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Veterans Issues in the 107th Congress

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Veterans Issues in the 107th Congress

Summary

VA Budget and Appropriations. The Administration has requested \$57.2 billion for Department of Veterans Affairs (VA) programs for FY2003. Congress appropriated \$52.7 billion for FY2002, and \$47.9 billion for FY2001.

The Administration proposes legislation to establish a \$1,500 per year deductible for veterans seeking VA medical services, and who do not have a service-connected condition or whose incomes are above VA's means-test for free care. On February 4, 2002, the copayment portion of cost-sharing had declined for most medical care outpatient visits to \$15, from its previous \$50, while raising the copayment for prescription drugs to \$7 per monthly prescription from \$2. The change, if enacted, would make the average copayment for outpatient visits around \$95 until the \$1,500 deductible limit is met.

Cost-of-Living Adjustment (COLA). Congress gave a 2.6% increase to VA compensation payments, matching the automatic increases received by most federal benefit programs.

Other Veterans Issues for the 107th Congress. President Bush signed H.R. 801 (P.L. 107-14), which improves Montgomery GI benefits for special categories of beneficiaries, increases burial and funeral benefits, provides greater amounts for adaptive equipment for the severely disabled, and excludes family farmland from the VA medical care means test. P.L. 107-11 has been enacted to expedite the completion of the World War II memorial on the Mall in Washington.

P.L. 107-103 made numerous changes, among which are ones which increase the monthly benefit under the Montgomery GI Bill education program to \$800 per month (as of January, 2002) for a 3-year enlistment, and raises it to \$900 per month on October 1, 2002, and \$985 per month, October 1, 2003. Two-year enlistment benefits rise from \$650, to \$732, to \$800 per month, over the same period.

Legislation to establish projects to demonstrate the feasibility of reimbursing VA for medical costs incurred by some veterans with Medicare (called Medicare "subvention") was supported by many Members in both Houses during the 106th Congress, but final work on the bill was not completed. Subvention remains an issue during the 107th Congress.

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Veterans Issues in the 107th Congress

Introduction

Federal policy toward veterans recognizes the importance of their service to the nation, and the effect that service may have 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 or worsened as a result of active duty military service; pensions for totally disabled, poor war veterans; cash payments for certain categories of dependents and/or survivors; free medical care for conditions sustained during military service, and medical care for other conditions, much of which is provided free 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 25.3 million veterans as of September 30, 2001, of whom 19.1 million had served during at least one period defined as wartime. Family members and survivors of veterans totaled about 41.4 million. Thus, VA is a potential source of benefits for almost one-fourth of the population of the United States. One-third of veterans live in 1 of 5 states: California, Florida, Texas, New York, Pennsylvania.

The number of veterans is declining, and their average age increasing. During the 5-year period from 2000-2005, the number of veterans is projected to decline by 9.2%, while the number of veterans 80 and older is expected to go up by 83.4%. At the end of FY2000, the median age of veterans was 57.4 years; 36% were over 65 years of age; about 5.5% were female. VA projects a decline of about 26% in the number of veterans between 1990 and 2010, down from one of four men in 1995 to one of eight in 2010, half of whom will be over age 62.

Decline in the size of military forces, and the corresponding effect that decline has had 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 deaths of existing beneficiaries and because veterans who might once have depended on 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. However, 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.

Overview 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 Administration. VA programs are funded through 21 separate lines of appropriations (including six revolving funds receiving appropriations), 10 revolving funds not receiving appropriations, two intragovernmental funds, two special fund, and six 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. Veterans entitlement benefits were once increasing rapidly, but now are a relatively stable federal obligation to a declining population of eligible beneficiaries, and constitute about 53% of VA spending.

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 VA programs. 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 VA health care, administration, and construction. By FY2002, mandatory spending had fallen to 53% of the total VA budget, as discretionary spending had risen to 47%. For the entire federal budget, about one-third of spending is discretionary.

VA Budget and Appropriations

Summary: Appropriations in the 107th Congress

FY2003. The Administration's budget request for Department of Veterans Affairs (VA) programs during FY2003 is \$57.2 billion, an increase of \$4.4 billion over the amount projected to be the final appropriations recorded for FY2002.¹ About \$1.8 billion results from projected increases in mandatory spending for VA cash entitlement programs. The VA medical care program would receive about \$2.6 billion in additional appropriations under the Administration's budget.

FY2002. After including updated spending for increased mandatory spending for VA entitlements, the Administration's FY2003 budget documents estimate VA's total appropriation for FY2002 to be \$52.7 billion. According to the conference report accompanying P.L. 107-73, the VA-HUD appropriation bill (as the bill

¹Final spending levels remain uncertain until all program experience has been recorded, and any supplemental appropriations or rescissions have been included.

containing annual appropriations for VA is popularly known) (H.Rept. 107-272), the Administration requested \$50.7 billion for VA programs for FY2002.

The House had previously approved \$51.4 billion for VA programs for FY2002; the Senate version of the bill contained \$51.1 billion. The difference was primarily in a fund the House bill proposed that would have provided \$300 million to upgrade VA medical facilities for safety, and for corrections of earthquake damages. The Concurrent Resolution on the Budget for FY2002 (H.Con.Res. 83) had assumed that the ultimate amount appropriated would be \$51.5 billion, after improvements to the Montgomery GI Bill and veterans burial benefits were adopted.

Spending for VA Programs

VA Cash 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. While the number of veterans is declining, VA entitlement spending, mostly service-connected compensation, pensions, and readjustment (primarily education) payments, reached \$23.4 billion in FY2000, \$25.7 billion in FY2001, is expected to be \$27.9 billion in FY2002, and is projected to reach \$29.3 billion in FY2003. Much of the projected increases for FY2001 and FY2002 result from liberalizations to the Montgomery GI Bill, the primary education program.

Compensation and pensions. The compensation program pays benefits to living veterans who have suffered a loss or reduction in earning capacity as a result of a condition traceable to a period of military service, and to the dependent survivors of certain veterans. The VA pension program is a means-tested benefit for permanently disabled (from a condition unrelated to their military service) veterans of war-time service, whose incomes and assets fall below certain levels. After taking into consideration the financial circumstances and dependents of eligible veterans, the pension payments, along with countable income, are intended to bring their total incomes to the targeted amounts.² Given the broad availability of other sources of income, including social security, program caseload is diminishing, as fewer veterans have incomes below the categorical levels.

