the implementation of, and recommendations for, the new §§ 1171-1175. On a quarterly basis during the 2-year period beginning on the date of enactment, VA would have to provide to Congress a briefing on the implementation of these provisions.
- Within 540 days of enactment, a report containing the review by the non-governmental entity or Federally funded research and development center on the implementation of the new §§ 1171-1175.

*Impact on Care and Benefits*

As the President said in the State of the Union earlier this month, VA already is pioneering new ways of linking toxic exposures to diseases, thus helping more Veterans receive their benefits. Based on a focused review of scientific and medical evidence related to exposure to fine particulate matter and the subsequent development of rare respiratory cancers, VA recently announced its intention to initiate rulemaking that would consider adding presumptions of service connection for several rare respiratory cancers for certain Veterans. This announcement follows VA's rulemaking action last year establishing a presumption of service connection for three chronic respiratory conditions, including asthma, rhinitis and sinusitis.

We appreciate that the bill, as passed, includes changes made in collaboration between VA and the House Committee on Veterans' Affairs. For example, removal of the Science Review Board and Working Group on presumptions of service connection would allow VA to implement an efficient, science-driven process. We are concerned, though, that the creation of a new Committee, particularly one subject to the Federal Advisory Committee Act, would likely slow existing mechanisms for proposing and conducting research.

Rather than using an advisory committee that would create significant administrative burdens and slow down the presumptive decision-making process, we recommend Congress consider requiring VA to publish in the Federal Register an annual list of conditions the Department plans to evaluate under VA's presumptive decision model, explain why the conditions were chosen for evaluation and seek input from the public on that list. This approach would enable transparency, intentionality and allow for public participation. It also would allow for a timelier decision-making process. We further recommend that Congress establish clear effective dates indicating when the proposed changes would take effect. VA recommends that sufficient time be given to allow it to implement this authority based on a variety of factors, including the regulatory

development and public comment process, as well as the significant implementation requirements and dependencies (such as staffing and resources) associated with the bill as a whole.

We also are concerned that the current bill text is ambiguous, notwithstanding the four “strength of evidence” categories listed in proposed § 1173, as to when a presumption is warranted. It remains unclear whether Congress intends for the Secretary to adopt the recommendations from the bill’s proposed process as a matter of course. If Congress intends to allow VA to determine the applicable standards for creating a presumption, it would be helpful to make that clear and to provide specific guidelines for when VA must create or modify these presumptions. For example, if the strength of evidence for a particular condition falls in the category of “equipoise and above,” it is unclear whether the Secretary would be required to establish a presumption or if the Secretary would have discretion in those instances. If Congress intends any specific, triggering standards governing these determinations, it would be helpful to clarify such standards in the bill. The court orders in the long-standing, complex class action litigation in *Nehmer v. U.S. Dep’t of Veterans Affairs (Nehmer)* were based on a finding that, in creating presumptions based on herbicide agent exposure, VA applied standards inconsistent with Congressional intent. It would be helpful for the Committee to clarify Congressional intent on this point to avoid similar consequences with respect to this bill.

The new § 1167 would impose a *Nehmer*-type effective date mechanism for new presumptions. We want to be clear to the Committee, though, that applying a *Nehmer*-like retroactive effective date provision in this instance would create a significant exception to the legal structure governing Veterans’ benefits. Applying this standard makes it difficult to predict the consequences of this type of effective date provision. VA would be required to apply the provision in this new authority not only to the presumptions created in this bill but also to any future presumptions created by regulation, statute or court order. This requirement would present extraordinary workload challenges to the agency and unprecedented delays in the delivery of benefits to Veterans. For example, every previously denied claim for any of the presumptive conditions identified in or contemplated by this bill (out of the nearly 3.5 million Gulf War-deployed Veterans) would now be subject to a retroactive effective date as far back as 1991 for Gulf War I Veterans and 2001 for Global War on Terrorism Veterans.

We would welcome the opportunity to work with Congress to ensure that new authorities in this area support our ongoing work to help us make informed decisions as quickly as possible.

#### *Costs and Resources*

VA is concerned that an extremely large and unprecedented disability claims backlog would be created if the *Nehmer*-like provisions in this bill are retained. Based on VA’s previous experience in implementing similar retroactive effective date provisions, we understand this provision would result in complex and time-intensive claims processing procedures. In this case, claims processors would be required to review 20 to 30 years

of evidence for a single issue. Considering that more than 1.9 million Gulf War-era deployed Veterans have filed disability claims in the past 30 years (over 900,000 of whom filed claims for respiratory issues), VA is very concerned about the impact of this provision. VA claims processors would be required to re-adjudicate hundreds of thousands of previously denied claims for earlier effective dates. Estimates from VA's initial technical assistance, without this provision, demonstrated a potential backlog increase to 1.5 and 1.8 million claims by the end of fiscal year (FY) 2023. Any further application of retroactive presumptions would drive further benefit delivery delays for all Veterans.

#### *Research*

Title II would establish a new Committee and institute new processes related to the identification of and support for research related to toxic exposures. As noted previously, we are concerned some of the specific provisions in this title would prove more onerous and less nimble than our current approach.

### **Title III: Improving the Establishment of Service Connection Process for Toxic-Exposed Veterans**

#### *Summary*

Title III, called the Veterans Burn Pits Exposure Recognition Act, would add two new sections in chapter 11 of title 38, U.S.C.:

- A new 38 U.S.C. § 1119, dealing with presumptions of toxic exposure, would provide that if a Veteran submitted to VA a claim for compensation for a service-connected disability under § 1110 with evidence of a disability and a toxic exposure that occurred during active service, VA could, in adjudicating such claim, consider any record of the Veteran in an exposure tracking record system and, if no record of the Veteran in an exposure tracking record system indicated the Veteran was subject to a toxic exposure during active service, the totality of the circumstances of the Veteran's service.
  - VA would, for purposes of § 1110 and VA health care, presume that any covered Veteran was exposed to the substances, chemicals and airborne hazards identified by VA during the service of the covered Veteran unless there was affirmative evidence to establish that the covered Veteran was not exposed to any such substances, chemicals or hazards.
  - VA would establish and maintain a list that contained an identification of one or more such substances, chemicals or hazards as VA, in collaboration with DoD, determined appropriate for purposes of this section.
  - This section would define the term "covered Veteran," as described in our previous summary of title I.
- A new 38 U.S.C. § 1168 generally would require that, if a Veteran submitted a claim for compensation for a service-connected disability with evidence of a disability and evidence of participation in a toxic exposure risk activity during

active service, and such evidence were insufficient to establish service connection for the disability, then VA would have to provide the Veteran with a medical examination under § 5103A(d) and obtain a medical opinion (to be requested by VA in connection with this medical examination) as to whether it is at least as likely as not that there is a nexus between the disability and the toxic exposure risk activity.

- In providing VA with a medical opinion, the health care provider would have to consider the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran.
- These requirements would not apply if VA determined there was no indication of an association between the disability claimed by the Veteran and the toxic exposure risk activity for which the Veteran submitted evidence.

In addition, title III would require VA to submit to Congress a biennial report identifying any additions to, or removals from, the list that identifies one or more substances, chemical, or airborne hazards as VA, in collaboration with DoD, may determine appropriate for purposes of eligibility of covered Veterans under the new § 1119.

#### *Impact on Care and Benefits*

Title III would adopt a policy for presumptions based on the period and place of service. We believe this approach is better than identifying a list of chemicals and substances, which often are difficult to measure or document the presence of, at the individual level. There are times when the scientific evidence demonstrates that a particular population was exposed to toxic levels of specific substances. VA relied on this evidence in presuming or conceding exposure to fine particulate matter in 38 C.F.R. § 3.320. But given the period of time involved—more than 30 years in parts of the Southwest Asia Theater of Operations (SWATO)—and the different locations involved, it would be extremely difficult to accurately measure and estimate all hazardous exposures for this population.

VA has taken extensive efforts to identify potential exposure to a wide range of toxins for deployed Veterans based on locations. VA is tracking over 3 million Veterans who were deployed to Southwest Asia and other locations and regularly analyzes claims activities and trends for such Veterans. For a specific example, VA is studying health outcomes and disability claims activities for the nearly 16,000 Veterans who served at Karshi-Khanabad (K2) Air Base in Uzbekistan from October 2001 to November 2005. There have been concerns over several potential exposures related to service at K2, and VA will continue to seek information on K2 exposure opportunities. For purposes of compensation benefits, VA already concedes exposure to airborne hazards if a Veteran indicates exposure to burn pits and records show service in the SWATO. In fact, of the locations identified in this title, the only one of concern is the Philippines, which does not have the same respiratory particulate profile known to cause certain lung diseases. As written, the bill would provide VA the flexibility to establish and maintain a list that contains identification of one or more substances, chemicals or airborne hazards as VA,

in collaboration with DoD, may determine appropriate. Allowing VA to establish and maintain this list would allow VA to make decisions based on scientific evidence; however, Congress may wish to make further clarifications to this provision. We have drafted language we are sharing in the Appendix on this provision for your consideration. This proposed change would remove any reference to a list of substances and chemicals but would still inherently consider and recognize the general hazards that are present in locations where Service members are deployed and would not result in the future establishment of service connection for conditions that may have no relationship to military service.

Regarding the proposed nexus examinations, current law requires such examinations only when necessary to make a decision on a claim. While VA would establish and maintain a list of identified substances, chemicals and airborne hazards, there is no way for examiners to measure the total potential exposure to a specific chemical, including the precise level of exposure or the duration of exposure. Therefore, attempting to determine the synergistic effects from exposures that are not well-characterized or have limited data would inevitably lead to a response from examiners that any opinion would be mere speculation. This outcome would likely result in delay in resolving appeals based on current caselaw.

Veterans who become eligible for benefits under the presumptions established under title III would also become eligible for health care benefits, as noted in our discussion of title I.

#### *Costs and Resources*

Title III and Title IV have the potential to have a significant impact on VA's claims processing system. VA would need additional mandatory funding appropriated to issue benefits payments for new presumptions of service connection for Veterans. VA also would need additional discretionary funds to support human resources management activities, including hiring, onboarding and training new staff, as well as to support costs related to these new employees. Further funding would be needed for outreach and vendor support. VA likely would need additional claims processing resources such as field support staff (including quality review teams, supervisors, analysts and human resources liaisons), systems and staff to identify an increased volume of requests (inbound calls, public contact team interviews, AskVA submissions for Intent to File claims status and general questions, and additional call center agents and other public contact staff at all regional offices), and more staff in VA Central Office to support training, administration and oversight. Technical resources to expand training administration and capacity, along with additional information technology (IT) equipment and bandwidth, also would be needed.

We further assume that additional claims will result in additional appeals and litigation, which would have resource implications for the Board of Veterans' Appeals and VA's Office of General Counsel, to handle appeals and litigation, respectively, as well as to advise on implementation of these new authorities. For example, we estimate the Office of General Counsel would need an additional 118 full time employee equivalents in



FY 2023, and 57 more in FY 2024 to account for the requirements in this bill as a whole. These personnel needs would require ancillary support through human resources, training, IT and other equipment. We have not consulted with the Court of Appeals for Veterans Claims or the U.S. Court of Appeals for the Federal Circuit, but as these courts hear these appeals, we anticipate they may require additional resources as well. Without these additional resources, resolution of appealed cases pending before the United States Court of Appeals for Veterans Claims and the Federal Circuit would be extended, resulting in further delays in outcomes on Veterans' cases. VA could begin to face sanctions if it was unable to meet all court-imposed litigation deadlines, and VA's ability to provide timely and complete legal support to other programs and initiatives relating to health care and benefits would be impaired.

#### *Research*

This title would not appear to have a significant impact on VA's medical research, although the identification of additional claims data could be used to support further understanding of health needs and conditions in this population. In turn, VA research would help identify the list that VA, in collaboration with DoD, would develop identifying one or more substances, chemicals or hazards for purposes of service connection.

#### **Title IV: Presumptions of Service Connection**

##### *Summary*

Title IV would establish a series of new presumptions of service connection.

- It would add Veterans who participated in the cleanup of Enewetak Atoll, and those who participated in a nuclear response near Palomares, Spain, and Thule Air Force Base, Greenland, to the list of Veterans who participated in a radiation-risk activity.
- It would remove references to specific periods of service in Vietnam and refer instead to an expanded list of locations where a Veteran may have served such that the Veteran would be presumed to have been exposed to certain herbicide agents in service, adding to the Republic of Vietnam the following locations: Thailand (at any U.S. or Royal Thai base); Laos; Cambodia at Mimot or Krek, Kampong Cham Province; Guam; and American Samoa.
- It would add hypertension and monoclonal gammopathy of undetermined significance to the list of presumptions of service connection for diseases associated with exposure to certain herbicide agents.
- It would authorize VA to pay compensation to Persian Gulf Veterans with a qualifying chronic disability that became manifest to any degree at any time.
  - It also would remove the requirement for VA to prescribe by regulation the period of time following service in the SWATO that VA determines is appropriate for presumption of service connection.
  - It would require VA to ensure that, if a Persian Gulf Veteran at a VA medical facility presents with any one symptom associated with Gulf War Illness, VA health care personnel would use a disability benefits questionnaire or successor questionnaire, designed to identify Gulf War

- Illness, in addition to any other diagnostic actions the personnel determine appropriate.
- It would include Afghanistan, Israel, Egypt, Turkey, Syria or Jordan in the SWATO for purposes of the definition of a Persian Gulf Veteran.
  - It would require VA to take such actions as necessary to ensure that VA health care personnel are appropriately trained to effectively carry out this section.
  - It would add a new § 1120 requiring VA to consider certain diseases to have been incurred in or aggravated during active service, notwithstanding that there is no record of evidence of such disease during the period of service.
    - These diseases would include asthma that was diagnosed after service of the covered Veteran, kidney cancer, brain cancer, melanoma, pancreatic cancer, chronic bronchitis, chronic obstructive pulmonary disease, constrictive bronchiolitis or obliterative bronchiolitis, emphysema, granulomatous disease, interstitial lung disease, pleuritis, pulmonary fibrosis, sarcoidosis, chronic sinusitis, chronic rhinitis, glioblastoma, and any other disease for which VA determines, pursuant to regulations, that a presumption of service connection is warranted based on a positive association with a substance, chemical or airborne hazard identified by VA under the new § 1119 as added by title III.
    - It also would include the following cancers of any type: head cancer, neck cancer, respiratory cancer, gastrointestinal cancer, reproductive cancer, lymphoma cancer, and lymphomatic cancer.

In addition, title IV would require VA to submit to Congress an annual report on the actions taken by VA to carry out training for compensation for disabilities occurring in Persian Gulf War Veterans.

*Impact on Care and Benefits*

Hypertension has the potential to significantly impact VA's ability to furnish care and benefits to all generations of Veterans. Hypertension is a common condition, and its prevalence increases with age, even among the general population. Currently, there are conflicting interpretations of the scientific evidence to prove or disprove that hypertension in Vietnam Veterans is due to exposure to Agent Orange rather than other factors (such as age). Creating a universal presumption for hypertension for Vietnam Veterans would result in a significant burden on the system for a diagnosis with conflicted science support its service connection; this would detract from VA's ability to deliver health care and provide benefits to other Veterans with diagnoses requiring more acute attention and with a clearer connection to military service. Based on this increase in workload, VA would need additional resources. Monoclonal gammopathy of undetermined significance is a laboratory finding measuring a protein; it has no known clinical manifestation, and hence, a disability rating could not be determined. The new § 1120 likely would have a significant impact on VA benefits and health care given the number of conditions identified.

Regarding the expansion of eligibility for Vietnam-era Veterans, it would be helpful for Congress to be clear whether it intends for this change to apply prospectively or retroactively for newly covered Veterans who are otherwise *Nehmer* class members. Whenever *Nehmer* applies to an expansion of the presumption of exposure to certain herbicide agents, that expansion becomes more expensive and more administratively complex than it otherwise would be. To provide clarity for Veterans and claim adjudicators, we recommend that Congress include language that either more explicitly addresses the *Nehmer* class of Veterans or includes effective date provisions that either include or exclude those Veterans (depending on Congressional intent).

Another concern with this title is that it would provide that if a Persian Gulf Veteran at a VA medical facility presented with any one symptom associated with Gulf War Illness, VA would have to ensure that providers use a disability benefits questionnaire designed to identify Gulf War Illness, in addition to any other diagnostic actions the personnel determine appropriate. We caution that any one symptom in medicine can have many different causes; we are concerned that this could lead to a harmful misdiagnosis and erroneous treatment recommendations. If the purpose of the questionnaire is for disability claims, we think this would be duplicative and unnecessary; for example, if a Persian Gulf War Veteran presents with one of the symptoms, but that symptom has an identified cause or etiology, completion of the Gulf War disability benefits questionnaire would be duplicative and waste resources that could be used providing examinations for other Veterans with pending claims. If the purpose of the questionnaire is for health care purposes, we recommend changing the name because disability benefits questionnaires are used in the disability medical examination process. There is no single set of criteria that defines Gulf War Illness, and there are collectively about 12 different symptoms. VA is actively studying and establishing a clinical definition of "Gulf War Illness" that would allow VA to evaluate and better monitor disability patterns that may be present in the Gulf War Veteran population. VA is completing its review using Artificial Intelligence/Machine Learning and intense chart reviews, and we hope to have a paper in the near future that may allow for a single case definition.

We believe this title would prematurely extend permanent eligibility to certain qualifying Gulf War disabilities without any apparent scientific justification. Further, VA has repeatedly extended the eligibility period for qualifying disabilities in regulation (see 38 C.F.R. § 3.317) and recently published rulemaking to effectively extend eligibility for 5 more years. We suggest Congress similarly extend eligibility for 5 years while VA continues to evaluate the health of Gulf War Veterans. We also have some concerns with including Veterans who served in Afghanistan, Israel, Egypt, Turkey, Syria or Jordan within the term Persian Gulf War Veteran, as these locations are not considered part of the SWATO.

We note that service connection is not a requirement for enrollment in VA health care, and many Veterans who would be covered under the presumptions established in this title are either already eligible for, or already enrolled in, VA health care. Enrolled Veterans are eligible to receive care for any medically necessary condition, including any of the conditions identified in this title.

*Costs and Resources*

As noted in our discussion of title III, this title could create significant additional demand that would require new staff, additional IT support, additional human resources support and related support services that would require additional appropriations. While this title is more specific as to the new presumptions that would be created, VA is still evaluating the gross impact of these provisions; however, initial estimates indicate VA would need to hire tens of thousands of additional employees, and the disability claims backlog could increase as a result of the provisions in titles II, III and IV between 1.5 million and 1.8 million claims by the end of FY 2023.

*Research*

We have concerns about the scientific basis for several of the presumptions that would be established under this title. For example, evidence does not show that Veterans who participated in the cleanup of Enewetak Atoll, for example, experienced significant radiation dosages or have increased cancer mortality. Similarly, there are at this time no known adverse health outcomes for Veterans who participated in nuclear responses near Palomares, Spain, or Thule, Greenland, as known radiation exposure did not exceed thresholds of concern in either location. Veterans who participated in clean-up operations at either location are still permitted under current regulations to file claims on a direct basis for consideration of service connection.

While current evidence does not support the addition of new presumptions for at least some of the exposures identified in this title, VA is actively engaged in conducting further research to better understand these risks and to determine if a presumption is warranted. For example, VA is monitoring Veterans who participated in the nuclear response near Palomares, Spain, for adverse health outcomes that could be related to radiation exposure.

At present, there is conflicting evidence regarding hypertension and Agent Orange exposure. VA is committed to analyzing the issue of hypertension and currently is reviewing relevant evidence to include the recently-completed Vietnam Era Health Retrospective Observational Study (VE-HEROeS). This VA-sponsored research will complete processes to ensure that findings are supported and accepted by the scientific community. If VA determines there is an association, VA could use its current regulatory authority to establish a presumption.

**Title V: Research Matters***Summary*

Title V contains nearly a dozen sections regarding data analyses and other research related to toxic exposure that would:

- Add a new § 7330D establishing an interagency working group (the Working Group) on toxic exposure research consisting of employees from VA, DoD, Department of Health and Human Services (HHS), Environmental Protection

Agency (EPA) and other Federal entities involved in research activities regarding the health consequences of toxic exposure experienced during active service.

- Require VA to compile and analyze, on a continuous basis, all clinical data that is obtained by VA in connection with health care furnished under § 1710(a)(2)(F) and likely to be scientifically useful in determining whether a positive association exists between the illness of the Veteran and a toxic exposure experienced during service in the Armed Forces. VA would have to ensure the compilation and analysis of this data be conducted and used consistent with the informed consent of the Veteran and in compliance with all applicable Federal law.
- Require VA, not later than 180 days after the date of enactment, to conduct an updated analysis of total and respiratory disease mortality in covered Veterans, an epidemiological study of covered Veterans and a toxicology study to replicate toxic exposures of healthy, young members of the Armed Forces and potentially susceptible members with pre-existing health conditions.
- Require VA to conduct an epidemiological study on the health trends of post-9/11 Veterans.
- Require VA to conduct a study on the incidence of cancer in Veterans to determine trends in the rates of incidence of cancer in Veterans and on available early detection diagnostics to determine the feasibility and advisability of including such diagnostics as part of VA health care.
- Require VA to conduct a study on the feasibility and advisability of furnishing hospital care and medical services to qualifying dependents of Veterans who participated in a toxic exposure risk activity for any illness determined by VA to be connected to such activity carried out by the Veteran, as determined by VA, notwithstanding that there is insufficient medical evidence to conclude that such illness or condition is attributable to such activity.
  - It also would require VA to assess the feasibility and advisability of phasing in the furnishing of such care to qualifying dependents by the decade in which such toxic exposure risk activity occurred, starting with the most recent decade.
  - VA would have to review known cases of toxic exposure on DoD military installations, analyze the liability of DoD in each such case and assess whether DoD should provide care and services relating to such toxic exposures under the TRICARE program.
- Require VA to conduct a study on the health trends of Veterans who participated in activities relating to the Manhattan Project or resided at or near several locations in the county of St. Louis, Missouri, during active service.
- Require VA to enter into an agreement with NASEM for the conduct of a study of Veterans to assess possible relationships between toxic exposures experienced during service in the Armed Forces and mental health outcomes.
- Require the Comptroller General to conduct a study on access and barriers to benefits and services furnished by VA in the U.S. territories.
- Require VA, in coordination with other Federal agencies and others, to establish and maintain a publicly accessible website that would serve as a clearinghouse for the publication of all toxic exposure research carried out or funded by the Executive Branch.

In addition, title V would require VA to submit to Congress:

- A report on the establishment of the Working Group within 1 year of the date of enactment; a report containing the collaborative research activities identified by, and the strategic plan developed by, the Working Group within 2 years of the date of enactment; and an annual report during the 5-year period covered by the strategic plan on the implementation of that plan.
- An annual report containing any data compiled under section 502; an analysis of the data; a description of the types and incidences of illnesses identified by VA; an explanation for the incidence of such illnesses and alternate explanations for the incidence of such illnesses as VA considers reasonable; and a description of VA's views regarding the scientific validity of drawing conclusions from the incidence of such illnesses regarding the existence of a positive association between such illness and a toxic exposure.
- A report within 2 years of enactment on an epidemiological study on the health trends of post-9/11 Veterans.
- A report within 2 years of enactment on the study of incidence of cancer in Veterans and available early detection diagnostics.
- A report within 2 years of enactment on the feasibility and advisability of providing care to qualifying dependents of Veterans who participated in a toxic exposure risk activity.
- A report within 1 year of enactment on the study on the health trends of Veterans who participated in activities relating to the Manhattan Project or resided at or near locations in the county of St. Louis, Missouri.
- A report within 2 years of enactment on the study by NASEM of possible relationships between toxic exposures and mental health outcomes.
- A public report within 1 year of enactment, and biennially thereafter for 8 years, discussing the effect of various different types of jet fuels used by the Armed Forces on the health of individuals.

It also would require the Comptroller General to submit a report to Congress within 1 year of the date of enactment setting forth the results of the study on access and barriers to benefits and services furnished by VA in the U.S. territories.

*Impact on Care and Benefits*

Title V generally would not have a direct impact on the delivery of care and benefits, but the number of reporting requirements contained in this title would require significant time and resources, which could divert attention and other resources from the pursuit of VHA's mission. The studies and research conducted under or supported through this title could inform VA decisions regarding presumptions or evidence-based treatment approaches.

*Costs and Resources*

Some of the requirements in this title would duplicate existing efforts. If these efforts, either currently underway or currently planned, were considered sufficient to meet the requirements of this title, the resource demands on VA would be reduced. We do not

have cost estimates for most of the provisions in this title, but we do estimate the study on cancer rates among Veterans would probably require approximately 20 additional full-time employee equivalents and IT funding of approximately \$12 million. The study on furnishing care to dependents of Veterans who participated in toxic exposure risk activities likely would require significant additional resources given the complexity of the work and the breadth of the requirements (such as reviewing known cases of toxic exposure on DoD installations and assessing DoD's liability in such cases), many of which are outside VA's areas of responsibility or expertise.

#### *Research*

Title V would require additional research and related activities to expand VA's and the public's understanding of the effects of different toxic exposures on the health of Veterans. Several requirements in this title could provide important support or findings. We believe the Toxic Exposure Working Group required by this title and its strategic plan would help advance our understanding of military exposures assessments and help inform care and policy. However, interagency collaboration will be required to ensure other agencies cooperate in forming and providing resources to the group and share their research results as contemplated by the bill.

With appropriate resources, a study on cancer rates among Veterans, conducted on a significant scale, could be very important and of high value to Veterans, VA and the public. We would welcome the Comptroller General's findings regarding barriers to care for Veterans in the U.S. territories, as this could help us engage and support the provision of services to Veterans living in these areas. While VA has robust websites for both its research and development programs and its public health programs, we agree that a website serving as a clearinghouse for toxic exposure research from across the Executive Branch would be beneficial, but we recommend against making the War Related Illness and Injury Study Center responsible for this effort due to the Center's small size. Further, the bill would require VA to coordinate with other Federal agencies, but VA has no authority to ensure that those agencies share the results of their research, which would be needed for a comprehensive clearinghouse.

Several of the other provisions, though, would replicate work already underway by VA researchers. For example, the compilation and analysis of clinical data is currently in progress through large, well-designed epidemiological studies, and the collection and organization of this data has been conducted successfully by VA for more than 30 years. It is possible, in some situations, to use this existing data in combination with other information to draw preliminary conclusions about the possible associations between disease and military toxic exposure. We are concerned that the bill's reporting requirements could risk drawing conclusions when there is inadequate data. VA has also undertaken health surveillance and longitudinal research on the health trends of post-9/11 Veterans. Other provisions, such as the mortality, epidemiological and toxicology studies of covered Veterans, would both duplicate current efforts and impose difficult reporting deadlines on VA (in this case, 180 days). VA is conducting studies to assess potential exposures and mental health outcomes. VA also is conducting an

investigation of the chronic effects of fuel exposure, and we would welcome the opportunity to report on the progress of these and other efforts.

Other provisions would impose requirements on VA where it lacks the scope or expertise to conduct such analyses. For example, the study related to the Manhattan Project would be better performed by NASEM. Similarly, the study on the feasibility and advisability of furnishing care to dependents of Veterans who participated in toxic exposure risk activities would require a national health record and national birth defects registry to explore intergenerational effects of exposures fully, but neither of these exist and would be outside VA's capacity to establish. Moreover, there currently is no science or evidence connecting adverse health outcomes of dependents with Veterans' exposures unless there is direct exposure of the dependents through contaminated water.

#### **Title VI: Improvement of Resources and Training Regarding Toxic-Exposed Veterans**

##### *Summary*

Title VI would be called the Toxic Exposure in the American Military Act, or the TEAM Act. It would include four substantive provisions that would require:

- VA to publish annually, update periodically and share with others a list of resources for toxic-exposed Veterans, their caregivers and their survivors in multiple languages. VA also would be required to develop an outreach program for Veterans on illnesses that may be related to toxic exposure and share both the list of recourses and outreach program with national Veterans Service Organizations and other Veterans groups.
- VA to incorporate a clinical questionnaire to help determine potential toxic exposures during active service as part of the initial screening conducted for an appointment with a VA primary care provider.
- VA to provide to its health care personnel training related to identifying, treating and assessing toxic exposures. Not later than 180 days from enactment, VA would have to ensure the existence of a standard training curriculum for:
  - VA claims processors who review claims for disability benefits relating to service-connected disabilities based on toxic exposure, and
  - Medical providers who conduct examinations and provide opinions pursuant to a new § 1168 (as added by section 303 of the bill), regardless of whether the provider is a VA employee or contractor.
- DoD and VA, no later than 90 days from enactment, to coordinate and establish joint guidelines to be used during training of members of the Armed Forces to increase awareness of the potential risks of toxic exposures and ways to prevent being exposed during combat.

##### *Impact on Care and Benefits*

Title VI generally would not have a direct impact on the delivery of care and benefits, particularly given VA's current efforts in many of these areas. VA strives to inform the public of VA resources through all available and appropriate means. Currently, we reach



out to Veterans and their family members, survivors and caregivers to provide information about military environmental exposures through blog posts, townhalls, radio spots, social media posts, surveys and a very complete VA website covering specific exposure concerns (see <https://www.va.gov/disability/eligibility/hazardous-materials-exposure/>; see also <https://www.publichealth.va.gov/exposures/index.asp>). VA also conducts outreach regarding exposure registry participation and topics related to VA health care for Service members leaving the military during the Transition Assistance Program. We note that it could be unnecessary for VA to develop a separate clinical questionnaire, as DoD has, in collaboration with VA, revised and developed a 24-page Separation Health Assessment to be administered to the Service member upon separation from service that provides extensive self-assessment, medical history (including exposure history), clinical assessment, and physical examination information. This new assessment will go into effect later this year. Further, VA currently is developing a clinical screening tool we believe would satisfy the intent of this provision.

