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Veterans and Smoking-Related Illnesses: Congress Enacts Limits to Compensation

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Summary

With enactment of P.L. 105-178 (H.R. 2400), the Transportation Equity Act for the 21st Century (TEA-21), Congress limited authority of the Department of Veterans Affairs (VA) to grant service-connected compensation to veterans who, after the enactment date, claim that their smoking-related illnesses are traceable to tobacco use that began during their military service. P.L. 105-178's prohibition on most smoking-related VA claims is the resolution of an issue with potentially explosive federal costs. Subsequent technical amendments included in P.L. 105-205, the Internal Revenue Service reform legislation, removed the implication that smoking may have been misconduct, and made other minor clarifications.

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 FY1998 and FY1999 budgets recommended prohibiting VA from awarding compensation to veterans for adverse effects of tobacco use, and 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 based on tobacco use had estimated the change would save \$10.5 billion over the period.

Conferees on TEA-21 used VA's savings estimate, committing \$15.4 billion to offset costs of highway construction; the remaining funds were used to improve various veterans benefits. Among improvements are a 20% increase to veterans education benefits; increased amounts for special adaptations to houses and automobiles for severely disabled veterans; increased payments for veterans requiring full-time aid and attendance; and restoration of payments for surviving spouses of disabled veterans, in cases in which the surviving spouse's subsequent marriage ends in divorce or death. Finally, P.L. 105-178 calls on VA to "take all steps necessary to recover from tobacco companies" the costs of medical care for veterans with smoking-related illnesses. (This report will be updated from time-to-time to reflect legislative developments.)

Background

In its FY1998 and FY1999 budgets, the Administration requested legislation that would deny that a service-connection exists for “disabilities or deaths based solely on their being attributable, in whole or in part, to veterans’ use of tobacco products during service.” The proposed legislation would negate a “precedent legal opinion” by the VA General Counsel in 1993 that, under current law, the VA is liable for compensation claims for illnesses related to tobacco use among veterans. According to the proposed legislation, only if the disease appeared before the period of service ended or during a post-service *presumptive* period¹ would the disease be considered service-connected.

To be compensable under current law, a disability may not be due to a veteran’s (1) abuse of alcohol or drugs; or, (2) willful misconduct. VA concluded that tobacco use is not drug abuse, nor is it willful misconduct (though VA might, in individual cases, find tobacco use willful misconduct if the veteran “knew or intended the consequences of tobacco use with a wanton and reckless disregard of its possible consequences”). Nevertheless, VA would not generally regard smoking as “wanton and reckless.”

The Administration’s FY1999 budget estimates savings from precluding tobacco-related compensation claims at \$16.9 billion over 5 years. CBO, using a slower claims growth rate in the early years, projected savings of \$10.5 billion over 5 years, and about \$45 billion over 10 years. Both projections use the same underlying assumptions about the number of veterans with smoking-related diseases who began tobacco use during military service; neither has attempted to fully assess VA’s total long-term exposure to claims based on nicotine addiction. Although regarding smoking-related illnesses as service-connected disabilities would give the affected veterans high-priority access to VA medical services, neither the Administration nor CBO estimated secondary cost effects on the VA medical care system by passage or rejection of the proposed language.

Following the 1993 opinion of its General Counsel, VA halted adjudication of tobacco-related claims while it studied ramifications. In May of 1997, VA’s Undersecretary for Health concluded that nicotine addiction is a disease; the General Counsel affirmed the 1993 decision, adding that when nicotine addiction is shown to be linked to diseases arising after separation from active duty, those “secondary” diseases are also to be regarded as service-connected. VA then began processing some 7,000 claims pending in various stages; less than 400 have been approved. The legal opinions from the VA General Counsel do not address claims by survivors of veterans whose deaths may be attributable to smoking-related illnesses. Such claims would likely be governed by a similar line of reasoning that led to the opinion concerning claims from veterans. Retroactive application to survivor claims would appear to be similarly governed.

While there are no actual data on the number of total possible claims, the potential number of claims is in the millions. Furthermore, the “echo” of service-connected claims may continue for decades, through payments that may automatically be paid to the dependents and survivors of veterans who die from service-connected conditions.

¹ VA law specifies various time periods after the completion of active duty during which the onset of certain diseases are automatically considered to be service-connected.

Issues

Balancing government and individual responsibility for nicotine addiction. One issue is the government's responsibility when its military personnel made unwise health choices, which were at least facilitated if not openly encouraged by government actions. Some argue that American taxpayers should not be held liable for illnesses caused by veterans' decisions to use harmful tobacco products. In testimony before the Senate Veterans Affairs Committee on March 31, 1998, acting VA Secretary Togo D. West, Jr. said that "the use of tobacco products is not a requirement of military service [and] it is inappropriate to compensate those veterans who do use tobacco, and their survivors, under a program developed for veterans who became disabled in service to our nation."

