Annual Legislative Presentation

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Paralyzed Veterans of America

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Chairman Isakson, Chairman Takano, and members of the Committees, I appreciate the opportunity to present Paralyzed Veterans of America's (PVA) 2019 policy priorities. For more than 70 years, PVA has served as the lead voice on a number of issues that affect severely disabled and catastrophically injured veterans in this country. Our work over the past year includes championing critical changes within the Department of Veterans Affairs (VA) and educating legislators as they have developed important policies that impact the lives of those who served.

Today, I come before you with our views on the current state of veterans' programs and services, particularly those that impact our members—veterans with spinal cord injuries or disorders (SCI/D). Our concerns and policy recommendations are particularly important in light of the continuing discussion about reforming the delivery of veterans' health care. As the Committees and the Administration advance reforms to the VA health care system, proper consideration must be given to how those reforms will impact veterans who rely primarily on the VA for their health care, and particularly those veterans who access the VA exclusively through specialized systems of care.

BACKGROUND—Our organization was founded in 1946 by a small group of returning World War II veterans, all of whom were treated at various military hospitals throughout the country as a result of their injuries. Realizing that neither the medical profession nor government had ever confronted the needs of such a population, these veterans decided to become their own advocates and to do so through a national organization.

From the outset, PVA's founders recognized that other elements of society were neither willing nor prepared to address the full range of challenges facing individuals with an SCI/D, whether medical, social, or economic. They were determined to create an organization that would be governed by the members themselves and address their unique needs. Being told that their life expectancies could be measured in weeks or months, these individuals set as their primary goal to bring about change that would maximize the quality of life and opportunity for all veterans and individuals with SCI/D—*It remains so today.*

Over the years, PVA has established ongoing programs to secure benefits for veterans; review the medical care provided by the VA's SCI/D System of care to ensure our members receive timely, quality care; invest in research; promote education; organize sports and recreation opportunities; and advocate for the rights of veterans and all people with disabilities through legal advocacy and accessible architecture. We have also developed long-standing partnerships with other veterans' service organizations. PVA, along with the co-authors of *The Independent Budget (IB)*—DAV (Disabled American Veterans) and the Veterans of Foreign Wars—continue to present comprehensive budget and policy recommendations to influence debate on issues critical to the veterans we represent. We are proud that *The Independent Budget* policy agenda has been presented for more than 30 years. We also recently released our budget recommendations to inform the debate on funding for the VA for Fiscal Years (FY) 2020 and 2021.

STRENGTHEN AND IMPROVE THE VA HEALTH CARE SYSTEM AND SERVICES

Oversight of the VA MISSION Act Implementation (P.L. 115-182)—The VA MISSION Act directs needed changes to VA's delivery of health care in the community and at VA health care facilities around the country. PVA supported the VA MISSION Act. We believe that integrated community care will ensure VA's ability to serve veterans with catastrophic disabilities remains strong.

We are now entering into the most critical phase of this effort; *implementation of the law itself.* If VA and Congress execute this law fully, faithfully, and effectively, veterans' health care will enter a new era marked by expanded, timely access to high quality care for all enrolled veterans. However, if implementation deviates from the clear and widespread consensus reached by all key stakeholders, the VA health care system could enter a period of decline with devastating consequences for veterans who rely on VA for their care, and perhaps even threaten the viability of the VA health care system

itself. No one wants that to happen, and we are ready and willing to work with you and VA to ensure the success of this important effort.

In late January, VA announced proposed access standards required by the VA MISSION Act that are based on average drive time and appointment wait times. For primary care, mental health, and non-institutional extended care services, VA suggests a 30-minute average drive time standard and for specialty care, a 60-minute average drive time standard. They are also proposing wait-time standards of 20 days for primary care, mental health care, and non-institutional extended care services, and 28 days for specialty care from the date of request with certain exceptions. Veterans who cannot access care within these standards would then be able to choose between eligible community providers and care at a VA medical facility. Eligible veterans would also have access to urgent (walk-in) care which gives them the choice to receive certain services when and where they need it. To access this new benefit, veterans will select a provider in VA's community care network and veterans with service-connected disabilities will be charged co-payments after three visits.