VA remains committed to providing all constituents, including Veterans Service Organizations and other Veterans groups, with timely, accurate, and complete information concerning disability benefits and health care and also is committed to working with the community to improve access to benefits and services. VA currently provides resources to the public in English, Spanish and Tagalog and free assistance to speakers of other languages (see <https://www.va.gov/resources/how-to-get-free-language-assistance-from-va/>). VA welcomes this Committee's ongoing support, along with the support from other Members of Congress, to share important information about military environmental exposures with Veterans, their family members, and the broader public.

VA's public health website provides a number of resources related to toxic exposures for Veterans and their families. Likewise, DoD has public health websites and a number of resources related to toxic exposure outreach and education. VA also is developing a screening tool, the Clinical Reminder for Environmental Military Exposure, to ensure that VA is able to identify deployment-related military environmental exposures (MEE) and offer referrals and resources for providers and patients. In fact, the Centers for Disease Control and Prevention recently selected VA's Health Outcomes Military Exposures' MEE to be placed on its website as "best" training in this topic.

VA strongly endorses training its health care and benefits personnel and has taken recent action to support these efforts even more. Last year, I signed a memorandum mandating all VA providers be trained in military environmental exposures. I also have encouraged non-VA providers who treat Veterans to complete this training, and I have encouraged VA providers and others to download the Exposure Ed App (available at <https://mobile.va.gov/app/exposure-ed>) to support their awareness and understanding of military exposures. While providers outside of public health often have limited time and opportunity to become experts in environmental exposure medicine, these trainings and resources can improve their ability to help identify potential exposures and concerns and refer Veterans to experts for further evaluation and treatment.

#### *Costs and Resources*

Many of the requirements in title VI are already under development or have been implemented. If these efforts, either currently underway or currently planned, were considered sufficient to meet the requirements of this title, the resource demands would be less. We believe additional resources would be needed to support a more comprehensive publication of resources required by this title, but VA is currently taking necessary steps to ensure timely compliance with the requirements of the Veterans and Families Information Act (Pub. L 117-62) and does not anticipate that publication of information in multiple languages would have more than a minimal impact on administrative costs. We do note the joint guidelines from VA and DoD could not be developed within the 90 days permitted under the bill. We believe 180 days would be a more realistic goal. We also anticipate that development and implementation of the required training for claims processors and adjudicators could be accomplished with existing resources and within the specified period. Similarly, VA anticipates that required review of the quality of adjudicated claims can be accomplished with existing resources and within the specified period.

#### *Research*

Title VI would not generally improve or enhance research directly, but many of the efforts VA has already taken consistent with the requirements of this section have been and will continue to be informed by available and appropriate research.

### **Title VII: Registries, Records, and Other Matters**

#### *Summary*

Title VII contains 17 different sections dealing with a range of issues. This title would:

- Require VA to establish and maintain a registry for eligible individuals who may have been exposed to per- and polyfluoroalkyl substances (PFAS) due to the environmental release of aqueous film-forming foam (AFFF) on military installations. VA would have to:
  - Include any information in such registry VA determines necessary to ascertain and monitor the health effects of the exposure of members of the Armed Forces to PFAS associated with AFFF;
  - Develop a public information campaign to inform eligible individuals about the registry and periodically notify them of significant developments; and
  - Coordinate with DoD in carrying out this registry.
- Require VA, in consultation with DoD, to establish and maintain the Fort McClellan Health Registry, provide examinations upon request of such Veterans stationed at Fort McClellan during the specified period and conduct ongoing outreach to individuals listed in the registry.
- Establish a Veterans Toxic Exposures Fund to provide for investment in the delivery of Veterans' health care, research and benefits associated with hazardous exposure in the service.
  - This section would authorize to be appropriated for FY 2023 and each subsequent fiscal year such sum as necessary for any expenses

(including administrative expenses and medical research) incident to the delivery of Veterans' health care and benefits associated with exposure to environmental hazards in service.

- Appropriated amounts would be counted as direct spending under the Congressional Budget and Impoundment Control Act of 1974 and any other Act.
- Amend § 5100 to include a definition of notice, which would mean a communication issued through means (including electronic means) prescribed by VA. Additional amendments would include:
  - Amending § 5104 to allow VA to provide notice of a decision affecting the provision of benefits to claimants electronically if a claimant (or the claimant's representative) elects to receive such notice electronically, with the option to revoke such an election at any time.
  - Requiring VA annually to solicit recommendations from stakeholders on how to improve notice under § 5104 and publish such recommendations on a publicly available website.
  - Amending § 5104B to remove the requirement that decisions be provided in writing; and amending § 7104 to require the Board of Veterans' Appeals to issue notice promptly after reaching a decision on an appeal while allowing VA to provide notice electronically if the claimant (or the claimant's representative) elected to receive such notice electronically., with the option to revoke such an election at any time.
- Authorize to be appropriated to VA \$30 million for FY 2023 to support expected increased claims processing for newly eligible Veterans pursuant to this Act.
- Add a new § 7414 that would provide that certain covenants to not compete when entered into by certain persons applying for direct care provider positions in VHA would have no force or effect with respect to VA's hiring of such persons.
- Amend § 7402 to allow VA to offer appointments in VHA to physicians on a contingent basis and update the physician qualification standards to require completion of a residency leading to Board eligibility in a specialty.
- Add a new section in chapter 63 authorizing VA to provide grants to States to carry out programs that improve outreach and assistance to Veterans and their families to inform them about any benefits and programs for which they may be eligible and facilitate opportunities for such Veterans to receive services in connection with benefits claims.
- Authorize to be appropriated to VA \$150 million for FY 2023 to continue the modernization and expansion of capabilities and capacity of the Veterans Benefits Management System (VBMS) to support expected increased claims processing for newly eligible Veterans pursuant to this Act.
- Require VA, within 180 days of enactment, to take actions necessary to ensure that the burn pit registry may be updated with the cause of death of a deceased registered individual by an individual designated by such deceased registered individual or, if no such individual is designated, an immediate family member of such deceased individual.
- Require VA medical professionals to inform a Veteran of the Airborne Hazards and Open Burn Pit Registry if such Veteran presents at a VA facility for treatment

the Veteran describes as being related or ancillary to exposure to toxic airborne chemicals and fumes caused by open burn pits.

Title VII also would require VA to submit to Congress:

- Within 1 year of enactment, a report on the sources of PFAS on military installations other than AFFF and any recommendations VA has regarding whether to expand eligibility for registry of PFAS exposed individuals.
- Within 2 years of establishment of the PFAS registry, an initial report providing an assessment of the effectiveness of actions taken by VA and DoD to collect and maintain information on the health effects of exposure to PFAS; recommendations to improve the collection and maintenance of such information; and recommendations regarding the most effective and prudent means of addressing the medical needs of eligible individuals with respect to PFAS exposure (using established and previously published epidemiological studies).
  - Within 5 years of submitting this initial report, VA would have to submit to Congress a follow-up report containing an update to the initial report and an assessment of whether and to what degree the content of the PFAS registry is current and scientifically up to date.
- Within 5 years of enactment, and every 5 years thereafter, recommendations for additional chemicals with respect to which individuals exposed to such chemicals should be included in the PFAS registry. VA would have to consult with DoD and EPA in developing this report.
- Annual detailed estimates for expenses incident to the delivery of Veterans' health care and benefits associated with exposure to environmental hazards in service, to be included in President's budget for the applicable fiscal year.
- Annual reports on the grant program established under chapter 63.
- On a quarterly basis, a report on each reported case of burn pit exposure by a covered Veteran during the previous quarter.
- Within 180 days of enactment, and annually thereafter, a report developed in collaboration with DoD detailing information about covered Veterans, including outcomes of their claims for disability compensation, conditions for which they seek treatment, locations of their exposure to open burn pits, illness related to such exposure and the total number who died after seeking care for such related illness. In the first report, VA also would have to include information otherwise required by each report with respect to reported cases of burn pit exposure made between January 1, 1990, and the day before the date of enactment.

Within 180 days of enactment, the Comptroller General would have to submit to Congress a report containing an assessment of the effectiveness of any memorandum of understanding or agreement entered into by VA with respect to the processing of reported cases of burn pit exposure and the coordination of care and provision of health care relating to such cases at VA medical facilities and at non-VA facilities.

Title VII also would create requirements for other Federal entities or establish authorities directly relevant to them, namely:

- It would require DoD, not later than 60 days after the date of enactment, to enter into a contract with an independent research entity to carry out a comprehensive study on ILER.
- It would require DoD, in consultation with VA, to submit to Congress, not later than 1 year after the date on which ILER achieves full operation capability, and every 180 days thereafter, a report on the data quality of the databases of DoD that provide the information presented in ILER and the usefulness of ILER in supporting members of the Armed Forces and Veterans in receiving health care and benefits from DoD and VA.
- It would require DoD, within 1 year of enactment, to submit to Congress a report on the feasibility of modifying ILER to ensure that a member of the National Guard who is deployed in connection with a natural disaster may record information regarding a suspected exposure by the member to toxic substances during such deployment.
- It would require DoD to provide a means for members of the Armed Forces and Veterans to reflect a toxic exposure by such Member or Veteran in ILER.
- It would establish a Federal cause of action allowing individuals (including Veterans), or their legal representatives, who were residing working, or otherwise exposed for not less than 30 days between August 1, 1953, and December 31, 1987, to bring an action in the U.S. District Court for the Eastern District of North Carolina to obtain appropriate relief for harm that was caused by exposure to the water at Camp Lejeune. Any award would be offset by the amount of any disability award, payment or benefit provided to the individual or legal representative under VA's authority or the Medicare or Medicaid programs, and in connection with health care or a disability relating to exposure to the water at Camp Lejeune.
- It would require DoD to conduct a study on the exposure of members of the Armed Forces to herbicide agents, including Agent Orange and Agent Purple, in the Panama Canal Zone between January 1, 1958, and December 31, 1999.
- It would require DoD to include in the budget submission of the President for each of FY 2023 through 2027 a dedicated budget line item for incinerators and waste-to-energy waste disposal alternatives to burn pits.

*Impact on Care and Benefits*

Many of the provisions in title VII would not directly affect the delivery of care and benefits. This title would create or require updates to several registries.

- VA, in concert with our interagency partners, would welcome the opportunity to work with Congress to ensure that new authorities on PFAS support ongoing interagency work to help us make informed decisions as quickly as possible. As would be required in the bill, the registry would not provide sufficient benefits to warrant the expenditure of resources, would require distinguishing occupational exposures from ubiquitous consumer product exposures, and it would also create unreasonable expectations on the part of participants when the science is still developing on health effects from specific PFAS and at what exposure levels. We are already engaging in interagency activities and working with DoD and other

Federal partners, such as the Agency for Toxic Substances Disease Registry and EPA to understand and differentiate occupational exposures through research.

- Regarding the Fort McClellan registry, in the absence of any identified public health risk at that location, there is little to no value in having a registry that will not address the concerns of Veterans who served there. We believe a more fruitful alternative than a self-reported registry (the use of which NASEM discourages) would be a large epidemiological study to assess the health risks of Veterans who served at Fort McClellan. VA already has authority to establish a registry for a specific cohort like this as needed.
- Concerning the provision that would require VA to take actions necessary to ensure that the Airborne Hazards and Open Burn Pit Registry could be updated with the cause of death of a deceased registered individual, VA is working on ways to allow updating of this registry, but we caution that the cause of death should be verified by the VA/DoD Mortality Data Repository, which provides authoritative data on the cause of death. Numerous improvements have been made and will continue to be made to the Registry, but we do not believe it would be appropriate to allow laypersons to enter data that could be erroneous or misunderstood. There are also data security issues that may arise from allowing access by other-than-registry participants.

We appreciate the proposed amendments to § 5100 and would welcome the opportunity to work with the Committee to ensure this provides VA broad authority to provide electronic notification to claimants or their authorized representatives. We recommend that instead of an opt-in method, the bill should provide VA broader authority and flexibility to determine the best means of notifying claimants and their representatives without needing further statutory amendments. We further recommend that the bill's changes to § 7104 be clarified to reflect that the requirements of § 5104(b) do not apply to decisions by the Board of Veterans' Appeals. Absent that clarification, the bill's cross-reference in section 7104 may further misperceptions regarding the notice requirements for such decisions.

We appreciate the provision regarding the non-applicability of non-VA covenants not to compete, as this could help VA consider and appoint more providers. This provision could provide some benefit in addressing the increased demand for care we anticipate would result from this bill. We have some concerns with the provision that would allow residents to be hired as physicians on a contingent basis, as that would conflict with physician qualification standards. We have recommended technical amendments in the appendix that would resolve these concerns.

Concerning the proposed grant program under chapter 63 described previously, VA testified in support of this concept before this Committee last November but asked that Congress adjust some details of the bill.

VA defers to DoD in terms of the impact of the following sections on its delivery of care and benefits to Service members and other beneficiaries:

- Section 703 (Independent study on Individual Longitudinal Exposure Record).
- Section 704 (Biannual report on Individual Longitudinal Exposure Record).
- Section 705 (Correction of exposure records by members of the Armed Forces and Veterans).
- Section 713 (Study and report on herbicide agent exposure in Panama Canal Zone).
- Section 714 (Budget information for alternatives to burn pits).

We do not anticipate these sections would have any direct impact on VA's delivery of care and benefits to its beneficiaries, although it is possible that some of the research or updates DoD performs could provide a basis for expanded eligibility for VA benefits. As noted previously, the number of reporting requirements in this title could affect the delivery of benefits and care by requiring additional administrative resources be available for collection and production of this information. We do note that the National Defense Authorization Act for Fiscal Year 2022 requires the Government Accountability Office to do a biennial study of the Individual Longitudinal Exposure Record, which could duplicate the requirements in this bill; it may be more advisable to change the biannual report on this Record to be a biennial report as well.

VA defers to the Department of Justice on section 706 (Federal cause of action relating to water contamination at Camp Lejeune, North Carolina).

#### *Costs and Resources*

The PFAS registry required in this title, as written, could cost in the billions and affect up to 60 million Veterans and Service members.

We do not believe the proposed funding amounts for VBMS and VA's claims process would be sufficient to cover system modernization and automation needs to address increased claim volumes specific to newly eligible Veterans. We also caution against referring specifically to modernization and expansion of capabilities and capacity of VBMS, as it would constrain VA's ability to develop solutions using the full suite of systems and capabilities available.

The proposed grant program would authorize one additional full-time equivalent employee for the Office of General Counsel between FY 2023 and 2027 to carry out duties under the accreditation, discipline and fees program. It is unclear if this single additional employee would be sufficient to support this program.

VA would require specific IT support and resources for several initiatives under this title, including proposed updates to the Airborne Hazards and Open Burn Pit Registry under section 716 of the bill. Other provisions, like the quarterly reporting requirements under section 717 of the bill, would be resource-intensive and unlikely to improve Veterans' care or add to our understanding of the medical consequences of exposure to airborne hazards. Further, section 717 of the bill would only require reports when the Veteran presents to a VA medical facility and specifically describes that his or her condition is due to burn pits. VA provides benefits and services to Veterans regardless of the basis

on which they are seeking benefits, so we believe that this reporting requirement would grossly undercount the number of Veterans actually affected by burn pits.

*Research*

While many of the provisions in title VII are intended to provide additional data on toxic exposures to aid our understanding of the consequences of such exposures, we do not believe many of these provisions would yield meaningful results and insights. Large, peer-reviewed epidemiological studies are more likely to produce findings that can inform policy on benefits and evidence-based care delivery. Separating the health care and claims-related reporting requirements in this title would ensure that a more comprehensive picture is developed, rather than just reporting claims activity for Veterans who present to VA for health care for treatment related to a burn pit exposure.

**Conclusion**

This concludes my statement. I am happy to answer any questions you or other members of the Committee may have.



**Appendix: Specific Technical Amendments****Section 105: Revision of breast cancer mammography policy of Department of Veterans Affairs to provide mammography screening for Veterans who served in locations associated with toxic exposure**

- We note that proposed section 7322(c) would only refer to “active military, naval, or air service,” but would not include service in the space force . We recommend this be revised for consistency.
- We also note that proposed section 7322(d)(2) refers to the date of the enactment of the Supporting Expanded Review for Veterans In Combat Environments Act of 2021, but no part of this bill would bear that name. We believe the proper reference would be to the COVENANT Act or the Honoring our PACT Act of 2021.

**Section 112: Authorization period for emergency treatment in non-Department of Veterans Affairs medical facilities**

- This section should define “emergency” consistent with the “prudent layperson standard” as set forth in § 1725(f)(1)(B).
- This section should refer to “presentation” to an emergency room, rather than “admission” as some types of emergency care result in treatment on an outpatient basis.
- This section should refer to “an eligible entity or provider” to be consistent with the language in § 1703 generally regarding eligible providers under VCCP.
- This section should refer to notification of VA of emergency care rather than “an application for such authorization,” as VA does not have a formal application process for emergency care authorization.
- This section does not address emergency transportation.

**Section 202: Improvements to ability of Department of Veterans Affairs to establish presumptions of service connection based on toxic exposure**

- The language in proposed § 1172(c)(1) and (d)(1) makes it sound as though dependents will be considered to have active service. We believe the intent is for the dependents to qualify based on the Veteran’s active service.
- VA recommends that Congress establish clear effective dates for when the proposed changes are to take effect. As Congress considers establishing effective dates, VA recommends that sufficient time be given for VA to implement based on a variety of factors including the regulatory development and public comment process, as well as the significant implementation requirements and dependencies involved with the bill, such as staffing and resources.

**Section 302: Presumptions of toxic exposure**

- In new § 1119, VA recommends deleting subsections (b)(2) and (3) and revising subsection (b) to read as follows:

“The Secretary shall, for the purpose of section 1110 and chapter 17 of this title, presume that any covered veteran was exposed to airborne hazards including fine particulate matter during the service of the covered veteran specified in subsection (c)(1), unless there is affirmative evidence to establish that the covered veteran was not exposed to any such airborne hazards in connection with such service.”

- VA recommends omission of the Philippines under proposed § 1119(c)(1)(B)(ix).

Section 403: Presumptions of service connection for diseases associated with exposures to certain herbicide agents for Veterans who served in certain locations

- We recommend that Congress include language that either more explicitly addresses the *Nehmer* class of Veterans or includes effective date provisions that either include or exclude those Veterans (depending on Congressional intent).
- The bill states that “active military, naval, air, or space service” should be struck in each place it appears in § 1116. However, the current version § 1116 does not include references to “space service,” and the bill should instead refer to “active military, naval, or air service.”

Section 501: Coordination by Department of Veterans Affairs of toxic exposure research

- We recommend Congress include language to explicitly state the Secretary would establish the interagency Working Group in collaboration with the Secretaries, Director(s) and heads of other agencies referenced in the Act to ensure interagency collaboration and support for the establishment and activities of the Working Group.
- The term “collaborative research activity” would include all research conducted by an entity represented by a member of the Working Group, funded by the Federal Government, and regarding the health consequences of toxic exposures experienced during active military, naval, air or space service. This scope of collaborative research activities overseen by the Working Group is overly broad. Collaborative research activities should instead mean a research activity “agreed upon by the Working Group and conducted by an entity represented by a member of the Working Group, funded by the Federal Government, and regarding the health consequences of toxic exposures experienced during active military, naval, air, or space service.”
- In section 501(c)(3), “a progress reports” should refer to “a progress report.”

Section 502: Data collection, analysis, and report on treatment of Veterans for illnesses related to toxic exposure

- The term “informed consent” is a legal term of art that is defined in 38 C.F.R. § 17.32, which implements 38 U.S.C. § 7331. Informed consent requirements apply only in connection with a patient’s receipt of VA recommended clinical treatment or procedures, or when a VA research subject undergoes treatment or procedures for research purposes, but that is not the case with data collection.

- In addition, the Clinical Data Warehouse currently provides an organized data mart of virtually every health care encounter delivered or paid for by VHA. In addition, VHA has successfully used these data for decades. No “informed consent” is required, as these data are collected as part of routine care and referred to as “extant” or operational/surveillance data, not research, which appears to have been the drafter’s assumption.
- Moreover, VHA has a long history of surveillance using extant data at the regional and national level. For studies that constitute research involving human subjects, VA follows all Federal human subjects protection regulations and privacy regulations and laws. This procedure is done to ensure any and all human subjects research in VA is done ethically and with protections for Veterans’ privacy.

Section 509: Study on Veterans in territories of the United States

- In section 509(a)(2)(G), it is unclear what the term “continuity of care” means in this specific context. We recommend deletion of the last phrase in this subparagraph.
- We also recommend the Comptroller General review include Veterans who reside in the Freely Associated States, as their citizens can participate in the Armed Forces.

Section 603: Incorporation of toxic exposure questionnaire during primary care appointments

- We previously provided technical assistance to the Committee on a similar provision the Committee incorporated in section 3 of the Health Care for Burn Pit Veterans Act. We appreciate the Committee’s work and recommend that language be adopted instead.

Section 708: Authorization of electronic notice in claims under laws administered by the Secretary of Veterans Affairs

- VA proposes replacing the language in § 5104(c) with the following:  
 “[t]he Secretary may provide notice under subsection (a) through available means in writing, to include electronically”.
- VA recommends amending paragraph (6) and adding a new paragraph (8) as follows:  
 (6) In section 7105A:  
     (A) in subsection (a) by:  
         (i) striking “mailed” and inserting “issued”, and  
         (ii) striking the phrase “at the last known address of the action taken” and  
     (B) in paragraph (b)(2) by striking the phrase “the last known address of record of.”

(8) In section 5112(b)(6) by striking the phrase “(at the payee’s last address of record).”

- VA recommends that the bill’s changes to § 7104 be clarified to reflect that the requirements of § 5104(b) do not apply to Board of Veterans’ Appeals (Board) decisions. Absent that clarification, the bill’s cross-reference in § 7104 may further misperceptions regarding the notice requirements for Board decisions.

Section 711: Recruitment of physicians on a contingent basis prior to completion of training requirements

- VA recommends the proposed subsection (h) of § 7414 read as follows:

“(h) The Secretary may provide job offers to physicians pending completion of residency training programs and completing the requirements for appointments under subsection (b) by not later than 2 years after the date of the job offer.”

Section 717: Burn pit transparency

- Regarding subsection (b)(1)(B)(ii)(IV), VA generally would not be able to provide accurate information on non-VA health care furnished to a covered Veteran unless that care had been authorized or paid for by VA.
- Regarding subsection (b)(1)(B)(ii)(V), there is no reason to believe that the rank of the covered Veteran would have a bearing on their care.
- Regarding subsection (b)(1)(B)(ii)(VII), we do not believe that burn pit location information can be reported reliably by VA.
- Regarding subsection (b)(2)(A), this would require VA collaborate with DoD in reporting this information, but we do not believe this interaction would be necessary or provide much additional value.
- Regarding subsection (b)(4), the Comptroller General report would require an assessment of the effectiveness of any memorandum of understanding or agreement entered into by VA with respect to the processing of reported cases of burn pit exposures and the coordination of care and provision of health care relating to cases of burn pit exposure at VA medical facilities and non-VA facilities. It is not clear that this assessment would address an actual need.

- VA suggests creating different definitions of the term “covered Veteran” for the purposes of health care and claims data. The following definition is suggested for disability claims reporting:

“For the purpose of disability compensation claims reporting, the term “covered veteran” means “a veteran who deployed to the Southwest Asia theater of operations any time after August 1990, or to Afghanistan, Syria, Djibouti or Uzbekistan after September 19, 2001, and who submits a claim for disability compensation under chapter 11 of title 38, United States Code.”



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**STATEMENT OF  
 SHANE L. LIERMANN  
 DEPUTY NATIONAL LEGISLATIVE DIRECTOR  
 OF THE DISABLED AMERICAN VETERANS  
 FOR THE SENATE COMMITTEE ON VETERANS' AFFAIRS  
 MARCH 29, 2022**

Chairman Tester, Ranking Member Moran, and Members of the Committee:

On behalf of DAV's (Disabled American Veterans) more than 1 million members, thank you for inviting us to provide testimony for the Senate Veterans' Affairs Committee hearing on the impact of the Honoring our Promise to Address Comprehensive Toxics Act of 2021 (PACT) on veterans and Department of Veterans Affairs (VA) operations.

It is poignant that today, March 29, on National Vietnam War Veterans Day, we are discussing toxic exposure legislation that will impact veterans exposed to Agent Orange. DAV strongly supports the Honoring Our PACT Act and we recognize the service and sacrifices of Vietnam veterans their families and survivors.

Mr. Chairman, we are at the precipice of a monumental event, solving the puzzle of comprehensive toxic exposure legislation for past, current and future generations of veterans exposed to environmental hazards. Collectively, we must act now as too many veterans are suffering from life-threatening illnesses, struggling with access to VA health care and benefits, and unsuccessfully navigating complex and uncaring exposure and presumptive processes.

That is why today's hearing on the Honoring Our PACT Act is so important. Our testimony will address toxic exposures' toll on veterans and their families, the timelines of previous toxic exposure legislation and actions, our recommendations to strengthen the Honoring Our PACT Act and our suggestions for VA to mitigate the increased workloads.

**THE TOLL ON VETERANS AND THEIR FAMILIES**

To fulfill DAV's service mission to America's injured and ill veterans and the families who care for them, DAV directly employs a corps of National Service Officers (NSOs), all of whom are themselves wartime service-connected disabled veterans, at VA regional offices (VARO) as well as other VA facilities throughout the nation. As DAV represents more than 1 million veterans and family members, we are unmistakably aware that the toll toxic exposures have had on veterans, their health, their livelihood and families, is incalculable. Below are two examples of veterans DAV represented from

two different generations, but both of whom faced great difficulty proving their toxic exposure claims for benefits.

### **Burn Pits**

Ashley McNorrill served the United States Army as a JAG Officer and in 2005 deployed to Iraq and was assigned to Camp Victory in Baghdad. Ashley and husband David had married in 2008. Not long after, they looked to expand their family, but Ashley found herself experiencing unexplained pain and fertility problems.

In 2011, Ms. McNorrill was beginning to have severe pains in her abdomen and on her right side under her rib cage. The cause was initially thought to be endometriosis, a relatively common health condition among women that causes uterine tissue to grow outside the uterus. Doctors recommended she undergo a hysterectomy. The McNorrills then pursued adoption as a path to parenthood, and on December 2, 2011, they welcomed newborn twin boys, Cole and Fletcher, to their family.

In February 2012, when the twins were only 2 months old, Ms. McNorrill went in for a hysterectomy. During the procedure, doctors found evidence of cancer. She was ultimately diagnosed with stage 4 appendiceal cancer, a rare form of the disease occurring in only one or two cases out of 1 million.

A fellow veteran advised her to investigate toxic exposures from burn pits like the large one at Camp Victory. In 2014, the McNorrills met with a DAV National Service Officer in South Carolina to find out what options were available. It had been two years since she had become ill, and her condition was worsening. With medical bills adding up and their young children requiring care, the family was struggling financially.

DAV proceeded to piece together Ms. McNorrill's VA disability claim, pulling together evidence from her deployment to Camp Victory and providing Ashley and doctors a list of toxins from burn pits that VA no longer has posted on its website and can only be found in its Adjudication Manual.

In her claim, she noted, "there was a burn pit just a few feet across from the [dining facility], and I remember that oftentimes, while [I was] waiting in line, someone would be manning the burn pit for hours, burning whatever it was they were burning." With DAV's assistance in formulating a request for medical opinion, she was able to obtain a private medical opinion linking her appendiceal cancer to the toxins emitted from the burn pit at Camp Victory.

After a lengthy claims and appeals process, VA ultimately granted service connection for her cancer and established a permanent and total VA disability rating. Shortly after receiving her decision, in March 2016, Ms. McNorrill died due to the cancer, leaving behind her husband to raise their two boys alone.

**Agent Orange**

Theodore Kalagian, of Tennessee, honorably served the United States Army in Vietnam and was discharged in 1973. When he reached out to DAV in 2014, Mr. Kalagian was struggling with his multiple diseases related to Agent Orange and facing a reduction in his benefits.

Mr. Kalagian filed a claim for bladder cancer due to Agent Orange in 2007 and VA denied it quickly as it was not a presumptive disease. He later developed diabetes mellitus, ischemic heart disease, and hypertension. VA also denied his hypertension as it is not a recognized presumptive disease. In 2014, when he reached out to DAV, VA was proposing to reduce the rating for the severity of his ischemic heart disease. With DAV's assistance he was able to maintain his benefits. In 2017, the veteran again filed a claim for his bladder cancer, was denied, and filed a Supplemental Claim. During this time, he developed prostate cancer, another presumptive disease for Agent Orange. With DAV assistance, his claim for prostate cancer was subsequently granted.

Right now, this Vietnam veteran is faced with two cancers, ischemic heart disease and diabetes, all due to his Agent Orange exposure. In addition he has hypertension, which VA has refused to acknowledge as a presumptive disease to Agent Orange, although it has the highest level of positive scientific association.

