16. VETERANS BENEFITS AND SERVICES

Table 16–1. Federal Resources in Support of Veterans Benefits and Services
(Dollar amounts in millions)

Function 700	1993 Actual	2001 Estimate	Percent Change: 1993–2001
Spending:			
Discretionary budget authority	16,235	22,512	39%
Mandatory outlays	19,848	22,918	15%
Credit Activity:			
Direct loan disbursements	2,211	1,709	–23%
Guaranteed loans	35,434	29,548	–17%
Tax expenditures	1,980	3,490	76%

The Federal Government provides benefits and services to veterans and their survivors of conflicts as long ago as the Spanish-American War and as recent as the Gulf War, recognizing the sacrifices of wartime and peacetime veterans during military service. The Federal Government spends over $45 billion a year on veterans benefits and services, and provides over $3 billion in tax benefits to compensate veterans and their survivors for service-related disabilities; provides medical care to veterans including lower-income and disabled veterans; and helps returning veterans prepare to reenter civilian life through education and training. In addition, veterans benefits provide financial assistance to needy veterans of wartime service and their survivors. Along with direct Federal funding, certain tax benefits help veterans. The law keeps all cash benefits that the Department of Veterans Affairs (VA) administers (i.e., disability compensation, pension, and Montgomery GI Bill benefits) free from tax.

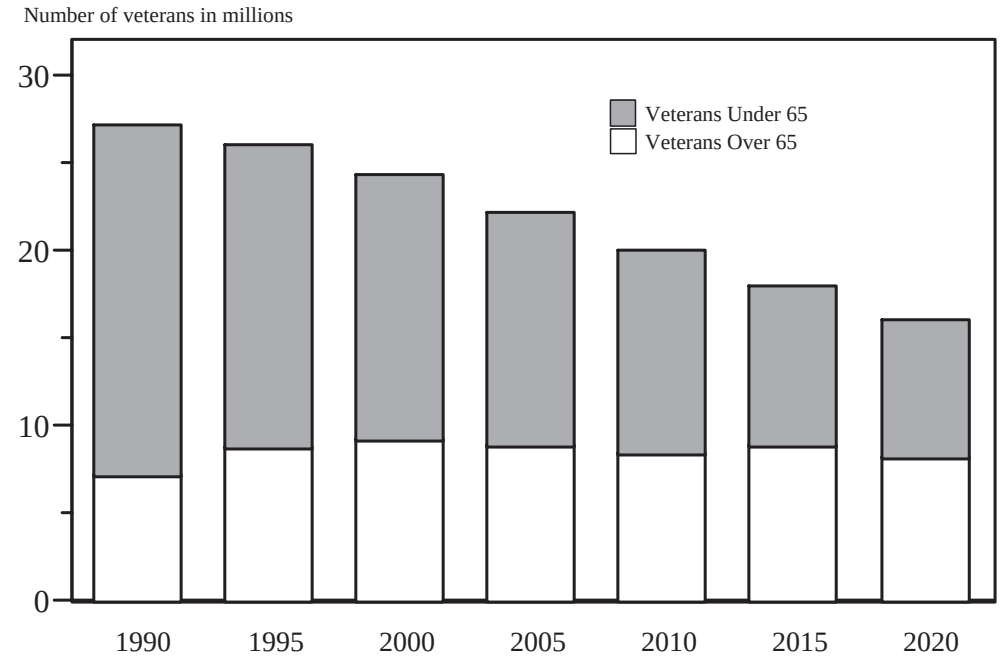
About seven percent of veterans are military retirees who can receive either military retirement from the Department of Defense (DOD) or veterans benefits from the VA. Active duty military personnel are eligible for veterans housing benefits, and they can contribute to the Montgomery GI Bill (MGIB) program for education benefits that are paid later. VA employs 21 percent of the Federal Government's non-DOD civilian work force—approximately 220,000 people, about 195,000 of whom deliver or support medical services to veterans.

The veteran population continues to decline and age (see Chart 16–1). These demographic shifts result in changes in the types of benefits and services needed by veterans. Further, as technology improves, access to, and the quality of service improves.