However, as James A. Endicott, Jr., former General Counsel of VA and author of the 1993 decision finding VA liable for tobacco-related claims as service-connected claims, pointed out during that same hearing, veterans were not generally aware of the dangers of smoking, "and our veterans were in many cases provided that first cigarette by our government as part of their daily food ration or as part of a comfort pack ... clearly, the government was the agent that ultimately gave those cigarettes to our veterans." Furthermore, VA generally views the origin in time of an illness or disability as more important than its cause. If the disability is traceable to a period of military service, VA regards it as service-connected, even if the cause is unrelated to the service itself.

Defining habits adverse to health as diseases. In 1997, the VA Undersecretary for Health concluded that nicotine addiction is a disease for purposes of VA benefit claims. However, others have argued that individuals' dispositions are often an important factor in addiction. If nicotine addiction is defined as a disease rather than simply as a condition about which health care professionals are understandably concerned, might other habits or addictions be regarded as medical problems warranting similar consideration? For instance, if dietary habits that originated during military service are shown to have potentially adverse effects on longer-term health, could such habits become the basis for claiming a service-connection if disabling conditions arise?

VA law forbids compensation when a condition results from "willful misconduct" or, in the case of alcohol or drugs, from "misuse." Thus, the law appears to distinguish between "use" and "abuse" of these substances. This distinction could apply to dependence on alcohol or various psychoactive prescription drug treatments in which frequent and legal use was never considered abuse or willful misconduct. Secondary disabilities arising from such habitual use could also be regarded as service-connected, using the analogous precedent of nicotine addiction as a disease in which its secondary effects are regarded by VA as service-connected conditions.

Including costs for nicotine addiction of veterans in any settlement with the tobacco industry. Some veterans advocates contend that because the Administration is pursuing liability for the addictive qualities of nicotine in settlements with the tobacco industry, costs of compensation to veterans should be a part of any liability settlement. Otherwise, these critics suggest, the Administration is arguing that tobacco manufacturers are liable for adverse effects of nicotine addiction on the one hand, and on the other hand, denying such liability for the federal government when it purveyed these harmful nicotine products, even after its own studies identified the probability of such harm.

Budget cost estimates likely understate the magnitude of the problem. For budget estimating purposes, VA and CBO projections rely upon data from an impact study of the effect on VA of allowing smoking-related claims.² That report projected that about 1.2 million veterans might be able to file such claims during the next 10 years. However, in anticipation of Congress enacting a strict limitation on tobacco-based disability claims, VA did not request additional appropriations to fund more claims processing staff, thereby placing some limits on the speed with which such claims could be adjudicated.

CBO estimates that annual outlays could reach \$9 billion within 10 years. Such costs could be substantially higher if more veterans claim that tobacco use originated with military service than was assumed for the estimates, and/or if a larger proportion of VA cases of each disease is linked to smoking than has been established for the general population. Assumptions used for the budget projections have the effect of artificially limiting estimates of VA's long-term exposure to smoking-related claims:

First, the projections estimate costs for veterans over age 45 who have already developed smoking-related illnesses. Additional diseases are likely to appear in that population. Survey data analyzed by VA show that the percentage of younger veterans who have ever regularly smoked is nearly as high as for older veterans, and among current smokers, younger veterans smoke in greater percentages than older veterans. As a result, the prevalence of smoking-related diseases may continue near current rates for a substantial period of time.

Second, based on survey data about what ages veterans began smoking, VA assumed that 44% of veterans who ever smoked could claim that their tobacco use began during military service. VA's impact study cites survey data showing that 70-75% of veterans had regularly smoked at some time in their lives. Because of the absence of any direct evidence, the VA study uses the percentages of those who began to smoke after age 18 as the basis for the assumption as to how many veterans began using tobacco during their military service. Yet, because of the absence of any hard evidence about when veterans actually started smoking, the percentage of veterans who might be able to claim to have begun using tobacco during military service could climb to near 70%: If a veteran could reasonably claim to have smoked at all, it would be difficult to rigorously evaluate or effectively rebut a claim that nicotine addiction had its origins during military service.

Third, prevalence rates among veterans of 12 categories of smoking-related diseases were assumed to match the rates for those diseases in the general population, after adjusting for demographic differences in the two populations.³ The prevalence rate for veterans is then multiplied by the fraction of that prevalence that medical science has estimated as attributable to smoking. However, this step confuses a rate at which these diseases among the population are linked to smoking, with a rate dependent upon the findings of adjudicators in specific cases. VA law assumes that the benefit of doubt will go to veterans with well-grounded claims. If 90% of lung cancers in men are caused by

² *Department of Veterans Affairs Tobacco-Related Compensation Claims*. Report of Jeffrey E. Harris, MD, PhD, Consultant to VA. September 15, 1997

³ The 12 categories include a number of specific kinds of cancer, three cardiovascular diseases, and two noncancerous respiratory diseases.

smoking, it would be difficult to deny any specific case in which a veteran with lung cancer claimed that it was attributable to a smoking habit begun during military service.

