Veterans Issues in the 105th Congress

Updated June 12, 1998

Dennis W. Snook
Specialist in Social Legislation
Education and Public Welfare Division

ABSTRACT

This report focuses on policies, programs, and benefits of interest to veterans. Included are discussions of issues before the 105th Congress, and the current status of major legislation. The report is updated from time-to-time to reflect developments in the issues and for actions taken on legislation important to veterans.

Veterans Issues in the 105th Congress

Summary

Veterans Affairs (VA) Budget and Appropriations. **P.L. 105-65** included $40.4 billion in FY1998 appropriations for VA programs. The FY1999 VA budget requests $42.8 for FY1999, and proposes that Montgomery GI benefits be increased by 20%, and compensation for certain Filipino veterans in the U.S. be increased to amounts for U.S. veterans. The Senate Budget Resolution assumes the requested level. The estimates include $560 million in nonappropriated funds collected from insurers of veterans to offset some of VA's costs for their health care. The Balanced Budget Act of 1997, **P.L. 105-33** approved language for VA to retain medical care cost recovery revenues rather than transfer the funds to the Treasury.

VA Medical Plans to Begin October 1, 1998. New VA regional health plans will administer all medical benefits as of October 1, 1998, but despite fears of some veterans, enrollment will be fairly easy, and can be done whenever they seek care.

Medicare Subvention. Congress gave VA authority to seek reimbursement for some of its costs, and recycle those funds into further care. One additional idea would combine Medicare benefits for certain veterans with their enrollment in VA health care plans, with Medicare partially reimbursing VA for those benefits. A bill, H.R. 3828, reported from Ways and Means would establish pilot projects.

Smoking-Related Diseases as Service-Connected. H.R. 2400, The Intermodal Surface Transportation Efficiency Act (ISTEA), adopted by both Houses May 22, 1998, ended VA authority to approve service-connected compensation for veterans who claimed disabilities linked to tobacco use begun during their military service. Some savings from the bill would be used to increase other veterans benefits.

Persian Gulf War Illnesses. Recently completed studies did not find causes of various disorders reported by Gulf War veterans. Many researchers conclude that no single cause will explain the diverse symptoms. Notably, the studies show that these veterans have not incurred diseases, been hospitalized, or died in unexpected numbers. **P.L. 105-114** expanded services for Persian Gulf veterans to include any medical problem related to Gulf service.

Veterans Preferences in Federal Jobs. Some veterans believe that common federal employment practices do not honor preference rights to which some veterans are entitled. Legislation **(H.R. 240; S. 1021)** has passed the House, and is being considered in the Senate, that would expand preferences and broaden appeal rights.

Other Issues. **P.L. 105-114** extended a Native American home loan program, strengthened VA's ability to resolve discrimination and sexual harassment complaints arising within VA employment, extended and expanded expiring programs to combat homelessness (especially as affected by mental illness and substance abuse), instructed VA to develop a mammography policy, and provided permanent authority for noninstitutional alternatives to nursing home care. Also, unlike many federal benefit programs, VA compensation is not automatically adjusted for inflation each year, and a cost-of-living adjustment (COLA) of 2.1% **(P.L. 105-98)** was enacted for 1998; another will be considered this year for 1999.

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Introduction

Federal policy toward veterans recognizes the importance of their service to the nation, and the effect that service may have had on their subsequent civilian lives. The Department of Veterans Affairs (VA) administers, directly or in conjunction with other federal agencies, programs that provide compensation for disabilities sustained in military service; pensions for disabled, poor war veterans; cash payments for certain categories of dependents and/or survivors; medical care for conditions sustained during military service, and for other conditions under a priority system that results in most care being provided to low income veterans; education, training, rehabilitation, and job placement services to assist veterans upon their return to civilian life; loan guarantees to help them obtain homes; life insurance to enhance financial security for their dependents; and burial assistance, flags, grave-sites, and headstones when they die.

The Veteran Population

There were about 25.9 million veterans as of July 1, 1996, of whom 19.9 million had served during at least one period defined as wartime. The number of veterans is declining, and the average age increasing. The median age of veterans was 57 years and 35% were over 65 years of age; about 4.6% were female. The VA projects a decline of about 26% in the number of veterans between 1990 and 2010, down from one of four men in 1994 to one of eight in 2010, 40% of whom will be over age 65.

Declines in the size of military forces, and the corresponding effect that decline has on the number of persons entering veterans status, means relatively stable numbers of compensated veterans and fewer veterans seeking readjustment for postservice education and training. The number of disabled wartime veterans receiving pensions is declining because of the death of existing beneficiaries and because veterans who might once have depended upon VA pensions as a social safety net now have other sources of social insurance, primarily Social Security, that bring their incomes above the VA pension eligibility levels. The increasing average age of veterans means additional demands for medical services from eligible veterans, as aging brings on chronic conditions needing more frequent care and lengthier convalescence.

Organization of the Department of Veterans Affairs

The VA is divided into three administrative structures: The Veterans Benefit Administration, the Veterans Health Administration, and the National Cemetery System. VA programs are funded through 24 appropriations (including seven

revolving funds that have appropriations), 10 revolving funds that do not have appropriation funding, an intragovernmental fund and seven trust funds.

The cash benefit programs, i.e., compensation and pensions (and benefits for eligible survivors); readjustment benefits (education and training, special assistance for the disabled); home loan guarantees; and veterans insurance and indemnities are mandatory (entitlement) spending, although required amounts are annually appropriated. Requested appropriations are equal to the expected payments, and final appropriations are based on the latest available reestimates. The remaining programs, primarily those associated with medical care, facility construction, and medical research are annual discretionary appropriations, as are funds for the costs of administering the VA programs.

