

**ENSURING ACCESS TO DISABILITY BENEFITS FOR
VETERAN SURVIVORS OF MILITARY SEXUAL
TRAUMA**

HEARING

BEFORE THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND
MEMORIAL AFFAIRS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTEENTH CONGRESS
FIRST SESSION

THURSDAY, JUNE 20, 2019

Serial No. 116-20

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.govinfo.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

40-821

WASHINGTON : 2021

COMMITTEE ON VETERANS' AFFAIRS

MARK TAKANO, California, *Chairman*

JULIA BROWNLEY, California	DR. PHIL ROE, Tennessee, <i>Ranking Member</i>
KATHLEEN M. RICE, New York	GUS M. BILIRAKIS, Florida
CONOR LAMB, Pennsylvania, <i>Vice-Chairman</i>	AMATA COLEMAN RADEWAGEN, American Samoa
MIKE LEVIN, California	MIKE BOST, Illinois
MAX ROSE, New York	DR. NEAL DUNN, Florida
CHRIS PAPPAS, New Hampshire	JACK BERGMAN, Michigan
ELAINE G. LURIA, Virginia	JIM BANKS, Indiana
SUSIE LEE, Nevada	ANDY BARR, Kentucky
JOE CUNNINGHAM, South Carolina	DAN MEUSER, Pennsylvania
GILBERT RAY CISNEROS, JR., California	STEVE WATKINS, Kansas
COLLIN C. PETERSON, Minnesota	CHIP ROY, Texas
GREGORIO KILILI CAMACHO SABLAN, Northern Mariana Islands	GREG STEUBE, Florida
COLIN Z. ALLRED, Texas	
LAUREN UNDERWOOD, Illinois	
ANTHONY BRINDISI, New York	

RAY KELLEY, *Democratic Staff Director*
JON TOWERS, *Republican Staff Director*

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

ELAINE LURIA, Virginia, *Chairwoman*

GIL CISNEROS, California	MIKE BOST, Illinois, <i>Ranking Member</i>
GREGORIO KILILI CAMACHO SABLAN, Northern Mariana Islands	GUS M. BILIRAKIS, Florida
COLIN ALLRED, Texas	STEVE WATKINS, Kansas
LAUREN UNDERWOOD, Illinois	GREG STEUBE, Florida

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Thursday, June 20, 2019

	Page
Ensuring Access To Disability Benefits For Veteran Survivors Of Military Sexual Trauma	1
OPENING STATEMENTS	
Honorable Elaine Luria, Chairwoman	1
Honorable Mike Bost, Ranking Member	2
Honorable Annie McLane Kuster, U.S. House of Representatives, (NH-02)	3
WITNESSES	
Mr. Steve Bracci, Director, Denver Benefits Inspection, Office of Inspector General, U.S. Department of Veterans Affairs	5
Prepared Statement	37
Mr. Willie Clark, Deputy Under Secretary for Field Operations, Veterans Benefits Administration	7
Prepared Statement	42
Accompanied by:	
Ms. Beth Murphy, Executive Director, Compensation Service, Veterans Benefits Administration	
Dr. Margret Bell, Ph.D., National Deputy Director for Military Sexual Trauma, Veterans Health Administration	
The Honorable Chellie Pingree, U.S. House of Representatives, (ME-01)	12
Ms. Elizabeth Tarloski, Adjunct Professor, Lewis B. Puller Jr. Veteran's Benefits Clinic, William and Mary Law School	27
Prepared Statement	47
Mr. Shane L. Liermann, Assistant National Legislative Director, Disabled American Veterans	29
Prepared Statement	49
Dr. Sharyn Potter, PhD, MPH, Executive Director of Research, Prevention Innovations Research Center, University of New Hampshire	30
Prepared Statement	54
STATEMENTS FOR THE RECORD	
Protect Our Defenders	56
Vietnam Veterans Of America (VVA)	57

ENSURING ACCESS TO DISABILITY BENEFITS FOR VETERAN SURVIVORS OF MILITARY SEXUAL TRAUMA

Thursday, June 20, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:30 a.m., in Room 210, House Visitors Center, Hon. Elaine Luria [Chairwoman of the Subcommittee] presiding.

Present: Representatives Luria, Cisneros, Allred, Underwood, Bost, Bilirakis, and Watkins.

Also Present: Representatives Pingree and Kuster.

OPENING STATEMENT OF ELAINE LURIA, CHAIRWOMAN

Ms. LURIA. Good morning. I call this legislative hearing to order. Welcome to the Subcommittee on Disability Assistance and Memorial Affairs hearing. Today, we are here to discuss legislation granting veteran survivors of military sexual trauma easier access to VA benefits, and to discuss VA's progress in correcting errors in claims processing for MST-related claims.

Survivors of MST are some of the most vulnerable veterans. The economic impacts and psychological trauma associated with MST make access to VA benefits critical. It is imperative that we make sure we have a system in place that works for veterans, and also affords these claims the level of sensitivity and deference they deserve, and does not re-traumatize and discourage veterans in the process.

Access to benefits is critically important for veterans who have suffered from MST. Experience has taught us that MST can result in a number of psychological conditions such as anxiety and depression, and not just PTSD. We also know that the psychological effects of trauma can last a lifetime.

MST survivors need VA's help. They need access to benefits, because many of them struggle financially to support themselves as a direct result of their trauma.

The legislation introduced by Ms. Pingree, H.R. 1092, codifies the relaxed evidentiary standard that simplifies the process for a veteran to establish the occurrence of MST. It also allows the VA to accept lay statements as sufficient evidence for MST. Many veterans did not report sexual violence while serving and, therefore, this alternative pathway to benefits is crucial; it is the difference

between the grant of a claim or a denial, along with the substantial economic and psychological relief that accompanies these benefits.

This bill also expands the definition of military sexual trauma to include technological abuse, recognizing the experience of servicemembers who were stalked, sexually harassed, and intimidated online. With the increasing presence of technology and social media in our culture, recognition of cybercrimes is necessary to broaden our understanding of sexual abuse.

While the best strategy to respond to MST is one of prevention, this Subcommittee has the opportunity to improve the livelihood and well-being of survivors and their loved ones. By increasing access to benefits, we provide economic and mental relief. Importantly, we also validate the experiences of the men and women who survive MST while serving our Nation.

I want to extend a warm welcome and thanks to our witnesses, some of whom have traveled a long way to be with us today. From the VA, we have Mr. Willie Clark, Ms. Beth Murphy, and Dr. Margret Bell; from the Office of the Inspector General, Mr. Steve Bracci.

From my home district in Virginia, we have Ms. Elizabeth Tarloski, a staff attorney and adjunct professor at the Lewis B. Puller, Jr. Veteran's Benefits Clinic at the William and Mary Law School. I want to take a moment to recognize the incredible work of this clinic, whose mission at the school has always been first and foremost to help veterans. I applaud the fine work that they do.

Finally, we welcome Mr. Shane Liermann of Disabled American Veterans, and Dr. Sharyn Potter of the University of New Hampshire.

Thank you for being here today to address the issue of access to benefits for veterans and MST survivors.

Before I recognize Ranking Member Bost for his opening statement, I want to welcome to this dais my colleague, Ms. Annie Kuster.

And we also expect Ms. Chellie Pingree shortly, who introduced this legislation, the Servicemembers and Veterans Empowerment and Support Act of 2019. It is one of the subjects of our hearing today. Representative Pingree has been working actively on this legislation for three consecutive Congresses.

We are also lucky to have Representative Annie Kuster with us today, and we appreciate your work to increase access to physical and mental health services for MST survivors. We look forward to hearing from you today.

Without objection, Representative Pingree and Representative Kuster are permitted to sit at today's dais during the hearing.

I now recognize Ranking Member Bost for his comments.

OPENING STATEMENT OF MIKE BOST, RANKING MEMBER

Mr. BOST. Thank you, Chair Luria. And thank all of you for being here today to discuss how the Department of Veterans Affairs can improve processing of claims based on military sexual trauma, or MST. These veterans have gone through an unimaginable ordeal and it is important for the VA to handle these sensitive cases properly.

In fiscal year 2019, the Department of Defense estimated that over 20,000 men and women servicemembers experience some form of MST and of those only 6,000 servicemembers reported the incident. Tragically, studies have shown that victims of MST may not feel comfortable reporting an assault due to fear of retaliation or concerns it may impact their career progression.

For these reasons, in 2002 the VA changes its regulations to be more lenient when verifying evidence of an in-service stressor for post-traumatic stress disorder claims based on personal trauma. Accordingly, VA determined a marker such as a documented change in behavior around the time of the alleged incident to prove a servicemember experienced a traumatic event during their service. Unfortunately, last August the Office of Inspector General, or IG, reported that PTSD claims based on MST were assigned to employees who did not have adequate training on developing these cases. As a result, the IG estimated that about 1300, or almost 50 percent, of the MST claims were not properly developed before the VA issued a denial. Although this does not mean that all of these cases were improperly denied, I am troubled that the VA did not ensure that these claims were handled as carefully as they should have been. VA owes it to these brave men and women to get their decision right the first time, so they can receive their benefits necessary to focus on their healing.

I was encouraged by Inspector General Missal's testimony during the November 30th, 2018 DAMA Subcommittee hearing that the VA is in the process of executing all of the IG's recommendations in the MST report. Today, I would like to receive an update on VA's progress in implementing those recommendations.

Additionally, last November DAMA's hearing focused on how the problems identified in the IG's MST report were not exclusive to MST claims. Instead, there was a systemic problem with the VA to design a plan that mitigates problems that may arise when implementing new programs. I appreciate the Under Secretary for Benefits Lawrence's commitment to changing the culture at VA by spending more time thinking about the potential risk and unintended consequences of proposed changes. I would like to know if there are any additional steps the VA can take to ensure that veterans are better served by the VA's claims process.

Lastly, this hearing will focus on Representative Chellie Pingree's bill, H.R. 1092, which is intended to help MST survivors receive the benefits and health care they deserve. I look forward to the discussion how this bill would impact veteran survivors of MST.

We all want the same thing, to ensure veterans who are struggling would trust VA and feel empowered to reach out and seek treatment for conditions.

Thank you and I yield back.

Ms. LURIA. Thank you. And now I would like to recognize Representative Annie Kuster for 5 minutes.

**OPENING STATEMENT OF HONORABLE ANNIE MCLANE
KUSTER**

Ms. KUSTER. Thank you, Chairwoman Luria and Vice Chair Bost. I very much appreciate you holding this important hearing,

and thank you for the opportunity to provide testimony this morning.

I want to welcome all the witnesses participating and especially I am excited to welcome Sharyn Potter, a doctor from the University of New Hampshire who does extensive research in this area. I think you will be pleased to hear her testimony and I appreciate her making the trip. Thank you.

Dr. Potter and her colleagues at the University of New Hampshire's Prevention Innovation Center perform outstanding and groundbreaking work with regard to sexual violence. Their collaboration with the Defense Department gives her a unique perspective on addressing military sexual trauma, known today as MST, and, more importantly, identifying how to prevent it.

I also want to acknowledge the incredible leadership of my colleague and good friend Chellie Pingree, who will be with us shortly.

I am a proud original cosponsor of the Servicemembers and Veterans Empowerment and Support Act, introduced by Representative Pingree, and I appreciate the Committee's interest in advancing this important legislation. It has been introduced for several cycles and I am hoping that this year will be the year that we get it through the House. As we continue working to foster a climate in the military where sexual violence and misconduct becomes eradicated, it is responsibility to ensure full services are readily available to those who suffer the trauma; the servicemembers and veterans who have stepped up to serve our Nation deserve nothing less. The Servicemembers and Veterans Empowerment Support Act takes an important step forward in reaching that goal.

Two years ago, I founded and continue to co-chair the Bipartisan Task Force to End Sexual Violence. Our task force takes a holistic approach to addressing sexual violence across every facet of our society and we do so in a way that engages both sides of the aisle. From that perspective and as a 6-year former Member of this Committee, I recognize just how groundbreaking Representative Pingree's legislation will be. It allows veterans who report their experience after leaving the service to still be eligible for VA care. And let me say, as a survivor of sexual violence myself who kept my experience secret for 40 years, I cannot understate the importance of this provision.

Our understanding of trauma has come so far, and we now recognize how difficult it is for survivors to acknowledge what happened to them and the risks that they take in reporting. That their military careers may be on the line only adds pressure and hesitation to this incredibly difficult decision.

And let me just say, I can guarantee your study of consequences will be extensive. I just this week visited a prison in my district—I also have a task force on the opioid epidemic and what we are now learning is that many people suffering from substance use disorder and other mental health consequences have trauma related to sexual assault, whether it is in the military or in their civilian lives—and I was told that 100 percent of the women incarcerated in our women's prison in New Hampshire are survivors of sexual trauma, 100 percent.

Those who report months or years after their attack need the same level of care as those who are able to report immediately. On

the task force, I have also had the opportunity to see the incredible trauma online and or cyber- harassment and violence can cause. It destroys careers, self-worth, and sometimes people's lives. I commend the inclusion of cyber-harassment and violence survivors in this legislation.

As the VA today provides updates on their work to improve MST claims processing and outreach, I urge my colleagues to remain vigilant on this issue. It is not an understatement to say that lives hang in the balance.

Regarding sexual harassment and violence within the VA itself, I am grateful that the Government Accountability Office is executing my recommendation to investigate this issue in greater depth. This is one of the very first issues that I took up when I came to this Committee 6 years ago. They plan to complete their study in early 2020. I look forward to working with this Committee to examine the study and determine what actions Congress should take to address this situation.

I again want to thank Chairman Luria and thank you, Vice Chair Bost, for your attention to this issue. I look forward to working with the Committee going forward and thank you for the partnership with our task force.

Ms. LURIA. Well, thank you, Representative Kuster, for joining us today. And I would like to now invite Panel 2 to the witness table.

Appearing before us are Mr. Steve Bracci, Director of the Denver Benefits Inspection at the VA Office of the Inspector General; and Mr. Willie Clark, Deputy Under Secretary for Field Operations at the Veterans Benefits Administration. Mr. Clark is accompanied by Ms. Beth Murphy, Executive Director of the Compensation Service at the Veterans Benefits Administration, and Dr. Margret Bell, National Deputy Director for Military Sexual Trauma at the Veterans Health Administration.

Thank you all for joining us today.

We will start with Mr. Bracci. You are recognized for 5 minutes. Thanks.

STATEMENT OF STEVE BRACCI

Mr. BRACCI. Chair Luria, Ranking Member Bost, and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's oversight of VA's processing of disability benefits for post-traumatic stress disorder related to MST.

Sexual trauma experienced while in military service affects both men and women with serious and long-term consequences. Survivors of MST are often reluctant to report incidents and, even when they do, face the potential for significant distress during the disability claims process.

According to the Department of Defense, more than 7600 individuals reported a sexual assault in fiscal year 2018 for an incident that occurred during their military service, an increase of about 12.6 percent over the previous year. As more MST survivors report their assaults, every effort must be made to ensure they receive care and services compassionately and fairly. Processing their claims accurately the first time should minimize additional trauma

while furthering VA's mission to serve the needs of our Nation's veterans.

The OIG's August 2018 report examined whether VBA staff correctly processed veterans' MST claims. We found that nearly half of denied MST claims were not correctly processed following VBA policy. We further identified several deficiencies that led to these improper denials, such as a lack of specialization, inadequate training for processing staff, deficient internal controls, and discontinued special focus reviews.

PTSD is a mental health condition that military members can develop after experiencing life-threatening events such as combat, natural disasters, and personal trauma. VBA defines MST as a subset of PTSD personal trauma claims specifically related to sexual harassment, sexual assault, or rape that occurred in a military setting.

According to studies, the vast majority of sexual assault survivors do not seek immediate care and do not report the incidents to authorities. As a result, it is often difficult for victims of MST to produce the evidence required to support their disability claims. Because of this, VBA provided further guidance in 2011 to help ensure consistency, fairness, and a liberal approach for MST claims.

The OIG audit team reviewed a sample of 169 MST claims that VBA staff denied during the period April 1st through September 30th, 2017. We found that VBA staff incorrectly processed 82 of the 169 claims and, based on those results, we estimated that VBA did not correctly process nearly 50 percent of denied MST claims during that same review period.

We determined there were four main causes for VBA's incorrect processing of these claims. First, there was a need for VBA staff with specialized knowledge and experience to process these sensitive claims. Second, VBA needed to improve the training provided to its employees. Third, VBA needed to establish an additional level of review for MST claims to ensure accuracy and consistency. And, fourth, VBA needed to reinstate special focus quality improvement reviews for MST claims, which VBA discontinued in December 2015.

We made six recommendations to the Under Secretary for Benefits, who agreed to implement the recommendations and make necessary changes to help ensure the accurate processing of MST claims. Some progress has been made. Since the report's publication, VBA has provided documentation to close two of the six recommendations and has provided acceptable actions plans for the remaining four open recommendations.

VBA provided the OIG their most recent status updates this week, which stated that implementation of the four open recommendations is still in progress. We will carefully review this update, as well as supporting documentation, and assess VBA's continued actions.

VBA has expressed a strong commitment to fixing deficiencies identified by the OIG, which should help alleviate victims' stress and could also encourage more eligible veterans to step forward.

The significant number of errors in denying MST claims, as detailed in our report, also highlights the need for continued vigilance even after all the recommendations are closed. We will continue to

provide oversight on this, as well as other benefits and services needed by the most vulnerable population of veterans.

Chair Luria, this concludes my statement, and I would be pleased to answer any questions you or other Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF STEVE BRACCI APPEARS IN THE APPENDIX]

Ms. LURIA. Thank you, Mr. Bracci, and great job. I understand it is your first time testifying before a Committee, so I thank you for being here.

And I would now like to recognize Mr. Clark.

STATEMENT OF WILLIE CLARK

Mr. CLARK. Good morning, Chair Luria, Ranking Member Bost, and Members of the Committee. Thank you for the invitation to speak today on VA disability benefits based upon military sexual trauma and H.R. 1092, the Servicemembers and Veterans Empowerment Support Act of 2019.

With me is Beth Murphy, Executive Director of the Compensation Service, and Dr. Margret Bell, National Deputy Director for Military Sexual Trauma.

Today, I will provide an update on our actions to improve MST claims processing, as well as provide the Department's views on the proposed legislation.

The VA OIG completed a review of MST-related claims in August 2018. We acknowledge and have concurred on OIG's findings and the six recommendations provided. As of today, we have fully implemented two and are actively working on the remaining four.

OIG's first recommendation was to review denied MST claims since 2017, which we implemented last year. As of yesterday, more than 92 percent of those reviews have been completed. We are continuing to track the cases that require corrective action.

In response to the second recommendation, in lieu of specialized teams, we have mandated that each regional office maintain a requisite number of highly skilled employees to process MST-related claims. These employees are initially placed on second-signature review until they reach a high level of accuracy. Using this protocol also ensures our employees stay proficient in processing other disabilities that oftentimes accompany MST claims.

OIG's final three recommendations relate to training and quality. We have significantly updated the training for processing MST-related claims, and will conduct a special-focus quality review and a targeted consistency study later this year to determine the effectiveness of those updates.

Beyond these specific recommendations, we are dedicated to improving outreach to all veterans affected by MST. We maintain two trained MST coordinators, one female and one male, in every regional office. I am committed to ensuring that MST remains a primary topic for our field leaders.

Last week, I discussed MST with all our assistant directors, and next week we are working with VHA to provide training and guidance to all of our Veterans Service Center managers at their annual conference. Ms. Beth Murphy leads that effort.

Starting next month, we will institute monthly coordinator calls, and in the first quarter of next year we are bringing all MST coordinators together for our inaugural annual conference.

We are committed to a robust outreach program for MST survivors. In the first 6 months of this fiscal year, we have provided over 2,000 veterans, family members, and other stakeholders with MST-related information at targeted outreach events. We collaborate with VHA on MST counseling and ensure a warm handoff.

VBA is also working actively with DoD to provide information and resources to transitioning servicemembers. Information regarding MST-related services is included in the Transition Assistance Program participant guide, emphasizing that veterans and servicemembers are eligible for MST-related health care.

I will now move on to providing the Department's views on H.R. 1092.

VA appreciates the intent of the Committee to support veterans who may have experienced MST during service; however, we oppose some provisions of the bill. VA has acknowledged a challenge of corroborating a veteran's account of MST, which is why we allow decision makers to consider alternate sources of evidence, including behavioral changes and statements from other servicemembers or family when deciding claims. It is not necessary—I wanted to make this comment—it is not necessary for survivors of MST to have reported the incident in service in order to be service-connected for PTSD due to military sexual trauma, it is not necessary to report it while you are in service; if it happens after you leave service, we develop for those claims, and those members are provided the treatment and benefits accordingly.

VA opposes the proposed amendment to Section 1154 of the bill; however, we have no objections to provisions in the bill that would reasonably expand the definition of "covered mental health condition."

