Chairman Daniel K. Akaka

OPENING STATEMENT
Markup of Pending Legislation
August 5, 2010

Today we will consider a number of bills – one original bill, and six others that are pending before the Committee. The agenda includes many provisions on a diverse array of issues such as education, employment, and claims processing. The clearest commonality is that all would improve the care and benefits provided to veterans and their family members. In my view that is the mission of this committee. I am pleased that we have gathered today to do the work we are meant to do.

Because the legislation on the agenda incorporates provisions from many of the Members here today, my remarks will focus mainly on a general summary of the bills.

S. 3107 is the Veterans' Compensation Cost-of-Living Adjustment Act of 2010. This is a straightforward bill, passed annually by Congress, to ensure that if the cost-of-living increases, compensation for veterans and surviving family members will rise at the same rate. If the cost-of-living decreases, as was the case last year, compensation will not decrease. As always, the rate of change in the cost-of-living will be determined by the Department of Labor's Bureau of Labor Statistics.

S. 3234 is the Veterans Employment Assistance Act of 2010. This bill is a modified version of legislation introduced by Senator Murray to curb the worrisome rate of unemployment among returning veterans. I thank Senator Murray for her work on this issue, and I look forward to our shared effort to enact this bill into law. I am especially hopeful about the impact of two provisions in this bill. First, this bill would require a three-year study on the unusually high rate of unemployment among women veterans. Secondly, to reduce veteran unemployment, assist cast-strapped states, and meet others needs among veterans at the same time, the bill would establish a Veteran-to-Veteran Corps. The Veteran-to-Veteran Corps would provide states with financial support to employ former-servicemembers in helping homeless veterans, jobless veterans, and those unaware of the benefits and care for which they are eligible.

S. 3325 is the Veterans Telehealth and Other Care Improvements Act of 2010. This legislation would improve the quality of health care provided by VA and would increase access to that care. I thank Senator Begich for providing leadership on this bill, especially his sponsorship of the original S. 3325 that would waive the collection of copayments from veterans' use of telehealth and telemedicine. Another key part of this bill is a program of outreach to veterans who live in economically distressed regions. This bill includes several provisions that enhance oversight and quality management of the use of radioactive isotopes at VA facilities. There is also a provision to improve the multifamily VA's transitional housing loan program in order to develop

transitional housing with onsite supportive services for homeless veterans. S. 3325 also contains several authorizations for leases and the construction of Department medical facilities.

S. 3447 is the Post-9/11 Veterans Educational Assistance Improvements Act of 2010. As one of three remaining senators who attended college on the original GI Bill, I have made it a personal goal to work with all parties to strengthen the education benefit for today's servicemembers and veterans. I introduced a draft bill prior to Memorial Day, and have engaged in discussions with advocates in and outside of Congress since then. The amended version of the bill before us today incorporates many of those ideas and would result in a broader, more inclusive, and less confusing Post-9/11 GI Bill.

S. 3609 is a non-controversial bill dealing with one element of the disability claims adjudication process. With the ongoing rise in disability claims, VA does not have enough physicians on staff to conduct timely medical evaluations for all claimants. To fill that gap, VA uses contract physicians, under authority provided by Congress. This bill would extend that authority, which expires at the end of the calendar year. The simple choice is whether we want to make it more difficult for VA to process disability compensation claims.

We also have an original bill on the agenda that would provide a number of improvements to veterans' benefits. This legislation is derived from proposals from the Administration, which I introduced on its behalf with minor modifications.

Lastly, S. 3517 is the Claims Processing Improvement Act of 2010. This legislation began as a discussion draft, through which I intended to address what many recognize to be the most challenging veterans' issue of the day: VA's broken disability compensation system.

It was clear to me when I introduced this bill that no one is pleased with the status quo. The Rating Schedule is in many respects outdated. As one example, in its 2007 report, the Institute of Medicine stated that the "Rating Schedule contains a number of obsolete diagnostic categories, terms, tests, and procedures, and does not recognize many currently accepted diagnostic categories. . . . In other cases, the diagnostic categories are current but do not specify appropriate procedures to measure disability for the condition."

My discussion legislation focused on adjudication, with most of the provisions limited to the processing of claims. The legislation also included a proposed pilot program. The pilot program had two goals: first, to test a new system using an internationally recognized method to identify the disabilities claimed. The second goal was to evaluate the effectiveness of utilizing a tested method of rating disabilities based on functional impairment.

My overarching goal, which I have been open about from the onset, was to encourage stakeholders to discuss how the current claims processing system should be improved.

One of the problems I sought to address is the reality that many of the disabilities that are claimed today do not have a specific code in the Rating Schedule. Committee oversight has

found that as a result of the disconnect between the current Rating Schedule and medical science, the same disability may be named and rated differently depending upon which analogous code is selected. In the Institute of Medicine report I mentioned earlier, the IOM committee working on the issue noted that orthopedic conditions are some of the most common conditions for which ratings are done by analogy because there is no specific rating code for the disability claimed.