VA's proposal to charge a copay after three urgent care visits is troubling. No other mechanism to depress demand for this service—such as prior approval by a triage nurse or a cap on the number of visits (like TRICARE did when it first started authorizing this type of care) appears to have been considered. We urge the Secretary to exercise authority given to him through the MISSION Act and not charge veterans who are not required to pay a copayment under Title 38 for VA direct care. Under no circumstances should a veteran ever be charged for care related to a service-connected illness or injury. Allowing these copays creates a slippery slope that neither Congress nor VA should allow because it contradicts the premise on which VA was founded.

Other early observations here are that the proposed new access standards will significantly increase the number of veterans eligible to access the community care system—perhaps by 20 to 30 percent according to VA's own assumptions. This would substantially increase health care costs for VA, and it will be critical that they manage this escalation to ensure that adequate resources for specialized services like the SCI/D System of Care are preserved.

PVA is particularly concerned with VA's ability to successfully implement the IT portion of the VA MISSION Act. Historically, VA has had difficulties with the planning and implementation of IT programs. At best, it would be a risky assumption that VA can get this part of the plan right, particularly with the target implementation date less than six months away. Prior to FY19, Congress agreed to provide $88.1 Billion in discretionary funding for the VA; however, it is yet to be seen if VA requested enough funding to completely develop and implement the IT infrastructure to support the provisions of the VA MISSION Act. If poor planning and project management requires VA to re-submit proposals for more funding, veterans will suffer. PVA is hoping Congress and its committees will continue to provide constant oversight to ensure VA is adhering to the legislation and that they will maintain transparency and constant communication through the process for successful implementation of the VA MISSION Act.

Finally and perhaps most important, VA and Congress must ensure the expansion into the community is not at the expense of the quality care currently provided through the VA health care system. Moreover, we urge you to resist VA proposals to merge programs and resources of the Choice program and Medical Community Care program into the Medical Services Accounts beginning in FY2020. This will ensure that VA resources already targeted for the health care system are not redirected to outside care options. Your continued oversight into the development and execution of this program is not only welcomed, *it is necessary.* Given the past problems with VA which have brought us to this point, American taxpayers and veterans will expect no less than this from you.

Title 38 Protections for Community Care—On a related matter, PVA remains deeply concerned about the exclusion of Title 38 protections in the conversations regarding expansion of community care. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability is incurred or health care problem arises. Under Title 38 U.S.C. § 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility. If medical malpractice occurs during outsourced care, however, the veteran must pursue standard legal remedies unlike similarly situated veterans who are privy to VA's non-adversarial process. Adding insult to literal injury, these veterans, if they prevail on a claim, are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again.

This is simply unacceptable. Congress must ensure that these protections follow the veteran into the community. Veterans who receive care in the community must retain current protections unique to VA health care under Title 38, particularly including medical malpractice remedies governed by 38 U.S.C § 1151, but also clinical appeal rights, no-cost accredited representation, and congressional oversight and public accountability.

Expand Eligibility for VA's Comprehensive Family Caregiver Program—Last year's expansion of eligibility for VA's Comprehensive Family Caregiver Program as part of the VA MISSION Act was of great significance to PVA members, and we look forward to working with VA as it begins to include catastrophically injured veterans from the WWII, Korean, and Vietnam eras this fall. So long as the expansion remains on track, in 2021, catastrophically-injured (service-connected) veterans from eras that pre-date September 11, 2001, will finally be eligible as well. We are extremely pleased with this action because it corrected an inequity that existed with the caregiver program and will improve the quality of life for thousands of deserving veterans and their caregivers.

There are a number of areas regarding the expansion of this program that we feel you should monitor. When the original program was launched in 2011, VA estimated some 4,000 veterans would apply. However, more than 45,000 applied and were deemed eligible, demonstrating the unmet need for services and supports for families. Currently, some 19,000 veterans access these services and in the years to come, an estimated

76,000 veterans are likely to enter the program. Thus, funding must match the level of participation.