These veterans and thousands like them, have been suffering far too long without their earned benefits and access to VA health care. Unfortunately, given the history of military toxic exposures and our country's often excessively slow reactions, it has become necessary to use presumptions to ensure we provide justice to veterans and their families. But even the process of creating presumptions has taken far too long, demonstrating the need to adopt comprehensive legislation and a new framework now.

**TIME IS NOT ON VETERANS' SIDE**

Even prior to World War I, veterans have been exposed to hazardous environments. We must revisit these exposures and the time it took our nation to react so that we do not continue to repeat these tragedies and truly appreciate the moment we have before us.

**Mustard Gas and Lewisite**

During World War II (WWII), both the Axis and Allies produced millions of tons of chemical weapons and had made massive preparations for their use. The U.S. established secret research programs to develop better chemical and toxic weapons and better methods of protecting against these poisons. At the end of WWII, over 60,000 U.S. service members had been used as human test subjects. At least 4,000 of these active military service members had participated in tests conducted with high concentrations of mustard agents or Lewisite in gas chambers or in field exercises over contaminated ground areas.



Not until 1991, over **70 years** after mustard gas use in WWI and over **50 years** after the secret testing in WWII, did the VA provide guidelines for establishing claims related to these exposures.

### **Radiation Exposure**

Some of the first atomic veterans were service members who were sent to Hiroshima and Nagasaki to assist in clean-up. Approximately 255,000 troops were involved in the occupation of Hiroshima and Nagasaki. From 1946 to 1962, the United States conducted about 200 atmospheric nuclear tests. Approximately 400,000 service members were present during these atmospheric tests, whether as witnesses to the tests themselves or as post-test cleanup crews. Sworn to secrecy, many of these service members never told anyone about what they witnessed. If they told anyone that they were involved in these nuclear tests, they could have been fined up to \$10,000 and tried for treason.

On October 24, 1984, **nearly 40 years** after the exposure, the Veterans' Dioxin and Radiation Exposure Compensation Standards Act was enacted to ensure compensation to veterans and their survivors for disabilities or deaths related to exposure to ionizing radiation during atmospheric nuclear testing or the occupation of Hiroshima and Nagasaki. In May 1988, new statutory provisions expanded compensation on a presumptive basis for other radiation-exposed veterans who developed specific diseases, over **25 years** after the last exposures from the atmospheric testing.

However, not all veterans who have been exposed to radiation in the line of duty have the same recognition. That's why the Honoring Our PACT Act would expand the recognized radiation-risk activities for those veterans who participated in cleanup operations at Palomares, Spain and Thule, Greenland, nearly **60 years** after exposure and Eniwetok Atoll, **40 years** after the exposure.

### **Agent Orange**

The U.S. program, code-named Operation Ranch Hand, sprayed more than 20 million gallons of various herbicides over Vietnam, Cambodia and Laos from 1961 to 1971. At the time of the spraying, 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD), the most toxic form of dioxin, was an unintended contaminant generated during the production of 2,4,5-T and so was present in the herbicide known as Agent Orange.

After their service, many Vietnam veterans were developing multiple illnesses and fatal diseases. It was not until the Veterans' Dioxin and Radiation Exposure Compensation Standards Act of 1984 that VA recognized presumptive service connection for an illness related to Agent Orange. In 1991, the Agent Orange Act became public law, **nearly 30 years** after the use of Agent Orange began and 20 years after the end of spraying.

Unfortunately, not all of the harmful diseases resulting from Agent Orange exposure nor all the locations of exposures have been covered yet. The Honoring Our PACT Act would add hypertension and monoclonal gammopathy of undetermined significance (MGUS) as presumptive diseases. Including hypertension is an immensely vital provision. This is in concurrence with the National Academies of Science, Engineering and Medicine report of 2018 that assigns the highest level of positive association between hypertension and Agent Orange exposure.

Veterans exposed to Agent Orange have an increased risk of developing hypertension more so than veterans not exposed and more so than the civilian population. Studies have shown that Agent Orange exposed veterans develop hypertension at an earlier age, at a higher rate and at a more serious degree than those not exposed. Plainly speaking, these veterans are placed at an increased risk of negative health impacts and death due to hypertension than those never exposed.

Additionally, the bill would expand conceded Agent Orange exposure in Thailand, Laos, Cambodia, Guam, American Samoa and Johnston Atoll. All of these actions would come **over 50 years** after the first exposures.

#### **Contaminated Water at Camp Lejeune**

From the 1950s through the 1980s, people living or working at the U.S. Marine Corps Base Camp Lejeune, North Carolina, were exposed to drinking water contaminated with industrial solvents, benzene, and other chemicals. The Caring for Camp Lejeune Families Act of 2012 recognized exposure and treatment for veterans and family members for 15 specific diseases.

In 2017, by regulation, the VA Secretary established eight presumptive diseases for active duty, reservists, and National Guard members who were stationed at Camp Lejeune for 30 aggregate days. These presumptives were established **over 60 years** from the first date of exposure and **30 years** after the date of last exposure. But just last year we learned of contaminated water in Hawaii; how long will those exposed veterans have to wait?

#### **Airborne Hazards, Open Burn Pits and Particulate Matter**

Veterans who served in Southwest Asia during the first Persian Gulf War as well as those serving in those locations, including Afghanistan after 9/11, have been exposed to the large scale use of burn pits. DOD has performed air sampling at Joint Base Balad, Iraq and Camp Lemonier, Djibouti. The air sampling performed at Balad and discussed in an unclassified 2008 assessment tested and detected all of the following: (1) Particulate matter; (2) Polycyclic Aromatic Hydrocarbons (PAH); (3) Volatile Organic Compounds; and (4) Toxic Organic Halogenated Dioxins and Furans (dioxins).

In August 2021, the VA announced three presumptive diseases, sinusitis and rhinitis, due to exposure to particulate matter. This includes veterans who served in the Southwest Asia theater of operations beginning August 2, 1990, to the present; or Afghanistan, Uzbekistan, Syria, or Djibouti beginning September 19, 2001, to the present. While VA has announced new presumptive diseases to be added, it still has been **over 30 years** since the Persian Gulf War and **over 20 years** since Afghanistan and almost **20 years** since the start of Operation Iraqi Freedom.

VA has recently announced the addition of nine new presumptive diseases for particulate matter exposure. These rare cancers of the respiratory systems are a welcome addition and we look forward to VA considering new diseases in the near future.

Unfortunately, there are many other generations of veterans who still have not had their exposures recognized and received access to VA health care or benefits, based on their exposures. We shall never forget the veterans who served at Fort McClellan, those exposed to lethal toxins in Uzbekistan, those who participated in radiation-risk activities, and those exposed to per-and polyfluoroalkyl substances (PFAS) at over 600 military installations.

As a nation, we have responded too slowly to provide health care and benefits for previous and current veterans. We have the opportunity now and we must get it right for the past, current and future generations of veterans exposed to toxins. We must get it correct, but, time is not on veterans' side, we need everyone committed to solve the puzzle and concentrate on the most comprehensive toxic exposure legislation that is before us. In comparison to the previous veteran exposures and our actions today, how will this historic moment be remembered?

#### **THE HONORING OUR PACT ACT**

DAV supports H.R. 3967, the Honoring Our PACT Act, which passed the House on March 3, 2022. It is the most comprehensive toxic exposure bill ever voted out of the House. We thank the Committee for all of the individual bipartisan toxic exposure bills that created the COST of War Act. All of these tremendous efforts led to it being reported out by the Committee.

An estimated 3.5 million veterans have been exposed to burn pits and even more have been exposed to Agent Orange, radiation, and contaminated water. Many are struggling without access to VA health care and benefits, the Honoring Our PACT Act addresses many of those issues. This bill would:

- Provide health care based on toxic exposures;
- Add 23 burn pit and toxic exposure-related diseases;
- Add hypertension as a presumptive disease associated with Agent Orange exposure;
- Concede exposure to burn pits and toxic environments;

- Provide a new framework for establishing presumptive diseases in the future;
- Expand radiation-risk activities to include veterans who participated in radiation cleanup at Enewetak Atoll, Palomares, Spain and Thule, Greenland as radiation-exposed veterans;
- Include Thailand, Cambodia, Laos, Guam, American Samoa and Johnston Atoll as conceded locations for Agent Orange Exposure; and
- Require registries for veterans who served at Ft. McClellan and for those exposed to PFAS chemicals.

DAV acknowledges this critical juncture and the need for expeditious actions; however, we are committed to getting this correct for today's and tomorrow's veterans. Therefore, we are providing the following recommendations to strengthen certain sections of the current legislative offering.

#### **Access to VA Health Care**

We applaud section 103, expansion of health care for specific categories of toxic-exposed veterans and veterans supporting certain overseas contingency operations. It aims to provide priority group 6 health care for toxic-exposed veterans. DAV has been advocating for years for the expansion of health care eligibility for combat veterans from five to 10 years. We are very appreciative of the inclusion of section 111, expansion of period of eligibility for health care for certain veterans of combat service.

However, section 103, as presented, will have a 10-year complete phase-in period based on periods of service, while section 111 will provide additional eligibility and a one-year open enrollment for those outside of the expansion from five to 10 years, we are concerned that there will be gaps where exposed veterans will find themselves. We understand that these provisions were included to mitigate the volume of new enrollees to not overwhelm the resources of the Veterans Health Administration (VHA). Veterans with serious life-threatening conditions should have immediate access to VHA.

We recommend the health care access requirements as noted in S. 927, the Toxic Exposure in the American Military or TEAM Act. It would provide immediate parity for toxic and burn pit exposed veterans with the same eligibility for veterans exposed to Agent Orange, radiation and the hazards in the Persian Gulf as noted in title 38, United States Code, § 1710.

#### **Formal Advisory Committee on Toxic Exposure**

DAV agrees with the addition of a formal advisory committee to assist with determining exposures and potential presumptive diseases, as noted in section 202, improvements to ability of Department of Veterans Affairs to establish presumptions of service connection based on toxic exposure. This section does not include an independent scientific panel or an independent stakeholder advisory committee.

The TEAM Act includes a separate scientific review entity and we prefer those concepts. Veterans should not rely solely on VA or other federal agencies for scientific reviews. Independent agencies or groups, to include the National Academies of Science, Engineering and Medicine and similar entities should be included in any medical or scientific evaluations. We recommend the inclusion of an independent scientific review contingency.

#### **Acknowledgement of exposure to toxins**

We are pleased to see the addition of several provisions from the Veterans Burn Pits Exposure Recognition Act (S. 437, H.R. 2436.). This will greatly aid veterans in establishing direct service connection if their specific diseases or condition is not listed as a presumptive disease. However, we have concerns that the list of 50 toxins associated with burn pit exposure that VA already accepts as noted in their fact sheet to examiners, were excluded from the Honoring Our PACT Act, section 302.

The provisions states that the Secretary shall establish and maintain a list that contains an identification of one or more such substances, chemicals, and airborne hazards as the Secretary, in collaboration with the Secretary of Defense, may determine appropriate. We adamantly believe there must be an accepted list of toxins for them to work from and not solely rely on the VA's decision on toxins. Again, they already have accepted a list of 50 toxins.

DAV fully supports the Honoring Our PACT Act and our recommendations to strengthen this critical legislation. We cannot afford further delays for the men and women subjected to toxins and environmental hazards. This legislation would increase the number of claims submitted to VA; however, there are several authorities and steps that VA could implement to mitigate the increased workload and not further delay entitlement to the benefits these men and women have earned.

#### **MITIGATING THE INCREASED WORKLOAD**

DAV appreciates that comprehensive toxic legislation including health care and benefits, will increase the workload within VHA and VBA. Instead of limiting the legislation for those concerns, we must be focused on solutions to mitigating the increase in claims and health care. VBA currently has several authorities or policies in place that can be used to address incoming claims quickly. We suggest VBA develop a plan now that considers the following offered mitigation strategies:

- **Establish a unique End Product code for all new presumptives added by new toxic exposure legislation.** This will allow VBA to track all new presumptive cases and to facilitate their adjudication through the National Work Queue or to a new triage unit; and
- **Implement a Triage Unit to address presumptives directly.** VBA can establish a quick response triage unit that is responsible for granting any incoming claims

possible without development. Any claims that cannot be granted by the triage unit can be deferred for additional development to include VA examinations. Claims granted by the triage unit would move automatically to authorization to formally grant benefits and access to VHA; or

- **Use authorities similar to title 38, Code of Federal Regulations, section 4.28, prestabilization ratings.** VBA could grant all incoming presumptives with a set amount of disability, such as 50% or 100% for active cancers and set up a future review of the disability. This would not create an overpayment if the disability was changed at a later time; or
- **Use authorities similar to the administrative decision process.** Per VBA's adjudication manual, the Under Secretary for Benefits can designate supervisory or adjudicative personnel to make decisions about eligibility for benefits under the laws administered by VA. VBA could extend this authority to make decisions, via a special triage unit, granting eligibility to benefits for new presumptives at a more expeditious rate; or
- **Use authorities similar to the Veteran Readiness and Employment (VR&E) Service for a Memorandum Rating.** As noted in VA's adjudication manual, prior to a decision on a claim for service connection, VR&E Services can make a memorandum decision to determine whether a veteran's disabilities meet the basic entitlement to the program and grant enrollment before a final claims decision is made. VBA could use this same or similar authority to establish entitlement to benefits, ancillary benefits and health care, prior to a final decision.

These suggestions can be implemented under VBA's current authority and would not require any regulatory changes. However, if these suggestions are to be implemented, we recommend that they be codified. This will give VBA those same authorities for future presumptives or similar instances of increased workloads.

In addition, section 715 of the bill authorizes \$150 million for VBA to begin a major overhaul of IT infrastructure to process claims, including developing claims automation. These funds can be used to automate and implement the suggestions we noted above.

We urge VBA to develop a plan now that includes leveraging their existing authorities to mitigate the impact of the expected claims and workload increases due to implementation of toxic exposure legislation. While there are existing concerns about the increase of costs associated with implementation, VBA and Congress can use these strategies to lessen the blow.

As we clearly indicated at the onset of this testimony, due to our country's overly slow reactions to the negative impacts of toxic exposures, these issues were not addressed in decades when we had the opportunity to solve them. Thus, here we are in

a position that the consideration of PAYGO will limit any meaningful toxic exposure legislation.

There have been instances within the veterans' arena when PAYGO was waived, such as the 2014 Veterans Access, Choice and Accountability Act. We must accept our current situation. DAV supports waiving PAYGO for comprehensive toxic exposure legislation as it cannot truly happen otherwise. When this nation has gone to war, it has not required PAYGO, yet we now expect those cuts from veterans' benefits in order to pay for their disabilities that were due to their honorable service in defense of this nation. Toxic exposure legislation must be considered a cost of war and not hindered by PAYGO.

Mr. Chairman, we must make this historic moment count and take full advantage of the opportunity to enact thoughtful and meaningful toxic exposure legislation. However, veterans and their families can ill afford to continue to wait for decades like past generations who were exposed to mustard gas, radiation, contaminated water and Agent Orange. Noted historian C. Northcote Parkinson said, "delay is the deadliest form of denial." We must act now.

This concludes my testimony on behalf of DAV. We stand ready to engage with the Committee on toxic exposures to pass comprehensive legislation that will finally solve this puzzle for veterans of all generations.



Statement of the  
**Fleet Reserve Association**

On  
**Veterans Toxic Exposure**

Presented to the  
United States Senate  
Veterans' Affairs Committee

By  
**Christopher J. Slawinski**  
**National Executive Director**

March 29, 2022



## **The FRA**

### *“Heading to 100 Years”*

Military service for our nation can require service members to go places that may expose them to toxins that cause illness and diseases that may not be diagnosed for years or even decades after their service. That is why the Fleet Reserve Association (FRA) is a member of the Toxic Exposures in the American Military (TEAM) Coalition to ensure that no veteran who suffered exposure to burn pits or other environmental toxins goes without access to VA health care benefits.

The Association is the oldest and largest organization serving enlisted men and women in the active, reserve, and retired communities plus veterans of the Navy, Marine Corps, and Coast Guard. The Association is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA), and entrusted to serve all veterans who seek its help.

FRA started in 1924 and its name is derived from the Navy’s program for personnel transferring to the Fleet Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

The Association testifies regularly before the House and Senate Veterans’ Affairs Committees, and it is actively involved in the Veterans Affairs Voluntary Services (VAVS) program. A member of the National Headquarters’ staff serves as FRA’s National Veterans Service Officer (NVS) and as a representative on the VAVS National Advisory Committee (NAC). FRA’s VSOs oversee the Association’s Veterans Service Officer program and represent veterans throughout the claims process and before the Board of Veteran’s Appeals.

In 2016, FRA membership overwhelmingly approved the establishment of the Fleet Reserve Association Veterans Service Foundation (VVF). The main strategy for the VVF is to improve and grow the FRA Veterans Service Officers (VSO) program. The newly formed foundation has a 501(c) 3 tax exempt status and nearly 800 accredited service officers with FRA.

FRA became a member of the Veterans Day National Committee in 2007, joining 24 other nationally recognized VSOs on this important committee that coordinates National Veterans’ Day ceremonies at Arlington National Cemetery. FRA will host the ceremony in their centennial year, 2024. The Association is a leading organization in The Military Coalition (TMC), a group of 35 nationally recognized military and veteran groups jointly representing the concerns of over five million members. FRA staff also serve in several key TMC leadership positions.

The Association’s motto is “Loyalty, Protection, and Service.”

### Introduction

FRA is thankful that President Joe Biden addressed the veterans burn-pit/toxic exposure issue in his first State of the Union address to Congress. He called on Congress to pass legislation. He noted his deceased Son Beau, an Army veteran, was exposed to burn pit pollutants and said many veterans, like his son, suffer from lifelong injuries, including cancer, after serving in combat. Beau may have developed his brain cancer as a result of exposure to toxins from burn pits in Iraq. The Department of Veterans Affairs (VA) is called upon to expand presumptions for these types of disability claims.

### VA Will Add Rare Cancers to Presumption List

In response to the President's State of the Union address the VA has proposed adding certain rare respiratory cancers to the list of presumed service-connected disabilities in relation to military environmental exposure to particulate matter.

The VA determined, through a review of scientific and medical evidence, there is biologic plausibility between airborne hazards, specifically particulate matter, and carcinogenesis of the respiratory tract. The unique circumstances of these rare cancers warrant a presumption of service connection. Based on these findings, VA's Secretary is proposing a rule that will add presumptive service connection for several rare respiratory cancers for certain veterans. The cancers under consideration include:

- Squamous cell carcinoma of the larynx;
- Squamous cell carcinoma of the trachea;
- Adenocarcinoma of the trachea;
- Salivary gland-type tumors of the trachea;
- Aden squamous carcinoma of the lung;
- Large cell carcinoma of the lung;
- Salivary gland-type tumors of the lung;
- Sarcomatoid carcinoma of the lung; and
- Typical and atypical carcinoid of the lung.

"This is the right decision. The rarity and severity of these illnesses, and the reality that these conditions present a situation where it may not be possible to develop additional evidence prompted us to take this critical action," said VA Secretary Denis McDonough. "We'll continue

to hold ourselves accountable to veterans to provide more care, more benefits and more services to more veterans than ever before.”

The VA intends to focus its rule on the rare respiratory cancers above in veterans who served any amount of time in the Southwest Asia theater of operations and other locations. VA will invite and consider public comments as part of this process. Once rulemaking is complete, the VA will conduct outreach to impacted veterans and survivors to inform them about potential eligibility.

### **Veteran’s Toxic Exposure Legislation**

FRA supports the “Health Care for Burn Pit Veterans Act” (S. 3541) sponsored by SVAC Chairman Jon Tester (Mont.) and Ranking Member Jerry Moran (Kan.) that was recently passed by the Senate unanimously. The bill offers Post 9/11 combat veterans, who are suffering from conditions caused by toxic exposures, access to VA health care. The bill creates a three-step approach to:

1. Expand access to health care for exposed veterans;
2. Establish a new process to determine future presumptive conditions; and
3. Provide overdue benefits to thousands of toxic-exposed veterans who have been ignored or forgotten.

The Association is a member of the Toxic Exposures in the American Military (TEAM) Coalition and wants to ensure that no veteran who suffered exposure to burn pits or other environmental toxins goes without access to VA health care benefits. The recent jet fuel leak at Hawaii’s Joint Base Pearl Harbor-Hickam, impacted more than 9,000 military families in Hawaii after jet fuel from underground storage tanks at the Red Hill Bulk Storage Facility leaked into a well that supplies water to their on-base homes. This is a perfect example for the need for toxic exposure presumption.

Last year the Senate Veterans Affairs Committee (SVAC) approved the “Comprehensive and Overdue Support for Troops (COST) of War Act” (S. 3003) sponsored by SVAC Chairman Jon Tester. The Senate approved this bill unanimously. The House also approved the "Honoring Our PACT Act" (HR 3967) sponsored by the House Veterans Affairs Committee (HVAC) Chairman Mark Takano (CA). Both bills would allow all veterans who were at risk of toxic exposure, including 3.5 million Iraq and Afghanistan veterans, to obtain immediate and lifelong access to health care from the VA for the first time. One of the largest expansions of health care eligibility in the VA’s history. The bills would provide presumptive care for numerous conditions for veterans sickened by exposure to burn pits and other toxins. Both bills would also establish a new science-based and veteran-focused process for the establishment of new presumptive conditions and would provide benefits to thousands of toxic exposure veterans who have been long-ignored or forgotten, including Agent Orange veterans suffering from hypertension. The “Promise to Address Comprehensive Toxins (PACT) Act” (H.R. 3967), goes much farther than the Senate bill. It creates new service presumptions for over 20 health conditions, expands

research, and allows more veterans to receive coverage for the effects of toxic exposure. Another major difference between the "Health Care for Burn Pit Veterans Act" (S. 3541) and legislation approved by both committees last year (S. 3003/HR 3967) is that S. 3541 applies only to Post-911 veterans and the bills from last year apply to all veterans. The "Promise to Address Comprehensive Toxins (PACT) Act" (H.R. 3967) is estimated to cost \$300 billion over 10 years.

Burn pits were a common way to get rid of waste at military sites in Iraq and Afghanistan. More than 3.7 million service members have been deployed to the Southwest Asia theater of military operations since 1990. Deployment to the region exposed service members to airborne hazards including oil-well fire smoke, emissions from open burn pits, dust suspended in the air, exhaust from military vehicles, and local industrial emissions. Temperature extremes, stress, and noise encountered by service members may have increased their vulnerability to these exposures. Toxins in burn pit smoke may affect the skin, eyes, respiratory and cardiovascular systems, gastrointestinal tract, and internal organs. The VA has received 12,582 claims related to burn pit exposure but only 2,828 have been granted.

As noted above many claims have been rejected because of the lack of evidence of burn pit exposure. Each VA claim related to burn pit exposure must include:

1. Medical evidence of a current disability;
2. Evidence of burn pit exposure; and
3. Evidence of a link between the claimed disease/injury and exposure to burn pits.

The second step puts a very high burden of proof on a service member: each has to provide their own, personal evidence that they were exposed to burn pits. FRA is looking forward to working with both committees and bill sponsors to pass a bill on toxic exposure this year.

#### **Agent Orange Blue Water Navy Claims**

FRA is thankful to members of both committees for their support of the Agent Orange Blue Water Navy Act that passed in 2019, and that the VA began re-adjudicating Blue Water Navy claims for veterans who served in the offshore waters of Vietnam. This review is part of the Veterans Benefits Administration's implementation of the U.S. District Court for the Northern District of California order to re-adjudicate previously denied claims, per the *Nehmer vs. U.S. Department of Veterans Affairs* consent decree.

"This review provides an entire generation of veterans with another shot at getting the health care and benefits they've earned. And it sends a clear message that VA is working to right a wrong perpetrated by a government that ignored their service and sacrifice for far too long." Said SVAC Chairman Jon Tester (Mt.). As of April 30, 2021, the VA processed more than 45,000 Blue Water Navy claims and paid nearly \$900 million in retroactive benefit payments to disabled Blue Water Navy veterans.

In March 2021, SVAC sent a bipartisan letter asking VA Secretary Denis McDonough to provide the VA's estimated timeline for completing initial processing of Blue Water Navy Vietnam Veterans Act claims and the VA's plan to adhere to the *Nehmer v. U.S. Department of Veterans Affairs* consent decree.

#### **Veterans Prostate Cancer**

FRA is supporting the “Veterans’ Prostate Cancer Treatment and Research Act” (S.2720/H.R. 4880) to expand treatment and research of prostate cancer to help diagnose and treat veterans through the VA. This is the number one cancer diagnosed by the Veterans Health Administration. Recent studies have reported over 500,000 veterans are living with prostate cancer and receiving treatment within VHA. There are over 16,000 of those with metastatic disease and there are over 15,000 new diagnoses annually. The need to standardize treatment across VHA with the introduction of a comprehensive system-wide Prostate Cancer Clinical Pathway should be implemented. Studies have shown that prostate cancer develops more frequently in men exposed to Agent Orange and VHA has established it is a presumptive condition thus qualifying exposed veterans for full disability benefits. New data supports a link between prostate cancer and exposure to jet fuel (JP-8), cadmium, and aircraft component cleaning solvents.

The need to enhance research for this disease is clear as the number of diagnosed veterans continues to rise. The legislation requires VHA to establish a Clinical Pathway for Prostate Cancer and to expand VHA research efforts related to screening, diagnosis, and treatment options. VHA should promote veteran’s prostate cancer awareness, standardization of diagnosis and treatment, expanded educational resources, and continued research.

#### **Gulf War Illness**

FRA appreciates that the VA last year extended the presumptive period to Dec. 31, 2026, for qualifying chronic disabilities rated 10 percent or more, resulting from undiagnosed illnesses in veterans from the Persian Gulf War. This is meant to ensure the benefits established by Congress are fairly administered.

If an extension of the current presumptive period was not implemented, service members whose conditions arise after Dec. 31, 2021, would be substantially disadvantaged compared to service members whose conditions manifested at an earlier date.

Limiting entitlement to benefits due to the expiration of the presumptive period would be premature given that current studies remain inconclusive as to the cause and time of onset of illnesses suffered by Persian Gulf War veterans.

The VA presumes certain medically unexplained illnesses are related to Persian Gulf War

service without regard to cause, including, chronic fatigue syndrome, fibromyalgia, and functional gastrointestinal disorders. Also included are undiagnosed illnesses with symptoms that may include but are not limited to abnormal weight loss, cardiovascular disease, muscle and joint pain, headache, menstrual disorders, neurological and psychological problems, skin conditions, respiratory disorders, and sleep disturbances.

### **Conclusion**

In closing, allow me to express the sincere appreciation of the Association's membership for all that you and the members of the Senate Veterans' Affairs Committees and your outstanding staffs do for our Nation's veterans.

Our leadership and Legislative Team stand ready to work with the Committee members and their staffs to improve benefits for all veterans who have served this great Nation.

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**Christopher J. Slawinski**  
**National Executive Director, FRA**

Christopher J. Slawinski serves as the thirteenth National Executive Director for the Fleet Reserve Association (FRA), a congressionally chartered military and veterans' service organization serving current and former enlisted members of the Navy, Marine Corps and Coast Guard.

First Hired in October 2004, Slawinski was the National Service Director and the Association's primary voice between our members and the Department of Veterans Affairs.

Slawinski is an accredited service officer with the FRA and holds TRIP certification within the VA. He is the National Representative with FRA in the VA Voluntary Service National Advisory Committee, and a local VAVS Representative for the VA Medical Center in Washington, DC. Slawinski also serves as the Treasurer and Board member for the VAVS James H. Parke Memorial Scholarship Fund.

Slawinski is a Vice President of The Military Coalition (TMC) along with being a Co-Chairman of TMC Veterans Subcommittee.

Slawinski is a life member of the FRA Navy Department Branch 181, Arlington, VA, and has served as president of the East Coast Region. During his term as a member of the Association's National Board of Directors, he represented FRA members who reside in Maryland, District of Columbia, Delaware, Virginia, West Virginia and North Carolina.

Slawinski enlisted in the Navy in 1978, transferred to the Naval Reserve in 1982 and retired in 1998. He holds a bachelor's degree in communications from The University of Toledo and spent 20 years in civilian broadcast media, during which he earned two regional Emmy awards.

Slawinski, born and raised in Toledo, Ohio, now resides in Annandale, Va. Chris is the proud father of his daughter, Victoria, who currently attends Pennsylvania State University (Penn State) in State College, PA.

STATEMENT OF

KRISTINA KEENAN, ASSOCIATE DIRECTOR  
NATIONAL LEGISLATIVE SERVICE  
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

UNITED STATES SENATE  
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

**“Honoring our Promise to Address Comprehensive Toxics Act of 2021 (PACT Act)”**

WASHINGTON, D.C.

March 29, 2022

Chairman Tester, Ranking Member Moran, and members of the Senate Committee on Veterans' Affairs, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our insights pertaining to the impact of the *Honoring our Promise to Address Comprehensive Toxics Act of 2021 (PACT Act)* on veterans and Department of Veterans Affairs (VA) operations.

