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Congressional Support of Veterans

Executive Summary

- Funding for veterans programs has substantially increased during the last three years. In particular, Congress has raised VA medical care spending, and expanded the Combat Related Special Compensation program.

- The overall Department of Veterans Affairs (VA) budget under President Bush has been increased considerably: by 9.5 percent in FY02; by 13.4 percent in FY03; and by 4.0 percent in FY04. The average percentage increase over these three fiscal years was 8.97 percent.

- For FY05, the Senate Budget Resolution includes $29.1 billion for veterans medical care – an increase of $1.4 billion, or 5 percent, over 2004.

- Spending for veterans medical care has doubled since 1993, and has gone up 34 percent under President Bush, an amount which has well surpassed the medical care inflation rate for the same period.

- Congress, in response to calls for full "concurrent receipt" of military retirement and VA disability, significantly enlarged the Combat Related Special Compensation (CRSC) program.

- Notwithstanding these increases, some veterans' groups have called for further expansion of their benefits and have urged the veterans medical budget be treated as mandatory spending, which they contend will assure predictable funding each year.

- In light of the substantial recent increases, any future significant increases or budgetary changes warrant careful scrutiny by Congress.

Introduction

Funding for veterans programs has substantially increased during the last three years. In contrast to the Clinton Administration, President Bush has requested and enacted significant increases for veterans medical care and other benefits for veterans every year he has been in office.

Notwithstanding these increases, some veterans' groups have called for further expansion of their benefits, specifically with regard to "concurrent receipt" and copayments for pharmaceuticals and medical services. They also urge placement of the veterans medical budget under mandatory spending, which they contend will ensure predictable funding each year.

In light of the increases that were passed in the first three years of the Bush Administration, Congress will need to review whether future expanded benefits and a structural change to the budget are merited.

Significant Increases in Veterans' Funding and Benefits

Each year since 2001, the President has requested and Congress has passed hefty increases for the Department of Veterans Affairs (VA). In particular, Congress raised VA medical care spending, which is a discretionary spending item. When viewed in the overall budget context, the increases for veterans are significant.

The overall enacted budget authority for the VA during the fiscal years President Bush submitted a budget are as follows:[1]

- $52.095 billion in FY02 (an increase of 9.5 percent over the previous year);
- $59.071 billion in FY03 (increase of 13.4 percent); and
- $61.45 billion in FY04 (increase of 4.0 percent).

The average percentage increase over these three fiscal years was 8.97 percent.

In comparison, the overall enacted budget authority for the VA during the final three fiscal years for which President Clinton submitted a budget were as follows:

- $44.157 billion in FY99 (increase of 3.2 percent);
- $45.514 billion in FY00 (increase of 3.1 percent); and
- $47.578 billion in FY01 (increase of 4.5 percent).

The average percentage increase over President Clinton's last three fiscal years was only 3.6 percent.

The VA funding increases are even more significant in light of the percentage increases in *total* budget authority for the entire federal budget for the first three fiscal years of the Bush Administration:[2]

[1] Budget authority numbers according to the Senate Budget Committee.
[2] Total budget authority numbers from Budget of the United States Government, FY05, "Historical Tables," Washington, DC, 2004. p. 92.

- 6.2 percent increase in FY02;
- 3.08 percent increase in FY03; and
- 4.11 percent increase in FY04.

The average percentage increase for total budget authority during FY02-FY04 was 4.46 percent, yet spending for the VA increased by an average of nearly 9 percent.

The percentage increases in *total* budget authority for the entire federal budget for the last three fiscal years of the Clinton Administration were:

- 4.99 percent in FY99;
- 2.71 percent in FY00; and
- 7.39 percent in FY01.

The average percentage increase for total budget authority during FY99-FY01 was 5.03 percent, as compared to the VA increase of 3.6 percent.

VA Medical Care Budget

In particular, the past three fiscal years have seen truly unprecedented increases in funding for medical programs for our nation's veterans. These increases are on track to continue next year as well. The FY05 Senate Budget Resolution included $29.1 billion for veterans medical care, an increase of $1.4 billion, or 5 percent, over 2004. Spending for veterans medical care has doubled since 1993, and the total enacted percentage increase in veterans medical for each year President Bush submitted a budget is 34.16 percent.[3]

In the following fiscal years, the Bush Administration requested that the VA medical programs be increased by:

- $743 million in FY02 (an increase of 3.4 percent);
- $1.27 billion in FY03 (an increase of 5.6 percent); and
- $1.3 billion in FY04 (an increase of 5.1 percent).