Veterans Health Administration (VHA)

Over the last eight years, VA has undergone sweeping reform that enabled its health care delivery system to provide medical care in a more efficient, outpatient-oriented system emphasizing continuity of care. VA provides health care services to 3.5 million veterans through its national system of 22 integrated health networks, consisting of 172 medical centers, 766 ambulatory clinics, 134 nursing homes, 40 domiciliaries, and 206 veteran centers. VA is an important part of the Nation's social safety net because over half of its patients are lower-income veterans who might not otherwise receive care. It also is a leading health care provider for veterans with substance abuse problems, mental illness, HIV/AIDS, and spinal cord injuries

Chart 16-1. Veterans Population Declines and Ages



Source: Department of Veterans Affairs

because private insurance usually does not fully cover these conditions.

Despite obstacles, VHA has dramatically transformed itself into a more efficient health care provider, with increased emphasis on quality and continuity of care. Early in the Clinton-Gore Administration, VHA began realigning 172 separate hospital campuses into 22 Veterans Integrated Service Networks (VISNs). This reorganization provided a new framework for management and change. The 22 network directors were empowered and held accountable to provide improved access and quality to needed health care services, while eliminating redundancy. In 1996, the Administration worked with the Congress to enact the Eligibility Reform Act. This allowed for the dramatic modernization of the system by allowing VA to treat patients in the most appropriate care setting, prioritizing veterans for eligibility, and allowing liberal contracting and sharing authorities (e.g., VA provides medical care services to DOD active duty military on a contract basis). Prior to eligibility reform, VA had to provide care as defined in statute. In many cases, it could only provide care on an inpatient basis. This requirement proved to be extremely costly, inefficient, and burdensome to VA and its veteran patients. Even simple procedures were being performed in hospitals. The shift from inpatient to outpatient care has allowed VHA to evolve into a more responsive health care delivery system.

Under this Administration, VA has aggressively shed unnecessary personnel and replaced them with direct patient care services, expanded contract services and sharing agreements, and centralized procurement to capitalize on its buying power. In addition, VA has implemented national pharmaceutical formularies, realigned clinical support services, and consolidated, privatized, or franchised some ancillary services, such as laundry,

food preparation, payroll/human resource administration, and fire protection.

VA's quality of care, based on industry standards, is very high and continually improving. VA has become a leader in such patient-safety techniques as bar-coding, which ensures that patients receive the correct drugs, and a comprehensive medical-error reporting system that helps find common errors and develop prevention processes. Over the last four years, VA has completely shifted to coordinated care by establishing clinical teams—consisting of physicians, nurses, pharmacists, etc.—to provide care in a more consistent and thorough manner. Prior to 1997, patients were randomly assigned to available medical staff. Today, each veteran is assigned to a team and continually sees the same providers, improving continuity of care and patient satisfaction.

VA also formed partnerships with the National Committee on Quality Assurance, the American Hospital Association, the American Medical Association, the American Nurses Association, and other national associations to ensure quality patient care. The Chronic Disease Care Index measures VA physicians' adherence to established industry practice guidelines for key diseases affecting veterans. It has increased from 44 percent to 90 percent over the past six years. Similarly, the Prevention Index measures adherence to disease prevention and screening guidelines and has seen an increase from 34 percent to 81 percent over the past six years.

In summary, the reengineering of VA health care has resulted in significant reductions in the cost per patient while quality of care increased. This included restructuring veterans' health care to include the organizational, financial, and management change associated with the VISNs, shifting care to more appropriate care settings with an emphasis on primary care, and implementing clinical and administrative efficiencies including consolidations and integrations. More specifically, since 1993:

- patients treated per year increased by over 35 percent (from 2.8 to 3.8 million). Further, 107 percent more homeless patients were treated in 2000 compared to 1993;
- annual inpatient admissions decreased 38 percent (317,688 fewer admissions) by 2000 while ambulatory care visits increased by 56 percent to 39.3 million (14.1 million increase);
- approximately 1,300 sites of care delivery have been organized under 22 Veterans Integrated Service Networks; and,
- over 350 new community-based outpatient clinics have been established.

