Order Code RL30803

Veterans Issues in the 107th Congress

Updated August 14, 2001

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Summary

VA Budget and Appropriations. The Administration requested $50.7 billion for Department of Veterans Affairs (VA) programs for FY2002. The Concurrent Resolution on the Budget for FY2002 (H. Con. Res. 83) assumed that the ultimate amount appropriated will be $51.5 billion. Congress appropriated $47.9 billion for programs for FY2001.

The House has approved $51.4 billion for VA for FY2002 (H.R. 2620); the Senate version of the bill contains $51.1 billion. The difference is primarily in a fund the House bill creates to provide $300 million to upgrade VA medical facilities for safety, and for corrections of earthquake damages. The House approved $21.3 billion for VA medical care programs for FY2002; the Senate version of the bill provides $21.4 billion. The Administration requested $21 billion for VA medical care for FY2002, up from the $20.3 billion appropriated for FY2001, which was 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. Thus, amounts approved by both versions of H.R. 2620 make certain that, in nominal dollars, VA medical care will have increased by 24% over the amount requested 2 fiscal years earlier, an indication of the blooming demand by veterans for VA medical care.

The Administration suggests that VA will focus medical care on veterans with service-connected disabilities, or who have established low-income eligibility, especially in those "living in underserved geographic areas." In what promises to become a major issue, the documents foreshadow the closing of certain VA hospitals, saying that budgetary savings "...from the disposal of underused VA facilities will support these improvements."

Cost-of-Living Adjustment (COLA). Congress gave a 3.5% increase to VA compensation payments, matching the automatic increases received by most federal benefit programs. A cost-of-living adjustment (COLA) for service-connected compensation benefit checks for 2002 has passed the House (H.R. 2540), and probably be enacted, as Congress routinely approves that legislation.

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

Legislation to establish projects to demonstrate the feasibility of reimbursing VA for medical costs incurred by some veterans with Medicare (called Medicare "subvention") was supported by many Members in both Houses during the 106th Congress, but final work on the bill was not completed. Subvention remains an issue during the 107th Congress. As instructed by P.L. 106-117, VA is also considering changes to the cost-

sharing burden some veterans have for VA medical care, and many veterans are paying close attention to any proposed changes.

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Recent Developments

Appropriations bills passed by House and Senate. On July 30, 2001, the House passed H.R. 2620 (H.Rept. 107-159), a bill to provide FY2002 appropriations to VA, Housing and Urban Development (HUD), and several other independent agencies. The Senate passed its version of the VA-HUD bill on August 2, after amending it with the text of the amended bill (S.1216) reported from the Senate Committee on Appropriations (S.Rept. 107-43).

President signs P.L. 107-14. On June 5, 2001, President Bush signed H.R. 801 (P.L. 107-14), a bill to improve veterans education programs, and to increase burial benefits (and for other purposes).

President signs P.L. 107-11. On May 28, 2001, President Bush signed H.R. 1696 (P.L. 107-11),, a bill to expedite the completion of the World War II memorial on the Mall in Washington. The location and design have been approved, and the new law would limit attempts to reopen the memorial planning to further review.

Congress approves H.Con.Res. 83, the Concurrent Resolution on the Budget for FY2002. On May 10, 2001, the Senate approved the Conference Report (H.Rept. 107-60) on the budget resolution, H.Con.Res. 83; the House approved the report the previous day.

House passes H.R. 811. On March 27, 2001, the House acted to authorize the construction projects for improving, renovating, and updating VA patient facilities. The bill would authorize the expenditure of $550 million for construction purposes, with the ultimate amount dependent on actual appropriations.

OMB approves request for 100% loan guarantees for homeless veterans. The Office of Management and Budget (OMB) has agreed to implement the transitional multi-family housing program for formerly homeless veterans. Congress included the program for up to 5,000 such guarantees for formerly homeless veterans who are demonstrating ties to the work force, in the Veterans Programs Enhancement Act of 1998 (P.L. 105-368). Under provisions of the Act, VA is required to submit a request for a waiver from OMB, if it wishes to include among the program projects, mortgages guaranteed for 100% of the mortgage value.