In response to these requests, Congress passed and the President signed even greater increases in VA medical programs. The enacted increases were:

- $1.587 billion in FY02 (an increase of 7.6 percent);
- $2.774 billion in FY03 (an increase of 12.3 percent); and
- $2.814 billion in FY04 (an increase of 11.1 percent).

Military retirees also will benefit from greater total spending on TRICARE over the past three fiscal years.[4] Total spending was increased by:

- $4.043 billion in FY02 (increase of 29.8 percent);
- $5.983 billion in FY03 (increase of 33 percent); and
- $480 million in FY04 (increase of 2 percent).

[3] Senate Budget Committee. Figures include FY02, FY03, and FY04.

[4] TRICARE funding numbers according to the Congressional Research Service (CRS). Actual funding for Defense Health Care noted above does not include the imputed cost of military personnel working in military treatment centers, which is about $5 billion annually. Note: starting in FY03, Congress required DoD to set aside funding for Tricare for Life, which is Medicare-wraparound coverage available for military retirees and their eligible family members.

In comparison, medical care inflation rates for the same years were: 4.61 percent in 2001; 4.72 percent in 2002; and 4.0 percent in 2003.[5]

These increases stand in stark contrast to budget requests made by the Clinton Administration. In FY98 and FY99, the Clinton Administration proposed that VA medical program funding be cut, and in FY00, that medical program funding be frozen in place:

- a proposed reduction of $83.3 million in FY98;
- a proposed reduction of $16.3 million in FY99;
- a proposed freeze of medical care spending in FY00.

These proposed cuts were not adopted by Republican-controlled Congresses, which passed increases in funding each of these fiscal years.

Concurrent Receipt

Another significant increase in veterans' funding is the enlargement of the Combat Related Special Compensation (CRSC) program – the Congressional response to veterans' calls for full "concurrent receipt" of military retirement and VA disability.

Until 2002, the law required that federal military retirement pay from the Department of Defense be reduced by the amount of any VA disability "service-connected" compensation received by the retiree. For many years, some military retirees had sought a change permitting full receipt of both benefits. This issue is referred to as "concurrent receipt," and legislation to allow this has been introduced during the past several Congresses.

In order to understand the debate surrounding concurrent receipt, it is important to note how VA service-connected disability ratings are determined. According to the General Accounting Office, "A disease or injury resulting in disability is considered service-connected if it was incurred or aggravated during military service. No causal connection between the disability and actual military service is required."[6] Simply stated, if a veteran was on active duty status when a disability developed, the VA considers it to be "service-connected."

For service-connected disabilities, the VA has a scale of 10 ratings, from 10 percent to 100 percent. Each percentage rating entitles the veteran to a specific level of disability compensation. A veteran receiving VA disability compensation can ask for a medical reexamination at any time (or, if a veteran does not receive disability compensation upon separation, a reexamination can occur later), as opposed to the DoD

[5] Bureau of Labor Statistics Consumer Price Index available at: http://www.bls.gov/data/home.htm.
[6] Cynthia A. Bascetta, Director of Education, Workforce, and Income Security Issues at the General Accounting Office, in prepared testimony delivered to the Senate Committee on Veterans' Affairs on September 23, 2003.

disability retirement system, where a one-time determination is made upon separation from service. [7]

As enacted in 2002, the Combat Related Special Compensation (CRSC) program allowed eligible veteran retirees to receive disability pay without any reduction in their military retirement pay from DoD. Eligible veterans were those with at least a 60-percent disability rating as a result of a disability incurred in military operations or training, and those who had received a Purple Heart (i.e., wounded in combat).

In 2003, the FY04 National Defense Authorization Act expanded the CRSC program to include: 1) payment of CRSC to all retired veterans with a disability incurred in military operations or training, regardless of the percentage of disability; 2) a 10-year phase-in of concurrent receipt for all military retirees whose disability is 50 percent or greater, regardless of the origins of their disability; and 3) the addition of reserve retirees to the program.

This expansion is estimated by the Congressional Budget Office to increase direct spending on retirement annuities for military retirees by $521 million in 2004, $5.5 billion over the 2004-2008 period, and $20.7 billion over the 2004-2013 period.[8]

Other Veterans Provisions of Note Passed During the Last Fiscal Year

Last year, a number of provisions benefiting veterans and their families became law, such as a 2.1-percent cost-of-living increase in disability compensation and survivors' compensation (DIC).

Congress passed other enhancements of benefits, including:

–Veterans Benefits Act of 2003 [P.L. 108-183] – increases surviving spouses'/orphans' educational assistance benefits; allows widows to retain survivors' compensation despite remarriage after age 57; provides benefits to spina-bifida-afflicted children of veterans exposed to Agent Orange in Korea; improves compensation benefits afforded to former POWs and Filipino veterans; and other provisions.

–Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 [P.L. 108-170] – extends requirement that VA provide nursing home care, outpatient-based, long-term care services, and homeless services; grants higher-priority healthcare eligibility for radiation-exposed veterans; eliminates pharmaceutical copayments for former prisoners of war; authorizes major medical facility construction projects; requires VA advance notice of proposed Capital Asset Realignment for Enhanced Services (CARES)-related actions; as well as other provisions.

[7] CRS, "Military Retirement: Major Legislative Issues," March 30, 2004.
[8] Congressional Budget Office, "H.R. 1588, National Defense Authorization Act for Fiscal Year 2004," November 25, 2003.

Additional Benefits Sought by Veterans' Groups

Notwithstanding these enhancements, veterans' groups are calling on Congress to further expand concurrent receipt, further reduce copayments for pharmaceuticals and medical services, and make the veterans medical budget a mandatory, rather than a discretionary, spending program.

Further Expansion of Concurrent Receipt

One proposal is to provide all disabled veterans concurrent receipt – that is, all veterans would be able to concurrently draw disability and military retirement, regardless of the degree of disability or how it was incurred (for example, disability due to diabetes developed while on active duty).

The argument in favor of full concurrent receipt has been made by several veterans' service organizations. Each year, AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States jointly prepare a document called "The Independent Budget." This document presents policy and budget recommendations on programs administered by the VA and the Department of Labor. "The Independent Budget" for FY05 states, with regard to concurrent receipt, "Compensation should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of compensation the veteran receives, our Government is in effect paying the veteran nothing for the service-connected disability he or she suffers."[9] Contrary to this assertion, the offset is not without benefit. All VA disability compensation is tax-free, which makes it very advantageous, compared to retired pay that is not tax-free. [10] As will be discussed below, many government retirement programs offset receipt of dual benefits for the same job.

Given the extent of the expansion of the Combat Related Special Compensation program under the FY04 National Defense Authorization Act, Congress must carefully consider whether further expansion of the program is merited at this time.

Pursuant to recent action by Congress, all retired veterans with disability ratings of 50 percent or greater already are receiving increased retired pay. By 2014, offsets will be fully eliminated for military retirees with at least a 50-percent disability. This is in addition to those veterans who incur a disability due to military operations or training, therefore already eligible for the Combat Related Special Compensation program before passage of the FY04 National Defense Authorization Act.

Because what constitutes a service-connected disability is broadly defined, compensation is already being paid to approximately 290,000 veterans whose disabilities are not a result of military operations or training. Granting disability status to this group

[9] Independent Budget Veterans' Service Organizations, "The Independent Budget – Fiscal Year 2005," accessed at: http://www.pva.org/independentbudget/ pdf/IB_2005.pdf.
[10] CRS, "Military Retirement: Major Legislative Issues," March 30, 2004.

already comes at a significant cost. Cynthia A. Bascetta, of the General Accounting Office, offered this testimony to the Senate Veterans' Affairs Committee in September 2003:

> In March 2003, the Congressional Budget Office (CBO) reported that, according to VA data, about 290,000 veterans received about $970 million in disability compensation payments in fiscal year 2002 for diseases identified by GAO as neither caused nor aggravated by military service. CBO estimated that VA could save $449 million in fiscal years 2004 through 2008, if disability compensation payments to veterans with several nonservice-connected, disease-related disabilities were eliminated in future cases. In August 2003, we also identified this as an opportunity for budgetary savings if the Congress wished to reconsider program eligibility.[11]

While Congress has not considered revising program eligibility, this testimony highlights the high cost already associated with the current structure.

Given the range of benefits already provided, and the added benefit of tax-free VA disability compensation, Congress will need to closely examine the cost associated with providing concurrent receipt for those currently not scheduled to receive it. If Congress were to extend concurrent receipt to all veterans – namely, to those with disability ratings below 50 percent for disabilities not incurred as a result of military operations or training – the estimated full cost from 2004 to 2013 would be $48.8 billion.[12]

Additionally, such an extension would worsen the discrepancy that exists between veterans and retirees from the Federal civilian service. Individuals who are eligible for benefits under a Federal civil service retirement system – such as the Civil Service Retirement System or the Federal Employees' Retirement System – and are also eligible for an award under the Federal Employees' Compensation Act (FECA) receive the FECA award subject to a limit on total compensation.

