

An hourglass-shaped graphic with a globe in the top bulb and another globe in the bottom bulb. The hourglass is light blue and has a dark blue cap at the top. The globe in the top bulb is dark blue, while the globe in the bottom bulb is light blue. The text is centered within the hourglass.

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Veterans Issues in the 106th Congress

Dennis W. Snook, Domestic Social Policy Division

Updated March 7, 2001

Abstract. This report focuses on policies, programs, and benefits of interest to veterans. Included are issues before Congress, and the status of major legislation.

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Veterans' Issues in the 106th Congress

Updated March 7, 2001

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Veterans' Issues in the 106th Congress

Summary

VA Budget. Congress appropriated \$47 billion for programs of the Department of Veterans Affairs (VA) for FY2001 (P.L. 106-377). The Administration requested \$20.3 billion in discretionary funds for VA medical care, and Congress approved that request, a \$1.3 billion increase above the appropriated amount for FY2000. Congress appropriated (P.L. 106-74) \$44.3 billion for FY2000, \$1.8 billion above the request for that year; \$1.7 billion of the difference was added to the VA medical care budget.

Recent legislative developments. To facilitate floor action, the House and Senate Veterans' Affairs committees often combine bills to reduce the number of bills reported. Three such bills were signed into law: H.R. 4850 (P.L. 106-413) which provided for a Cost-of-Living Adjustment (COLA) for 2001 (3.5%); and S. 1402 (P.L. 106-419), which made many relatively small changes to VA benefit and health care programs. Another new law, P.L. 106-475 (H.R. 4864), changed the extent to which VA personnel are required to assist applicants for benefits as they prepare their claims and compile supporting evidence.

Veterans Millennium Health Care Act of 1999 (P.L. 106-117). This new law, enacted in the 1st Session, expanded long-term care; increases home health care; gave higher priority access to long-term care to severely disabled veterans and to those needing care for service-connected conditions; provided higher priority access to veterans awarded Purple Hearts and certain military retirees; authorized VA to increase copayments for pharmacy benefits used for treatment of nonservice-connected conditions; and authorized emergency care coverage for certain veterans without health insurance. The law also refined the management of underutilized VA capital assets by conditioning the disposition of VA properties. Other provisions of P.L. 106-117 make eligible for compensation, surviving spouses of certain totally disabled former prisoners of war; extend authorization for homeless veteran programs; and, provide borrowing authority for the American Battle Monuments Commission so that work can begin on the WWII memorial.

Other Veterans' Issues. P.L. 106-50, enacted during the 1st Session, provides expanded Small Business Administration assistance to veterans owning or beginning small businesses. P.L. 106-169, a bill to improve foster care programs, included language giving Supplemental Security Income (SSI) benefits of 75% the normal rate to certain Filipino veterans (who served under US command during WWII) who return to the Philippines. The FY2000 National Defense Authorization Act (P.L. 106-65) provided additional payments (up to \$300 monthly) to disabled military retirees with VA compensation ratings of 70% or greater. Legislation (S. 1928) to establish eight demonstration projects to examine the feasibility of reimbursing VA for medical costs incurred by some veterans with Medicare (called Medicare "subvention") was reported by the Senate Finance Committee near the end of the 1st Session, but final work on the bill was not completed.

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Veterans' Issues in the 106th 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 in military service; pensions for disabled, poor war veterans; cash payments for certain categories of dependents and/or survivors; free medical care for conditions sustained during military service, and for other conditions under a priority system that results in most care being provided to low income veterans; education, training, rehabilitation, and job placement services to assist veterans upon their return to civilian life; loan guarantees to help them obtain homes; life insurance to enhance financial security for their dependents; and burial assistance, flags, grave-sites, and headstones when they die.

The Veteran Population

There were about 24.4 million veterans as of July 1, 1999, of whom 19.3 million had served during at least one period defined as wartime. The number of veterans is declining, and their average age increasing. The median age of veterans was 57.7 years; 36% were over 65 years of age; about 4.6% were female. The VA projects a decline of about 26% in the number of veterans between 1990 and 2010, down from one of four men in 1994 to one of eight in 2010, 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.

Organization of the Department of Veterans Affairs

The VA is divided into three administrative structures: The Veterans Benefit Administration, the Veterans Health Administration, and the National Cemetery Administration. VA programs are funded through 22 appropriations (including six

revolving funds receiving appropriations), nine revolving funds not receiving appropriations, two intragovernmental funds, one special fund, and seven trust funds.

The cash benefit programs, i.e., compensation and pensions (and benefits for eligible survivors); readjustment benefits (education and training, special assistance for the disabled); home loan guarantees; and veterans' insurance and indemnities are mandatory (entitlement) spending, although required amounts are annually appropriated. 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 FY2000, VA discretionary spending has risen to 47% of VA's total budget. For the entire federal budget, about one-third of spending is discretionary.

Cash benefit programs. Under entitlement programs, definitions of eligibility and benefit levels are in law. During FY2000, about 2.3 million veterans drew an average of \$561 in monthly compensation for service-connected disabilities; about 303,000 of their survivors averaged about \$970 in monthly payments. Pensions for 373,000 veterans averaged about \$524 monthly; 266,000 survivors of veterans pensioners averaged about \$221 monthly. About 266,000 veterans were receiving readjustment education benefits, averaging \$3,241 annually.

Medical care. VA operates the nation's largest health care system, with 172 hospitals, 132 nursing homes, 40 domiciliarys, 206 readjustment counseling centers (Vet Centers), 73 home health-care programs, and over 800 outpatient clinics. The FY2000 caseload was projected to reach nearly 3.8 million unique patients, an increase of 185,000 veterans served over FY1999, rising to 3.9 million during FY2001. VA health care continues to place increasing emphasis on outpatient care: according to VA projections accompanying the FY2001 Budget, the inpatient caseload for FY2000 will be 738,000, a decline by about 14,000 patients. In contrast, outpatient visits will increase by 2.6 million to 40.4 million.

VA Budget and Appropriations

VA Appropriations

FY2001 (P.L. 106-377). Congress appropriated \$47 billion for Department of Veterans Affairs (VA) programs for FY2001, \$55 million more than the President requested. The House recommended \$46.910 billion (H.R. 4635) for VA for FY2001. The Senate, in amending the House bill, adopted its Appropriation

Committee's recommendation of \$46.966 billion, and then subsequently amended the bill to incorporate the version agreed to in a preliminary conference between the two Houses. That version was the final one agreed to by both Houses, and signed by the President as P.L. 106-377.

