

Testimony

of



**Legislative Priorities
&
Policy Initiatives**

Presented by

**John Rowan
National President**

Before the

**House and Senate
Veterans' Affairs Committees**

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Good morning, Chairmen Isakson and Dr. Roe, Ranking Members Tester and Walz, and members of these two very vital committees. On behalf of our members and their families, I appreciate the opportunity to present to you the legislative agenda and policy initiatives of Vietnam Veterans of America for the second session of the 115th Congress. As you know, although VVA is the only Vietnam veterans service organization chartered by Congress, we advocate on behalf of veterans of all eras, those who served before us and those who have served most recently in the ongoing fighting in Southwest Asia.

The fullest possible accounting of America's POW/MIAs has long been VVA's top priority. Of the 2,636 Americans known to be missing in Southeast Asia on May 7, 1975, 1,601 still are listed by DoD as Killed In Action, Body Not Recovered. VVA continues to press for answers regarding the loss of these Americans in Vietnam, Laos, and Cambodia, in the Gulf of Tonkin and the South China Sea. We will assist however we can DPAA, the Defense POW/MIA Accounting Agency, to ensure they receive the funding they need to investigate potential crash and burial sites. And we will continue our Veterans Initiative, which has fomented continued cooperation by Vietnamese and Lao authorities with DoD search teams.

Privatization

Today, though, I want to focus on an issue that is critical to ensuring that President Lincoln's pledge to care for those who were diminished physically and/or mentally during their military service and, for those who gave the last true measure of devotion, for their families and/or their survivors. Mr. Lincoln augured the role of the Department of Veterans Affairs which over the years has been built up so that it provides top-flight mental health care along with uniformly good to excellent physical health care to the almost seven million veterans who depend on the healthcare lifeline that the VA extends. And always remember: *Caring for veterans is part of the continuing cost of the national defense.*

We know this. You know this. There are some among us, however, who would twist the nation's obligation to those who served. They demean the VA. They enlarge any criticism, any whiff of scandal, for their own ends. And in the end, after the barrage of words about the sanctity of caring for Our Nation's Heroes, in

reality, it's all about one thing: \$\$\$\$. Which is why they continue to preach their mantra of privatization.

There are those who would turn the VHA, the Veterans Health Administration, into a cash cow by giving veterans eligible for VA health care unfettered choice to seek their medical treatment anywhere with a clinician of their choosing. Should this come to pass, it will take the VA – and the taxpayers, and the vast majority of veterans who choose the VA for all or most of their healthcare needs – down a very slippery slope to a very expensive disaster. VVA and just about all of the *legitimate* VSOs and MSOs who represent the interests of our nation's veterans know this; we believe you, too, acknowledge this.

Why will a move to privatize most of the VA's healthcare function, which we understand is being advocated by some in the White House, be a disaster? Just think for a moment about this. Think about the metastasizing costs of the Choice Act program. Should the idea behind Choice be expanded, think as well about what it will inevitably do to the health care resources of the VA. With fewer patients, the VA will not be an attractive place to work for some of the most committed and competent clinicians you are likely to encounter, clinicians who provide some of the Best Care Anywhere.

As you know, the Choice Act – the Veterans Access, Choice and Accountability Act of 2014 – was borne of the so-called scandal at the Phoenix VA Medical Center. That this was a scandal which had been ongoing for two decades got lost in the headlines. It was rooted not in incompetence or venality but by a serious shortage of clinicians needed to meet a steadily increasing demand for health care, a situation exacerbated by the economic downturn of the Great Recession and by the VA's ridiculously long process of hiring an employee – something that you in Congress have the power to do something about.

Consider some numbers. The latest projection based on new data released by the Association of American Medical Colleges, the AAMC, foresee a shortage of between 40,800 and almost 105,000 medical doctors by 2030. By that year, said AAMC President and CEO Darrell Kirch, MD, "the U.S. population of Americans aged 65 and older will grow by 55 percent, which makes the projected shortage especially troubling. As patients get older, they need two to three times as many

services, mostly in specialty care, which is where the shortages are particularly severe.”