The number one priority of VBA is to provide veterans with the benefits they have earned in a manner that honors their service. This statement is one of the three principles that our Under Secretary, Dr. Paul Lawrence, regularly speaks to our agency about. In fact, he set the initial tone about our need for a compassionate and competent approach to MST claims by posting a video on YouTube. VBA must provide veterans affected by MST compassionate assistance in completing their claims. To that end, we have ensured these claims are processed by highly skilled and experienced employees engaged in comprehensive action and improved outreach, and committed to sustaining and enhancing these developments moving forward.

This concludes my testimony. I will be happy to address any questions from Members of the Committee.

[THE PREPARED STATEMENT OF WILLIE CLARK APPEARS IN THE APPENDIX]

Ms. LURIA. Well, thank you, Mr. Clark.

I now recognize myself for 5 minutes. I will start out by questioning Mr. Clark and Ms. Murphy about a comment that you made. You quickly mentioned that you are opposed to Section 3, but during your remarks, maybe in the interest of time, you didn't

amplify what that particular provision was and so I will call that out for other people who are participating in the hearing. That is the provision that allows for the VA to provide counseling and treatment for trauma resulting from sexual harassment using social media and cyber-bullying.

In your more thorough written statement, you cite that your contact with field staff over the years, that, quote-unquote, “many clinicians would include this definition.”

Why do you resist removing the ambiguity of what many clinicians might recognize and codifying that this in fact a means by which sexual harassment and bullying happen, and therefore should be clear for the veterans who might wish to file a claim, as well as the processors to understand that it is within the realm of the evidence that can be provided.

Mr. CLARK. Thank you. I would like to allow my VHA counterpart, Dr. Margret Bell, to speak to this topic.

Dr. BELL. I believe actually Section 3 may speak to expanding the definition used by VHA to provide MST-related care and, as noted in our written testimony, we certainly don't oppose the expansion to include the technological abuse. I think, at a practical level, VHA is already operating in a way that encompasses much of what is included in that definition.

Ms. LURIA. You say you think. Is it perfectly clear? Is it in writing? Why should we leave the ambiguity?

Dr. BELL. I think it would be perfectly fine to put it in writing and to include that in the formal definition in 1720(d).

I know, as a national office, if asked for guidance on that issue, our response to the field would certainly be that technological abuse would be kind of the means or the forums by which sexual harassment might be occurring and our authorization already includes the ability to provide care for sexual harassment, kind of the substance of it. And so, regardless of the means by that is occurring—

Ms. LURIA. No, but at this point we are talking about evidence. So I think that, you know, digital media, social media, records of that are certainly evidence that we should allow people to present if that is the means by which the abuse occurred.

So, in the interest of time, I will move on to another question for you, Dr. Bell. H.R. 1092 expands the list of MST-related psychological diagnoses beyond just PTSD. Can you speak briefly to the ways that MST can manifest psychologically and why it is necessary to recognize any related clinical diagnosis such as anxiety and depression also as diagnoses that would then qualify for a disability related to MST?

Dr. BELL. Absolutely. The mental health impact that MST can have on our veterans can be very broad-ranging. I do think it is important to honor and acknowledge that many of our veterans show incredible resilience after MST, but, unfortunately, a good number do struggle in profound ways afterwards.

In VHA, the top diagnoses that we see among the veterans that we are providing MST-related care for are post-traumatic stress disorder and depressive disorder, those are by far the top two, but then also rounding out the top five are anxiety disorders, bipolar disorders, and alcohol and substance use disorders.

Ms. LURIA. Thank you.

And I will switch to Mr. Bracci now. Out of the errors that you identified in the MST-related claims processing during your additional review, was there one or a couple that stood out as most common?

Mr. BRACCI. Yeah, the top two categories of errors were—the first one is that there was evidence that was sufficient to request a medical exam, but staff did not do that. That accounted for about 28 percent of the errors. And then the second one was evidence-gathering issues. And an example of that is staff not requesting veterans' private treatment records or their full military personnel file, and that accounted for about 13 percent.

Ms. LURIA. Thank you.

And switching back to Mr. Clark or one of the people accompanying you. I know that one of the recommendations was to establish a checklist, that was recommendation number 6 and that has been complete. I would assume that—does the checklist encompass those things that were the common errors in order to prevent that in future instances?

Mr. CLARK. Yes, Chair Luria, it does. And that checklist we effectuated several months ago, and it is being used by all of our individuals processing these claims.

Ms. LURIA. Well, thank you. And I know that there is a period of time where it was identified that a lot of these errors occurred, and then it was required on the OIG to look back between October 1st, 2016 and June 30th, 2018. Yet, between June 30th, 2018 and the present, just based off of historical evidence and the amount of time that, you know, it has taken to implement some of these suggestions, would you recommend that between June 30th and present, essentially until we accomplish all of the recommendations of the OIG report, should we continue to evaluate that period, just to make sure that no veterans have fallen through the cracks during this transition period?

Mr. CLARK. Yes, I do, Chair Luria. And we are actually doing that, performing those. We continue to re-look; the reviews are ongoing. Once the reviews are finished, we are 92 percent through those reviews, then we are going to look at all of these on the aggregate. We are updating our training programs as we speak. My colleague here is in charge of training and quality and we have—

Ms. LURIA. I'm sorry to cut you off—

Mr. CLARK. Yes.

Ms. LURIA [continued]. —I am sure we will have an opportunity to talk about training—

Mr. CLARK. Yes.

Ms. LURIA [continued]. —but I am out of time and I want to make sure that I give other Members—

Mr. CLARK. Thanks.

Ms. LURIA [continued]. —ample time to ask questions.

So I now recognize Mr. Bost for 5 minutes.

Mr. BOST. Thank you, Madam Chair.

I know that all of us are wanting to make sure whatever we implement actually allows for the opportunity of these victims to make sure that they are processed correctly.

Mr. Clark, either you or your colleagues, can you please describe the VA's concern that they have with H.R. 1092 where it may impact the integrity of the claims process due to the changes it would make to evidence accepted as proof of MST? And I don't think it is the sponsor's intent or anyone on this Committee to change it to where it would make it worse, we want to make it better. So what do you see as a danger there?

Ms. MURPHY. So thank you, Ranking Member Bost. I think the concern that we have is that we have liberalized since 2002 the manner that we go about trying to connect the dots through the markers and indicators if somebody doesn't claim it during service. We have that for the PTSD, and we do support the portion of expanding to other conditions such as depressive disorder.

The concern for liberalizing almost to a combat level is that the tenets of combat are such that it is not, you know, documenting and record keeping that is going on at that time. It is a serious situation with people ducking and trying to just execute the mission. So to compare combat and military sexual trauma, we have concerns about going that far.

Mr. BOST. Then I am going to ask to try to work with the sponsor to figure that out. As I said—

Ms. MURPHY. Absolutely.

Mr. BOST [continued]. —right off the start, we want to make it that the process is as easy and as less stressful, because of the trauma itself at the level that we are dealing with, to make sure that those who truly are deserving of the benefits receive it.

Let me switch right quick, if I can. Mr. Bracci, your testimony mentioned that in 2010 the IG reported and in 2014 the GAO reported both recommendations that the VA improve training and enhance quality controls for MST-related claims. Are you confident that the VA responds in August 2018 will the IG report will provide the long-term solution that ensures the claims processors can handle MST claims properly?

Mr. BRACCI. Yes, we are cautiously optimistic that VBA can achieve this. They have a renewed focus on MST claims, that is evident, and the Under Secretary for Benefits agreed with our recommendations; they have implemented two of them already and we have closed them, and the remaining four they have provided acceptable action plans and they are making progress on those.

Mr. BOST. Okay, good.

Mr. Clark, I want to come back to you and your colleagues. On November 30th, 2018 at the DAMA hearing, USB Lawrence discussed how he planned to adjust the way the VBA will approach changes in the future to avoid the challenges the IG identified with the MST reporting. Can you kind of explain or provide examples of how the VA has used recommendations from the MST reporting to improve other aspects of the VA's claim process?

Ms. MURPHY. So I think we moved from an individual regional office working in a paper form on only its own state's claims to a national work queue, an electronic claims processing system, electronic national workload distribution system. So we went from each state, each regional office working its own state's claims, to moving the work around broadly.

We did gain efficiencies there, but I think that we have learned in the process is that swinging the pendulum over to move the work everywhere, we lost some of the specialization that we had with individuals focusing on important cases such as military sexual trauma, ALS, Lou Gehrig's disease, traumatic brain injury. So we have learned from this, returned to specialized, specially-trained individuals processing these claims.

Mr. BOST. Yeah, as you worked on the national queue—I am going off script here, okay?

Ms. MURPHY. Sure.

Mr. BOST. And this is the concern I had when we actually received that testimony. Quite often, as the VA has learned, to try to—and thank you for trying to speed up the process, but if you don't have specialists on those fields and getting them in the hand of the specialist, all you have done is got them in the hand of somebody to take care of it, and then when you deal with these particular ones, I hope that you have realized that that is not the best way. Without proper training—everybody doesn't have an expertise in this field—

Ms. MURPHY. Yes, and—

Mr. BOST [continued]. —I guarantee you, I wouldn't.

Ms. MURPHY [continued]. —I agree with you, sir. And I think the other piece of that is making sure that these specialized individuals see these cases often enough to maintain their proficiency. That we train them, we continue to check in with them, do quality assurance reviews, and additional measures that Mr. Clark described, having a conference, a training event in the fall.

Mr. BOST. Thank you, Madam Chair. I yield back.

Ms. LURIA. Well, thank you, Ranking Member Bost.

And we have now been joined by our colleague Representative Chellie Pingree. She was on the House floor, working on some other legislation. But, as a reminder, she has introduced H.R. 1092, the Servicemembers and Veterans Empowerment Support Act, and I would like to yield 5 minutes to Ms. Pingree to discuss her bill.

STATEMENT OF HONORABLE CHELLIE PINGREE

Ms. PINGREE. Well, thank you very much, Madam Chair and Ranking Member Bost. I apologize for being late. It is hard to be in two places at once and it is a busy week, as we all know, but thank you so much for the opportunity to participate in the hearing. And, most importantly, thank you for focusing attention on proper compensation for those who have suffered sexual trauma during their military service.

I want to go back a little bit and talk about how I got to the point of submitting this particular piece of legislation. My experience on this issue goes back to my first years in Congress. Women and men who had experienced military sexual trauma came to my office seeking help as a desperate last resort, because many of them found that someone refused to believe their story or because the case was buried to protect the service's reputation, or because benefits were denied because the law, frankly, hasn't kept up with the science.

Through hundreds of contacts from MST survivors from all over the country, we have been haunted and humbled by the stories

that we have heard, and let me just read one from someone who contacted us who said, “Since being raped at my first Reserve duty station, I have lived off the grid. I have not been able to work around people, cannot sustain any relationships. I don’t really go anywhere or have any friends, and I am filled with anxiety. Despite receiving VA counseling for PTSD, I was told by an examiner that I did not have PTSD, so could not use my markers for service-connection with the VA. I have waited over 20 years to tell anyone and I don’t know if I can go on.”

For this and many stories that we have heard, we have had the desire to finally pass some legislation that would update VA policy.

Seven years ago—I have been here ten years—I sat with this very Committee in a hearing on my bill related to MST. Studies had already found that PTSD claims following MST were granted at much lower rates than PTSD claims resulting from combat trauma—we have heard a little bit about that since I was able to come in—but with lower rates for men than for women. Plus, there was a different standard of evidence for PTSD claims based on combat versus sexual assault.

As a result, the VA then agreed to create a dedicated, specialized MST claims processing team within each VA regional office for exclusive handling of MST-related PTSD claims with specific training.

Further, at my request then, and after conceding that they had inappropriately denied many claims, the VBA agreed to review denied MST claims for possible errors. But here we are, 7 years later, the Inspector General has reported that the VA has failed once again after abandoning specialized—claims specialization training and oversight. Nearly half of the veterans—and I know you have already heard this this morning—who had submitted claims following MST had not been even provided the opportunity for exam or they were inappropriately denied.

We should feel a lot of anger and disappointment about not being able to fix this problem.

I understand the pressure to reduce the claims backlog, but abandoning a long-awaited, more effective process for adjudicating claims following MST was unbelievably shortsighted. Many survivors have waited decades to tell the stories of their sexual assault while serving. They interpret denials as a, quote, “the VA thinks I’m a liar.” Of course, not every denial is in error, but these denials are traumatizing. Given the concern about veteran’s suicide, we must resolve the problem of inappropriate denials.

I am lucky enough to be a member of the MilCon VA Subcommittee of Appropriations and at our hearing in March I asked Secretary Wilkie what he was doing to ensure the VA didn’t repeat that mistake. He said all the right things, but top officials come and go, and so I think this falls on all of you, the career people.

I know you have acknowledged dropping the ball and I want to hear more about how you are implementing the IG recommendations, and how you will foster cultural change at the VBA.

Following a lawsuit almost two decades ago, the VA conceded that most survivors of sexual trauma would not have specific evidence in their military records. As a result, they created a relaxed

evidentiary standard for PTSD claims following MST. That was a big leap forward, but it wasn't sufficient.

As the regulations were written, the relaxed standard does not apply to veterans diagnosed with other mental disorders. Not every survivor develops PTSD. Today, we better understand the range of mental health disorders that sexual trauma can cause, including major depressive disorders or anxiety disorders, as well as newly recognized trauma disorders as defined by the American Psychological Association DSM-5. But despite the advancements in diagnosis and treating of mental health problems following sexual trauma, only survivors with PTSD can use evidence not in their personnel file for service-connection. The VA has conceded that most veterans don't tell, so won't have the evidence in their files, and this is the case regardless of their eventual diagnosis.

At that hearing in March, VBA Under Secretary Lawrence agreed on the need for a uniform standard. He said the VA couldn't do it; it would take a change in the law.

We have known this was a problem for a very long time, this is why I reintroduced 1092, the Servicemembers and Veterans Empowerment Support Act. This bill would add anxiety, depression, and other mental health diagnoses in addition to PTSD as connections eligible to utilize secondary markers as evidence for service-connection as a result of sexual trauma while serving.

I am out of time. So I will stop there, but I know I have covered the ground, you know very well what I am talking about and addressing, and we can't let this stand the way it is.

So, thank you so much, Madam Chair.

Ms. LURIA. I will now recognize one of our other colleagues for 5 minutes, Representative Underwood.

Ms. UNDERWOOD. Thank you, Madam Chair, and thank you to all of our witnesses joining us today.

I appreciate how seriously the Department of Veterans Affairs has taken the recommendations laid out in the Office of Inspector General's report, which will help identify and overcome the barriers that survivors of military sexual trauma face while applying for service-connected disability benefits. It is essential that the VA confront these barriers head-on, because the epidemic of sexual abuse in the military is a critical moral and national security failure and, by some metrics, it is getting worse.

A recent Pentagon study highlighted that cases of sexual assault in the military increased by 38 percent from 2016 to 2018, even as reporting of assaults has gone down. The sexual assault rate for women servicemembers is at its highest level since 2006.

So, Ms. Murphy, many of those women will eventually seek care and benefits from the VA. Ms. Murphy, right now is the VA sufficiently prepared and equipped to handle the anticipated rise in applications for disability compensation related to their military sexual trauma as these servicemembers transition into the veteran's population?

Ms. MURPHY. Certainly we are equipped as far as our training and the quality reviews, making sure that they are doing the right job, gathering the right evidence, and making sure they don't miss any of the steps along the way in the claims process. And we do

applaud the IG for helping us to look into that and to illuminate some of these things with us.

As far as the number of claims we receive, we have made some projections and we have some cost analysis regarding the additional amount of resources it would take to process those claims.

Ms. UNDERWOOD. So in addition to the projections and the cost analysis, can you detail any other specific steps that the VA is taking to prepare for the increase in benefits claims that we are expecting to come to the VA related to MST?

Ms. MURPHY. So we work closely with the Office of Field Operations, who runs our 56 regional offices. Certainly we would be looking at the IT support equipment, IT support systems for that, where to put the folks, how to get them through our challenge training for newly hired and newly promoted individuals that my office runs, and just continuing to bring the focus to this.

And I can't agree more with what everyone has said today that this is an evolving issue and it is something that we continue to learn more about. I have learned some things, particularly about the 100-percent rate in prison, that I didn't know before this morning. So I think as we all learn more and can bring additional focus to this important issue, that is what we need to continue to do.

Ms. UNDERWOOD. And are there any additional resources that the VA needs in order to ensure the timely processing of all these benefits claimed?

Ms. MURPHY. We would be able to give you some information about that. We have done the cost analysis to figure out how many more claims processors it would take both for claims and appeals.

Ms. UNDERWOOD. Great, please do.

Ms. MURPHY. Sure.

Ms. UNDERWOOD. The number of women veterans using the Veterans Health Administration has more than tripled and currently 30 percent of new users of VA health care are female. In a previous hearing in this Committee with Secretary Wilkie, I raised my concerns regarding the lack of data on issues facing women veterans.

Dr. Bell, given that military sexual trauma disproportionately affects women servicemembers, what steps are being taken to ensure that the VA maintains accurate, gender-specific data on the effects of military sexual trauma on veterans?

Dr. BELL. That is an incredibly important issue. As you noted, the issue of MST is one that disproportionately affects women. It is certainly an issue that is exceptionally difficult for both men and women, but there can be particular issues that women may struggle with differentially because of some of the gender-specific issues.

We do maintain all our data separately for men and women, so that we are able to look at that information. Currently, about 29—so we have a universal screening program in VHA wherever veteran seen for health care is asked whether they experienced MST, that is an important way that we make sure to connect them with services, if those are appropriate or needed for them. And in those data, we see that about 29 percent of women respond yes, that they did experience MST during their service, about 1 percent of men respond yes.

Ms. UNDERWOOD. Yeah.

Dr. BELL. So we do maintain that data separately and our treatment data, and all of that is—we are able to disaggregate that by gender as well.

Ms. UNDERWOOD. Yeah, that is consistent with what we have heard from other sources as well.

So, Dr. Bell, male survivors of a military sexual trauma can face unique barriers and stigmas, what steps is the VA taking to help them navigate these unique challenges?

Dr. BELL. Well, as noted, it is very important to be paying attention to the gender-specific issues that both men and women are facing.

Ms. UNDERWOOD. Right.

Dr. BELL. We do in our screening program screen all of our veterans, both men and women, all of our treatment services are available to men and women, make sure that in the implementation of those services that they are sensitive to gender concerns. So we don't ask men to meet in a women's clinic or need to meet with a women's health provider, make sure that there is a space in a clinic where they are able to get that care in a way that doesn't aggravate some of the stigma or the gender-specific concerns they might struggle with.

Our outreach materials make a concerted effort to make sure that we are using gender-neutral pronouns, both he and she, include photos of men and women, and generally be conveying that our services are available to men and women, and that we want to make sure that everyone who comes through our doors is going to be comfortable and able to access the care they need.

Ms. UNDERWOOD. Awesome. Well, thank you so much for being here and providing the Committee this information today.

And, Madam Chair, I yield back.

Ms. LURIA. Thank you.

I now recognize Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you, Madam Chair, I appreciate it very much. And thank you all for your testimony this morning.

Mr. Clark, I understand that VA did a review of denied PTSD claims based on MST and found that about 20 percent of the denied claims had errors that required additional work. It doesn't surprise me that the OIG had recommended that all MST claims go specifically to specialized, well-trained veterans service center representatives when the error rate is that high. And I would hope that a full reexamination of the training process would be done, of course, in order to ensure VA is avoiding unnecessary new work for yourselves.

Have you taken in any feedback from employees on how to tweak the training documents and guidance further on MST claims, or are you sticking primarily with the top-down approach?

Mr. CLARK. Thank you for that question. We are collaborating with DoD, we are collaborating with the VHA, we are collaborating with the VSOs, and also our employees. We are taking a top-down approach. I had mentioned earlier that our Under Secretary, Dr. Paul Lawrence, developed a video and posted it. We need to get the word out to everyone about this military sexual trauma and the difficulties that our claimants are dealing with, and we need to do a better job in processing these claims.

So, to your specific question as well, bottom-up, if our employees come in and they say that here are some suggestions for processing these claims, we incorporate those into our process as well. Ms. Murphy is in charge of training and she handles that aspect of our training very well.

I want to make it clear that while we don't have specialized teams like we used to have, we do have specific individuals at each RO, we have to maintain a requisite amount of individuals to make sure that we are processing these claims timely. Now, we certainly want to get a highly accurate claim, but when we ensure that we have certain individuals doing this work and make sure that they get enough repetition so they can maintain that quality, that is how we provide better service.

Mr. BILIRAKIS. All right, thank you.

Next question, again for Mr. Clark. One of the action items VA had committed to was conducting a consistency study to determine whether training is effective. I fully agree that we need to ensure that processing of MST claims occur consistently across the board and that coordinators all know how to look for the necessary signs. Can you please provide us with an update as to where you are in that consistency study or some specific plans as to how you are going to administer the study on MST-related claims? I think it is so very important that it be, of course, accurate, quality—timely is so important, but quality even more, and accuracy and consistency. I mean, our veterans are entitled to that.