FY2000 (P.L. 106-74). Congress provided \$44.3 billion for the Department of Veterans Affairs (VA) for FY2000. Included in the bill was a \$19 billion appropriation for VA medical care, which was a \$1.7 billion increase above FY1999 and \$.7 billion more than requested by the Administration (whose initial FY2000 budget request for VA entailed a freeze to medical care funding). Congress also provided \$225 million for federal construction projects for VA, and \$115 million for extended care facilities and veterans' cemeteries operated by the states (\$50 million more than requested for extended care, and \$14 million more than for cemeteries.)

In later action (P.L. 106-113), Congress enacted language requiring a 0.38% cut to most discretionary spending, including VA medical care.

For additional information on VA appropriations for FY2001, see CRS Report RL30504, *Appropriations for FY2001: VA, HUD, and Independent Agencies*, Dennis Snook and Richard Bourdon, Coordinators.

VA Cash Benefits. While the number of veterans is declining, VA entitlement spending, mostly service-connected compensation, pensions, and Montgomery GI-Bill education payments, rose by \$18 million in FY2000, to \$23.397 billion, and is projected to require \$24.6 billion in FY2001. 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. Much of the projected increase results from liberalizations to the Montgomery GI Bill, the primary education program.

The Balanced Budget Act of 1997 included language that ended the long-standing VA practice of paying compensation and pension benefits on Friday, when the 1st day of the month occurred on a weekend. October 1, 2000, the start of FY2001, fell on a Sunday, and the Administration proposed that the payments be made the previous Friday. P.L. 106-246 repealed the 1997 language, clearing the way for the payment due in October, 2000 to be paid on September 29. This change shifted \$1.832 billion in mandatory spending from FY2001 to FY2000.

Veterans' Housing Benefits. Historically, the opportunity for veterans to have home loans guaranteed by the federal government was a significant contribution to the national goal of increasing the number of families who owned 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.

Table 1 shows appropriations enacted for VA programs for FY2000 and requested and enacted for FY2001.

**Table 1. Appropriations: Department of Veterans Affairs,
FY2000-2001**
(\$ in millions)

Program	P.L. 106-74	FY2001 request	House- passed (H.R. 4635)	Senate Comm. (H.R. 4635)^a	P.L. 106-377
Income security					
Comp.; pensions; burial	\$21,568	\$22,766	\$22,766	\$22,766	\$22,766
Insurance; indemnities	29	20	20	20	20
Education, training					
Readjustment benefits	1,469	1,634	1,664	1,634	1,634
Msc. loan, admin. exp.	1	1	1	1	1
Housing programs					
Current (admin. exp.)	158	167	162	163	163
Indefinite	282	166	166	166	166
Trans. Housing Loans	48	—	—	—	—
Medical programs					
Medical care ^b	18,926	20,282	20,282	20,282	20,282
Medical research	321	321	351	331	351
Med. admin. and misc.	60	65	62	62	62
Construction					
Major construction	65	62	62	49	66
Minor construction	160	162	100	162	162
Other					
Gen. Operating Expenses	913	1,062	1,006	1,050	1,050
Office of Inspector Gen.	43	46	46	46	46
Grants, state nurs. homes	90	60	90	100	100
Grants, state cemeteries	25	25	25	25	25
Nat'l Cemetery Admin.	97	110	107	110	110
<i>Mandatory (entitlements)^a</i>	<i>23,397</i>	<i>24,586</i>	<i>24,616</i>	<i>24,586</i>	<i>24,586</i>
<i>Discretionary (exclud.. MCCF)</i>	<i>20,859</i>	<i>22,363</i>	<i>22,294</i>	<i>22,380</i>	<i>22,417</i>
Total VA Appropriations	\$44,255	\$46,948	\$46,910	46,966	47,003

Source: H.Rept. 106-988 (Conference report on H.R. 4635)

Note: Rounded, may not add. Mandatory spending includes payments for income security; education, training and rehabilitation; and subsidies for home loan guarantees. Administrative expenses for these programs are included in totals for discretionary spending.

^a After several procedural steps, the Senate approved the version of the bill arising from an informal conference; data in this column reflects the recommendations in the earlier amended version of H.R. 4635 reported from the Senate Committee on Appropriations.

^b Net, after cuts of \$80 million (0.38%) required by P.L. 106-113. The medical care account also receives transfers, estimated to be \$608 million for FY2000 and \$639 million for FY2001, from the Medical Care Collections Fund (MCCF) of reimbursements from private insurers (whose health plans cover certain veterans treated by VA for nonservice-connected conditions), and copayments and deductibles from veterans ineligible for free care.

Guaranteed Transitional Housing Loans for Homeless Veterans Program Account. P.L. 105-368, the Veterans Programs Enhancement Act of 1998 established a pilot project to expand the supply of transitional housing for homeless veterans. The program was authorized to guarantee up to 15 loans with a maximum aggregate value of \$100 million, with no more than five loans guaranteed during the first 3 years. These housing plans must enforce sobriety standards, as well as provide various supportive services, such as substance abuse counseling and job readiness skills workshops. Residents must pay a reasonable fee to reside in the project homes. P.L. 106-74 included an estimate that \$48.25 million for program costs for the program would be required during FY2000, based on the loan limitation of \$100 million. The program does not require additional spending in FY2001.

Medical Care. Congress approved the President's recommendation of \$20.3 billion for VA medical care for FY2001, an increase of nearly \$1.3 billion over FY2000. Congress approved \$19 billion for FY2000, after adding \$1.7 billion to the Administration's request of \$17.3 billion. (The appropriation was reduced by \$79.5 million by the across-the-board cut of 0.38% mandated by P.L. 106-113.) The Administration had initially requested the same amount for FY2000 as had been appropriated for FY1999, a freeze in part intended to force efficiencies within the VA medical system. Faced with mounting criticism in Congress of the requested levels, the Administration added \$1 billion to its original request.

In addition, 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 \$583 million in recycled spending authority in FY1999, \$608 million in FY2000, and is projected to add \$639 million in FY2001.

Medical research. Congress appropriated \$351 million for VA medical research projects for FY2001, the same as the House approved (H.R. 4635); the Senate committee version recommended \$331 million. Congress appropriated \$321 million for medical research for FY2000.

Response to Hepatitis C (HCV). Evidence suggests that veterans have a substantially higher infection rate for this dangerous communicable disease. A VA survey 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. Leading veterans' groups and some health care professionals have advocated an aggressive response by VA to combat the threat, and 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.

The two committee reports accompanying H.R. 4635 (H.Rept. 106-674; S.Rept. 106-410) emphasize the need to focus necessary resources on research, diagnosis,

and treatment of this disease; the Conference Report to accompany H.R. 4635 (H.Rept. 106-988) affirmed this emphasis, and instructed VA to include the disease in its complex care calculation for purposes of resource distribution among its 22 regional plans.