The majority of veterans currently in the program are in their 30s. Having been injured young, they are still finding the new normal for their lives. Oftentimes, these veterans access services for three to four years before graduating out of the program when their conditions improve to a degree where a daily caregiver is no longer needed. But as the program expands to include additional eras of service, this trend line will likely stop, as the majority of geriatric veterans are unlikely to see their independence improve to the point of no longer needing daily caregiving. Also, while an older veterans' participation is unlikely to fluctuate, the caregivers of older veterans likely will. Younger veterans tend to rely consistently on a spouse or a parent for care. Older veterans, on the other hand, are less likely to have a spouse still capable of the physical demands of providing daily care. We anticipate adult children, nieces, nephews, or other family or community members of veterans will provide care in greater numbers. VA must be able to accommodate rotating caregivers, and provide the adequate and relevant training they need in order to sustain their veteran and maintain their own health.

Regarding the development of IT to support the new program, VA is working on a new system for the expanded Caregiver Program but given its recent failures in the technology area, it is unclear if this program is on track to be fully operational by the fall.

Perhaps the most important consideration with VA's Program of Comprehensive Assistance for Family Caregivers is that it must be fully resourced to meet the expansion timelines in order to serve veterans injured before September 11, 2001. Without proper funding, this program has little chance of succeeding. Moreover, we understand that VA has the authority to bring five additional program staff on board but that increase will not likely be enough to manage the expansion.

There is, however, another deserving group of veterans that were not included under the original program or the expansion; veterans with service-connected illnesses such as ALS or the hundreds of other illnesses included in the VA's Presumptive Disease List. This too is unjust. For this program to be genuinely inclusive of all our nation's veterans and their caregivers, it must not exclude those with service-connected illnesses. Therefore, PVA urges the Committees to consider expansion of the program to service-connected illnesses, not just injuries from all eras of service.

Improve Access to VA's Long-Term Services and Supports—PVA continues to be concerned about the lack of VA long-term-care (LTC) beds and services for veterans with SCI/D. Many aging SCI/D veterans are currently in need of VA LTC services at the 24 VA SCI/D centers (or "hubs"). Unfortunately, we believe the VA is not requesting, and therefore Congress cannot provide sufficient resources to meet the current demand. In turn, as a result of insufficient resources, the VA is moving toward purchasing private care instead of maintaining LTC in-house at SCI/D centers.

The VA has designated SCI/D LTC facilities because of the unique comprehensive

medical needs of SCI/D veterans, which are usually not met in community nursing homes and non-SCI/D–designated facilities. SCI/D centers provide a full range of services and address the unique aspects of delivering rehab, primary, and specialty care. SCI/D veterans require more nursing care than the average hospitalized patient. Additionally, in SCI/D LTC units, the distribution of severely ill veterans is even more pronounced as a sizable portion requires chronic pressure ulcer, ventilator, and tracheotomy care due to secondary complication of SCI/D issues.

Currently, the VA operates only six SCI/D LTC facilities, with the newest facility being located at the Long Beach VA Medical Center. The Long Beach facility has a capacity of 12 inpatient beds and because it is always full, it has a long wait list to receive admissions. Unfortunately, this woefully inadequate number of beds available barely addresses the high demand in that region. In fact, residing in an SCI/D center was the third most common response from SCI/D veterans when asked about their LTC plans.

Through our interaction with SCI/D patients, we know that many of VA's LTC centers are not properly staffed or equipped to handle the number of veterans needing care. In some areas there are no VA LTC beds available for veterans with SCI/D. In these instances, the only option is to place the veteran into the local community where they receive suboptimal care by untrained SCI/D technicians. Some VA facilities are operating at near capacity, while others only achieve a fraction of theirs due to insufficient staffing. And it is especially difficult to find placement for veterans who are ventilator dependent.

Although VA has identified the need to provide additional SCI/D LTC facilities and have included these additional centers in ongoing facility renovations, such plans have been languishing for years. To ensure that SCI/D veterans in need of LTC services have timely access to VA centers that can provide quality care, both the VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing SCI/D LTC facilities. PVA, in accordance with the recommendations of *The Independent Budget* Policy Agenda for the 116th Congress, recommends that VA SCI/D leadership design an SCI/D LTC strategic plan that addresses the need for increased LTC beds in VA SCI/D centers.