So, please.

Ms. MURPHY. So if I could answer that, sir.

Mr. BILIRAKIS. Yeah, that's fine.

Ms. MURPHY. The consistency studies and the special-focus reviews that we agreed to in the IG report are run by my office. First, we are looking at the consistency study. So we will run a test across all of our folks who do MST claims processing and they will have a pretest, some training, if necessary, and a post-test. A secondary piece of that will be this special-focus review that we are doing. We just started the pulls now.

We wanted to make sure we conducted the training, let some of the feedback from the case reviews trickle down to the field. And then we are at the point now we are just starting to do the random pulls and then do the review in this last quarter, so that we can see what the impact of the additional training and the revamped training is that we have provided. So we are doing that now and we are on track to finish that by the end of this fiscal year.

Mr. BILIRAKIS. Very good. Follow-up, and whoever wants to take it is fine. Is VA using other approaches such as the results of second-signature reviews to assess the effectiveness of its new training, or how are you planning on measuring the outcomes of the changes you have made to new training requirements? I know you have touched on it, but if you could elaborate, I would appreciate it.

Mr. CLARK. As part of any good, quality program, there is a continuous improvement aspect in that, as you review the work that you have done and you see errors, that you have to incorporate that back into the process. So one of the things, Ms. Murphy had talked about these focused reviews that we will be doing, but in re-

viewing the cases, we have gotten through 92 percent of them right now, we are finding things we need to, and we are incorporating back into the process.

And I want to just point out that 20 percent is too high and we are going to get better at that, but that 20 percent means that one or more issues we found that we should have done, it doesn't necessarily mean that would have resulted in a denial and, as we go through, we are finding that some of those will not change the result. Still, we need to make sure that we go through, develop a case properly. If an examine is needed or if we need to contact the veteran, and to be less caustic and to prevent them from reliving this situation over and over the fewer times that we must, and then deliver a quality product, that is our goal.

Mr. BILIRAKIS. All right, thank you very much.

I yield back, Madam Chair.

Ms. LURIA. Thank you.

I would now like to recognize Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Thank you, Madam Chair.

I just want to follow up on the training. I know you have already taken a lot of questions on that already, but I just want to talk also, go through the process.

If an individual is going to report, a veteran, one of our veterans is going to report an MST, who is the first person that they report that to?

Mr. CLARK. We get it a myriad of ways. It could be a VSO that they claim could have come in, they could call in through our 1-800 number, they could walk in through one of our public contact areas. We work in concert with VHA, Dr. Bell runs our national office, and they may be seeking treatment and it comes in that way. And we have some reciprocity in that if someone is seeking medical treatment and there is a claims question or benefits, they contact us and—

Mr. CISNEROS. So there is a variety of individuals—

Mr. CLARK. There is a variety.

Mr. CISNEROS [continued]. —that they can report this to. Have all those individuals been trained on how to respond and how to take the response, the proper response when somebody comes to them with that MST claim?

Mr. CLARK. Yes, sir. Now, not all individuals are tasked to know how to develop the claim, but certainly to acknowledge and receive a claim—

Mr. CISNEROS. Receive and who to refer it to?

Mr. CLARK. And to whom to refer it, that is correct. We have to provide a warm handoff to the individuals that are responsible, up to and including Beth and myself. If something comes in, we know the steps to take and, obviously, Dr. Bell. So, yes, sir.

Mr. CISNEROS. Once that referral is made, how long does it take for the veteran to get a response back?

Mr. CLARK. A response back about the claim being completed or—

Mr. CISNEROS. Right, to let them know—

Mr. CLARK [continued]. —just to acknowledge that—

Mr. CISNEROS [continued]. —that it has been handed off and it has been acknowledged, and now somebody is calling them to deal with their claim?

Mr. CLARK. Well, I would have to get back with you on a time, but we as expeditiously as possible, if someone comes into our office, if they walk into the office, then we call the MST coordinator down right then that day. If they call in, the person, there is a protocol for the individual that is receiving calls, and they are to provide a warm handoff to VHA and to our office in how to produce that claim, and they should get a callback within a few days.

Mr. CISNEROS. So the MST coordinator, where are they located? Are they located at VHAs or are they located—?

Mr. CLARK. Yes, sir.

Mr. CISNEROS. So every veteran's hospital has an MST coordinator?

Mr. CLARK. Mr. Cisneros, I will allow Dr. Bell to speak to that, but in every regional office we have a male and a female MST coordinator. Additionally, nationally, we have a male and a female coordinator that coordinates with VHA about getting training materials out nationally. We are a learning organization and we need to do better. But if someone comes to our agency and they file a claim, we will get back with them, we will undertake the proper development and, when we find that we haven't, we will get it right.

And, Dr. Bell, if you want to speak to VHA?

Dr. BELL. I was just going to point out, so there are MST coordinators on both sides of the VA. So that VHA has its own MST coordinators that can assist veterans with seeking treatment or making sure the system, the VHA part of the system is doing what it should be doing to assist them, and then VBA has its own MST coordinators and they have close relationships across the two sites and make sure they talk to each other.

Mr. CISNEROS. Are they receiving the same training?

Dr. BELL. The VHA coordinators would receive training specific to VHA. So clinical care issues, we have a mandatory training that all of our mental health and primary care providers need to complete on MST. Our MST coordinators are typically mental health professionals, so they would complete that mental health training.

Mr. CISNEROS. Okay. So, once somebody reports an MST, are they dealing with the VBA or are they dealing with the VHA?

Dr. BELL. So if they are interested in care, they would be on the VHA side, and the—typically, the way VHA would learn about an experience of MST would be in a clinical context. So someone would be seeking mental health treatment or some other treatment, we would ask them if they had these experiences during their service and, if they said, yes, they did, then we would talk to them about the services that VHA could provide them and also, as needed, refer them to VBA to file a disability compensation claim, if they were interested in that.

Mr. CISNEROS. Okay, last question. And, Mr. Clark, you stated in your opening statement, 18,000 MST claims each year that people are reporting; are we sharing this information with the DoD and letting them know that, you know, this is what we are seeing?

Or is there any coordination to work with DoD to try and—well, to keep them informed and let them know what is going on?

Mr. CLARK. We do coordinate with DoD. In fact, Ms. Underwood spoke to this 38 percent increase that was in USA Today a few weeks ago, we provided that training to all of our senior leaders going forward, we are having conferences of our MST coordinators. Ms. Murphy and I regularly talk to DoD personnel about that and other things as well. But, yes, the answer is, we do coordinate with DoD. And usually, of course, they come up with metrics that tell us there is an increase and, accordingly, an increase of individuals claiming MST, and that gears us up to say, hey, that we have got a potential increase in claims coming. But we are resourced, and we are trained to handle those claims and, when we find that we are not, we take efforts to improve upon that process.

Mr. CISNEROS. All right. Thank you very much. My time has expired.

Ms. LURIA. Thank you. I now recognize Mr. Allred for 5 minutes.

Mr. ALLRED. Thank you, Madam Chair, and thank you for holding this important hearing.

As my colleagues have noted we are of course experiencing a crisis of military sexual assault with claims likely to increase on VBA and VHA going forward.

I have the honor of representing the Great State of Texas. We are home to the most women veterans of any state, and I am very proud of our 181,000 women veterans who have served us. And I want to make sure that we do everything we can to serve them. I know you do as well. And I want to thank you for that.

I want to begin with you, Mr. Clark, though and ask you, because I have spoken with a lot of our women veterans service organizations that have mentioned that we need to do a better job of tailoring both our VHA and VBA services and benefits and outreach to women veterans.

And I just want to begin by asking what we are doing and what you are doing to target your outreach to women veterans about the VBA services here?

Mr. CLARK. Thank you, Mr. Allred.

We have a robust outreach program. Again, we need to do more. But working with our VSOs, working with the VHA, working with DoD, we are holding events, claims clinics, town

halls and working with all of those entities that I spoke of to get the word out. And just so far this year we have had roughly 155 events. We have reached a little over 2,000 veterans and their families and the like.

We need to get the word out, and we ask all of our leaders top down that they are to know about MST processing and as they go out and do outreach throughout the state and throughout this great country of ours, then we need to get the word out that we are here to serve individuals that make it possible for us to live in this great country.

And all of our senior leaders are aware of this. But it is a continual process. You can't do a one and done and think you have got it. We embrace the OIG to take a look at us to help us get this right.

And so when we get these—they tell us that we have challenges we take that upon ourselves as a way to try to improve rather than just being in denial.

Mr. ALLRED. To you and to the IG as well, do you anticipate that you need more resources to better access and reach out to our women veterans?

Mr. CLARK. I think we have got the resources we need. You know, the easiest thing to do is always ask for more resources. The hard thing to do is to look within and to get more efficient. Our boss is about efficiency and done. So thanks to Congress we get the resources that we need to do this work.

Mr. ALLRED. Mr. Bracci.

Mr. BRACCI. Yeah. As far as resources go, I know there is a budget process. I think the question of whether or not we have sufficient resources is probably better answered by our inspector general, Mr. Missal.

Mr. ALLRED. Okay. Well —

Ms. MURPHY. I'm sorry. Could I add—

Mr. ALLRED. Go ahead.

Ms. MURPHY [continued]. —that I think also to your question earlier, also there is no wrong door here and we are all in this together. And I do want to applaud Ms. Pingree's office. We work closely with her staff. And she has referred several cases after she gets the privacy release, several cases that our national star team looks at. And we have been able to take a few of those and do a little extra or look a little deeper.

And I would offer that to anybody. If anybody has a case in their jurisdiction or that comes to their attention and you want us to take a deeper look, we are happy to do that. Just reach out to myself, Mr. Clark, and we will get our national level quality reviewers to take a second look.

Mr. ALLRED. Yeah. Well, I would encourage you to reach out to my office as well and see if we can be helpful in Texas.

Ms. Murphy, I want to in my last minute here ask you a question about your opposition to Memo 2, Section 1164 that mimics the combat presumption because the circumstances of MST are not similar to the circumstances of combat. But with both combat and MST related injuries we see chronic underreporting. Should we not ease the strict standard for proving in-service assaults by accepting satisfactory lay statements?

Ms. MURPHY. So I would say that we do that now. We look for markers. We take lay statements. We take all the evidence that we can gather, and we weigh it and we look deeper.

So I think the concern that we have is that within a combat situation there is a reason that we don't—sometimes we don't have that record-keeping is because of the nature of the combat environment. We—I certainly understand why folks would not want to come forward and report. That is an individualized decision as to whether you want to come forward with that.

Our concern is making the situation so that if it is a mere statement and there is any mental health professional who says, yes, I think that this happened because of this, in private sector sometimes they don't get a chance to look at the full claims folder. Our concern is mainly that we would be defaulting to the fact that this

happened without an appropriate level of corroboration that we have in the current way we process claims.

Mr. ALLRED. And—

Mr. CLARK. And, sir—

Mr. ALLRED. Go ahead.

Mr. CLARK [continued]. —can I add to that, please?

Mr. ALLRED. Sure.

Mr. CLARK. I'm sorry for interrupting you.

The onus, though, falls upon the VA to make sure that our folks are properly trained to help corroborate that story. When someone just—the only thing they have is the statement that they made. So that is where we need to get better at. And we have done some great things with accepting markers, lay statements, behavioral changes, these things that lend itself to something happened and we need to help to flush that out.

Mr. ALLRED. Yeah. One overall concern with underreporting and that is what we are trying to address here. So thank you so much.

Ms. LURIA. Well, thank you. And just based off the responses to the last two lines of questioning I wanted to follow up from the VHA and give an example.

Say you have a patient who comes in for other treatment. They have routine headaches or a broken arm or whatever it is, but in the course of their care they happen to mention to the medical provider that this happened.

My first question is does the medical provider themselves just providing primary care, for example, know whether the person has a claim or has a rating for disability for a particular instance? I mean, would that primary care provider already know that this person had been approved for, you know, the MST?

Dr. BELL. So just to provide a little context that can help me answer that question, one of the wonderful things on the VHA side is that veterans do not need to be service-connected, have a disability claim in order to receive free MST-related care through VHA.

Ms. LURIA. Right. But that's really not my question.

Dr. BELL. Right.

Ms. LURIA. Like the person just come in because they have a broken arm. But during the course of that, this is very traumatizing so that brings up memories and now they start talking about an issue related to MST. Does the provider treating them for the broken arm know what conditions they are covered for as service related disabilities? Just a general question, does every—

Dr. BELL. If—

Ms. LURIA [continued]. —provider know the scope of what's—

Dr. BELL. If it has been adjudicated, then, yes, that would be—

Ms. LURIA. It is in their record.

Dr. BELL [continued]. —in the system. Yes.

Ms. LURIA. Okay. And so then that provider hears this, and this person has never been adjudicated, never put in a claim for this, you know, has no background of it. Is that provider obligated in any way to counsel that patient and say, you know, thank you for sharing this sensitive information with you. Are you aware that the, you know, VA can help you with this issue and I would recommend that you would now warm handoff to the VBA to talk

about whether you want to put in a claim about this? Is there any obligation on the part of the provider to make a next step with the information that they are given?

Dr. BELL. There would not be an obligation. They—again, because the care on the VHA side related to MST would be provided regardless. They certainly could provide the care.

In terms of the claim—

Ms. LURIA. Oh, so would they not even need a claim? Like if the primary care provider—

Dr. BELL. Correct.

Ms. LURIA [continued]. —learned about this issue could they then give them a referral to mental health services?

Dr. BELL. Absolutely.

Ms. LURIA. Already, without ever—

Dr. BELL. Without a claim, without filing a claim, without an approved claim.

Ms. LURIA. So say in this scenario then the person did say that is a great idea. I would love to speak to a counselor and then they go speak to a counselor, at what point in the process would they—would it be brought to their attention that, you know, this could actually also be a service-related disability and you should follow up with this claims process?

Dr. BELL. Yeah. Certainly, our VHA outreach materials refer to the potential for seeking disability compensation related to experiences of MST. As a mental health provider I know that is often one of the issues that comes up early in treatment just as something we will explore with someone or they may already be involved in the process and we will be checking in with them about how that is going.

So certainly in a mental health context it will often come up and be discussed at that point.

Ms. LURIA. Okay. And just to clarify, so any primary medical condition, the broken arm example, that someone brings up an issue, MST related or not, but that the primary care provider thinks that they might also need to be referred for mental health services, they are always referred even if that is not a service-related or service-connected disability that has already been recognized?

Dr. BELL. If the veteran is interested in mental health treatment or, you know, evidences some need for that, of course we would connect them with the appropriate care.

I assume because they are being seen in the system, they are eligible for care in general. And so absolutely they would then be eligible for mental health care regardless of whether it was MST related or not.

But certainly, again, if the care was MST-related, again, that does not require disability compensation. It does not require any evidence or documentation that the MST occurred. There are some veterans that can get free MST related care from VHA even if they are not eligible for other VHA care.

Ms. LURIA. Okay. Thank you for clarifying.

And I—and, Mr. Bost, do you have any further comments on that topic?

Okay. I would now like to recognize Ms. Kuster for 5 minutes.

Ms. KUSTER. Thank you very much. And I very much appreciate your testimony. But I share the concern of my colleagues, especially Representative Pingree who has been working on this for a long time.

And in particular I just wanted to explore with you in terms of the training, it seems to me the added trauma of having the claim denied will exacerbate the underlying condition and the response to the military sexual trauma.

I can just say for myself, I mentioned in my opening statement that I was a victim of sexual assault in a college experience and actually once here working on Capitol Hill, and I didn't tell anyone for 40 years.

And what I didn't even understand until much, much later when I finally told the story was when I was a Member of Congress and this—there was a great deal of press attention during the last presidential election. And I was in the midst of a press interview and a reporter asked me, what are the ramifications of this. And I started to say, oh, I am fine, and then I realized I didn't even understand the connection. I said, well, I can't actually be alone in my home and sometimes I wake up in the night screaming.

Now I have never told anybody this. So I am telling you this to say, do you have survivors as part of your training because I think it is very important that your people—and I appreciate Mr. Bost. We all want to try to get past this. And, clearly, we have more work to do as Members of Congress with the Armed Services, with the DoD, in HASC. I am shocked. I am stunned actually to hear the statistic that our colleague Representative Underwood has shared today.

This is a national tragedy that the people in uniform that are serving our country, 1 in 3 women are experiencing sexual assault and military violence, a 38 percent increase. So I am not blaming any of you for that. But I hope you will work with us and the VA so that not a single person is ever traumatized further.

But I would just ask the question, are survivors' part of your training and would you consider that going forward?

Mr. CLARK. I will allow Ms. Murphy to also speak to this, but we will be having our first annual conference on MST training the first quarter of fiscal year 2020. And to be honest I hadn't thought of that, not for MST because one of the things in my limited knowledge is that you try to not allow individuals to relive that.

We use that modality of training when we are talking about prisoners of war and things like that. We have used that. And, again, that is traumatic as well. But for MST we hadn't, but I am—

Ms. KUSTER. I would love to have you consider it and—

Mr. CLARK. Yes, ma'am.

Ms. KUSTER [continued]. —and I think Dr. Potter from the University of New Hampshire who is on the next panel could help you with those resources because it is something that needs to be described from the perspective of somebody who has experienced it.

The whole notion of why people don't come forward, they don't come forward because they are not believed. In the case of 50 percent of the claims being denied, why would you come forward? I mean, it is not like people don't know this information, because

their privacy is breached, because, you know, it impacts their career.

I mean, trust me. It is not easy for me as a Member of Congress to go talking about it.

Mr. CLARK. Yes. Yes, ma'am. Thank you for sharing and I appreciate that. Again, we will take that under consult and certainly Dr. Bell, you know, working with the VHA, that is who—with whom we collaborate. And certainly if it is felt, you know, taken what you say, if that is the course of action, you know, we are benefits, not experts, and clinical issues. So certainly we will take their consult and act appropriately.

But, again, thank you—

Ms. KUSTER. Thank you.

Mr. CLARK [continued]. —for sharing.

Ms. KUSTER. I appreciate it. We are all learning and thank you for all the work you do. And I yield back. And thank you again for allowing me to appear today.

Ms. LURIA. Well, thank you for joining us. And I now recognize Representative Pingree for 5 minutes.

Ms. PINGREE. I thank you again for having this hearing, my colleague from New Hampshire for sharing her own experience, and just reminding us all that it sort of doesn't matter what position you take on in life. These are—these things stay with you for a very long time and are incredibly difficult to discuss. So thank you so much for doing that.

I guess what troubles me, and I had the chance to, you know, read my testimony earlier about the bill and recount that I have been here before in this Committee and also served on the Armed Services Committee and, you know, been through a lot of the shock at how deep this goes. And, you know, 7 years ago we had some very positive conversation about moving forward. And the fact that we thought we did and then perhaps because of a reorganization and, you know, a hurry to get through claims, you know, what good had been done was already lost and now we have a promise of doing that again.

But it is just unthinkable that in this day and age we ask people to serve in the military. They have these horrendous experiences, and then—so, a, that's an Armed Services Committee issue and we need to continue to address that.

But then people present themselves for claims and many of them going back, you know, an incredibly long period of time and then hit these brick walls. So I know there is some opposition to this bill. And I think what troubles me most deeply is 7 years ago and then today we are being told that part of the problem is that it is just going to cost money, you know, the more claims that we process and the more we recognize that people have real issues.

And one of the—I think in one of the written testimony the estimated cost is nearly \$10 billion over 10 years. But a large portion of this legislation, the use of secondary marketers to establish services already exists in the VA regulations. So why in the world are we saying it is going to cost \$10 billion? And, even if it was, it is our obligation to make sure we make people whole again. We do everything we possibly can. But that just seems to me a completely disproportionate cost.

And can you address—I just think that is unreasonable and I just think it is what we use all the time to not move forward.

Ms. MURPHY. I would say one piece of that is we have made reference earlier; we get an average of about 18,000 claims a year for military sexual trauma. Off the top of my head I think the first couple of years we are expecting it would be about 30 or 35,000 claims if we implemented the bill. And I think a piece of that is some folks don't come forward if they aren't diagnosed with PTSD. And the fact that we are opening this up to other related mental health concerns would make more people eligible. So if you have a depressive disorder and it has been several years since you were in service, maybe you wouldn't be coming forward.

So I think a big—a piece of the cost is that more folks would be eligible to pursue a claim and be paid because we would be expanding the types of conditions apart from just PTSD.