These numbers are for the American populace in general. When it comes to veterans, the situation is far more dire, because veterans present with *three and four and often more times as many health issues as non-veterans*. Veterans who enroll in the VA healthcare system are generally older, sicker, and poorer than the general populace. Additionally, four out of ten live in rural areas where access to any care is exacerbated by distance, lack of transportation, difficulty in recruiting specialty care providers, and other barriers to care that are well documented by the Veterans Affairs’ Office of Rural Health. And there simply is not now and will not be in the future the organizational capacity to treat our nation’s veterans in the public and private hospitals across the country.

The Choice Act was supposed to eliminate the delays in treating veterans. It set arbitrary eligibility parameters of 30 days/40 miles. Two contractors, TriWest and Health Net, were engaged to solve the problem. Yet in too many instances, they succeeded only in making it worse. Some veterans found that the delays they experienced in getting an appointment with a clinician longer than in their VA medical center or community-based outpatient clinic. Several clinicians dropped out of the program, citing the inability to quickly and efficiently get paid for the services they’d provided. Although the contractors at first handled making the payments, the VA was of course blamed. Over time, overpayments to clinicians amounted to millions of dollars. In the public’s eye, again the VA was faulted.

You’ll recall that when the Veterans Access, Choice and Accountability Act was enacted, one provision called for the creation of a commission on care. Well, the 15-member Commission on Care was constituted, and did yeoman work. This was reflected in the final report to you and the President and the Secretary of Veterans Affairs at the end of June 2016. After careful deliberation, 12 of the commissioners rejected out of hand unfettered choice as fiscally wasteful and medically unnecessary; after all, the impetus never was the quality of care provided by the VA but rather *access* to that care, care that was acknowledged, in many areas, to be superior to the care provided in public, or private, hospitals.

The commission did recommend that veterans ought to be able to choose a primary care clinician from the community, a recommendation that we oppose because it distorts **the central and necessary role the VA plays in coordinating care and prescription medications** for the veterans who receive much if not most of their health care at VA facilities.

Appendix A of the commission's report, which is addended to this testimony, estimates the cost of alternative policy proposals presented to the commission by a team of economists, which noted, "Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death." It also stated, "On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care." Source: Commission on Care final June 30, 2016 report https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf.

So, consider this: The economists, noting several assumptions and caveats, offered a quartet of projections from 2014-2034. They noted, however, the importance of their caveats and assumptions, that if these "do not hold, [our] estimates will be inaccurate." The commission's *Recommended Option* would expand community care . . . provided by an integrated network consisting of providers . . . vetted by VA or a third-party administrator . . . [which] will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We would also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community . . ."

In the *Recommended Option*, estimates range from \$65 billion to \$85 billion in 2019 "for well-managed, narrow networks." For "the less-managed, broader network scenario," the estimate jumps to \$106 billion in 2019. Though estimates in the first alternative option are roughly the same, this is dependent in part to a switch from VA unit costs to Medicare allowable rates. In the second alternative, "estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123

billion,” with costs pushed “substantially higher” should certain factors come to pass. In the third alternative, which would offer “an extremely generous benefits package for patients,” costs would soar in the first year, ranging from \$156 billion to \$237 billion, with a mid-range estimate of a staggering annual expenditure of \$195 billion.

These projections should give you pause – and cause for concern. Because radically expanding community care through integrated networks will be fiscally unsustainable, far more than the 10 percent of VA healthcare dollars expended for fee-basis and contract care over the past few decades. In fact, in the President’s FY’19 budget request for veterans health care, VA projects the cost of care in the community at \$14.2 billion, or 18.5 percent of the VA’s health care budget.

Still, there are those who would destroy VA health care for their own short-term profit. Those who knock the “failed” VA, seemingly oblivious to the reform efforts advocated for and instituted by Secretary Shulkin, do not take into account the undeniable cost increases of privatizing much of VA health care.