Permanent Access to In-vitro Fertilization (IVF)—Last year, Congress approved legislation extending IVF services for qualified wounded veterans for another two years. That legislation also included a modification lifting what was a three-year limit on the coverage of cryopreservation of embryos. The continued provision of procreative services through VA will ensure that these veterans are able to have a full quality of life that would otherwise be denied to them as a result of their service. PVA calls on Congress to go a step further and make such services a permanent part of the medical benefits package at VA. It is Congress that has a moral obligation to restore to veterans what has been lost in service, to the fullest extent possible.

VA's current temporary authority prohibits the use of gametes that are not a veteran's and his or her spouse. For many veterans, their injuries destroyed their ability to provide

their own sperm or eggs for IVF. Because they require donated gametes, they are ineligible for IVF through VA. This is an unexplainable requirement that only harms those who need this service the most. A cruel irony of the prohibition of donated gametes for IVF is that there is no such prohibition when veterans pursue artificial insemination. Only in the provision of IVF can VA not authorize care if the use of donated gametes is necessary. Congress must correct this restriction. Finally, Congress should allow further services to address the needs of women veterans whose injuries prevent a full-term pregnancy.

While we are very excited that procreative services remain temporarily available for catastrophically disabled veterans and thrilled to learn of veterans and their spouses who are expecting, our work is not done. We encourage the members of these committees to support S. 319 and H.R. 915, which would make this service a permanent part of the medical benefits package at VA.

Greater Focus Needed to Improve Prosthetics Services—The VA's Prosthetics and Sensory Aids Service (PSAS) is charged with providing prosthetics, orthotics, and adaptive equipment to replace missing parts of the body and support bodily functions to enable veterans to regain independence and mobility. The advances in prosthetics technology and complexities of function have greatly enhanced disabled veterans' ability to assimilate back into the community. However, the cost of technology, materials development, scientific research, engineering skills, and knowledge required to produce and manufacture prosthetics have significantly increased. The sophistication to then fit the prosthetic to the disabled veteran's body requires individuals specifically trained to do so. No group of veterans appreciates the importance of prosthetics more than veterans with SCI/D who have lost mobility and function.

The VA's mission is to care for the disabled veteran in a uniform and standardized manner, but PSAS has unfortunately demonstrated that it is missing the mark. Prosthetics services vary widely from VA medical center to medical center. The primary reasons are the national prosthetic policy charges local VA medical centers with holding down costs; a lack of training; lack of knowledge; and poor communications. In addition, the VA Handbooks and Directives, the majority of which are over a decade old, are woefully inadequate to the task of meeting the challenges of the advances made in prosthetics for the last 15 years. The VSOs have been told that there are rewrites in progress, but we have not been asked to participate in the critical development phase of these directives. The result will ultimately be flawed because those VSOs most knowledgeable about prosthetics are not included in development of the final product. Lack of direct stakeholder engagement has long been a problem for VA, resulting in the need for major revisions and clarifications after the fact, once those policies are applied out of the abstract and actually impact the lives of veterans.

Prosthetics equipment will continue to increase in complexity and costs. The VA must meet the demand by ensuring an adequate budget, a continuous training program for prosthetics and clinical staff, and increased staff. The VA will make a serious mistake if it attempts to mitigate costs by reducing the personnel who administer the program.

Another potential problem for VA would be an effort to provide prosthetics through the community health care systems. The administrative burden for VA prosthetics staff to properly manage, maintain the quality of prosthetics, and control the costs will lead to more delays, inappropriate and non-standard care, and increased complaints about the VA's delivery of these critical services. It is incumbent upon Congress to conduct more thorough oversight of the VA's prosthetics program to ensure that the VA is doing all it can to restore lost mobility and independence for veterans who rely upon prosthetics equipment and services.

E*nsure Effective Outreach by VA to Veterans with SCI/D*—PVA members, as well as all veterans with SCI/D served by the VA (now believed to be more than 43,000), are encouraged to complete comprehensive annual examinations and preventative screenings at VA SCI/D centers. These services help prolong veterans' lives and maintain good health, while also allowing the VA to study longitudinal information on the course of SCI/D over individuals' lifetimes.