Spending Trends for Veterans Programs

For FY1997, federal appropriations for veterans programs under VA administration totaled $40.1 billion. VA spending (outlays in current dollars) increased 103% during the period FY1977-96. As a proportion of total federal spending, VA costs are going down. In FY1977, VA spending was 5% of total federal spending and 11% of spending for social welfare; in FY1996, that percentage was down to 2.5%, 5% of social welfare. Compared to the 98% increase in VA income security spending over the period, federal spending for all other income security programs increased by 284%. While VA health care costs rose by 269%, other federal health program costs increased by 792% over the 20-year period.[1]

VA Entitlement Spending. Veterans entitlement benefits, primarily for compensation for service-connected disabilities and deaths, means-tested pensions for disabled and needy wartime service veterans, loan guarantees, and readjustment benefits (primarily education) constitute 54% of total VA spending. Veterans entitlement benefits were once increasing rapidly, but now are a relatively stable federal obligation to a declining population of eligible beneficiaries.

VA Discretionary Spending. Unlike the ratio of entitlement spending to discretionary spending in the rest of the federal budget, the entitlement portion (income security, mostly for disability compensation, pensions, and education benefits) of VA is declining as a percent of total VA spending. In FY1976, entitlements constituted 73% of VA's budget, with the remaining 27% discretionary appropriations for health care and VA administration, including construction of VA facilities. By FY1996, VA discretionary spending for health and VA administrative costs had risen to 47% of VA's total budget. For the entire federal budget, about one-third of spending is discretionary.

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[1] Historical spending (outlays) data are from the Historical Tables, Budget of the United States Fiscal Year 1998. *Social Welfare* is defined as budget function categories Education, Training, Employment, and Social Services; Health; Medicare; Income Security; Social Security; and Veterans Benefits and Services. *Health* is defined as the total for budget categories Health and Medicare.

VA Budget and Appropriations: FY1998 and FY1999

Congress enacted **P.L. 105-65**, an appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development (HUD) and several independent agencies. The Act provides $40.438 billion for veterans programs in FY1998. In its FY1999 Budget Submission for VA, the Administration estimates that VA spending FY1998 will actually be nearer to $42.4 billion, after adjustments for reestimated entitlement spending, and for budget authority that reflects income to VA from sources other than appropriations.

VA Cash Benefits. FY1998 appropriations included $22.8 billion for VA cash entitlement benefits. Spending for the VA cash benefit programs is mandatory, and the amounts requested by the budget are based on projected caseloads. Definitions of eligibility and benefit levels are in law. About 2.3 million veterans will draw an average of $478 in monthly compensation for service-connected disabilities; about 307,000 of their survivors will average about $890 in monthly payments. Pensions for 410,000 veterans will average about $485 monthly; 304,000 survivors of veterans pensioners will average about $210 monthly.

For FY1999, the Administration estimates that VA entitlement programs will require $23.3 billion in mandatory appropriations. The Budget proposes to increase by 20%, readjustment education benefits payable under the voluntary participation program, the Montgomery GI bill. Currently, these participants, who contribute $100 monthly during their first 12 months on active duty, are eligible for education assistance cash payments of as much as $439.85 monthly for full-time enrollment for up to 36 months in an approved course of study. The estimated cost for this benefit liberalization is $190.6 million in FY1999, and $1 billion over 5 years.

Medical Care. VA operates the largest health care system in the nation, encompassing 172 hospitals, 175 nursing home and long-term care facilities, and 439 outpatient clinics. The FY1998 caseload is expected to increase by 135,000 veterans served, with the number of different patients served by VA reaching 3.1 million. VA health care continues to place increasing emphasis on outpatient care: the inpatient caseload will decline by nearly 83,000 patients to 827,000 while outpatient visits will increase by 2.5 million to 32 million, according to VA's budget documentation.

FY1998. Congress appropriated $17.0 billion in funds for VA medical care for FY1997, and the Administration's FY1998 budget requested a freeze at that level through FY2002.[2] The Administration contended that VA could increase its patient load by 20% over the period, paid for by efficiency savings and nonappropriated sources of funds not then available to VA for medical care spending. The Administration proposed, and Congress enacted a proposal that net receipts of the Medical Care Cost Recovery (MCCR) fund remain available to VA for medical services to veterans rather than be transferred to the Treasury as under current law. The provision was included in the **Balanced Budget Act of 1997 (P.L. 105-33)**, which renamed the fund the Medical Care Collections Fund (MCCF). (For further

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[2] Legislation (P.L. 104-262) in 1996 capped medical care spending for FY1998 at $17.9 billion.

information on the proposal to retain MCCR receipts within VA, see *Medical Care Cost Recovery* in the section, **Access to VA medical services**, below.)

FY1999. For FY1999, the Administration has again proposed a near freeze to medical care appropriations (various unobligated balances and carryover budget authority make estimations of frozen appropriation levels somewhat imprecise). The VA budget estimates the MCCF collections will fall slightly (from $688 million in FY1998 to $677 million in FY1999). Otherwise, the Administration will continue in its efforts to achieve greater efficiencies, thereby increasing the number of veterans for whom it could provide medical services, according to VA budget documents.

The Senate Budget Resolution. The Senate Budget Resolution for FY1999 assumes $42.8 in VA appropriations. The Resolution assumed no new construction projects for FY1999, but does assume $1 billion in renovation funds. The Resolution also assumes that language negating the effects on VA of its General Counsel's ruling that current law requires awarding compensation to veterans who incur disabilities linked to nicotine addiction that originated with tobacco use begun during military service. Passage of the Intermodal Surface Transportation Efficiency Act (ISTEA, H.R. 2400) effectively ends VA authority to grant compensation for tobacco-related compensation claims. (More on this issue can be found under the heading **Service-Connection for Smoking Related Illness**, below.)