Ms. PINGREE. And I—look, I am on the appropriations side of this so I shouldn't be arguing about the finances here today, but I just think that that often gets used. And then what perversely happens is they get used to limit the amount of eligibility, just as you said. We say, well, then that disorder shouldn't be allowed, or those particular markers, or you didn't come forward in time, or all these road blocks that have been set up along the way are in a sense the byproduct of the fact that we say, well, it will cost us money if we allow that to be claim instead of saying, we recognize this is a serious problem and we need to make sure that we do everything we can to understand how people are going to present, which way they are going to deliver their claim, what mental conditions that people might experience and mental health issues that people might experience should be covered.

And so I am just appalled that I have to keep facing this argument every time we come before trying to change the public policy about something that I think in a very bipartisan way we agree shouldn't be going on. And then we agree that people can be left with the ramifications of this trauma for years and years and years deeply impacting their life, their family life, their ability to make a living, just a whole variety of things.

And I guess I would add that, you know, and I have seen it some of the testimony and you have talked a little bit about, you know, trying to make the distinction between the combat claims. And I understand this is a different situation, but much of it is exactly the same. You know, when you have PTSD you can't always define exactly when in combat that happened. You can't report immediately because you are in the thick of a war or you are in the thick of a battle. And for so many people they are in the same situation.

I am out of time and I mostly lectured you. I am sorry. But, you know, I have just been around this too long. And one of the reasons we have very proactively in the bill talked about these teams and these specialized claim—you know, what to do is because we were told it was all going to happen and then the VA decided to reorganize and said, oh, we gave that up because we were rushing through too many claims. And now you guys say, okay, we are going to go back and do that. But it has got to get done.

Thank you, Madam Chair.

Ms. LURIA. Well, thank you. And just to offer if anyone on the panel has any additional questions for this set of witnesses before we move on.

Okay. Well, thank you very much. I really appreciate your taking the time to be here today and to work so diligently on these issues. So thank you for appearing today. And we will give a few minutes to shift over to the next panel of witnesses.

While we do that, I will introduce the third panel. On this panel we will have Ms. Elizabeth Tarloski, Adjunct Professor at the Lewis B. Puller Jr. Veteran's Benefits Clinic at William and Mary Law School; Mr. Shane Liermann, Assistant National Legislative Director at the Disabled American Veterans; and Dr. Sharyn Potter, Executive Director of Research at the Prevention Innovations Research Center at the University of New Hampshire.

So we will give you a few minutes to get situated and then we will move on to the next portion of our hearing.

[Pause]

Ms. LURIA. Okay. Well, thank you again for being here and thank you again to Ms. Tarloski for traveling here from William and Mary in Virginia, and also for Dr. Sharyn Potter for visiting us from New Hampshire to bring your experience.

And we will start by giving Ms. Tarloski 5 minutes for your opening statement.

STATEMENT OF ELIZABETH TARLOSKI

Ms. TARLOSKI. Thank you.

Good morning, Madam Chairwoman Luria, Ranking Member Bost, and Members of the Subcommittee. Thank you for the invitation to speak here today on an important and pressing issue.

Along with law students, I assist veterans in filing and appealing complex disability claims involving PTSD, TBI as well as mental health claims based on military sexual trauma.

I have witnessed firsthand the uphill battle MST survivors face in submitting and appealing PTSD claims. It is no secret that the VA claims process can be long and confusing, and when a veteran has experienced trauma this process is that much more daunting.

One of the requirements for establishing service-connection for PTSD is to produce credible evidence of the occurrence of an in-service stressor. When the in-service stressor involves combat or fear of hostile military or terrorist activity, a lay statement is enough to establish the stressor occurred, if consistent with the circumstances of one's service.

This, however, is not enough for a PTSD claim when the in-service stressor is sexual assault or harassment because the VA requires additional evidence in the form of markers.

I support House Bill 1092 because it would recognize the unique nature of MST claims by extending the standard applied to combat and fear of hostile military or terrorist activity to those who file mental health claims not just for PTSD, and would be sending a clear message to our Nation's veterans that they will be believed and supported.

As noted on the VA's own website, sexual assault is actually more likely to result in symptoms of post-traumatic stress disorder than other types of trauma including combat.

Also, the experience of MST can differ from the experience of other traumas and even from the experience of sexual trauma in the civilian world. The VA has acknowledged that sexual assaults and harassment are underreported in the military, but at the same time ignoring the shame, embarrassment and stigma that leads to the silence of veterans after service.

Studies have shown that there are multiple barriers faced by veterans to disclosing MST or even seeking out mental health treatment after they leave service. This makes it difficult for a veteran to submit evidence even in the form of markers to indicate the in-service stressor event occurred if that evidence does not exist, is hard to find, destroyed or never documented in the first place.

Gathering evidence for these claims is also burdensome and confusing. As pointed out in the 2014 government accountability office report regarding MST, 2 VA claims adjudicators could look at the same marker and come to different conclusions, and both would be right according to the VA's own regulations. My own experience assisting veterans and reviewing VA decision letters denying benefits reflects this finding.

The current standard is not practical given the length of time it may take for a veteran to come forward to file a claim. Many veterans wait years, if not decades, before deciding to tell their story, let alone submit a disability claim, and some will never do either.

Many veterans applied once years ago before the standard was relaxed to include markers and never reapplied after being denied. It is not uncommon for veterans and their advocates to wait over a year just to receive military personnel and medical records, and sometimes they are incomplete and hard to read.

Private medical records are usually destroyed after 5 to 10 years, and the absence of records is important because many of the examples of markers, such as episodes of depression or anxiety, visits to medical centers, substance abuse, et cetera can be best shown by these medical records.

The stigma of MST while it is now lessening is still salient, especially for older generations. Requiring those who may have never before disclosed trauma to provide documentation of markers is unreasonable and infeasible for many, especially because the documentation may no longer exist.

Male veterans are also negatively affected by the current standard. Men are less likely to report sexual assaults and harassment in the military, and they are generally less likely to talk about MST or seek mental health treatment after service, meaning they are less likely to be able to depend on in-service reports or even evidence that could serve as markers.

In Section 4 of the proposed bill a claim for MST still must be supported by a diagnosis as well as an opinion by a mental health professional that a mental health condition is related to MST. Even so, evidence can be rebutted by clear and convincing evidence to the contrary.

I do believe H.R. 1092 would streamline the processing of these claims and reduce the number of appeals, which at this point can take up to 4 years to decide, if not longer if they continue to be appealed.

The wounds associated with PTSD and MST are not always visible, and many veterans will go decades without disclosing the MST to anyone, including mental health professionals. The reforms contained in H.R. 1092 would put veterans who have experienced MST on equal footing with other veterans who submit claims for PTSD and would ease the burden survivors of MST currently face.

Thank you. That concludes my statement, and I am happy to answer any questions.

[THE PREPARED STATEMENT OF ELIZABETH TARLOSKI APPEARS IN THE APPENDIX]

Ms. LURIA. Well, thank you.

And I will now recognize Mr. Liermann for 5 minutes.

STATEMENT OF SHANE LIERMANN

Mr. LIERMANN. Thank you.

Chairman Luria, Ranking Member Bost, and Members of the Subcommittee, on behalf of DAV's more than 1 million members we thank you for the opportunity to testify at today's hearing on ensuring access to disability benefits for veteran survivors of military sexual trauma.

For nearly 21 years I have represented thousands of veterans in claims and appeals before 4 different VA regional offices and the Board of Veterans' Appeals. So I personally understand the challenges facing veteran survivors of MST and the issues navigating the VA claims system.

Madam Chair, military sexual trauma has become an all too common experience for women and men who serve in our armed forces. According to DoD's 2018 annual report, sexual assault was experienced by 6 percent of women and 0.7 percent of men. However, that actual number is nearly equal. Rates of reporting MST are growing from 1 out of 14 in 2006 to 1 out of 3 in 2017.

Sexual harassment occurs even more frequently than assault, with 24 percent of women and 6 percent of men indicating they have experienced.

First, we need to find a way to end MST in the Armed Forces.

Second, DoD needs to make it easier for survivors to report these assaults. When MST incidents are not reported to military authorities, it complicates VA's current claims process for establishing service-connection for PTSD related to that assault.

PTSD claims based on MST do not require survivors to have absolute verification of the incident, only corroboration. And as noted, this threshold differs from other PTSD related claims due to the lack of documentation of such incidents.

However, VA has demonstrated persistently a systemic problem in implementing this regulation. VA has shown its inability to properly train, develop and adjudicate claims for PTSD based on MST as evidenced by the numerous reports of the OIG and GAO.

In the 2010 OIG report VA denied 50 percent of female veterans for PTSD claims versus 38 percent of male veterans. In the 2011 OIG report it was noted that VA staff did not correctly process PTSD claims which was due to the staff lacking sufficient experience and training to process these claims accurately.

In 2014 GOA report it found confusion among adjudicators and examiners in how to evaluate a claim and recommended 5 actions to include expanding training on MST related claims, develop a more comprehensive quality review of MST claims, and to expand their outreach.

In the 2018 report OIG estimated that VA staff incorrectly processed approximately 49 percent, almost 50 percent of MST related claims. The reasons were due to a lack of previous specialization, lack of additional level of review, discontinued special focus reviews and inadequate training. The report concluded with 6 recommendations, but to date VA has completed 2 of the 6.

In order to ensure VA's compliance and accountability with MST related claims, DAV believes it is time for Congress to enact H.R. 1092, the Service Members and veterans Empowerment and Support Act of 2019. This legislation would essentially codify several parts of the regulation and also add other mental health conditions in addition to PTSD as being related to MST.

H.R. 1092 would add electronic media as a source of harassment and abuse as well as require VA to reestablish specially trained teams to adjudicate MST related claims for mental health conditions.

Finally, the bill would require VA to report MST claims annually to Congress to help ensure that these claims are adjudicated equitably. DAV strongly supports H.R. 1092 and we urge Congress to pass this legislation.

Madam Chair, since the inclusion of personal assault provisions in 2002, veteran survivors of MST have faced countless challenges in obtaining their earned benefits. For 9 years VA has struggled to properly train, develop and adjudicate all claims for PTSD based on MST.

We want to thank you, Madam Chair, and the Committee for holding this oversight hearing today. And the DAV looks forward to working with you and the community in the future to ensure all MST veteran survivors receive fair and equitable access to their earned benefits.

This concludes my testimony, and I would be pleased to answer any questions you or any of the other Members may have.

[THE PREPARED STATEMENT OF SHANE LIERMANN APPEARS IN THE APPENDIX]

Ms. LURIA. Well, thank you.

And now I recognize Dr. Potter for 5 minutes.

STATEMENT OF SHARYN POTTER

Dr. POTTER. Chair Luria, Ranking Member Bost, and Congressmen Kuster and Pingree, I am honored to testify today.

I have spent the better part of 20 years developing, administering and evaluating sexual violence prevention and response strategies. My recent research focuses on the economic impact of sexual assault. My research shows the devastating cost of sexual violence and its impact on victims' health, education and career trajectories.

One participant we interviewed described the sexual assault perpetrated against her as the bomb that shattered everything as no part of her life was left intact.

H.B. 1092 will provide an easier path for veterans to prove they suffered MST making them eligible to receive disability benefits.

Additionally, the proposed bill's inclusion of technological abuse is critical for addressing the increasing prevalence of technology as a tool for perpetrators.

While I have developed a technology application that assists victims, I have also seen how technology that we use every day is used by perpetrators to isolate, control, scare and intimidate victims.

The Department of Defense report on sexual assault in the military indicates that 7,500 active duty military men and 13,000 women were sexually assaulted in 2018. Only one-third of these military people reported to a Department of Defense authority. The low reporting rates are consistent with research on colleges and workplaces, and there are many sound reasons why victims do not come forward, including fear of jeopardizing their career, retaliation and shame.

In addition to the mental and physical health consequences of MST, victims face substantial impediments to completing their education and attaining their career goals further undermining their economic success. My study of campus sexual assault victims ages 24 to 65 at the time of the study highlights some economic losses. One-third never finished college and many recounted serial low wage positions with limited health care coverage.

In my research I have interviewed both veterans and civilians who were sexually assaulted as they pursued their military careers or education. Many describe how the health problems caused by sexual trauma hinder their ability to maintain stable employment. Sexual trauma victims are often triggered or re-traumatized by workplace incidents, including being left alone in an office or dealing with an inappropriately behaving boss or customer.

When people transition in and out of the workplace, they face economic instability, posing challenges in their ability to obtain food, housing, transportation and health care. Access to disability benefits will reduce the veteran's MST burden, allowing them to attain medical assistance and financially support themselves and their families.

Victims of MST suffer unimaginable personal and financial loss. The significant societal costs of not treating MST include drug addiction, homelessness and incarceration.

Providing help for male MST victims poses unique challenges as the military culture expects men to be hyper-masculine and physically strong. The stigma of MST makes male veterans less likely than female veterans to report and seek treatment, exacerbating the impact of the MST in all areas of the veteran's life.

Veterans who suffered active duty injuries from an explosion or a vehicle crash during active duty are eligible for disability benefits. However, the shame of MST prevents the majority of active duty men and women from coming forward. Yet we know when MST victims receive help, even belatedly, their lives and the lives of their families and our societies are improved.

Amending the evidentiary standards and claims for compensation for MST induced psychological trauma is critical in supporting our servicemembers who have suffered sexual assault while serving their country.

This concludes my testimony.

Thank you.

[THE PREPARED STATEMENT OF DR. SHARYN POTTER APPEARS IN THE APPENDIX]

Ms. LURIA. Well, thank you.

And I now yield 5 minutes to myself for some questions.

I would like to start with Ms. Tarloski, and I want to in the process of this, you know, bring out a quote that I am going to highlight in the VA's statement and some of the statements that you made.

So, basically, I will read this first. It says: "The VA strongly opposes the amendment to Section 1154 because the VA is concerned that the bill's language would functionally require VA to accept all allegations of an MST stressor and potentially award service-connection based on a single lay statement from the veteran without even minimal supporting the existence of an in-service stressor."

And it goes on to say that, "In essence, the bill would require the VA to award service-connection as long as there is a current diagnosis of a covered mental health condition and a mental health professional that would corroborate that."

So basically what they are saying is that, you know, this particular proposed legislation is too liberal and that someone might just make a statement in order to gain the system or the way I read it without particularly sound evidentiary standards.

So in your experience of dealing with lots of these cases and lots of veterans, in your professional opinion do you ever see people who just try to gain the system? I mean, this seems like a very painful thing to put yourself through in reporting. And so just from your experience on a legal side is that something that you would be concerned about in this legislation?

Ms. TARLOSKI. No, not at all. The veterans that I do see as clients are extremely hesitant to open up to us at all. It takes sometimes multiple meetings building trust. A lot of them feel like they are not deserving of the benefits and it usually takes them, like I said, decades to even come forward at all. I don't think this is an experience people want to share readily, let alone make up.

And I am concerned that the differing standards kind of puts our PTSD survivors who are veterans in 2 different categories that we should believe those who are in combat that can't document them or document what happened, but we need additional evidence from those who suffer from MST. And to me that is troubling. I do believe the standard should be the same for those who are in combat as well as those who experience MST.

Ms. LURIA. Well, thank you.

And I will shift to Dr. Potter. From your experience, what portions of the process of applying for these benefits, either in your experience or anecdotally from your expertise in the field, what portions of this process would be re-traumatizing for a victim and how could that be improved just to be able to provide your experience

and expertise, you know, back to the VBA as far as how they handle these claims?

Dr. POTTER. So I can't speak to the experience of seeking these benefits, but what we do know is that when victims come forward, how they are responded to can actually be re-traumatizing, especially if they feel like they are not being believed or they are being shut down.

And by the time a victim comes forward, it has taken so much courage for them to disclose what has happened to them to an authority that to be treated as if they are not telling the truth would shut them down and would probably put them further into the pain that they are already in.

Ms. LURIA. Well, thank you.

And just, I would like to share from my experience in the limited time since I have been here, I have had a group of female veterans come to my office to talk to me about this issue. And it was very frequently the case that they having been denied or having peers who had been denied just really felt the re-traumatization and sort of, that were kind of thrown to the wayside because they weren't believed.

And so I do think that the expanded types of evidentiary standards will be helpful in making sure that people's stories are believed and that all evidence available is used to adjudicate a claim.

I will shift last to Mr. Liermann.

So if an MST survivor is separated with a bad paper discharge other than honorable or some type of discharge that would otherwise make them not eligible for care under the VA, do you find that it is less likely that they could eventually be treated for things related to MST? And is there anything that we can do about that because we have frequently talked about some of the mental health issues, some of the things that have been leading to increases in veteran suicide and making sure that everyone can be seen in a crisis.

And do you see, you know, direct correlations with MST cases similar to some of the other areas where we have talked about this issue?

Mr. LIERMANN. Absolutely. DAV issued 2 women veteran studies in 2014 and 2018, and one of the things that we did highlight is when there is a discharge and it is due to something that would preclude maybe health care or even service-connection, a lot of times they are going to remain untreated for years, whether in some cases it is true or not, they just may hear that they are not entitled. So a lot of times they won't even file a claim or seek health care.

So one of the things we are trying to establish is ways around those types of situations because I believe within the last year or so they did state that VA will now treat those with certain types of discharge, especially if it is due to MST, TBI and PTSD and other type issues for health care. And that is encouraging because once we can establish the health care, then essentially maybe we can establish a claim, because if there is no diagnosis and no mental health treatment up front it will complicate the entire process.

Ms. LURIA. Thank you.

And I now give Mr. Bost 5 minutes for questions.

Mr. BOST. Thank you.

Ms. Tarloski, and understand that all of us involved with the panel and everyone with the VA, we want to make sure that we get this right. We have to get it right. But as we move forward, we have the obligation to the veteran. We have an obligation to a taxpayer. But our first obligation is to the veteran. Okay. We all know that.

So do you know in your studies and what you have witnessed, is there people who have received, who have MST that do not have some form of the markers that the VA have out there? I mean, is there a case where, okay, they don't show any of that?

Ms. TARLOSKI. I would say most cases, at least in the cases I have handled where there is markers in decision letters that have denied those veterans benefits, those markers are either attributed to another trauma, which I see quite often. They are ignored. I mean, they are acknowledged in the letter and then ignored.

I have seen a case where the VA honed in on a discrepancy of 2 days when the veteran says the assault happened in 2 different letters that this person submitted, and they said, well, you know, obviously this isn't a credible lay statement because you are changing your story in an assault that happened 41 years ago.

So where there are markers, I think they are not being interpreted correctly or they are just not being adjudicated correctly. I have seen some claims with no markers at all where the veteran is coming forward for the first time. However, if a marker could be interpreted as a medical record because they have said something to a VA health care professional, then it should be weighed, but I don't find that it usually is.

Mr. BOST. Dr. Potter, would you agree with that, that—and I'm just trying to figure out, okay, I know that there is people that I know in my family that have experienced this. And I know certain things and certain actions that have changed in their life after the experience.

So are there those that have no identifying markers?

Dr. POTTER. I doubt it. When I was read the proposed bill, I thought the 4 secondary markers really encompassed all of, or most of, all of the victims I have spoken to and all of the research.

These markers are well documented in the research and I was really impressed that they were going to be used as proxies because there are so many good reasons, as we have talked about, why people can't come forward in the aftermath of the assault. And they are great reasons and we have to respect those individual decisions.

So I think those markers are spot on.

Mr. BOST. Okay. Mr. Liermann, what are you suggesting or what suggestions might the DAV have for how to better train or are we moving in the right direction with the VA on the training that is given to those people because you have seen a lot of these claims? You have also seen other combat claims and post-traumatic stress in many ways. Are we training right and are we training enough to deal with the situations as they occur?

Mr. LIERMANN. Well, as the OIG report noted that previously a lot of the MST claims and the training was one time. I don't believe

training somebody once on how to handle these issues is ever going to be enough.

For example, within DAV and our national service officers around the country we provide annual training on MST sensitivity claims, the entire process, to make sure it is always fresh, we understand, plus if something new comes out we can always train or alter or tailor that training just to make it one of those issues that we fully understand.

As far as VA's new training or what they are doing now, I really can't comment because I haven't seen any of the new training as of yet. DAV would love to be a part of it and partner with VA in developing some of the training.

And I love the point that was made earlier, that something from a survivor's point of view really is, I think, needed in the training because if you haven't experienced it yourself, it is hard to always have enough empathy for somebody.

Mr. BOST. Sure.

Mr. LIERMANN. And unless you can really put a face with it and emotion with it and truly understand the impact it has on people.

Mr. BOST. All right. Well, my time is expired, and I want to thank you for being here. But I will turn it over—I will yield back.

Ms. LURIA. Thank you.

Would you like more time for any additional questions?

Mr. BOST. Just a comment, if I could.

Ms. LURIA. Of course.

Mr. BOST. Let me say this, and for all of the panel of us here. As I said, this is vitally important. We have kept our head in the sand for a very, very long time on these issues. The military today has got to be a tremendous, tremendously different than when I went in because it was strictly a case that if something like this occurred, you just didn't report it. You just didn't, at all. It could ruin your career. It was embarrassing. The list goes on and on. And the worst thing about it was back then your superiors knew it.