Veterans Benefits Administration (VBA)

VBA processes veterans' claims for benefits in 57 regional offices across the country. These benefits include compensation for service-connected disabilities, pensions for low-income veterans, vocational rehabilitation, education, home loans, and life insurance. Since 1993, VBA has realigned 57 regional offices into nine service delivery networks. It has established nine Regional Loan Centers for housing loans and four Regional Processing Offices for education claims in an effort to improve efficiency and quality of services to its customers. VBA has also taken steps to integrate information technology into claims processing to improve timeliness and quality of service delivery. It has also implemented a "balanced scorecard," a tool that has helped management to weigh the importance of and measure progress toward meeting VBA's strategic goals, which include:

- improving responsiveness to customers' needs and expectations;
- improving service delivery and benefit claims processing; and,
- ensuring best value for the available taxpayers' dollar.

VBA monitors its performance in awarding disability benefits claims through measures of accuracy, customer satisfaction, processing timeliness, and unit cost.

Disability Compensation: Veterans with disabilities resulting from, or coincident with, military service receive monthly compensation payments based on the degree of disability. The payment does not depend on a veteran's income or age or whether the disability is the result of combat or a natural-life affliction. It does depend, however, on the average decline

in earnings capacity that the Government presumes for veterans with the same degree of disability. Survivors of veterans who die from service-connected injuries receive payments in the form of dependency and indemnity compensation. Compensation benefits are indexed annually by the same cost-of-living adjustment as Social Security. While the veteran population is declining, the compensation caseload is currently remaining relatively constant due to changes in eligibility, better outreach efforts, and increasingly complicated disabilities as veterans age.

Since 1993, compensation benefits have been expanded for Gulf War- and Vietnam-era veterans. Initially, VA established six "presumptive" service-connected disabilities for Vietnam veterans for herbicide exposure under the Agent Orange Act; there are currently nine presumptive conditions. The development of presumptive disabilities makes it easier for disabled veterans to obtain compensation benefits by eliminating the burden to prove that the disabling event occurred during military service. In 1994, VA designed and implemented criteria for the first time to compensate veterans with chronic disabilities resulting from undiagnosed illnesses (otherwise known as Gulf War Syndrome). In 1997 and 2000 respectively, the Administration worked with the Congress to impart monetary benefits, heath care, and vocational rehabilitation to the children of Vietnam veterans who suffered from spina bifida or birth defects—extending benefits to children for the first time.

Education Benefits: The Government originally created the MGIB as a test program, with more generous benefits than the post-Vietnam-era education program, to help veterans move to civilian life and to help the Armed Forces with recruitment. Service members who choose to enter the program have their pay reduced by $100 a month in their first year of military service. VA administers the program and pays basic benefits once the service member becomes eligible. Since 1994, the benefit automatically increases each year in relation to the general inflation rate. Moreover, the Veterans Benefits and Health Care Improvement Act of 2000 allows service-members to increase their benefits by up to $150 over the basic monthly amount by contributing an additional $600.

MGIB beneficiaries receive a monthly check based on whether they are enrolled as full-time or part-time students. They can get 36 months worth of payments, but they must certify monthly that they are in school. DOD may provide additional benefits to help recruit certain specialties and critical skills. The MGIB also provides education benefits to members of the Selected Reserves. DOD funds these benefits, and VA administers the program. Over 90 percent of MGIB beneficiaries use their benefits to attend a college or university. Basic benefits available now total over $23,400 per recipient, compared to $12,600 in 1992 (an 86-percent increase).

National Cemetery Administration (NCA)

VA provides burial in its national cemeteries for eligible veterans, active duty military personnel, and their dependents. VA manages 119 national cemeteries across the country. In addition, VA has jointly funded 47 State veterans cemeteries through its State Cemetery Grants Program. Since 1993, NCA has expanded service by opening five new national cemeteries (Kent, Washington; Schuylerville, New York; Elwood, Illinois; Dallas, Texas; Rittman, Ohio), provided grants to States to establish 25 new State veteran cemeteries, and acquired 3,000 acres of land to meet burial demands. NCA improved service by installing 24 information kiosks and by encouraging non-VA national and State veterans cemeteries to place headstone orders online. In addition, VA will establish six additional national cemeteries in areas of the United States in which the need for burial space is greatest. Those areas are: Atlanta, Georgia; Detroit, Michigan; Miami, Florida; Sacramento, California; Pittsburgh, Pennsylvania; and, Oklahoma City, Oklahoma.