VA Construction. Construction appropriations for VA major and minor construction projects over the 10-year period FY1987-FY1996 averaged around $600 million per year. During FY1997, these construction appropriations totaled $426 million (including $32.1 million for a replacement hospital at Travis, California).

FY1998. For FY1998, Congress appropriated $352 million in new construction funds, and redirected the $32.1 million that had been approved for constructing the Travis hospital to outpatient access projects in California. VA canceled the Travis project. Congress appropriated funds for construction of ambulatory care additions at Asheville, North Carolina and Lyons, New Jersey; and for environmental improvements at Omaha, Nebraska and Waco, Texas. Also funded was a renovation at the facility in Pittsburgh, Pennsylvania.

FY1999. The Administration's FY1999 budget requests $238 million in new construction spending, including $73 million for correcting earthquake damage in San Juan, Puerto Rico and Long Beach, California, and $69 million for increasing outpatient access in various locations.

Balanced Budget Act of 1997 (P.L. 105-33). P.L. 105-33 extended several savings provisions; most originated with the **Omnibus Reconciliation Act of 1993 (OBRA 93)** and were expiring at the end of FY1998. The provisions improve loan collections, continue cost-sharing for some veterans receiving VA health care, recover costs from veterans' private health plans, limit pensions for nursing home residents, and match income reported on pension and health care means-tests with data from IRS and Social Security. These proposals were included in Administration budgets and in Congressional Budget Resolutions for FY1996-FY1998, and were included in the 1995 Reconciliation bill that passed Congress, but vetoed for reasons unrelated to the VA savings package.

Table 1 shows final appropriations for VA programs for FY1997, enacted appropriations for FY1998, and requested appropriations for FY1999.

Table 1. U.S. Department of Veterans Affairs Appropriations

($ in millions)

Program	FY1997	FY1998	FY1999 (request)
Income security			
Compensation; pensions; burial	$19,599	$20,483	$21,857
Insurance and indemnities	39	51	46
Education, training, and rehabilitation			
Readjustment benefits	1,377	1,366	1,175
Misc. loan accnts.; admin. exp.	1	1	1
Housing programs			
Current	139	160	159
Indefinite	417	875	264
Medical programs			
Medical care	17,013	17,057	17,028
Transfer from MCCF[a]		688	677
Medical research	262	272	300
Medical admin. and misc.	61	60	60
Construction			
Major construction[b]	251	177	97
Minor construction	175	175	141
Parking garage fund	12	0	0
Other			
General Operating Expenses	828	786	850
Office of Inspector General	31	31	33
Const. grants, state nursing. homes	47	80	37
Const. grants, state cemeteries	1	10	10
National Cemetery System	77	84	92
Total mandatory (entitlements):	*21,433*	*22,775*	*23,342*
Total discretionary (without MCCF)	*18,898*	*18,894*	*18,808*
Total discretionary (with MCCF)	*18,898*	*19,582*	*19,484*
Total VA Appropriation (rounded-may not add)	$40,331	$42,357	$42,827

Source: Department of Veterans Affairs, FY1999 Budget Submission.

[a] The Medical Care Collections Fund, which receives reimbursement from private insurers who share coverage of certain veterans with VA; also the fund receives copayments and deductibles for which some veterans are obligated.

Other FY1999 VA Budget Issues. Other issues raised in the FY1999 VA budget concern increasing benefits for certain Filipino veterans who served with U.S. Armed Forces during World War II, and shifting some of the planning for future VA spending to the Department of Defense (DoD). The budget also renews a request that Congress enact a limitation on the extent to which disability compensation can be considered service-connected, if the claim is based on a smoking-related condition that is traceable to tobacco use begun during active duty. (For further information on smoking as a basis for disability claims, see **Service-Connection for Smoking Related Illness**, below.)

Increases for Filipino Veterans Residing in the U.S. During World War II, Filipino citizens in the military forces of the Army of the Commonwealth of the Philippines were drawn into that War under authority of U.S. Armed Forces, on the basis of legislation enacted in 1934 preparatory to Philippine independence. Some of these soldiers were disabled during the course of their service under U.S. Armed Forces command, and became eligible for service-connected compensation from VA. Because of differences between the economies of the U.S. and the Commonwealth of the Philippines, the compensation payments were provided, under federal law, to these disabled Filipino veterans at a rate equivalent to 50 cents for each dollar that would be paid to a similarly disabled veteran in the U.S. Armed Forces, regardless of whether the Filipino veteran resided in the U.S. or the Philippine Islands.

The disparity in payments for U.S. residents entitled to VA compensation has been a recurring issue since that time. Initially, it was argued before the Congress by proponents of the lower payments, that the distinction was necessary to prevent the benefits from becoming an inducement to seek residence in the U.S. solely for that purpose. Some also argued that the Commonwealth would reach political stability more easily if these disabled veterans remained in the Philippines during the post-war period. In recent years, Filipino advocates have pointed to the large number of Filipino veterans in the U.S. as legal residents, and have called for legislation to address their claims for full benefits. The Administration's FY1999 Budget calls for legislation to pay disabled Filipino veterans and their survivors residing in the U.S. the full rate, at a cost of $5 million during FY1999, and $25 million over 5 years.

Advance Funding for VA Benefits. The Administration has proposed that the DoD budget begin to reflect the full cost of military forces, by incorporating into the defense budget the estimated future costs of long-term entitlement obligations entailed by current military service. According to the Budget, this would make the true cost of defense more evident to taxpayers.

For example, the budget estimates that current military forces will accrue roughly $4 billion in future disability compensation from service attributable to FY1999, or about 11.6% of the pay granted to military personnel. The total for all VA entitlement benefits attributable to FY1999 duty would be 16.9% of pay, or $5.8 billion in long-term obligations, according to Budget documents. The Administration hopes to work with Congress on consideration of ways to transfer long-term VA obligations to DoD, including transferring accruing costs to the Defense budget.

