

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, and the globe in the bottom bulb is light blue. The text is centered within the hourglass.

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Report 97-266

VETERANS ISSUES IN THE 105TH CONGRESS

Dennis Snook, Education and Public Welfare Division

Updated November 11, 1998

Abstract. Issues considered by the 105th Congress included the FY1999 budget request, Persian Gulf War illnesses, access to medical care, adjudication of disability claims, and veterans preferences in federal jobs.

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Veterans Issues in the 105th Congress

Updated November 11, 1998

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ABSTRACT

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

Veterans Issues in the 105th Congress

Summary

Veterans Affairs (VA) Appropriations. Congress appropriated \$42.6 billion in FY1999 appropriations for VA (P. L. 105-276), up from \$41 billion in FY1998. In addition, as in FY1998, VA medical facilities will have a total of \$558 million in nonappropriated funds collected from insurers to offset some of VA's costs for care of veterans with other insurance. The Balanced Budget Act of 1997 allowed VA to retain these collected funds rather than transfer them to the Treasury.

VA Medical Plans Began October 1, 1998. As of October 1, 1998, VA regional health plans administer all of VA's medical benefits; despite fears of some veterans, enrollment has been fairly easy, usually whenever they seek care.

Medicare Subvention. Congress gave VA authority to seek reimbursement for some of its costs, and recycle those funds into further care. One additional idea would combine Medicare benefits for certain veterans with their enrollment in VA health care plans, with Medicare partially reimbursing VA for those benefits. Proposed pilot projects (H.R. 3828), were considered but not enacted.

Smoking-Related Diseases as Service-Connected. P.L. 105-178, the Transportation Equity Act for the 21st Century (TEA21), included language ending VA authority to approve service-connected compensation for disabilities linked to tobacco use begun during their military service. Some savings from the change would be used to increase other veterans benefits. P.L. 105-206, the law to reform the Internal Revenue Service, contains language clarifying the changes, and removes the suggestion that smoking was misconduct.

Persian Gulf War Illnesses. Studies have not found causes of various disorders reported by Gulf War veterans. Many researchers conclude that no single cause will explain the diverse symptoms; the studies show that these veterans have not incurred diseases, been hospitalized, or died in unexpected numbers. Legislation (H.R. 4110) awaiting the President's signature, extends services for such veterans to include treatment of any medical problem related to Gulf service through 2001, and further expands treatment of any Gulf War illnesses to veterans' dependents (through 1999), and calls on the National Academy of Sciences to study ways to improve treatment.

Veterans Preferences in Federal Jobs. Some veterans believe that common federal employment practices do not honor preference rights to which some veterans are entitled. Legislation was enacted (P. L. 105-339) to expand preferences and broaden appeal rights.

Other Issues. H.R. 4110 also provides a COLA for VA compensation (1.3% for 1999, thereby matching COLA for many other federal benefit payments); revises various aspects of the programs for veterans receiving education benefits; adds to types of housing eligible for loan guarantees; authorizes construction of more outpatient medical facilities; transfers some aspects of cemetery services to the states; and renames the National Cemetery System as the National Cemetery Administration.

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Veterans Issues in the 105th Congress

Introduction

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

The Veteran Population

There were about 25.6 million veterans as of July 1, 1997, of whom 19.6 million had served during at least one period defined as wartime. The number of veterans is declining, and the average age increasing. The median age of veterans was 57.7 years and 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 65.

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

Organization of the Department of Veterans Affairs

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

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

The cash benefit programs, i.e., compensation and pensions (and benefits for eligible survivors); readjustment benefits (education and training, special assistance for the disabled); home loan guarantees; and veterans insurance and indemnities are mandatory (entitlement) spending, although required amounts are annually appropriated. 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 54% of VA spending. Definitions of eligibility and benefit levels are in law. During FY1999, about 2.3 million veterans will draw an average of \$478 in monthly compensation for service-connected disabilities; about 307,000 of their survivors will average about \$890 in monthly payments. Pensions for 410,000 veterans will average about \$485 monthly; 304,000 survivors of veterans pensioners will average about \$210 monthly.