At a joint hearing before the House and Senate Committees on Veterans' Affairs in March 2021, and in hearings in April and May 2021, the VFW called upon Congress to work in a bipartisan manner and with Veterans Service Organizations (VSOs) to develop a comprehensive solution for toxic exposure. Our message was heard, and several toxic exposure bills were put together to address the different pieces of the puzzle to take care of veterans from all eras. Along with more than forty veterans organizations, the VFW strongly supports the passage of H.R. 3967, *Honoring our Promise to Address Comprehensive Toxics Act of 2021 (PACT Act)*. We were encouraged when bipartisan and bicameral effort resulted in the House passage of the *PACT Act* on March 3, and are hopeful that the Senate will follow suit. On March 8, President Biden addressed the public from Fort Worth, Texas, and urged Congress to get this legislation to his desk for signature “immediately.”

The *PACT Act* would help millions of toxic-exposed veterans. It would address the still lingering conditions and unrecognized locations of Vietnam War veterans exposed to Agent Orange. It would take care of Atomic veterans and veterans from the K2 base in Uzbekistan. It has a significant focus on burn pits and improving the VA disability claims process. The time is now to pass the *PACT Act* and finally address the needs of sick and disabled veterans.

The four main elements of the *PACT Act* are critical pieces of the puzzle. Without all four, veterans will not have access to both the health care and benefits they deserve. These four elements include health care for toxic-exposed veterans; a concession of exposure to burn pits for



veterans who served in certain locations; a list of presumptive conditions related to burn pit exposure; and a framework for VA to review and grant new presumptive conditions for all toxic exposures, past, present, and future. Additionally, the bill includes critical training necessary for VA health care providers to better diagnose and treat veterans with conditions related to toxic exposures and for VA disability claims processors to understand how to properly rate and adjudicate toxic exposure claims.

### **Health Care**

The health care expansion within Title I of the *PACT Act* is vital for toxic-exposed veterans who need treatment for current conditions and for preventive care. In the same way that Vietnam era veterans have access to VA health care even if they do not have service-connected disabilities, so should veterans from the Persian Gulf War and the Post-9/11 conflicts who were exposed to burn pits and other environmental toxins. VA has grouped at-risk veterans, such as Vietnam veterans who were exposed to toxic substances during service, into Priority Group 6 health care. This category also includes veterans who were exposed to radiation and veterans exposed to contaminated water at Camp Lejeune. Veterans exposed to burn pits should be added to this priority group to give health care parity to veterans of the current era.

This shift would indeed increase the number of users of the VA medical system, but it is certainly necessary after more than twenty years of conflict and is something VA should have anticipated. By providing veterans care now, VA could deliver lifesaving, early detection for serious and rare conditions. Delaying access to medical care will only create a larger and potentially more costly problem in the future as some veterans will require significant care as their conditions worsen.

### **Framework**

The process by which VA reviews and considers new presumptive conditions is fundamentally broken. Under the authority of the *Agent Orange Act of 1991*, VA entered into an agreement with the National Academy of Sciences (NAS)—now part of the National Academies of Sciences, Engineering, and Medicine (NASEM)—which assessed the strength of association between herbicide exposure and various health conditions. The legislation also provided VA with timelines to review the findings of NAS, determine whether a presumption of service connection was warranted for each condition, and issue proposed regulations. Under this framework, the majority of Agent Orange presumptive conditions were determined, but the two conditions of hypertension and monoclonal gammopathy of undetermined significance (MGUS) remain. NASEM determined in 2018 that there was sufficient evidence of an association for these two conditions, which is a level of association higher than some of the other conditions on the Agent Orange list. The fact that VA still has not added those conditions to the list points to the now-expired authority of the legislation and VA's unwillingness to add these conditions on its own without the passage of new legislation. The VFW supports adding hypertension and MGUS to the Agent Orange list of presumptive conditions.

It is clear that a new presumptive process is needed at VA. The VFW acknowledges that VA is currently in the process of developing a new presumptive pilot program, with the expressed goal

“to lower the burden of proof for Veterans impacted by exposures and speed up the delivery of health care and benefits they need.” The VFW has not yet been presented with the full details of the pilot decision-making process, nor have VSOs been included in its development. This does not change the fact that we believe a new and effective framework must be codified by statute so that future administrations will continue to be held to the same standard.

Title II of the *PACT Act* would establish a toxic exposure presumptive process to review any exposure from past, present, and future conflicts, at locations domestic and abroad. This framework includes a permanent Formal Advisory Committee to review data on certain toxic exposures and recommend further review if required. A review body determined by the VA Secretary would then conduct a formal evaluation, using the standard of positive association, of the exposures or conditions recommended by the advisory committee. This body would analyze scientific evidence, VA disability claims data, and other relevant factors and make recommendations as to whether a presumption of service connection should be established. The evaluation process would take no longer than 120 days. The Secretary would then have 160 days from receiving the recommendations to determine if a presumption of service connection is warranted, and would then promulgate regulation. If the Secretary determines a presumption of service connection is not warranted, that decision would be published in the Federal Register with the reasons for the decision.

The VFW supports the establishment of the new presumptive process with as much transparency as possible, including timelines and the standard of positive association. The VFW would like to work with VA and make recommendations as it uses what it learns from the current presumptive pilot program in the development of the formal evaluation process outlined in the *PACT Act*.

### **Concession of Exposure**

VA reporting indicates that nearly eighty percent of toxic exposure disability claims related to burn pits are denied. The most difficult aspect veterans face in applying for these benefits is the inability to prove that an exposure took place. Without documentation from their service records, veterans often lack evidence that provides a nexus to their health conditions and the in-service event, which is a requirement to be granted service-connection.

In 1991, after decades of advocacy, Vietnam War veterans were finally presumed to have been exposed to herbicides known as Agent Orange. This is a “concession of exposure.” It is important because it is an acknowledgement that service members at certain locations during certain time periods were exposed to particular toxins, removing the burden of proof from the veteran. Title III of the *PACT Act* includes a concession of exposure to burn pits for those who served in Iraq, Afghanistan, and other key locations during the Persian Gulf War and the Global War on Terrorism. This would help veterans with serious health conditions more easily access the care and benefits they so desperately need.

### **Presumptive Conditions**

Another key aspect of *PACT Act* is the list of presumptive conditions related to burn pit exposure. Title IV provides a list of serious respiratory conditions and cancers that are

scientifically linked to exposure to the burning of waste. In nearly all wars and conflicts in American history, open-air burn pits were used to dispose of waste generated during deployments. It is illegal to burn trash in your backyard in the United States today, but our service members lived and slept near burn pits in Iraq, Afghanistan, and many other locations where literally tons of waste were burned each day.

Burn pits include chemicals, plastics, medical waste, human waste, metals, munitions, and they typically use jet fuel as the accelerant. There already exists a large body of research evidence pointing to the health effects of humans exposed to burning trash where jet fuel is the most common accelerant. The presumptive conditions listed in the *PACT Act* address some of the most serious conditions that veterans are facing, and are integral to accessing vital care and benefits in a timely manner.

### **Implementation and Recommendations**

In anticipation of the increase in users of the VA health care system and the increased workload for disability claims processors, changes specifically suggested by VA were made to the text of the *PACT Act* to ensure the legislation could be fully implemented. Once those changes were made, the White House expressed strong support of H.R. 3967 in a Statement of Administration Policy on February 28, which was just days before the House vote on this bill. The VFW supports many of those changes and offers some additional suggestions for further improvement.

**Title I:** A change in the health care eligibility within the *PACT Act* added a “phase in” of veterans to access VA health care with two-year increments over the next ten years. These phases are based on discharge dates, locations, and toxic exposure risk activity. There would also be an extension of health care eligibility for combat veterans from five years after discharge to ten years, with a one-year open enrollment period for those who fall outside of that time frame. While these changes are intended to bring in veterans into the health care system in phases, the changes create gaps that would potentially leave some toxic-exposed veterans waiting until 2032 for health care. To close these gaps, the VFW recommends extending the health care eligibility for combat veterans beyond ten years after separation, lengthening the open enrollment period, or having periodic open enrollment. What we would like to achieve is Priority Group 6 health care at VA for all toxic-exposed veterans. This would allow at-risk veterans exposed to burn pits and airborne hazards to access VA health care for preventive care or if they become seriously ill.

Aside from this legislation, the VFW recommends that VA strongly considers adding all cancers to priority processing of claims, regardless of a terminal diagnosis, so these claims are expedited. The urgency for treatment from the moment of a cancer diagnosis is critical, and VA should do all it can to care for veterans before treatment is no longer an option.

**Title II:** The new presumptive process established in the *PACT Act* would be guided significantly by input from VA itself. Five out of the nine members of the Formal Advisory Committee would be staff from within VA and the formal evaluation process would be conducted completely by VA. Involving VA in the process to this extent would make it

vulnerable to changes in administrations that may have differing views on the need to establish new presumptive conditions. The VFW recommends that there be a role added within the new toxic exposure presumptive process for an independent scientific body, such as NASEM, so that veterans are guaranteed a fair review of the scientific evidence.

**Title III:** When first introduced, the *PACT Act* contained a list of toxic substances from burn pits and other airborne hazards detected during Department of Defense testing of air samples at various deployment locations. This list was removed from the concession of exposure and now gives the Secretary the authority to determine the substances, chemicals, and airborne hazards included. Giving VA the authority to determine the list of substances linked to burn pit exposure creates a risk that VA will not concede exposure to the full gamut of potential hazards associated with a variety of adverse health conditions, potentially limiting the ability for veterans to obtain service connection.

**Title VII:** The VFW acknowledges that the passage of the *PACT Act* would create an increased workload for VA claims processors due to an increase in veterans applying for disability benefits. To address this, two sections were added to the legislation. Section 709 would authorize thirty million dollars to be appropriated to the Secretary to support automation for claims processing. Section 715 would authorize one hundred fifty million dollars to be appropriated to the Secretary for continued modernization and expanded capabilities of the Veterans Benefits Management System for claims processing. The VFW has made and will continue to make annual budget recommendations as part of The Independent Budget VSOs for increased VA funding for information technology upgrades and improvements to automation to manage any potential increases of disability claims in the future.

Chairman Tester, Ranking Member Moran, this concludes my testimony. I am prepared to answer any questions you may have. Thank you.

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**Pre-Hearing  
Questions for the Record**

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**Legislative Hearing on *the Honoring Our PACT Act* pre-hearing questions for the National Academies of Sciences, Engineering, and Medicine (NASEM) from Senator Moran**

1. While we do have some doctors serving in Congress, the majority of members and their staffs are not medical professionals. The National Academies of Sciences, Engineering, and Medicine (NASEM) serve “to provide independent, objective analysis and advice to the nation and conduct other activities to solve complex problems and inform public policy decisions.” In the Senate Committee on Veterans’ Affairs’ purview, one example of this is the National Academy of Medicine’s—formerly the Institute of Medicine’s—series of reports on health outcomes of veterans exposed to Agent Orange in Vietnam, veterans who served in Persian Gulf War, and most recently post-9/11 veterans.
  - **This research and analysis in these reports over the decades has been vital to the provision of health care and benefits to veterans who were made sick through their service, and has informed the related decisions made by 10 VA Secretaries. It is important that decisions that impact veterans not unfairly privilege one generation over another, which can be difficult as science and knowledge progresses. Can you elaborate on the research process that yields each of these reports in their respective series and is your process sound to ensure accuracy of findings amidst a changing research environment as new information comes to light?**

Response: The process used by the National Academies’ committees is sound and ensures that the most up-to-date information is identified and considered in an environment in which medical and scientific knowledge is ever-changing and evolving.

For each request for the National Academies to form a consensus committee to draw conclusions about the strength of the evidence associating particular exposures encountered during military service with adverse health outcomes, the process begins with a comprehensive literature search. The literature search includes the use of multiple medical, chemical, and other scientific databases as appropriate given the exposures or health outcomes in question. Searches also included reports and other publications—such as those from the Department of Veterans Affairs (VA) or the Department of Defense (DoD)—that undergo some type of review but may not be included in such databases. For National Academies reports that are a continuation of a series, the comprehensive search strategy is adapted from the approach used in the previous report(s). Such adaptations may include using a newly available database or adding specific key words, based on that committee’s statement of task. For example, in the most recent *Veterans and Agent Orange*–series report [*Update 11 (2018)*], the committee added terms to the search strategy related to specific medical conditions that were called out in the statement of task : myeloproliferative neoplasms, and brain cancer, in particular, glioblastoma multiforme (Box 3-1 of that report lists all of the search terms used). Analogous modifications to the literature review were made for the various reports in the *Gulf War and Health* series and other standalone reports addressing service members and veterans of these and other eras. Every National Academies report includes a detailed description of the process used to search and evaluate the literature considered.

Literature searches include the full text of each article to ensure they are exhaustive. Restrictions such as the date and language of the publication, or populations it examines (for example, adults) are applied where appropriate to focus on the information most relevant to a military population. Once the search is completed, the committee and National Academies project staff (under direction of the committee) screen the identified abstracts based on inclusion and exclusion criteria developed by the committee, and again adapted from previous reports if applicable to a

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particular series. Depending on the search strategy and topic, tens of thousands of abstracts may be identified in this process. Each abstract is screened by multiple people on the study committee and on the National Academies staff to minimize the risk that a relevant article or publication will be inappropriately excluded. After screening is complete, the full text of the publications meeting the inclusion criteria are reviewed. This serves as an additional check to ensure an identified article meets the inclusion criteria for the study and its statement of task.

The final set of identified studies are evaluated and used to draw conclusions regarding the strength of evidence of an association between an exposure of interest and a health outcome. Each study is examined with regard to the methods used for selecting the study population and conducting the research (i.e., the design, measures of exposure and health outcomes, statistical analyses used, adjustment factors, etc.), and the results presented; and an assessment of the strengths, limitations, and potential biases is conducted. Those studies determined to be of higher quality because they meet standards consistent with high methodologic rigor are generally given more weight than studies that are found to not meet such standards. Lesser quality studies may, for example, have non-specific exposure measures or design issues that weaken confidence in their results. Studies identified for inclusion are reviewed in detail in the text of the report. For those reports that are part of a series, the committee's conclusions are based on these reviews plus the accumulated evidence of all previous reports.

In addition to the literature search process, the expert consensus committees conduct several additional activities to develop the scientific foundation for a report's findings, conclusions, and recommendations. These include holding open sessions to gather information from authorities who have particular knowledge on report topics (for example, presentations from experts in glioblastoma multiforme, as was done for *Veterans and Agent Orange: Update 11* (2018)); and from veterans, their loved ones, veteran service organization representatives, and other stakeholders who have first-hand experience with health problems that may be service-related. The input provided in these sessions is used to identify information gaps and stimulate additional lines of inquiry. Study committees also make information requests to VA, DoD, or other appropriate agencies or organizations to follow up on issues raised during the course of their work.

Together, these methods result in a rigorous, objective, and sound process for evaluating the strength of the scientific evidence of associations between exposures and health outcomes to inform policy decisions.

2. NASEM was charged with reviewing and describing how Department of Veterans Affairs (VA) presumptions have been made in the past and, if needed, to make recommendations for an improved scientific framework that could be used in the future for determining if a presumption should be made. NASEM stood up a Committee and published the 2008 report *Improving the Presumptive Disability Decision-Making Process for Veterans*. The Committee made 19 recommendations to varying government entities, to include Congress, VA, and the Department of Defense (DOD) and concluded that improvements are needed throughout the presumptive decision-making process.
  - **The case studies conducted by the 2008 study committee probed deeply into this ad hoc VA process and the case studies pointed to a number of difficulties that the committee said needed to be addressed in any future approach. Please**



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**elaborate on the importance of putting those recommendations into action and how the lessons learned would be useful to incorporate in solutions within any new approach.**

Response: The case studies conducted by the 2008 study committee probed deeply into VA's approach to presumptive disability decision making. The case studies pointed to a number of difficulties that the committee said needed to be addressed in any future approach:

- Lack of information on exposures received by military personnel and inadequate surveillance of veterans for service-related illnesses.
- Gaps in information because of secrecy.
- Varying approaches to synthesizing evidence on the health consequences of military service.
- In the instance of wartime exposures to herbicides in Vietnam, classification of evidence for association but not for causation.
- A failure to quantify the effect of the exposure during military service, particularly for diseases with other risk factors and causes.
- A general lack of transparency of the presumptive disability decision-making process.

The study committee discussed in great depth potential alternative approaches to establishing a scientific foundation for presumptive disability decision-making, including the methods used to determine if exposure to some factor increases the risk for disease. This assessment and the findings of the case studies led to a number of observations and recommendations to improve the process:

- Congress could provide a clearer and more consistent charge on how much evidence is needed to make a presumption. There should be clarity as to whether the finding of an association in one or more studies is sufficient or the evidence should support causation.
- Due to lack of clarity and consistency in congressional language and VA's charges to the committees, National Academies committees have taken somewhat varying approaches since 1991 in reviewing the scientific evidence, and in forming their opinions on the possibility that exposures during military service contributed to causing a health condition. Future National Academies committees could improve their review and classification of scientific evidence if they were given clear and consistent charges and followed uniform evaluation procedures.
- The internal processes by which the VA makes its presumptive decisions following receipt of a National Academies report have been unclear. VA should adopt transparent and consistent approaches for making these decisions.
- Adequate exposure data and health condition information for military personnel (both individuals and groups) usually have not been available from DoD in the past. Such information is one of the most critical pieces of evidence for improving the determination of links between exposures and health conditions. Approaches are needed to ensure that such information is systematically collected in an ongoing fashion.

All of these improvements were thought to be feasible over the longer term and, the study committee said, are needed to ensure that the presumptive disability decision-making process for

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veterans is based on the best possible scientific evidence. Decisions about disability compensation and related benefits such as medical care for veterans should, they asserted, be based on the best possible documentation and evidence of their military exposures as well as on the best possible information. The committee concluded that a fresh approach could do much to improve the current process.

- **Have there been any scientific developments that suggest that VA ought to deviate from the recommendations made in the 2008 report when creating presumptions?**

Response: The 2008 study committee's recommended approach for presumptive disability decision-making had several parts:

- an open process for nominating exposures and health conditions for review, involving all stakeholders in this process;
- a revised process for evaluating scientific information on whether a given exposure causes a health condition in veterans, including a revised set of categories to assess the strength of the evidence for association and an estimate of the numbers of exposed veterans whose health condition can be attributed to their military exposure;
- a consistent and transparent decision-making process by the VA;
- a system for tracking the exposures of military personnel (including chemical, biological, infectious, physical and psychological stressors), and for monitoring the health conditions of all military personnel while in service and after separation; and
- an organizational structure to support this process.

There have been many medical and scientific developments in the 14 years since the report was published. In addition, it is our understanding that VA has piloted a new system for determining presumptions that may incorporate facets of the recommendations provided in the 2008 report.

However, the National Academies have not revisited VA's approach to presumptive disability decision-making since the publication of the 2008 report. Consideration might be given to conducting an updated analysis that would evaluate the information and experience developed in the intervening years.

- **Does NASEM stand by the recommendations for VA in the 2008 report? If not, please explain what scientific evidence suggests VA ought to take a different approach.**

Response: The National Academies stand by our reports and the objective and rigorous process used to inform the conclusions and recommendations those reports contain. Because more than 14 years have passed since the 2008 committee conducted its work, an updated assessment of the recommended approach using information on current policies and procedures and lessons learned may be warranted.

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3. In NASEM's 2020 report *Respiratory Health Effects of Airborne Hazards Exposures in the Southwest Asia Theater of Military Operations*, the assembled expert committee examined 21 respiratory disorders, six categories of cancer, and three respiratory symptoms identified as possibly being associated with airborne hazards encountered in Southwest Asia.
- **Of these health outcomes examined, only the respiratory symptoms of chronic persistent cough, shortness of breath, and wheezing met the criteria for limited or suggestive evidence of an association for both veterans who served in the Persian Gulf War and those who served in the post-9/11 conflicts. Is NASEM's process for identifying health outcomes to examine sound and can you elaborate on that process for selecting health outcomes to examine?**

Response: The process used by the committee responsible for the above referenced report is sound and based on the same rigorous process as described in question 1. The committee formed to address this task comprised 11 experts in epidemiology, pulmonology, pathology, exposure assessment, military and veteran's health, and toxicology. The 27 respiratory conditions and cancers considered in the report were either named in the committee's statement of task (cancer, bronchial asthma, chronic bronchitis, sinusitis, constrictive bronchiolitis); derived from respiratory health outcomes that had been considered or reviewed in Volumes 4, 8, and 10 of the *Gulf War and Health* series or two other National Academies reports that focused on exposures to burn pits; or identified from detailed and comprehensive searches of the literature dating back to 1991. In keeping with the committee's statement of task, the literature review was a targeted examination of epidemiologic studies of respiratory health outcomes—including excess mortality due to respiratory disease—in military and veteran populations potentially exposed to airborne hazards in the Southwest Asia theater.

Five medical and scientific databases were searched for more than 225 terms that were named in the committee's search strategy. Included in these were the full and abbreviated names, common and scientific names, and Medical Subject Heading (MeSH) descriptors for each of the exposure and health outcomes considered. After removing duplicate studies that were found in multiple databases, 41,646 titles and abstracts were identified for initial screening, using the process explicated in the response to question 1. Publications found to meet inclusion criteria were examined for all respiratory health outcomes reported. Each respiratory health outcome reported in a publication was checked against the existing list of conditions and, if new, added to the list.

- **Can you opine on the committees' processes over the decades of identifying the health outcomes examined in the reports series *Veterans and Agent Orange* and *Gulf War and Health*?**

Response: The process used by appointed expert consensus committees to evaluate health outcomes potentially associated with exposure to a particular chemical or hazard are described in the response to question 1.

4. In that same 2020 report NASEM asserted that findings of insufficient or inadequate evidence of an association “do not mean that there is no association between deployment to the Southwest Asia theater and the respiratory health outcomes in this category, but

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instead that the available evidence does not allow a more definitive determination to be made about the potential association.”

- **Would studies conducted on the topics of mortality of veterans who served in Southwest Asia, health trends of post-9/11 veterans, cancer rates among veterans, and increased training of VA health care providers on effects of toxic exposure help to close identified knowledge gaps?**

Response: The 2020 report, *Respiratory Health Effects of Airborne Hazards Exposures in the Southwest Asia Theater of Military Operations*, examined the then-available literature on mortality due to respiratory-related causes of both 1990-1991 Gulf War and Post-9/11 veterans. The committee’s review of that literature found that the most recently published mortality study of 1990–1991 Gulf War veterans, which included death due to chronic obstructive pulmonary disease and from respiratory system diseases in general, used 2004 as its cutoff date, while the most recently available salient study of post-9/11 veterans who had been deployed to the theater was generated using data from 2011 and offered no breakout of respiratory disease mortality.

Studies of mortality data in general, and of respiratory conditions and cancers specifically, are important in order to identify whether there are respiratory health outcomes that warrant more intense examination or surveillance of this population. The lack of recent mortality analyses led the 2020 report committee to recommend that an updated analysis of mortality in Southwest Asia theater veterans be conducted. Such updated or future mortality studies, the committee indicated, need to be based on analyses that compare higher- and lower-exposed veterans, rather than analyses comparing all veterans to the general population. This in turn will require that a retrospective exposure assessment be included so that the study can produce useful estimates of exposure-related mortality risk. An informative new study to determine whether there is excess mortality in deployed veterans should also consider not just the cause of death and contributing causes of death but also other underlying health conditions that might not be listed as a cause or contributing cause of death but that might confound an association as well as detailed demographic and service information on the veterans and their circumstances of deployment.

Another large knowledge gap concerns the lack of information about exposures, specifically in-theater airborne exposures. A number of airborne exposures were present in the Southwest Asia theater of military operations that could have influenced respiratory health outcomes, including environmental (e.g., sand, dust, industrial pollutants) and occupational (pesticides, solvents, and fuels; duty near burn pit operations) exposures, as well as those resulting from personal behavior (cigarette smoking) and the other circumstances of service in the theater. However, little contemporaneous data were collected, biologic markers have not been identified for many exposures of interest, exposure proxies are often imprecise and otherwise problematic, and self-reports of exposure may be subject to recall bias.

The 2020 report committee concurred with several previous committees responsible for reports in the *Gulf War and Health* series that raised concern over the lack of good exposure information on airborne hazards as well as other exposures including depleted uranium (IOM, 2000b, 2008); insecticides and solvents (IOM, 2003); and fuels, combustion products, and propellants (IOM, 2005). As Volume 10 of the series stated: “[t]he lack of specific individual exposure information is not unexpected in wartime situations, but it nonetheless limits the ability to draw conclusions about observed health effects” (NASEM, 2016b, p. 240). An additional complication arises with hazards such as burn pit emissions, which were highly variable over time, depending on which

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materials were burned and at what temperature combustion occurred (IOM, 2011; NASEM, 2017). Burn pits were later supplemented with or replaced by incinerators at some larger installations, which further complicates the evaluation of exposures over time, given the lack of emissions monitoring.

Exposure characterization is a pervasive challenge in studies of the effects of exposures on military personnel. Basic information is often lacking on who was exposed, what they were exposed to where and when, at what level, over what time period, and with what frequency. National Academies committees have put forward recommendations on closing exposure information gaps through modeling, the use of newly emerging technologies (retrospective satellite imagery analysis, for example), more systematic collection and consolidation of exposure-related information, and a focus on the free flow of information on exposures encountered during military service and on the health of personnel before, during, and after deployment and after transition to veteran status.

No National Academies committee has addressed the issue of increased training of VA health care providers on the effects of toxic exposures.

These observations are illustrative of the gaps in information that represent barriers to the analysis of potential health effects.



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**Questions for the Record**

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**STATEMENT OF  
 SHANE L. LIERMANN  
 DEPUTY NATIONAL LEGISLATIVE DIRECTOR  
 OF THE DISABLED AMERICAN VETERANS  
 QUESTIONS FOR THE RECORD  
 MARCH 29, 2022**

Questions for the Record Received from Senator Sinema:

On behalf of DAV's (Disabled American Veterans) more than 1 million members, thank you for your questions in reference to our testimony for the SVAC hearing on the Honoring Our PACT Act held on March 29, 2022.

**Questions for Disabled American Veterans**

**1. Mr. Liermann's testimony mentioned toxic exposure locations that are currently not a focus of this toxic exposure bill. Are we leaving certain populations of servicemembers and veterans out of our review?**

There are certain groups of exposed veterans that are not included specifically in the Honoring Our PACT Act. Two prominent examples are explained below. Burn pits were used during Operation Joint Endeavor in Bosnia from 1995 to 1996; however, those groups of veterans are not included in this bill.

Additionally, while the Honoring Our PACT Act does include veterans who served at Karshi-Khanabad Air Base, known as K2, it is only for the burn pits. It does not address the chemical weapons, enriched uranium and soil saturated with fuels and other solvents. It is important to note the U.S. Army study from 2015 found that veterans exposed at K2 have a 500% increased likelihood of developing cancer to include malignant melanoma and neoplasms of the lymphatic and hematopoietic tissues.

**2. What recommendations do you have for the implemented review board to ensure every veteran is getting the adequate care they need?**

The Honoring Our PACT Act would provide health care to potentially millions of veterans not currently eligible for health care based on toxic exposures. The proposed review board would address future presumptive diseases related to toxic exposures and not specifically health care. Our one recommendation for this bill as written, would be to not phase in the eligibility for health care as proposed. We believe toxic exposed veterans should have immediate access to health care.

**3. Should our focus strictly be on toxic exposure overseas, or should we be looking at domestic locations as well?**

Although the Honoring Our PACT Act does specifically address toxic exposures overseas, it does address some domestic locations such as registries for Fort McClellan and PFAS contaminated water at over 600 military installations including domestic sites. However, that does not include other domestic locations with known exposures such as the fuel contaminated water in Hawaii due to the Red Hill release of fuel and water mixture.

Additionally, in December 2019, the Department of Defense released a report on herbicides used at locations outside of Vietnam including domestically to include Elgin AFB in Florida, Fort Gordon in Georgia and Aberdeen Proving Grounds in Maryland. These have not been included in the current bill.

As these additional domestic sites have not been added to the bill, we would love to work with you and your staff to consider separate legislation in this Congress and the next.

**4. Should we be considering military families, and DOD and VA civilian employees in this review?**

Historically, veterans have been waiting decades for acknowledgement of their exposure to hazardous environments and we believe that VA's first responsibility is to provide health care and benefits for those veterans exposed and are suffering. Equally important are their family members that may have been exposed. Families and civilian employees of DOD and VA should be considered for health care as well and the responsibility of this nation. However, we believe those are better suited to be handled directly by DOD and not be the responsibility of the VA.

**5. Domestically, our military and their families have been exposed to superfund sites, condemned buildings and drinking water contamination. What can we include in this legislation to ensure we are not leaving those exposed behind?**

In reference to superfund sites, condemned buildings and water contamination, the Honoring Our PACT Act does include a registry for Fort McClellan, which is near a superfund site. We agree that enough has not been done for all of these areas. At this time, we are not sure on the direction to take to include all of these in this legislation, but we are willing to discuss all of these concerns with you and your staff.

**6. Do we need a PFOA/PFOS exposure registry?**

The Honoring Our PACT Act includes a registry for PFAS contaminated drinking water. Per the Environmental Protection Agency, PFAS are a group of manufactured chemicals that have been used in industry and consumer products since the 1940s

because of their useful properties. There are thousands of different PFAS, some of which have been more widely used and studied than others.

Perfluorooctanoic Acid (PFOA) and Perfluorooctane Sulfonate (PFOS), for example, are two of the most widely used and studied chemicals in the PFAS group. PFOA and PFOS have been replaced in the United States with other PFAS in recent years. PFOA and PFOS are considered part of the PFAS chemical group; therefore, we do not believe there needs to be a separate registry from the one included in the bill.