During FY2002, about 2.3 million veterans are drawing an average of \$633 in monthly compensation for service-connected disabilities; about 310,000 of their dependent survivors are averaging about \$1,021 in monthly payments. Pensions for 346,000 veterans averaged about \$569 monthly; 233,000 survivors of veterans pensioners averaged about \$245 monthly.

Readjustment. Following a tradition going back to the beginnings of the Republic, near the end of World War II Congress enacted a series of programs to assist veterans in their readjustment to civilian life, and to help the national economy adapt to the influx of demobilizing armed forces. The GI Bill has entered the national

²For 2002, the annual basic level for an eligible single veteran is \$9,556; with 1 dependent, \$12,516; and each additional dependent, \$1,630. Additional amounts are available for eligible veterans who are housebound, or in need of aid and attendance.

lexicon as an example of federal responsibility for this readjustment responsibility, and many citizens continue to refer to the current array of programs by that historical name. Indeed, the largest current program providing readjustment education benefits is named the Montgomery GI Bill program, after its congressional sponsor and the heritage it brought into the age of an all-volunteer military service.

Without conscription to fill the ranks of active duty armed services, the inducements to potential recruits must be sufficient to attract them to enlist. The Montgomery GI Bill provides recruits with the promise of educational assistance when they separate, and the amounts that eligible participants receive has climbed significantly over the last few years, currently \$800 per month for 36 months for a 3-year enlistment, and scheduled to rise to \$900 per month on October 1, 2002, and \$985 per month on October 1, 2003. During FY2003, about \$2.2 billion in total payments for education payments will go to 326,000 active duty veterans, 79,000 reservists, and 50,000 dependents.

Table 1 shows appropriations enacted for FY2001, amounts requested enacted for FY2002, and amounts requested for FY2003.

**Table 1. Appropriations: Department of Veterans Affairs,
FY2001-FY2003**
(\$ in millions)

Program	FY2001	FY2002	FY2003
	P.L. 106-377 Enacted	P.L. 107-73 Enacted	Request
Income security			
- Comp.; pensions; burial	\$23,356	\$24,944	\$26,245
- Insurance; indemnities	20	26	28
Education, training			
- Readjustment benefits	1,981	2,135	2,265
- State grants (proposed)	—	—	197
Housing programs			
- Current (admin. exp.)	163	165	177
- Indefinite	336	754	438
Medical programs			
- Medical care	20,182 ^a	21,330 ^a	23,537
- Medical research	351	371	409
- Med. admin. and misc.	62	67	77
- Improvement fund (receipts) ^b	—	(226)	(365)
- Med. Care Cost Collections ^b	(768)	(805)	(1,084)
Construction			
- Major construction	66	183	194
- Minor construction	166 ^a	211	211
Other			
- Gen. Operating Expenses	1,100 ^a	1,199	1,317

Program	FY2001	FY2002	FY2003
	P.L. 106-377 Enacted	P.L. 107-73 Enacted	Request
- Office of Inspector Gen.	46	52	58
- Grants, state nurs. homes	100	100	100
- Grants, state cemeteries	25	25	32
- Nat'l Cemetery Admin.	109 ^a	121	138
- Parking revolving fund	—	4	0
<i>Mandatory (entitlements)</i>	25,692	27,860	29,254
<i>Discretionary (includes receipts)^b</i>	23,144	24,860	27,896
Total Appropriations (rounded; includes receipts)	48,836	52,719	57,150

Source: H.Rept. 107-272; FY2003 Budget Submission of the Department of Veterans Affairs.

^a Net, after rescissions and transfers to other accounts.

^b Includes estimated receipts from the Medical Care Collections Fund (MCCF), which consists of payments from sources responsible for a share of cost for services provided to certain veterans, and from the Health Services Improvement Fund, which consists of receipts from increased pharmacy copayments and from leased capital assets or contracted (shared) VA services.

Medical Care. VA operates the nation's largest health care system, with 172 hospitals, 137 nursing homes, 43 domiciliaries, 206 readjustment counseling centers (Vet Centers), 73 home health-care programs, and about 900 outpatient clinics. About 88% of VA's 207,000 employees will be involved in the provision of medical services to an estimated 4.7 million veterans during FY2002, a caseload expected to reach 4.9 million by the end of FY2003. The FY2001 caseload was about 4.2 million unique patients.

Outpatient visits are climbing rapidly. The total number of such visits had reached 43.8 million during FY2001, and is projected to increase by 2.3 million over FY2002-FY2003, from slightly less than 47 million to 49.2 million. Patients will average around 12 visits per veteran patient served. Almost 2,000 medical care employment slots will shift from inpatient programs to outpatient care.

According to VA data accompanying the FY2003 Budget, the daily inpatient caseload for FY2002 is projected to be 57,522, rising to 58,361 patients by the end of FY2003. There is a decline in all service units except for 2 categories, acute care and nursing homes. Acute care patients have increased because of the larger number of total numbers of veterans who are seeking VA medical services, and while the total number of acute care cases has increased by 2,700 over the last year, the average daily census for acute care has actually declined by 20 patients. In a reflection of the aging of the veteran population, and the commitment by Congress to increase the capacity of VA to serve an aging veteran population, the number of patients given convalescent care is projected to increase by over 7,000 during the next year, with the average daily nursing home census rising by 1,205 patients.

The Administration has asked Congress to provide \$23.5 billion for VA medical care for FY2003, continuing the annual increases in funds as the program continues to serve a larger number of veterans each year. FY2002 congressional appropriations for VA medical care were \$21.3 billion, \$1 billion above the \$20.3 provided for FY2001. Congress approved \$19 billion for FY2000.

Medical Care Cost Collections. In addition to the funds provided by Congress, VA medical care is also authorized to “recycle” budget authority from amounts VA facilities collect from various sources with an obligation to help defray the cost of VA care for certain patients. The Balanced Budget Act of 1997 (P.L. 105-33) gave VA authority to retain net receipts of the Medical Care Collections Fund (MCCF), allowing the funds to be spent for medical services to veterans rather than be transferred to the Treasury as under previous law. Current estimates are that the change added an estimated \$767 million in recycled spending authority in FY2001, and will generate an estimated \$805 million in FY2002, and \$1.08 billion in FY2003.