The remaining programs, primarily those associated with medical care, facility construction, and medical research are annual discretionary appropriations, as are funds for the costs of administering the VA programs. Unlike the ratio of entitlement spending to discretionary spending in the rest of the federal budget, the entitlement portion (income security, mostly for disability compensation, pensions, and education benefits) of VA is declining as a percent of total VA spending. In FY1976, entitlements constituted 73% of VA's budget, with the remaining 27% discretionary appropriations for health care and VA administration, including construction of VA facilities. By FY1999, VA discretionary spending for health and VA administrative costs had risen to 45% of VA's total budget. For the entire federal budget, about one-third of spending is discretionary.

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

Spending Trends for Veterans Programs

For FY1998, federal appropriations for veterans programs under VA administration totaled \$41 billion. VA spending (outlays in current dollars) increased 103% during the period FY1977-96. As a proportion of total federal spending, VA costs are going down. In FY1977, VA spending was 5% of total federal spending and 11% of spending for social welfare; in FY1996, that percentage was down to 2.5%, 5% of social welfare. Compared to the 98% increase in VA income security spending over the period, federal spending for all other income security programs

increased by 284%. While VA health care costs rose by 269%, other federal health program costs increased by 792% over the 20-year period.¹

VA Construction. Construction appropriations for VA major and minor construction projects over the 10-year period FY1987-FY1996 averaged around \$600 million per year.

VA Budget and Appropriations: FY1998 and FY1999

Enacted FY1999 Appropriations. Congress has enacted P. L. 105-276, an appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development (HUD) and several independent agencies; the bill includes \$42.588 billion in appropriations for VA for FY1999, up from \$40.977 billion for FY1998 (after incorporating supplemental appropriations, and various reestimates of mandatory spending for that year). The Administration had requested \$42.150 billion for FY1999; the Senate approved \$42.522 billion; the House, \$42.653 billion. The Administration recommended a slight decrease in medical care funding — the House and Senate called for increases, and conferees settled on \$278 million more than provided in FY1998. Both Houses approved almost identical amounts for new construction projects, an amount about \$80 million more than requested — conferees accepted the levels in the bills passing the two Chambers. The final bill also added to the Administration's request for grants to states to help fund veterans' facility projects at the state level.

VA Cash Benefits. FY1998 appropriations included \$22.1 billion for VA cash entitlement benefits, mostly service-connected compensation, pensions, and Montgomery GI-Bill education payments. 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. For FY1999, the Administration estimates that VA entitlement programs will require \$23.3 billion in mandatory appropriations. P. L. 105-276 provides the estimated amounts.

Medical Care. Congress appropriated \$17.057 billion in funds for VA medical care for FY1998, an amount fairly close to the amount provided by direct appropriations for FY1997, after considering various differences in accounting between the 2 fiscal years. Congress also enacted language in the Balanced Budget Act of 1997 (P.L. 105-33) so that net medical cost reimbursement receipts from the Medical Care Collections Fund (MCCF) remain available to VA for medical services to veterans rather than be transferred to the Treasury as under previous law; that change added an estimated \$558 million (\$543 million of which was guaranteed

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

under P.L. 105-65) to medical care spending authority for FY1998. The Committees estimated that the MCCF collections will be \$558 million in FY1999.

For FY1999, the Administration again proposed a near freeze to medical care appropriations, requesting \$17.028 billion (various unobligated balances and carryover budget authority make estimates of frozen appropriation levels somewhat imprecise). The House approved \$17.361 billion; the Senate approved \$17.250 billion. The Conference Report encourages VA to seek further efficiencies in medical care services to expand the number of veterans who can be served with these appropriated resources. In general, the additional funds would expand outpatient care resources, fund telemedicine projects for veterans in remote areas, and provide increased access to medical care for veterans in rural areas.