VA Construction. The Administration requested \$62 million for major construction and \$162 million for minor construction for FY2001; Congress provided \$66 million for major construction, and \$162 million for minor construction.. Major construction projects have an estimated cost over \$4 million. Many of the minor construction projects will continue VA's overall strategy of expanding outpatient access. P.L. 106-74 included \$65 million for major construction, and \$160 million for minor construction (projects with an estimated cost under \$4 million), for FY2000.

Program Administration. P.L. 106-377 included \$1.050 billion of the requested \$1.062 billion requested for General Operating Expenses (GOE) for FY2001. 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 Administration projects overall VA employment will average 203,352 during FY2001, down from an estimated average of 204,115 during FY2000, and 205,547 in FY1999. Much of the decline will be in medical staff: VA estimates 179,206 medical care slots for FY2001, down 1,300 positions from an estimated 180,510 in FY2000, and 182,661 in FY1999. Medical care staff positions will have declined by 12% from its high of 204,527 at the end of 1993, if these estimates are matched with experience.

For further information on FY2000 appropriations for VA, see CRS Report RL30204, *Appropriations for FY2000: VA, HUD, and Independent Agencies*.

Veterans' Issues Continuing in the 106th Congress

Veterans' Medical Services: More Efficient, Greater Access

Introduction: Historical Trends and Modern Challenges. The VA medical care system is experiencing a steadily increasing number of veterans seeking care in VA facilities. VA estimates that its medical services will be given to 3.9 million different patients in FY2001, up from 2.7 million in FY1997. Initially, medical care services were provided for these additional patients without substantially increasing appropriations to VA for its medical care programs. VA improved its efficiency in the delivery of medical services by increasing the number of outpatient access points, distributing resources from underutilized facilities to under-served areas, and identifying non-appropriated funds that could be used to expand medical capabilities. However, Congress appropriated \$19 billion for FY2000, \$1.7 billion above the Administration's initial request, and the Administration requested, and Congress has approved, \$20.3 billion for FY2001.

Potential Conflicts Between Medical Judgements and Administrative Practices. VA medical care professionals and VA administrative staff are attempting to increase the number of veterans served by VA medical staff by becoming more efficient without sacrificing the quality of care. However, these potentially competing objectives may be difficult to reconcile, especially because the responsibility for meeting the objectives are handled differently by medical personnel and administrators. How efficiently and effectively can VA administrators manage health care resources, when resource decisions are often made by medical staff with differing objectives?

Clearly, if all 25 million veterans sought care in VA facilities, the system would be unable to meet all of the demands thereby placed upon it. On the other hand, the provision of care to specific patients depends on the access such patients have to the services of individual providers. VA medical care personnel can operate with enough flexibility in the number of patients they see, and the amount of time they spend with each patient, so that the total amount of access that can be provided over a period of time is largely indeterminable for any given level of resources.

Reforming VA Medical Care to Meet the Challenges. The VA hospital-based medical care system is traceable to the end of World War II, and rapid construction of VA hospitals to meet the expected medical needs of returning troops. Over the years, however, advances in medical care made it possible to have needed services available through clinics and other outpatient venues. VA was slower to adapt to these changes, but in spite of rules that seemed to encourage hospitalization of veterans in order to assure their treatment, VA began to find effective care could be more efficiently provided on an outpatient basis, especially with the development of self-administered drugs to treat many conditions. To accommodate these changes in medical practice, a combination of administrative and legislative decisions made major changes to the VA health care system.

Eligibility Reform. The 104th Congress reformed the rules governing access to VA health care. Until P.L. 104-262, many veterans had clear rights to acute care but not to basic services, leaving many veterans uncertain as to the medical benefits available to them, and arguably resulting in inefficient use of resources. Substantial evidence existed that demands for VA health care differed from one region to another, and the distribution of medical resources around the country did not match that demand.

Managing Access. Theoretically, access to VA health care is governed through a system in which veterans are enrolled in health plans according to a schedule of priorities. These priorities are based on eligibility criteria intended to preserve sufficient resources so that high priority veterans (primarily those with service-connected conditions, or who have disability compensation ratings for such conditions), can be assured of receiving all care that might be medically indicated.

There is a potential conflict between the objective of administrative staff to manage resources to stay within budgetary constraints, while preserving resources to meet the medical needs of veterans with the highest priority for medical services, and the objective of medical staff to see all patients with complaints about their health.

The medical profession views the treatment of patients' medical requirements to be the primary purpose of their decision-making process, and that professional commitment could transcend the administrative commitment to preserve scarce resources according to a system of priorities unrelated to medical need.

Generally, appropriations have been sufficient so that priority categories 1 through 6 are assured of medical services. In recent years, because of greater efficiency in the managing of VA medical resources, Priority 7 veterans have also been able to enroll in VA medical plans if they choose to, and thereby be assured of access to VA medical services during the period of their enrollment. While the enrollment period theoretically begins each October 1 (coinciding with the beginning of a fiscal year, and the expected certainty of spending authority available for that fiscal year), VA does not require renewing enrollment, nor does it have a method for "disenrolling" a veteran once the veteran applied for enrollment. VA plans on continuing to enroll all eligible veterans who apply during FY2001.

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. VA patients tend to be “older, sicker, poorer, and more likely to have social problems and mental illness than persons using private health care facilities.”¹

Regional Administration. The VA reorganized the medical system into 22 regional entities, called Veterans Integrated Service Networks (VISNs). Each VISN manages all resources within the region, consolidating and integrating service capabilities to avoid duplication and increase efficiency. Annual evaluations guide the allocation among VISNs, and among units within VISNs. VA is developing unit/cost data to more accurately assess patient costs, and to identify differences in efficiencies across regions.

To provide veterans with a clearer sense of the medical benefits they could expect to receive, each VISN established health plans to administer veterans’ health care — these plans began enrolling veterans October 1, 1998. Currently, all veterans applying for enrollment are accepted; this practice will continue at least through FY2000. Veterans can enroll in advance of seeking care; severely disabled are exempt from enrollment, as are veterans in a current treatment program; all others can enroll at the time they are seeking medical services.

Reallocating Resources to Achieve Efficiencies and Improve Access. A system for measuring the relative needs for resources among VISNs, called the Veterans Equitable Resource Allocation (VERA), guides the shift of resources according to a methodology that identifies underutilization and rewards efficiency. According to the General Accounting Office (GAO), the objective of VERA is to provide “... comparable resources for a comparable workload ... so that veterans within the same priority categories have the same availability for care, to the extent practical, throughout the VA healthcare system.” VERA is predicated on the assumption that reallocation is necessary when “... one network is allocated more funds *per veteran* than another network.”