Health Services Improvement Fund. Congress also created a new fund for FY2002 (the Health Services Improvement Fund), which collects increases in pharmacy copayments that went in to affect on February 4, 2002. This new fund also receives income from “enhanced use leases,” which are arrangements for sharing VA medical assets with paying customers from outside of VA. These leases can include the revenue from liquidation or leasing of VA capital assets, as well as income from VA services for which users have contracted. An estimated \$226 million will be recycled to VA facilities from this fund in FY2002, and an estimated \$365 million will be gained in FY2003.

Medical research. The VA engages in research as a ancillary function of the treatment of veterans, and conducts independent research projects intended to advance medical science. Almost one-half of VA’s research funding comes from conventional medical research funding sources, the bulk of which is provided through grants from the National Institutes of Health (NIH). The remaining funds supporting VA research are split almost evenly between appropriations from Congress specifically for such research, and salaries and expenses from the VA medical care budget for the VA medical staff who are producing the studies that exhibit VA’s research findings. About two-thirds of the research projects are initiated by the medical staff reporting their findings. These projects are giving greater attention to the diseases associated with an aging population, especially in conjunction with the management of those chronic conditions that are a growing part of the outpatient workload.

The Administration has requested \$409 million in direct appropriations for VA research in FY2003, Congress provided \$371 million for VA research in FY2002, \$350 million for FY2001, and \$321 million for FY2000.

Response to Hepatitis C (HCV). The Centers for Disease Control and Prevention (CDC) estimates that over 4 million Americans are infected with Hepatitis C, and some data exists that the disease is even more prevalent among veterans than in the general population. A VA study in 1999 found that the veterans it surveyed had a prevalence rate of 6.6%, compared to an estimated 1.8% in the general population. Upon release of the study, leading veterans groups and some health care

professionals advocated an aggressive response by VA to combat the contagious threat. The Administration's budget estimated that funding for the diagnosis and treatment of infected veterans would rise to \$340 million in FY2001, up from \$195 million in FY2000, and \$46 million in FY1999.

However, VA analysts were concerned that "...no comprehensive system was in place to collect information about actual workloads and costs" for the Hepatitis C program because the projections for them "were based on formulas that relied on untested assumptions" and "actual performance (particularly for FY2000) did not bear out projections." While Hepatitis C continues to be a serious health issue in need of dedicated attention to its causes, prevalence, diagnosis, treatment, management and possible cure, it does not appear as if the dire predictions about its effect on the veteran population has occurred. Actual costs for HCV related medical services during FY2001 are estimated to have been \$98 million, and for FY2002 are projected to reach \$105 million, with \$111 million expected to carry out diagnosis and treatment during FY2003.

Veterans housing benefits. The VA program to guarantee home loans for veterans has made a significant contribution to the national goal of increasing the number of families who own their own homes. Because of the guarantees, lenders are protected against losses up to the amount of the guarantee, thereby permitting veterans to obtain mortgages with little or no down payment, and with competitive interest rates. These guarantees, and certain direct loans to specific categories of veterans were obligations of the federal government that constituted mandatory spending; administrative expenses are discretionary appropriations transferred from the home loan programs to the General Operating Expenses account.

VA construction. The Administration has requested \$194 million for major construction projects for FY2003, and requested the same amount for minor construction as was appropriated for FY2002. Congress provided \$183 million in major construction for FY2002, and \$211 million in minor construction. Major construction projects are those with an estimated cost over \$4 million. Many of the minor construction projects will continue VA's overall strategy of expanding outpatient access. Congress provided \$66 million for major construction, and a total of \$171 million for minor construction for FY2001. P.L. 106-74 included \$65 million for major construction, and \$160 million for minor construction for FY2000.

Capital asset realignment. VA has developed a comprehensive planning approach to constructing, altering, extending, or otherwise improving facilities. In part, this new planning approach, called Capital Asset Realignment for Enhanced Services (CARES), is the Department's reaction to the criticism it has received from areas of the country in which hospital resources have been cut back, in order to redirect those resources to outpatient care, usually in other geographical areas. While VA has been successful in expanding the number of patients it serves, conflict continues between advocates of a more efficient use of resources (who advocate reducing hospital space and closing or selling superfluous inpatient facilities), and veterans groups (who see any reduction in inpatient care as a threat to the medical care needs of the veteran population).

The CARES effort is an attempt to make the planning process by which the capital assets are developed, used, modified, or relinquished, open to veterans groups. Often, the fears about reductions in health care to veterans are based on an inadequate understanding of the improvements in care for more veterans that such realignment of resources makes possible, and the CARES approach may lessen those misunderstandings.

Some veterans have expressed the belief that, over time, moving resources from an inpatient facility in one area to outpatient access in another yields an unacceptable rate of deterioration in the former facility, as the commitment to maintain the building is diminished as the Department moves toward its eventual abandonment.

Burial and cemetery benefits. Payments to honor and help defray the cost of veterans' burials will total about \$155 million in FY2003, and cover about 84 thousand burials, 69 thousand burial plots, 9 thousand service-connected deaths, 528 thousand flags, and 354 thousand headstones and markers.

Department administration. The Administration has requested \$1.317 billion for General Operating Expenses (GOE) for FY2003, and \$77 million for medical administration. Congress approved the Administration's request for funds for administration for FY2002, providing \$1.195 billion for GOE and \$68 million for medical administration. P.L. 106-377 included \$1.050 billion of the requested \$1.062 billion requested for GOE, and \$62 million for medical administration for FY2000. P.L. 106-74 provided \$913 million for GOE, and \$60 million for administration of the medical care programs for FY2000.

VA employment estimates. The Bush Administration projects overall VA employment will decline to an average of 204,670 in FY2002, down from an average 205,896 during FY2001, which was up from an average of 202,621 during FY2000, and 205,547 in FY1999. Much of the decline will be in medical staff, which VA projects will average 179,300 during FY2002. Currently, VA projects that VA medical care slots will average 181,500 in FY2001. VA originally estimated that 179,206 medical care slots were needed for FY2001, compared to an 179,520 in FY2000, and 182,661 in FY1999.

Accrual Accounting. Part of the \$4.4 billion increase in total VA spending for FY2003 does not reflect expanded program costs for additional benefits or medical services to veterans, but rather a change in methods by which future compensation for VA employees who will eventually retire is attributed to current service those employees perform. This new accounting method would result in the transfer of \$892 million to central accounts in the Treasury to fund the accruing future cost of retirement and retiree health benefits for VA employees. Because the accrued funds would be retained in a government fund, this new accounting practice does not affect employees' benefits in any way, nor does it have a direct impact on taxpayers.