Other Veterans Issues Before the 105th Congress

Persian Gulf War Illnesses and the Presumption of a Service Connection

Modern Warfare in the Persian Gulf. American experience with the Persian Gulf War differed from previous large-scale military operations of the 20th Century. Instead of manpower provided through conscription, our forces were comprised of mostly volunteer soldiers. Regular active-duty personnel were supplemented by a large contingent of reservists drawn from their civilian lives on fairly short notice. The usual stresses of warfare were intensified by factors such as desert deployment in a country with a radically different culture, an order of battle that elevated technical sophistication to new heights, unseen adversaries from microscopic organisms to distant rocket launchers, and infrequent relief from the stench of oil well fires. Personnel were exposed to strong chemicals to ward off irritating and potentially dangerous insects, given drugs (pyridostigmine bromide) to provide a measure of protection against possible nerve-gas attack, and subjected to a steady dose of propaganda by the foe that, in spite of the apparent odds against them, victory would inevitably belong to Iraq.

Since returning from service in the Gulf, many veterans have complained of a illnesses that they thought might be attributable to their service there. Commonly reported symptoms included fatigue, muscle and joint pain, severe headaches, and memory loss. Media reports began to characterize the array of symptoms as the *Gulf War Syndrome*, although no single illness with the multitude of symptoms has been diagnosed, and no common characteristics of the veterans' circumstances have been identified other than Persian Gulf service, on land or at sea. Although a majority of ill veterans have been diagnosed with a recognized disease, a significant number remain undiagnosed, and appear to be suffering from multiple illnesses with overlapping symptoms and causes.

Congress provided for all illness claims of Persian Gulf War veterans to be examined at VA medical facilities, illnesses diagnosed whenever possible, symptoms treated if necessary, and a data-base created to facilitate further research into causes.[3] More than 100 federally-funded research studies pertaining to Gulf War illnesses are underway. To date, clinical studies have not found an unexplained increase in deaths, hospitalizations, or diagnosed diseases among the Gulf War veteran population. No evidence has been found of a new or unique disease connected to Gulf War service.

Evidence steadily emerges that Gulf War veterans were in a complex environment, contaminated by multiple chemical substances, some of which had been introduced to improve the safety and comfort of friendly forces. Perhaps as many as 25,000 American soldiers may have been exposed to chemical weapons; while they were not actually used in combat, some believe the destruction of the

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[3] The DoD Medical Registry and the VA Persian Gulf Health Registry have had some clinical evaluation contact with about 100,000 of the nearly 700,000 Gulf War veterans.

weapons released toxins that may have caused illnesses with delayed symptoms. So far, no evidence has been presented that would support a conclusion that Persian Gulf War illnesses are related to chemical weapons, but studies of the possible effects of multiple chemical exposure, including the effects of low-level exposure to chemical weapons are underway.

The Presidential Advisory Committee on Gulf War Veterans' Illnesses. Finding that "[m]any veterans clearly are experiencing medical difficulties connected to their service in the Gulf War," the Advisory Committee reviewed numerous studies of Gulf War veterans and their health complaints. The Advisory Committee's report, dated December 31, 1996, concluded that scientific evidence had not produced "a causal link between symptoms and illnesses reported by Gulf War veterans and exposure [to] pesticides, chemical warfare agents, biological warfare agents, vaccines, pyridostigmine bromide, infectious diseases, depleted uranium, oil-well fires and smoke, and petroleum products." Nevertheless, the Advisory Committee recommends further research in several areas, including the medical risks, especially long-term risks, that might be related to multichemical exposure, low-level exposure to chemical warfare agents, and other toxic substances with recognized carcinogenic potential that were known to present in the Persian Gulf War. Finally, the report of the Advisory Committee emphasizes the need to examine closely the relationship between wartime stress and "the broad range of physiological and psychological illnesses currently being reported by Gulf War veterans."[4]

The Broader Issue of Presumptive Service-Connections. Health services and potential cash payments may be given to veterans who experience disabilities traceable to a period of military service. However, with some disorders, evidence of a service-connection is inconclusive. Congress has sometimes granted a *presumption* of a service-connection, so that veterans can be treated, and given appropriate compensation while scientific studies attempt to determine whether a correlation can be found between risks encountered during military service and the subsequent manifestation of a disorder.

Current concern that latent illnesses could be related to toxic exposure during Gulf War service was preceded by similar concern that certain diseases could be related to exposure to Agent Orange or other herbicides in Vietnam. That concern was preceded by concerns that certain diseases could be related to exposure to nuclear radiation during World War II or during atomic testing in the 1950s. In these cases, policy objectives were based on the rationale that veterans should be given the benefit-of-the-doubt as to the treatment of illnesses potentially traceable to military service: (1) these veterans were sick with serious diseases needing treatment; (2) they did serve their country, often in a wartime combat zone; and (3) capacity to provide the services existed if they were given high-priority access.

The Effect of a Risk Presumption on Scientific Study. When concern mounted that exposure to herbicides in Vietnam could have posed a health risk, the Department of Defense examined its records to determine which personnel may actually have been exposed and what level of exposure they may have experienced.

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[4] Report of the Presidential Advisory Committee on Gulf War Veterans' Illnesses. p 125.

However, deployment records and troop movement data could not pinpoint exposure with accuracy, and the conclusion was drawn that exposure to Agent Orange (or to other herbicides, regardless of their toxicity) at sufficient levels to be potentially disease-causing had to be presumed, given the widespread use of herbicides. Because exposure to toxic herbicides was *presumed* for any military personnel who served in Vietnam during the period in which Agent Orange was used, science need only provide evidence of an association between a particular disease and exposure to herbicides *in any setting and at any level of exposure* in order to validate a presumption that the disease is service-connected.