And consider this: Most VAMCs in effect provide eligible veterans with “one-stop shopping” for everything from flu shots to life-saving surgery, coordinated by their primary care provider. Savvy veterans can stack three, four, five appointments in a single day. Try doing this in your local hospital or medical center. Does anyone here think that getting appointments to see three, four, or five specialists in a day is feasible in these entities? Will the VA pay 41.5 cents per mile to those veterans who drive to and from clinicians in a brave new world of privatization?

Some of you are aware that several months ago I had a heart procedure that I opted to have done at the Manhattan VAMC. My surgery was performed by a top cardiologist from the NYU Medical Center who, if I was lucky enough to engage him privately, would have cost ten times what it cost in the VA system. But the main difference was that my aftercare was in the VA. It was excellent – and inherently far less expensive than it would have been in the private sector.

Vietnam Veterans of America, after careful consideration, is fully behind the Secretary’s plan to improve the health care experience for veterans. Recognizing that the VA cannot “do it all,” Dr. Shulkin has put together a thoughtful, measured program, a program built on past experiences, recommendations from expert

panels, and numerous reports, including the Final Report of the Commission on Care. We believe the Secretary is heading in the right direction and it is time for all concerned to embrace the plan and assist the VA with implementing long overdue improvements to the system.

The VA needs to be strengthened, not decimated by false choice. Yes, in those instances where the VA cannot provide urgently needed care, Secretary Shulkin's blueprint for community care warrants our support. And it warrants your support.

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Let me note now VVA's other top priorities for the remaining months of the 115th Congress. These along with other priorities are to be found in our Legislative Agenda and Policy Initiatives for the 115th Congress, which we have also addended to this testimony.

Source: <https://vva.org/wp-content/uploads/2017/08/VVALegAgenda2017to2018.pdf>

The Legacy of Toxic Exposures

As you know, for several years VVA's top legislative goal was enacting a statute that would foster the peer-reviewed research necessary to determine if a parent's exposure to toxic agents might be responsible for certain birth defects, cancers, and learning disabilities that have afflicted far too many of our children and our grandchildren.

In one of the final acts of the 114th Congress, you enacted a "minibus" which incorporated much of the focus of S. 901 and H.R. 1769, the Toxic Exposure Research Act. This legislation lays the groundwork for the research we need on the health of our offspring whom we believe have been impacted by exposures during our military service. It does not focus on Agent Orange, but rather on any and all exposures to toxic agents whether in CONUS or overseas. This legislation will ensure that our newest veterans will not have to wait 50 years for answers.

Vietnam veterans' experience with exposure to the defoliant Agent Orange is hardly atypical. During the first Gulf war in 1991, 110,000 troops were exposed to fallout from a toxic plume consisting of who knows what after the Khamisiyah ammo dump was blown. Over the next several years, thousands of these men and

women reported a variety of ills now known collectively as “Gulf War Illness.” In the wars in Afghanistan and Iraq, thousands more veterans have come down with dermatological and respiratory from exposure to the foul-smelling burn pits, and harmful side effects from the anti-malarial mefloquine and other drugs.

We now must focus on finding champions from both sides of the aisle in both houses of Congress to introduce, and pass, what we are calling the **Toxic Wounds Registries Act of 2018**. It would direct the Secretary of Veterans Affairs to establish a master registry to incorporate registries for:

- Exposure to Agent Orange during and in the aftermath of the Vietnam War;
- Exposure to toxins relating to deployment during the 1990 Persian Gulf War;
- Exposure to toxins from a deployment during Operations Iraqi Freedom, New Dawn, and Enduring Freedom, and the Global War on Terror;
- Exposure to toxins during a deployment to Bosnia, Somalia, or the Philippines; and
- Exposure to toxins while stationed at a military installation contaminated by toxic substances overseas and here in CONUS.