The Senate added \$10 million to the Administration's request of \$300 million for medical and prosthetic research, mostly to fund research in alcoholism and its treatment, and for research on the disease *neurofibromatosis*; the House approved \$320 million. Conferees provided \$316 million in the final bill.

For additional information on VA medical care, see CRS Report 97-786, *Veterans Medical Care: Major Changes Underway*, by Dennis Snook.

VA Construction. For FY1999, Congress provided \$317 million in new construction project funding. For FY1998, Congress appropriated \$353 million for new construction and redirected to outpatient access projects, \$32.1 million that had been previously authorized and appropriated for a new hospital in California.

The Administration's FY1999 budget requested \$238 million in new construction spending, including \$73 million for correcting earthquake damage in San Juan, Puerto Rico and Long Beach, California, and \$69 million for increasing outpatient access in various locations. Congress added \$80 million more for construction projects than the budget requested. The additional funds would allow upgrades for facilities to occur sooner than otherwise would be possible.

The Conference Report calls for expanded outpatient access in the Wade Park facility in Cleveland, Ohio (\$21 million); renovations for nursing home care at Lebanon, Pennsylvania (\$9.5 million); and improved outpatient access in Tucson, Arizona (\$25 million). P. L. 105-276 provides \$53 million more in grants for state extended care facilities than requested, so that a \$150 million backlog of scheduled projects under the federal/state program can be accomplished more quickly.

Program Administration. The appropriations bill provides \$856 million for the General Operating Expenses (GOE) account for administering VA benefit programs, and \$63 million for medical care administration, for FY1999. Congress appropriated \$786 million for GOE for FY1998, and \$60 million for medical administration. Average employment requested for VA benefit programs for FY1999 is 11,221, a decrease of 125 from FY1998. Medical staff, most of whom are engaged in patient care, is expected to decline during FY1999, to 180,411 from 183,000 in FY1998.

Enacted FY1998 Appropriations. For FY1998, Congress enacted P.L. 105-65, the VA-HUD bill, providing \$40.43 billion for veterans programs in FY1998. However, reestimates indicated that additional caseload and cost-of-living adjustments (COLA) required additional funds; P.L. 105-174 added \$550 million in supplemental appropriations. S.Rept. 105-216 reports FY1998 VA spending will reach \$40.98 billion.

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

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

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

Table 1 shows final appropriations for VA programs for FY1998 and FY1999, and requested appropriations and amounts in the House- and Senate-passed appropriations bills for FY1999. For further information on FY1999 appropriations for VA, see CRS Report 98-204, *Appropriations for FY1999: VA, HUD, and Independent Agencies*,.

² P.L. 104-262 in 1996 capped medical care spending for FY1998 at \$17.9 billion.

Table 1. U.S. Department of Veterans Affairs Appropriations
(\$ in millions)

Program	FY1998	FY1999			
	final	request	H.R. 4194	S. 2168	P.L. 105-276
Income security					
Comp.; pensions; burial	\$20,483	\$21,857	\$21,857	\$21,857	\$21,857
Insurance; indemnities	51	46	46	46	46
Education, training, and rehabilitation					
Readjustment benefits	1,366	1,175	1,175	1,175	1,175
Msc. loan, admin. exp.	1	1	1	1	1
Housing programs					
Current	162	159	159	159	159
Indefinite	166	264	264	264	264
Medical programs					
Medical care	17,057	17,028	17,361	17,250	17,306
Transfer from MCCF ^a	(558)	(558)	(558)	(558)	(558)
Transfer Guarantee	15	0	0	0	0
Medical research	272	300	320	310	316
Med. admin. and misc.	60	60	60	60	63
Construction					
Major construction ^b	178	97	143	142	142
Minor construction	175	141	175	175	90
Other					
Gen. Operating Expenses	786	850	856	855	856
Office of Inspector Gen.	31	33	33	36	36
Grants, state nurs. homes	80	37	101	90	90
Grants, state cemeteries	10	10	10	10	10
Nat'l Cemetery System	84	92	92	92	92
<i>Total mandatory (entitlements)</i>	<i>22,067</i>	<i>23,342</i>	<i>23,342</i>	<i>23,342</i>	<i>23,342</i>
<i>Total discretionary (without MCCF)</i>	<i>18,910</i>	<i>18,808</i>	<i>19,311</i>	<i>19,180</i>	<i>19,246</i>
<i>Total discretionary (with MCCF)</i>	<i>19,468</i>	<i>19,366</i>	<i>19,869</i>	<i>19,738</i>	<i>19,804</i>
Total VA Appropriations (rounded-may not add)	\$40,977	\$42,150	\$42,653	\$42,522	\$42,588