New Sources of Funds Instead of Additional Appropriations. To make up the difference between appropriated funds and projected increases in medical care costs, the Administration’s budgets for FY1998, FY1999, and FY2000 assumed revenues from new sources of funds. VA estimated that by FY2002, about 10% of the medical care budget could be derived from cost recovery, Medicare reimbursement, and revenue from leases and service agreements. (The FY2000 Budget revised this figure downward to 7.6%, largely because the original assumption incorporated revenues from Medicare that have not been authorized.) Together with individual patient efficiency savings of 30%, VA estimated that the reforms could permit serving a 20% increase in caseload without an increase to annual appropriations. While the guideline estimates may not be accurate, the thrust

¹FY2000 VA Budget Submission, v. 2, Medical Programs, p. 2-8.

of VA medical care programs continues to be in the direction of more primary care, provided to more veterans, through increasing reliance on outpatient visits provided by expanding outpatient access.

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.² 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 2000, \$22,887, single; \$27,468, one dependent; \$1,532 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 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.

For inpatient care, copayments are equivalent to the Medicare cost-sharing schedule. For 2000, veterans' pay \$776 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 \$50.80 for outpatient visits in 2000. Veterans (single, no dependents) with incomes above \$8,989 in 2000 are obligated for \$2 for each monthly outpatient prescription filled through the VA pharmacy system.

Changes due in VA copayment schedule. Under authority of the Millennium Health Care Act (P.L. 106-117, discussed later in this report under a heading of that name), VA has been given the authority to revise the cost-sharing structure to bring copayments more into line with prevailing private sector practices. These changes will greatly aid 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.

Priority 7 veterans (often called Category C veterans, based on a previous access priority schedule) who seek care for a nonservice-connected condition from VA medical facilities become obligated for copayments. Given the relatively high

²Although 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.

copayment for a VA outpatient visit (\$50.80 in 2000), many veterans express 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 seek care from VA because they have been given an expensive prescription by another medical care provider, and they do not have insurance benefits that will pay the cost of that prescription. Frequently, these veterans are covered by Medicare, and do not understand why they should need to see two providers at government expense, when it is the same condition to be treated.

As a result of instructions given to the Department by P.L. 106-117, VA is working toward a new copayment schedule, with outpatient visits reportedly near \$15 for the first visit for a specific condition, and a prescription copayment of \$5 monthly. Most veterans in Priority Categories 1 through 6 would not pay copayments for outpatient visits for medical care given for nonservice-connected conditions, although some veterans who qualify for free care because of low incomes may be obligated to pay copayments for prescribed medications.

It should be noted that 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.³ 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.

Stepped up collections of outstanding cost-sharing obligations. On July 14, 2000, VA began notifying veterans with outstanding obligations for copayments and deductibles that the Department would become more aggressive in its efforts to recover the owed amounts. Citing requirements on the VA contained in P.L. 99-272 and P.L. 101-508, and with reference to the Debt Collection Improvement Act of 1996, VA informed veterans that outstanding cost-sharing obligations would be offset from other federal payments, including for the first time from Social Security benefits to which the veteran is entitled (limited to 15% of the benefit in excess of \$750 per month). Federal employees, who are also veterans with unpaid cost-sharing obligations for past VA medical care, may also have their federal pay offset to satisfy the outstanding amounts. While authority for these offsets has existed for some time, past offsets have been limited to amounts due for VA disability compensation and federal income tax refunds.

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

³The VA pharmacy formulary does not prevent a VA physician from prescribing outside the formulary, provided the physician has a medical justification for doing so.

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

In the past, VA's MCCF fund (previously called the Medical Care Cost Recovery fund) received all medical care cost collections. Each year, VA transferred the funds to the Treasury, after subtracting the cost of administering the collection procedures. To enforce discipline on the program, and to encourage medical facilities to be more aggressive in pursuing funds VA had authority to collect, the Balanced Budget Act of 1997 requires VA to bear the costs of MCCF collections, but lets the medical program keep the funds. According to the Administration's budget, \$667 million were collected during FY1998 and \$583 million in FY1999; were expected to have collected \$608 million in FY2000, and were projected to collect \$639 million in FY2001.

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

In addition, VA has temporary authority (extended by P.L. 106-117 until December 31, 2011) to enter into "enhanced use" leases, in which VA facilities and/or services can be contracted by other entities. After taking into consideration how the leasing arrangement would affect local commercial and community interests, VA can enter into leases of up to 75 years if it determines that the activities would not interfere with VA programs, and would in some way serve the interests of veterans. These leases may be additional sources of revenue to the facilities, and may serve to increase the use of capacity that would otherwise be underused.

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

If Medicare were to transfer funds to cover the cost of VA's services to its existing caseload of patients who are also covered by Medicare, Medicare 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.

The 105th Congress considered Medicare subvention bills, but ended with no final action. One bill (H.R. 3828), to authorize a pilot project at three locations for 3 years, was reported by the House Committee on Ways and Means, with approval of the House Committees on Veterans Affairs, and Commerce. The pilot project would have permitted veterans in those three locations, whose priority status requires them to share in the cost of their medical care (called Category C veterans in the bill), to enroll in a VA plan and have their Medicare benefits provided through that plan. Medicare would then pay VA the same rate, per covered person, that it would pay for those persons to enroll in a similar private prepaid plan approved by Medicare. The bill would also have permitted veterans who live in “geographically remote areas”, and who have high-priority access to VA health care (called Category A veterans in the bill), and who are also covered by Medicare, to receive their Medicare benefits through one of VA’s VISN health plans.⁴

This approach to 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. In the 105th Congress bill, Medicare would have been authorized to reimburse VA for up to \$50 million in the year 2000, \$75 million in 2001, and \$100 million in subsequent years for care provided to Category A veterans, and \$50 million for each of 3 years for the Category C veterans.

The approach had bipartisan support (with 92 cosponsors), but the 105th Congress ended with the bill not acted upon by the full House. The substance of H.R. 3828 was included in H.R. 4567, which passed the House on October 10, 1998, but no action was taken in the Senate before the end of the 105th Congress.

On February 24, 1999, the Senate passed S. 4, a bill to improve pay and retirement equity for members of the Armed Forces. Attached to the bill was an amendment to establish Medicare/VA subvention demonstrations in up to 10 sites. The proposed pilot projects would meet criteria for providing Medicare benefits through VA health care plans for certain veterans with coverage under the Medicare program. These plans would be regarded by the Medicare program as qualified Medicare providers.

On November 16, 1999, the Senate Finance Committee reported the Medicare Subvention Demonstration for Veterans Act of 1999 (S. 1928; S.Rept. 106-222),

⁴There is no Category B. Common practice in veterans’ health care discussions, divides veterans into these two categories, one of which has access to free VA care, while the other agrees to share in costs. Although the categories are not found in VA law, some years ago VA law did categorize veterans according to access priority categories A, B, and C.

which would establish up to eight demonstration sites to deliver Medicare-covered services to certain Medicare-eligible veterans. VA would be authorized, upon agreement with the Department of Health and Human Services (HHS), to establish an equal number of coordinated care and fee-for-service plans, one of each of which must be located within a predominately rural area. VA would provide, at a minimum, Medicare benefits equivalent to those benefits received by Medicare beneficiaries in other plans.