It is my hope the DoD has been very, very clear in making sure that as you mentioned earlier that we have got to stop it on that end. But we still have to deal with its aftermath and that is the VA's job. Unfortunately, quite often the VA's job is to clean up the mistakes and mess that the DoD does. And I don't mean to bad mouth the DoD here. I am just saying that that is military life. But a lot of it that happens is not acceptable, and we have got to do our job on this side of the dais to make sure that you are doing that—give you all the tools you can on that side to make sure that we deal with those that are dealing with this.

So thank you.

Ms. LURIA. Well, thank you.

And I wanted to wrap up and conclude by thanking all of you again for agreeing to come today and participate in this very important discussion.

And I also wanted to thank the representatives from VA and OIG for staying to hear the additional testimony because I think the ongoing dialogue between experts in the legal field, the medical field and then the Veterans Service Organizations is a very important part of solving these problems and how we can attack this and

other issues that are important for our veterans receiving the benefits that they have earned and deserve.

So I would like to thank you again and give one more opportunity if Mr. Bost would like to make any more closing remarks. And I would like to remind all Members that they have 5 legislative days to revise and extend their remarks and include any extraneous material.

So thank you and the hearing is adjourned.

[Whereupon, at 12:24 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Steve Bracci

Chairwoman Luria, Ranking Member Bost, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the Department of Veterans Affairs' (VA's) processing of disability benefits for posttraumatic stress disorder related to military sexual trauma (MST). Sexual trauma experienced while in military service affects both men and women with serious and long-term consequences. According to the Department of Defense, more than 7,600 individuals reported a sexual assault in fiscal year (FY) 2018 for an incident that occurred during their military service, an increase of about 12.6 percent from the previous year.¹ Understandably, many survivors are reluctant to report the sexual assault either at the time of its occurrence or even much later. It is, therefore, imperative that VA reviews each MST-related claim for benefits expeditiously, thoroughly, and with sensitivity by engaging a group of specialized staff to ensure eligible veterans receive the benefits to which they are due. Accurate and efficient claims management and decision-making can help minimize additional trauma while furthering VA's mission to serve the needs of the nation's veterans.

In August 2018, the OIG published the report, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*. The OIG's audit team examined whether responsible staff correctly processed veterans' MST-related claims in accordance with Veterans Benefits Administration (VBA) procedures.² Based on the review, the OIG found that nearly half of denied MST-related claims were not properly processed following VBA policy. The potential impact on veterans seeking benefits related to MST is considerable given VBA's estimate of about 12,000 MST overall claims being processed per year and the growing number of reports to the Department of Defense. The audit team identified several deficiencies that led to the improper denial of benefits such as lack of specialization, inadequate MST-related claim training for processing staff, deficient internal controls, and discontinued special focus reviews.

BACKGROUND

In October 2017, the OIG implemented a new national inspection model for VBA oversight. Under this new approach, the OIG conducts nationwide audits and reviews of high-impact programs and operations within VBA. The purpose of these types of audits and reviews is to identify systemic issues within VBA that affect veterans' benefits and services, determine the root causes of identified problems, and make useful recommendations to drive positive change across VBA. Previously, the OIG largely conducted its oversight through routine inspections of VBA's 56 regional offices. The OIG's August 2018 MST report was one of the first reports that the OIG published under the new national inspection model.³

PTSD

Posttraumatic Stress Disorder (PTSD) is a mental health condition that military members can develop after experiencing or witnessing life-threatening events such

¹Department of Defense Annual Report on Sexual Assault in the Military, Fiscal Year 2018.

²Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma, August 21, 2018.

³Other reports published under the new national inspection model include *Unwarranted Medical Reexaminations for Disability Benefits*, July 17, 2018; *Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits*, August 21, 2018; *Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis*, November 20, 2018; *Deferrals in the Veterans Benefits Management System*, May 15, 2019; *Decision Ready Claims Programs Hindered by Ineffective Planning*, May 21, 2019; *Inadequate Oversight of Contracted Disability Exam Cancellations*, June 10, 2019.

as combat, natural disasters, personal trauma, or other significant stressors.⁴ According to VBA, a veteran must have a current diagnosis of PTSD, credible evidence that the stressor occurred during military service, and a link between the current PTSD symptoms and the in-service stressor for VBA to establish service-connection for PTSD.

MST

VBA defines MST as a subset of PTSD personal trauma claims, specifically related to sexual harassment, sexual assault, or rape that occurred in a military setting.⁵ According to a 2013 report by the RAND Corporation National Defense Research Institute, the vast majority of sexual assault survivors do not seek immediate care and the incidents are not reported to authorities.⁶ Reasons for not reporting, which are particularly relevant to the military, include reluctance to submit a report when the perpetrator is a superior officer, concerns about negative implications for performance reports, worries about punishment for collateral misconduct that may be related to the trauma, and the perception of an unresponsive military chain of command.

It is often difficult for victims of MST to produce the required evidence to support the occurrence of the sexual harassment, sexual assault, or rape. Because of this difficulty with obtaining evidence of stressors, VBA provided further guidance in 2011 to ensure consistency, fairness, and a “liberal approach” for MST-related claims.⁷ These guidelines eased the requirements for the types of supporting evidence VBA could accept to support and identify an in-service stressor for MST.

The MST-Related Claims Process

Each VA Regional Office (VARO) has two MST coordinators—one male and one female. They are designated as the local points of contact for veterans with MST-related claims. These employees typically also have other claims processing responsibilities. Upon receipt of an MST-related claim, the coordinator must attempt to contact the veteran by telephone. The purpose of this telephone call is to determine whether the veteran reported the claimed traumatic event in service, and if so, determine how they reported it and identify how to obtain this evidence. If the assault was reported, the veteran is urged to supply the report or provide the name of the military base where the report was filed. If the MST coordinator is unable to reach the veteran by telephone, a Veterans Service Representative (VSR) must send a letter to the veteran requesting information about the reporting of the sexual assault.

VSRs are VARO employees whose duties include determining what evidence is necessary to decide an MST-related claim, undertaking development action to obtain necessary evidence, and determining when a claim is ready for decision. Once obtained, VSRs must thoroughly review all evidence to confirm the stressor or identify behavior markers for MST. A marker is an indicator of the effect or consequences of the personal trauma on the veteran. If the evidence shows possible PTSD symptoms or a current diagnosis, credible evidence of the stressor, or a single marker for MST, the VSR must request a medical examination. The purpose of this examination is to provide a report that includes a medical diagnosis, if warranted, and an opinion about whether the diagnosis is related to the claimed sexual assault to establish the required nexus.

The claim evidence and exam results are then sent to a Rating Veterans Service Representative (RVSR), who are also VARO employees, with the authority to make formal decisions on veterans’ claims. Before RVSRs can decide a veteran’s MST-related claim, they must ensure that all required steps were completed. These steps include executing the procedures for obtaining the veteran’s complete military personnel file; thoroughly reviewing all evidence, including military personnel files and service medical records for potential behavioral markers; and requesting a medical examination when appropriate. Once RVSRs determine that all appropriate procedures were completed, they evaluate the evidence and make a decision on the veteran’s claim. RVSRs may deny an MST-related claim without requiring a medical examination only if there is no “credible evidence” of a stressor, no evidence of a behavioral marker, or no evidence of symptoms of a mental disorder.

PREVIOUS OIG AND GAO REPORTS IDENTIFIED ISSUES WITH MST-RELATED CLAIMS PROCESSING

⁴ 38 Code of Federal Register §3.304(f), Posttraumatic stress disorder.

⁵ M21-1 Adjudication Procedures Manual, Part III, Subpart iv, Chapter 4, Section H, Topic 4, General Information on Personal Trauma. (Historical)

⁶ Coreen Farris, Terry L. Schell, and Terri Tanielian, Physical and Psychological Health Following Military Sexual Assault, Recommendations for Care, Research, and Policy, RAND, 2013.

⁷ VBA Training Letter, Adjudicating PTSD Claims Based on MST. (Historical)

In December 2010, the OIG published a report, *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits*.⁸ The report assessed whether VBA developed and disseminated MST training and policies to claims processors. The OIG identified deficiencies in evaluating and processing MST claims and recommended that VBA conduct specialized training and an analysis of the consistency in which MST claims were processed. As a result, VBA implemented special focus quality improvement reviews of MST-related claims and directed VAROs to designate MST specialists beginning in 2011.

In June 2014, the Government Accountability Office (GAO) published a report, *Military Sexual Trauma Improvements Made, but VA Can Do More to Track and Improve the Consistency of Disability Claim Decisions* and identified similar deficiencies.⁹ GAO noted that VBA began assigning MST-related claims to specialized claims processors and required them to receive MST-specific training; however, quality reviews and analyses of claim decisions had shortcomings. They recommended improved training and enhanced MST-related quality reviews and outreach.

OIG FINDS ALMOST HALF OF VETERANS' DENIED MST-RELATED CLAIMS WERE PROCESSED INCORRECTLY

At the time of the OIG review, VBA reported to the OIG that over the last three years it had been processing approximately 12,000 veterans' claims per year for PTSD related to MST. In FY 2017, VBA denied about 5,500 of those claims (46 percent). The OIG review covered a population of 2,851 MST-related claims that VBA staff denied and completed from April 1, 2017, through September 30, 2017, of which 169 MST-related claims were sampled.

Incorrectly Processed Claims

The OIG audit team found that VBA staff incorrectly processed veterans' denied MST-related claims in 82 of 169 cases during the review period. The team provided VBA with details on the 82 veterans' claims that staff incorrectly processed. VBA reviewed the cases and agreed with the OIG audit team's conclusions. Based on this review, the OIG estimates that VBA did not properly process approximately 1,300 of 2,700 denied MST-related claims (49 percent).

The following table summarizes the projected errors based on the results of the OIG's claims review.¹⁰

Table 1. Incorrectly Processed Denial Error Projections for MST-Related Claims

Error Category	Projected Number of Errors	Projected Percentage of Errors
Evidence was sufficient to request a medical exam and opinion, but staff did not request one	740 cases	28%
Evidence-gathering issues, such as VSRs not requesting veterans' private treatment records	340 cases	13%
MST Coordinator did not make the required telephone call, or VSRs did not use required language regarding the reporting of the assault in letter sent to the veteran	300 cases	11%
RVSRs made a decision on the veteran's claim based on contradictory or otherwise insufficient medical opinions	270 cases	10%
Total	1,300 cases	49%

Source: VA OIG analysis of statistically sampled MST related claims completed from April 1, 2017, through September 30, 2017.

Impact of Incorrectly Processed Claims

The OIG team found that VBA staff did not follow required procedures for processing these claims, which potentially resulted in undue stress to veterans as well as a denial of compensation benefits for survivors of MST who could have been enti-

⁸ Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits, December 16, 2010.

⁹ Military Sexual Trauma Improvements Made, but VA Can Do More to Track and Improve the Consistency of Disability Claim Decisions, June 2014.

¹⁰ The OIG team estimated that in about 300 cases (11 percent), multiple errors contributed to the incorrect processing of the denials. Therefore, the numbers and percentages do not sum.

tled to receive them. One mental health provider confirmed for the OIG audit team that it can be traumatizing for individuals claiming MST benefits to relay their stories during examinations. Another mental health provider noted that veterans are confused and upset when VBA denies their claims, and this undue stress can interfere with the treatment process. As a result, the OIG audit team concluded that the trauma of restating or reliving stressful events could cause psychological harm to individuals experiencing MST and prevent them from further pursuing their claims. Additionally, incomplete processing may lead to inaccurate claims decisions and a significant amount of rework for VBA employees.

Causes for Incorrectly Processed Claims

The OIG determined there were several root causes for VBA's failure to properly process MST-related claims.

Need for Specialization. In 2016, the VBA Office of Field Operations implemented the National Work Queue to manage and distribute the national claims inventory and improve VBA's overall production capacity. The distribution of daily workload is based on VARO capacity, national claims processing priorities, and special missions. Prior to implementation of the National Work Queue, VBA had VAROs use the Segmented Lanes Organizational Model, which required VSRs and RVSRs on Special Operations teams to process claims VBA designated as requiring special handling, which included MST-related claims. The OIG team found these staff developed special expertise on these highly sensitive claims due to focused training and repetition. The National Work Queue model allowed these sensitive claims to be directed to any VSR or RVSR, regardless of their experience and expertise. VARO staff suggested that VBA reestablish specialized processing to help employees redevelop the expertise needed for more consistent and accurate MST-related claims outcomes.

Inadequate Training. The goal of VBA's MST training is to improve employee awareness of the characteristics and impacts of MST and ensure claims processors correctly apply the relevant regulations and policies. At the time of OIG's review, VBA had not updated the MST training modules since 2014, despite multiple changes to the Adjudication Procedures Manual. The OIG audit team reviewed the MST training modules and identified several deficiencies including the following:

- Consistently referred to a development checklist that was outdated and inaccurate
- Included erroneous development procedures, such as instructing claims processors to use incorrect medical opinion language
- Misstated the MST Coordinator's role and responsibilities
- Did not address how to rate claims where a diagnosis other than PTSD was provided
- Included incomplete information regarding what constitutes an insufficient or inadequate examination

Furthermore, MST training was provided as one-time only, with no requirement for annual refresher training. The OIG team, therefore, recommended improvements to VBA's training for MST-related claims.

Lack of an Additional Level of Review. At the time of the OIG's work, VBA required a second level of review for some complex claims, such as traumatic brain injury cases, but not for MST-related claims. An additional level of review would serve as an internal control to help ensure VBA staff process claims properly. VBA staff generally thought that an additional level of review would be helpful and could improve accuracy. Compensation Service management indicated this second review would have to be weighed against the cost of the requirement, as well as the delay in claims processing. Still, given the sensitive and time-consuming nature of MST-related claims, the OIG team determined that this added internal control would be appropriate and would help improve the quality of claims decisions.

Discontinued Special Focus Reviews. The Systematic Technical Accuracy Review (STAR) team conducts reviews of claims at each VARO as part of the Compensation Service national quality assurance review program. STAR staff completed special focus quality improvement reviews of MST-related claims beginning in 2011. These reviews, designed to correct deficiencies identified during the claims process, occurred in response to the previously mentioned 2010 OIG report related to "combat stress" experienced by women veterans, and continued, in part, because of the 2014 GAO report on MST-related claims. Staff performed the reviews twice a year and identified errors similar to those identified by the OIG team, such as missed evidence or markers and failure to request necessary medical exams. In December 2015, the STAR office stopped completing reviews of MST-related claims because the error rate for these claims improved from 2011 to 2015. Given the resurgence

of a high error rate, the OIG team determined that the STAR team should reinstate special focus quality improvement reviews for MST-related claims.

RECOMMENDATIONS

The OIG made six recommendations to the Under Secretary for Benefits, who agreed to implement the recommendations and make necessary changes to ensure the accurate processing of MST-related claims. Since the report's publication on August 21, 2018, VBA has provided documentation to close recommendations two and six listed below and has provided acceptable action plans for implementing the remaining four open recommendations.

The following list presents additional information on the status for each OIG recommendation based on a March 2019 VBA status update on the implementation of the recommendations:

1. Review all denied MST-related claims since the beginning of FY 2017, determine whether all required procedures were followed, take corrective action based on the results of the review, and render new decisions as appropriate. *Status: Open.*

Status of VBA's Action Plan: VBA reported that it has implemented a plan to conduct a review of the denied MST-related claims decided between October 1, 2016, through June 30, 2018, and take corrective actions based on the review if an incorrect decision was made. From December 2018 through the March update, VBA has reviewed 25 denied claims at the Columbia VARO. These claims were reviewed as part of VBA's first phase review plan to validate the established review process. This first phase ensured the effectiveness of the policies, procedures, and guidance related to the review. In March 2019, VBA began its second and final phase of the review which has been expanded to Muskogee, Cleveland, Huntington, and Portland VAROs. These VAROs will be reviewing approximately 9,700 remaining MST claims with a target completion date of September 30, 2019. Targeted Completion Date: September 30, 2019.

2. Focus processing of MST-related claims to a specialized group of VSRs and RVSRs. *Status: Closed.*

Status of VBA's Action Plan: VBA advised that on November 20, 2018, the Office of Field Operations issued guidance for designating a specialized group of trained VSRs and RVSRs at each regional office to process MST-related, amyotrophic lateral sclerosis, and traumatic brain injury-related claims. Completion Date: April 2, 2019.

3. Require an additional level of review for all denied MST-related claims and hold the second-level reviewers accountable for accuracy. *Status: Open.*

Status of VBA's Action Plan: VBA reported it has instituted a process to conduct second-level reviews of MST-related claims. The OIG is awaiting additional evidence from VBA that a sufficient number of denied claims will be reviewed as part of this process. Targeted Completion Date: November 30, 2019.

4. Conduct special focus quality improvement reviews of denied MST-related claims and take corrective action as needed. *Status: Open.*

Status of VBA's Action Plan: VBA stated that STAR staff will conduct a special focus review of denied MST claims in the fourth quarter of FY 2019. Targeted Completion Date: September 30, 2019.

5. Update the current training for processing MST-related claims and monitor the effectiveness of the training. *Status: Open.*

Status of VBA's Action Plan: VBA stated that it is finalizing the "PTSD Due to MST" training course and would mandate all VSRs and RVSRs training be completed by May 31, 2019. By September 30, 2019, VBA will administer a targeted consistency study to assess the effectiveness of the training. Targeted Completion Date: October 31, 2019.

6. Update the development checklist for MST-related claims and require claims processors to certify that they completed all required actions. *Status: Closed.*

Status of VBA's Action Plan: VBA reported that on October 1, 2018, it released the updated development checklist for MST-related claims. VBA developed a training module to complement the checklist. When RVSRs sign the rating decision for any disability compensation claim, they are certifying all required development actions have been taken regardless of claim type. Completion Date: January 8, 2019.

The OIG anticipates receiving an additional status update from VBA by June 21, 2019, and will monitor VBA's progress until all proposed actions are completed. The OIG website provides information on the real-time implementation status of all OIG recommendations.

CONCLUSION

Survivors of MST are often reluctant to report incidents and, even when they do, face the potential for significant distress during the claims process for related benefits. Every effort must be made to minimize that from happening. VBA has expressed a strong commitment to fixing deficiencies identified by the OIG that should help alleviate that stress and could also encourage more eligible veterans to step forward. Sustainable progress in reducing the large number of errors associated with denied MST claims can only be made by trained specialists who have the expertise and experience to routinely manage these claims in a sensitive and timely manner. Prior OIG and other oversight reports detailed some of the same problems that were identified in the OIG's most recent report. The significant number of errors in denying MST claims, as detailed in the OIG's 2018 report, and the recurrence of prior problems should indicate the need for vigilance in ensuring that after all OIG recommendations are closed, VBA needs to take measures to sustain that progress. The OIG will continue to provide oversight on these and other processes that have a significant impact on veterans who have suffered harm during their military service.

Chairwoman Luria, Ranking Member Bost, and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions.

Prepared Statement of Willie C. Clark, Sr.

Good morning Chairwoman Luria, Ranking Member Bost, and Members of the Committee. Thank you for the invitation to speak today on the important topic of VA disability compensation benefits based on military sexual trauma (MST) and H.R. 1092, the Servicemembers and Veterans Empowerment Support Act of 2019. With me is Beth Murphy, Executive Director of Compensation Service, and Margaret Bell, National Deputy Director for Military Sexual Trauma, Veterans Health Administration (VHA). In this statement, I will provide an update on VA's actions to review and improve MST claims processing and outreach, as well as provide the Department's views on the proposed legislation.

Office of the Inspector General (OIG) Report & Veterans Benefits Administration Actions

Over the past five years, VA has processed approximately 18,000 MST-related claims each year, on average. The VA OIG completed a review in August 2018 to determine if claims adjudicators correctly processed MST-related claims in accordance with VBA policy. VA strives to provide accurate and timely benefits to our Veterans and appreciates the efforts of the OIG to assist us in this regard. As a result of this review, the OIG made six recommendations. VBA acknowledges and concurs with OIG's findings and took immediate steps to ensure MST-related claims are processed accurately. As of today, VBA has fully implemented two of the six recommendations and these have been closed by OIG. One recommendation is fully implemented but pending closure by OIG. VBA is actively working on the remaining three recommendations.

Review of Previously Denied Claims

OIG's first recommendation was to review all previously denied claims since the beginning of fiscal year (FY) 2017, which consisted of a universe of 9,724 claims. Last year, VBA implemented that review of denied MST-related claims decided between October 1, 2016, through June 30, 2018, and is taking corrective actions as necessary. On November 14, 2018, VBA began the first phase of this review. This initial review allowed VBA to ensure the effectiveness of the policies, procedures, and guidance related to the review. In March 2019, VBA began the second and final phase to review the approximately 9,700 remaining claims. As of May 29, 2019, more than 75 percent of reviews have been completed. VBA is finding that approximately 20 percent of claims reviewed have an error that requires additional development. VBA is taking necessary actions on these claims and all affected Veterans will be notified. Once the additional development actions are complete, each of those claims will be re-adjudicated to determine whether the decision to the Veteran changes. The most common development errors that have been identified from this review are:

- The Development Letter did not have the appropriate Department of Defense (DoD) report notification language;
- The MST Coordinator did not attempt to contact the Veteran for any additional reports; and
- The Veteran was not asked whether DoD Forms 2910 or 2911 were completed, nor whether the report was restricted or unrestricted.