However, to cover the accrual payments, the changing practice makes the apparent current cost of VA employment somewhat higher, especially in the labor intensive medical programs, as appropriations to fund requested program levels must be higher than would otherwise be required to maintain the same level of services.

Although there is no necessary reason for accrual accounting to make any difference in total government expenditures, the apparent higher personnel costs for individual agencies may act as a psychological impetus to reduce personnel expenditures if Congress requires the agency to absorb the accrual transfer within an appropriation that does not increase to meet the new requirement.

A Closer Look at Ongoing Issues

Medical Care

In recent years, Congress has invested substantial resources to improve the efficiency, quality and breadth of VA medical care, and to make that care more accessible to more veterans. The VA medical care system has been transformed from a hospital-based program providing most of its services to inpatient treatment of a relatively small percentage of veterans who tended to be older, sicker, poorer, and more frequently minorities than the general population. While VA continues to provide inpatient treatment to its traditional clientele, the VA system is increasingly emphasizing outpatient care, administered through regional VA health plans, organized around managed primary care principles, and provided in an increasing number of outpatient clinics.

The number of individual veterans served by VA medical care staff has increased by 65% in the last 7 years, and nearly all of that increase has been in primary care provided through outpatient clinics. In FY1996, VA medical care resources were split evenly between inpatient and outpatient services; by FY2003, inpatient care will consume less than one-third of the resources.

As the average age of the veterans population rises, more attention is being directed toward the additional medical issues pertinent to older aged patients. The 106th Congress enacted legislation directing VA to expand its geriatric services, including nursing home care and other extended care capacity, and to develop more “assisted living” arrangements and practices consistent with an evolving medical view about improving the lives of elderly people. At the same time, an increasing reliance on outpatient services has increased the importance of VA’s pharmacy program in its role implementing outpatient treatment plans. The increasing awareness of VA pharmacy benefits has magnified the relative absence of similar benefits under Medicare, the primary federal medical program serving people over the age of 65.

Veterans are not denied care. Currently, VA medical personnel can be expected to provide medical services to all veterans who appear at VA medical facilities seeking care. Veterans seeking appointments may sometimes be discouraged by VA administrative staff from having their medical needs served through VA, and encouraged to seek health care services elsewhere in the community. In practice, however, all veterans presenting health complaints to VA medical facilities are screened to determine their medical condition; the disposition of most cases occurs simultaneously with that screening.

For instance, a veteran complaining of a sore throat asks to see a doctor; VA medical staff examine the patient, diagnose an infection, prescribe an appropriate

antibiotic, which is then filled at an on-site VA pharmacy. If, during this screening, a patient is discovered as having an “emergent” condition (a condition, that left untreated, could threaten the health of the patient), the medical staff can be expected to initiate an appropriate course of treatment without regard to eligibility status.

In the event that the medical staff commitment to address all complaints was to come into conflict with resource limitations, VA’s medical care professionals would allocate the services they could provide according to the traditional *triage* model: applicants would be given access to care based on the urgency and type of conditions presented, and those veterans most in need of care would be given high priority for services regardless of those veterans’ overall place in the priority schedule administered by VA health care resource management.

This potential sharp contradiction between medical and administrative priorities has not occurred. Appropriated resources, and the shift of more services from inpatient to outpatient settings has allowed VA to serve all veterans applying for care, without denying care to any particular veteran with a medical need identified by VA medical professionals. While some veterans have complained that services are not given to them in the same manner or location as they had previously experienced, this change is not itself a denial of care, but rather a byproduct of the efficiency efforts.

Yet, some areas of the country continue to feel the pinch of reduced VA medical resources, as programs dependent upon inpatient capacity give way to outpatient services. Shifting resources from underutilized inpatient care to outpatient clinics increases the number of veterans who can be served by the same number of VA medical personnel; 75% of the VA medical care budget funds medical care personnel, either as federal employees or through contracted care. At the same time, this shift in resources can result in the termination of programs that often rely upon inpatient capacity, especially those concerned with mental health and substance abuse programs.

Cost-sharing for veterans. Medical care for the treatment of service-connected conditions is free to veterans. Care for nonservice-connected conditions is also free for veterans rated at 50% or greater for purposes of VA compensation for service-connected conditions.³ The largest category of other veterans eligible for free, nonservice-connected care have limited assets (below \$50,000) and income below an annually adjusted standard (in 2001, \$23,688, single; \$28,429, one dependent; \$1,586 each additional dependent). Veterans awarded a Purple Heart for injuries sustained during combat are exempt from copayments for medical services, but may remain subject to copayments for pharmacy benefits. Other veterans who may be eligible for free care, are those who were exposed to environmental contaminants (such as Agent Orange, during service in Vietnam), or who were prisoners-of-war.

Remaining veterans (Priority 7) are primarily veterans who do not have a rating for a compensable service-connected disability, are not seeking care for a condition

³Although the law specifies that veterans with 50% or greater disability ratings are assured free VA medical care, in practice, VA generally does not seek cost-sharing payments from veterans with service-connected disability ratings of 10% or greater.

potentially traceable to an environmental hazard encountered in Vietnam or the Persian Gulf, do not meet other specific criteria associated with the circumstances of the military service, and have incomes and assets above the VA medical care means test. These Priority 7 veterans can receive VA care, but are obligated for a share of the costs of such care.

In the past, VA patients tended to be “older, sicker, poorer, and more likely to have social problems and mental illness than persons using private health care facilities.”⁴ Increasingly, VA patients are drawn from a cross section of the population that more closely resembles the general public (after considering the differences in demographics between the veteran population and others). Indeed, the Administration reports that the largest growth in veterans seeking VA care are veterans who do not have a service-connected condition, do not have incomes that fall below VA’s income test, and do not meet any other criterion warranting free VA care under current law. These Priority 7 veterans have climbed from about 2% of the patients seen in 1986, to about 33% currently, and are projected to climb to 42% of the patients VA provides services to by 2010, according to VA documents supporting the Administration’s request for FY2003.

For inpatient care, copayments are equivalent to the Medicare cost-sharing schedule. For 2002, veterans pay \$792 for the first 90 days of hospitalization during any 365 day period, plus \$10 per day; each additional 90 days requires a copayment of one-half that initial amount, plus \$10 per day; the nursing home charge is equal to the full amount, plus \$5 per day. For outpatient care, veterans are obligated for 20% of the projected average cost of an outpatient visit. This formula yields a copayment of \$50 for outpatient visits in 2001. Veterans (single, no dependents) with incomes above \$9,304 in 2001 are obligated for \$2 for each monthly outpatient prescription filled through the VA pharmacy system.