The Medicare Trust Fund would 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. Unlike the House bill of the 105th Congress, only Category 7 veterans (those ineligible for higher priority, free VA care) could join the demonstration projects. (The House bill of the 105th Congress would have allowed enrollment in the demonstrations by veterans eligible for high-priority access to VA care, but who live in remote areas.) Other requirements upon VA and the Medicare program are much the same as in the House bill of the 105th Congress, and would be coordinated between VA and HHS.

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. Currently, there is no active legislation to bring about a Medicare Subvention project for coordinating medical benefits for veterans with rights to both VA and Medicare.

Finally, language was included in H.R. 5109 (*VA Health Care Personnel Act of 2000*) which addressed issues in VA-Medicare Subvention. The provisions were dropped when other provisions in H.R. 5109 were added to S. 1402 before its enactment. The subvention provisions engendered some debate among veterans' service organizations, with the American Legion and the Veterans of Foreign Wars endorsing the provision and the Disabled American Veterans and the Paralyzed Veterans of America opposed to its enactment. The provision 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 would expire

in 2005, and 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, who 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 Millennium Health Care Act (P.L. 106-117). Near the end of the 1st Session, Congress approved the Millennium Health Care Act (H.R. 2116). The new law expands 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. The Act also authorizes 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 Act also authorizes the creation of such a capability to the level sufficient to assure access to the services for 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 instructs VA to increase emphasis on mental health services, especially such services applicable to post-traumatic stress disorder and substance abuse.

P.L. 106-117 grants high priority access to VA medical services for military retirees, regardless of their placement in the priority system that governs the access of all veterans to VA medical care. This change would have 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 would be given access to free, higher priority health care.

The new law also raises the visibility and accountability of VA efforts to manage its extensive capital stock of buildings and other permanent medical care capability and support. VA would be required to consider alternatives and to draw upon funds for furthering these alternatives, in any situation in which a building, wing, service unit, or other facility is subject to closing. The purpose of the provisions would be to enable VA, and the communities in which the facilities are located, to determine if facilities threatened with closure could be used in some other manner to serve veterans, such as for convalescent care or other assisted living arrangements, before that building is liquidated by demolition or sale to the private sector. VA would be permitted to retain any funds obtained through leasing or

selling facilities, and use such funds for the financing of other forms of disposition, including conversions of the facilities for other veteran uses.

The new law authorizes 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. VA is also authorized under the Act, to establish nonprofit research corporations at VA medical centers to facilitate research, education and training; to revise the priority system for the award of grants under the programs assisting in the funding of "State Veterans Homes," with priority given to renovation, especially when considerations about patient safety are involved.

Finally, P.L. 106-117 authorizes a number of construction projects, among which are ones that would provide a domiciliary in Orlando, Florida; add a long-term care facility at the Lebanon, Pennsylvania complex; complete renovations at VA medical centers in Fargo, North Dakota and Atlanta, Georgia; and demolish surplus and antiquated buildings at the Leavenworth, Kansas, medical facility.

Other Veterans' Issues

Legislation during the 2nd Session of the 106th Congress. Near the end of the pre-election portion of the 2nd Session of the 106th Congress, several bills affecting veterans' benefits were enacted, resulting in three new public laws. In order to expedite action, the final versions of the bills incorporated features from a number of other bills. Among the provisions adopted are ones which would provide a cost-of-living adjustment for service-connected disability and survivor compensation benefits (H.R. 4850); one which would revise the limits that a court decision placed on VA when the Department's employees render assistance to a veteran filing a claim for benefits, (H.R. 4864); and an omnibus bill (S. 1402) that made numerous changes to health care programs, readjustment benefits, VA personnel management and compensation, and certain other changes.

Cost of Living Adjustment (P.L. 106-413). By enacting H.R. 4850, Congress provided inflation increases to disability compensation received by veterans with service-connected conditions, and to compensation paid to the survivors of such veterans.

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 cost-of-living adjustment (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.

The Veterans Claims Assistance Act of 2000 (P.L. 106-475). This new law (H.R. 4864), reversed a 1999 decision of the Court of Appeals for Veterans Claims, which found that VA is required to help veterans obtain records relevant to a claim they file with VA, only if it can be proved that the claim is “well-grounded.”

By tradition, and consistent with its interpretation of the statutes governing veterans’ benefits, VA had assumed considerable responsibility for assisting veterans as they seek benefits from a VA program. In practice, VA claims processors exercised some discretion with respect to the assistance provided, sometimes discouraging veterans from filing claims for which there was ample precedent of similar claims being denied. On the other hand, these same processors provided valuable assistance to veterans with claims that had some potential merit, helping them identify sources of potentially useful information and supporting documentation.

In reviewing the disposition of a recent claim (*Morton v. West*, currently on appeal to the U.S. Court of Appeals), the Court of Appeals for Veterans Claims called into question the regulations and manuals that provided guidance as to the respective obligations of both the veteran claimants and the VA with respect to the filing of a “well grounded” or plausible claim with VA. The Court asserted that VA’s statutory obligation was more limited than their practices indicated, and that the veteran had the sole responsibility of developing information that would lead to a finding by VA that the claim was well grounded, that is, that there was at least some basis for proceeding with developing a case file. Only at that point, could VA become involved in providing assistance to veterans as they developed supporting evidence for their claims.

Partially in response to the unfolding controversy about the Department’s obligations to assist veterans from the beginning of their claims process, VA proposed new regulations⁵ that would require most veterans to submit information demonstrating that their claims are plausible. VA would continue to assume responsibility to assist at all stages, those veterans who may be presumed to be unable to prepare their own claims. VA believed the approach was consistent with existing law, and would resolve the apparent conflict between the statutes and the practices of claims examiners by continuing to assist veterans who cannot help themselves, while asking veterans and their representatives to gather some information that would be needed to begin the claims adjudication process. The veteran service organizations were asked to participate in the refinement of the proposed regulations, and to suggest categories of veterans who should be provided assistance even if their claims do not initially appear to be well grounded.

Some veterans’ service organizations regarded the decision as a significant step back in the kind of assistance that veterans seeking benefits had a right to expect

⁵Proposed Revision to 38 C.F.R. sec. 3.159; December 2, 1999, volume 64 of the Federal Register, pages 67,528 to 67,534.

from the Department's staff, and that the proposed regulations were inadequate protection to veterans who could find themselves unable to proceed with their claims under the new procedures. H.R. 4864 and S. 1810 (the Senate version of this legislation) received substantial support within the veterans' advocacy community.