Together, these development errors account for over 70 percent of the issues discovered in this review, and many of VBA's actions in providing additional training and guidance to claims processors and outreach personnel are aimed at preventing these errors of inadequate development. The target completion date for this recommendation is September 2019.

Specialized MST Processing

The second recommendation was to focus the processing of MST claims to specialized employees, as would also be required in H.R. 1092, the Servicemembers and Veterans Empowerment Support Act of 2019. VBA completed this recommendation, which OIG has now closed, and has designated specialized teams of trained Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs) at every RO to process MST-related claims. These specially trained employees will maintain proficiency by working MST claims on a regular basis. Leveraging this best practice, VBA has proactively designated specialized teams for two other high-priority and often complex claims: amyotrophic lateral sclerosis and traumatic brain injury.

Additional Level of Review

The third recommendation required an additional level of review for all denied MST-related claims. In conjunction with establishing the specialized teams, VA instituted a requirement for 90 percent accuracy on at least 10 cases per employee, with all cases subject to a second-signature review until that accuracy rate is achieved. Single-signature authority is granted for this specialized group of claims processors once the required accuracy rate has been accomplished. These claims are also subject to VBA's standard quality review process. VBA has requested closure of this recommendation.

Special Focus Review

OIG's fourth recommendation is to conduct a special focus quality improvement review of denied MST-related claims. As such, in the fourth Quarter of FY19 VBA will conduct a special focused review of MST claims that were denied between May 1, 2019 and June 30, 2019. The purpose of this initiative is to assess the impact of the updated guidance and training to improve the overall quality of MST decisions.

Training

With regard to OIG's fifth recommendation to update and monitor the effectiveness of training, VBA has significantly updated and improved the VSR and RVSR training for processing MST-related claims. VBA has updated courses on MST markers and claims development, as well as the overall "PTSD due to MST" course and has mandated this training for all VSRs and RVSRs who handle MST claims. Additionally, VBA will administer a targeted consistency study to assess the effectiveness of the training; this is on track for completion in September 2019.

Development Checklist

VBA fully implemented OIG's sixth recommendation to update the development checklist for MST-related claims in December 2018, and OIG closed this recommendation in January 2019. The updated checklist includes the specific steps claims processors must take in evaluating MST claims.

MST Outreach

Beyond the specific recommendations from the OIG, VBA is dedicated to improving outreach to Veterans affected by MST. VBA maintains two trained MST coordinators in every RO (one male and one female) whose names are posted on VBA's public facing website at <https://benefits.va.gov/benefits/mstcoordinators.asp>. The coordinators case-manage MST claims and personally reach out to Veterans to ensure they understand the types of information needed to process the claim. MST Coordinators serve as the primary point of contact for all claims related to MST and are expected to be subject matter experts for all Veteran and/or VBA staff questions regarding MST. MST coordinators can assist Veterans during the claims process and connect Veterans to MST-related resources available within the Veterans Health Administration and the local community. Also, two MST program managers in VBA central office provide guidance to the field on MST-related outreach. I have personally engaged MST coordinators and claims processors in the field and am committed to ensuring that MST remains a priority topic for our field leaders.

While it can be challenging to complete outreach for MST due to the sensitivity of the trauma, VBA ensures that all public contact representatives receive training

to help them identify indicators of stressors that result from MST and signs of possible MST. VBA conducts routine targeted outreach that includes briefings on MST to inform, educate, and empower Veterans on access to the benefits and resources available to them. This includes information on how to file an MST claim and how to contact an MST coordinator. As of the second quarter in FY 2019, VBA completed 155 hours of MST-related outreach at over 49 events, reaching 2,067 Veterans, family members, beneficiaries, and other stakeholders.

Additionally, VBA collaborates with VHA on MST counseling and treatment to ensure a warm hand-off and has provided MST-related training to DoD personnel.

Finally, VBA publishes MST-related information across its public-facing web and social media channels, and in November 2018, VA's Under Secretary for Benefits, Dr. Paul R. Lawrence, released a video emphasizing VBA's commitment to supporting those who have experienced MST, providing treatment to help the healing process, and ensuring compensation for those disabled by MST. This video can be viewed at <https://www.youtube.com/watch?v=-b6NdB6cMwo>.

H.R. 1092 - Servicemembers and Veterans Empowerment and Support Act of 2019

I will now move on to providing the Department's views on H.R. 1092, Servicemembers and Veterans Empowerment and Support Act of 2019.

H.R. 1092 would amend several sections of title 38, United States Code (U.S.C.) relating to the administration of health care and benefits based on military sexual trauma. VA appreciates the intent of the Committee to enhance the processing of disability claims and treatment of Veterans who may have experienced MST during service. Provided Congress finds corresponding funding offsets, VA does not object to certain provisions of the bill but VA opposes others.

VA does not object to section 2 of the bill, which would add "technological abuse" to the list of definitions provided in 38 U.S.C. § 101. Further, VA does not object to the portion of section 4 of the bill, which would amend 38 U.S.C. § 1154 to include "technological abuse of a sexual nature" within the meaning of the term "MST." "Technological abuse" would include behavior such as cyber bullying, stalking, or nonconsensual sharing of photographs or videos that may occur via the Internet, social media platforms, mobile devices, etc. VA views this addition and expansion of terminology as reasonable given the prevalence and access of cellular and internet-based communications in society.

Section 3 of H.R. 1092 would amend 38 U.S.C. § 1720D(a)(1) to authorize VA to provide a Veteran with counseling and care and services needed to overcome psychological trauma determined (in the judgment of a VA mental health professional) to have resulted from technological abuse of a sexual nature.

VA does not support section 3, as we believe VA's current authority is adequate in this regard. Under section 1720D, VA is authorized to provide counseling and treatment for trauma resulting from sexual harassment (defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character"), and this can include sexual harassment that is conducted through cyber contact, including the use of Internet social media services. Contacts with field staff over the years suggest that many clinicians would currently conceptualize experiences similar to those described in section 2 as falling within the scope of the existing definition of MST, assuming they had a sexual component, and this is consistent with the views of VHA's leadership and subject matter experts.

Section 4 of the bill would amend 38 U.S.C. § 1154 to specify the standard of proof for service-connection of mental health conditions related to MST. VA does not object to the provision that would define the term "covered mental health condition" to include posttraumatic stress disorder (PTSD), anxiety, depression, or other mental health diagnoses described in the current version of the Diagnostic and Statistical Manual of Mental Disorders that VA determines to be related to MST. In doing so, the bill would expand the coverage of the lowered evidentiary standard provided in VA regulation (38 CFR § 3.304(f)(5)), which currently only applies to MST-based claims for PTSD, to also apply to claims for other mental health disorders based on MST.

VA strongly opposes the amendment to section 1154 in section 4 of the bill that would require VA to accept as sufficient proof of service-connection a diagnosis of a covered mental health condition by a mental health professional together with satisfactory lay or other evidence of such trauma and an opinion by the mental health professional that such covered mental health condition is related to MST in service. VA acknowledges that the circumstances of service make the claimed MST stressor more difficult to corroborate, and to that end, VA has promulgated regulations in 38 Code of Federal Regulations (CFR) §§ 3.303 and 3.304(f)(5), which establish equi-

table standards of proof and provide examples of the type of evidence needed to corroborate an in-service injury, disease, or event, for purposes of service-connection.

The amended section 1154, as written, would, however, substantively create a new standard for establishing a nexus between a claimed mental health condition and a claimed MST stressor, and verification of stressful events when adjudicating and determining service-connection for MST-related conditions. VA is concerned that the bill's language would functionally require VA to accept all allegations of an MST stressor and potentially award service-connection based on a single lay statement from the Veteran, without even minimal evidence supporting the existence of an in-service stressor event (such as the supporting evidence and behavioral changes listed in VA regulations). VA views this type of evidence as needed to maintain the integrity of the claims process. In essence, the bill would require VA to award service-connection as long as there is a current diagnosis of a covered mental health condition, and a mental health professional who is willing to speculate that the claimant's symptoms are related to an event in military service reported by the Veteran. This would occur despite the mental health professional's inability to assess whether the claimed in-service stressor or event occurred.

The current statute, in 38 U.S.C. § 1154, emphasizes the importance of considering the time, place, and circumstances of service when evaluating disability claims. Subsection (b) of section 1154 specifically refers to consideration of claims based on engagement in combat with the enemy. Proposed H.R. 1092 mimics this combat language and places MST claims on par with combat related claims. The combat provision is based on acknowledgement of the disruptive circumstances occurring on a battlefield and the resulting incomplete record keeping. This is the reason for a lowered evidentiary standard with acceptance of the combat Veteran's lay statement as sufficient evidence of a combat stressor. It is not clear how the circumstances of MST events are similar enough to those of combat trauma to be placed in the same statute or why there is no necessary threshold evidentiary requirement beyond a lay statement related to MST, as distinguished from lay statements related to combat stressor events. Unlike in-service events related to combat, MST is not linked to the "places, types, and circumstances" of a Veteran's service, but can happen anywhere and at any time during service. Even with this lowered standard under current section 1154 for combat Veterans, VA must obtain threshold evidence that verifies the Veteran engaged in combat before the lay statement can be accepted. By contrast, the proposed bill, as drafted, would essentially preclude VA from verifying basic information about claimed MST stressors.

Moreover, the proposed amendment would create a conflict with proposed section 1164(f)(3) which, when VA obtains conflicting evidence related to the substantiation of the claim, would require VA to "give more credence to the evidence that is more beneficial to the claimant." An unsupported lay assertion is "evidence" and would thus appear to take precedence over conflicting evidence of any nature. For example, if a claimant alleges that an assault occurred on a military base in Afghanistan, and VA obtains information reflecting that neither the claimant nor the assailant ever served in Afghanistan, VA adjudicators arguably would be required to give more credence to the claimant's allegation despite the provision in proposed section 1154(c)(1) that states "[s]ervice-connection of such covered mental health condition may be rebutted by clear and convincing evidence to the contrary." This conflict may result in disparate treatment of similarly situated claimants in VA adjudications.

Apart from our above-stated concerns regarding section 1164(f)(3), the addition of a new section 1164 to title 38, U.S.C., is unnecessary because such similar provision already exists in VA's regulations (see 38 C.F.R. §§ 3.303 and 3.304(f)(5)). VA has acknowledged the challenge of corroborating a Veteran's account of an MST, which led to the promulgation of regulations that allow decision makers to consider alternative sources of evidence (i.e., markers) when corroborating the MST stressor. These markers include substantially the same evidence listed in the proposed bill such as records from non-military health professionals, behavioral changes, and statements from other Servicemembers or family members. VA regulations also include the requirement contained in the bill to provide, prior to any denial of a claim based on MST, the proper notice and opportunity for the claimant to supply non-military evidence relating to the MST claim, and the requirement to solicit an opinion from a medical professional as to whether evidence provided by the claimant indicates an MST event occurred.

The proposed section 1164 would also require VA to establish points of contact in letters to claimants and establish trained specialized teams to process MST claims. These statutory requirements would be redundant of requirements that VBA has instituted across all ROs.

VA opposes the provision of section 4 of the bill that adds a new section 1165 to title 38, U.S.C., which would require VA to submit annual reports to Congress on

several aspects of MST claims processing through 2027. VA stands ready and willing to provide Congress with available data on MST at any time. However, certain reporting requirements from the bill would be untenable, and the proposed required data and metrics may not be captured by our current information technology/business systems. For example, VA cannot accurately identify the numbers of Veterans who fail to report for an examination annually. In addition, such reporting requirements would not represent a reasonable use of VA full-time equivalent capacity as such resources could be used in adjudicating claims. For example, VA notes the extensive efforts required to meet the bill's requirement to annually report a description of MST-related training, including frequency, length, and content of the training. Training across the 56 regional offices varies depending on the position (i.e., MST coordinator, Rating Veterans Service Representative, etc.), employee turnover, individual quality review results, etc.

Section 4 of the bill would also require that VA establish specialized teams to process MST claims and to ensure team members are trained to identify markers indicating military sexual trauma. As mentioned, this requirement would be redundant as VA has already implemented specialized teams and ensured robust training for these designated claims processors. VA believes this provision is unnecessary and it reduces VA's flexibility in managing workload appropriately.

Section 5 of the bill would require DoD to provide Servicemembers with information regarding eligibility of services from VA. The Secretary of Defense would be required to ensure that DoD's Sexual Assault Response Coordinators advise members of the Armed Forces who report instances of sexual trauma about their eligibility for services from VA.

While VA defers to the Secretary of Defense on the specific obligations this section would impose, we support this section in principle. VA currently provides counseling for MST to Servicemembers and is pleased to do so. Informing Servicemembers of the benefits for which they are eligible is important to ensuring they receive the care and services they need.

Section 6 of the bill would express the sense of Congress that members of the Reserve and the National Guard should be able to access all VA health care facilities, not just Vet Centers, to receive counseling and treatment relating to MST.

While VA generally defers to Congress in expressing its sense, we note that Active Duty Servicemembers and National Guard and Reserve Component Servicemembers on Active Duty can receive care at VA medical facilities (VAMC) in emergency situations or upon referral by military treatment facilities. Members of the Reserve and National Guard who are not on Active Duty have the option to purchase TRICARE Reserve Select, which could be a means for them to obtain a TRICARE referral and thus access care at a VAMC. For those members of the Reserve or National Guard who do not have TRICARE coverage, VA's Vet Centers remain an important option for receiving care through VA. Vet Centers are widely available and provide MST-related individual and group counseling, marital and family counseling, referral for benefits assistance, liaison with community agencies, and substance use information and referral. Vet Center counselors are fully trained and licensed mental health professionals who are clinically experienced in treating psychological trauma and associated issues such as anxiety, depression, and substance abuse. Vet Center Client Records are maintained independent of, and governed by, policies different than VA's medical facility records. They are thus completely confidential and unable to be shared with DoD without the permission of the Servicemember. This is in contrast to VA medical facility records, which are available to DoD providers via VA-DoD open record sharing. We further note there are some technical concerns with this section, such as the reference to section 1720D(a)(1) in section 6(b)(1), and we would be happy to work with the Committee to address these concerns.

Benefit costs associated with section 4 are estimated to be \$272.6 million in 2020, \$3.6 billion over five years, and \$9.7 billion over ten years. In addition, significant administrative costs are associated with implementing the benefits proposed in this bill.

Looking Ahead

VA is grateful for the support of this committee and the ongoing efforts of this Congress and OIG in enhancing claims processing, treatment, and outreach for Veterans who have experienced MST.

We will continue to explore other ways to improve and supplement training and outreach for MST-related claims. We have internalized the actions initiated in response to the VA OIG report recommendations to ensure that robust training and quality systems remain in place for MST-related claims and the entire claims process. I look forward to continuing to work with the committee on initiatives to improve the Veteran experience with VA.

Conclusion

The number one priority of VBA is to provide Veterans with the benefits they have earned in a manner that honors their service. Due to the sensitive nature of the events that caused conditions related to MST, VBA must provide compassionate assistance to affected Veterans in gathering evidence necessary to complete their claims. To that end, VBA has ensured these claims are processed by highly skilled and experienced employees who receive specialized training on MST claims, engaged in comprehensive action to improve outreach, and committed to sustaining and enhancing these developments moving forward.

This concludes my testimony. I would be happy to address any questions from Members of the Committee.

Prepared Statement of Elizabeth A. Tarloski, Esq.

I would like to begin by thanking the Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs for inviting me to speak on this important issue.

I currently serve as a staff attorney and adjunct professor at the Lewis B. Puller, Jr. Veterans Benefits Clinic at William and Mary Law School and I am submitting this testimony in my individual capacity. The clinic assists veterans in filing and appealing disability claims and focuses on complex claims involving Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), as well as mental health claims based on Military Sexual Trauma (MST). I regularly work with veterans to gather evidence in support of MST-related claims, and appeal decisions that deny them benefits.

I support H.R. 1092 because it would put veterans who have experienced MST on equal footing with other veterans who have non-personal trauma PTSD claims. The VA's own internal manual sets forth the following: "If a claimed stressor is not related to combat, experience as a former prisoner of war, fear of hostile military or terrorist activity, or drone aircraft crew member duties, a claimant's lay testimony regarding in-service stressors is not sufficient, by itself to establish the occurrence of the stressor, and must be corroborated by credible supporting evidence."¹ This creates an unfair burden on veteran survivors of MST that many other veterans who suffer from PTSD do not bear.

The VA has repeatedly said that it has "lowered the burden" of evidence required to substantiate a claim for PTSD related to personal trauma, which includes MST claims. The current standard allows for the submission of "markers" to be submitted as supporting evidence that the in-service stressor occurred. The VA allowed for the use of additional evidence starting in 2002, and it issued a description of markers that could be used as evidence in 2012. But the supposed lowered burden is not much different from the previous standard because documentation is still required. H.R. 1092 would allow a veteran's own testimony to be used to establish the occurrence of a stressor and would not require the additional burden of markers from records that may no longer exist.

Markers divide into two major categories: (1) alternative sources of evidence, and (2) behavioral changes. Alternative sources of evidence can include records of visits to medical facilities, police reports, or statements from chaplains. Behavioral changes can include substance abuse issues, episodes of depression and anxiety, and changes in performance while in the military.²

With the current standard, the VA acknowledges that records of assaults and harassment are often unavailable because of barriers veterans face in reporting during service. Even so, the VA requires veterans to produce other documentation, such as medical records, to show proof of behavioral changes that may indicate that an MST event occurred. Indeed, multiple studies have shown that there are many barriers

¹ VA ADJUDICATION PROCEDURE MANUAL M21-1, Pt. III(iv), Ch. 4, ¶ O(g), <https://www.knowva.ebenefits.va.gov/system/templates/selfservice/va--ssnew/help/customer/locale/en-US/portal/55440000001018/content/554400000076270/M21-1,-Part-III,-Subpart-iv,-Chapter-4,-Section-O---Mental-Disorders#4f> (last updated Oct. 19, 2018) (emphasis added).

² VA ADJUDICATION PROCEDURE MANUAL M21-1, Pt. III(iv), Ch. 4, ¶ O(d)-(e), <https://www.knowva.ebenefits.va.gov/system/templates/selfservice/va--ssnew/help/customer/locale/en-US/portal/55440000001018/content/554400000076270/M21-1,-Part-III,-Subpart-iv,-Chapter-4,-Section-O---Mental-Disorders#3d> (last updated Oct. 19, 2018).

faced by veterans not only to reporting MST in service, but also seeking health-care, or discussing the sexual assault or harassment post-service.³

In addition to the reluctance of veterans to report or discuss sexual assault or harassment, the absence of records and the passage of time adds to the difficulty of finding evidence of markers. In my practice, it is not uncommon for my veteran clients to wait years, sometimes decades before filing MST/PTSD claims. Private medical records are usually destroyed after only 5 to 10 years and when military records do exist, it can take veterans-or those helping them-over a year just to receive a copy of those records. Further, those in-service medical and personnel records often contain thousands of pages and can include handwritten, hard to read medical notes. Sifting through these records to determine what may be considered a marker is difficult, confusing, and time intensive.

Older veterans, who may not have electronic access to records, are additionally burdened. The stigma of military sexual trauma, while it is now lessening, is still salient. This is even more true for veterans of past eras. Requiring veterans, who may never before have disclosed trauma, to provide documentation of markers is unreasonable and infeasible for many, especially because that documentation may no longer exist.⁴

Not only is this a higher burden for older veterans, male veterans are also negatively affected by the current standard. Men are less likely to report sexual assaults in the military, and they are generally less likely to disclose MST and seek mental health treatment after service.⁵ The 2018 Department of Defense annual report on sexual assaults notes that only 17% of men who have experienced sexual assaults report them in the military, compared to 38% of women.⁶ Therefore, while the percentage of women who experienced sexual assault in the military, compared to men, has recently increased overall, men are both more likely to be forced into depending on the markers standard and less likely to have documented post-service medical evidence that could serve as a marker.⁷

By allowing veterans' lay statements to establish the occurrence of the stressor, as it does in cases of PTSD related to combat or fear of hostile military or terrorist activity, the VA would be recognizing the trauma and burden imposed on veterans by the requirement of marker evidence. The current standard reinforces victim-blaming and rape myths and as a result, veterans may be reluctant to reapply for benefits after receiving denials in decision letters that offer little to no explanation. The process can be stressful for veterans because it forces them to relive trauma, and the process of submitting a claim can result in undue stress and confusion.⁸ When the VA erroneously denies an MST claim, a veteran is essentially being told that the event did not happen, fulfilling the worst fear of many MST survivors: that they will not be believed.