Unfortunately, we still encounter too many cases where veterans do not know they are entitled to an annual examination or have not been encouraged by a VA clinician to complete one. As a result, those veterans eventually end up at one of the 24 VA SCI Centers; however, instead of preventative care, it is to treat a severe bedsore; a renal, circulatory, or respiratory condition that has progressed to a point requiring critical intervention; or some other acute health condition.

PVA believes an adequately staffed system of care with statutorily mandated staffed beds, coupled with a proactive outreach and education program, will improve what is already regarded as the best SCI/D System of Care in the world while also guaranteeing the best health care option for catastrophically disabled veterans. The new community care program may soon serve other segments of the veteran population well, but our members have overwhelmingly made their choice. They want VA's SCI/D System of Care, so Congress and the Administration owe it to these veterans to ensure that their choice is indeed a viable one.

Disaster Response and Recovery that Meets the Needs of People with Disabilities—Although it is not within the jurisdiction of the Committees, there is an issue of concern to PVA that is related to your work with veterans. Since Hurricane Maria devastated Puerto Rico in 2017, I have made two visits to the Commonwealth to check on our chapter and its members to see how they fared in the immediate aftermath of the storm and in the year since. As you know, the Veterans Health Administration has a role in the broader emergency response framework of this nation, and we understand VA officials and personnel took their responsibilities seriously despite the many challenges presented by that disaster. We also understand that the VA medical center has taken steps to address many problems identified in the process of responding to the hurricanes that struck the island in 2017. PVA remains concerned, however, about the integration of the VA and proper attention to the concerns of veterans with disabilities in the broader emergency preparation, response, and recovery context. We encourage the

Committees to continue their oversight in this arena to ensure that the VA's Fourth Mission is carried out appropriately for all veterans, including those with disabilities.

BENEFITS IMPROVEMENTS AND APPEALS REFORM IMPLEMENTATION

Oversight of the Veterans Appeals Improvement and Modernization Act (P.L. 115-55)—For many years**,** VA has had a complex claims and appeals system. This "legacy" system was divided amongst two of VA's three administrations and the Board of Veterans' Appeals (BVA), creating a confusing process with many unnecessary steps. Over time, this complex process contributed to lengthy waits for veterans with appeals before the Board.

In March 2016, PVA joined the BVA, Veterans Benefits Administration (VBA), and other VSOs to form a working group with the goal of reforming the appeals process. Working with Congress, these actions led to the creation of the Veterans Appeals Improvement and Modernization Act of 2017 which became law on August 23, 2017. The new system offers three review options: a "higher-level review" by a more senior claims adjudicator; a "supplemental claim" option for new and relevant evidence; and an "appeal" option for review by the BVA. Under the new framework, claimants may choose the option that meets their needs and, if properly implemented, this should reduce the time it takes to process appeals yet ensure that veterans receive fair decisions.

Even though the new program launched on February 19, PVA representatives still do not have full access to the Caseflow program used to track and process benefit claim appeals; they have not yet been informed of the new Outside Medical Opinion (OMO) process; and they still have unanswered questions regarding time limits for Informal Hearing Presentations (IHPs). We also have strong concerns regarding the 30 minute time limit that has been placed on in-person hearings. These official inquiries are intended to provide veterans an easy process in a non-adversarial environment to finally vocalize their story—*many of whom have waited years to do so*. Time limits make this process less than hospitable, and it appears VA is once again shifting responsibility to the veteran to assist with the reduction of the backlog of hearings.

PVA is anticipating your continued oversight to ensure lingering issues like the ones described are resolved. Also, we believe that an ongoing, strong, and close collaboration with VA and Congress is vital to ensuring the implementation and utilization of the new appeals system is conducted with maximum transparency and effectiveness. VA must also provide clear metrics to measure the progress and success of appeals and claims reform and strengthen Congress's ability to hold VA accountable for meeting targets and goals.

Benefits Improvements for Catastrophically Disabled Veterans

PVA believes it is time to improve benefits for the most severely disabled veterans, particularly in regard to the way automobile and housing grants are dispensed and the rates of Special Monthly Compensation.