On behalf of DAV, we thank you for your questions and commitment to keep the promise to our nation's veterans, their families and survivors.

Department of Veterans Affairs (VA)  
Questions for the Record Submitted to  
The Honorable Denis McDonough, Secretary of Veterans Affairs  
from the Committee on Veterans' Affairs  
United States Senate  
"Honoring our PACT Act of 2021"

March 29, 2022

Questions for the Record from Senator Jerry Moran:

**Question 1:** Mr. Secretary, I am interested in the findings of the pilot that the Department has conducted and the factors being used in decision-making that may represent a departure from how these decisions have been made historically. What can you share to illuminate what VA has learned with regard to evidence consulted to inform decisions on presumptive illnesses?

**VA Response:** To date, the new presumptions process is currently being reviewed. It has initially been tested using established Agent Orange presumptions that reviewed the previous science, but also considered Veterans Benefits Administration (VBA) data to evaluate exposures. The rationale for the selection of Agent Orange conditions was that these had been thoroughly evaluated for decades and, if a condition that had previously been given presumptive status would have fallen out as not presumptive through this model, that would suggest that we needed to fine tune processes. Similarly, if a condition that had been thoroughly reviewed and previously determined to have no evidence of association was found by the model to have an association, the team would need to rethink the model.

**Question 2:** In your testimony regarding Hypertension and its prevalence, you stated that "there is conflicting evidence regarding hypertension and Agent Orange exposure and that VA is committed to analyzing the issue of hypertension and currently is reviewing relevant evidence to include the recently-completed Vietnam Era Health Retrospective Observational Study (VE-HEROeS). This VA-sponsored research will complete processes to ensure that findings are supported and accepted by the scientific community. If VA determines there is an association, VA could use its current regulatory authority to establish a presumption." Further, in an RFI associated with Hypertension sent by my staff in September 2021, VA responded with an explanation that VA is still reviewing data and report-writing the findings from the VE-HEROeS Study and the Vietnam Veterans Mortality Study, and "as soon as the analysis from these studies are available, VA will review it and make a recommendation to VA Secretary." When can I anticipate a decision on whether you will add Hypertension to the list of diseases presumed to be service connected to Vietnam? What scientific standard will you use to make this determination?

**VA Response:** Our plan is to review hypertension once the process is validated by an external group, but we are unable to provide a specific date since the process is still undergoing review.

**Question 2a:** Will the scientific standard employed to make this decision match the standard utilized in the Department's recently concluded pilot model for new presumptive decisions related to toxic exposure? If not, how does it differ?

**VA Response:** The final results of the VE-HEROeS study are still potentially months from publication. A finding of an increase in hypertension (HTN) was found among Veterans in the VE-HEROeS study. A major limitation of the study is the lack of Veteran-level or even unit-level exposure data. Because of this limitation, the study characterizes deployment as the primary exposure, which could include traumatic events and military environmental exposures, among others. The results of the VE-HEROeS study are not expected to provide the conclusive answers regarding Agent Orange and HTN. The scientific standard is and will be the same as used in the presumptions decision-making process.

**Question 3:** Mr. Secretary, you referenced in your written testimony that Friday, April 1st, you will be receiving the results of your piloted model on presumptive decision-making, and that the president has asked that VA use this new presumptive decision-making model to assess associations between environmental exposures and constrictive bronchiolitis, rare brain cancers, and lung cancer. How could legislation that wasn't crafted to accommodate this ongoing work by the department slow down results for veterans?

**VA Response:** Section 202 of the House-passed PACT Act of 2021 would establish the procedures by which the Secretary could establish or remove presumptions of service-connection based on toxic exposures. The bill would establish a new Formal Advisory Committee on Toxic Exposure, which would be composed of nine members (five appointed by the Secretary, and one each appointed by the Speaker of the House of Representatives, the minority leader of the House of Representatives and the majority and minority leaders of the Senate).

VA is concerned that the creation of a new Committee, particularly one subject to the Federal Advisory Committee Act, would likely slow existing mechanisms for proposing and conducting research, conducting analysis and making decisions.

VA believes that the new framework for decision-making on presumptions should endure changes in Administration. VA's updated approach to handling environmental exposure-related policy issues is not limited to development of the new model to accelerate the decision-making process to consider adding new presumptive conditions. This approach also includes a governance structure with a focus on evidence-based decision-making, execution accountability, value creation and outcomes.

**Question 3a: With regard to veterans exposed to burn pits with rare cancers, how would Priority Group 6 care help in their treatment?**

**VA Response:** The most important aspect of addressing Veterans with rare cancers is to get them enrolled in VA health care so they can receive care and treatment. While all enrolled Veterans are eligible to receive the entire medical benefits package, enrollment in Priority Group 6 primarily benefits Veterans by exempting them from copayment requirements for conditions that may be related to their service; other Veterans who do not have a service-connected disability would generally be subject to copayments for their care. In addition to different copayment liabilities, the priority groups also may guide VA's allocation of resources in the rare case of an overburdened system (e.g., national disaster or insufficient personnel or financial resources).

VA priority groups generally are determined by law and are based on the following:

- Military service history;
- Disability rating;
- Income level;
- Qualification for Medicaid; and
- Other benefits that may be accorded (like VA pension benefits).

**Question 3b: What barriers might be preventing veterans with cancer who were exposed to burn pits from getting care at their VA? What would get these veterans in need through the doors of a VA medical center with the most speed?**

**VA Response:** Veterans exposed to a burn pit during their military service could be eligible to receive care from VA if they enrolled during their post-separation window or if they established a service-connection for their disability. These Veterans may also be eligible to enroll in VA health care based on their income or on another basis. Some Veterans did not elect to enroll during their post-separation window of eligibility, and for these Veterans who are not otherwise eligible for enrollment, expanding health care eligibility related to military environmental exposures from 5 to 10-years post-separation and creating a 1-year open enrollment period would remove barriers for these Veterans. As VA continues to assess different conditions through its presumptive model, it may establish new presumptions for service-connection that would also allow Veterans with cancer to enroll in VA health care. The Veterans Health Administration (VHA) and VBA have done significant outreach with social media, media tours using radio and TV spots and direct mailings and emails. Approximately 70 percent of Veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom have enrolled in VA health care.

**Question 4: VA noted in its assessment of the PACT Act and the COST of War Act that significant additional resources would be required to implement those bills, and additional personnel would be required to prevent delays in care and to minimize the backlog of disability claims. Secretary McDonough, what additional staff and funding will VA need to address the backlog of claims and increased**

**care just from the 12 new presumptions you have announced in August and March, even without any changes that would be made by legislation?**

**VA Response:** The projected Medical Care funding need for the 12 new presumptions announced in August and March is about \$58 million per year, and this cost is included in the President's Fiscal Year (FY) 2023 Budget. The 12 new presumptions are projected to affect 69,000 enrollees who are expected to move into service-connected priorities by 2023 as a result of the new presumptive conditions for the 9 rare respiratory cancers and the 3 Gulf War conditions.

In the President's FY 2023 Budget, VBA requested \$37.4 million and 319 full-time employees to support growing demands, including 1,930,200 compensation and pension claims with a goal of completing most claims within the strategic 125-day target. This includes full-time employee equivalents (FTE) for claims processing functions in various field offices based on projected workload analysis.

VA requests \$111.4 million and 795 FTE in the President's FY 2023 Budget to address 3 new presumptives, which include asthma, sinusitis, and rhinitis for certain Gulf War Veterans. FTE for the 9 rare cancers are not included in the VBA FY2023 budget request. VA's decision was announced after the President's FY 2023 Budget was finalized, so costs were not included.

**Question 4a: Are those required increases in personnel and funding reflected in the President's FY23 budget request?**

**VA Response:** Yes, the health care cost impact of \$58 million from the three new presumptions announced in August, and the costs for the 9 new presumptions announced in March are expected to be insignificant can be accommodated within the overall VHA medical care funding request in the President's FY 2023 Budget request for VHA.

The VA budget would increase resources for new presumptive disability compensation claims related to environmental exposures from military service. The budget also would invest \$51.0 million within VA research programs for the Military Exposures Research Program and \$63.0 million within the VA medical care program for Health Outcomes of Military Exposures (HOME) to increase scientific understanding of and clinical support for Veterans and health care providers regarding the potential adverse impacts from environmental exposures during military service. The \$63.0 million investment in the FY 2023 HOME budget would be an increase of \$32.0 million above the FY 2022 budget.

The President's FY 2023 Budget for VBA includes a request for \$111.4 million and 795 FTE for the three presumptive respiratory conditions. Specific funding requirements for the nine rare respiratory cancers were not included in the VBA FY 2023 budget request. VA's decision was announced after the President's FY 2023 Budget was finalized, so

costs were not included. The additional VHA costs for the nine rare respiratory cancers are expected to be insignificant and can be accommodated within the overall VHA medical care funding request

**Question 5:** Secretary McDonough, you referenced in testimony the potential challenges associated with overlap among the cohorts of veterans within this legislation, who could become eligible for VHA enrollment due to different provisions of the bill, including the phased-in eligibility. Adding in the language from the *Health Care for Burn Pit Veterans Act* also creates overlaps in authorities and the pathways for veterans to become eligible for VHA care. Could you please speak to strategies the department could employ to make certain that under any legislation, veterans who may be in need of care would be notified of their eligibility to enroll?

**VA Response:** Consistent with previous strategies employed to notify Combat Veterans of changes related to the enhanced enrollment authority for Combat Veterans, VA will consider employing the following actions:

- Create direct outreach via postal mail to impacted Veterans;
- Inform Veterans of the benefit through VHA's social media accounts and through additional communication stream;
- Veterans Experience Office and VHA Communications will collaborate to develop a comprehensive communications plan focused on the new eligibilities;
- Announce the new benefit on VA's website;
- Provide updated guidance to VA employees on the new law and changes to ensure consistency of Veteran care; and
- Update Veteran Enrollment System to facilitate the new provisions of law.

**Question 5a:** Could you opine on the importance of immediate expansion of VA's enhanced eligibility from 5 years to ten years? What advantages are inherent in this approach of broadening an existing VA enrollment mechanism?

**VA Response:** Expanding the enhanced eligibility period will serve to increase the number of exposed Veterans who are eligible for VA medical care, including mental health services and counseling, to Veterans who:

- (1) Were exposed to a toxic substance or radiation; or
- (2) Served in specified locations during specified periods.
- (3) Veterans were unaware of military environmental exposures and may have had concerns or medical issues that arose will be able to enroll in VA healthcare. Screening is available as needed for those enrolled in VA healthcare.

**Question 5b:** There have been proposals that any health care eligibility reform should contain language prioritizing certain health conditions with greater severity or in more dire need of treatment. Can you speak to this idea and the



**concept of triage with regard to expanding eligibility to Priority Group 6 for toxic-exposed veterans from over 30 years of war?**

**VA Response:** As in question 3a, the most important aspect of addressing Veterans with cancers or severe health conditions is to get them enrolled in VA health care so they can receive screening and when needed care and treatment. Once Veterans are enrolled, VA can ensure those Veterans in greatest need of care are seen quickly by the appropriate personnel.

**Question 6: Mr. Secretary – Can you please expound on your testimony that indicates “VA is concerned that an extremely large and unprecedented disability claims backlog would be created if the Nehmer-like provisions in this bill are retained?” Would this impact all eras of veterans awaiting a decision on their claims?**

**VA Response:** The creation of Nehmer-like provisions would apply to all presumptions of service-connection created on or after the date of enactment of the PACT Act of 2021. It would obviate ordinary effective date principles in many cases and would raise fairness and equity issues in relation to other classes of Veterans who are either not entitled to presumptions of service-connection or are entitled to presumptions of service-connection established prior to the enactment of the PACT Act of 2021. This disparity in the application of effective date provisions would potentially impact all eras of Veterans awaiting decisions on their claims.

As VA provided through prior enhanced technical assistance, if this provision is enacted, the backlog could rise to 1.8 million claims by the end of FY 2023. This would impact all Veterans awaiting disability benefits, as VBA scaled claims processors, training programs, hiring efforts and technology solutions to handle the expected influx of Veterans seeking benefits. The requirement would present extraordinary workload challenges to the agency. In the bill, the proposed provision would apply to the presumptions created by the bill and any future presumptions created by regulation or statute. The Gulf War deployed population contains nearly 3.5 million Veterans who may have had claims previously denied and would now potentially be entitled to retroactive effective dates as far back as 1991 for Gulf War I Veterans and back to 2001 for Global War on Terror Veterans. This type of in-depth, detailed file review necessary to identify claims that were previously evaluated and denied, but that might have been evaluated differently based on a new presumption for claims spanning up to 30 years in the unprecedentedly large Gulf War Veteran population, would require a significant amount of employee time in reviewing and processing the claims and impact the timeliness of decisions.

**Question 6a: How would it impact the Board of Veterans Appeals, as well?**

**VA Response:** As VBA claims are the primary driver of the appeals workload to the Board, any large increases to the VBA compensation and pension (C&P) workload result in an increased volume of appeals. The Board works closely with VBA to

coordinate workload forecasts and anticipates the potential influx of claims identified by VBA would also impact Veterans awaiting a decision on their appeal for benefits and services. VA further notes that increases to the Board's workload results in an increase volume of appeals to the U.S. Court of Appeals for Veterans Claims and the U.S. Court of Appeals for the Federal Circuit, creating an impact on the workload and resources of the Office of General Counsel.

**Question 6b: In the FY23 Budget, you're requesting a \$120M increase in resources for disability claims processing. Would this cover any increased demand from the PACT Act, if it were to pass tomorrow?**

**VA Response:** The request for \$120 million is specific to the Disability C&P Claims Modernization. The investment would automate components of the C&P claims process from submission to decision. While the initiative would increase VA's capability to deliver fast, accurate and consistent claim decisions for Veterans, it is not specific to the PACT Act of 2021.

**Question 6c: Do you still agree that the best path forward for veterans and the Department's adjudication of disability claims, both current and future, is to leave that to your current authority that you claim you have?**

**VA Response:** VA supports the PACT Act of 2021 for many reasons, the first reason being that it helps VA accomplish a priority goal: getting more Veterans into VA care. VA believes in the need to ensure the presumption process created by this bill allows VA and future Secretaries to act with transparency, efficiency and public participation for the benefit of Veterans—not create additional administrative burdens that slow down presumptive decision-making.

Section 202 of the House-passed PACT Act of 2021 would establish the procedures by which the Secretary could establish or remove presumptions of service-connection based on toxic exposures. The bill would establish a new Formal Advisory Committee on Toxic Exposure, of nine members (five appointed by the Secretary, and one each appointed by the Speaker of the House of Representatives, the minority leader of the House of Representatives and the majority and minority leaders of the Senate).

VA is concerned that the creation of a new Committee, particularly one subject to the Federal Advisory Committee Act, will slow existing mechanisms for proposing and conducting research, conducting analysis and decision-making.

Rather than using an advisory committee that would create significant administrative burdens and slow down the presumptive decision-making process, we recommend Congress consider requiring VA to publish in the Federal Register an annual list of conditions the Department plans to evaluate under VA's presumptive decision model, explain why the conditions were chosen for evaluation and seek input from the public on that list. This approach allows VA to provide timely decisions with full transparency and public participation.

VA believes that the new framework for decision-making on presumptions should endure changes in Administration. VA's updated approach to handling environmental exposure-related policy issues is not limited to development of the new model to accelerate the decision-making process to consider adding new presumptive conditions. This approach also includes a new governance structure with a focus on evidence-based decision-making, execution accountability, value creation and outcomes.

Questions for the Record from Senator Kyrsten Sinema:

**Question 1: Mr. McDonough, Sec. 202 of the Honoring our PACT Act establishes a committee, panels, and boards for review of toxic exposure. What measures would this committee take to ensure all domestic and overseas locations are getting an adequate review, and what measures will be required to establish a toxic exposure connection?**

**VA Response:** Section 202 of the House-passed PACT Act of 2021 would institute procedures by which the Secretary could establish or remove presumptions of service-connection based on toxic exposures. The bill would establish a new Formal Advisory Committee on Toxic Exposure, composed of nine members (five appointed by the Secretary, and one each appointed by the Speaker of the House of Representatives, the minority leader of the House of Representatives and the majority and minority leaders of the Senate).

VA is concerned that the creation of a new Committee, particularly one subject to the Federal Advisory Committee Act, would likely slow existing mechanisms for proposing and conducting research, conducting analysis and decision making.

VA is working closely with DoD to enhance the use of the Individual Longitudinal Exposure Record (ILER) in the Electronic Health Record. VA (ORD) is actively reviewing opportunities with DoD to improve environmental monitoring and use of wearable monitoring applications.

As noted earlier, VA supports Congress considering requiring VA to publish in the Federal Register an annual list of conditions the Department intends to evaluate under VA's presumptive decision model rather than using an advisory committee, which would create significant administrative burdens and slow down the presumptive decision-making process. This would allow VA to explain why the conditions were chosen for evaluation and seek input from the public on that list. This approach would enable transparency, allow for public participation and would provide a faster decision-making process. VA believes use of this new framework for decision-making would endure changes in Administration.

**Question 2: What procedures does the Veterans Affairs plan to enact to evaluate which areas are considered for toxic exposure, and will servicemembers and veterans be notified if they served in these areas?**

**VA Response:** VA regularly evaluates existing areas of concern, like Southwest Asia and health concerns from airborne hazards and burn pits including research through the Airborne Hazards Burn Pits Center of Excellence and clinical case definition development for constrictive bronchiolitis; Vietnam and Agent Orange with continued literature review for new studies on the health outcomes among Vietnam Veterans in the VE-HEROeS study; and health concerns from Karshi-Khanabad (K2) in Uzbekistan with the K2 Surveillance Program. VA performs routine and ongoing surveillance on

possible exposure cohorts to look for trends and health outcomes to include systematic review of VHA health outcomes data, exposure data and deployment cohorts when available, and routinely publishes updates of this data. VA regularly evaluates Veteran concerns, concerns from Veterans Service Organizations (VSO), follows news reports and monitors VA health surveillance to determine which deployments or areas are considered for potentially hazardous exposures. Examples of this approach includes new efforts to understand exposures to directed energy (“Havana Syndrome”); exposure to fuels from the Red Hill, Hawaii water contamination; and interagency efforts to understand the health effects from Per- and Polyfluorinated Alkyl Substances.

When VA has established a presumption for an exposure, Veterans are reached through a variety of communication channels. VA’s Office of Public and Intergovernmental Affairs sends out press releases through a number of media channels to include VSO notifications and social media. If the exposure is related to airborne hazards, notifications go out through the email list of the AHOBPR list. HOME also has a newsletter called Military Exposures and Your Health at <https://www.publichealth.va.gov/exposures/meyh/publications/index.asp> that reaches out to Veterans on a broad number of topics related to the health effects of military environmental exposures.

Veterans have also received notifications from VBA about benefits. VA also communicates with VSOs to help disseminate information for Veterans if they served in an area with exposures of concern.

**Question 3: What factors are going to be used for establishing a nexus for service member and veterans’ condition if they have a causal connection to a toxic exposure site?**

**VA Response:** The new presumptive decision-making model currently being piloted reviews the science, but also considers VBA and other data to evaluate exposures. While science has primacy in this model, **VBA data are considered for the first time** and is most valuable in cases where the science is not decisive. Additionally, the model also considers “other factors” that may include, for example, the severity of the disease such as in aggressive, terminal illnesses. VA is confident this model is a consistent and better way forward in considering all available information in establishing presumptions.

There are a wide range of military and environmental exposures that can occur during military service and may lead to various chronic illnesses and diseases that impact Service members and Veterans over their lifetimes. In many cases, especially where a disability manifests while on active duty or is diagnosed within 1-year following discharge from military service, VA can link the current chronic condition to the exposure event through treatment that is received within and outside of service on what is deemed a “direct” basis. However, often, the manifestation of these diseases and illnesses that related to military environmental exposures does not occur within immediate timeframes thereafter (or may not manifest until several years after the military service is over). In the instances where there is a delayed onset of disease or

illness, it is often difficult for Veterans to prove that the current chronic conditions they are facing were the result of military service that occurred several years earlier. Therefore, VA relies on evidence of a nexus or link between the currently diagnosed condition and the in-service military exposure event. For example, a physician's medical opinion may also be submitted to demonstrate that there is a likelihood that the current ailment is due to the military environmental exposure.

VA recognizes that it is often difficult for Service members and Veterans to provide evidence of a nexus between their current conditions and military service events; however, by law, VA must make its determinations based on evidence and must reconcile the facts of the claim through medical opinions and/or verification through the Department of Defense (DoD).

VA requests information from DoD to verify military environmental exposure incidents, obtains service treatment records and gathers military personnel pages that are reviewed to help determine in-service exposures, in-service events and current diagnosis and severity of the claimed condition.

Additionally, in many cases, through the C&P examination process, VA facilitates the gathering of these examinations and medical opinion as evidence that is necessary to complete the claim and to make the rating determination as to whether the condition is related to military service. VA requires that its medical examiners review the military service records to advise on any in-service event and treatment, to include the nature of hazards and exposures. To facilitate this review, the examiner is provided with corresponding fact sheets and information that is relevant to the environmental exposures and related medical conditions, to ensure the opinions are fully informed based on all known objective scientific and medical facts. After reviewing the evidence, the examiner provides a medical determination regarding the likelihood that there is a link or connection between the diagnosed medical condition and the environmental exposure.

VA acknowledges that in certain instances, the Veteran may not have evidence to verify a particular exposure during service, and that VA or DoD also may not have the precise data on the characterization of a Veteran's claimed exposure. This gap has been highlighted over the years by NASEM as they emphasized the need to perform population-based studies of those who have known exposures. VA has adopted broad-based concessions of exposure policies to mitigate this gap. For example, for claims specifically related to burn pit exposure, VA concedes such exposure for Veterans who served in Southwest Asia. VA continues to address ways to better verify individual exposure for Veterans' claims through utilization and development of the Individual Longitudinal Exposure Record (ILER). However, establishing presumptions where warranted further reduces the evidentiary burden on Veterans and reduces the evidence-gathering required by VA.

**Question 4: Domestically, our military and their families have been exposed to superfund sites, condemned buildings and drinking water contamination. What**

**can we include in this legislation to ensure we are not leaving those exposed behind?**

**VA Response:** With respect to Service members and Veterans, rather than include additional authority in this legislation, we instead ask that you continue to allow us to implement and refine our new process for determining toxic exposure presumptions. The process is not limited in any geographic manner and can be used to evaluate potential exposures occurring both domestically and abroad, thereby ensuring that non-deployed cohorts are not left behind.

Matters involving exposures of Service members' families to toxins at superfund sites or other environmental hazards may present a wide variety of issues and may implicate authorities and potential solutions beyond the scope of the Veterans' benefits scheme.

In terms of current benefits available to Veterans, Service members and their family members who were exposed to environmental hazards at such locations, VA can provide health care and benefits in some situations. For example, under 38 U.S.C. 1710(e)(1)(F), VA can provide health care to Veterans who served on active duty in the Armed Forces at Camp Lejeune, North Carolina, for not fewer than 30 days between August 1, 1953, and December 31, 1987. Similarly, under 38 U.S.C. 1787, VA can provide health care for 15 specific conditions or illnesses to the family members of such Veterans if the family members resided at Camp Lejeune, North Carolina, for not fewer than 30 days during that period or who was in utero during such period while the mother resided there. Under 38 C.F.R. 3.307(a)(7) and 3.309(f), Veterans who had at least 30 days of service at Camp Lejeune during that same period and develop any of eight listed diseases are presumed to have incurred or aggravated the disease in service for purposes of entitlement to VA benefits. For other exposures, VA currently can only provide health care when the Veteran or family member is otherwise specifically eligible under another authority. Veterans who can establish the illness or condition is connected to their military service may be awarded service-connection and receive benefits, which can also establish eligibility for health care for the Veteran, and in some cases their family members.

As we discussed in our testimony, a number of the provisions in the Honoring our PACT Act of 2021 would support new research into potential exposures, and this research could advance our understanding of these issues and locations, which can provide a basis for service-connection or other action by VA to provide assistance to individuals who were exposed to environmental hazards.

**Department of Veterans Affairs  
June 2022**





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**Statements for the Record**

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**THE NATIONAL ACADEMIES 2008 REPORT TITLED “IMPROVING THE PRESUMPTIVE  
DISABILITY DECISION-MAKING PROCESS FOR VETERANS”**

Testimony for the Record  
Submitted by

Monica N. Feit, Ph.D., M.P.H.  
Executive Director  
Health and Medicine Division  
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for the  
Committee on Veterans’ Affairs  
United States Senate

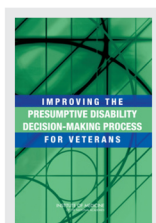
March 29, 2022

Chairman Tester, Ranking Member Moran and members of the Committee, thank you for inviting the National Academies to submit our 2008 report, *Improving the Presumptive Disability Decision-Making Process for Veterans*, as testimony for today's hearing on the impact of the Honoring our Promise to Address Comprehensive Toxics Act of 2021 (PACT Act) on veterans and Department of Veterans Affairs (VA).

In 1863, President Abraham Lincoln signed a congressional charter to create The National Academy of Sciences as an independent, authoritative body outside the government that could advise the nation on matters pertaining to science and technology. Every year, thousands of leading scientists, engineers, and medical experts serve on our study committees as volunteers without financial compensation for their time. We enlist their expertise across disciplines to examine the best available evidence, reach consensus, and identify a path forward. We do not advocate for specific policy positions.

Enclosed are responses to Senator Moran's pre-hearing questions and the summary of the National Academies 2008 report, which examined VA's process for determining disability presumptions and recommended areas for improvements. The full report is available for download from: <https://www.nap.edu/catalog/11908/improving-the-presumptive-disability-decision-making-process-for-veterans>

The National Academies stand ready to assist if you have any additional questions about our previous reports, current studies, or potential future work on veterans' health matters or other issues.

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### Improving the Presumptive Disability Decision-Making Process for Veterans (2008)

#### DETAILS

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**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*

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

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*“Knowing is not enough; we must apply.  
Willing is not enough; we must do.”*  
—Goethe



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## Reviewers

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. We wish to thank the following individuals for their review of this report:

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Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations nor did they see the final draft of the report before its release. The review of this report was overseen by **Gilbert S. Omenn**, University of Michigan Medical School, and **Willard G. Manning**, University of Chicago. Appointed by the National Research Council and Institute of Medicine, respectively, they were responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authoring committee and the institution.

## Preface

This committee, the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans (Committee), was charged with describing the current process for how presumptive decisions are made for veterans who have health conditions arising from military service and with proposing a scientific framework for making such presumptive decisions in the future. Although an individual veteran can establish a direct service connection for an illness, the needed information on the responsible exposure received during military service may be unavailable or incomplete. Additionally, there may be scientific uncertainty as to whether the exposure is known to cause the health condition. To ensure that veterans are compensated when information for direct service connection is needed but unavailable, Congress or the Secretary of the Department of Veterans Affairs (VA) can decide to service connect entire groups of veterans for specific health conditions due to exposures received during service. This decision to compensate particular groups of veterans is called a presumptive disability service-connection decision or, simply, a presumption. A presumption may address unavailable or incomplete information on exposure or gaps in the evidence as to whether the exposure increases risk for the health condition.

Each veteran identified as eligible for coverage under a presumptive decision will have a separate, individual disability rating conducted by the VA and will be eligible for disability compensation based on the nature and severity of the health condition. That is, the presumptive disability service-connection decision is separate from the rating evaluation and compensation process.

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The Committee took on the task of addressing presumptions while the United States was involved in conflict in Iraq and Afghanistan and veterans from prior conflicts were developing health conditions linked to service in Vietnam and the 1990 Persian Gulf War. The Committee's charge involved examination of the processes used by all participants in the presumptive disability decision-making process for veterans—Congress, VA, the National Academies (National Research Council [NRC] and Institute of Medicine [IOM]), veterans service organizations, and veterans. The Committee examined the processes used by the NRC and IOM to evaluate scientific evidence in support of presumptive disability decision-making by the VA and how the VA used the syntheses and scientific classifications of the NRC and IOM, along with other information, to establish presumptive decisions. The Committee was asked to describe the current process. The Committee's approach involved a series of case studies, intended to draw out "lessons learned" that would inform the development of a new approach. The case studies are not intended as criticisms about the work of past NRC or IOM committees or previously established presumptive decisions by Congress and VA. Rather the case studies serve as an appropriate and informative foundation for proposing an approach for the future.

The Committee concluded that the presumptive disability decision-making process should be based on evidence about veterans' health and how their health had been affected by military service. The Committee proposes a framework for the future that will be based on findings about the health of veterans that come from careful charting of Service member exposures during military service and tracking of their health at entry into, during, at separation from and after military service. The proposed framework may be applied to all types of exposures (e.g., chemical, biological, infectious, physical, and psychological); however, we recognize that characterizing psychological stressors, particularly under combat circumstances, is particularly difficult, although highly relevant to the chronic neuropsychiatric disorders faced by veterans. The Committee offers its framework for evaluation of the resulting evidence and for considering the evidence from studies of veterans in the context of all other relevant lines of scientific evidence. The Committee recommends a two-step approach for evaluation of scientific evidence on exposures of military personnel and risks to health. The first step is to determine the strength of evidence in support of causation and to classify the strength of the causal classification. The second step is to describe the magnitude of the disease burden caused by the exposure in a specific group of veterans.

