

# **The Independent Budget CRITICAL ISSUES REPORT ON FISCAL YEAR 2005**

*The Independent Budget* for FY 2005 will be the 18th budget proposal for the Department of Veterans Affairs (VA) developed by the coalition of four congressionally chartered veterans service organizations: AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States. *The Independent Budget*, developed by veterans for veterans, will be released alongside the president's budget in February 2004 to serve as a guide to Congress as it develops VA budget and appropriations policy for FY 2005. This Critical Issues Report is intended to transmit our identified critical issues relating to VA health care and benefits for that budget cycle. We are releasing this document now as a guide to policy makers in the current administration as they craft the president's FY 2005 budget submission.

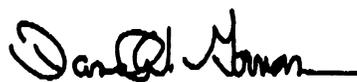
*The Independent Budget* is built on a systematic methodology that takes into account changes in the size and age structure of the veteran population, federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans to be laid to rest in our nation's cemeteries. *The Independent Budget* also takes into consideration changes in medical and information technologies and their effects on health care and benefits delivery.

*The Independent Budget* is the voice of responsible advocacy. Our budget recommendations will be rational, rigorous, and sound. We urge you to review these preliminary recommendations that we have identified as issues critical to the delivery of quality, timely, and efficient health care and benefits to our nation's veterans.

Sincerely,



James B. King  
National Executive Director  
AMVETS (American Veterans)



David W. Gorman  
Executive Director  
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Robert E. Wallace  
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**CRITICAL ISSUE #1: Acute Need for Health-Care Funding**

***Lack of adequate funding has placed VA health care in critical condition.***

The Department of Veterans Affairs (VA) health-care system is at a crossroads. One road leads to a VA that provides the finest health care to our nation's veterans, a system that can meet the demands of today, and the challenges of the future. The other road leads to a system starved of the resources it needs to provide basic health care, a system that hangs on to viability by rationing basic services, disenrolling veterans, and making sick and disabled veterans wait months for appointments. In many ways, this coming fiscal year will be the year of decision for VA, and it will be clearer which road the administration and Congress chooses.

This year has been a troubling time for veterans. We have witnessed an inadequate budget proposal submitted by the administration, filled with gimmicks instead of real dollars. We have seen the House of Representatives pass a budget resolution that called for \$28 billion in veterans' cuts over 10 years—a budget passed as the war in Iraq began—and then ultimately agree to the Senate-passed amount, which would have provided sufficient health-care resources to match *The Independent Budget's* recommendation. But when the House next acted, it provided only the amount recommended by the administration, yet again breaking faith with veterans. Sadly, this funding uncertainty happens nearly every year as veterans' issues are not accorded the priority that lip-service pays them.

As VA faces an uncertain future, we must bear in mind that VA does not operate in a vacuum: It is an integral part of our national health-care delivery system. Trends and decisions made in one part affect all other components. There is little doubt that the lack of a national pharmaceutical benefit has caused many veterans to seek out the VA drug benefit. Likewise, the growing problem of the uninsured will have a ripple effect on the number of veterans seeking care.

The Kaiser Family Foundation reports, “[o]ver 43 million Americans had no health insurance coverage in 2002 according to the latest estimate from the U.S. Census Bureau—an increase of 2.5 million people over the previous year and the largest annual increase in more than a decade of monitoring this key indicator of Americans' health and health care.” *The New York Times*, in a piece by Robert Pear, stated that “middle-income households accounted for most of the increase in the number of uninsured. In households with annual incomes of \$25,000 to \$74,999, the number of uninsured people rose last year by 1.4 million to 21.5 million, and the increase was most noticeable among households with incomes of \$25,000 to \$49,999.”

This is an especially troubling trend for veterans and VA health care. The very group that was hardest hit by losing their health-care insurance is the very income group cut off for health-care enrollment by the VA in its attempt to ration care.

These trends lead to more veterans seeking VA health care. VA can either meet this swelling demand by rationing basic services, or the administration can propose, and

Congress can put into effect, adequate resources to enable VA to meet its legal and moral duties.