Smith selected new chairman of House Committee on Veterans Affairs; Specter begins the 107th Congress as chairman of Senate Committee on Veterans Affairs, to be replaced by Rockefeller as the

Majority shifts to the Democrats. Representative Christopher H. Smith is the new Chairman of the House Committee on Veterans Affairs. The previous Chairman, Bob Stump, finished three terms as chairman, the maximum permitted under current rules adopted by the Majority and has moved on to the chairmanship of the House Armed Services Committee. The Chairman of the Senate Committee on Veterans Affairs during the 106th Congress, Senator Arlen Specter, returned as chairman for the beginning of the 107th Congress. With Democrats ascending to the Majority in the Senate in June, the Chairmanship will shift to Senator John D. Rockefeller, IV.

Bush chooses VA Secretary. President Bush selected, and the Senate approved Anthony J. Principi to be Secretary of VA. Principi served as Acting Secretary during 1992-1993, and as Deputy Secretary from 1989-1992. More recently, Principi chaired the Congressional Commission on Servicemembers and Veterans Transition Assistance, which examined programs to assist veterans in their readjustment to civilian life.

Introduction

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

The Veteran Population

There were about 24.4 million veterans as of July 1, 1999, of whom 19.3 million had served during at least one period defined as wartime. Family members and survivors of veterans totaled about 45.5 million. Thus, VA is a potential source of benefits for about one-fourth of the population of the United States.

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.

Overview of the Department of Veterans Affairs

The VA is divided into three administrative structures: The Veterans Benefit Administration, the Veterans Health Administration, and the National Cemetery Administration. VA programs are funded through 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 had 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 domiciliaries, 206 readjustment counseling centers (Vet Centers), 73 home health-care programs, and over 800 outpatient clinics. About 91% of VA's 205,000 employees will be involved in the provision of medical services to an

estimated 4.1 million veterans during FY2002. The FY2001 caseload was about 3.9 million unique patients. VA health care continues to place increasing emphasis on outpatient care: according to VA data accompanying the FY2002 Budget, the inpatient caseload for FY2000 was 718,000, projected to decline to about 681,000 patients by the end of FY2002. In contrast, outpatient visits will increase by 1.4 million to 40.6 million over that same period. Nearly all categories of inpatient care show declining numbers admitted. The exception is nursing home and residential care, which is projected to increase 9% over the period, to an average daily census of 45,000 veterans, 51% of the veterans receiving inpatient care in all venues.

VA Budget and Appropriations

VA Appropriations in the 107th Congress

FY2002. According to congressional estimates, the Administration requested $50.7 billion for Department of Veterans Affairs (VA) programs for FY2002. The Concurrent Resolution on the Budget for FY2002 (H.Con.Res. 83) assumed that the ultimate amount appropriated will be $51.5 billion, after improvements to the Montgomery GI Bill and veterans burial benefits are adopted. Conferees on the Resolution rejected recommendations approved by each House that would have provided for additional VA spending. The House had approved $52.3 billion and the Senate $53.8 billion, in their respective versions of the Resolution.

In passing H.R. 2620, the House has approved $51.4 billion for VA programs for FY2002; the Senate version of the bill contains $51.1 billion. The difference is primarily in a fund the House bill creates to provide $300 million to upgrade VA medical facilities for safety, and for corrections of earthquake damages.

Congress appropriated $47.9 billion for programs for FY2001, $25.5 billion of which was for mandatory spending for VA cash benefit programs. Mandatory spending for VA entitlements is projected to rise by $1.8 billion during FY2002, to a total of $27.3 billion. Congress provided $22.4 billion for discretionary programs for FY2001, $20.3 billion of which is for medical care. The Administration requested $23.4 billion for discretionary programs for FY2002; House bill approved $24.05 billion, the Senate approved $23.83 billion. The Administration requested $21 billion for medical care for FY2002; the House approved $21.3 billion, the Senate provided $21.4 billion.

During the last 2 fiscal years, Congress has added to the request for VA medical services funds, providing increases of $1.7 billion for FY2000, and $1.3 billion for FY2001 (in each case, compared to the previous fiscal year). These added funds have permitted the VA to encourage more veterans to enroll in VA health plans, and to meet the medical service expectations of this substantially increased caseload of veterans. Congress can expect pressure to sustain, and perhaps further expand VA medical care, especially as more veterans become familiar with its value in the modern era of insecure health insurance coupled with high cost prescription drugs.