Presumptive decisions, while based in evidence on risks to health status, are also affected by other considerations. The report acknowledges these considerations. The Committee recognizes that its proposed framework for the future will be applied in a context set by many considerations beyond



## PREFACE

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the scope of scientific evidence and its classification with regard to the strength of evidence for causality. Nonetheless, the Committee respectfully hopes that the Veterans' Disability Benefits Commission will recommend and that Congress and the VA will adhere to an evidence-based approach for the future presumptive disability decision-making process for veterans.

I am highly appreciative of the dedication and work of the members of the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans. They willingly took on this important effort at a time when every American is aware of the great sacrifices that military service men and women and our veterans have and do make each day. The Committee addressed its charge with great dedication and worked tirelessly to consider all of the relevant information, to deliberate at length in committee meetings and conference calls. Of course, each committee member invested substantial time in this effort, reflective of its importance and of its challenging nature. The proposed scientific framework, levels for strength of evidence, and other recommendations in this report reflect the thoughtful and carefully considered conclusions of the Committee. The Committee wishes to express its appreciation for the valuable support of its dedicated staff directed by Catherine Bodurow. This report would not have been possible without their contributions.

Veterans have sacrificed a great deal for our nation. We owe them the best possible process for ensuring that those having service-related health conditions are properly identified, treated, and compensated.

Jonathan M. Samet, M.D., M.S.  
*Chair, Committee on Evaluation of the Presumptive  
Disability Decision-Making Process for Veterans*

## Acknowledgments

The Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans (Committee) and Institute of Medicine (IOM) staff would like to thank many individuals for providing information, data, discussions, and comments throughout this study. The Committee and IOM staff are indebted to these individuals for their assistance and contributions.

The Committee and IOM staff would like to acknowledge and thank members of the Veterans' Disability Benefits Commission (VDBC) for taking time to attend and participate at the Committee's open session meetings. The commissioners include: James T. Scott (VDBC's Chairman), John Grady, Rick Surratt, and Joe Wynn. We would also like to recognize the VDBC Staff for their attendance and participation at the Committee's open session meetings as well as any needed technical assistance throughout the study. These individuals include: Ray Wilburn (VDBC's Executive Director), Jacqueline Garrick, Kathleen Greve, Steve Riddle, Jim Wear, and Donald Zeglin. IOM staff is appreciative of the assistance provided by Marcelle Habibon (Department of Veterans Affairs' [VA] Director of Program Evaluation Service in the Office of Policy and Planning) during the course of the study. Many others from VA also provided information, presented at Committee meetings or participated in meetings with the Committee Chair and IOM staff. They are recognized, as follows, in alphabetical order: David Barrans, Mark Brown, Douglas Dembling, Lawrence Deyton, Patrick Dunne (VA's Assistant Secretary for Policy and Planning), George Fitzelle, Duane Fleming, Bradley Flohr, Paul Hutter (VA's Acting General

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Throughout the course of the study, the Committee received written comments from veterans service organizations, individual veterans, and the public. These comments served to heighten awareness of important issues

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IOM staff assembled an extensive electronic library of public laws, *Federal Register* notices, and all related presumptive disability decision documents with the assistance of librarians and experts at the Library of Congress. These individuals provided assistance in assembling an enormous knowledge base—from microfiche to electronic files—for the Committee, which was extensively researched and used throughout the study process. IOM staff is greatly indebted to the staff at the Library of Congress for these efforts.

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## Acronyms and Abbreviations

ACB	Army Classification Battery
ACES-EM	Automated Civil Engineering System-Environmental Management
ACHRE	Advisory Committee on Human Radiation Experiments
ADA	American Diabetes Association
AEC	Atomic Energy Commission
AF	Attributable fraction
AF-EMIS	Air Force Environmental Management Information System
AFCESA	Air Force Civil Engineer Support Agency
AFHLTA	Armed Forces Health Longitudinal Technology Application
AFHS	Air Force Health Study
AFHSC	Armed Forces Health Surveillance Center
AHA	American Heart Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AhR	Aryl hydrocarbon receptor
AIDS	Acquired immunodeficiency syndrome
AIS	Automated information systems
ALS	Amyotrophic lateral sclerosis (Lou Gehrig's disease)
AML	Acute myelogenous leukemia
ANG	Air National Guard
ANLL	Acute non-lymphocytic leukemia

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## ACRONYMS AND ABBREVIATIONS

APIMS	Air Program Information Management System
AS	Assigned share
ASTM	American Society for Testing and Materials
ATSDR	Agency for Toxic Substances and Disease Registry
BEIR	Biological Effects of Ionizing Radiation
BMI	Body mass index
C&P Service	Compensation and Pension Service
CCB	Configuration Control Board
CCS	Command Core System (Air Force)
CDC	Centers for Disease Control and Prevention
CDVA	Commonwealth Department of Veterans' Affairs
CERHR	Center for the Evaluation of Risks to Human Reproduction
CES-D	Centers for Epidemiological Studies-Depression Scale
CFR	Code of Federal Regulations
CHD	Coronary heart disease
CHF	Congestive heart failure
CHPPM	Center for Health Promotion and Preventive Medicine (Army)
CI	Confidence interval
CIA	Central Intelligence Agency
CIRRPC	Committee on Interagency Radiation Research and Policy Coordination
CLL	Chronic lymphocytic leukemia
CNS	Central nervous system
COPD	Chronic obstructive pulmonary disease
CRDP	Concurrent Retirement and Disability Payments
CRS	Congressional Research Service
CRSC	Combat-Related Special Compensation
CSM	Cerebrospinal malformation
CSP	Cooperative Studies Program
CVD	Cardiovascular disease
DALY	Disability-adjusted life year
DCI SCI	Director of Central Intelligence Sensitive Compartmented Information Programs
DECC-D	Defense Enterprise Computing Center-Detachment
DHHS	Department of Health and Human Services
DISA	Defense Information Systems Agency
DMDC	Defense Manpower Data Center

## ACRONYMS AND ABBREVIATIONS

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DMSS	Defense Medical Surveillance System
DNBI	Disease and nonbattle injury
DoA	Department of the Army
DoD	Department of Defense
DoDI	Department of Defense Instruction
DOE	Department of Energy
DOEHS	Defense Occupational and Environmental Health Readiness System
DoL	Department of Labor
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised
DTAS	Defense Theater Accountability Software
EA	Exposure Assessment
EAR	Excess absolute risk
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
EESOH-MIS	Enterprise Environmental Safety and Occupational Health-Management Information System
EO	Executive Order
EPA	Environmental Protection Agency
EPCRA	Emergency Planning and Community Right-to-Know Act
ERIC	Epidemiologic Research and Information Center
ERR	Excess relative risk
FECA	Federal Employees' Compensation Act
FERS	Federal Employees Retirement System
FHIE	Federal Health Information Exchange
FHP	Force Health Protection
fMRI	Functional magnetic resonance imaging
FN	False negative
FNR	False negative rate
FOUO	For official use only
FP	False positive
FPR	False positive rate
FR	Federal Register
FY	Fiscal Year
GAF	Global Assessment of Functioning
GAO	Government Accountability Office
GBD	General birth defect
GBS	Guillain-Barre syndrome

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## ACRONYMS AND ABBREVIATIONS

GPS	Global Positioning System
GT test	General Technical test
GW	Gulf War
Gy	Gray (measure of dose of irradiation)
HART	Health Assessment Review Tool
HCFA	Health Care Financing Administration
HEW	U.S. Department of Health, Education, and Welfare
HHIM	Health Hazard Information Module
HIV	Human immunodeficiency virus
HMMS	Hazardous Materials Management System
HUS	Hemolytic-uremic syndrome
IARC	International Agency for Research on Cancer
ICD	International Classification of Diseases
IH	Industrial hygiene
IHIMS	Industrial Hygiene Information Management System (Navy)
IOM	Institute of Medicine
IQ	Intelligence quotient
IREP	Interactive RadioEpidemiological Program
IU	Individual unemployability
LIMDIS	Limited Dissemination
LMF	Lovelace Medical Foundation
MDS	Myelodysplastic syndrome
MFUA	Medical Follow-up Agency
MMPI	Minnesota Multiphasic Personality Inventory
MOA	Memorandum of Agreement
MOS	Military occupational specialty
MRI	Magnetic resonance imaging
MS	Multiple sclerosis
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEH	National Center for Environmental Health
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NEHC	Navy Environmental Health Center
NESHAP	National Emission Standards for Hazardous Air Pollutants
NHANES	National Health and Nutrition Examination Survey
NHL	Non-Hodgkin's lymphoma

## ACRONYMS AND ABBREVIATIONS

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NHLBI	National Heart, Lung, and Blood Institute
NHS	Nurses Health Study
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NOCONTRACT	Not releasable to contractors
NOED	Navy Occupational Exposure Database
NOFORN	Not releasable to foreign nationals
NPV	Negative predictive value
NRC	National Research Council
NTP	National Toxicology Program
NTS	Nevada Test Site
OEF	Operation Enduring Freedom
OEH	Occupational and environmental health
OEHHA	Office of Environmental Health Hazard Assessment
OEHS	Occupational environmental health and safety
OEL	Occupational exposure limit
OGC	Office of the General Counsel
OH	Occupational health
OHMIS	Occupational Health Management Information System
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
OPHEH	Office of Public Health and Environmental Hazards
OPM	Office of Personnel Management
OR	Odds ratio
ORCON	Originator controlled dissemination and extraction of information
ORD	Office of Research and Development
OSHA	Occupational Safety and Health Administration
OSTP	Office of Science and Technology Policy
PAF	Population attributable fraction
PAR	Population attributable risk
PC	Probability of causation
PCB	Polychlorinated biphenyl
PDDM	Presumptive disability decision making
PHA	Periodic health assessment
PKDL	Post-kala-azar dermal leishmaniasis
PL	Public Law
POM	Program Objectives Memorandum
POW	Prisoner of War
PPB	Parts per billion
PPG	Pacific Proving Grounds

<i>xxx</i>	<i>ACRONYMS AND ABBREVIATIONS</i>
PPM	Parts per million
PPV	Positive predictive value
PSA	Prostate-specific antigen
PSG II	Professional Staffing Group II
PTF	Presidential Task Force
PTSD	Posttraumatic stress disorder
PY	Person-year
RADS	Reactive airways dysfunction syndrome
RCT	Randomized controlled/clinical trial
RD	Restricted data
ReA	Reactive arthritis
RECA	Radiation Exposure Compensation Act of 1990
RECAC	Radiation Exposure Compensation Act Committee
REVCA	Radiation-Exposed Veterans Compensation Act
RO	Rey-Osterreith Test
ROC	Receiver Operator Characteristics curve
RR	Relative risk/risk ratio
RTI	Research Triangle Institute
SAD	Service-attributable disease
SAF	Service-attributable fraction
SANG	Saudi Arabian National Guard
SAP	Special Access Program
SCI	Sensitive Compartmented Information
SCID	Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders
SCL	Symptoms Checklist
SEER	Surveillance Epidemiology and End Results
SEG	Similar exposure group
SES	Socioeconomic status
SF	Standard Form
SFFWG	Shared Functions Focus Working Group
SHAD	Project Shipboard Hazard and Defense
SMITREC	Serious Mental Illness Treatment Research and Evaluation Center
SMR	Standardized mortality ratio
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TBI	Traumatic brain injury
TCDD	Tetrachlorodibenzo- <i>p</i> -dioxin

## ACRONYMS AND ABBREVIATIONS

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TN	True negative
TNR	True negative rate
TP	True positive
TPR	True positive rate
UNSCEAR	United Nations Scientific Committee on the Effects of Atomic Radiation
USC	United States Code
USPSTF	U.S. Preventive Health Services Task Force
VA	Department of Veterans Affairs
VAO	Veterans and Agent Orange
VASRD	Veterans Administration Schedule for Rating Disabilities
VBA	Veterans Benefits Administration
VDDB	Veterans' Disability Benefits Commission
VDRECSA	Veterans' Dioxin and Radiation Exposure Compensation Standards Act
VES	Vietnam Experience Study
VET (registry)	Vietnam Era Twin (registry)
VHA	Veterans Health Administration
VHI	Veterans Health Initiative
VISTA	Veterans Health Information Systems and Technology Architecture
VOC	Volatile organic compound
VSO	Veterans Service Organization
WAIS-R	Wechsler Adult Intelligence Scale-Revised
WNINTEL	Warning notice, intelligence sources, and methods involved
WRISC	War-Related Illness and Injury Study Centers
WWI	World War I
WWII	World War II
YLD	Years of life lived with disability
YLL	Years of life lost



## Summary

### INTRODUCTION

The United States has long recognized and honored military veterans' service and sacrifices. Veterans injured by their service, becoming ill while in service, or having an illness after discharge as a long-term consequence of their service have been given healthcare coverage and disability compensation. As the complexity of exposures during combat has increased, the list of service-connected illnesses has grown. The Department of Veterans Affairs (VA) now provides disability compensation to approximately 2.6 million veterans for 7.7 million disabilities annually, expending approximately \$24 billion for this purpose (VBA, 2006, pp. 19, 24, 27).

Disability compensation for military veterans requires that there be a service connection. A medical illness or injury that occurred while a member was in military service is considered service connected whether caused by or aggravated by an exposure or event during service or *simply occurring coincidentally* with military service. However, if a medical condition appears after the period of military service and it is presumed to be caused by or aggravated by an exposure or an event that occurred during military service, then veterans may receive compensation based on that presumption (Pamperin, 2006).

In making a decision to provide compensation, VA needs to determine whether the illness of concern can generally be caused by exposures received during service and whether the illness in a specific claimant was caused by the exposure. The answer to the general question of causality comes from a careful review of all available scientific information, while the answer

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to the question of causation in a specific person hinges on knowledge of the exposure received by that individual and of other factors that may be relevant. If the scientific evidence is incomplete, there may be uncertainty on the question of causation generally; if there is limited or no information on exposure of individual claimants or if other factors also contribute to disease causation, there may be uncertainty on the question of individual causation.

To provide benefits to veterans in the face of these two broad types of uncertainty, Congress and VA make presumptive decisions that bridge gaps in the evidence related to causation and to exposure. Presumptions may relieve the veteran of persuading VA that the exposure produced the adverse health outcome and of proving that an exposure occurred during military service (Pamperin, 2006). Once a medical condition is service connected through presumptions, and the veteran can document military service consistent with having received the given exposure, the veteran only has to show the basic fact that he or she suffers from the condition in order to receive a disability payment and eligibility for medical care (Zeglin, 2006).

In 2004, Congress established the Veterans' Disability Benefits Commission (the Commission), which was charged with "studying the benefits provided to compensate and assist veterans for disabilities attributable to military service" (VDBC, 2006, p. 1; as found in Appendix A). The Commission identified the presumptive disability decision-making process as a topic needing assessment and asked the Institute of Medicine (IOM) to establish a committee for this purpose that would be funded by VA. The resulting committee, the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans (the Committee), was given the following charge by VA:

- Describe and evaluate the current model used to recognize diseases that are subject to service connection on a presumptive basis.
- If appropriate, propose a scientific framework that would justify recognizing or not recognizing conditions as presumptive.

The Commission further elaborated the charge, asking the Committee to "help ensure that future veterans are granted service connection under a presumptive basis based on the best scientific evidence available" (VDBC, 2006, p. 4; as found in Appendix A). The Commission asked the Committee to "evaluate the current model used to determine diseases that qualify for service connection on a presumptive basis, and if appropriate, propose improvements in the model" (VDBC, 2006, p. 1; as found in Appendix A). The Commission emphasized that "having a method of granting service connection quickly and fairly based on a presumption is

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of critical importance to our disabled veterans and their surviving spouses” and that “ensuring that future presumption processes reflect the then current medical knowledge about the causal relationship would benefit the entire veteran community” (VDBC, 2006, p. 4; as found in Appendix A). The Commission’s summary statement further commented that “[f]or the extent possible, suggestions that will avoid the necessity for many future presumptions by ensuring that exposure of service members is documented and scientific evidence is made available would be important” (VDBC, 2006, p. 4; as found in Appendix A).

IOM appointed a 14-member committee that covered the broad scientific and medical areas of general, occupational, and psychiatric medicine; biostatistics; epidemiology; toxicology; industrial hygiene; and exposure and risk assessment. The Committee’s members also brought expertise in law, philosophy, causal decision making, and policy as well as knowledge of the Department of Defense (DoD) and VA’s approach to disability compensation.

## THE COMMITTEE’S APPROACH TO ITS CHARGE

In fulfilling its charge, the Committee first investigated and attempted to characterize Congress’ and VA’s recent approach to presumptive disability decision making, and then developed a conceptual framework for a new, more evidence-based process. It then constructed a way to move forward that builds on the framework and addresses deficiencies of the current process.

The Committee held three open meetings to gather information on the current presumptive disability decision-making process. The Committee heard from past and present congressional staff members, representatives of VA, DoD, IOM, various stakeholder groups (e.g., veteran service organizations [VSOs]) and the general public. Committee members also participated in conference calls with DoD experts on medical surveillance and exposure data collection and exposure assessment systems.

The Committee reviewed extensive background information including: documents provided by the Commission, public laws and supporting House and Senate reports, *Federal Register* notices, VA documents (e.g., cost estimates, a white paper on VA’s decision-making processes [found in Appendix G], and responses by VA to written questions from the Committee), DoD documents, and past IOM reports commissioned by DoD and VA. The Committee conducted 10 case study reviews—Mental Disorders’ Presumptions, Multiple Sclerosis Presumption, Prisoners of War Presumptions, Amputees and Cardiovascular Disease Presumption, Radiation Presumptions, Mustard Gas and Lewisite Presumptions, Gulf War Presumptions, Agent Orange and Prostate Cancer Presumption, Agent Orange and Type 2

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Diabetes Presumption, and Spina Bifida Program (not a presumption but a VA program area)—that cover a wide variety of circumstances for which presumptions have been established by Congress and VA since 1921. The case studies were a foundation for the Committee's efforts in understanding past practices of all participants in the presumptive disability decision-making process (see Appendix I).

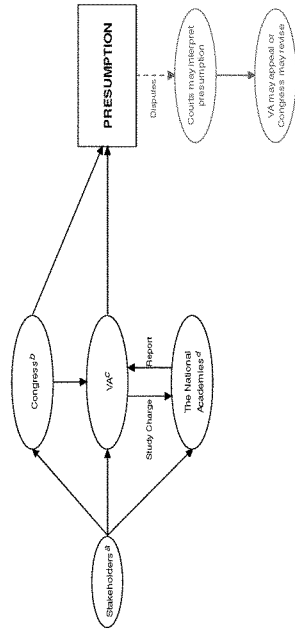
The Committee also researched and considered capabilities and limitations of the exposure data and health outcome information available to DoD and VA for exposure assessment, surveillance, and research purposes. The Committee examined whether DoD and VA have a strategic research plan and vision for the necessary interface between the agencies, as well as with other, relevant research organizations.

The Committee considered the use of scientific evidence in guiding the process for making presumptive decisions that affect the compensation of veterans. Drawing upon the Committee members' expertise in epidemiology, medicine, toxicology, biostatistics, and causal decision making, the Committee covered the evaluation of evidence for inferring association and causation as well as methods for quantifying the contribution of an agent to disease causation in populations and extending this quantification to individuals. Using this framework, the Committee developed an evidence-based approach for making future decisions with regard to presumptions.

**THE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS**

In 1921 Congress empowered the VA Administrator (now Secretary) to establish presumptions of service connection for veterans. Only Congress and the VA Secretary have the authority to establish presumptions. Over time, presumptions have been made to relieve veterans of the burden to prove that disability or illness was caused by a specific exposure that occurred during military service (e.g., Prisoners of War). Since 1921, nearly 150 health outcomes have been service connected on a presumptive basis (see Appendix F). In February 2006, Congress codified all regulatory presumptions that VA had put in place to that time.

The current presumptive disability decision-making process for veterans involves several steps and several organizations. The process involves input from many parties—Congress, VA, the National Academies, and stakeholders (e.g., VSOs, advisory committees, and individual veterans) (Figure S-1). Congress has made presumptions itself. In the current model, Congress or stakeholders acting through Congress may call on VA to assess whether a presumption is needed. The VA turns to IOM for completion of a review of the scientific evidence. The findings of that evaluation are consid-



**FIGURE S-1** Roles of the participants involved in the presumptive disability decision-making process for veterans. 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). 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. 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. The National Academies (Institute of Medicine and National Research Council) submit reports to VA based on requests and study changes from VA.

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ered by VA in its presumptive disability decision-making process. Decisions made in the courts have also influenced the current presumptive process.

Three major legislative actions by Congress have influenced the recent presumptive decisions—the Radiation Exposed Veterans Compensation Act of 1988 (Public Law 100-321, 100th Cong., 2d Sess.), the Agent Orange Act of 1991 (Public Law 102-4, 102d Cong., 1st Sess.), and the Persian Gulf War Acts of 1995 (Veterans' Benefits Improvement Act of 1994, Public Law 103-446, 103rd Cong., 2d Sess.) and 1998 (Making Omnibus Consolidated and Emergency Appropriations for the Fiscal Year Ending September 30, 1999, and for Other Purposes, Public Law 105-277, 105th Cong., 2d Sess.). The concept of “at least as likely as not” with regard to exposure potential was introduced for radiation exposures and its use has since been continued. The Agent Orange Act (Public Law 102-4, 102d Cong., 1st Sess.) grew out of events following the Vietnam War, and its language expresses substantial and significant elements of the presumptive story. The presumptions put in place by Congress for Gulf War illnesses represent the first time that Congress produced a list of health outcomes that it defined as “undiagnosed illnesses” (Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, 107th Cong., 1st Sess.).

When Congress enacted the Agent Orange Act of 1991 (Public Law 102-4, 102d Cong., 1st Sess.), it started a model for a decision-making process that is still in place. Congress asked VA to contract with an independent organization—VA contracted with IOM—to review the scientific evidence for Agent Orange. Since 1994, IOM has produced biennial reports on Agent Orange for VA to use as it considers making presumptive decisions (IOM, 1994, 1996, 1999, 2001, 2003b, 2005b). IOM has also delivered five volumes on the Gulf War (IOM, 2000a, 2003a, 2005a, 2006, 2007). Congress requires VA to respond after receiving an IOM report with a determination as to whether VA will make a service connection for particular health outcomes on a presumptive basis. VA has described its internal decision-making processes to the Committee in a general fashion, and the Committee has reviewed VA's *Federal Register* notices and documents (see Chapter 3). However, it remains unclear to the Committee how VA makes particular determinations with regard to weighing strength of evidence for causation and exposure potential in making its presumptive decisions.

Analysis of the Agent Orange and Gulf War case studies (see Appendix 1) shows important similarities and differences relevant to the overall presumptive process. One difference is that Agent Orange is a single product (actually a mixture of compounds that contains the contaminant dioxin), extensively researched for associated health outcomes, whereas the health consequences of the Gulf War are unlikely to be the result of any single agent. Military service men and women may have received a number of health-relevant exposures during service in the Persian Gulf, complicating the development of evidence reviews. For Agent Orange, there is one

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exposure of concern and a more constrained set of health indicators. There have been some differences in approaches of Agent Orange and Gulf War committees. The IOM Agent Orange reports (IOM, 1994, 1996, 1999, 2001, 2003b, 2005b) did not explicitly include a causal category in their evaluations whereas recent Gulf War reports (IOM, 2000a, 2003a, 2005a, 2006, 2007) did include a category for evidence sufficient to infer causation when characterizing the strength of evidence for agents evaluated. For neither set of reports does VA describe in its *Federal Register* notices how it accounted for exposure potential or magnitude in making its presumptive decisions.

## FINDINGS OF CASE STUDIES

The case studies offered a diverse set of lessons learned and indicated elements of the current process that need to be addressed. In carrying out the case studies, this Committee had the opportunity to retrospectively examine the work of IOM committees as they grappled with the challenge of using uncertain evidence and of VA staff as they used the findings of IOM committees to make decisions about presumptions. The case studies demonstrate that the process has acted to serve the interests of veterans in many instances. Congress and VA have repeatedly acted to maximize the sensitivity of presumptive decisions so as to assure that no veteran who might have been affected is denied compensation. On the other hand, in maximizing sensitivity of presumptive disability decision making, substantial numbers of veterans whose illnesses may or may not have been actually service related are nonetheless compensated. There are both financial and nonfinancial costs to such decisions.

The case studies illustrate the use of presumptions to cover gaps in evidence, gaps that exist in part because of lack of information on exposures received by military personnel and inadequate surveillance of veterans for service-related illnesses. Secrecy is a particularly troubling source of incomplete information, as illustrated by the veterans who participated in studies of mustard gas and lewisite. Research carried out directly on the health of veterans has proved useful in some instances, leading to a decision, for example, on granting disability compensation for cardiovascular disease in amputees. But the research has not been systematic, and in the example of cardiovascular disease in amputees no further evidence relevant to a presumption made in 1979 has been collected. Research on radiation risks in veterans has been severely constrained by a lack of dose information, and the studies on radiation-exposed veterans have not been highly informative.

Across the case studies, the Committee found variable approaches to synthesizing evidence on the health consequences of military service. The inferential target of scientific evidence reviews has not been consistent

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and varied between causation (e.g., mustard gas and lewisite, Gulf War) and association alone (e.g., Agent Orange). The more recent IOM Agent Orange reports have emphasized findings of observational studies on association and interpretation that might have been enhanced by placing the findings within a biological framework strengthened by greater attention to other lines of evidence. In the Agent Orange case studies, the category “limited/suggestive” for classifying evidence for association has been used for a broad range of evidence from indicating the mere possibility of an association to showing that an association is possibly causal. The “limited/suggestive” evidence of association—on which the VAs presumptive decisions to compensate type 2 diabetes and prostate cancer were made—may be below the level of certainty needed to support causation absent strong mechanistic understanding or to meet the congressional language of “if the credible evidence for the association is equal to or outweighs the credible evidence against the association,” which the Committee refers to “at least as likely as not.”

Both prostate cancer and type 2 diabetes illustrate situations in which the contribution of military exposures should be assessed against a background of disease risk that has other strong determinants: age in the case of prostate cancer and family history and obesity in the case of type 2 diabetes, as indicated by the IOM committee in its report (IOM, 2000b). For both type 2 diabetes and prostate cancer, the magnitude of the relative risks observed for pesticide exposure implies that the contribution of military exposures is likely to be small in comparison to those of the other contributing factors. In such circumstances, an estimation of the proportion of cases attributable to military exposures could be helpful to the VA in considering whether or not to presumptively service-connect disabilities. The Committee recognizes that development of such estimations is a complicated process dependent on acquiring better exposure data, which may not be available for some period of time.

In the case studies, the Committee’s analyses were based on the very general information provided by VA about its internal decision-making processes. The case studies and VA’s decision to withhold documents related to specific decisions from the Committee did make clear, however, that these processes are not fully transparent. VA believes that access to predecisional documents by outside sources could stifle candid staff discussions on issues. Once IOM carries out its reviews and provides VA with reports documenting the extent of evidence available on associations, the internal processes of VA that follow are not fully open to scrutiny. This closed process could reduce trust of veterans in the presumptive disability decision-making process and may hinder efforts to optimize the use of scientific evidence. The Committee also found inconsistency in the decision-making process.



SCIENTIFIC FOUNDATION FOR  
PRESUMPTIVE DISABILITY DECISION MAKING

In developing a future approach for presumptive disability decision making, the Committee first gave extensive consideration to causal inference and the processes used to make causal judgments. In other words, the Committee considered how scientific evidence is used to determine *if* exposure causes some disease. These determinations are generally made by expert committees that examine all relevant evidence for strengths and weaknesses and then synthesize the evidence to make a summary judgment. The Committee defines "exposure" in a broad manner to include chemical, biological, infectious, physical, and psychological stressors. The Committee recognizes that psychological stressors may be particularly difficult to describe, let alone measure and quantify.

The Committee then considered the quantification of the contribution of a particular exposure to disease causation. This second issue addresses the question of *how much* of the observed disease in a group, in both absolute and relative terms, is caused by the exposure.

Provision of compensation to veterans on a presumptive basis, or to any other group that has been injured, requires a *general* decision as to whether the agent or exposure of concern has the potential to cause the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in a particular individual. The determination of causation in general is based in a review and evaluation of all relevant evidence including (1) data on exposures of military personnel during service; (2) evidence on risks for disease coming from observational (epidemiologic) studies of military personnel; (3) other relevant epidemiologic evidence, including findings from studies of nonmilitary populations exposed to the agent of interest or similar agents; and (4) findings relevant to plausibility from experimental and laboratory research. The determination of causation in a particular case is based first on the general determination as to whether the exposure can cause disease, then on information about the exposures of the individual being evaluated for compensation, and on any other relevant information about the individual.

The Committee considered the properties of a decision-making process, recognizing the possibility of two types of systematic errors: making a decision to compensate when the exposure has not caused the illness (false positive) and to not compensate when the exposure has actually caused the illness (false negative). The Committee recommends that any decision process consider the trade-off between these two errors and attempt to optimize both the sensitivity (i.e., minimize the false negatives) and the specificity (i.e., minimize the false positives). Generally, higher sensitivity

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cannot be achieved without lower specificity. These errors have costs. False positive errors result in the expenditure of funds for cases of disease not caused by military service while false negative errors leave deserving veterans uncompensated. The appropriate balancing of these costs also needs consideration.