As long as these registries are not simply used as mailing lists as the current Agent Orange Registry has been, they should provide ample justification for research not only by the VA’s R&D operation but by DoD’s CDMRP program as well.

It is our intent to identify “champions” from both parties to introduce this registries legislation in both houses of Congress, and to enlist a coalition of VSOs and MSOs to work in concert, buttressed by a coordinated grassroots campaign, to enact this legislation into black-letter law.

Extending and Expanding the Relationship with the NAM

The Agent Orange Act of 1991 mandated that the Department of Veterans Affairs engage the National Academy of Medicine (formerly the Institute of Medicine) of the also renamed National Academies of Sciences, Engineering, and Medicine to convene panels of experts every two years to review the scientific literature, hold public hearings, produce their findings on health conditions that may have an association with exposure to dioxin, and publish these findings in biennial editions of *Veterans and Agent Orange*.

In our estimation, there is a real need for you to not only authorize the funding so that this update can be continued for at least another decade, but also to expand its scope to embrace **the potential effects of toxic exposures on veterans of *all* eras**, including service in places known for the presence of toxic substances – places like Fort Detrick, Maryland; the defunct training base for the Army’s chemical specialists, Fort McClellan, Arkansas; and the shuttered Marine air base at El Toro, California.

Fixing the VA: Oversight and Accountability

The formula for estimating the funding to be needed in future years by the VA healthcare system has been incorrect since it was initially implemented in 2003. A civilian formula, it failed to take into account that veterans have more things wrong with them as they age than their civilian counterparts. It failed to estimate the increasingly complex needs of combat-wounded warriors. It failed to take into account the greater medical and mental health needs of the average VA patient. It did not anticipate dramatically increased enrollment. The bottom line: the VHA does not have enough clinicians to accommodate the veterans who use its facilities.

Adequate funding, however, is not the overwhelming issue in shrinking the backlog of claims and appeals encountered by long-suffering veterans through the long-beleaguered Veterans Benefits Administration. VVA will continue to work with the VBA to introduce and **integrate pilot IT projects** that have shown promise in streamlining the compensation and pension system, including the bloat of claims currently before the Board of Veterans Appeals. There also must be: competency-based testing of service representatives and VA adjudicators; “challenge training” for *all* staff; expansion of the “lane” model to reduce the scandalous number of overpayment cases.

Clearing Up the ‘Backlog’

The VBA has made significant progress in shrinking the backlog of claims while adjudicating a steadily increasing number of new claims. Still, it must move forward with force and focus because in our estimation the fix engineered by Congress and signed into law by the President is no fix at all.

The VBA should **triage all new claims** in its enhanced “lane” system. There is no reason why a relatively simple claim cannot be resolved in a few months. Claims for the obvious, e.g., the traumatic amputation of a limb, or blindness, or paralysis, also could receive an initial adjudication for the major wound, with associated or secondary conditions rated later.

The manner in which VBA managers grade their raters needs to be re-examined, inasmuch as the current system puts a premium on volume and speed at the cost of getting it right the first time. The result is an unacceptably high number of remands when veterans and their advocates appeal their denials or the amount of their awards. Part of the answer is a **revamped training regimen** not only for new raters – and veterans benefits representatives – but for *all* VBA employees involved on the benefits side of the VA, and a revised standard for adjudication of claims that does not credit raters for speed and volume but rather on the efficacy of their adjudications.

In the era of the National Work Queue (NWQ), where claims are being adjudicated in jurisdictions other than the state in which the claimant resides, it is crucial to prioritize the VSO’s recommended requirement updates to VBMS and other VA programs so that VSOs can continue to adequately represent veterans and their family members. VVA has and continues to advocate for certain updates to VBMS that would simply permit service officers to provide continual representation to claimants. As of now, due to the NWQ, it is nearly impossible for a service officer to adequately track all of her claims. VVA encourages VA to truly partner with VSOs as the work our service officers do contributes to obtaining a final and just decision at the lowest appeal level possible.