The Benefit of the Doubt and Persian Gulf War Syndrome. In the absence of firm scientific evidence to the contrary, Congress has given veterans of the Persian Gulf War the benefit-of-the-doubt that their ailments may be connected to their military service. However, the basis for establishing scientifically a link between an exposure to risk and the incidence of a disease could be further eroded. Persian Gulf War veterans were potentially exposed to a large number of toxins, and are now authorized to receive priority treatment for a virtually unlimited list of symptoms. Researchers caution that it may be impossible to identify the causes of illness in many Gulf War veterans because of the absence of baseline data on the health of military personnel, and the lack of reliable data on levels of exposure to potential risks in their wartime environment. In effect, because both exposure to a toxic risk and the presence of a disorder are presumed, the statistical relationship between the risk level for one and the incidence of the other may be indeterminable.

Authority to Provide Priority Health Care and Disability Compensation. Authority to provide high-priority medical care for Vietnam veterans with diseases presumed linked to herbicide exposure expires December 31, 2002. Authorization for priority health care for veterans with diseases presumed linked to radiation exposure has been made permanent.

Federal Research. The DoD, VA, and HHS, through the Persian Gulf Veterans' Coordinating Board, have established a comprehensive research program to provide information about the prevalence, distribution, and causes of illnesses among Gulf War veterans. According to a GAO report, federal agencies spent a total of $37 million on research on Gulf War veterans' illnesses through FY1996, and several additional projects are currently underway. (For additional information on federal research, see CRS Report 98-21, *Gulf War Veterans' Illnesses: Federal Research and Legislative Mandates.*)

Veterans Medical Services: Resource Reallocation and Cost Recovery

The 104th Congress saw significant changes to the structure of the VA medical system. Before reform of the rules governing access to VA health care, many veterans had a right to acute care but not to basic services, arguably resulting in inefficient use of resources. Substantial evidence existed that demands for VA health care differed from one region to another, and resource allocations did not match that demand. The objective of reform was to treat more veterans with the same resources:

inefficient uses of inpatient care would shift to outpatient access, and from underused venues to underserved locales.

The 105th Congress continues to oversee the effect of these changes. A new system for distributing medical resources, called the Veterans Equitable Resource Allocation (VERA), will shift resources according to a methodology that identifies underutilization and rewards efficiency.

VA Health Care System Reform. The combination of administrative reorganization and passage of **P.L. 104-262** yielded five fundamental changes to the approach taken toward veterans health care:

- Veterans eligibility rules were changed so that veterans could be served in whatever treatment venue was medically indicated. Most medical care will be provided to veterans enrolled in new VA health plans. While care continues to be assured for service-connected conditions, most care will still go to veterans who qualify because of low incomes.

- The VA health care system itself was reorganized. VA medical facilities had operated with considerable autonomy within a structure centered at Department headquarters. A more decentralized, regional structure, called Veterans Integrated Service Networks, (VISNs) replaced that administrative design.

- Numerous projects to improve and increase ambulatory services were proposed, authorized, and funded.

- Spending for VA medical programs was "capped" to prevent increased outpatient access from substantially increasing costs. The spending cap for FY1997 was $17.25 billion, about $24 million more than appropriated. For FY1998, VA health care spending is capped at $17.9 billion.

- A method for measuring demands met with efficient performance, based on per capita unit costs, was instituted that will permit integration, coordination, and reallocation of resources from one specialty or subservice to another within a facility, from one facility to another within a VISN, and from one VISN to another.

If service demands increase beyond the levels supported by appropriations and efficiency savings, rationing could occur. Rationing makes scarce resources evident, but also makes facilities where rationing does not occur subject to greater scrutiny. Eligibility reform, with costs constrained by spending caps, and resource efficiency measured through VA's unit-cost methodology, could force reductions in inpatient capacity in some regions to improve outpatient access in other regions.

New VISN Medical Benefit Plans Beginning October 1, 1998. The new health benefit plans through which VA medical services will be administered beginning on October 1, 1998 are intended to more effectively measure the cost of resources given to veterans in various regions. Veterans are also expected to have a greater understanding of the benefits for which they are eligible, and VA staff

would have clear authorization to provide services in the most efficient venue possible. Also, data developed through the plans would be more uniform, thereby facilitating analysis of the effectiveness of various procedures.

Some veterans have mistakenly concluded that their benefits will be cut off on the October 1 date unless they are enrolled in the plans, and have contacted congressional offices to express their concerns. Veterans will not be denied services because of the plans; some are enrolled automatically, including those receiving services in the months before the October date. Most veterans will enroll at the time they apply for services, and many veterans are exempt from enrollment altogether.

Veterans Equity Resource Allocation. The reallocation system is called Veterans Equity Resource Allocation (VERA). VERA has generated considerable inquiries to Congress from constituencies opposing or favoring resource shifts. VERA is intended to support resource reallocation from underutilized inpatient facilities toward outpatient demands; it follows that outpatient clinics in Sunbelt regions would receive resources and World War II era hospitals in population centers in the northern regions would lose resources. VERA also takes into account "snowbirds" who receive care through more than one VISN during the year, as they temporarily move to warmer locales during the colder months. According to VA, 16 of 22 VISNs will have increased funding during FY1998 if the VERA distribution method is followed. About $200 million will be reallocated in FY1998, and the full reallocation is expected to be phased in over 3 years. As resource allocations begin to be understood, various affected interests could begin to pressure the Congress to mitigate, or accelerate their effect.