Source:H.Rept. 105-769

^aThe Medical Care Collections Fund, which receives reimbursement from private insurers (who share coverage of certain veterans with VA), and copayments and deductibles from some veterans. For FY1998 only, Congress provided a guarantee of \$543 million in collections, at an appropriated cost (premium) of \$15 million.

Other Veterans Issues Before the 105th Congress

Persian Gulf War Illnesses and the Presumption of a Service Connection

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

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

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

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

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

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

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

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

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

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

⁴ Report of the Presidential Advisory Committee on Gulf War Veterans’ Illnesses. p 125.

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

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

Priority Health Care and Disability Compensation. Authority to provide high priority medical care for Vietnam veterans with diseases presumed linked to herbicide exposure expires December 31, 2002. Authorization for priority health care for veterans with diseases presumed linked to radiation exposure has been made permanent. Authority for priority health care for Persian Gulf War veterans has been extended through 2001.

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

The Persian Gulf War Veterans Health Care and Research Act of 1998 (H.R. 3980; S. 2358). These bills passed their respective Chambers; a compromise version was incorporated into H.R. 4110, the Veterans Programs Enhancement Act of 1998, which awaits the President's signature. H.R. 4110 extends VA health care for Persian Gulf veterans through 2001; expands coverage to include treatments for veterans' dependents when their illnesses are related to the veterans' Gulf War service; and requires VA to seek advice from the National Academy of Sciences on ways in which these veterans can be more effectively treated. The law also will establish an independent mechanism recommended by the Academy, so that research into Gulf War illness claims can be evaluated outside of the federal government.

Veterans Medical Services: Resource Reallocation and Cost Recovery

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

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

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

- Veterans eligibility rules were changed so that veterans could be served in whatever treatment venue was medically indicated;
- The VA health care system itself was reorganized into a more decentralized, regional structure, called Veterans Integrated Service Networks (VISNs), each of which established health plans to administer veterans' health care;
- Numerous projects to improve and increase ambulatory services were proposed, authorized, and funded;
- Spending for VA medical programs was limited to prevent increased outpatient access from substantially increasing costs. Appropriations for health care for FY1997 were \$17.01 billion; for FY1998, \$17.06 billion; and for FY1999, \$17.31 billion.
- A method for measuring demands met with efficient performance, based on per capita unit costs, was instituted that will permit integration, coordination, and reallocation of resources from one specialty or subservice to another within a facility, from one facility to another within a VISN, and from one VISN to another.

New VISN Medical Benefit Plans. Beginning on October 1, 1998, new VISN health benefit plans administer VA medical services. The new plans are intended to more effectively measure the cost of resources given to veterans in various regions. Veterans are also expected to have a greater understanding of the benefits for which they are eligible, and VA staff would have clear authorization to provide services in the most efficient venue possible. Also, data developed through the plans would be more uniform, thereby facilitating analysis of the effectiveness of various procedures.

Some veterans mistakenly concluded that their benefits would be cut off on the October 1 date unless they were enrolled in the plans, and contacted congressional offices to express their concerns. Veterans will not be denied services because of the

plans; some are enrolled automatically, including those receiving services in the months before the October date. Most veterans will enroll at the time they apply for services, and many veterans are exempt from enrollment altogether.