Changes made in VA copayment schedule. Under authority of the Millennium Health Care Act (P.L. 106-117), VA was given the authority to revise the cost-sharing structure to bring copayments more into line with prevailing private sector practices. These changes reduce the out-of-pocket cost to veterans who seek care in VA facilities because of lack of health insurance elsewhere, or because the insurance they have (including Medicare) does not provide much in the way of coverage for prescription drugs.

Before February 4, 2002, Priority 7 veterans were obligated for a relatively high copayment for a VA outpatient visit (\$50), and many veterans expressed dismay when told that they owe an outpatient visit copayment even if they are only seeking to have a prescription filled by a VA pharmacy, at a \$2 per month copayment. Many of these veterans sought care from VA because they had been given an expensive prescription by another medical care provider, and they did not have insurance benefits that would pay the cost of that prescription. Frequently, these veterans were covered by Medicare, and did not understand why they should need to see two providers at government expense, when it was the same condition that was to be treated.

⁴FY2000 VA Budget Submission, v. 2, Medical Programs, p. 2-8.

As a result of instructions given to the Department by P.L. 106-117, VA has introduced a new copayment structure, beginning February 4, 2002. Under the new structure, Priority 7 veterans will pay a copayment of \$15 for a primary care visit, and \$50 for a visit to a specialist. Those veterans obligated for a copayments for drugs will now pay \$7 dollars for each month's supply. Preventive medical services, including flu shots, laboratory tests, certain radiological services, hepatitis C screening, and certain other preventive services would not require a copayment in most cases.

A proposed deductible. In its budget proposals for VA for FY2003, the Administration has requested legislation that would establish a deductible for Priority 7 veterans of \$1,500 per year, assignable at a rate of 45% of the cost of each visit until the maximum level is reached. Thus, under the Administration's plan, veterans who have had their copayment reduced from \$50 per visit under provisions engendered by P.L. 106-117, would have their copayments increased to about an average of \$95 per visit, until the maximum of \$1,500 is reached in a calendar year.

In part, the basis for the Administration's request is to discourage the rise in the rate at which Priority 7 veterans are enrolling in VA health care plans. Copayments are generally not thought of as ways of raising money from the population of patients affected, but as a way of discouraging those persons from seeking care through that system of services. VA projects that the imposition of their proposal would yield \$260 million in copayments, and reduce services by \$885 million, by discouraging Priority 7 enrollees from seeking services for which the copayment is applicable.

The VA pharmacy formulary. VA does not operate a pharmacy in the same sense in which a drugstore can be expected to fill prescriptions across the full spectrum of available medical supplies. VA operates a pharmacy in conjunction with the treatment plans developed by VA medical staff for treating specific conditions among its patient-veterans. In order to improve the efficacy of its treatments, and to maximize the bargaining position of VA pharmaceutical purchasing agents, VA staff developed a limiting list, called a *formulary*, that guides the VA physician in prescribing drugs from among those that have similar effectiveness.⁵ Thus, a VA physician must see a veteran in order to prescribe drugs for that patient, both to assure that VA quality of care criteria are respected (and will continue to develop through statistical examination of patient outcomes), and to match the veterans prescription needs with those available through a VA pharmacy.

The 107th Congress will likely continue to encourage the directions taken by the VA medical program over the last few years. In the absence of a comprehensive prescription drug benefit under the Medicare program, veterans otherwise eligible for Medicare benefits will continue to seek pharmacy benefits from VA, and will continue pressure on Congress and the Department to modify the amounts veterans obligated for cost-sharing payments are expected to pay for outpatient visits.

⁵The VA pharmacy formulary does not prevent a VA physician from prescribing outside the formulary, provided the physician has a medical justification for doing so.

Geriatric care. P.L. 106-117 added to extended care services for veterans, including geriatric evaluation, nursing home care, domiciliary services, adult day health care, non-institutional alternatives to nursing home care, home or residence assistance, and respite care for caregivers. The Act instructed VA to assure access for the services to any veteran who needs such care for a service-connected condition, and to any veteran with a service-connected disability rated at 70% or higher.

Language in the Act also instructed VA to increase emphasis on mental health services, especially such services applicable to post-traumatic stress disorder and substance abuse. The Act also authorized VA to pay for emergency care on behalf of uninsured, enrolled veterans who are within 2 years of having received VA health care at the time of the emergency. The new law authorized VA to increase, from \$2 monthly, the copayment obligation on those veterans ineligible for free prescriptions; establish a maximum monthly and annual amount for veterans with multiple prescriptions; and revise outpatient care copayments for higher income veterans.

P.L. 106-117 gave high priority access to VA medical services for military retirees, which had the effect of placing priority access for military retirees ahead of veterans who do not qualify for free, relatively high-priority care because they do not meet the standards for service-connected free care, and they do not have incomes and assets below VA's means-tested threshold. Also, veterans awarded a Purple Heart are now to be given access to free, higher priority health care. It should be noted, however, the priority access has not had the effect of denying care to any veterans, as the VA health plan enrollment system has remained open to all veterans who enroll.

Medicare Subvention. Work will likely continue on rationalizing the relationship between the VA and Medicare programs. 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 program outlays could increase, and VA would experience an increase in spending authority. 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. If subvention caused the government to provide more in total services than would otherwise have been provided, overall federal spending would increase unless savings in the cost of providing those services through VA instead of through Medicare reimbursement of private health care providers equals or exceeds the cost of the additional services.

However, the real stumbling block to subvention appears to be the fact that VA already serves Medicare patients for which it is not reimbursed by Medicare, and that

will continue without a change in law. Under any scenario, Medicare would transfer funds to VA for services VA provided to Medicare-covered veterans, and for which Medicare would otherwise be obligated to pay to private providers. Thus, there is no real incentive for Medicare advocates to support a plan which transfers Medicare funds to VA to pay for services that Medicare would not otherwise pay for at all.

Subvention: Recent proposals. One approach receiving attention in the last two Congresses would have permitted veterans with Medicare eligibility, whose VA eligibility requires them to share in the cost of their medical care, 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.

Medicare subvention 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 Medicare-eligible veteran receives less in medical benefits through VA than would be received directly through Medicare, and that reimbursements to VA from Medicare do not exceed established limits.