New Sources of Funds Instead of Additional Appropriations. To make up the difference between appropriated funds and projected increases in medical care costs, the Administration's FY1998 budget (repeated in the FY1999 budget) assumed revenues from new sources of funds. VA estimated that by FY2002, about 10% of the medical care budget could be derived from cost recovery, Medicare reimbursement, and revenue from leases and service agreements. Together with individual patient efficiency savings of 30%, VA estimates that the reforms could permit serving a 20% increase in caseload without an increase to annual appropriations.

Medical Care Collections Fund (MCCF). Veterans whose nonservice-connected conditions are treated by VA, and who are not eligible for free care[5] for

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[5] Under current law, VA provides care free to all but about 3-4% of the patients it serves. Care for the treatment of for all service-connected conditions is free. Care for nonservice-connected conditions is free for veterans meeting certain criteria, and most veterans with service-connected conditions can receive free care for nonservice-connected conditions as well. The largest category of veterans eligible for free, nonservice-connected care (but subject to resource limitations) have limited assets (below $50,000) and income below an annually adjusted standard (in 1998, $22,064, single; $26,480, one dependent; $1,476 each additional dependent). Veterans with incomes above $8,665 in 1998 are expected to pay $2 for each monthly outpatient prescription filled through the VA pharmacy system.

such conditions are obligated to pay copayments and deductibles.[6] Also, third-party insurers who would be obligated for at least a portion of the costs of a veteran's medical care costs if the veteran were to be treated by providers outside the VA system are obligated to pay VA for the cost of that care.

In the past, VA's MCCF fund (previously called the Medical Care Cost Recovery fund) received all medical care cost collections. At the end of each year, VA transferred the funds to the Treasury, after subtracting the cost of administering the collection procedures. Some analysts believed that this approach had an adverse administrative incentive: VA was able to pass onto the MCCR whatever personnel costs it could justify as necessary to the operation of the MCCR program; and, VA could not keep any funds it collected.

To enforce discipline on the program, and to encourage VA medical facilities to be more aggressive in the pursuit of funds VA had the authority to collect, the Balanced Budget Act of 1997 requires VA to bear the costs of MCCF collections, but lets the VA medical program keep the funds. The FY1999 budget estimates that $688 million in FY1998, and $677 million in FY1999 will be available to the VA medical care account, as a result of collection efforts.

Medicare "Subvention". Many veterans advocates have suggested that VA should also be reimbursed for nonservice-connected care VA provides veterans who are also covered by Medicare. (Medicare *subvention*, meaning a transfer or subsidy from the Medicare trust funds, is the term by which this proposal is known.)

If Medicare were to transfer funds to cover the cost of VA's services to its existing caseload of patients who are also covered by Medicare, Medicare costs would increase, and VA would experience an increase in spending authority, leading to an overall increase in federal spending. On the other hand, if VA served *additional* veterans whose care is currently paid by Medicare, and if VA provided that care less expensively than providers who would otherwise be reimbursed through Medicare, then real savings could be possible, both to taxpayers and to Medicare. Offset against this potential savings would be any costs accrued by VA for services to additional patients, and for benefits that VA provides that Medicare does not cover for its participants, such as prescription drugs.

The FY1998 Budget (and repeated in the FY1999 budget) proposed a Medicare subvention demonstration, a pilot study that would attempt to determine an appropriate sharing of responsibilities between VA and Medicare for jointly covered veterans. Legislation to establish a pilot project at 12 locations passed the House in 1997 **(H.R. 1362)**. A similar version was included in the Senate version of the 1997 reconciliation bill (The Balanced Budget Act of 1997), but was dropped in conference.

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[6] For inpatient care, the amount is equivalent to the Medicare cost-sharing schedule. For 1998, veterans pay a copayment of $764 for the first 90 days of hospital care during any 365 day period, plus $10 per day; each additional 90 days requires a copayment of ½ that initial copayment, plus $10 per day; the nursing home charge is equal to the full deductible, plus $5 per day. Outpatient visits are $45.80.

Legislation **(H.R. 3828**) to authorize a pilot project at 3 locations for 3 years was ordered reported on May 14, 1998 by the House Committee on Ways and Means. The pilot project would permit veterans in those 3 locations, whose priority status requires them to share in the cost of their medical care (called Category C veterans in the bill), to enroll in a VA plan and have their Medicare benefits provided through that plan. Medicare would then pay VA the same rate, per covered person, that it would pay for those persons to enroll in a similar private prepaid plan approved by Medicare. The bill would also permit veterans with high-priority access to VA health care (called Category A veterans in the bill), who are also covered by Medicare, to receive their Medicare benefits through one of VA's VISN health plans.[7]

The bill would require VA and the Department of Health and Human Services (HHS) to coordinate the collection of data, which would be analyzed to make sure that no veteran receives less in Medicare benefits through VA than would be received directly from Medicare, and that reimbursements to VA from Medicare do not exceed the limits established by the bill. Medicare may reimburse VA for up to $50 million in the year 2000, $75 million in 2001, and $100 million in subsequent years for care provided to Category A veterans, and $50 million for each of 3 years for the Category C veterans.

Provisions of H.R. 3828 prohibit the bill from becoming effective unless Congress adopts language prohibiting VA from paying service-connected compensation based on tobacco-use traceable to military service, and Congress has passed such legislation (For more information, see *Veterans and Smoking-Related Illnesses: Congress Enacts Limits to Compensation,* CRS Report 98-373). However, the bill's costs were to be offset by some of the savings from the limitations on tobacco-related claims, and H.R. 3828 may require amendment because those savings were otherwise allocated under terms of H.R. 2400. (See **Service-Connection for Smoking Related Illnesses**, below.)