H.R. 1092 also allows for the expansion of mental health diagnoses, beyond PTSD, to be included in the proposed standard. Trauma manifests in different ways for different people and the effects of conditions such as depression and anxiety can be crippling and harmful to our veterans. Including other mental health conditions in the proposed bill is a much-needed addition and will go a long way in recognizing that veterans are impacted and suffer in different ways beyond just PTSD. The cur-

³J. A. Turchik, C. McLean, S. Rafie, T. Hoyt, C. S. Rosen, & R. Kimerling, Perceived barriers to care and provider gender preferences among veteran men who have experienced military sexual trauma: A qualitative analysis, 10 PSYCHOLOGICAL SERVICES, 213 (2013) (available at <http://dx.doi.org/10.1037/a0029959>).

⁴U.S. GOVT ACCOUNTABILITY OFF., GOA-14-477, MILITARY SEXUAL TRAUMA: IMPROVEMENTS MADE BUT VA CAN DO BETTER TO TRACK AND IMPROVE THE CONSISTENCY OF DISABILITY CLAIM DECISIONS, 22 (2014), <https://www.gao.gov/assets/670/663964.pdf>. ("[R]epresentatives from four of five veteran advocacy organizations we interviewed expressed concern that the requirement to substantiate an MST incident is still difficult to meet for many with valid claims. Some of these representatives said that even markers can be difficult to find or may not exist, since veterans may have initially tried to hide their experience due to fear of reprisal or feelings of shame or embarrassment, among other reasons.")

⁵See Mental Health After Military Sexual Trauma, U.S. DEPT OF VETERANS AFFAIRS, <https://www.publichealth.va.gov/exposures/publications/oef-oif-ond/post-9-11-vet-fall-2016/mst.asp> (last visited June 17, 2019).

⁶This is supported by the most recent data released by the 2018 Department of Defense report on sexual assault, DEPT OF DEFENSE, ANN. REP. ON SEXUAL ASSAULT IN THE MIL., 3 (2018), <https://www.sapr.mil/sites/default/files/DoD-Annual-Report-on-Sexual-Assault-in-the-Military.pdf>. Overall, an estimated 20,500 service members, representing about 13,000 women and 7,500 men, experienced some type of contact or penetrative sexual assault in 2018. *Id.* This is up from approximately 14,900 in 2016. *Id.*

⁷*Id.* at 4.

⁸DEPT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL, 17-05248-241, DENIED POSTTRAUMATIC STRESS DISORDER CLAIMS RELATED TO MIL. SEXUAL TRAUMA, 9 (2018), <https://www.va.gov/oig/pubs/VAOIG-17-05248-241.pdf>

rent standard does not even allow for the use of markers for mental health diagnoses other than PTSD. For veterans claiming other mental health conditions related to MST, such as anxiety or depression, this creates an almost impossible standard to meet unless a stressor event was reported in service or they received mental health treatment in service.

Potential fixes within VA employee trainings, while helpful, would still not fully address the heavy burden that the markers standard places on veterans. Even if the VA did in fact address inconsistencies in the adjudication of MST claims, as proposed in the 2014 Government Accountability Office (GAO) report and 2018 Inspector General report, the high amount of subjectivity remains. The 2014 GAO report noted that two VA claims adjudicators could come to entirely opposite conclusions about a marker, and that both could be considered correct under the current VA standard.⁹ The burden to find what the VA deems to be credible supporting evidence is difficult enough for professional claims adjudicators, let alone veterans.¹⁰

By definition, MST includes not only assaults, but harassment as well. MST is defined as “psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training.”¹¹

From this definition, it is clear that there are additional requirements for service-connecting a PTSD claim resulting from MST beyond proving an in-service incident occurred. These additional requirements remain in the proposed changes. Medical evidence must establish a link between a veteran’s current symptomatology and the claimed in-service stressor, and a diagnosis by a psychologist or psychiatrist is still required in H.R. 1092. For the VA, however, this is not enough.

Changing the burden of evidence will assist those veterans who do decide to submit a claim and this change would likely expedite the processing of MST claims and lead to fewer appeals. Allowing for the submission of lay evidence from veterans, as proposed by H.R. 1092, would lessen the psychological burden on veterans and create a more streamlined process for claims adjudicators.

In summary, the current standard for proving an MST-related PTSD claim is overly burdensome on veterans. It forces them to determine what a marker could be and to scour records, if they still exist, to prove to the VA that a traumatic event has taken place. The wounds associated with PTSD and MST are not always visible, and many veterans will go decades without disclosing the trauma to anyone, including medical health professionals. While the VA may claim to have “lowered” the standard of proof in MST-related PTSD cases, these changes have had the chief effect of burdening veterans who are submitting these claims. The reforms contained in H.R. 1092 require the VA to listen to veterans and are a much-needed step in the right direction.

Prepared Statement of Shane L. Liermann

Chairwoman Luria, Ranking Member Bost, and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today’s hearing on “Ensuring Access to Disability Benefits for Veterans Survivors of Military Sexual Trauma (MST).”

DAV is a congressionally chartered national veterans’ service organization of more than one million wartime veterans, all of whom were injured or made ill while serving on behalf of this nation.

To fulfill our service mission to America’s injured and ill veterans and the families who care for them, DAV directly employs a corps of more than 260 National Service Officers (NSOs), all of whom are themselves wartime service-connected disabled veterans, at every VA regional office (VARO) as well as other VA facilities throughout the nation. Together with our chapter, department, transition and county veteran service officers, DAV has over 4,000 accredited representatives on the front lines providing free claims and appeals services to our nation’s veterans, their families and survivors. We represent over one million veterans and survivors, making DAV the largest veterans service organization (VSO) providing claims assistance.

As a DAV Service Officer for nearly twenty one years, I have personal experience in representing thousands of veterans in claims and appeals, including MST-related claims, before four different VA Regional Offices and the Board of Veterans’ Ap-

⁹ U.S. GOVT ACCOUNTABILITY OFF., *supra* note 3, at 17–18.

¹⁰ See *id.*

¹¹ 38 U.S.C. § 1720D (2019)

peals. Based on this collective experience, our testimony will discuss DoD's recent annual report on military sexual trauma, VA's claims process for MST-related claims and its persistent inability to properly train, develop, and adjudicate claims for PTSD based on MST, and the impact that H.R.1092, the Servicemembers and Veterans Empowerment and Support Act of 2019, would have on MST-related claims.

DoD'S 2018 ANNUAL MILITARY SEXUAL TRAUMA REPORT

Madame Chair, military sexual trauma has become an all-too-common experience for women and men who serve in our armed forces. According to DoD's 2018 annual report, sexual assault was experienced by 6.2 percent of women and 0.7 percent of men in military service during the preceding 12 months. However, the number of men and women experiencing MST are nearly equal. Significant growth in this rate among women has occurred in every service branch, with the highest prevalence rate in the Marine Corps (10.7 percent) and the lowest rate in the Air Force (4.3 percent). Men are also affected by the experience, but growth in the prevalence rates is more contained.

Sexual harassment occurs even more frequently than assault. Almost a quarter of service women (24.2 percent) and 6.3 percent of men indicated that they had experienced it. Sadly, 20 percent of service women and about eight percent of men who experience harassment also experienced assault. This indicates that units with significant numbers of service members reporting sexual harassment may be workplaces with climates that seem to sanction sexual assault to perpetrators.

Despite the feelings of pain, fear, shame, embarrassment and betrayal that many survivors feel after being sexually attacked, rates of reporting the assault are growing from 1 out of 14 in 2006 to 1 out of 3 of those service members who experienced assault reporting it to a DoD authority in 2018.

DoD has also learned that survivors' fears of retaliation for reporting are real. Twenty-one percent of service members who reported an incident of assault reported experiencing actions that meet the legal definition of retaliatory behavior. Unfortunately, this justified fear of reporting incidents of sexual assault and harassment has compounding effects for survivors who often forego the care and treatment they require.

DAV's 2018 report, *Women Veterans: The Journey Ahead*, which examines the challenges women veterans face, detailed the story of member and Navy veteran, Leeia Isabelle, who, like so many MST survivors, did not report the crime against her claiming she wanted to "bury it and make it go away."

"I was just going through the motions and I wasn't really fully engaged in my life," she reported. Seeing the effects of MST on her relationships motivated her to begin the long road to recovery for which she credits VA group therapy with other women veterans, cognitive behavioral therapy, and local involvement with DAV.

Ms. Isabelle's story is typical of many veterans with post-traumatic stress disorder. Symptoms include numbness, hypervigilance, irritability, and lack of interest in the people or activities that once brought them joy. These changes can strain relationships, threaten employment, and isolate them from their families and communities.

When these incidents are not reported to military authorities, it complicates VA's current process for establishing service-connection for PTSD related to personal assault. Although current regulations do not require verification of the incident, it does require corroboration, thus unreported incidents in the military can frustrate MST survivors in the existing claims process.

VA CLAIMS PROCESSING FOR PTSD BASED ON MST AND 38 C.F.R. 3.304(F)(5)

Currently, claims based on PTSD are not codified, but rather controlled by VA regulations, 38 C.F.R. 3.304(f). These regulations require a diagnosis of PTSD, and in most instances, a verified stressful event in service, and a medical opinion linking the diagnosis to the stressful event in service.

Specifically for MST-related or assault based PTSD claims, in 2002, 38 C.F.R. 3.304(f)(5) was added to explain the requirements for PTSD based on personal assault and notes that verification of the stressful event is not required, only corroboration.

It provides, "if a posttraumatic stress disorder claim is based on in-service personal assault, evidence from sources other than the veteran's service records may corroborate the veteran's account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests

or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy. Evidence of behavior changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavior changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes. VA will not deny a posttraumatic stress disorder claim that is based on in-service personal assault without first advising the claimant that evidence from sources other than the veteran's service records or evidence of behavior changes may constitute credible supporting evidence of the stressor and allowing him or her the opportunity to furnish this type of evidence or advise VA of potential sources of such evidence. VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred."

This means that PTSD claims based on MST do not require survivors to have absolute verification of the incident, only corroboration. This is a lower threshold that differs from other PTSD related claims. However, the Veterans Benefits Administration (VBA) has persistent and systemic problems implementing this regulation. VBA has shown its inability to properly train, develop, and adjudicate claims for PTSD based on MST, as evidenced by the numerous reports of the VA Office of the Inspector General (OIG) and the United States Government Accountability Office (GAO).

December 2010 OIG Report

The December 16, 2010, OIG report, *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits*, found differences in VBA's denial rates among male and female veterans' claims for PTSD or for other mental health conditions. Specifically, VBA denied female veterans at a higher rate than male veterans for PTSD. The report estimated that VBA denied 49.8 percent of female veterans compared to 37.7 percent of male veterans who applied for PTSD disability compensation.

The 2010 report further revealed that none of the regional offices visited had specialized workgroups dedicated to processing MST-related claims. The report concluded that VBA had not assessed the feasibility of implementing MST-specific training and testing for claims processors who work on MST-related claims because it has not analyzed available data on its MST-related workload and how consistently these claims were adjudicated.

May 2011 OIG Report

In the OIG report of May 18, 2011, *Systemic Issues Reported During Inspections at VA Regional Offices*, it was noted that 50 percent of the VAROs reviewed did not follow VBA policy when processing PTSD claims. OIG projected VARO staff did not correctly process about 1,350 (8 percent) of approximately 16,000 PTSD claims completed from April 2009 through July 2010. This generally occurred because VARO staff lacked sufficient experience and training to process these claims accurately. Additionally, some VAROs were not conducting monthly quality assurance reviews. For these reasons, veterans did not always receive accurate benefits.

VBA Subsequent Actions

Starting in 2011, VBA began directing VAROs to designate MST specialists from among their adjudicators with experience processing complex claims. This was designed to improve adjudicator adherence to processing requirements for MST-related claims. The purpose of specialization was to allow regional offices to identify staff with the appropriate skills and sensitivity and afford specialists the opportunity to hone their knowledge of the MST requirements over many claims.

Subsequently, VBA developed additional guidance and training for MST specialists. Specifically, in late 2011, the agency issued a guidance letter and rolled out 1.5-hour and 4-hour training sessions on how to process PTSD claims related to MST. VBA also rolled out a one-hour training session on sensitivity in June 2011. All MST specialists were required to take each course once. With regard to medical examiners who conduct exams for MST-related claims, during this period, VHA instituted comparatively limited training.

Recognizing the systemic problems processing MST claims, in April 2013, VBA sent 2,667 notification letters to veterans whose PTSD claims related to MST were denied between September 2010 and April 2013. VBA advised the veterans to resubmit previously denied PTSD claims related to MST. The initiative was designed to correct any development errors that had occurred before VBA undertook its specialization and training initiatives.

June 2014 GAO Report

In June 2014, GAO released its report, *Military Sexual Trauma: Improvements Made, but VA Can Do More to Track and Improve the Consistency of Disability Claim Decisions*. The report concluded that in contrast to VA's actions to date, which largely have been taken in response to external requests, a more proactive and systematic approach could further dispel confusion among adjudicators and examiners, identify errors, and inform veterans of opportunities to resubmit denied claims. The GAO report recommended the Under Secretary for Benefits (USB) undertake a number of actions:

- Expand existing training and guidance to adjudicators responsible for MST-related claims by, for example, providing mandatory refresher courses or regularly distributing examples of relevant errors identified from quality assurance reviews.
- Develop a plan for conducting more comprehensive quality reviews of MST-related claims that allows the agency to identify problem areas, target improvement efforts, and track performance over time.
- Further analyze existing data on MST-related claim decisions by, for example, determining approval rates by regional office and veteran gender.
- Explore ways to systematically collect additional data on MST-related claims that might allow the agency to better track consistency. Such data could include reasons for denials, whether claim evaluations included a medical exam, and how often related medical exam reports are returned to VHA for clarification or deemed insufficient.
- Expand outreach to veterans who are eligible to resubmit their previously denied PTSD claims related to MST. The agency should conduct this outreach in partnership with the Veterans Health Administration or external organizations, such as veteran service organizations

August 2018 OIG Report

On August 21, 2018, VA OIG published its findings on *Denied Post-traumatic Stress Disorder Claims Related to Military Sexual Trauma*. The OIG report team found that VBA staff did not always follow VBA's policy and procedures, which may have led to the denial of veterans' MST-related claims.

The review team found that VBA staff did not properly process veterans' denied MST-related claims in 82 of 169 cases. As a result, the OIG estimated that VBA staff incorrectly processed approximately 1,300 or 49 percent of the 2,700 MST-related claims denied during that time. Due to the severity and volume of these errors, VA OIG recommended that VBA review all denied MST-related claims since the beginning of FY 2017 and reopen the cases with errors to ensure veterans receive accurate claims decisions as well as better customer service.

In reviewing the MST-related claims denied by VBA, the review team found that staff did not follow the required claims processing procedures. The most commonly encountered errors in processing were:

- Evidence was enough to request a medical examination and opinion, but staff did not request one;
- Evidence-gathering issues existed, such as Veterans Service Representatives (VSRs) not requesting veterans' private treatment records;
- MST Coordinators did not make the required telephone call to the veteran, or VSRs did not use required language in the letter sent to the veteran to determine whether the veteran reported the claimed traumatic event in service and to obtain a copy of the report; and
- Rating Veterans Service Representatives (RVSRs) decided veterans' claims based on contradictory or otherwise insufficient medical opinions.

The reasons MST-related claims were incorrectly processed were due to lack of previous specialization, lack of additional level of review, discontinued special focused reviews and inadequate training.

VBA previously implemented the Segmented Lanes model, which required VSRs and RVSRs on Special Operations teams to process all claims VBA deemed highly complex, as well as sensitive issues such as MST-related claims. The OIG review team concluded that staff on the Special Operations teams developed subject matter expertise on these highly sensitive claims due to focused training and repetition. Under the National Work Queue (NWQ), VBA no longer utilized the Special Operations teams. Under this new model, the NWQ distributed claims daily to each VARO and the VARO determined the distribution of MST-related claims.

As a result, MST-related claims were processed by any VSR or RVSR, regardless of their experience and expertise. The OIG review team determined VSRs and

RVSRs that did not specialize, lacked familiarity and became less proficient at processing MST-related claims.

VARO staff suggested VBA reestablish specialized processing, allowing employees to develop the necessary expertise to ensure consistency and accuracy in processing these sensitive claims. The Deputy Under Secretary for Field Operations agreed that dedicated staff working MST-related claims would help improve the quality of claims processing.

VBA currently requires an additional level of review for some types of complex claims, such as traumatic brain injury cases, but does not require this additional level of review for MST-related claims. RVSRs, quality review personnel, and supervisors interviewed at the four VAROs visited generally thought an additional level of review would be helpful and could improve accuracy. The Deputy Under Secretary for Field Operations and Compensation Service Quality Assurance personnel agreed that an additional level of review would help improve the accuracy of processing MST-related claims.

The national Systematic Technical Accuracy Review (STAR) team for Compensation Service and the Quality Review Teams (QRT) at each VARO execute VBA's quality assurance programs. MST-related claims are included in the STAR and QRT claim reviews. However, MST-related claims are only a small percentage of the overall claim volume and are less likely than other claim types to be randomly selected for STAR and QRT reviews. Therefore, STAR and QRT staff did not frequently review them.

STAR staff completed special focused quality improvement reviews of MST-related claims beginning in 2011, based on the deficiencies identified in a 2010 OIG report related to combat stress in women veterans. These reviews continued based on a 2014 Government Accountability Office (GAO) report on MST-related claims that found the problems persisted. Staff performed the reviews twice a year and identified errors like those this OIG review team found, such as missed evidence or markers and failure to request necessary medical examinations.

The STAR office stopped completing special focused quality improvement reviews of MST-related claims in December 2015. VBA's Quality Assurance Officer indicated the STAR office stopped performing special focused quality improvement reviews because it had met the GAO requirement. The Assistant Director of Quality Assurance for Compensation Service also stated that they reallocated resources towards other areas because the error rate declined for MST-related claims from 2011 to 2015.

Given the high error rate identified during its review, the OIG review team determined the STAR office should reinstate special focused quality improvement reviews of MST-related claims.

Compensation Service delivered MST training through four modules using VBA's online training management system. The MST-related claims training was one-time only and there was no requirement for annual refresher training.

The OIG report concluded their report with six recommendations:

- 1.The Under Secretary for Benefits reviews all denied MST-related claims since the beginning of FY 2017, determines whether all required procedures were followed, takes corrective action based on the results of the review, renders a new decision as appropriate, and reports the results back to the Office of Inspector General.

- 2.The Under Secretary for Benefits focuses processing of MST-related claims to a specialized group of VSRs and RVSRs.

- 3.The Under Secretary for Benefits requires an additional level of review for all denied MST-related claims and holds the second-level reviewers accountable for accuracy.

- 4.The Under Secretary for Benefits conducts special focused quality improvement reviews of denied MST-related claims and takes corrective action as needed.

- 5.The Under Secretary for Benefits updates the current training for processing MST-related claims, monitors the effectiveness of the training, and takes additional actions as necessary.

- 6.The Under Secretary for Benefits updates the development checklist for MST-related claims to include specific steps claims processors must take in evaluating such claims in accordance with applicable regulations, and requires claims processors to certify that they completed all required development action for each MST-related claim.

VBA responded to the OIG recommendations and indicated the target dates for implementation. At the time of this testimony, VBA has complied with recommendations number two and six. VBA responded in reference to recommendation number

three and advised that a second level review was only completed by local quality review and requested the issue to be closed. However, the OIG has indicated their recommendation was not for a peer review but a second tier review to include Quality Review. The other recommendations are still considered pending as they were assigned target dates in the near future.

As noted by the several OIG reports and the GAO report, VA has persistently and improperly developed and adjudicated PTSD claims related to MST. The reasons MST-related claims were incorrectly processed were due to lack of previous specialization, lack of additional level of review, discontinued special focused reviews and inadequate training. These problems have continued since first identified in 2010. After nine years of incorrect processing, it becomes paramount to establish unrelenting congressional oversight and implementation of all of the OIG recommendations to alleviate VA's systemic problem with PTSD claims related to MST.

SERVICEMEMBERS & VETERANS EMPOWERMENT & SUPPORT ACT OF 2019

As we have indicated above, it is necessary for Congress to take legislative action and codify H.R. 1092, the Servicemembers and Veterans Empowerment and Support Act of 2019. It would essentially codify several parts of 38 C.F.R. 3.304(f)(5) but also would add other mental health conditions, in addition to PTSD, as being related to MST. This is a significant change over the current regulatory provision that only considers PTSD as a related mental health condition.