Under legislation deliberated in the previous two Congresses, the Medicare Trust Fund would have been authorized to reimburse VA for Medicare services it provides to these dually-covered veterans by up to \$50 million annually. VA would serve the Medicare-covered veterans in these plans in the most appropriate venue, whether in a VA facility, or through contracts with private health care providers.

Late in the 2nd Session of the 106th Congress, an amended version of the evolving Medicare Subvention proposal was deliberated during the development of legislation to enact comprehensive changes to Medicare. Various participants, including the House Ways and Means Committee, the House Commerce Committee, the Senate Finance Committee, together with House and Senate leadership, proposed an agreement, called *The Medicare, Medicaid, and SCHIP Benefits and Improvement and Protection Act of 2000*, which was then attached to H.R. 2614, a bill to amend the Small Business Investment Act. The agreement passed the House on October 26, 2000, but the provisions to establish a Medicare Subvention pilot program were dropped from the bill before action was taken.

Another approach deliberated during the 106th Congress, that addressed some of the same issues in dual Medicare/VA medical coverage, would have permitted VA to pay some of the costs associated with treatments given to a veteran in a non-VA medical facility, when VA determined that it is in the veteran's medical interest to provide such care outside VA for practical reasons, such as the distance a veteran might need to travel to reach an appropriate VA medical facility.

Four pilot projects were to be authorized, and the projects selected were to be located in such a way as to limit the number of veterans participating to no more than 15% of those living in the area; 70% of the veterans in the area must have travel of more than 2 hours to reach a facility; and the total that could be spent on the projects in any fiscal year was to be limited to \$50 million. The pilot projects were to expire in 2005, and any adverse effects on VA medical facilities would have prompted changes in projects.

Proponents of these provisions pointed to the increased access that would result from veterans becoming able to seek care closer to their homes, and noted that the number of veterans seeking care from VA is increasing fast enough to compensate for diminished demand at the facilities affected. In effect, the provisions would have allowed VA to pay costs, including copayments and deductibles, for veterans in VA plans who were also covered by other plans, including Medicare.

Opportunities for veterans to seek care elsewhere alarms some veterans organizations, which believe it could lead to an erosion of VA specialization in veterans' disability services, and declines in the number of veterans seeking services at VA medical facilities. They conclude that such changes, when combined with VA efficiency moves shifting care from inpatient facilities to outpatient clinics, would mean the eventual closing of VA hospitals.

The Ongoing Issue of Presuming Service Connections: The Relationship Between Risk Exposure and Subsequent Disabilities.

Introduction. Some veterans and their advocates believe that exposure to environmental toxins or unknown and mysterious diseases during military service has left many veterans vulnerable to an array of disabilities later in life. In recent times, Congress has considered the concerns of veterans with claims arising from service in nuclear testing areas, Vietnam, and the Persian Gulf. Authority for VA to provide medical treatment for diseases presumed linked to radiation has been made permanent. Similar authority to receive high priority medical treatment for diseases presumed related to exposure to Agent Orange (and other herbicides) in Vietnam expires at the end of 2002. Authority for priority medical treatment for veterans who may have been exposed to toxic substances or environmental hazards during the Persian Gulf War expired at the end of 2001; authority to evaluate the health of spouses and children of Persian Gulf War veterans expires at the end of this year.

Although major legislation has not been considered in the 107th Congress, the issue of presuming disabilities to be service-connected, and the implications of such presumptions, is of ongoing concern to Congress and to veterans service organizations. The following discusses the history and current status of this issue.

Giving veterans the benefit of the doubt. The nation has accepted an obligation to veterans who incur injury, disease, or aggravate an existing condition (VA law calls all of these *disabilities*) while in service to the country. Health services, cash payments, and other benefits may be given to veterans who experience disabilities traceable to a period of military service. These disabilities need not have occurred in the line of duty, or even be related to active duty: for a condition to be regarded as service-connected, veterans need show only that the condition occurred (or was aggravated) as a result of military service, or arose during that period.

To receive benefits for a service-connected disability, veterans are required to document that their condition is related to their service. The claim is often clearly documented by pertinent military records. 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 the veteran encountered during military service and the subsequent manifestation of a disorder.

Early in the 20th Century, these presumed service-connections permitted VA and its administrative forerunners to treat veterans for a variety of little understood ailments that they might have contracted during duty in far-off lands. While many tropical diseases long defied routine diagnosis, more familiar diseases such as malaria were diagnosed accurately, and the sporadic recurrence of its symptoms over time were well known. The passage of time between a veteran's exposure to risk, and onset or recurrence of a specific disease made the use of presumptions an attractive alternative to protracted examination of a claim that was necessarily difficult to validate or rebut.

Recent Presumption Issues. 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.

From a scientific standpoint, the evidence necessary for VA to conclude that a particular presumption should be expanded to include additional diseases is not a particularly high threshold. Generally speaking, the law excludes extending presumptions to disorders in which scientific evidence has found no correlation between exposure to a risk and the contraction of a disorder, or when the disorder is attributable to another cause. Yet, other scientific evidence, even when inconclusive, may be enough for the list of disorders with a presumptive service link to be expanded.

Presumptions and Exposure to Nuclear Radiation. From 1945 until 1963, the U.S. exploded approximately 235 nuclear devices in the atmosphere, potentially exposing an estimated 220,000 military personnel to unknown levels of radiation. Some of these veterans later claimed that low level radiation released during the testing may be a cause of certain adverse health consequences they had experienced. In addition, some veterans who had been among occupation forces in Hiroshima and Nagasaki after the atomic bomb attacks on those cities also claimed that they had experienced adverse health effects because of that occupation service.

While carcinogenic and other health effects of high radiation doses was well-known, scientific evidence about the long-term health consequences of exposure to low levels was inconclusive. In 1987, Congress chose not to "... abide by its long-standing tradition that benefits should be paid only where substantive evidence is clearly available to establish that the disabling conditions existed while on active duty or are clearly related to such period of service." Instead, Congress accepted the conclusion that because the evidence of exposure-level risk could not be verified, it

should depend instead on correlation of various diseases with radiation exposure. P.L. 100-321 included language establishing a presumption that 13 diseases would be presumed to be service-connected if they manifested in veterans whose service histories included active duty in a “radiation-risk activity.”⁶

The VA opposed passage of the bill, arguing that existing law was sufficient to permit awarding benefits in cases in which the evidence linking diseases to radiation exposure was conclusive. At the heart of the objection to the bill, was the Administration’s claim that the “... overwhelming majority of veterans covered by [the bill] received very low doses of radiation, whether they participated in the weapons tests or the occupation of Hiroshima or Nagasaki.” VA examined scientific data on correlations between various cancers and radiation exposure at the level that had been experienced by the veterans, and projected that of the 32,000 to 34,000 deaths from cancer that would otherwise occur among the 200,000 veterans made eligible for the presumption under the law, the additional exposure from their service experience would lead to 10 additional deaths.