Sharing Arrangements and Enhanced Use Leases. VA medical centers have the authority to enter into sharing agreements with other health care providers in the communities in which they are located. VA is authorized to obtain services by contract whenever such contracts would be more efficient than for VA to provide the services directly. In some instances, specialized services are available from VA that other community providers seek, and VA is authorized to collect and retain fees for those services. This authority extends to support services, and some VA facilities partially offset their costs by selling such laundry or ambulance services to other health care providers.

In addition, VA has temporary authority (until December 31, 2001) to enter into "enhanced use" leases, in which VA facilities can be contracted by other entities. After taking into consideration how the leasing arrangement would affect local

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[7] There is no Category B, in keeping with a common practice in veterans health care discussions of dividing veterans into 2 categories, roughly reflecting whether the veterans have access to free VA care, or are required to share in costs. Although the categories are not found in VA law, some years ago VA law did contain the categorization, which at that time, also included a Category B designation.

commercial and community interests, VA can enter into the leases if it determines that the activities would not interfere with VA programs, and would in some way serve the interests of veterans. These leases may be additional sources of revenue to the facilities, and may serve to increase the use of capacity that would otherwise be underused.

In the FY1998 and FY1999 budgets, the Administration has asserted that by FY2002, the combination of Medicare subvention, other MCCR collections (copayments and deductibles from veterans, reimbursement from third-party insurers, and receipts from VA service-sharing arrangements with nonfederal health care providers), together with more efficient operations would support a level VA medical budget that provides services to 20% more of the veteran population. MCCR collections would fund 10% of VA's medical care budget in that year (according to the projections), and cost efficiencies are assumed to reduce the average cost for individual patients served by 30%. VA's documentation claims that these projections are reasonable if the expansion of services is conducted according to the VA efficiency guidelines, but the basis for those assumptions is not shown in the VA documents.

P.L. 105-114, Medical Construction Authorizations. Congress enacted construction authorization language that would continue the trend toward expanding outpatient access. Funds that had been approved for the construction of a hospital at Travis, California to replace one destroyed by an earthquake would be redirected to outpatient access in California. The Administration dropped its plans for the hospital; the legislation authorizes $55 million for major construction projects and $16 million for leases. In addition, the legislation authorizes $35 million for seismic corrections at the Memphis, Tennessee VA medical center.

For more on VA medical care issues, see CRS Report 97-786, *Veterans Medical Care: Major Changes Underway*.

Veterans Preferences in Federal Employment (H.R. 240; S. 1021)

Veterans advocates have argued that the preference rights under federal employment practices to which some veterans are entitled are often not properly honored in hiring and retention decisions made in federal agencies. Some suggest that the "earned" rights of veterans are treated as less important than the "bestowed" rights of individuals claiming instances of discrimination. Individuals who believe that they have been victims of discrimination in the workplace can seek to resolve their complaints through various administrative remedies, but until they are actually hired, veterans do not now have administrative recourse if they believe their preference rights have been improperly ignored.

Legislation addressing these concerns **(H.R. 240**), passed the House April 10, 1997. A similar bill, **S. 1021** is under consideration in the Senate. The bills would expand access to jobs, provide veterans with some additional rights during agency downsizing, extend veterans preference rights to some employment now exempted, establish new procedures for veterans to appeal decisions, and designate the circumvention of veterans preferences as a prohibited personnel practice.

For further information on this issue, see *Veterans Preferences: Current Law and Proposed Legislation,* CRS Report 98-493.

Service-Connection for Smoking Related Illness

Both the FY1998 and FY1999 VA budget requests proposed to preclude claims that a service-connection exists for "disabilities or deaths based solely on their being attributable, in whole or in part, to veteran's use of tobacco products during service." The issue surfaced in 1993, when the VA General Counsel determined that under VA law — which conditions veterans compensation on disabilities traceable to military service — diseases linked to tobacco use that began during military service are service-connected disabilities. After several years of study, in 1997 the VA Undersecretary for Health concluded that nicotine addiction is a disease, and the General Counsel reaffirmed the 1993 decision.

The President's FY1999 budget estimated the savings to be $16.9 billion over 5 years. The Congressional Budget Office (CBO), using a slower rate in the growth of claims estimated the change would save $10.5 billion over the period. Conferees on ISTEA used the Administration's savings estimate, committing $15.4 billion to offset costs of ISTEA; the remaining funds were used to improve various veterans benefits (see **The Veterans Benefits Act of 1998**, below).

For further information on this issue, see *Veterans and Smoking-Related Illnesses: Congress Enacts Limitations to Compensation,* CRS Report 98-373.

P.L. 105-111, Revision of Veterans Benefit Decisions for Clear and Unmistakable Error (H.R. 1090; S. 464)

Instead of passively receiving and adjudicating benefit claims, the VA actively assists veterans during each step of the application process. A decision contrary to the interest of the veteran can be appealed simply by stating the veteran's disagreement; a claim can be reopened anytime the veterans asserts that new evidence is available for presentation. Given these reapplication and appeal opportunities, no decisions are absolutely final.

Initial claims decisions are made by VA Regional Offices in which the claim was filed. Appeals can be made to the Board of Veterans Appeals (BVA) in Washington, D.C., and its decisions are subject to a motion to the BVA Chairman for reconsideration. If the Chairman grants the motion, a panel reviews the basis for the decision, issuing a finding that affirms the decision, allows the claim, or remands it to the Regional Office for further development. If the Chairman does not submit the claim for reconsideration by BVA, that round of decisions with respect to the claim are ended.