For FY 2004, *The Independent Budget* recommended a \$3.3 billion increase for VA health care, a 13.9 percent increase, for a total of \$27.2 billion in appropriated dollars. The Administration proposed a \$1.4 billion increase, a 5.6 percent increase from FY 2003.

In testimony before the House Committee on Veterans' Affairs on January 29, 2003, Dr. Robert Roswell, the VA's under secretary for health stated:

One of the things that we have determined is that in a typical year, our expenses increase 6 to 7 percent by new enrollment in Priorities 1 through 7. In addition to that [enrollment growth], increased utilization, because the veteran population ages, and health-care expenditures and health-care utilization increase. With every increasing year of age, particularly in an elderly population, we have another 2 to 3 percent incremental cost every year. So a 7 percent increase associated with enrollment in our highest priority groups, coupled with another 2 to 3 percent of increased utilization costs, coupled with a conservatively estimated health care inflation rate of 4.5 or 5 percent, yields a 13 or 14 percent per year increase in the money available to take care of just our core population of veterans.

The amount recommended by *The Independent Budget* as necessary to operate the VA health-care system was therefore corroborated by VA. Depending on the final outcome of the FY 2004 appropriation, *The Independent Budget* will undoubtedly recommend a similar increase for FY 2005 in order to enable VA to simply not lose ground. But we need VA to move forward to meet its responsibilities to sick and disabled veterans. An additional amount will be recommended to meet the health-care demand of the men and women returning from our ongoing conflicts abroad. Public Law 105-368 mandated health care for a period of two years for these returning warriors. In addition, *The Independent Budget* will seriously weigh the increasing costs of pharmaceuticals, and their increasing role in the provision of health care; the protection and improvement of specialized services; and the infrastructure needs of VA as it attempts to meet the health-care challenges of the coming century.

There are, therefore, two roads the VA health-care system can travel. One meets the needs of the men and women who serve our nation at great sacrifice. A road that ensures that VA is around for today's veterans and the veterans of tomorrow. A road that guarantees VA's ability to meet its four core missions. The other road is one of decline and ultimate death of a health-care system devoted to the special health-care needs of veterans. A road of ever-increasing health-care rationing, and ever-more broken promises. Congress and the administration must decide which road to take—their decision will either live up to our national promises and commitments or call these into question.

“Big Increase Seen in People Lacking Health Insurance” - Robert Pear, *The New York Times*, September 30, 2003

“The number of people without health insurance shot up last year by 2.4 million, the largest increase in a decade, raising the total to 43.6 million, as health costs soared and many workers lost coverage provided by employers, the Census Bureau reported today.

The increase brought the proportion of people who were uninsured to 15.2 percent, from 14.6 percent in 2001. The figure remained lower than the recent peak of 16.3 percent in 1998.

A continued erosion of employer-sponsored coverage was the main reason for the latest increase, the bureau said. Public programs, especially Medicaid, covered more people and cushioned the loss of employer-sponsored health insurance but ‘not enough to offset the decline in private coverage,’ the report said.

But middle-income households accounted for most of the increase in the number of uninsured. In households with annual incomes of \$25,000 to \$74,999, the number of uninsured people rose last year by 1.4 million to 21.5 million, and the increase was most noticeable among households with incomes of \$25,000 to \$49,999.”

“Boiling Brew: Politics and Health Insurance Gap” - Robin Toner, *The New York Times*, September 30, 2003

“Health care costs are soaring again, after several years of stability: average premiums rose nearly 14 percent this year, the third year of double-digit increases, according to the Kaiser Family Foundation. Employers are pushing more of the costs onto their workers, raising co-payments and deductibles. At the same time, many Americans saw their health benefits jeopardized by layoffs, which have continued despite the official end of the recession in November 2001.”