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

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

Medical Care Collections Fund (MCCF). Veterans whose nonservice-connected conditions are treated by VA, and who are not eligible for free care⁵ for such conditions are obligated to pay copayments and deductibles.⁶ Also, third-party insurers, who would be obligated for at least a portion of the costs of a veteran’s medical care costs if the veteran were to be treated by providers outside the VA system, are obligated to pay VA for the cost of that care.

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

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

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

To enforce discipline on the program, and to encourage VA medical facilities to be more aggressive in the pursuit of funds VA had the authority to collect, the Balanced Budget Act of 1997 requires VA to bear the costs of MCCF collections, but lets the VA medical program keep the funds. The FY1999 appropriations process included estimates that \$558 million in each of FY1998 and FY1999 will be available to the VA medical care account, as a result of collection efforts.

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

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

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

Legislation (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 permit 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 permit veterans with high-priority access to VA health care (called Category A veterans in the bill), who are also covered by Medicare, to receive their Medicare benefits through one of VA's VISN health plans.⁷

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

The bill 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.

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

In addition, VA has temporary authority (until December 31, 2001) to enter into "enhanced use" leases, in which VA facilities can be contracted by other entities. After taking into consideration how the leasing arrangement would affect local commercial and community interests, VA can enter into the leases if it determines that the activities would not interfere with VA programs, and would in some way serve the interests of veterans. These leases may be additional sources of revenue to the facilities, and may serve to increase the use of capacity that would otherwise be underused.

In the FY1998 and FY1999 budgets, the Administration has asserted that by FY2002, the combination of Medicare subvention, other MCCR collections (copayments and deductibles from veterans, reimbursement from third-party insurers, and receipts from VA service-sharing arrangements with nonfederal health care providers), together with more efficient operations would support a level VA medical

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

budget that provides services to 20% more of the veteran population. MCCR collections would fund 10% of VA's medical care budget in that year (according to the projections), and cost efficiencies are assumed to reduce the average cost for individual patients served by 30%. VA's documentation claims that these projections are reasonable if the expansion of services is conducted according to the VA efficiency guidelines, but the basis for those assumptions is not shown in the VA documents.

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

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

Benefits for Filipino Veterans of World War II (H.R. 836; S. 623)

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. H.R. 836 and S. 623 would have removed the section of veterans benefits law that specifically deems this Filipino service during World War II to not be active duty military service for purposes of VA benefits.

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 budget calls 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 FY1999, and \$25 million over 5 years. Hearings in the House Committee on Veterans Affairs on the subject were held July 22, 1998. No further action was taken on these bills.

Veterans Employment Opportunities Act of 1998 (P.L.105-339)

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

Legislation addressing these concerns (H.R. 240), passed the House April 10, 1997. The bill would have expanded access to jobs, provided veterans with some additional rights during agency downsizing, extended veterans preference rights to some employment now exempted, established new procedures for veterans to appeal decisions, and designated the circumvention of veterans preferences as a prohibited personnel practice.

A veterans preference bill, S. 1021 was reported by the Senate Committee on Veterans Affairs. The bill, which was originally introduced in the Senate as a companion to H.R. 240, was amended in Committee. The Committee's version modified provisions in H.R. 240 so that expanded access only applied to those jobs open to outside applicants. The Senate bill also eliminated the additional RIF protections of H.R. 240. The bill retained the right for veterans to appeal personnel decisions to the Merit Systems Protection Board (MSPB) if their appeals to the Department of Labor do not resolve their complaints. Added to the Senate version, were provisions expanding veterans preference rights to veterans of the Persian Gulf War, who seek jobs with contractors with more than \$10,000 in annual contracts with the federal government. The bill, which passed the Senate October 6, and the House, October 8, 1998 (without amendments), was signed by the President on October 31, 1998.