The new law increased VA's obligations to help veterans at the initial claims stage. Initially, VA voiced concerns that enactment of provisions could substantially increase VA claims processing workloads without substantially changing the ultimate approval rate of applications for benefits. Although VA claimed that the additional workload could have the effect of slowing down the claims process and lead to longer time periods before claims are adjudicated, the Department ultimately did not resist the legislation's progress toward passage.

The Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419). On October 12, 2000, Congress approved an amended version of S. 1402, which the Senate had approved during the 1st Session as the All-Volunteer Force Educational Assistance Programs Improvements Act of 1999. Before enactment, conferees included provisions from several other bills that had been reported from either the House or Senate Committees on Veterans Affairs.

Educational assistance provisions. The new law contains many of the recommendations of the Commission on Servicemembers and Veterans Transition Assistance (discussed later in this report under a heading of that name). Among provisions in the final bill are those which:

- Increase, effective November 1, 2000, the rates of veterans' basic educational assistance under the Montgomery GI Bill (MGIB), from \$528 to \$650 monthly for 3-year enlistees, and from \$429 to \$528 monthly for 2-year enlistees;
- Permit certain Post-Vietnam Era Veterans Educational Assistance Program (VEAP) participants to enroll in the MGIB program;
- Permit participants in the MGIB program to add to their benefit rights (up to \$5,400 over 36 months) by increasing by \$600 their initial \$1,200 contribution;
- Increase the rates for survivors' and dependents' educational assistance to \$558 monthly, automatically adjusted annually thereafter, equal to the COLA applied to other benefit programs;
- Permit the survivor and dependent education assistance payments to be paid retroactively to the date of the entitling event (death or determination of 100% disability);
- Allow education assistance payments to be paid between terms for a period of up to 8 weeks;
- Repeal the requirement that an MGIB participant have a completed high school diploma or equivalency certificate before ending their initial period of active duty;
- Repeal the requirement that MGIB entitlement is predicated on completing an initial obligated period of service, so that eligibility can be based on subsequent periods of service;
- Authorize VA educational assistance programs to pay for vocational or professional certification and/or licensing tests, up to a maximum of \$2,000; and

- Extend through December 31, 2008 certain VA home loan guarantees, and through September 30, 2008 the authority for home loan fees, foreclosure sales procedures, and income verification rules in the VA home loan guarantee program.

Health care provisions. Before action on S. 1402 was completed, provisions of *Veterans Affairs Health Care Personnel Act of 2000 (H.R. 5109)* were included. The personnel provisions included ones which:

- Authorize annual comparability raises for VA nurses similar to those provided other federal employees;
- Incorporate more localized data to assure that VA nurses are compensated competitively with nurses in facilities outside VA;
- Limit the extent to which VA management can modulate nursing pay increases contrary to independent survey data;
- Provide for nurse participation in policy decision-making at network and medical centers levels;
- Revise and increase special pay for dentists;
- Add VA pharmacists to occupations exempt from statutory caps on special pay rates;
- Require VA to include physician assistants (PAs) as consultants in the development of responsibility guidelines for PAs;
- Authorize VA to hire for two year appointments, PAs who have successfully completed the full course of training and are awaiting certification;
- Authorize temporary extensions of term appointments for medical staff doing VA-funded research;
- Authorize VA to waive state licensing requirements for VA social workers who are undergoing pertinent training;
- Extend and modify employee buyouts through December 31, 2002;
- Authorize VA to furnish veterans those accompanying veterans with temporary lodging in conjunction with treatments or services;
- Clarify language establishing VA outpatient clinics at state veterans' homes; and
- Provide a Sense of Congress resolution encouraging joint VA-DoD procurement of medical products including prescription drugs.

The bill would also increase VA's efforts to monitor the relationship between active duty experience and subsequent health issues, attaching the refined data to the veterans' medical records; monitor the Post Traumatic Stress Disorder experience and treatment approaches for veterans of Vietnam; extend the reporting requirements of VA with respect to the Department's handling of mentally ill veterans; and refine the provisions by which VA enters into leasing arrangements of VA facilities and recaptures funds by those arrangements; and require employers to grant leave to reservists who are called to participate as honor guards at funerals of veterans.

In addition to these were provisions authorizing additional construction projects, primarily at VA medical facilities. Among projects authorized are a psychogeriatric care building at Palo Alto, California (\$26.6 million); a utility plant and electrical "vault" at the medical center in Miami, Florida (\$23.6 million); seismic corrections, clinical consolidations, and other improvements at the center in Long Beach,

California (\$51.7 million); and renovation of psychiatric nursing units at the center in Murfreesboro, Tennessee (\$14 million).

Other benefit provisions. Provisions of the *Veterans Benefits Act of 2000*, which included provisions from other bills (H.R. 3998; H.R. 3816; H.R. 4131; and H.R. 4376) were attached to the COLA bill before House passage, and subsequently incorporated into S. 1402 before work was completed on that bill. These bills would expand benefits under the programs for a variety of veterans and family members. Among the provisions are those that would:

- Establish that a stroke or heart attack incurred or aggravated by a member of a reserve component in the performance of duty during inactive duty training shall be considered service-connected;
- Provide that the loss of one or both breasts due to radical mastectomy for a condition traceable to a period of active duty will entail eligibility for a special monthly compensation (currently \$76);
- Permit certain members of the Ready Reserve to participate in the Servicemembers' Group Life Insurance program;
- Increase from \$1,500 to 5 times the benefit amount payable to a totally disabled veteran residing in an institution at VA expense, the amount of resources an incompetent veteran with no dependents may retain, and still qualify for benefits;
- Cap Service Disabled Veterans' Life Insurance (SDVI) premiums at the age 70 renewal rate, and require VA to report on plans to eliminate the SDVI unfunded liability;
- Increase the maximum amount of coverage available through the Servicemembers Group Life Insurance (SGLI) program, and the Veterans' Group Life Insurance (VGLI) program from \$200,000 to \$250,000;
- Permit members of the Individual Ready Reserve subject to involuntary call-up to enroll in the SGLI; and
- Expand full burial and cemetery rights to qualified members of the Philippine Commonwealth Army who have become citizens, legal residents, or who are receiving service-connected compensation, or who would have been eligible for a VA war-time, means-tested pension if their service would have been deemed to be active duty service in the United States Armed Forces during World War II.

Legislation during the 1st Session of the 106th Congress. In addition to the Millennium Health Care Act (P.L. 106-117) discussed earlier in this report, Congress enacted other legislation of interest to veterans during the 1st Session of the 106th Congress.