Finally, the recent expansion of the Combat Related Special Compensation program should be viewed in the context of other, similar federal benefit program rules. At the request of the Senate and House Committees on Armed Services, the Congressional Research Service (CRS) analyzed 25 pairs of programs that pay benefits to individuals based on employment or disability.[13] Of the 17 program pairs that involved benefits from the same employment, the analysts found that only four programs contained a form of full concurrent receipt, and "were either explicitly combined by

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[11] Cynthia A. Bascetta, Director of Education, Workforce, and Income Security Issues at the General Accounting Office, in prepared testimony delivered to the Senate Committee on Veterans' Affairs on September 23, 2003.

[12] Sarah T. Jennings, Principle Analyst for Defense, International Affairs, and Veterans' Affairs Cost Estimates Unit at Congressional Budget Office, testimony before Senate Armed Services Committee Subcommittee on Personnel, March 27, 2003.

[13] CRS, "Concurrent Receipt of Military Retired Pay and Veterans' Compensation: Analogies and Issues," May 5, 1993.

Congress to achieve income adequacy objectives or were not given much consideration by Congress when the programs were designed." The remaining 13 of the program pairs had some level of offset, generally due to "what the Congress considered to be overly generous benefit packages."

Further analysis will be devoted to the subject of disability compensation levels. The FY04 National Defense Authorization Act established a 13-member Veterans' Disability Benefits Commission, which will conduct a comprehensive assessment of all Federal benefits that compensate veterans and their survivors for disability or death attributable to military services. The commissioners will be appointed by both the President and the Congress and will report their conclusions in spring 2005.

Removal of all Copayments

In addition to full concurrent receipt, several veterans' groups propose the removal of all copayments for medical services and pharmaceuticals. According to the veterans' service organizations' "Independent Budget" for FY05:

> Through extraordinary sacrifices and contributions, veterans have earned the rights to certain benefits. As the beneficiaries of veterans' service and sacrifice, the citizens of a grateful nation want our Government to fully honor our moral obligation to care for veterans and generously provide benefits and health care free of charge. Asking veterans to pay for part of the benefit is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans.[14]

While the Bush Administration has proposed increases in some veterans' copayments and user fees each year it has submitted a budget, Congress has rejected these proposals. Senator Christopher (Kit) Bond, chairman of the VA-HUD Appropriations Subcommittee, stated during a hearing on April 6, 2004, regarding the FY05 copayment proposals, "These budget proposals were unacceptable last year to the Congress and I can almost assure you they will be unacceptable again this year."[15] Below is a review of the President's FY05 proposals for VA copayments.

Veterans receiving medical benefits from the VA are placed in priority groups ranging from 1 to 8, with 1 being the highest priority for enrollment. For example, those in Priority Group 1 are veterans with service-connected disabilities rated 50 percent or more disabling.

Under President Bush's FY05 proposed budget, copayments and user fees would only increase for Priority Groups 7 and 8 – that is, those veterans who are "non-poor" [as defined by a VA Means Test and the HUD geographic index – incomes approximately

[14] Independent Budget Veterans' Service Organizations.
[15] VA-HUD Appropriations Subcommittee Hearing, April 6, 2004, as reported in *CongressDailyAM*, April 7, 2004.

$25,000 and greater for single, $28,000 and greater with dependents], and who do not have service-connected disabilities.

The copayment increases proposed by the President – only for Priority Groups 7 and 8 – would go from $15 to $20 for outpatient services, and from $7 to $15 per 30-day pharmaceutical prescription.

A user fee of $250 (not an enrollment fee) is also proposed, again only for Priority Groups 7 and 8. The Veterans' Health Care Eligibility Reform Act of 1996 required the VA to establish and implement a national enrollment system to manage the delivery of health care services. Certain limited groups of veterans do not need to enroll to receive care. While many veterans enroll to be eligible for VA medical care, not every veteran enrolled is an actual *user* of that care in a given year, and therefore would not be required to pay the fee, even if he or she is in Priority Group 7 or 8.

It is important to note that the Administration also proposes eliminating pharmacy copayments for all poor veterans with non-service connected disabilities, and for all former POW's, and also proposes the Federal government cover the deductibles for all enrolled veterans who need emergency care at a non-VA facility.

The levying of copayments for services to non-poor, non-service connected disabled veterans is partially a means to collect revenues for the VA budget, but primarily a means to control demand for services by those who are likely to have access to health care through their employer.

The VA estimates that there would be 200,000 fewer users of VA-provided services in Priority Groups 7 and 8 if the aforementioned proposals were enacted – largely because many of those veterans use VA medical care as a supplement to their primary source of coverage.