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

Service-Connection for Smoking Related Illness

Both the FY1998 and FY1999 VA budgets proposed to preclude claims that a service-connection exists for "disabilities or deaths based solely on their being attributable, in whole or in part, to veteran's use of tobacco products during service."

The issue surfaced in 1993, when the VA General Counsel determined that under VA law — which conditions veterans compensation on disabilities traceable to military service — diseases linked to tobacco use that began during military service are service-connected disabilities. After several years of study, in 1997 the VA Undersecretary for Health concluded that nicotine addiction is a disease, and the General Counsel reaffirmed the 1993 decision.

The President's FY1999 budget estimated the savings to be \$16.9 billion over 5 years. The Congressional Budget Office (CBO), using a slower rate in the growth of claims estimated the change would save \$10.5 billion over the period. Conferees on the highway construction reauthorization bill, H.R. 2400, the Intermodal Surface Transportation Equity Act (ISTEA) used the Administration's savings estimate, committing \$15.4 billion to offset costs of the final version, The Transportation Equity Act for the 21st Century (TEA21), which became P.L. 105-178.

The remaining funds were used to improve various veterans benefits (see *The Veterans Benefits Act of 1998*, below). Congress has also approved P.L. 105-206, an act to reform the Internal Revenue Service, which also includes technical amendments to the prohibition on smoking-related compensation. Of particular importance to some veterans is the removal of language that some people thought suggested that veterans who smoked were guilty of misconduct.

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

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

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

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

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

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

Cost-of-Living Adjustments (P.L. 105-98); (H.R. 4110; S. 2273)

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

Similar legislation to provide a COLA for 1999, H.R. 4110 and S. 2273, passed both Houses. After a conference on H.R. 4110, elements of several bills reported from the Committees on Veterans Affairs of the two Chambers were attached, and that bill passed both Houses, with Presidential signature announced for Veterans Day, November 11, 1998. Thus, a COLA of 1.3% can be expected for veterans disability and survivor programs beginning January, 1999. (For more details on the provisions of H.R. 4110, see below.)

H.R. 4110, Veterans Programs Enhancement Act of 1998

It is common with legislation pertaining to veterans, for many provisions originating in other bills to be combined in one bill near the end of a legislative calendar. Congress is then able to consider them expeditiously, and assure that the core bill, which provides a COLA to the compensation and survivors program, can be enacted in time for the adjustment to appear in January checks of the following year. This year was no exception, and H.R. 4110 contains 26 separate changes to programs administered by VA. Most of these are technical changes or extensions of current law. In addition to the changes affecting health care for veterans of the Persian Gulf War discussed above, among other notable changes are the following:

Education programs. VA pays fees to educational institutions enrolling veterans, to offset costs associated with the reports the institutions must submit to VA. The method for calculating the costs will be changed to reflect veterans who enroll at different times during the year, thereby encouraging more veterans outreach at the institutions. The bill also provides for some flexibility in payments to veterans for work-study in VA regional offices; allows for college credit for life experiences to be counted as credit under VA education programs; waives certain salary requirements for on-the-job training programs sponsored by state and local governments; and expands outreach and eligibility information programs of the various military service branches.

Employment rights. The bill refines the enforcement provisions for veterans' employment and reemployment rights under the Uniformed Service Employment and Reemployment Rights Act; extends those rights to veterans employed overseas by companies with headquarters in the United States; and clarifies the employment and reemployment rights pertaining to federal employment and veterans.

Compensation, Pension, and Insurance programs. The bill increases special pension payments to Medal of Honor recipients from \$400 to \$600 per month; provides for accelerated death benefits to terminally ill persons under veterans' group life insurance; and authorizes dividends to 1000 holders of certain World War II-era National Service Life Insurance (VA will contact each eligible veteran to provide for payment of these dividends).