“Access to Care for the Uninsured: An Update” - Kaiser Family Foundation

Over 43 million Americans had no health insurance coverage in 2002 according to the latest estimate from the U.S. Census Bureau—an increase of over 2.5 million people over the previous year and the largest annual increase over more than a decade of monitoring this key indicator of Americans' health and health care. The uninsured come primarily from working families with low and moderate incomes—families for whom coverage is not available in the workplace or not affordable for them. Medicaid and the State Children’s Health Insurance Program (SCHIP) help fill the gaps for many, but the states’ fiscal crises limit their ability to meet the needs of all low-income Americans.

“Census Finds Many More Lack Health Insurance” - Ceci Connolly, *The Washington Post*, September 30, 2003

House Committee on Veterans' Affairs, Budget Views and Estimates, Dr. Roswell's testimony:

“One of the things that we have determined is that in a typical year, our expenses increase 6 to 7 percent by new enrollment in Priorities 1 through 7. In addition to that [enrollment growth], increased utilization, because the veteran population ages, and health-care expenditures and health-care utilization increase. With every increasing year of age, particularly in an elderly population, we have another 2 to 3 percent incremental cost every year. So a 7 percent increase associated with enrollment in our highest priority groups, coupled with another 2 to 3 percent of increased utilization costs, coupled with a conservatively estimated health-care inflation rate of 4.5 or 5 percent, yields a 13 or 14 percent per year increase in the money available to take care of just our core population of veterans.”

From the V&E

“The medical care component of the Consumer Price Index (CPI) continues to escalate, outpacing all other items in the CPI for the past seven years. The Bureau of Labor Statistics (BLS) released inflation rate data in December 2002 that showed the overall health care inflation rate was 5 percent for calendar year 2002. Within that level, hospital care inflation was the highest single component at 10.2 percent, followed by prescription drugs and medical supplies at 6 percent. An experimental price index Congress directed BLS to develop also reveals that persons 65 years of age and over are spending more than twice as much on health care as the total population.”

**CRITICAL ISSUE #2: Service-Connected Disability**

***To maintain an equitable, effective, practical, and workable compensation program for veterans disabled in service to our nation, our government must refrain from ill-advised schemes to reduce and restrict eligibility for disability benefits for political purposes.***

The Administration and some in the majority leadership in Congress have recently shown a willingness to consider fundamental changes in VA's eligibility standards for veteran's disability compensation benefits.

A primary and paramount responsibility of any national government is to provide for the common defense. It follows that one of the most essential and fundamental obligations of any legitimate national government is to provide for and guarantee the care of those who defend and preserve it against the designs of its enemies. Those few who are willing to risk life and limb for their country and fellow citizens must be assured that their government will fulfill its reciprocal duty to care for them if they are disabled during military service. All citizens who enjoy the fruits of our democracy and national security individually bear a responsibility for the common defense. Mindful of those principles and genuinely grateful for the contributions and sacrifices of those who serve in the armed forces, our citizens, through our government, have provided for our country's military veterans since our nation was born. Each new generation is the inheritor of the

great republic that all of our thousands of men and women of the armed forces have fought and died for, and we have a continuing solemn obligation to preserve it with a strong national defense, of which proper treatment of our veterans is an integral and indispensable element. The future strength of our nation depends on the willingness of young men and women to serve in our military, and that depends in part on the willingness of our government to meet its obligation to them as veterans.

The core veterans' benefits are those provided to relieve to the extent possible the effects of service-incurred disabilities or to relieve the economic loss dependents and survivors suffer as consequence of veterans' service-connected disabilities and deaths. The general principle, or test, for service connection is whether a disability was incurred or aggravated during, or "coincident with," service in the armed forces. Proof of a cause-and-effect relationship between military service and the disability is not required if the disability is shown during service or an applicable presumptive period immediately following service.