My legislation would have required that the diagnosis be identified using the appropriate code from the International Classification of Diseases. ICD codes are standardized codes and names for medical conditions used universally by physicians, hospitals and other medical providers. By using ICD codes to identify a disability, the diagnostic term used would be consistent with current medical identification criteria and promote interoperability. The intent of the ICD code proposal was to provide a clearer and more consistent diagnosis for the claimed condition and to enable VA to move toward an interoperable electronic records system using standard medical terminology. Dr. Lonnie R. Bristow, the former Chairman of the IOM Committee wrote in a letter to me that "requiring that the appropriate ICD/DSM codes be in the medical documentation and explicitly included in the rating decision would be a definite improvement over the current process."

Contrary to some of the testimony provided on the bill, my legislation would not have incorporated all ICD codes into the regulations of the Rating Schedule. The legislation would have required reference to the ICD code so that the current medical scientific basis for the naming of the disability would be used. If the full ICD codes were to put into regulations, they would not always be current, because the codes are updated more often than can be accomplished in a formal regulatory process.

I expect that the use of ICD codes would have avoided a problem recently brought to my attention by a veteran who is service-connected for a disability recognized as a bone marrow malignancy by its ICD code and by the National Cancer Institute, but who was nonetheless determined by a VA physician to not have cancer.

I will continue to explore ways to promote the use of ICD codes in medical documentation of disabilities and the rating decision to make such improvements.

The other principal issue the pilot program would have addressed is the actual process for assessing the impact of a disability on an individual. During Committee oversight, the failure of the Rating Schedule to address many common disabilities claimed by veterans appears to contribute to inconsistent ratings.

For example, far too often a veteran with a diagnosis of chondromalacia patella, a softening and degeneration of the cartilage underneath the kneecap, is rated at zero percent because the most common measures for orthopedic evaluations such as X-rays do not typically show this abnormality and loss of range of motion is not a primary characteristic of the disease. The

cardinal symptom is pain that worsens after sitting for long periods of time and performing other movements. Participation in strenuous activity must be avoided and medication is needed to relieve the pain. A rating of zero percent does not consistently recognize the functional limitations on sitting, running and climbing stairs which may be imposed by this disability. However, in rare cases such as when the disability is active at the time of a compensation and pension medical examination, the veteran may receive a rating as high as 40 percent. Using a functional impairment evaluation, as proposed in my legislation, would enable the examiner to more appropriately and accurately rate this disability.

In another example, the ratings for spinal conditions were revised in 2003. The ratings for intervertebral disc syndrome are based upon the number of weeks of "incapacitating episodes" characterized by bed rest for treatment of the condition. However, current medical science indicates that only a short period of bed rest is appropriate followed by physical therapy. Research has found that long periods of bed rest may result in serious complications such as blood clots. When veterans are required to show evidence of a treatment that is not currently recommended for a diagnosed medical condition, they are unlikely to receive the benefits that a grateful nation should provide. Again, an evaluation of functional impairment would result in a more accurate reading of this disability.

According to VA's Inspector General audit of VBA compensation rating accuracy and consistency reviews for fiscal year 2008, "VBA officials identified 61 diagnostic code reviews with inconsistencies in either a regional office's grant/denial rate for a specific diagnostic code or a regional office's evaluation (the percentage of compensation granted to a claimant) of a specific diagnostic code." Such disparities result in similarly situated veterans receiving different amounts of compensation. I believe that veterans would be better served by a system which encourages a fair evaluation of the functional impairments resulting from a veteran's service-connected disability.

I have been open to ideas, even competing proposals, which may do a better job of achieving reform. I did not expect all parties to embrace every provision of the first version of this bill, but I did expect a constructive discussion centered on what to change, not whether to stay with a failing system that, in some respects, has not been overhauled since I returned from World War II. Frankly, my expectations were not met.

In some cases, this legislation was endorsed. In others, parties made recommendations on how to improve the bill. But in most cases, those commenting on the legislation focused on criticizing the pilot program, rather than offering ideas on how to improve it, or suggesting additional provisions to be added to the processing section of the bill. Others urged Congress to sit on the sidelines until VA completed pilot programs already underway. However, none of the VA pilot programs are addressing changes to the Rating Schedule. The one VA pilot for which rating decisions were reviewed found a significant number of errors in the rating decisions.

At this stage, I am persuaded by practical considerations – the lateness of the Congressional session and the lack of helpful dialogue – to move the claims processing bill without the pilot

program. With this change, I certainly hope that the amended version of the claims processing improvement bill will go forward. I continue to express my willingness to work with all interested parties, especially those willing to offer substantive contributions to the development of legislation that will provide fair, timely, and accurate compensation for disabled veterans. Ignoring the flaws of VA's antiquated rating scheme will only make it more outdated and result in more veterans who are not fairly and adequately compensated for the disabilities incurred or aggravated by military service. I hope that all of those interested will work together next year to develop a real plan for reform.

I know that my colleagues are here to give their remarks, and I am eager to do our business. I close by again thanking my colleagues from both sides of the aisle, the Administration, and the veterans' community for contributing to this agenda.

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