The Administration concluded that “... the issue really becomes whether the federal government should presume that all 32,010 eventual cancers among atomic veterans are service-connected in order to assure that the 10 *possible* excess cases related to service are covered, or whether it is better public policy to look at each case individually to separate the more deserving claims from those less deserving.”⁷ In spite of the VA opposition, the bill passed, and subsequently has been amended to include additional diseases.

Expanding Presumptions to Include Exposure to Agent Orange.

Congress also granted priority medical treatment to veterans who had been exposed to the defoliant Agent Orange. The active ingredient in that defoliant is the chemical dioxin, for which there is some evidence of a disease-causing potential. By the time that Congress enacted legislation authorizing the treatment of diseases possibly linked to radiation exposure, increasing numbers of veterans of service in Vietnam were claiming a service-connection for disabilities that they believed were related to exposure to Agent Orange.

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. However, deployment records and troop movement data could not pinpoint exposure with accuracy. Congress drew the conclusion 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 find some evidence suggestive of an association between a

⁶H.Rept. 100-235, a report from the House Committee on Veterans Affairs to accompany the Atomic Veterans Compensation Act of 1987 (P.L. 100-321).

⁷*Ibid.*, p. 10-11

particular disease and exposure to herbicides *at any level* in order to validate a presumption that the disease is service-connected.

A Presumption for Spina Bifida. In 1996, Congress amended VA law to grant the presumption of a service-connection, to claims on behalf of children stricken by the disease spina bifida who are born to Vietnam veterans. Spina bifida is a birth-related disease that can entail intensive and expensive assistance to the child for years. The basis for this expansion was a National Academy of Sciences (NAS) report reviewing studies of a correlation between toxic exposure of Vietnam veterans and children born to them with spina bifida. While the scientific studies were inconclusive, NAS did find some evidence suggestive of such a correlation.

Expanding Presumptions and the Persian Gulf War Syndrome.

After returning from service in the Persian Gulf War, some veterans began complaining of 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.⁸ 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 weapons released toxins that may have caused illnesses with delayed symptoms. So far, medical experts report that no conclusive evidence has been presented 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

⁸The 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.

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 recommended 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 be present in the Persian Gulf War. Finally, the report of the Advisory Committee emphasized 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."⁹

Priority Health Care. 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. P.L. 105-368 extended high priority health care for Persian Gulf veterans through 2001; expanded coverage to include treatments for veterans' dependents when their illnesses are related to the veterans' Gulf War service; and required VA to seek advice from the National Academy of Sciences on ways in which these veterans could be more effectively treated. The law also established an independent mechanism recommended by the Academy, so that research into Gulf War illness claims could be evaluated outside of the federal government.

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*.)

Potential for Adverse Effects of the Persian Gulf Presumptions on Future Scientific Studies. 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 were 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

⁹Report of the Presidential Advisory Committee on Gulf War Veterans' Illnesses. p 125.

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.

Overcoming a Presumed Service-connection: Tobacco Related Illnesses. In the 105th Congress, action was taken to prevent a service-connection to a toxic risk. After several years of study, in 1997 VA had concluded that nicotine addiction is a disease that could be linked to tobacco use that began during military service. Thus, if nicotine addiction has its origins in military service, then “secondary” diseases linked to tobacco use were arguably service-connected. While there are no actual data on the number of total possible claims, the potential number of claims was in the millions. Moreover, the “echo” of service-connected claims could have continued for decades, through compensation automatically paid to the dependents and survivors of veterans who die from service-connected conditions.

At issue was 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 argued that American taxpayers should not be held liable for illnesses caused by veterans’ decisions to use harmful tobacco products. However, as a former VA official pointed out during a recent hearing, “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.”

While some veterans advocates vigorously opposed changing the law, others focused on securing some of the savings for veterans benefits. A provision restricting VA from paying compensation to veterans for adverse effects of tobacco use was included in P.L. 105-178, the Transportation Equity Act for the 21st Century (TEA-21). A similar proposal in the President’s FY1999 budget estimated the 5-year savings at \$16.9 billion; \$15.4 billion of that estimated savings were used to offset spending for highway projects, and the remainder was directed toward improvements in various veterans benefits.

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

Other Issues

Cost-of-living adjustments (COLA). P.L. 107-94 provided a cost-of-living adjustment (COLA) to VA disability compensation payments of 2.6%, first payable in checks issued in January, 2002.

With the exception of the service-connected disability and survivors programs, veterans cash programs are fully and automatically adjusted each year for changes in the COLA in the same manner granted to most federal benefit programs, including Social Security. Why these two important federal obligations are not also automatically linked to the official measurement of changes to the cost-of-living is largely tactical: instead of amending VA law to make COLA automatic, the strong commitment to these programs means that legislation to provide an annual adjustment

is sure to receive procedural attention, even during the frantic days at the end of a legislative session when floor time to consider bills is at a premium. To facilitate the passage of other veterans legislation when Congress becomes pinched for time, the House and Senate Committees on Veterans Affairs report legislation each year that provides for an increase to these programs equal to the increases automatically applied to most other entitlement benefits, attaching to the bill other veterans legislation approved by House and Senate conferees.

For information on issues in veterans legislation enacted during previous Congresses, see CRS Report RL30099, *Veterans Issues in the 106th Congress*, and CRS Report 97-266, *Veterans Issues in the 105th Congress*.

The Insurance Dividend: A Hoax Reappears on the Internet. The Internet has made possible the dissemination through “chain letter” postings, of numerous reports which give every appearance of being factually correct, but which are in fact, totally false. One such disseminated false “report” tells of a supposed dividend that Congress has recently enacted, and for which veterans are eligible if they apply. Rumors of this “bonus” have surfaced periodically through various forms of informal media for nearly 50 years, defying vigorous attempts by VA and Congress to eradicate it from the common sense.