Finally, further growth in appropriations for VA medical care might be entailed, as VA begins to implement legislation enacted during the 106th Congress (P.L. 106-117; P.L. 106-419) to improve extended care and assisted living arrangements for an aging veteran population.

VA Appropriations in the 106th Congress

FY2001 (P.L. 106-377). Congress appropriated $47 billion for VA programs for FY2001, $55 million more than the request, a $2.7 billion increase above amounts for FY2000. About $1.3 billion of the increase in VA appropriations funded medical care for veterans, marking continued expansion of VA's capacity to provide medical services to an increasing number of veterans and in more locations.

FY2000 (P.L. 106-74). Congress provided $44.3 billion for VA for FY2000, including $19 billion appropriation for medical care, a $1.7 billion increase above FY1999 and $.7 billion more than requested by the Clinton Administration (whose initial FY2000 budget request for VA entailed a freeze to medical care funding).

Additional information on VA appropriations for FY2001, see CRS Report RL30504, *Appropriations for FY2001: VA, HUD, and Independent Agencies.*

Spending for VA Programs

VA Cash Benefits. Spending for the VA cash benefit programs is mandatory, and the amounts requested by the budget are based on projected caseloads. Definitions of eligibility and benefit levels are in law. Much of the projected increases for FY2001 and FY2002 result from liberalizations to the Montgomery GI Bill, the primary education program. 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 $23.4 billion, and is projected to require $24.6 billion in FY2001, and $27.3 billion in FY2002, not including changes to the Montgomery GI-Bill that Congress is considering, and for which funds were assumed in the Concurrent Resolution for FY2002 (H.Con.Res. 83).

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. P.L. 106-246 repealed the 1997 language, clearing the way for Friday payments when the month begins during a weekend. This change had the effect of shifting $1.8 billion in spending from what would have been recorded as FY2001 expenditures, back to FY2000.

Veterans Housing Benefits. The VA program to guarantee home loans for veterans has made a significant contribution to the national goal of increasing the number of families who own their own homes. Because of the guarantees, lenders are protected against losses up to the amount of the guarantee, thereby permitting veterans to obtain mortgages with little or no down payment, and with competitive interest rates. These

guarantees, and certain direct loans to specific categories of veterans were obligations of the federal government that constituted mandatory spending; administrative expenses are discretionary appropriations transferred from the home loan programs to the General Operating Expenses account.

Table 1 shows total appropriations for FY2001, and requested appropriations for FY2002, and amounts approved by the House and Senate.

Table 1. Appropriations: Department of Veterans Affairs, FY2000-FY2002

($ in millions)

Program	FY2001 Enacted	FY2002 Request	FY2002 House H.R. 2620	FY2002 Senate H.R. 2620
Income security				
- Comp.; pensions; burial	$23,356	$24,944	$24,944	$24,944
- Insurance; indemnities	20	26	26	26
Education, training				
- Readjustment benefits	1,981	2,135	2,135	2,135
- Msc. loan, admin. exp.	1	1	1	1
Housing programs				
- Current (admin. exp.)	163	165	165	165
- Indefinite	166	204	204	204
Medical programs				
- Medical care[a]	20,282	20,980	21,282	21,380
- Medical research	351	360	371	390
- Med. admin. and misc.	62	68	67	68
- Health serv. improvement fund (receipts)	—	(121)	—	---
Construction				
- Major construction	66	183	183	155
- Facility rehabilitation fund	—	—	300	---
- Minor construction[b]	171	179	179	179
Other				
- Gen. Operating Expenses	1,050	1,195	1,196	1,195
- Office of Inspector Gen.	46	48	52	48
- Grants, state nurs. homes	100	50	100	100
- Grants, state cemeteries	25	25	25	25
- Nat'l Cemetery Admin.	110	121	121	121
- Parking revolving fund	—	4	4	4
Mandatory (entitlements)	*25,522*	*27,309*	*27,309*	*27,309*
Discretionary (includ. MCCF)	*22,426*	*23,377*	*24,046*	*23,830*

Total VA Appropriations (rounded)	**47,948**	**50,686**	**51,355**	**51,139**

Source: FY2002 Budget Justification for the Department of Veterans Affairs; H.Rept 107-159; S.Rept. 107-43; H.Rept. 107-148

[a] The amounts shown for medical care are net, after rescissions, and after adding transfers from the Medical Care Collections Fund (MCCF), which consists of payments from sources responsible for a share of cost for services provided to certain veterans. The MCCF collected $564 million in FY2000, and is estimated to collect $639 million in FY2001, and $691 million in FY2002.