Memorial Affairs. The bill authorizes memorial markers for certain armed forces veterans and spouses in cases in which remains are unavailable for interment; extends eligibility for burial in national cemeteries, and funeral benefits to veterans of the Merchant Marine who served from August 16, 1945 to December 31, 1946; modifies agreement with states so that VA pays 100% of the cost of construction and the state pays operating expenses; and redesignates the National Cemetery System as the National Cemetery Administration, thereby elevating to the same organizational level in VA as the Benefits Administration and the Health Administration.

Housing. The bill would make available loan guarantees for multifamily transitional housing for homeless veterans; and extends home loan guarantees for members of National Guard and Reserves components to the end of FY2003.

Construction and facilities. The bill authorizes \$241 million in construction and \$8.5 million in leases. Among the projects authorized are: construction at Long Beach, California; San Juan, Puerto Rico; Washington, D.C.; Palo Alto, California; Cleveland, Ohio; Tucson, Arizona; Dallas, Texas; Tampa, Florida; and numerous smaller projects at various facilities around the country. Most of the projects increase outpatient access to VA medical services.

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

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

provide noninstitutional alternatives to nursing home care. VA is instructed by the new law to develop a mammography policy, with specifications as to how often screening should be done, and for whom. Finally, P.L. 105-114 adopted provisions of H.R. 1703, which established methods for alleviating problems of employment discrimination in VA facilities.

Arlington National Cemetery Burial Eligibility Act of 1998 (H.R. 3211)

Concerns about presidential discretion to waive restrictions on burial in Arlington National Cemetery prompted legislation to codify regulations on such burials. Under H.R. 3211, only persons specifically covered by the bill's language could be buried at Arlington. The bill would have eliminated 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 have continued to be buried in the same grave with that veteran without a waiver. The bill passed the House; no action was taken by the Senate.

The Veterans Benefits Act of 1998

A separate title of the Transportation Equity Act for the 21st Century (H.R. 2400; P.L. 105-178) made several amendments to veterans benefits. Under pay-as-you-go spending rules, these changes were funded from savings achieved by prohibiting VA from approving most service-connected compensation claims for tobacco-related illnesses. The improvements include the following, effective October 1, 1998:

- The basic rate for determining education benefits payable under the Montgomery GI Bill program was raised by 20% (similar to a proposal included in the Administration's FY1999 budget).
- Amounts VA can spend for adapting a house for a severely disabled veteran was raised from \$38,000 to \$43,000; for adapting a car, the amount was raised from \$5,500 to \$8,000.
- Maximum rates of means-tested pensions for totally-disabled wartime veterans in need of full time aid and attendance was raised by \$600 annually (the total amount payable depends on dependents, assets, and other income).
- Benefits were restored for the surviving spouses of veterans who died of service-connected disabilities, for cases in which a subsequent marriage of the surviving spouse ended in divorce or death.

Government Performance and Results Act (GPRA)

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

established, with 5-year strategic plans and measurable performance goals first being specified with the FY1999 budget.

Commission on Service Members and Veterans Transition Assistance

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

The Commission is examining “the adequacy, effectiveness, and appropriateness of transition and assistance programs,” and will make recommendations to Congress for changes to VA law to improve federal efforts to assist veterans readjust to civilian life. The Commission is reviewing the allocation of the programs among federal agencies, and will “determine the feasibility and desirability of consolidating such programs in one department or agency.” The Commission’s report is expected to be released in early December of 1998.

One issue receiving scrutiny by the Commission is the primary education program, the Montgomery GI Bill (MGIB). The MGIB provides monthly benefits for up to 36 months for participating veterans entering approved education programs, primarily college. Payments are adjusted annually for inflation, and in 1998 are \$439.85 for personnel who complete 3 or more years of active duty. Participants are required to pay \$100 per month for the first 12 months of active duty, and the money is not refundable. The Administration’s FY1999 budget requested that the Montgomery GI bill payments be increased by 20%, and that increase was enacted as part of P.L. 105-178, the highway construction reauthorization bill (H.R. 2400, the Intermodal Surface Transportation Efficiency Act [ISTEA]).

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