Whether or not nicotine addiction is classified as a service-connected condition may effect access to VA medical care for some veterans. The Administration does not address the implications to the VA medical system of the decision to regard tobacco-related diseases as service-connected, or of reversing that decision. In contrast to the relatively automatic or “mandatory” appropriations Congress provides to meet the funding requirements for VA’s compensation program, Congress determines the level of funding for VA medical care resources each year during the appropriations process. Thus, there is no necessary connection between a change in the numbers of veterans eligible for VA compensation and the number of veterans who can be provided VA medical services.

A change in the classification of particular veterans seeking VA medical care can, however, affect whether those veterans are likely to have access to such care. Access to VA medical care is controlled through a system of priorities, so that all resources available to the system can be used, while assuring that services will be available for veterans whose claims for medical care have the highest priority. Veterans with the highest priority are those seeking care for service-connected conditions, followed by categories of veterans awarded service-connected disability compensation, who are seeking care for other conditions. Others with relatively high priority are veterans in special groups, such as former prisoners-of-war, and veterans presumed exposed to Agent Orange, nuclear radiation, or unknown environmental contaminants in the Persian Gulf. The remaining category of veterans with free, high-priority access to VA medical care qualify because their incomes and assets fall below certain levels.

About 96% of all VA medical services are free to veterans to whom they are provided. About 40% of veterans seeking care have a service-connected condition; VA medical resources are sufficient to assure that these veterans receive all services they require. About 54% of veterans receiving services qualify for free VA care by meeting the income and asset threshold. The remaining 4% are provided “discretionary” care as defined under VA law. Veterans in the discretionary category have access to services only if resources are available to them after services have been provided to all applicants of a higher priority. Such veterans become obligated for cost-sharing payments roughly equivalent to similar payments under the Medicare program for any services they receive.

Veterans with diseases related to nicotine addiction that began during military service have the highest priority access to VA medical care. Approving compensation claims based on a disability related to service-connected tobacco use, or removing nicotine addiction and diseases related to that addiction from the category of service-connected conditions, could change the priority position of some afflicted veterans seeking medical service. Under the Administration’s proposal, veterans with diseases related to nicotine addiction, who are not also in one of the above high priority categories, would be moved down the priority schedule to the discretionary care level.

Legislation

The Senate Budget Resolution calls for denying tobacco related claims. The Senate Budget Committee assumed savings of \$10.5 billion over FY1999-2003, in VA mandatory spending from passage of the proposed reversal of VA’s decision, using the

funds as a partial offset for costs of the highway bill. During debate, several Members argued that compensation for adverse effects of nicotine addiction was a significant expansion of the disability program that should not occur without a vote by Congress. Others claimed that any savings from the change should be used to expand VA medical care, or other veterans programs.

Legislation to block VA claims based on tobacco use is included in TEA-21.

During development of legislation authorizing highway construction projects, both Houses considered using savings from blocking tobacco-related VA compensation claims; the Senate's bill, S. 1173, contained the change as an offset to the bill's costs. Veterans groups mounted a vigorous campaign seeking a different outcome; some advocates opposed the change outright, others sought a share of any savings for veterans programs. The House version, H.R. 2400, contained a provision expressing the sense of the House that the bill's costs would not be offset by funds drawn from changes to veterans benefits, a position subsequently reaffirmed by a unanimous vote. However, both Houses overwhelmingly adopted the renamed bill (the Transportation Equity Act for the 21st Century) which contained the provision ending VA tobacco-related claims.

The conference report incorporated the Administration's higher savings estimate of \$16.9 billion for the changes, allocating \$15.4 billion for TEA-21, with the remainder used for specific improvements to various veterans benefits. Effective October 1, 1998, the following benefits are improved:

- 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 veterans 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.

Veterans whose applications were filed before enactment, will have their application adjudicated under old law. The bill also contains language calling on VA to seek recovery from tobacco companies, of all costs incurred by VA for the treatment of tobacco-related illnesses, and recommends that Congress adopt language authorizing VA to provide such medical care to veterans with tobacco-related illnesses. Language encouraging VA to seek reimbursement from tobacco companies for all costs it sustains because of smoking-related illnesses among veterans is also contained in S. 1415, the Universal Tobacco Settlement Act, under consideration in the Senate.

Immediately after enactment of P.L. 105-178, VA identified changes that were needed to clarify its application. In addition, veterans complained that the new law made it appear that their smoking was misconduct. Language to clarify the changes, and to remove the implications of misconduct, was included in P.L. 105-208, the reform of the Internal Revenue Service.