Automobile Allowance Grants and Adaptive Equipment—The Automobile Adaptive Equipment (AAE) program is critical for veterans with disabilities. The Handbook governing AAE, however, was written 18 years ago. The VA is currently trying to rewrite it with a new rule, but there have been multiple delays. There was only one forum where input was sought from VSOs, and there has been no follow up from VA. PVA and other VSOs have met with VA many times in the last three years to provide recommendations as to how to improve the provision of AAE. We have offered to provide guidance and help to rewrite the Directives and suggest methods to incorporate new technology into AAE. At this point, VA has refused to accept help and has refused to include VSOs in the development of rewriting the AAE Directive.

Access to an adapted vehicle is essential to the mobility and health of disabled veterans. Unfortunately, VA's actions have moved AAE to the top of our priorities that must be addressed by VA. We encourage the Committees to conduct oversight of this program to shed light on the problems inherent in much of the policy redesign that is going on behind closed doors at VA. Additionally, we hope the Committees will help us hold the VA accountable for quickly updating and rewriting the AAE Directive by establishing a taskforce of VA and VSO experts to write and review recommendations for reimbursement of AAE. This should include a process to conduct a yearly review and update of the AAE Directive.

In addition, PVA asks you to support legislation allowing veterans to utilize the Automobile Allowance Grant more than once for the purchase, not lease, of an adapted vehicle. Since vehicles do not last a person's lifetime, veterans should have the ability to purchase a vehicle, once every ten years without having to shoulder the burden of the full cost of a vehicle themselves. In addition, VA must continue to reimburse for adaptive equipment requirements as stated in statute. Veterans should not have to submit an itemized list of this equipment to qualify for the grant. Finally, PVA supports legislation to allow veterans who have non-service-connected SCI/D to receive the same type of adaptive automobile equipment as veterans whose injuries are service connected.

Prioritizing Claims for Specially Adaptive Housing for Veterans with ALS—VA's Specially Adapted Housing (SAH) grant program provides home modifications for catastrophically disabled veterans with service-connected disabilities to help them live barrier-free lives. Many PVA members have benefited greatly from the SAH grant program. The accessibility it provides significantly increases the quality of life for these veterans.

However, the current SAH process is simply too cumbersome to account for time-sensitive situations, like a veteran who has been diagnosed with ALS. It is not uncommon for veterans to wait an average of 6-8 months for modifications after approval and in some cases it can take up to two years. Meanwhile, a person

diagnosed with ALS lives an average of two to five years after diagnosis and many PVA represented veterans have lived only one year after their diagnosis. In these cases, timely completion of SAH modifications was imperative, but sadly, the current system did not allow that to occur. Although VA will expedite claims for veterans with terminal illness, the SAH Program will not prioritize claims for them. Congress should pass legislation that gives VA the authority it needs to prioritize SAH claims of terminally ill veterans.

PVA is also concerned about inconsistencies in the administration of the SAH program. Some of our service officers have raised concerns about the quality and speed of the work which seemed to depend entirely on the geographic location of the veteran. This is troubling based on the fact that compared to other programs, SAH is a very small program and it should not be as difficult for VA to maintain a standard across the board. Veterans should not be punished for where they choose to reside. Instead, they should be able to receive quality service regardless of the location of their residence.

Aside from changes VA could make to improve the administration of SAH, we also believe that Congress must act to improve access to needed housing adaptations. In its recommendations to the 116th Congress, the IBVSOs recommended that Congress establish a supplementary housing grant that would cover the cost of new home adaptations for eligible veterans who have already used their initial grants. Without the ability to access such a grant, veterans may be forced to choose between surrendering their independence by moving into an inaccessible home or staying in their current home simply because they are unable to afford the cost of modifying a new home. The IBVSOs recommend that the supplementary grant amounts be at least half of the maximum amount at the time of application for the supplementary grant.

Alternatively, we would support Congress providing increased funding for the grant to better meet the needs of veterans throughout their lives. Although PVA appreciates previous changes that resulted in the grant being increased based on the Commercial Construction Index (CCI), the current benefit of $85,645 for SAH may not be enough to cover the costs associated with making the necessary modifications to a home. Veterans with catastrophic disabilities related to their military service have the right to live as independently as possible for as long as they are able. The SAH program must support that independence.