[b] Amounts shown under Minor Construction include projects paid from the Parking Revolving Fund, totaling $6.5 million in FY2001, and estimated to be $4 million in FY2002.

Medical Care. The House version of H.R. 2620 provides $21.282 billion for VA medical care for FY2002; the Senate version of the bill contains $21.380 billion. The Bush Administration requested $20.980 billion. Congress approved President Clinton'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 Clinton 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, $564 million in FY2000, and is projected to add $639 million in FY2001, and $691 million in FY2002. The House Appropriations Committee report to accompany H.R. 2620 (H.Rept. 107-159) also projects $121 million will be returned as asset liquidations, which will also be available for spending by VA medical facilities in the region responsible for acquiring that savings.

Medical research. The House bill provides $371 million for VA research in FY2002; the Senate version of the bill provides $390 million. The Administration requested $360 million for medical research projects for FY2002. Congress appropriated $351 million for research projects for FY2001, and $321 million for FY2000.

Response to Hepatitis C (HCV). 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 contagious 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.

However, VA analysts were concerned that "...no comprehensive system was in place to collect information about actual workloads and costs" for the Hepatitis C program because the projections for them "were based on formulas that relied on untested assumptions" and "actual performance (particularly for FY2000) did not bear out projections." Thus, the Administration's planning documents project that the amount spent on evaluation of those at risk for the disease, diagnosis, and treatment will not exceed $152 million of FY2002 medical care appropriations.

VA Construction. The House version of H.R. 2620 provides $183 million in major construction; the Senate approved $155 million. The Administration has requested $183 million for major construction. Both the House and Senate bills approved the Administration's request for $179 million for minor construction for FY2002. The House also approved $300 million for immediate rehabilitation of medical facilities with concerns about patient safety.

Congress provided $66 million for major construction, and a total of $171 million for minor construction for FY2001. 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. Both versions of H.R. 2620 essentially approve the Administration's request for funds for administration, including $1.195 billion for General Operating Expenses (GOE), and $68 million for medical administration for FY2002. P.L. 106-377 included $1.050 billion of the requested $1.062 billion requested for GOE, and $62 million for medical administration 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 Bush Administration projects overall VA employment will decline to an average of 204,670 in FY2002, down from an average 205,896 during FY2001, which was up from an average of 202,621 during FY2000, and 205,547 in FY1999. Much of the decline will be in medical staff, which VA projects will average 179,300 during FY2002. Currently, VA projects that VA medical care slots will average 181,500 in FY2001. VA originally estimated that 179,206 medical care slots were needed for FY2001, compared to an 179,520 in FY2000, and 182,661 in FY1999.

Veterans Issues Continuing in the 107th Congress

Medical Care

In recent years, Congress has invested substantial resources to improve the efficiency, quality and breadth of VA medical care, and to make that care more accessible to more veterans. The VA medical care system has been transformed from a hospital-based program providing most of its services to inpatient treatment of a relatively small

percentage of veterans who tended to be older, sicker, poorer, and more frequently minorities than the general population. While VA continues to provide inpatient treatment to its traditional clientele, the VA system is increasingly emphasizing outpatient care, administered through regional VA health plans, organized around managed primary care principles, and provided in an increasing number of outpatient clinics. The number of individual veterans served by VA medical care staff has more than doubled in 4 years.

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

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

For instance, a veteran complaining of a sore throat asks to see a doctor; VA medical staff examine the patient, diagnose an infection, prescribe an appropriate antibiotic, which is then filled at an on-site VA pharmacy. If, during this screening, a patient is discovered as having an "emergent" condition (a condition, that left untreated, could threaten the health of the patient), the medical staff can be expected to initiate an appropriate course of treatment without regard to eligibility status.