Origin of the dividend rumor. In 1950, VA paid \$2.7 billion in special dividends to 16 million World War II veterans who had National Service Life Insurance policies with premiums paid to 1948 (the 1948 Special Dividend). From that point forward, the possibility of dividends has led to periodic rumors that Congress has again passed such a benefit (or is considering doing so).

For instance, in 1965, for unknown reasons, some newspapers published stories reporting of the special dividends that had been paid in the early 1950s, as if the dividends were being paid at the time the stories were published. While VA attempted to squash the misinformation with factual stories, each time the false reports surfaced, the stories would take on a local circulation life, gradually drifting to more marginal print media, such as newsletters, flyers, and local bulletins, and sometimes accompanied by bogus application forms. At some points, VA received as many as 20,000 inquiries per week about this supposed dividend, and in 1970 the volume of requesters prompted Congress to enact legislation declaring steps to be taken whenever VA was presented with such bogus applications.

The stories are false. There has been no recent legislation that would authorize “special dividends.” Dividends are not payable to current service members insured under the Serviceman’s Group Life Insurance (SGLI) or Veterans’ Group Life Insurance (VGLI), both of which are group policies without dividend concepts involved. VA does automatically pay dividends on some policies of other programs that have that intended feature, but then only to veterans who have kept the policies in force. In the event a veteran is due one of these dividends, it is paid automatically on the anniversary date of the policy, and no application for the payment is necessary.

Legislation

The 107th Congress has enacted several bills affecting benefits for veterans:

P.L. 107-14, Veterans' Survivor Benefits Improvements Act of 2001 (H.R. 801). This law created new life insurance and health care benefits for spouses and children of certain veterans.

P.L. 107-95, Homeless Veterans Comprehensive Assistance Act of 2001 (H.R. 2176). This law authorized 2,000 new Section 8 housing vouchers over the next 4 years to help veterans undergoing treatment for mental illness and substance abuse; and, increased authorization to \$60 million, of the Homeless Grant and Per Diem Program for FY2002 (rises to \$75 million at the end of FY2002).

P.L. 107-103, The 21st Century Montgomery GI Bill Enhancement Act (H.R. 1291). This new law made a number of important changes to VA programs:

Educational assistance provisions. The bill:

- Increased basic educational benefits under the Montgomery GI Bill to \$800 per month beginning January, 2002; \$900 per month, beginning October 1, 2002; and \$985 per month, beginning October 1, 2003, for a 3-year enlistment. For a two-year enlistment, the monthly amounts are \$650, \$732, and \$800 per month, respectively;
- Increased the rate of Survivors' and Dependents' Educational Assistance from \$608 to \$670, per month;
- Preserves or restored educational assistance for participants in VA-administered programs for persons called to active duty;
- Increased from \$2,000 to \$3,400 the maximum payable to certain Reserve Officer Training Candidates;
- Expanded the work-study program to include jobs in the veteran's academic discipline, in state veterans nursing homes, and in various benefit outreach efforts;
- Added to the list of "private technology entities" that can meet the definition of approved educational institutions;
- Provided for the disabled spouse, or surviving spouse of a veteran with a severe service-connected disability to receive special restorative training;
- Allowed for some cases of independent study that qualify for Montgomery GI Bill payments.

Transition and outreach provisions. The bill included expansion of outreach to veterans during transition from active duty. Among the efforts are those that:

- Give VA authority to provide transition assistance in permanent offices overseas;
- Extend pre-separation counseling to as early as 12 months before discharge, and 24 months before retirement;
- Improve outreach to veterans, dependents, and survivors to provide them with enhanced access to VA services and benefits.

Medical benefits.

- Repealed the 30-year presumptive period for respiratory cancers linked to exposure to herbicides;
- Expanded the list of illnesses presumed to be service-connected to Gulf War service to include a medically unexplained chronic multisymptom illness, such as chronic fatigue syndrome, fibromyalgia and irritable bowel syndrome which has been defined by a cluster of signs or symptoms.

Memorial affairs, insurance, and other provisions. The bill also adds to memorial benefits. The bill:

- Increased burial and funeral allowances from \$1,500 to \$2,000 for veterans dying from service-connected conditions; and increased the allowance from \$300 to \$500 for other veterans; and increased the burial plot allowance from \$150 to \$300;
- Increased the amounts available to adapt automobiles or other equipment for severely disabled veterans from \$8,000 to \$9,000; and increased housing adaptation grants for such veterans from \$43,000 to \$48,000; and for the less disabled, from \$8,250 to \$9,250;
- Revised the means-test rules for VA's wartime-service pension, so that agricultural real estate is excluded from asset determinations;
- Expanded outreach programs for dependents, and expanded the period during which transition counseling is available to persons leaving active duty;
- Permits veterans to receive education benefits for independent study from qualified institutions of higher learning;
- Increased the home loan guaranty from \$50,750 to \$60,000; and,
- Assures that war-time service veterans aged 65 and above can be eligible for means tested pension assistance without a determination of disability.

P.L. 107-11, a bill to expedite the completion of the World War II memorial, (H.R. 1696). Concern in Congress about the pace of construction on the memorial to honor World War II veterans led to the passage of legislation to expedite the memorial's completion, and to block further efforts that had surfaced to modify the design and placement of that memorial. The new law specifies that the memorial, "...as described in plans approved by the Commission of Fine Arts on July 20, 2000 and November 16, 2000, and selected by the National Capital Planning Commission on September 21, 2000 and December 14, 2000, and in accordance with the special use permit issued by the Secretary of the Interior on January 23, 2001, and numbered NCR-NACC-5700-0103, shall be constructed expeditiously at the dedicated Rainbow Pool site in the District of Columbia."

Other Legislation.

Veterans' Hospital Emergency Repair Act (H.R. 811). The recent earthquake in Seattle prompted Chairman Smith to introduce a bill to authorize \$550 million in construction projects, including those that would repair damage done by the quake, and others which would make modifications to reduce future seismic risk. In addition, the bill would authorize projects to expand outpatient access in several facilities, and to renovate and repair existing facilities. Longer-term assessment of VA

capital improvements awaits completion of The Capital Assets Realignment for Enhanced Services (CARES) review, which is expected to issue findings that the review identified as in need of renovation, modification, expansion, or closing. Actual amounts available for VA construction depends on levels appropriated for that purposes through the normal appropriations process.

The House passed the bill on March 27, 2001. The bill currently awaits further action in the Senate Committee on Veterans Affairs.