Special Monthly Compensation (SMC)—There is a well-established shortfall in the rates of Special Monthly Compensation (SMC) paid to the most severely disabled veterans that the VA serves. SMC represents payments for “quality of life” issues, such as the loss of an eye or limb, the inability to naturally control bowel and bladder function, the inability to achieve sexual satisfaction or the need to rely on others for the activities of daily life like bathing or eating. To be clear, given the extreme nature of the disabilities incurred by most veterans in receipt of SMC, PVA does not believe that a veteran can be totally compensated for the impact on quality of life; however, SMC does at least offset some of the loss of quality of life. Many severely injured veterans do not have the means to function independently and need intensive care on a daily basis.

Many veterans spend more on daily home-based care than they are receiving in SMC benefits.

One of the most important SMC benefits is Aid and Attendance (A&A). PVA recommends that Aid and Attendance benefits be appropriately increased. Attendant care is very expensive and often the Aid and Attendance benefits provided to eligible veterans do not cover this cost. Many PVA members who pay for full-time attendant care incur costs that far exceed the amount they receive as SMC-Aid and Attendant beneficiaries at the R2 compensation level (the highest rate available). Ultimately, they are forced to progressively sacrifice their standard of living in order to meet the rising cost of the specialized services of a trained caregiver; expensive maintenance and certain repairs on adapted vehicles, such as accelerated wear and tear on brakes and batteries that are not covered by prosthetics; special dietary items and supplements; additional costs associated with "premium seating" during air travel; and higher-than-normal home heating/AC costs in order to accommodate a typical paralyzed veteran's inability to self-regulate body temperature. As these veterans are forced to dedicate more and more of their monthly compensation to supplement the shortfalls in the Aid and Attendance benefit, it slowly erodes their overall quality of life.

Chairmen Isakson, Chairman Takano, and members of the Committees, I would like to thank you once again for the opportunity to present the issues that impact PVA's membership directly. As the VA continues to evolve in a manner that can improve access to veterans seeking care, it will be imperative to remember that any changes to the VA health care system will affect our members, and other veterans with specialized health care needs, who use the VA almost exclusively for services. We cannot stress enough the need to preserve and strengthen the VA health care system while more resources, including the community, are leveraged to expand access to care.

We look forward to continuing our work with you to ensure that veterans get timely access to high quality health care and all of the benefits that they have earned and deserve. I would be happy to answer any questions that you may have.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2019

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $193,247.

Fiscal Year 2018

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $181,000.

Fiscal Year 2017

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $275,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

DAVID ZURFLUH
NATIONAL PRESIDENT

David Zurfluh was re-elected national president of Paralyzed Veterans of America (Paralyzed Veterans) during its 72nd Annual Convention in May 2018, and took office on July 1, 2018.

Prior to becoming president in 2017, Zurfluh had served as national senior vice president since May 2015. A member of the Air Force from 1987 to 1995, Zurfluh served as a jet engine mechanic and a crew chief in Operation Desert Shield and Operation Desert Storm. He was injured in 1995 in a motor vehicle accident while on active duty in Hachinohe, Japan, suffering a shattered left arm, broken left wrist and a broken neck. He was diagnosed with incomplete quadriplegia spending one year as an inpatient, and two years as an outpatient in Seattle VA spinal cord injury unit.

Zurfluh joined Paralyzed Veterans in 1995. He has been active since 2003, with the Northwest Chapter. He has held chapter-level positions as legislative director, vice president, president, and member of the sports committee. Zurfluh currently serves on the National Board of Advisors of the Museum of Aviation Foundation. A native of Washington, he served on the Veterans Legislative Coalition in Olympia, WA, and served as co-chair of the West Slope Neighborhood Coalition in Tacoma, WA.

In addition to his work on behalf of Paralyzed Veterans, Zurfluh is a lector at Holy Rosary Church and volunteers at local food banks. His hobbies include handcycling, shooting sports (trap, handgun, and archery), golf and snow sports. President Zurfluh divides his time between Tacoma, Washington and Washington, DC.