VVA was one of the few VSOs to have expressed substantial concerns with the new appeals law in its conceptualization and its implementation, in both its draft and now final form. While we have argued that the current claims system is broken, while we understand the need for urgent modifications, the new appeals law falls far short of fixing the fundamental problems that plague the system. Significantly, the new law fails to address the need for a legal precedent-setting mechanism in the VA claims process; without binding precedent at the core of any changes to the system, the main problems with the claims process will not

be resolved. It is imperative that once a decision is rendered on a particular type of claim, this should be applied to any subsequent similar claim.

Organizational Reform

The VA must embrace a corporate culture that measures its vocational rehabilitation programs and educational initiatives as to whether and how much it assist veterans obtain and sustain gainful employment at a living wage.

The VA moved in the right direction by creating an Office of Economic Opportunity. This administrative change, however, does not go far enough. VVA, therefore, will continue to advocate for legislation to **create** a fourth entity within the VA, what we're calling **the Veterans Economic Opportunities Administration**, to be headed by an Under Secretary nominated by the President and confirmed by the Senate.

The VEOA would house under one roof within the VA the Vocational Rehabilitation Service, the Veterans Education Service, and the Center for Verification and Evaluation; and grant functional control, if not the outright transfer, of VETS, the Veterans Employment and Training Service, from the Department of Labor, as well as newly federalized DVOP (Disabled Veterans Outreach Program) and LVER (Local Veterans Employment Representative) positions, which currently reside in state departments of labor.

On behalf of our members and their families, I thank you for the opportunity to present VVA's top legislative agenda items and policy initiatives for the 115th Congress. And I want to thank all of you for all that you have done, and all that you are doing, for all of our nation's veterans. I will of course be pleased to answer any questions you may have regarding our testimony.

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VIETNAM VETERANS of AMERICA

Funding Statement

March 6, 2018

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

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

For further information, contact:

Executive Director for Policy and Government Affairs
Vietnam Veterans of America
(301) 585-4000 ext. 127

House Veterans' Affairs Committee Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires witnesses to disclose to the Committee the following information.

Your Name, Business Address, and Telephone Number:

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1. On whose behalf are you testifying? Vietnam Veterans of America

If you are testifying on behalf of yourself or on behalf of an institution other than a federal agency, or a state, local or tribal government, please proceed to Question #2. Otherwise, please sign and return form.

2. Have you or any entity you represent received any Federal grants Yes (No) or contracts (including any subgrants or subcontracts) since October 1, 2004?

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the entity you represent.

Signature: 

John Rowan
National President

Date: 3/6/2018

Please attach a copy of this form, along with your curriculum vitae (resume) to your written testimony.

JOHN ROWAN

John Rowan was elected National President of Vietnam Veterans of America at VVA's Twelfth National Convention in Reno, Nevada, in August 2005.

John enlisted in the U.S. Air Force in 1965, two years after graduating from high school in Queens, New York. He went to language school, where he learned Indonesian and Vietnamese. He served with the Air Force's 6990th Security Squadron in Vietnam and at Kadena Air Base in Okinawa, helping to direct bombing missions.

After his honorable discharge, John began college in 1969. He received a BA in political science from Queens College and a Master's in urban affairs from Hunter College, also of the City University of New York. Following his graduation from Queens College, John worked in the district office of Rep. Ben Rosenthal for two years. He then worked as an investigator for the New York City Council and retired from his job as an investigator with the New York City Comptroller's office.

Prior to his election as VVA's National President, John served as a VVA veterans' service representative in New York City. John has been one of the most active and influential members of VVA since the organization was founded in 1978. He was a founding member and the first president of VVA Chapter 32 in Queens. He served as the chairman of VVA's Conference of State Council Presidents for three terms, on the national Board of Directors, and as president of VVA's New York State Council.

He lives in Middle Village, New York, with his wife, Mariann.