The Committee considered ways to classify evidence, reaching the conclusion that a broader and more inclusive evidence review process is needed. It found that IOM reviews could be enhanced if a broader array of epidemiologic and other evidence (e.g., animal and mechanistic data) was considered. The Committee also found that the target of inference had varied from causation (e.g., mustard gas and lewisite, Gulf War) to association (e.g., Agent Orange). Consequently, the Committee recommends that categories of evidence for reviews be established to make clear those relationships that are at least as likely as not to be causal. The Committee has concluded that a categorization of evidence is needed that gives a scientifically coherent rendering of the language employed by Congress in calling for review of available scientific evidence. The Committee proposes a four-level hierarchy that classifies the strength of evidence for *causation*, *not just association*, and that incorporates the concept of equipoise; that is, whether the weight of scientific evidence makes causation at least as likely as not in the judgment of the reviewing group.

The Committee also gave consideration to the quantification of the burden of disease attributable to an exposure. This quantification would be made to provide an evaluation of the numbers of veterans to be compensated, but it would not be a component of the evidence evaluation for causation. For the purpose of quantification, the attributable risk, termed the *service-attributable fraction*, can be calculated if the needed information is available on the relative risk of disease among exposed individuals. For those exposures meeting the necessary level of evidence for compensation, the Committee recommends that the service-attributable fraction should be estimated overall and for subgroups of veterans, perhaps grouped by level of exposure, if the requisite data are available. Until more complete exposure information becomes available in the future, such calculations may not be possible for all conditions for which presumptions are made.

## COMMITTEE'S RECOMMENDED APPROACH FOR THE FUTURE

## Overview

The Committee's recommended approach for the future (Figure S-2) has multiple new elements: a process for proposing exposures and illnesses for review; a systematic evidence review process incorporating a new evidence classification scheme and quantification of the extent of disease

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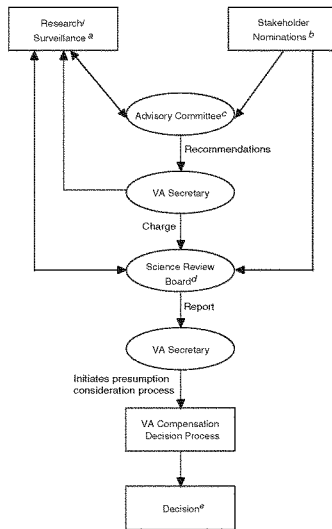


FIGURE S-2 Proposed framework for future presumptive disability decision-making process for veterans.

<sup>a</sup> Includes research for classified or secret activities, exposures, etc.

<sup>b</sup> Includes veterans, Veterans Service Organizations, federal agencies, scientists, general public, etc.

<sup>c</sup> 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.

<sup>d</sup> The board conducts a two-step evidence review process (see report text for further detail).

<sup>e</sup> Final presumptive disability compensation decisions are made by the Secretary, Department of Veterans Affairs, unless legislated by Congress.

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attributable to an exposure; a transparent decision-making process by VA; and an organizational structure to support the process. The Committee also calls for comprehensive tracking of exposures of military personnel and monitoring of their health while in service and subsequently.

**Organizational Structure**

The Committee recommends the creation by Congress of two new permanent boards: the Advisory Committee, serving in an advisory capacity to VA, and the Science Review Board (independent from VA). The Advisory Committee would consider the exposures and illnesses that might be a basis for presumptions and recommend to the VA Secretary exposures and illnesses needing further consideration. It would also consider research needs and assist VA with strategic research planning. The Science Review Board would evaluate the evidence for causation and, if warranted, estimate the service-attributable fraction of disease in veterans. One critical element in the deliberations of the Science Review Board would be evidence from monitoring the exposures and health of the veterans. The Science Review Board would provide VA with input for its presumptive decisions, including a summary report of the available scientific evidence in a standardized classification scheme.

Congress and VA may find alternative processes to achieve the overall objective of the Committee's recommendations: an evidence-based approach to making presumptive disability decisions. The Committee recognizes that specific elements of its proposal (e.g., the call for carrying out exposure assessments and making exposure estimates) are not yet fully practicable and would take time to develop and implement. However, future methodologic developments should enhance the feasibility of some of the challenging elements of this proposal. The Committee believes that this proposal can significantly improve the presumptive disability decision-making process for veterans and, therefore, the process for implementing it should begin without delay.

**Underlying Principles**

VA's decision to make a presumption may involve weighing difficult and incomplete scientific evidence, in the context of veterans' concerns and society's obligations to the affected veterans, and potential costs. Although the potential complexity of the decision-making process may make a complete codification difficult, the underlying principles can be clearly expressed. The Committee suggests the following six principles as a foundation for its proposed framework: (1) stakeholder inclusiveness; (2) evidence-based decisions; (3) transparent process; (4) flexibility; (5) consistency; and (6) using

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causation, not just association, as the basis for decision making. Flexibility and consistency are not contradictory constructs here. Flexibility refers to the ability to be adaptable through time in evaluating scientific evidence, and consistency refers to being consistent in the process of evaluating evidence and making consistent decisions based on a comparable level of certainty based on the scientific evidence.

**Proposals to Review for Potential Presumption**

In this process, conditions and causative agents or circumstances would be proposed for review based on evidence of a connection between the condition and military service and evidence that a sizable or well-defined group of veterans is likely to be affected. The possibility of a need for a presumption might arise from surveillance of veterans or active military personnel, laboratory research discoveries, or findings from studies of exposed workers. The process would be open, with proposals accepted from any source (e.g., veterans, veterans' families, VSOs, VA, DoD, other governmental bodies, researchers, the general public). Proposals accepted by the VA Secretary would be sent to the Science Review Board for full, comprehensive scientific evaluation.

**Science Review Board**

The Committee recommends a two-step process for scientific evaluation by the Science Review Board. The first step would involve a systematic review of all relevant data to decide the strength of evidence for causation, using one of four categories:

1. *Sufficient*: The evidence is sufficient to conclude that a causal relationship exists.
2. *Equipose and Above*: The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. *Below Equipose*: The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. *Against*: The evidence suggests the lack of a causal relationship.

If the evidence for causation were categorized as *Sufficient* or at *Equipose and Above*, then we anticipate that VA would consider a presumptive service connection based upon causal evidence categorization and its consideration of the service-attributable fraction if available (to be estimated in the second step of the process, described below). As is current VA policy,

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if the evidence is at *Equipose*, the benefit of the doubt would be given to the veteran. If the evidence were categorized as *Against*, then we anticipate that VA would not consider a presumptive service-connection. If, however, the evidence were categorized as *Below Equipose*, then we anticipate that VA would, after carefully considering the prospects and recommendations for future research, decide on an appropriate time frame for the subsequent scientific review of the evidence, with the expectation that the evidence would then be sufficient to resolve matters either for or against the causal claim at that time. Such information would be considered by the Advisory Committee serving in its capacity as overseer of the overall process and advisor to the VA Secretary.

If the VA Secretary were to decide that a presumption would not be established for evidence categorized as *Below Equipose* or, for other reasons, for evidence categorized as *Equipose and Above*, then during the period of further evidence development and gathering and prior to the subsequent scientific review of the evidence, VA should consider providing some support to potentially affected veterans, such as providing provisional access to medical care.

As evidence accumulates, the balance might move to strengthen or to weaken the case for causality. Importantly, the Science Review Board should be free to upgrade the level of evidence, to downgrade the level of evidence, or to leave it as the same categorization. For evidence that has reached the classification of *Sufficient*, we would not anticipate a potential lowering of the classification, if the original determination was correctly made and based on sound scientific evidence.

If the strength of the evidence reaches *Sufficient* or *Equipose and Above*, then the evaluation would move to step two, the calculation of the service-attributable fraction of disease when required data and information are available. This calculation is independent of the classification of the strength of evidence for causation, and the magnitude of the service-attributable fraction is not considered in the application of the four-level schema for categorizing evidence. Rather, the service-attributable fraction would be of value for decision making, giving an understanding of the scope of the population to be covered by a presumption.

In step two, the Science Review Board would consider the extent of exposure among veterans and subgroups of veterans, as well as dose-response relationships. When such information is available, the board would estimate the service-attributable fraction and its related uncertainty. The purpose of step two is to convey the impact of the exposure on veterans as a whole for the purpose of decision making and planning, but not to serve inappropriately as an estimate of probability of causation for individuals. Some exposures may contribute greatly to the disease burden of veterans, while other exposure (even with a known causal effect) may have

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a small impact overall. This additional information would be useful to VA in its decision making as to whether a presumption should be made for the veteran population in general, for subgroups, or not at all. In the absence of service-attributable fraction data, as will likely occur for many exposures over the short term, we assume the VA would consider presumptions on the information contained in step one.

**Expanding the Evidence Base**

In the Committee's view, the best scientific decisions about presumptions can be made only with comprehensive exposure and health surveillance of military personnel. Data collection should begin on entry into the military and continue through discharge, and when harmful exposures are suspected surveillance should be extended indefinitely. Surveillance refers to the ongoing collection, analysis, and use of data relevant to the health of a population. Elements of a surveillance system are already in place, but fall short of what is required. A fully functioning surveillance system would track military exposures and health outcomes, during military service and after discharge, and maintain a repository of data and biological specimens so that emerging and unanticipated questions could be retrospectively addressed. The system needs to be seamless in following military personnel, including National Guard and reservists, from active duty as they transition and become civilians.

This surveillance system should also track job and deployment history for each Service member through the period of service, with exposure assessment and monitoring for a range of job categories. Information on disease risk factors more generally could also be tracked. Use of personal biological samples for individual monitoring also holds promise.

Assessing exposures relevant to the neuropsychiatric disorders that are frequent among veterans of recent and current combats is particularly problematic. Documentation of stress is requisite to the diagnosis of post-traumatic stress disorder (PTSD), but approaches for capturing exposures to such stressors and to the circumstances of combat have not yet been developed and put into place. Research is needed for this purpose that builds on existing approaches so that data become available over the long-term.

In addition to surveillance, the Committee recommends an effort to coordinate and focus research on the health effects of military exposures. Associations identified in the surveillance data might need follow-up through more focused epidemiologic studies or exposure assessments. Toxicological research might be indicated to explore the mechanistic basis for an association between an exposure and a health condition.

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Ultimately, the decision regarding which proposed topics for potential presumptions deserve full evaluation resides with VA. In the Committee's proposed process, VA also receives scientific input from the Science Review Board. We recommend that VA establish a uniform and transparent process for making decisions regarding presumptions following receipt of evidence reviews. VA should establish procedures with input from the many stakeholders, and a clear, evidence-based rationale should be offered for all decisions. The Committee's recommendations are aimed at providing a sound scientific framework for the presumptive disability decision-making process. The Committee clearly recognizes that there are social, economic, political, and legal factors beyond the scope of scientific evidence that may influence the presumptive disability decision-making process for veterans and the presumptive decisions that are established by Congress and VA.

Scientific evidence is not static, and it often is less than certain. Given that the scientific basis for presumptive decisions will change over time, the Committee recommends that VA should be able to adjust future decisions when such change is scientifically justified. This does not mean that the Committee recommends that benefits previously granted should be terminated. The Committee is aware that disabled veterans and their families are often dependent on such payments and that it could create a hardship to remove them, a matter that VA disability policy recognizes in other situations.

**SPECIFIC RECOMMENDATIONS**

Based on its evaluation of the current process for establishing presumptive disability decisions and its consideration of alternatives, the Committee has specific recommendations for an approach that would build stronger scientific evidence into the decision-making process and, at the same time, be even more responsive and open to veterans. We propose a transformation of the current presumptive disability decision-making process. We recognize that considerable time would be needed to implement some of these recommendations as would additional investment to create systems needed to track exposures and health status of currently serving military service personnel and veterans. Progress depends on greater research capacity and improvements in the evaluation and utilization of scientific evidence in making compensation decisions. We find that there are elements of the current process that could be changed quickly and we recommend that VA consider prompt action as it moves toward implementation of a new approach. The recommendations that follow are based around the Committee's proposed framework for making presumptive decisions. We list the recommendations in relation to the appropriate body.



## Congress

Recommendation 1. Congress should create a formal advisory committee (Advisory Committee) to VA to consider and advise the VA Secretary on disability-related questions requiring scientific research and review to assist in the consideration of possible presumptions.

Recommendation 2. Congress should authorize a permanent independent review body (Science Review Board) operating with a well-defined process that will use evaluation criteria as outlined in this Committee's recommendations to evaluate scientific evidence for VA's use in considering future service-connected presumptions.

## Department of Veterans Affairs

Recommendation 3. VA should develop and publish a formal process for consideration of disability presumptions that is uniform and transparent and clearly sets forth all evidence considered and the reasons for the decisions reached.

## Science Review Board

The recommendations that follow are directed towards the proposed, future Science Review Board, the entity to be established in the Committee's proposed approach.

Recommendation 4. The Committee recommends that the goal of the presumptive disability decision-making process be to ensure compensation for veterans whose diseases are *caused by* military service and that this goal must serve as the foundation for the work of the Science Review Board. The Committee recommends that the Science Review Board implement its proposed two-step process.

Recommendation 5. The Committee recommends that the Science Review Board use the proposed four-level classification scheme, as follows, in the first step of its evaluation. The Committee recommends that a standard be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the frequency or severity of disease as there is evidence against, then a service-connected presumption will be considered.

1. *Sufficient*: The evidence is sufficient to conclude that a causal relationship exists.

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2. *Equipose and Above*: The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. *Below Equipose*: The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. *Against*: The evidence suggests the lack of a causal relationship.

**Recommendation 6.** The Committee recommends that a broad spectrum of evidence, including epidemiologic, animal, and mechanistic data, be considered when evaluating causation.

**Recommendation 7.** When the causal evidence is at Equipose and Above or Sufficient, the Committee recommends that an estimate also be made of the size of the causal effect among those exposed.

**Recommendation 8.** The Committee recommends that, as the second part of the two-step evaluation, the relative risk and exposure prevalence be used to estimate an attributable fraction for the disease in the military setting (i.e., service-attributable fraction).

Department of Defense and Department of Veterans Affairs

The following recommendations are intended to improve the evidence on exposures and health status of veterans:

**Recommendation 9.** Inventory research related to the health of veterans, including research funded by DoD and VA, and research funded by the National Institutes of Health and other organizations.

**Recommendation 10.** Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the Gulf and Afghanistan.

**Recommendation 11.** Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans.

**Recommendation 12.** Assess the potential for enhancing research through record linkage using DoD and VA administrative and health record databases.

## SUMMARY

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Recommendation 13. Conduct a critical evaluation of Gulf War troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment.

Recommendation 14. Establish registries of Service members and veterans based on exposure, deployment, and disease histories.

Recommendation 15. Develop a plan for an overall integrated surveillance strategy for the health of Service members and veterans.

Recommendation 16. Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual Service member exposure information that is included as part of the individual's health record.

Recommendation 17. Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection.

Recommendation 18. Develop a data interface that allows VA to access the electronic exposure data systems used by DoD.

Recommendation 19. DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret.

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**STATEMENT OF  
THE AMERICAN LEGION  
BEFORE THE  
SENATE COMMITTEE ON VETERANS' AFFAIRS  
ON  
HONORING OUR PROMISE TO ADDRESS COMPREHENSIVE TOXICS ACT OF  
2021**

**MARCH 29, 2022**

Chairman Tester, Ranking Member Moran, and distinguished members of the committee, on behalf of our National Commander, Paul E. Dillard, and our nearly 2 million members, we thank you for the opportunity to comment on the Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2021. The American Legion is directed by its membership, who dedicate their time and resources to continued service for veterans, servicemembers, and their families. As a resolution-based organization, The American Legion's positions are guided by more than 100 years of advocacy that originates at the grassroots level of our organization. Every time The American Legion testifies before Congress, the veteran community is given a direct voice in the legislative process.

The men and women of the U.S. Armed Forces confront health challenges of a scope and complexity that few others experience. In addition to the immediate life-threatening realities of the battlefield, many servicemembers have been exposed to slower-acting, and in some cases just as lethal, toxins in the form of atomic radiation, toxic defoliations, and burn pits. These toxic exposures have resulted in service-related illnesses, some of which veterans are unable to seek care for at the Department of Veterans Affairs (VA).

The American Legion has been at the forefront of the fight to ensure that veterans receive the care they have earned for decades. In 1983, Columbia University published a study that served as the scientific foundation upon which presumptive conditions were eventually established for Vietnam War veterans. This study was sponsored by The American Legion and since then, our organization has been heavily invested in the issue of presumptive conditions for veterans who suffered from toxic exposures during their service.

It took decades for VA to provide relief for Vietnam veterans exposed to Agent Orange. Now a new generation of veterans has deployed in support of the Global War on Terror (GWOT) and is coming home with illnesses and conditions caused by toxins. We must break this cycle of providing care that is considered "too little, too late" for our veterans. They cannot wait decades to receive the care they need and rightfully deserve.

In August 2021, the VA announced that asthma, rhinitis, and sinusitis would be the first presumptive conditions for veterans exposed to burn pits and other airborne toxic hazards during the GWOT. Additionally, in March 2022, VA announced its intention to add nine rare respiratory cancers to the list of presumptive conditions for those exposed to toxic chemicals in the Southwest

Asia theater of operations. While the efficiency of VA rulemaking allows for quicker action, legislation is needed to comprehensively address the deadly effects of toxic exposures.

The American Legion National Commander testified before a joint session of the Senate and House Veteran Affairs Committee and urged them to pass legislation that uses a three-prong approach of (1) establishing a concession of exposure to all veterans deployed to identified locations during the Gulf War and the Global War on Terror; (2) establishing a list of presumptive illnesses associated with exposure to burn pits and other toxic hazards where sufficient scientific evidence exists; and (3) by creating a transparent framework for VA to establish additional presumptive illnesses when scientific evidence displays an association between exposure and illness.<sup>1</sup>

The American Legion supports the Honoring Our PACT Act as this legislation meets the criteria outlined in this three-pronged approach and goes even further to support veterans of previous conflicts. Through Resolution No. 118: *Environmental Exposures*, The American Legion supports efforts to expand access to VA healthcare benefits for veterans who have been exposed to toxic hazards while on active duty. We support legislative action that vigorously ensures veterans are properly compensated for disabilities that have a positive association with particular exposures.<sup>2</sup>

This comprehensive legislation ensures that desperately needed care is made available to multiple generations of toxic exposed veterans and Congress must act swiftly to ensure its passage. It is imperative that any final version of this legislation include:

- Expansion of access to VA healthcare by granting Priority Group 6 eligibility to veterans of the Gulf War and GWOT.
- Establishment of a presumptive framework that includes a scientific review board and a formal advisory committee with Veteran Service Organization (VSO) representation.
- A concession of exposure for veterans who were exposed to airborne hazards and toxic substances from burn pits while deployed in support of the Global War on Terror.
- A list of presumptive conditions associated with exposure to airborne hazards and burn pits.
- Expansion of a presumption of service connection for those exposed to Agent Orange and atomic radiation.

### CONCLUSION

Despite U.S. troops being withdrawn from South Vietnam in 1973, the VA only recognized presumptive conditions associated with service in 1993.<sup>3</sup> Almost 50 years later, Vietnam veterans are still fighting for the care they rightfully deserve. We cannot repeat these injustices by failing to provide another generation of veterans the care they need.

<sup>1</sup> Mackenzie Wolf, "Dillard Presses Congress on Legion's Key Legislative Issues," Dillard presses Congress on Legion's key legislative issues (The American Legion, March 8, 2022), <https://www.legion.org/washingtonconference/255129/dillard-presses-congress-union%E2%80%99s-key-legislative-issues>.

<sup>2</sup> The American Legion Resolution No. 118 (2016): *Environmental Exposures*

<sup>3</sup> "Secretary Brown Approves Service-Connection for Respiratory Cancers and Multiple Myeloma: Regulations Finalized." *Agent Orange Review*, Vol. 11, No. 1, October 1994.

Chairman Tester, Ranking Member Moran, and distinguished members of the committee, The American Legion thanks you for your leadership on this matter and for allowing us the opportunity to explain the position of our nearly two million members. For additional information regarding this testimony, please contact Mr. Lawrence Montreuil at The American Legion's Legislative Division at (202) 861-2700 or [lmontreuil@legion.org](mailto:lmontreuil@legion.org).

**Statement of the U.S. Department of Defense  
Before the  
United States Senate Committee on Veterans' Affairs on  
Honoring Our PACT Act of 2021  
March 29, 2022**

Chairman Tester, Ranking Member Moran, and distinguished Members of the Committee, thank you for the opportunity to submit written testimony regarding the Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2021.

The Department is grateful to President Biden for his leadership and support of our Veterans, including by expanding Veterans' access to health care and benefits to address the health effects of harmful environmental exposures that occurred during their military service. The Department of Defense's most critical asset is our people. Indeed, we remain the preeminent fighting force in the world because of our personnel in and out of uniform. We will never spare support for our people, including by protecting the safety, health, and welfare of service members and their families, as well as our civilian employees. In addition, we will continue to work closely with others in the Administration as well as Congress to ensure that we properly support our Veterans and their families long after their military service has ended.

The health effects from environmental exposures during military service are a particularly difficult problem, with overlapping and complex causes, and with symptoms that can take years to manifest. The PACT Act would help fulfill our sacred obligation to our Veterans, their families, caregivers, and survivors by addressing burn pits, radiation, and other environmental conditions, and mandating several research studies on militarily related environmental exposures to provide new data on their long-term impacts.

The Department of Defense, together with the Departments of Justice and Veterans Affairs, welcomes the opportunity to work with Congress on how to most effectively address needs for Camp Lejeune Veterans and their families as proposed in the PACT Act. Section 706 adds a new federal cause of action, in addition to the Federal Tort Claims Act and Veterans Affairs processes, for any individual who resided, worked, or was otherwise exposed to contaminants in drinking water at Camp Lejeune in North Carolina for 30 days or more during the period August 1, 1953 through December 31, 1987. Under the proposal, these



individuals may bring an action in the United States District Court for the Eastern District of North Carolina to obtain relief for harm which was “as likely as not” caused by exposure to the water, after going through a DoD administrative claims process. The Department defers to the Department of Justice to specifically address Federal Tort Claims Act issues and encourages a dialogue with Congress to avoid any potential unintended consequences, as well as possible confusion for our Veterans and their families.



**STATEMENT FOR THE RECORD OF THE  
TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS (TAPS)  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE**

**HONORING OUR PROMISE TO ADDRESS COMPREHENSIVE TOXICS  
ACT OF 2021**

**MARCH 29, 2022**

The Tragedy Assistance Program for Survivors (TAPS) is the national provider of comfort, care, and resources to all those grieving the death of a military loved one. TAPS was founded in 1994 as a 501(c)(3) nonprofit organization to provide 24/7 care to all military survivors, regardless of a service member's duty status at the time of death, a survivors' relationship to the deceased service member, or the circumstances of a service member's death.

TAPS provides comprehensive support through services and programs that include peer-based emotional support, casework, assistance with education benefits, and community-based grief and trauma resources, all at no cost to military survivors. TAPS offers additional programs including, but not limited to: a 24/7 National Military Survivor Helpline; national, regional, and community programs to facilitate a healthy grief journey for survivors of all ages; and information and resources provided through the TAPS Institute for Hope and Healing. TAPS extends a significant service to military survivors by facilitating meaningful connections to other survivors with shared loss experiences.

In 1994, Bonnie Carroll founded TAPS after the 1992 death of her husband Brigadier General Tom Carroll, who was killed along with seven other soldiers when their Army National Guard plane crashed in the mountains of Alaska. Since its founding, TAPS has provided care and support to more than 100,000 bereaved military survivors.

As the leading nonprofit organization offering military grief support, TAPS builds a community of survivors helping survivors heal. TAPS provides connections to a network of peer-based emotional support and critical casework assistance, empowering survivors to grow with their grief. This is why in 2021 alone, 9,246 newly bereaved military survivors came to TAPS for care. This is an average of 25 new survivors coming to TAPS each and every day. Of the survivors seeking our care, 31% were grieving the death of a loved one to illness and 27% were grieving the death of a military loved one to suicide.

Chairman Tester and Ranking Member Moran, and distinguished members of the Senate Committee on Veterans' Affairs, the Tragedy Assistance Program for Survivors (TAPS) appreciates the opportunity to provide a statement for the record on issues and concerns of importance to the 100,000 plus family members of all ages, representing all services with losses from all causes that we have been honored to serve. Every survivor in our nation benefits from the critical work of this committee and we thank you.

The mission of TAPS is to provide comfort, care, and resources for all those grieving the death of a military loved one regardless of the manner of death, the duty status at the time of death, the survivor's relationship to the deceased, or the survivor's phase in their grief journey. Part of that commitment includes advocating for improvements in programs and services provided by the U.S. federal government, Department of Defense (DOD), Department of Veterans Affairs (VA), Department of Education (DoED), Department of Labor (DOL), and Department of Health and Human Services (HHS), and state and local governments.

TAPS and the VA have mutually benefited from a long-standing, collaborative working relationship. In 2019, TAPS and the VA entered into a new and expanded Memorandum of Agreement that formalized their partnership with the goal to provide earlier and expedited access to needed survivor services. TAPS works with military survivors to identify, refer, and apply for resources available within the VA including education, burial, benefits and entitlements, grief counseling, and survivor assistance.

TAPS also works collaboratively with the VA and DOD Survivors Forum, which serves as a clearinghouse for information on government and private sector programs and policies affecting surviving families. Through its quarterly meetings, TAPS shares information on, and supports referrals to, its programs and services that support all those grieving the death of a military loved one.

TAPS President and Founder, Bonnie Carroll serves on the Secretary of Defense Roundtable for Military Service Organizations and the Department of Veterans Affairs Federal Advisory Committee on *Veterans' Families, Caregivers, and Survivors* where she chairs the Subcommittee on Survivors. The Committee advises the Secretary of the VA on matters related to Veterans' families, caregivers, and survivors across all generations, relationships, and veteran statuses. Ms. Carroll also serves as a PREVENTS Ambassador for the VA's suicide prevention initiative.

**PASS LANDMARK TOXIC EXPOSURE LEGISLATION**

As the leading voice for the families of those who died as a result of illnesses connected to toxic exposure and a founding member of the Toxic Exposure in the American Military (TEAM) Coalition, TAPS worked with Members of Congress to introduce legislation during the 117th Congress, which collectively address the devastating effects of toxic exposure on our veterans, their families, caregivers, and survivors.

TAPS is grateful to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs for crafting comprehensive Toxic Exposure legislation, which incorporate key aspects of these important bills. TAPS was honored to testify in support of the ***Comprehensive and Overdue Support for Troops (COST) of War Act (S.3003)*** and the ***Honoring Our Promise to Address Comprehensive Toxics (PACT) Act (H.R.3967)***, and to share our recommendations with Congress, the Department of Veterans' Affairs, the Department of Defense, and the White House.

We are extremely gratified by President Biden's remarks during the State of the Union Address on March 1, 2022, stating, *"I am calling on Congress to pass the law to make sure veterans devastated by Toxic Exposure in Iraq and Afghanistan finally get the benefits and the comprehensive health care they deserve"*.

**TAPS appreciates the President's remarks and urges the Senate to swiftly pass the *Honoring Our PACT Act (H.R.3967)*. Our veterans exposed to toxins and their families do not have time to wait. Every day counts!**

This comprehensive legislation passed the House of Representatives on March 3, 2022, with a bipartisan vote of 256-174 and is supported by 42 veteran service organizations, to include TAPS. This landmark bill will ensure over 3.5 million veterans exposed to toxins and airborne hazards get immediate, lifelong access to VA health care.

The ***Honoring our PACT Act*** will also ensure the following:

- Provide extension of combat eligibility for health care from 5 to 10 years with a one-year open enrollment period for those veterans who missed their window;
- Streamline VA's review process for establishing toxic exposure presumptions;
- Concede exposure to airborne hazards and burn pits based on locations and dates of service;

- Require medical exams and opinions for certain veterans with toxic exposure disability claims;
- Add hypertension and Monoclonal Gammopathy of Undetermined Significance to the list of presumptions for Agent Orange exposure;
- Establish a presumption of service connection for 23 respiratory illnesses and cancers related to burn pits and airborne hazards exposure;
- Create a presumption of exposure to radiation for veterans who participated in cleanup activities in Palomares, Spain, and Enewetak Atoll;
- Allow for a new tort claim for veterans and families exposed to toxic water at Camp Lejeune;
- Expand agent orange exposure to veterans who served in Thailand, Laos, and Cambodia;
- Improve data collection between VA and the Department of Defense;
- Commission studies related to incidents of cancer among veterans, health trends of Post 9/11 veterans and feasibility of providing healthcare to dependents of veterans;
- Require VA to provide standardized training to improve toxic exposure disability claims adjudications;
- Require VA to conduct outreach and provide resources to toxic exposed veterans.

TAPS appreciates that the ***Honoring Our PACT Act*** will provide health care and benefits to veterans of all generations exposed to toxins and airborne hazards as a result of their military service. We are also grateful the bill streamlines VA's review process for establishing toxic exposure presumptions, reduces the burden of proof for toxic exposure service-connection, standardizes training to improve disability claims adjudications, and strengthens VA's outreach to impacted veterans.

TAPS is especially gratified that the legislation includes an extension of combat eligibility for veterans to access health care from 5 to 10 years with a one-year open enrollment period. We have long championed this critical improvement in health care eligibility for veterans, since many rare cancers are not diagnosed until eight to ten years after military service. Allowing veterans who missed the window of opportunity to enroll within a one-year open enrollment period, is critical for these veterans and their families and may help extend and save lives.