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

This potential sharp contradiction between medical and administrative priorities has not occurred. Appropriated resources, and the shift of more services from inpatient to outpatient settings has allowed VA to serve all veterans applying for care, without denying care to any particular veteran with a medical need identified by VA medical professionals. While some veterans have complained that services are not given to them in the same

manner or location as they had previously experienced, this change is not itself a denial of care, but rather a byproduct of the efficiency efforts.

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

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 2001, $23,688, single; $28,429, one dependent; $1,586 each additional dependent). Veterans awarded a Purple Heart for injuries sustained during combat are exempt from copayments for medical services, but may remain subject to copayments for pharmacy benefits. Other veterans who may be eligible for free care, are those who were exposed to environmental contaminants (such as Agent Orange, during service in Vietnam), or who were prisoners-of-war.

Remaining veterans (Priority 7) are primarily veterans who do not have a rating for a compensable service-connected disability, are not seeking care for a condition 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 $796 for the first 90 days of hospitalization during any 365 day period, plus $10 per day; each additional 90 days requires a copayment of one-half that initial amount, plus $10 per day; the nursing home charge is equal to the full amount, plus $5 per day. For outpatient care, veterans are obligated for 20% of the projected average cost of an outpatient visit. This formula yields a copayment of $50 for outpatient visits in 2001. Veterans (single, no dependents) with incomes above $9,304 in 2001 are obligated for $2 for each monthly outpatient prescription filled through the VA pharmacy system.

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

[2]Although the law specifies that veterans with 50% or greater disability ratings are assurred 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.

Changes due in VA copayment schedule. Under authority of the Millennium Health Care Act (P.L. 106-117), 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 copayment for a VA outpatient visit ($50), 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.

The 107th Congress will likely continue to encourage the directions taken by the VA medical program over the last few years. In the absence of a comprehensive prescription drug benefit under the Medicare program, veterans otherwise eligible for Medicare benefits will continue to seek pharmacy benefits from VA, and will continue pressure on Congress

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

and the Department to modify the amounts veterans obligated for cost-sharing payments are expected to pay for outpatient visits.

A summary of recent VA medical care legislation. In addition to the substantial increases in funds for VA medical care provided through the last two appropriations bills, the authorizing committees have also been actively involved in expanding the scope of VA medical care. The centerpiece of VA medical care authorizing legislation during the 106th was P.L.106-117, the Millennium Health Care Act.

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

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

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

Late in the 2nd Session, the 106th Congress enacted P.L. 106-419, which included language to further refine the intent of the P.L. 106-117. Numerous amendments to the VA medical personnel and patient record-keeping administrative structure were adopted. In addition, the bill expanded the scope of conditions to be regarded as service-connected, and extended eligibility to certain categories of reservists.

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

If Medicare were to transfer funds to cover the cost of VA's services to its existing caseload of patients who are also covered by Medicare, Medicare program outlays could increase, and VA would experience an increase in spending authority. On the other hand, if VA served *additional* veterans whose care is currently paid by Medicare, and if VA provided that care less expensively than providers who would otherwise be reimbursed through Medicare, then real savings could be possible, both to taxpayers and to Medicare.

Offset against this potential savings would be any costs accrued by VA for services to additional patients, and for benefits that VA provides that Medicare does not cover for its participants, such as prescription drugs. If subvention caused the government to provide more in total services than would otherwise have been provided, overall federal spending would increase unless savings in the cost of providing those services through VA instead of through Medicare reimbursement of private health care providers equals or exceeds the cost of the additional services.

One approach receiving attention in the last two Congresses would have permitted veterans with Medicare eligibility, whose VA eligibility requires them to share in the cost of their medical care, to enroll in a VA plan and have their Medicare benefits provided through that plan. Medicare would then pay VA the same rate, per covered person, that it would pay for those persons to enroll in a similar private prepaid plan approved by Medicare.

Medicare subvention would require VA and the Department of Health and Human Services (HHS) to coordinate the collection of data, which would be analyzed to make sure that no Medicare-eligible veteran receives less in medical benefits through VA than would be received directly through Medicare, and that reimbursements to VA from Medicare do not exceed established limits.