Veterans' Benefits Improvement Act of 1999 (P.L. 106-117). As Congress neared final consideration of the Millennium Health Care Act (H.R. 2116), the House and Senate Veterans Affairs committees combined features of several other bills (H.R. 2280; S. 1402), and added the language — titling the final bill the Veterans' Millennium Health Care and Benefits Act. In addition to the health care provisions described in the previous section, the Act:

- Authorizes the payment of Dependency and Indemnity Compensation to surviving spouses of certain former prisoners of war who died with a service-connected condition rated 100%;
- Restores eligibility for certain medical, education, and housing benefits to surviving spouses who lost eligibility for these benefits as a result of remarriage. This language restores the benefits when the second marriage ends, just as previous legislation (P.L. 105-178) restored the primary cash payment in similar circumstances;
- Expands the authority for the American Battle Monuments Commission to raise funds for the expedited completion of the World War II memorial, and authorizes up to \$65 million in loans from the Treasury to begin construction;
- Directs VA to obligate a portion of FY2000 appropriations to establish four new national cemeteries by 2008, and to contract for an outside comprehensive assessment of future VA cemetery needs;
- Authorizes \$100 million in appropriations during FY2000-FY2004, for the Homeless Veterans Reintegration Program, administered by the Department of Labor under the Stewart B. McKinney Homeless Assistance Act;
- Includes courses that assist with preparation for college and graduate school entrance exams for purposes of payments under the Montgomery GI Bill readjustment program; and
- Authorizes a series of early-out incentives, including buy-outs of up to \$25,000, for employees of VA whose jobs are being phased out during efficiency improvements.

Cost-of-living Adjustments (P.L. 106-118). As of January, 2000, VA disability compensation and benefits for dependents under the Dependency and Indemnity Compensation (DIC) programs were increased by 2.4%, the same cost-of-living adjustment (COLA) granted to most federal benefit programs, including Social Security. P.L. 105-368 provided the cost-of-living adjustment (COLA) for the service-connected disability compensation programs for CY1999, and an adjustment of 1.3% was applied beginning with checks received in January, 1999.

Increases for Retired Military with Severe Service-connected Disabilities. The FY2000 National Defense Authorization Act (P.L. 106-65) includes a provision that adds monthly payments for retired military personnel who have severe service-connected disabilities rated by VA at 70% or above. Generally, military retired pay and VA compensation are offset against each other, although VA compensation is not subject to taxes on income and military retirement is taxable as ordinary income. Some military retiree advocates have long argued that retirees with service-connected compensation should be permitted to receive both. Opponents of concurrent receipt argue that such individuals should not be compensated twice for the same period of service — once as a retiree, and again as a compensation recipient.

P.L. 106-65 provides taxable monthly payments of \$100 for military retirees with service-connected conditions rated by VA at 70% or 80%; \$200 monthly for retirees with 90% ratings; and \$300 monthly for retirees rated as 100% disabled, provided that these ratings were received from VA within 4 years after retirement from military service.

For further discussion of this provision and of military retirement in general, see CRS Issue Brief IB85159, *Military Retirement: Major Legislative Issues*, by Robert L. Goldich. For further discussion of the issues involved in concurrent receipt, see CRS Report 95-469, *Military Retirement and Veterans' Compensation: Concurrent Receipt Issues*, by Robert L. Goldich and Carolyn L. Merck.

Arlington National Cemetery Burial Eligibility Act (H.R. 70; S. 1076).

Concerns about presidential discretion to waive restrictions on burial in Arlington National Cemetery led to proposals to codify regulations on such burials. Under H.R. 70, only persons specifically covered by the bill's language could be buried at Arlington. The bill would eliminate automatic eligibility for Members of Congress, Cabinet members, and ambassadors who would not otherwise qualify because of military service. Close family members of eligible veterans could continue to be buried in the same grave with that veteran without a waiver. H.R. 70 passed the House on March 23, 1999. On July 26, 1999, the Senate approved S. 1076, with language to accomplish similar purposes contained in the provisions of H.R. 70.

Veterans Entrepreneurship and Small Business Development Act of 1999 (P.L. 106-50). On August 17, 1999, the President signed H.R. 1568, originally reported from the Committee on Small Business, to assist veterans who own, or would like to start businesses. The new law raises the profile of veterans assistance in the Small Business Administration (SBA) by creating an office specifically charged with veterans business assistance. The Office of Veterans Business Development will now oversee technical and informational assistance, and will include service-disabled veterans within the definition of "handicapped individual" for eligibility for SBA business loans. The SBA is authorized to make loans to veterans who own businesses, and who are called to active duty. Veterans are now eligible for participation in programs intended to give small business owners greater participation in federal procurement contracts. SBA will become more involved in assuring that veterans are not subject to discrimination in the startup and operation of small businesses, and that they benefit from various programs intended to improve such opportunities for veterans. Finally, SBA is required to collect data on veterans' small business opportunities and successes, and report annually on veterans and their business ventures.

Supplemental Security Income (SSI) payments for Filipino veterans who have returned to the Philippines (P.L. 106-169). The Foster Care Independence Act of 1999 (P.L. 106-169) contains incidental amendments to the SSI program. One such change permits the continued payment of SSI benefits to Filipino veterans of U.S. Armed Forces service during World War II, when such veterans return to the Philippines. The benefits will be paid at a level equivalent to 75% of the benefit level these veterans would receive if they remained in the U.S. The 75% figure is intended to make these Filipino veterans who return to the Philippines, financially about the same as they would be were they to be eligible in the Philippines for wartime service pensions from VA at the same 50% level paid for other Filipino benefits administered by VA. Veterans who are totally disabled, and who have at least one day during a period defined as wartime, are eligible for VA wartime pensions, which, like SSI, are means-tested payments.

Background on the issue of benefits for Filipino veterans of World War II. During World War II, Filipino citizens in the military forces of the Army of the Commonwealth of the Philippines were drawn into that War under authority of U.S. Armed Forces, on the basis of legislation enacted in 1934 preparatory to Philippine independence. Many of these Filipino veterans believe that their service was active duty service in the U.S. military that should qualify them for the same benefits as other veterans of active duty. Legislation passed in 1946 specifically excludes such Filipino veterans from full veterans' benefits, and pressure to amend that exclusion has periodically surfaced since that time.

Some of the Filipino soldiers were disabled during the course of their service under U.S. Armed Forces command, and became eligible for service-connected compensation from VA. Because of differences between the economies of the U.S. and the Commonwealth of the Philippines, the compensation payments were provided, under federal law, to these disabled Filipino veterans at a rate equivalent to 50 cents for each dollar that would be paid to a similarly disabled veteran in the U.S. Armed Forces, regardless of whether the Filipino veteran resided in the U.S. or the Philippine Islands.