P.L. 105-111 makes decisions of the Regional Office and the Board, including denial of the motion for reconsideration by the Chairman, reversible in cases in which the veteran claims that the decision was based on a "clear and unmistakable error." It should be noted that the words *clear and unmistakable error* are a simple statement of the premise in most appeals, and not a finding achieved through an

additional appellate level. The new law adds a further review of decisions adverse to veterans' claims, but would not alter the basis for their adjudication, nor would it create a new level of adjudication authority. The new law simply requires further review and documentation of the findings of that review. The Administration opposed a similar bill in the 104th Congress because VA argued that it would add to claims backlog. Advocates of the bill argued that it would codify a review step necessary to properly adjudicate claims in which an error may have been made.

P.L. 105-98, Cost-of-Living Adjustments (COLA, H.R. 2367; S. 987)

With the exception of service-connected disability and survivors programs, veterans cash programs are fully and automatically adjusted each year for changes in the cost of living. An adjustment of 2.1% for 1998 was applied beginning with checks received in January. P.L. 105-98 was enacted to provide the same COLA for the service-connected disability compensation programs. Similar legislation can be expected to provide a COLA for 1999.

P.L. 105-114, Veterans' Benefits Act of 1997 (various bills)

Congress combined several bills before enacting **P.L. 105-114.** One bill (**H.R. 2206**), extended two expiring laws authorizing small programs that Congress created and VA administers to serve homeless veterans, especially homeless veterans afflicted with mental illness. A program providing drug and alcohol treatments through contracts with local treatment facilities was replaced by a range of services, many of which could be provided through VA medical facilities no longer needed for acute medical care. A provision authorizing grants to local homeless assistance programs that expired on September 30, 1997 was extended until September 30, 1999, provisions that allow VA to provide direct loans to Native Americans who are unable to secure home mortgages for residences on tribal land were extended through 2001. **P.L. 105-114** also provides for comprehensive services to be provided to veterans suffering from undiagnosed disorders related to service in the Persian Gulf, and for other environmental hazards that veterans might have encountered during their military service. In addition, the new law makes permanent VA authority to provide noninstitutional alternatives to nursing home care. VA is instructed by the new law to develop a mammography policy, with specifications as to how often screening should be done, and for whom. Finally, **P.L. 105-114** adopted provisions of **H.R. 1703**, which established methods for alleviating problems of employment discrimination in VA facilities.

The Veterans Benefits Act of 1998

As a separate section under **H.R. 2400**, the Intermodal Surface Transportation Efficiency Act (ISTEA), several amendments were made to veterans benefits. Under pay-as-you-go spending rules, these changes were funded from savings achieved by prohibiting VA from approving most service-connected compensation claims for tobacco-related illnesses. The improvements include the following, effective October 1, 1998:

- The basic rate for determining education benefits payable under the Montgomery GI Bill program was raised by 20%.
- Amounts VA can spend for adapting a house for a severely disabled veteran was raised from $38,000 to $43,000; for adapting a car, the amount was raised from $5,500 to $8,000.
- Maximum rates of means-tested pensions for totally-disabled wartime veterans in need of full time aid and attendance was raised by $600 annually (the total amount payable depends on dependents, assets, and other income).
- Benefits were restored for the surviving spouses of veterans who died of service-connected disabilities, for cases in which a subsequent marriage of the surviving spouse ended in divorce or death.

Government Performance and Results Act (GPRA)

In 1993, Congress enacted **P.L. 103-62**, the Government Performance and Results Act, to encourage greater efficiency, effectiveness, and accountability in federal spending. To accomplish this objective, federal departments, agencies, and programs were required to develop comprehensive plans within guidelines that permitted assessment of goals, performance toward those goals, and the interrelationship between federal operations with the same general missions. The basic method by which federal agencies are to comply with the provisions of GPRA is through the strategic plans and performance measures. A seven-year timetable was established, with 5-year strategic plans and measurable performance goals first being specified with the FY1999 budget.

Commission on Service Members and Veterans Transition Assistance

The 104th Congress established a commission to study programs designed to help with readjustment problems encountered by personnel reentering civilian life after military service. Under current law, various federal agencies, among them the Departments of Veterans Affairs, Defense, and Labor, and the Small Business Administration, administer programs to assist military personnel in their transition from active duty to civilian life. Programs include education assistance, job training, vocational rehabilitation (for disabled veterans), job placement and counseling, home loans, and small business consultations. Veterans seeking employment with the federal government may also be eligible for certain preferences in hiring and retention (see also the above section, *Veterans Preferences in Federal Employment).*

The Commission is examining "the adequacy, effectiveness, and appropriateness of transition and assistance programs," and make recommendations to Congress for changes to VA law to improve federal efforts to assist veterans readjust to civilian life. The Commission is reviewing the allocation of the programs among federal agencies, and "determine the feasibility and desirability of consolidating such programs in one department or agency." The Commission's report is scheduled for completion in August of 1998.

One issue receiving scrutiny by the Commission is the primary education program, the Montgomery GI Bill (MGIB). The MGIB provides monthly benefits

for up to 36 months for participating veterans entering approved education programs, primarily college. Payments are adjusted annually for inflation, and in 1998 are $439.85 for personnel who complete 3 or more years of active duty. Participants are required to pay $100 per month for the first 12 months of active duty, and the money is not refundable. The Administration's FY1999 budget has requested that the Montgomery GI bill payments be increased by 20%, an increase enacted as part of H.R. 2400, the Intermodal Surface Transportation Efficiency Act (ISTEA).

Although initial participation in the program is high (95% in 1996), those who do not participate make an irrevocable decision that can be ill-considered, due to their ages or financial circumstances at their point of their enlistment. Also, completion rates for veterans entering approved programs after their active duty is not as high as veterans advocates believe they should be. About 37% of veterans do enter degree-granting institutions after leaving military service; although education benefits are payable for 36 months of schooling, only one of four eligible veterans remain in school to earn a degree. The Commission is examining ways to improve on the number of veterans receiving degrees, certificates or other evidence of successful completion.