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

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

Another approach deliberated during the 106th Congress, that addressed some of the same issues in dual Medicare/VA medical coverage, would have permitted VA to pay

some of the costs associated with treatments given to a veteran in a non-VA medical facility, when VA determined that it is in the veteran's medical interest to provide such care outside VA for practical reasons, such as the distance a veteran might need to travel to reach an appropriate VA medical facility.

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

Other Issues

Cost-of-living adjustments (COLA). The House passed H.R. 2540 on July 30, 2001, which would provide VA compensation programs with a COLA (estimated to be 2.5%) beginning with checks issued January, 2002. While the Senate has not yet taken action on the bill, movement toward enactment can be expected before the end of the 1st Session of the 107th Congress.

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.

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

Legislation

The President has signed two veterans bills, P.L. 107-14 (H.R. 801), and P.L. 107-11 (H.R. 1696).

P.L. 107-14, Veterans' Opportunities Act of 2001 (H.R. 801). Congress has completed its work on H.R. 801, which makes changes in educational assistance, transition and outreach, memorial affairs, insurance, and other matters.

Educational assistance provisions. The bill:

- Increases from $2,000 to $3,400 the maximum payable to certain Reserve Officer Training Candidates;
- Expands the work-study program to include jobs in the veteran's academic discipline, in state veterans nursing homes, and in various benefit outreach efforts;
- Adds to the list of "private technology entities" that can meet the definition of approved educational institutions;
- Provides for the disabled spouse, or surviving spouse of a veteran with a severe service-connected disability to receive special restorative training;
- Allows for some cases of independent study that qualify for Montgomery GI Bill payments;

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

- Gives VA authority to provide transition assistance in permanent offices overseas;
- Extends preseparation counseling to as early as 12 months before discharge, and 24 months before retirement;
- Improves outreach to veterans, dependents, and survivors to provide them with enhanced access to VA services and benefits;

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

- Increases burial and funeral allowances from $1,500 to $2,000 for veterans dying from service-connected conditions; and increase the allowance from $300 to $500 for other veterans; and increase the burial plot allowance from $150 to $300;
- Increases the amounts available to adapt automobiles or other equipment for severely disabled veterans from $8,000 to $9,000; and increase housing adaptation

grants for such veterans from $43,000 to $48,000; and for the less disabled, from $8,250 to $9,250;

- Revises the means-test rules for VA's wartime-service pension, so that agricultural real estate is excluded from asset determinations;
- Expands outreach programs for dependents, and expand the period during which transition counseling is available to persons leaving active duty; and
- Permits veterans to receive education benefits for independent study from qualified institutions of higher learning.

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

Veterans' Hospital Emergency Repair Act (H.R. 811). The recent earthquake in Seattle prompted Chairman Smith to introduce a bill to authorize $550 million in construction projects, including those that would repair damage done by the quake, and others which would make modifications to reduce future seismic risk. In addition, the bill would authorize projects to expand outpatient access in several facilities, and to renovate and repair existing facilities. Longer-term assessment of VA capital improvements awaits completion of The Capital Assets Realignment for Enhanced Services (CARES) review, which is expected to issue findings that the review identified as in need of renovation, modification, expansion, or closing. Actual amounts available for VA construction depends on levels appropriated for that purposes through the normal appropriations process.

The House passed the bill on March 27, 2001. The bill currently awaits further action in the Senate Committee on Veterans Affairs. The House version of H.R. 2620, FY2002 appropriations for VA, includes $300 million to carry out the purposes of H.R. 811.

The 21st Century Montgomery GI Bill Enhancement Act (H.R. 1291). This bill, which has passed the House (June 19, 2001) and awaits further action in the Senate Committee on Veterans Affairs, would increase the current monthly education benefit over the next 3 years by 70%, in an attempt to improve the attractiveness of armed forces enlistment relative to the array of alternatives available to young people considering their choices. The total education benefit would climb from $23,400 to $39,600 for a three year enlistment, raising the monthly amount from $650 to $1,100 over the next 3 years, and indexing it to annual COLA for other benefit programs. The Concurrent Resolution on the Budget for FY2002 (H.Con.Res. 83) includes an assumption that such

an increase will be provided, and the H.Rept. 107-159, the report to accompany H.R. 2620, appropriations for VA for FY2002 acknowledges the expectation that such legislation will require additional mandatory spending.