The disparity in payments for U.S. residents entitled to VA compensation has been a recurring issue. Initially, it was argued before Congress by proponents of the lower payments that the distinction was necessary to prevent the benefits from becoming an inducement to seek residence in the U.S. solely for that purpose. Some also argued that the Commonwealth would reach political stability more easily if these disabled veterans remained in the Philippines during the post-war period.

In recent years, Filipino advocates have pointed to the large number of Filipino veterans in the U.S. as legal residents, and have called for legislation to address their claims for full benefits. The Administration's FY1999 and FY2000 budgets have called for legislation to pay disabled Filipino veterans and their survivors residing in the U.S. the full rate, at an additional cost of \$5 million during the first year, and \$25 million over 5 years. Legislation to provide these increased payments was included in P.L. 106-377, VA, HUD, and Independent Agencies Appropriations for FY2001.

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 reason, 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.

Transition from Active Duty to Civilian Life: Are Readjustment Programs Inadequate?

One of the traditional responsibilities of VA is to assist veterans in readjusting to civilian life. Readjustment assistance is also provided to service-disabled veterans to enable them to achieve maximum independence in their daily lives. As a result of the decline in the numbers of veterans, the importance of these readjustment programs is perhaps less evident than it has been during periods in which large numbers of troops were demobilized. The Veterans Affairs Committees in both Houses of the 106th Congress are considering legislative proposals based on recommendations of a recent congressional commission that examined these programs.

Most of the current programs originated with the GI Bill of 1944. Under the GI Bill and subsequent additions and variations, the VA has spent over \$65 billion training or educating more than 20 million veterans. Over 14 million veteran home loans have been guaranteed.

All veterans are also assured assistance in preparing for and finding employment. Educational assistance, job retention rights, preferences in federal hiring (and with employers having federal contracts of \$10,000 or more per year), guaranteed direct loans, and insurance for veterans are among the kinds of assistance provided veterans. Some programs assisting in veterans’ readjustment are administered through agreements between VA and other agencies, including the Departments of Labor, Defense, and Transportation.

Educational Assistance. The original GI Bill was in part intended to help alleviate shortages in trained manpower, as well as provide opportunities for veterans to better adapt to civilian life. For many returning troops, the GI benefits assisted in

furthering education interrupted or postponed by war service, while for others, it provided an inducement to seek training they might otherwise never have pursued. The combination of policy objectives helped both society and veterans adapt to postwar economic conditions.

The current version of the veterans education and training program, called the Montgomery GI Bill (MGIB), meets a somewhat different objective. With the end of conscription and the move to an all volunteer force, Congress enacted a program that serves as a recruiting inducement to young people considering their opportunities for future economic improvement. The Montgomery GI Bill provides educational assistance to veterans who agree to have their military pay reduced by \$100 per month for the first 12 months of active duty. The money is not refundable if the participant does not elect to enroll in eligible education or training.

When the period of active duty is completed, the MGIB participant is eligible for monthly education benefits of \$650 monthly for 36 months for a 3-year active duty enlistment, and \$528 monthly for enlistments of less than 3 years. Other amounts may be added as inducements to join difficult to fill active duty job assignments. Other, somewhat lesser amounts may be paid to reservists, and veterans whose eligibility is traceable to an earlier program. Benefits of the MGIB program are granted a COLA each October.

Commission on Servicemembers and Veterans Transition Assistance. This congressional commission examined programs that help veterans adjust to civilian life after active duty in the armed forces, concluding that some programs "... have become so outdated, and program management so ineffective that they break faith with those who served, and currently serve, their Nation in uniform." The commission's recent report goes on to recommend "... fundamental and far-reaching reforms" to veterans' programs and their administration.⁶

The commission's proposals would enforce tight performance standards on veterans employment and training programs; initiate a common framework between VA and the Department of Defense (DoD) for the resolution of disability claims; improve medical coverage for newly separating veterans; coordinate VA and DoD medical care systems; increase home loan opportunities and establish a small business loan program; and permit active duty military personnel to participate in the Federal Employees Thrift Savings Plan (TSP) on the same basis as civilian federal workers.

A proposal to increase education benefits. Perhaps the major recommendation of the Commission concerns the role VA education benefits play in recruitment of an adequate supply of young and able military personnel. At issue is a key finding of the Commission: While college attendance is a major goal of high school graduates and their parents, the value of MGIB benefits toward a college

⁶Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance, transmitted to the Committees on Veterans Affairs, Armed Services, and National Security of The Senate and House of Representatives of the United States, January 14, 1999. The Commission was established by P.L. 104-275.

education is relatively less attractive than it once was. Other programs targeting the same population have increased in scope and generosity, causing military service to be viewed "... as a detour around college enrollment, not as a way to achieve it...Congress appropriates billions of dollars for non-veteran education programs that are available to any American without enduring the risks and sacrifices inherent in military service. A veterans' education conditioned on military service must offer a substantial advantage over programs available to all Americans"

The Commission proposed a substantial liberalization of the MGIB, eliminating its pay reduction in the first year of active duty, and providing a monthly stipend, funds for books, tuition, and fees "... to attend any institution of higher learning in America for which they qualify ..." to any veteran who has completed an enlistment of at least 4 years. For enlistments of less than 4 years, the Commission recommends an increase to \$600 monthly, and providing the money at the beginning of an academic term. Versions of these changes were included in P.L. 106-419 (discussed above), enacted late in the 2nd Session of the 106th Congress.

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 medical treatment for veterans who may have been exposed to toxic substances or environmental hazards during the Persian Gulf War expires 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 106th 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.”⁷

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.”⁸ In spite of the VA opposition, the bill passed, and subsequently has been amended to include additional diseases.

Radiation-exposed veterans continue to have various illnesses considered for inclusion within the presumption. On February 25, 1999, the Senate, before passage of S. 4, amended it to include language offered by Senator Wellstone that increased the number of diseases for which a presumption of service-connection would exist for disabilities experienced by “radiation-exposed veterans.”

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

⁷H.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).

⁸*Ibid.*, p. 10-11

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 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.⁹ 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.

⁹The 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.

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 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."¹⁰

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

¹⁰Report of the Presidential Advisory Committee on Gulf War Veterans' Illnesses. p 125.

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 are now authorized to receive priority treatment for a virtually unlimited list of symptoms. Researchers caution that it may be impossible to identify the causes of illness in many Gulf War veterans because of the absence of baseline data on the health of military personnel, and the lack of reliable data on levels of exposure to potential risks in their wartime environment. In effect, because both exposure to a toxic risk and the presence of a disorder are presumed, the statistical relationship between the risk level for one and the incidence of the other may be indeterminable.

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*.

For further information on veterans' issues in the 105th Congress, see CRS Report 97-266, *Veterans' Issues in the 105th Congress*.