***UNDERSTANDING ILLNESSES THAT MAY RESULT FROM TOXIC EXPOSURE***

According to the VA, a significant number of veterans who served after 9/11 were exposed to more than a dozen different wide-ranging environmental and chemical hazards, most of which cause serious health risks. Whether from open burn pits, depleted uranium, toxic fragments, or particulate matter, service members and veterans are getting sick and prematurely dying from uncommon illnesses and diseases that are tied to exposures to toxins.

Since 2008, over 16,500 survivors whose military loved ones died due to an illness have contacted TAPS. As mentioned, in 2021 alone, 9,246 newly bereaved military survivors came to TAPS for care, and 31% were grieving the death of a loved one to illness, surpassing all other circumstances of death, including hostile action. Sadly, we project this number to increase by more than 3,000 each year based on current trends.

As a result of these increasing losses and the challenges they pose for grieving loved ones, many who have often cared for their service member or veteran without recognition or governmental support for years before their death, TAPS is committed to promoting a better shared understanding of the illnesses that may result from exposures to toxins. Our desire is to ensure surviving families have access to all available benefits earned through the service of their loved one. The information gathered from our survivor histories is also invaluable in establishing patterns and baselines that can be applied to the veteran community, save lives, and prevent this now and in the future.

TAPS annually conducts Illness Loss Survivor Surveys to understand the issues faced by service members and veterans who have passed away post-deployment. TAPS conducted an Illness Loss Survivor Survey in 2020, which was included in our 2020 Impact Report. From the survey data we learned:

- Of the 505 respondents, **57% of service members were diagnosed with a form of cancer prior to passing away**, with rates nearly equivalent for those that served pre-9/11 and post-9/11.
- Among the respondents who indicated their loved one served post-9/11, **60% of these service members required a caregiver prior to their death.**
- Among the respondents who indicated their loved one served post-9/11, **41% indicated that a loved one's illness had been initially misdiagnosed.**

The data from the TAPS Illness Loss Survivor Survey in 2021 shows these trends are holding and that there continues to be reports of the misdiagnosis of cancers for service members and veterans dying of cancer, and there remains a need for caregiver support.

#### **CAREGIVER SURVIVORS AND THEIR CHILDREN NEED SUPPORT**

The VA supports thousands of veteran caregivers each year in numerous ways through its Caregiver Support Programs. Regrettably, each year many of these caregivers become caregiver survivors on the death of their loved one. In loss, they must not only face their own grief but must often continue to care for other family members including the children and youth who were also left behind. The impact of cumulative caring and grief can be overwhelming for adults and also for the youngest survivors who have experienced the presence of illness and even contributed to caring as our nation's Hidden Helpers. Without help navigating the maze of care and benefits they are entitled to and connections to timely and age-appropriate bereavement support, the impact of the veteran's loss on all survivors can be debilitating, and developmentally impact them for the rest of their lives. These caregiver survivors need to have access to legal and financial assistance, mental health counseling, and grief and bereavement support for themselves and their children before and after their loved one dies.

Through our annual Illness Loss Survivor Survey, and extensive outreach and engagement with caregiver survivors of all ages, TAPS has gained the following valuable insights:

##### **Early Diagnosis Saves Lives**

There is an urgency of early diagnosis and intervention which saves and prolongs the lives of service members and veterans, beloved by family and friends who consider each day together as precious and irreplaceable.

##### **Loss and Anticipatory Grief Begin Before A Diagnosis**

The losses experienced by caregiver survivors of death by toxic exposure illness begin before a diagnosis with changes in abilities, expectations, roles, and the introduction of anxiety and fear. Anticipatory and ambiguous grief are also experienced by the service member or veteran and by their caregivers – parents, spouse, children and youth of all ages – as soon as a sense of unwellness is experienced and the dread of “what if” begins.



**Children and Youth Are Significantly Impacted by Illness Loss**

The lasting impact of illness loss of a parent or other adult on children and youth has been documented to be a significant and long lasting adverse childhood experience.

**ILLNESS LOSS SURVIVOR TESTIMONIALS**

The information that TAPS has gathered from our survivor histories is invaluable in establishing patterns and baselines that can inform the policy and programmatic considerations of the DOD, VA and Congress as they seek to address ways to prevent these exposures, address health care needs of military members and veterans, support their caregivers, and ensure that their survivors are fully covered with the care, benefits, resources and services they need after loss and in their future.

TAPS has shared many personal testimonials of survivors whose loved ones have died as a result of their exposure to toxins, open burn pits, and airborne hazards while deployed. Sadly, many service members and veterans were misdiagnosed. Though each survivor's story is different, the underlying thread is the desire to share their loved ones story to help save lives now and in the future. Here are just some of the many stories impacted survivors have shared with us:

**Coleen Bowman, Surviving Spouse of SGM Robert Bowman**

*"Rob was the picture of health before he deployed, he was an Airborne Ranger. When he returned from his second deployment from Iraq, he was sick. In June 2011, Rob was diagnosed with an extremely rare cancer Cholangiocarcinoma (bile duct cancer). During deployments, Rob was in close proximity to an open-air burn pit that burned around the clock. His vehicle was struck at least ten times by IEDs, stirring up particulate matter.*

*Had we known he had been exposed and to what toxins, we could have shared the information with doctors, and it wouldn't have taken six months of misdiagnoses before we learned he had stage 4 inoperable cancer. **Had we known earlier, he might still be alive today.** For 19 months my daughters and I cared for him, and on January 13, 2013, Rob passed away at the age of 44. Several of the men that Rob served with have many different illnesses, to include cancer, and several have passed away at very young ages."*

**Laura Forshey, Surviving Spouse of Sgt Curtis Forshey**

*"Three months into his deployment, he began to experience bloody noses that would go on for hours at a time. He went to the doctor there on the FOB where they ran bloodwork. The results showed his white blood count was way off. They flew him to Landstuhl, Germany. His wife, Laura, and 3-month-old son, Ben, along with Curt's parents flew to be with him in Germany. While they were in flight, Curt passed away.*

*His cause of death was a brain aneurysm, caused from the cancer they discovered, Acute Promyelocytic Leukemia. Curt was 22 years old. He died on March 27, 2007. **With proper diagnosis and treatment it is curable in 80-90% of patients."***

**June Heston, Surviving Spouse of BG Michael Heston**

*"Mike was active duty in the Vermont National Guard. He deployed to Afghanistan three times. First in 2003 for 7 months, then 2006-2008 for 15 months, and last 2011-2012 for one year. In April of 2016, Mike had gone into the doctor not feeling well. **For 10 months doctors couldn't figure out what was wrong with him.** Finally, in January of 2017, Mike was diagnosed with a very rare form of pancreatic cancer, stage 4. Mike passed away shortly after that on November 14, 2018."*

**Tim Merkh, Father of Corpsman Richard Merkh**

*"My son Richard Merkh was a Corpsman in the Navy. He had served over 15 years and died from cancer on October 3, 2018. Richard served several tours with the Marines during the war. His lodging facilities were on only trash or dump sites. It is my belief that Richard contracted stage 4 cancer from his exposure during the war. Unfortunately, he was diagnosed after his entire liver and colon was infected with cancer.*

*I am a retired USAF veteran. I know what we put our troops through. Some things must change. Richard was survived by his wife of twelve years and a beautiful 4-year-old daughter, my precious granddaughter. **We can't change Richard's outcome, but we must ensure we treat and support our troops better."***

**CONCLUSION**

Exposures to deadly toxins and airborne hazards as a result of military service is not a new phenomenon. Unfortunately, generations of service members have been exposed to environmental toxins while deployed and died as a result of their exposure.

TAPS is grateful that the ***Honoring Our PACT Act*** addresses issues affecting veterans across generations, who have served in defense of our country. As a nation, we must do more to prevent environmental exposures, properly treat illnesses, and provide earned health care and benefits to impacted veterans and their survivors. It is our sacred obligation.

TAPS thanks Chairman Tester, Ranking Member Moran, and committee members for holding this hearing to review the ***Honoring Our Promise to Address Comprehensive Toxics Act***. Our veterans who volunteer their lives to protect the freedom of our nation, and the families who stand beside them, must know that America's priority is to protect and provide for all those who are ready to make the ultimate sacrifice.

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WOUNDED WARRIOR PROJECT  
STATEMENT FOR THE RECORD

BEFORE THE

UNITED STATES SENATE  
COMMITTEE ON VETERANS' AFFAIRS

HEARING ON

“THE HONORING OUR PROMISE TO ADDRESS  
COMPREHENSIVE TOXICS ACT OF 2021”

March 29, 2022

Chairman Tester, Ranking Member Moran, and distinguished members of the Committee, thank you for inviting Wounded Warrior Project (WWP) to submit the following statement on H.R. 3967, the *Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2021*. WWP strongly supports this legislation, and we are grateful to the Committee for holding today's hearing.

Wounded Warrior Project's mission is to connect, serve, and empower our nation's post-9/11 wounded, ill, and injured veterans, Service members, and their families and caregivers. We are meeting our mission through life-changing programming, public policy advocacy, and partnership with like-minded organizations. Since our founding in 2003, WWP has grown from a small, volunteer-led program to an organization with over 800 employees across the country and overseas. Our programs cover a range of services, including benefits counseling, mental health treatment, physical health and wellness activities, job placement assistance, and social engagement opportunities. These programs, services, and connection points contribute to our organizational impact and inform the positions in our statement.

Last year, our nation marked the 20th anniversary of the beginning of the Global War on Terrorism. Throughout this period, young Americans have volunteered for service in the U.S. Military, understanding the risk of combat in places like Iraq, Afghanistan, and elsewhere. They did so with some understanding of the danger to life and limb posed by enemy fire and roadside bombs. Less understood was the very real possibility that they would experience prolonged and pervasive exposure to toxic fumes from burn pits and other dangerous chemicals that they would not be able to avoid, resulting in serious illnesses that would follow them long after they returned home.

DUTY ★ HONOR ★ COURAGE ★ COMMITMENT ★ INTEGRITY ★ COUNTRY ★ SERVICE

woundedwarriorproject.org



Just as our nation has a responsibility to provide health care and benefits to veterans who suffer physical and mental injuries in service, we must also meet the needs of those who suffer from illnesses associated with toxic exposures, both on the battlefield and in peacetime. The Department of Veterans Affairs (VA) estimates that as many as 3.5 million post-9/11 veterans served in areas where they may have been exposed to burn pits and other toxic substances. Now, many of them have developed rare diseases like cancers, respiratory conditions, and other serious illnesses. These conditions are often appearing earlier in life than one might expect and without any family medical history that might help make sense of their unexpected appearance. Sadly, the commonality around these illnesses have been overseas deployments and exposure to toxic substances in service. With this in mind, WWP is committed to addressing their toxic wounds with the same urgency which we address the physical and invisible wounds of war.

Results from WWP's 2021 *Annual Warrior Survey* illustrate the extent to which post-9/11 veterans suffered toxic exposure during their service and the health conditions they are now facing. Among those deployed in support of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), 72.8% reported serving near a burn pit, meaning a burn pit was located either on their base or close enough that they could see smoke. Of those, 67.4% report being near a burn pit on a daily basis. Additionally, nearly all warriors (97.9%) reported some exposure to hazardous or toxic substances during military service, which include desert sands, petrochemicals, and powerful solvents.

Historically, Congress has dealt with military toxic exposures with era-specific legislation. Vietnam veterans' exposures were addressed with the *Agent Orange Act of 1991* (P.L. 102-4), and Desert Storm/Desert Shield veterans' exposures were addressed by the *Persian Gulf War Veterans Act of 1998* (P.L. 105-368 §§ 101-107). However, no comprehensive legislation has been enacted to specifically address the toxic exposure concerns of current and future generations of veterans.

Multiple pieces of legislation introduced in the Senate during the 117<sup>th</sup> Congress would address individual challenges faced by current-era veterans who were exposed to toxic substances. Notable examples include the *Toxic Exposures in the American Military (TEAM) Act* (S. 927), introduced by Senators Tillis and Hassan, the *Veterans Burn Pits Exposure Recognition Act of 2021* (S. 437), introduced by Senators Sullivan and Manchin, and the *Presumptive Benefits for War Fighters Exposed to Burn Pits and Other Toxins Act of 2021* (S. 952), introduced by Senators Gillibrand and Rubio. Similar efforts were seen in the U.S. House of Representatives.

Recognizing that these bills were complementary, they were combined into omnibus legislation offering comprehensive solutions: Chairman Tester's *Comprehensive and Overdue Support for Troops (COST) of War Act* (S. 3003), and House Veterans' Affairs Committee Chairman Takano's *Honoring our PACT Act*. WWP voiced strong support for these landmark pieces of legislation, which would fully address the toxic exposure concerns of the current generation of veterans. In doing so, they would also finally create parity for the post-9/11 generation with what Congress has done to provide health care and benefits for previous generations of veterans who suffered toxic exposures during military service.

On March 3, 2022, the House voted to pass the *Honoring Our PACT Act* on a bipartisan basis with the strong support of WWP and the veterans service organization (VSO) community, and a statement of support from the White House. We note that the version of the bill passed by the House contained several changes to the text as originally introduced. We understand that many of these changes were made to ensure that VA can smoothly implement the legislation without disrupting services for veterans currently in the system. While we offer certain suggestions that we believe would further strengthen the bill, WWP continues to fully support the House passed *Honoring Our PACT Act*, as it would accomplish all of our legislative priorities regarding toxic exposures as outlined below.

#### ***Health Care Eligibility for All Exposed Veterans***

Wounded Warrior Project strongly believes that VA health care enrollment eligibility should be granted to any veteran who suffered toxic exposures while in service, regardless of service connection. Context proves that establishing service connection is an exceedingly difficult task for those seeking treatment for toxic-exposure related conditions. According to VA, from June 2007 to July 2020, only 2,828 of the 12,582 veterans (22%) who claimed conditions related to burn pit exposure were granted service connection.<sup>1</sup> This is generally consistent with findings from our *Annual Warrior Survey*, which revealed that warriors who filed claims for conditions related to toxic exposures were successful only 31.9% of the time. One critical consequence of a denied disability claim is an inability to access to VA care. Reversing that outcome is a top priority.

Our call for guaranteed health care access is not unprecedented. Legislation enacted over the course of several decades has provided health care eligibility to previous generations of veterans with toxic exposure concerns. Veterans who served in the Republic of Vietnam between January 9, 1962, and May 7, 1975, and the Persian Gulf War between August 2, 1990, and November 11, 1998, are eligible for permanent Priority Group 6 VA health care enrollment without the need to establish a service-connected disability. Those who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987, are also guaranteed permanent Priority Group 6 enrollment eligibility due to their exposure to contaminated drinking water. In contrast, veterans who served in combat during the Global War on Terrorism, all of whom were potentially exposed to burn pits or other toxic substances, are only eligible for enrollment on this basis for a period of five years after separation.<sup>2</sup>

To illustrate the impact of the five-year policy, we point to VA data showing that as of June 30, 2015, there were 1,965,534 separated veterans of OEF, OIF, and OND,<sup>3</sup> all of whom are now outside the five-year enrollment eligibility period. Taken together with the fact that only 62 percent of deployed post-9/11 veterans have established a service-connected disability as of March 2021,<sup>4</sup> it can be reasonably estimated that nearly 750,000 current-era veterans who served

<sup>1</sup> *Toxic Exposures: Examining Airborne Hazards in the Southwest Asia Theater of Military Operations: Hearing Before the Subcomm. on Disability Assistance and Memorial Affairs of the H. Comm. on Vet. Affairs*, 116th Cong. 3 (2020) (statement of Laurine Carson, Dep. Exec. Dir., Vet. Benefits Admin., Dep't of Vet. Aff.).

<sup>2</sup> See 38 U.S.C. § 1710.

<sup>3</sup> U.S. DEP'T OF VET. AFFAIRS, ANALYSIS OF VA HEALTH CARE UTILIZATION AMONG OPERATION ENDURING FREEDOM (OEF), OPERATION IRAQI FREEDOM (OIF), AND OPERATION NEW DAWN (OND) VETERANS 6 (2017).

<sup>4</sup> U.S. DEP'T OF VET. AFFAIRS, FACT SHEET: VBA CLAIMS DATA – COMPARISON BY COHORTS (as of March 2021) 6 (2021).

in areas of known exposure are presently ineligible for VA health care if they have not established a service-connected disability. If any of them become ill with a condition they suspect is related to their exposure and seek care at a VA facility, they would be turned away and told to return only after they are service connected.

If enacted, the *Honoring Our PACT Act* would expand permanent Priority Group 6 enrollment eligibility to any veteran who was discharged after August 2, 1990, and served in an area of known exposure, regardless of location. This would include any veteran who participated in a “toxic exposure risk activity” inside or outside the United States as reflected by the Individual Longitudinal Exposure Record (ILER). The *Honoring Our PACT Act* would also expand eligibility to include any veteran who served after certain dates in locations of current-era deployments, to include Iraq, Afghanistan, Uzbekistan, and surrounding areas; and contingency operations, to include Operations Enduring Freedom, Freedom’s Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission.

A significant change made in the current version of the *Honoring Our PACT Act* is that it now includes a 10-year phase-in period for enrollment eligibility, with those who were discharged at earlier dates gaining access to care sooner. Veterans who participated in a toxic exposure risk activity or deployed to a covered location and were discharged from August 2, 1990 to September 11, 2001 would be eligible beginning October 1, 2024; those discharged from September 12, 2001 to December 31, 2006 would be eligible beginning October 1, 2026; those discharged from January 1, 2007 to December 31, 2012 would be eligible beginning October 1, 2028; and those discharged from January 1, 2013 to December 31, 2018 would be eligible beginning on October 1, 2030. All remaining veterans who participated in a covered contingency operation would become eligible on October 1, 2032.

Another change made to the original version of the *Honoring Our PACT Act* is that the current version now incorporates the health care expansion language of Chairman Tester and Ranking Member Moran’s *Health Care for Burn Pit Veterans Act* (S. 3541). This provision would extend eligibility for Priority Group 6 enrollment for recently discharged combat veterans from five years to 10 years. For those who were discharged over 10 years ago, it would establish a one-year open enrollment period, beginning on October 1, 2022. An outreach plan by VA would be required to inform veterans of these new eligibility rules.

When combined, these provisions represent a significant expansion of health care eligibility for veteran who suffered toxic exposures while in service. However, we have identified certain gaps in eligibility that would be created by this incremental approach. For instance, a veteran who was discharged in 2006 after being exposed to burn pits in Afghanistan and who misses the one-year open enrollment period ending on September 30, 2023, would become ineligible for enrollment under the new statute until October 1, 2026 (unless they are establish service connection or eligibility under some other authority). If the veteran was discharged in 2007, they would be ineligible from September 30, 2023, to October 1, 2028.

While we understand that the 10-year phase-in was designed to avoid overwhelming the Veterans Health Administration with a sudden influx of new patients, we would like to offer suggestions that we feel would further strengthen the legislation without doing away with the

phase-in altogether. The 10-year enhanced enrollment period and the one-year open enrollment period complement the phase-in by mitigating gaps in eligibility to some extent. If the 10-year period were extended, or the open enrollment period is lengthened, the gaps could be further reduced. We also suggest that any covered veteran who presents at a VA facility with a potentially life-threatening condition (if left untreated) should be granted immediate enrollment eligibility, regardless of when they were discharged, at any time during the phase-in period.

Although WWP would strongly support these changes, failure to adopt them would not prevent our continued support for Senate passage of the legislation. In any case, once the phase-in period is complete, the *Honoring Our PACT Act* would finally provide parity to the post-9/11 generation by granting them the same access to VA care that Congress has established for previous generations of exposed veterans. This would ultimately achieve one of our long-held priorities to provide permanent access to lifesaving treatment and preventative care to all those who were exposed to toxic substances while in service.

Another change made to the *Honoring Our PACT Act* is that it also now includes the language of the *Supporting Expanded Review for Veterans in Combat Environments (SERVICE Act of 2021)* (S. 2102), introduced by Senators Boozman and Wyden, and passed by the Senate on March 24, 2022. This provision would require VA to offer mammograms to women veterans who served in areas of known exposure, regardless of whether they have any other risk factors for breast cancer such as age, symptoms, or family history. We believe this could provide lifesaving early detection for women veterans who were exposed to toxic substances. WWP fully supports this provision.

#### *A Scientific Framework*

In recognition of the challenges associated with establishing direct service connection for toxic exposure-related conditions, Congress has historically created mechanisms to require VA to decide on whether to establish presumptive service connection when scientific data show a link between specific exposures and associated illnesses, as it did for Vietnam veterans with the *Agent Orange Act of 1991*. However, no law currently exists to require VA determinations on illnesses associated with all toxic exposures, regardless of location or period of service.

The *Honoring Our PACT Act* would address this by establishing a Formal Advisory Committee to review scientific data and receive public input on all potential exposure-related conditions in veterans and their family members who were military dependents. The Committee would be subject to the *Federal Advisory Committee Act* (P.L. 92-464), except for the sunset requirement, allowing it to operate permanently. The Committee would be comprised of nine members, with five members appointed by VA and four members appointed by Congress, with at least two members representing veteran service organizations.

Upon review of the scientific data, the Committee would have the option to advance recommendations to the Secretary of Veterans Affairs for formal evaluation. This process, which would be established by the Secretary, would assign the strength of evidence for a positive association to one of four categories: "sufficient," "equipoise or above," "below equipoise," or "against." This formal evaluation process would be completed in no more than 120 days. Upon



receiving the results of a formal evaluation, the Secretary would have 160 days to establish a presumption of service connection or publish reasoning in the Federal Register explaining why presumptive service connection is not warranted.

We recognize that VA is also piloting its own internal presumptive decision-making model. WWP praises VA for taking this proactive step to formalize the Secretary's broad authority to establish presumptive disabilities when warranted by scientific data. The pilot is scheduled to conclude in April 2022, and we will assist VA in any way we can to support this process. Regardless of how its created, we look forward to supporting the establishment of a scientific framework that maintains a level of independence, adheres to an evidentiary standard of positive association, and requires decisions within established timeframes. *The Honoring Our PACT Act* in its current form accomplishes these goals.

*The Honoring Our PACT Act* would also require that whenever a presumption of service connection is established or modified, VA must identify claims from all covered veterans who were previously denied service connection for that condition. Outreach and reevaluation of this group's claims would be required and, if granted, they would be awarded an effective date of the previously denied claim. WWP supports this provision.

#### *Concession of Exposure*

Traditionally, VA disability claims are granted by establishing direct service connection through a medical nexus that links a veteran's current diagnosis to an in-service event. In the case of toxic exposure-related claims, however, the in-service event, such as burn pit exposure, can be nearly impossible to prove since these events were often never documented. Since the veteran has no documentation of burn pit exposure (e.g., time and location), no in-service event is established, and VA often rejects the claim without providing additional consideration of whether the claimed illness is connected to the veteran's service.

*The Honoring Our PACT Act* would address this by conceding that any veteran who was deployed to locations of known exposure, to include Iraq, Afghanistan, Uzbekistan, and surrounding areas was exposed to a list of substances, chemicals, and airborne hazards that the Secretary shall establish and maintain. This represents a change from the original version of the legislation, which conceded exposure for covered veterans to burn pits and other toxic substances currently accepted by the VA adjudication manual. If enacted, we look forward to working with VA to ensure that the list of substances reflects the toxic exposures experienced by veterans who served in covered locations. It would also require VA to request a medical opinion on the link between illness and exposure when the underlying facts do not provide prima facie evidence to grant the claim.

While VA's grant rate of 22 percent for burn pit-related claims is discouragingly low, we believe that claims will be more likely to succeed if burn pit exposure is conceded for veterans who served in areas where burn pits are known to have been used. Current law grants a concession of exposure to herbicide agents for Vietnam veterans (38 U.S.C. § 1116(f)), in recognition of that fact that many lack documentation of where and when they were exposed to Agent Orange. Current era veterans deserve concession of exposure for the same reason. We

note that even if a list of presumptive disabilities was established in connection with burn pit exposure, proving exposure would still be necessary for veterans who wish to claim direct service connection for any illness that is not presumed to be related to exposure.

#### *Presumptive Disabilities*

Recognizing the possible relationship between in-service exposure and illnesses, the U.S. has invested resources in scientific studies to determine the nature of those associations. Still, after two decades of war, the science is disappointingly inconclusive. In its most recent report on the topic, released on September 11, 2020, the National Academies of Science, Engineering, and Medicine (NASEM) stated that its analysis of previous epidemiologic studies found them inadequate to associate illnesses with airborne hazards, largely due to a lack of good exposure characterization. However, they stated, “this should not be interpreted as meaning that there is no association between respiratory health outcomes and deployment to Southwest Asia, but rather that the available data are, on the whole, of insufficient quality to make a scientific determination.” Consequently, NASEM recommends that new epidemiologic studies should be conducted.<sup>5</sup> Unfortunately, new studies could take years without the promise of more conclusive outcomes.

The *Honoring Our PACT Act* would bypass this scientific gridlock by establishing a presumption of service connection for any veteran who served on current-era deployments to areas of known exposure and is now suffering from any one of 24 different cancers or serious respiratory conditions, including head cancer, neck cancer, respiratory cancer, gastrointestinal cancer, reproductive cancer, lymphoma, lymphatic cancer, kidney cancer, brain cancer, pancreatic cancer, melanoma, asthma, chronic bronchitis, chronic obstructive pulmonary disease, constrictive or obliterative bronchiolitis, emphysema, granulomatous disease, interstitial lung disease, pleuritis, pulmonary fibrosis, sarcoidosis, chronic sinusitis, chronic rhinitis, and glioblastoma.

We note that the majority of conditions on this list are devastating to a veteran’s health and can severely impact their ability to earn a living. For these veterans, disability compensation would be a lifeline, offering them a chance to support themselves and their families while continuing to battle their illnesses. Many of the conditions on this list are also life-threatening and often terminal, and service connection would afford those veterans a sense of peace knowing that their families would have the support of Dependency and Indemnity Compensation after their passing. Veterans who volunteered to serve our country in a combat zone where they were exposed to toxic substances and are now severely ill or dying surely deserve those basic dignities.

While we understand that any influx of new claims would create an increased workload for the Veterans Benefits Administration (VBA) in the short term, this gives us no pause in our support for the *Honoring Our PACT Act*. Historically, WWP and the VSO community have been critical of the VA claims backlog and have supported policies and legislation aimed at reducing it. We see a clear distinction, however, between a backlog that is the result of

<sup>5</sup> NAT’L ACADS. OF SCIS., ENG’R, AND MED., RESPIRATORY HEALTH EFFECTS OF AIRBORNE HAZARDS EXPOSURES IN THE SOUTHWEST ASIA THEATER OF MILITARY OPERATIONS 181 (2020).

processing inefficiencies or the need for modernization, and an increased claims workload resulting from a significant number of new claims filed by veterans who have been waiting far too long for the care and benefits they deserve. WWP looks forward to working with Congress and VA to ensure VBA is properly resourced and staffed to handle any increased workload that would result from passage of the *Honoring Our PACT Act*.

In August 2021, VA announced that it would begin processing claims for asthma, rhinitis, and sinusitis on a presumptive basis for veterans who served in Southwest Asia, Afghanistan, Uzbekistan, and surrounding areas due to presumed exposure to particulate matter. While WWP applauded the Secretary for using his rulemaking authority to establish these presumptive conditions, we expressed our disappointment with VA's decision to only include veterans who can produce evidence that their conditions manifested within 10 years of discharge. We believe that this unfairly excludes many veterans who were discharged over 10 years ago and may have chosen to self-treat for these conditions. Given the slim chances of establishing service connection, these individuals may have never gathered evidence to file a claim or sought a formal diagnosis of their symptoms. Consequently, they have no medical evidence of when their conditions first manifested, even if symptoms have been present since returning from deployment. For this reason, we urge Congress to codify these presumptive conditions without the 10-year time limitation by passing the *Honoring Our PACT Act*.

Additionally, VA recently announced that it would initiate rulemaking to establish nine rare cancers of the throat and lungs as presumptive disabilities due to exposure to particulate matter. WWP commends the VA for this additional step and looks forward to the rulemaking process. Passage of the *Honoring Our PACT Act* would serve to codify these conditionals as presumptive disabilities for veterans who served in areas of known exposure, as they would all fall under the category of respiratory cancer.

#### ***Other Provisions***

Finally, the *Honoring Our PACT Act* contains various provisions to support toxic exposure research, improve toxic exposure training for VA employees, promote toxic exposure-related VA resources for veterans, and expand on toxic exposure registries and records. Notably, this would include the establishment of a toxic exposure questionnaire to be administered during all VA primary care appointments. Currently, veterans are asked questions during primary care exams regarding mental health, lifestyle, and smoking to identify those who may need additional help or information on VA programs available to them. By adding questions regarding toxic exposures to these primary care visits, we hope that the provider and the veteran can start to identify possible health risks that could lead to early detection of any underlying conditions.

In closing, WWP thanks the Committee for prioritizing this urgent issue and considering the *Honoring Our PACT Act*. We are proud to champion this landmark legislation which would finally provide parity to current-era veterans who suffered toxic exposure by granting them the same access to care and earned benefits as previous generations of exposed veterans before them. We now urge Congress to work swiftly on a bicameral basis to address any outstanding concerns and send this comprehensive toxic exposure legislation that accomplishes each of our stated goals to the president's desk without delay.