The legislation would require the Secretary to accept as sufficient proof of service-connection a diagnosis of such mental health condition by a mental health professional together with satisfactory lay or other evidence of such trauma and an opinion by the mental health professional that such covered mental health condition is related to such military sexual trauma, if consistent with the facts of such service, notwithstanding the fact that there is no official record of such incurrence or aggravation in such service. It also requires the Secretary to resolve every reasonable doubt in favor of the veteran.

The bill would also add technological abuse, defined as behavior intended to harm, threaten, intimidate, control, stalk, harass, impersonate, or monitor another person, that occurs via the Internet, through social networking sites, computers, mobile devices to the types of trauma and resulting conditions for which survivors may seek both benefits and health care.

H.R. 1092 would require VA to re-establish specially trained teams to adjudicate MST-related claims for mental health conditions. We appreciate the role of the NWQ; however, as was found by the OIG, the removal of the specially trained teams for MST claims was part of the improper claims processing.

Finally, the bill would require VBA to report MST claims annually to Congress to ensure that these claims are adjudicated equitably. We believe this congressional oversight is required given the nine-year history of processing failures.

This bill is consistent with DAV Resolution No. 042, which calls for VA to conduct rigorous oversight of adjudication personnel who are responsible for evaluating disability claims associated with military sexual trauma and review of data to ensure existing policies are being faithfully followed and standardized in all VA regional offices.

In conclusion, DoD's recent annual report on military sexual trauma clearly notes the continuing problem with sexual trauma in the military including the substantial under reporting by the survivors of the trauma. As demonstrated, since the inclusion of personal assault provisions in 2002, VA has struggled to properly train, develop, and adjudicate claims for PTSD based on MST. It is time for decisive congressional action to alleviate VA's systemic problem with PTSD claims related to MST and pass H.R.1092, the Servicemembers and Veterans Empowerment and Support Act of 2019.

Madame Chair, this concludes my testimony on behalf of DAV. I would be happy to answer any questions you or other members of the Subcommittee may have.

Prepared Statement of Sharyn J. Potter, PhD, MPH

Chair Luria, Ranking Member Bost, Representatives Kuster and Pingree and Subcommittee Members,

I am honored to testify today. My name is Sharyn Potter, I am a professor of sociology and executive director of research at the Prevention Innovations Research Center at the University of New Hampshire. I have spent the better part of the last 20 years developing, administering, and evaluating sexual violence prevention and

response strategies. The focus of my recent work has been the economic impact of sexual assault. My research shows the devastating cost of sexual violence and its catastrophic impact on victims' health, education, and career trajectories. One participant we interviewed described the sexual assault perpetrated against her as the "bomb that shattered everything" as no part of her life was left intact following the assault (Potter et al. 2018).

House Bill 1092 will amend the evidentiary standards that veterans need to prove in-service Military Sexual Trauma (MST) providing an easier path for veterans to prove they suffered MST, making them eligible to receive disability benefits. Under House Bill 1092 the Department of Veteran Affairs will be able to accept secondary markers, including behavior changes, requests to transfer, reporting to a friend, or obtaining testing for pregnancy or sexually transmitted infections. These secondary markers are well documented in the research as legitimate substantiation of victimization and will support veterans' claims of MST, facilitating their ability to receive disability benefits for MST.

Additionally, the proposed bill's inclusion of technological abuse is critical for addressing the increasing prevalence of technology as a tool for perpetrators. While I have developed a technology application that assists victims, I have also seen how the technology we use every day is used by perpetrators to isolate, control, scare and intimidate victims, adversely affecting victims' daily lives.

The proposed bill would provide economic assistance to veterans suffering from MST. In the 2018 Department of Defense Annual Report on Sexual Assault in the Military, 0.7% of enlisted men and 6.2% of enlisted women reported an assault. In other words, approximately 7,500 active duty military men and 13,000 women were sexually assaulted in 2018. However, only one-third of these victims reported the assault to a Department of Defense authority. The low reporting rates are consistent with research on colleges and workplaces. There are many sound reasons victims choose not to report, including fear of jeopardizing their careers, retaliation, and shame. Furthermore, the Office of Inspector General (OIG) found that, of the incidences that were reported, nearly half of denied MST-related claims were not properly processed following Veterans Benefits Administration (VBA) policy (Department of Veterans Affairs, Office of Inspector General, 2018).

The mental and physical health consequences that MST victims suffer in the aftermath of sexual assault, including drug abuse and suicide, are well documented in the research (Office of Women's Health, 2019), as are the long-term health impacts (Thurston, Chang, & Matthews, 2019). Additionally, victims face substantial impediments to completing their education and meeting their career goals, further undermining their economic success. A non-representative study of campus sexual assault victims, ages 24 to 65 years at the time of the study, highlights the economic and human-capital losses: One-third of the participants never finished college, over half took longer than normal to earn a degree, and many recounted serial low-wage jobs with limited health-care coverage (Potter, 2018; Potter, Howard, Murphy, & Moynihan, 2018).

Centers for Disease Control and Prevention researchers estimate the measureable costs (e.g., medical care costs, lost productivity) per rape victim are \$122,461, while the life time societal cost for 25 million U.S. rape victims is approximately \$3.1 trillion dollars (valued in 2014 dollars) (Petersen et al., 2017).

In my research, I have interviewed both veterans and civilians who were sexually assaulted as they pursued their military careers and their education. Many of these survivors describe the spectrum of long-term health impacts and how these health problems hinder their ability to maintain stable employment. Sexual trauma victims are often triggered or re-traumatized by workplace incidents, including being alone in an office or dealing with an inappropriately behaving boss, client, or customer. These are factors that employees who have not suffered sexual trauma acknowledge, but which usually do not cause them to leave their positions.

When people transition in and out of the workplace or rotate among low wage positions, they face economic instability, posing challenges in their ability to obtain food, housing, transportation and health care. Access to disability benefits will reduce the veteran's MST burden, allowing them to attain medical assistance and financially support themselves and their families.

Victims of MST suffer unimaginable personal and financial loss. Further, the significant societal costs of not treating MST include drug addiction, homelessness, and incarceration. In a recently published study, researchers found that veterans who were victims of MST were 50% more likely to be homeless 30 days, 1 year, and 5 years after their discharge date when compared to veterans who did not suffer MST (Brignone et al., 2016).

Finally, in a review of the research on MST, compared to female veterans who were victims of MST, male veterans who suffered MST reported higher rates of sui-

cide, alcohol abuse, and other psychiatric health problems (Suris & Lind, 2008). Yet, providing help for male veterans who are victims of MST poses unique challenges, as military culture expects men “to be hypermasculine, and physically strong,” (Turchik et al., 2013, p. 214). Therefore, male victims of MST are less likely than their female counterparts to report and seek treatment (Eckerlin, Kovalesky, & Jakupcak, 2016), exacerbating the impact of the MST in all areas of the veteran’s life (e.g., health, relationships, work).

Veterans who have suffered active duty injuries from an explosion or vehicle crash are eligible for disability benefits. However, the shame of being a victim of MST prevents the majority of active duty men and women from coming forward. Yet, we know that when MST victims receive help, even belatedly - their lives, the lives of their families, and our society are improved.

Amending evidentiary standards in claims for compensation for MST-induced psychological trauma is critical in supporting our service members who have suffered sexual assault while serving their country. Thank you.

References:

Brignone, E., Gundlapalli, A. V., Blais, R. K., Carter, M. E., Suo, Y., Samore, M. H., Fargo, J. D. (2016). Differential risk for homelessness among us male and female veterans with a positive screen for military sexual trauma. *JAMA Psychiatry*, 73(6), 582-589. doi: 10.1001/jamapsychiatry.2016.0101

Department of Veterans Affairs, Office of Inspector General. (2018). Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma. Retrieved from website: <https://www.va.gov/oig/pubs/VAOIG-17-05248-241.pdf>

Eckerlin, D. M., Kovalesky, A., & Jakupcak, M. (2016). Military sexual trauma in male service members. *American Journal of Nursing*, 116(9), pages unavailable. doi: 10.1097/01.NAJ.0000494690.55746.d9

Office on Women’s Health. (2019). Effects of violence against women. Retrieved from website: <https://www.womenshealth.gov/relationships-and-safety/effects-violence-against-women>

Peterson, C., DeGue, S., Florence, C., & Lokey, C. (2017). Lifetime economic burden of rape in the United States. *American Journal of Preventive Medicine*, 52(6), 691–701. <https://doi.org/10.1016/j.amepre.2016.11.014>

Potter, S. J. (2018). Why Society Can’t Afford Campus Sexual Violence. TEDxPortsmouth. <https://www.youtube.com/watch?v=JFgYreDQ25o>

Potter, S. J., Howard, R., Murphy, S., & Moynihan, M. M. (2018). Long-term impacts of college sexual assaults on women survivors’ educational and career attainments. *American Journal of College Health*, 66(6), 496–507. <https://doi.org/10.1080/07448481.2018.1440574>

Suris A., & Lind L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in Veterans. *Trauma, Violence, & Abuse*, 9(4), 250–269. <https://doi.org/10.1177/1524838008324419>

Thurston, R. C., Chang, Y., & Matthews, K. A. (2019). Association of Sexual Harassment and Sexual Assault with Midlife Women’s Mental and Physical Health. *JAMA Internal Medicine*, 179(1), 48–53. doi: 10.1001/jamainternmed.2018.4886

Turchik, J. A., McLean, C., Rafie, S., Hoyt, R., Rosen, C.S., & Kimerling, R. (2013). Perceived barriers to care and provider gender preferences among veteran men who have experienced Military sexual trauma: A qualitative analysis. *Psychological Services*, 10, 213–222. doi: 10.1037/a0029959

United States Department of Defense Sexual Assault Prevention and Response. (2018). The fiscal year 2018 annual report on sexual assault in the Military. Retrieved from website: <https://sapr.mil/reports>

STATEMENTS FOR THE RECORD

PROTECT OUR DEFENDERS

In an era where almost everyone is connected through some form of social or electronic media, men and women are at greater risk of experiencing virtual and electronic sexual harassment and assault. Never before have there been so many ways of perpetuating harassment. While not necessarily physical, crimes of a sexual na-

ture involving telephonic, electronic, and virtual communications or unpermitted access and tracking are no less harmful to one's psyche and mental well-being. Thus, Protect Our Defenders fully supports HR 1092 in expanding the coverage of VA counseling and treatment to include technological abuse of a sexual nature.

As President of Protect Our Defenders, I have spoken with numerous victims of this type of abuse. One such victim was, an officer in the Army who received hundreds of text messages from her commander, all of them unwanted, and many of them of a sexual nature. At first, the abuse manifested itself solely via electronic communications. However, the commanding officer escalated his abuse to the level of physical assault, which resulted in the victim fearing to go anywhere on base alone. The commanding officer continued to message her inappropriately, even after she told him on multiple occasions to stop.

In another instance, an officer's wife began receiving flirtatious messages via Facebook from her husband's superior officer. The harassment continued, and the victim was eventually ostracized by the unit.

In yet another instance, a woman's image was taken from her personal webpage and was manipulated to look like an advertisement for pornography. The perpetrators then disseminated the image over Facebook, made T-shirts bearing the image (which they then sold online), and began a smear campaign against her.

In each of these cases, the perpetrators utilized social media, text messaging or crowd-sharing mechanisms to abuse their victims. Each of these survivors were severely traumatized, expressed distrust in forming relationships or building online portfolios, and were mentally, emotionally, and physically exhausted from battling for justice. They also experienced debilitating depression, anxiety, and PTSD. While two of the three were never physically assaulted or harassed, they were all victims of MST and thus deserving of treatment.

We can also look to the national news for the impact of these cyber crimes. The recent Marines United scandal highlighted the pervasiveness of this conduct. The Facebook group consisted of over 30,000 members and became infamously known for the dissemination of intimate pictures of hundreds of women without their consent. Sadly, Marines United is just one example of a military-themed social media group engaged in this criminal activity. The outcry over Marines United was intense and justified. Before the Senate Armed Services Committee, Gen. Robert Neller asked the following: "Was it enough when Maj. Megan McClung was killed by an IED in Ramadi? Or Capt. Jennifer Harris was killed when her helicopter was shot down while she was flying blood from Baghdad to Fallujah Surgical? Or corporals Jennifer Parcell and Hallie Ann Sharat and Ramona Valdez all killed by the hands of our enemies? What is it going to take for you to accept these Marines as Marines?" What he didn't address in his testimony to Congress was the psychological damage that these crimes leave in their wake for the women and men whose privacy has been violated, whose identities have been tainted, and whose images will forever linger on who knows how many web pages, dark or otherwise. The scale of abuse is unmeasurable.

More often than not, crimes involving sexual assault and sexual harassment don't leave physical traces or evidence that an assault or a crime occurred. However, the impact may last a lifetime and often goes untreated. When left untreated, survivors face life altering consequences impacting their work and family lives. It was for these reasons, that it is critical that VA services be expanded to include victims of this scourge, and I urge you to pass HR 1092.

Col. Don Christensen, USAF (Ret.)
President, Protect Our Defenders

VIETNAM VETERANS OF AMERICA (VVA)

Submitted by

Kate O'Hare Palmer
Chair, Women Veterans Committee

Good morning, Madam Chairwoman Luria, Ranking Member Bost, and distinguished members of the Subcommittee on Disability Assistance and Memorial Affairs. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record regarding "Ensuring Access to Disability Benefits for Veterans Survivors of Military Sexual Trauma."

Since the founding of Vietnam Veterans of America in 1978, we have been working with Congress to address the unmet needs of our veterans and to ensure they

receive the health care and benefits they have earned by virtue of their service to our nation.

We have been at the forefront in advocating for expanded care for Military Sexual Trauma survivors. By the VA's own numbers, one in four females and one in one hundred males report a history of MST when screened by a health care provider at a VA facility, and these numbers only reflect the veterans who use the VA. In 2014, VVA worked with Senator Gillibrand and Service Women Action Network (SWAN) on the Military Justice Improvement Act of 2014. This Bill was accepted without a key component that we still support: the removal of the chain of command within the judicial process for military sexual trauma cases. The current SAPRO reports still show a lack of improvement in statistics regarding MST in our military academies and in our military forces.

CSP 579, Health Views: Health of Vietnam Era Veteran Women's Study is the only study that has looked at female active-duty members serving around the world, including those women who served in Vietnam during the Vietnam era. The prevalence of lifetime PTSD in these women was 27 percent; and the prevalence of partial PTSD in women serving in-country was 21 percent. The higher prevalence of PTSD for in-country women is not due to preservice trauma. Rather, the variables are related to age at enlistment (older age, a protector); service time (20+ years); wartime sexual discrimination/harassment; and performance.

Ten percent of women who served outside a war zone experienced 10 percent lifetime PTSD, and 50 percent of all women serving throughout the world reported a combination of exposure to sexual harassment and/or military sexual trauma.

It wasn't until 1980 that PTSD was added to the DSM III. In 1992, after a series of hearings on women veterans' issues, the VHA was first authorized to provide outreach and counseling for sexual assault to women veterans. Vietnam Veterans of America was involved in these hearings, and the issues facing women veterans were highlighted during the dedication of the Vietnam Women's Memorial 1993. The term "Military Sexual Trauma" was adopted by the VHA in 2003. Public Law 108-422, made the VA's provision of sexual trauma services a permanent benefit. Today, while DoD continues to implement programs to contain military sexual trauma and harassment, the data indicates that the population of sexually traumatized men and women who are under the care of the VHA is alarmingly large and suffers from substantial morbidity.

The Veterans Benefits Administration (VBA), and to a lesser extent, the National Cemetery Administration (NCA), have been less proactive than the Veterans Health Administration in targeting outreach to women veterans and in ensuring competency in managing claims filed by women veterans.

Today, women veterans have earned and are entitled to full health-care services, including care for gender-specific illnesses, injuries, and diseases as a result of their military service. However, the Veterans Healthcare Administration has yet to take sufficient action to address the effects of combat-related Post-traumatic Stress Disorder (PTSD) among America's women veterans. PTSD is a recurrent emotional reaction to a terrifying, uncontrollable, or life-threatening event. The symptoms may develop immediately after the event or may be delayed for years. How many veterans, male and female, who are diagnosed with Sexual Trauma and PTSD, are eligible for VA compensation? VVA urges this Subcommittee to request data from the Veterans Benefits Administration on how many woman veterans are being compensated for PTSD secondary to Sexual or Personal Trauma.

MILITARY SEXUAL TRAUMA

It has become clear in the last decade that sexual harassment and sexual abuse are far more rampant than what had been acknowledged by the military. Reported instances of sexual harassment and abuse represent only the tip of the proverbial iceberg. While we are pleased that both the Departments of Defense and Veterans Affairs seem now to be taking this seriously, finally explicitly acknowledging sexual trauma as a crime under the Uniform Code of Military Justice (UCMJ) in the Defense Authorization Act of 2005, there is still a long road to travel to change the current culture that conditions victims of sexual abuse to not report this abuse to authorities. VVA urges your colleagues on the House Armed Services Committee to ensure that penalties for military sexual trauma under the Uniform Code of Military Justice are enforced in all branches of the military, and to explore such mechanisms to achieve quality assurance on uniformity of enforcement, such as a worldwide Internet address and a nationwide toll-free number, that would be staffed by counselors 24/7 who are trained to effectively assist, counsel, and refer service members (or family members) who have been the victim of sexual assault. VVA believes that only by means of such a mechanism that is not dependent on local command can there be uniformity of quality assistance and equal application of justice.

Vietnam Veterans of America has been at the forefront of advocating for the needs of veterans of all genders since the Vietnam War. The number of women in the military has risen consistently since the two percent cap on their enlistment in the Armed Forces was removed in the early 1970s.

Since then, Congress has passed laws to ensure greater equity, safety, and provision of services for the growing number of women veterans in the VA system. However, these changes and improvements have not been implemented throughout the entire VA system. In some locations, women veterans are still experiencing significant barriers to adequate health care. As a result, VVA had asked former VA Secretary Shinseki to ensure senior leadership at all VA facilities and in each VISN be held accountable for making certain that women veterans receive appropriate care in an appropriate environment by appropriate staff. VVA also recommended that the Subcommittee and the Secretary seek guidance from the VA Center for Women Veterans and the VA Advisory Committee on Women Veterans, both of which have done considerable work and analysis of these issues.

In addition, VVA wrote to former Secretary Shulkin, requesting the implementation status of Section 402 for the Veterans Access, Choice, and Accountability Act of 2014 - P.L. 113-564, which expanded eligibility for care and services related to Military Sexual Trauma at VA medical facilities to active-duty service members. Active-duty service members would not be required to obtain referrals from the Department of Defense before seeking treatment at a VA facility for MST. This section would take effect on the date that is one year after the date of the enactment of this Act. In a 2014, Congressional Briefing Report for the 114th Congress, the VA wrote that its focus and priority is on efficient and effective implementation of this highly complex law. In this 2014 report, the VA stated collaboration had begun with Department of Defense Health Affairs to discuss the implementation of Section 402 of VACAA. Section 402 authorizes VA to provide MST-related health-care services to active-duty service members without a referral from TRICARE or a military treatment facility. This collaboration will require continued and close collaboration between VA and DoD. <https://www.va.gov/OCA/114th%20Congress%20Welcome%20Packet/114th-New-Member-Packet-Final-508-Version-for-Website.pdf> An article written in The Washington Post, "Trusted troops become accused of assault," by Craig Whitlock drew our attention to what the "Catch-22" members of the Armed Forces on duty status are subjected to in cases of sexual assault and trauma. More importantly, we see that the implementation of authorizations included in 38 US Code 1720D for VA "counseling and care and services" for these servicemembers, without a referral from the Department of Defense, is an immediate need for the health, wellbeing and safety of these survivors.

Madam Chairwoman, VVA has not seen any movement on the implementation of Section 402 of Public Law-113-564, since the law was signed, and we request that the VA provide the Subcommittee with a detailed timeline outlining what the VA has done to date to implement this section of the law.

In regards to H.R. 1092, Servicemembers and Veterans Empowerment and Support Act of 2019, introduced by Congresswoman Chellie Pingree, D-ME-1, the bill, when enacted into law, would amend Title 38, United States Code, to expand health care and benefits from the Department of Veterans Affairs for military sexual trauma and for other purposes. The inclusion of technological abuse is way past due. The risk of cyber harassment is prevalent for anyone who uses Facebook or similar social media platforms. It takes one tap to tag someone in a photograph, revealing both their location and behavior. Stalkers and harassers use such tactics to intimidate or shame their victims. If veterans have experienced sexual harassment, abuse, or bullying online, they may experience negative feelings or other mental or physical effects. This bill, which would add technological abuse defined as "behavior intended to harm, threaten, intimidate, control, stalk, harass, impersonate, or monitor another person, that occurs via the Internet, through social-networking sites, computers, mobile devices" to the types of trauma and resulting conditions for which survivors may seek compensation benefits and health care. VVA supports the bill as written.

VVA would like to thank Congresswoman Luria for her hard work and dedication to women veterans, and we thank this Subcommittee for the opportunity to submit our views for the record.