The VA expects that the higher pharmacy copayment would result in savings (about $83 million) to the system due to fewer users of the pharmacy benefit, as well as an increase in revenues (about $135 million) from the higher copayment paid by those veterans in Priority Groups 7 and 8 who choose to continue receiving the benefit.[16] Similarly, the expected impact of the $250 user fee is $141 million in savings due to fewer users, and an increase in revenue of $268 million from those who continue to use the system. It is important, again, to note that the proposed $250 is not an enrollment fee.[17]

Veterans Medical Care as Mandatory Spending

Several veterans' groups also want spending for veterans medical care to be a mandatory funding item as opposed to a yearly discretionary spending item. Veterans'

[16] FY05 Department of Veterans Affairs Medical Care Budget, Volume 1 of 4, 2E 1-12.
[17] FY05 VA Medical Care Budget.

groups have argued that veterans medical care should be mandatory so as to "avoid the uncertainties of the annual appropriations process."

The veterans' service organizations state in "The Independent Budget" for FY05

> Year after year, the [Independent Budget veterans' service organizations] have fought for sufficient funding for VA health care and a budget that is reflective of the rising cost of health-care and increasing need for medical services. Despite our continued efforts, the cumulative effects of insufficient health-care funding have now resulted in the rationing of medical care. We believe mandatory funding for VA health care is a reasonable long-term solution to VA's funding crisis.

One such bill to make veterans medical care a mandatory spending item cited by the veterans' service organizations is S. 50, the Veterans Health Care Funding Guarantee Act of 2003 (sponsored by Senator Tim Johnson). S. 50 would establish a mandatory funding level for the Veterans Health Administration (VHA) each year. Under S. 50, 120 percent of the amount obligated during FY 2002 divided by the number of patients enrolled for care would be mandated for VHA per enrollee beginning in FY05 (approximately $4,600/patient based on FY02 data). Thereafter, the FY05 amount would be increased annually, based on the number of enrolled veterans and the percentage increase in the Consumer Price Index (CPI).

While it is understandable that groups would want "guaranteed" funding, the funding mechanism envisioned by the bill may not actually result in enhanced resources for veterans medical care.

> –First, funding under S. 50 is not based on demand. That is because funding is based on the number enrolled, not on the number of actual users of the system (currently, there are approximately 7.6 million veterans enrolled and only 4.9 million users). The number of veterans enrolled could increase rapidly in one year without an increase in actual users of the system, resulting in excess funding for VHA that is not related directly to an increase in users of veterans medical care.
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> –Second, it could also transpire that the number of enrollees remains relatively static, while the number of users within it goes up. As stated above, while most veterans are required to enroll to be *eligible* for VA medical care, a smaller number of enrollees are actual *users* of the system. Under this scenario, the actual demand will have increased, yet since the number of enrollees failed to increase, the per-dollar allocation based on veterans enrolled would not increase.
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> –Third, while the formula provided in S. 50 arbitrarily provides a starting allocation of $4,600/year per veteran, the reality is that some veterans will cost $40,000/year and others will only cost $400/year. This could put pressure on the VA to ration health care to veterans if too many have care exceeding the

$4,600/year allocation, making the system a glorified health maintenance organization (HMO).

–Fourth, the bill assumes that under the current discretionary structure, veterans medical care has been inadequate and unable to expand commensurate with the needs of beneficiaries. S. 50 takes FY02 as a baseline, adds 20 percent, and then increases funding by the Consumer Price Index, taking into account the number enrolled. However, FY03 and FY04 have already seen increases of 11.3 and 11 percent, respectively. The additional 20 percent added by S. 50 is consumed and subsequent increases are tied to the Consumer Price Index, which does not necessarily reflect increases or decreases in health care demand. Nor does the Consumer Price Index take into account new technology or its effect on the cost of, and demand for, health care. Veterans likely would receive more generous medical care under the current discretionary funding structure. Finally, if funding under this mandatory mechanism proved to be inadequate, supplemental appropriations would be required, which is a discretionary spending measure.

Given the complexity of veterans' health care needs, and the challenges in making sure a mandatory funding mechanism adequately meets those needs, Congress must weigh the above issues when considering this idea.

Conclusion

The men and women of our armed forces, to whom we owe so much, deserve good care. The increases in veterans' benefits over the past three years have been robust and, by recent historical standards, extraordinary. While there have been claims by some veterans' groups that funding for veterans programs has been inadequate, the recent increases demonstrate Congressional commitment to veterans' programs. Like any government spending item, further expansion of funding following such substantial increases warrants careful scrutiny by Congress.