Unlike civilian employment where an individual is typically on the job and under supervision of an employer eight scheduled hours a day, five days a week, and has the option to refuse unwise or unduly dangerous tasks, a member of the armed forces is obligated to, and under the absolute control and discretion of, the government 24 hours a day. All daily activities are incident to military service, except those in which an individual is physically unavailable to perform military duties as when absent without permission or confined by military or civilian authorities for serious crimes. The overall military environment is one inherently involving greater risks of injury and greater physical and mental stresses than those existing in civilian life. These greater risks and physical and mental stresses are not confined to times and places where the servicemember is actively engaged in the direct performance of military occupational functions. There is no practical basis to distinguish between job functions, per se, and general military duties and activities because all are necessarily directly or indirectly connected to military service and the unique military environment. Members of the armed forces are knowingly, and unknowingly, exposed to risks and environmental hazards associated with weaponry and military materials. Most civilians never need be concerned that they will be exposed to the most toxic substance known to humankind—dioxin; to ionizing radiation; to microwaves; to exotic tropical diseases; to mustard gas and other chemicals contained in weapons or military materials; to the extremes of the inhospitable climes of warfare in deserts, jungles, or cold regions; to the mental effects of isolation and long separations from family members; or to the stresses of combat and being stationed in war zones. The military experience is not severable into employment and non-employment activities. Injuries during service cannot practically or fairly be categorized as due to or not due to the performance of duty. Diseases arising during service (or within a presumptive period) usually cannot be associated with particular military activities or disassociated from the general military environment.

Despite the problematic and unjust nature of a strict performance of duty standard for service-connection, some in our government, apparently blindly driven by dollar signs, sought to impose such an unworkable and unconscionable requirement upon disabled

veterans seeking benefits to relieve the effects of their service-related disabilities. Such a requirement would prevent men and women returning home from the service as disabled veterans from being compensated, from being rehabilitated, and possibly from being medically treated. It would prevent many survivors from receiving indemnification for the service-connected deaths of servicemembers or veterans. Such a requirement is simply unjustifiable.

Although the administration and those in Congress pushing for the strict performance of duty standard did not persist and include provisions for this purpose in the annual defense authorization bill as initially planned, Congress has included provisions in the bill for a commission to study the appropriateness of disability benefits. Bad ideas are hard to kill in Washington.

To protect essential benefits for service-connected disabled veterans from arbitrary, unwarranted, and unjustified elimination purely for savings to the government, *The Independent Budget* recommends that the administration refrain from further ill-advised efforts to avoid the government's obligation to compensate veterans disabled in the line of duty and reject any recommendations to change the terms for service connection of disabilities or deaths.

**CRITICAL ISSUE #3: Mandatory vs. Discretionary Funding**

***It is imperative that Congress make VA health-care funding mandatory so that all enrolled veterans have access to high quality health-care services in a timely manner.***

*The Independent Budget* veteran service organizations (IBVSOs) firmly believe that our nation's veterans have earned the right to Department of Veterans Affairs (VA) medical care through their extraordinary sacrifices and service to this nation. However, funding for veterans' health care remains a discretionary program, and each year funding levels must be determined through an annual appropriations bill. Year after year the IBVSOs 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, inflation-eroded appropriations for health-care funding, coupled with a significantly increased demand for care, have now resulted in the severe rationing of medical care. We believe making VA health-care funding mandatory is a reasonable solution to address these serious problems.

In May 2001, President George W. Bush signed Executive Order 13214, creating the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans.

The PTF was charged to identify ways to improve health-care delivery to VA and Department of Defense (DOD) beneficiaries. Of most importance to the IBVSOs is the task force's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its *Final Report* that "...it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DOD but, if unresolved, will delay veterans' access to care and

could threaten the quality of VA health care.” As a solution to this complex problem, the PTF recommended the government provide full funding for VA health care for Priority Groups 1 through 7 by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal to ensure enrolled veterans are provided the current comprehensive benefits package, in accordance with VA’s established access standards. The PTF also suggested the government address the present uncertain access status and funding of Priority Group 8 veterans.

The PTF final report noted that the discretionary appropriations process has been a major contributor to the historic mismatch between available funding and demand for health care services. We agree that to improve timely access to health care for our nation’s sick and disabled veterans, the federal budget and appropriations process must be modified to ensure full funding for the veterans health-care system. The long-term solution must factor in how much it will cost to care for each veteran enrolled in the system and a guarantee that the full amount determined will be available to VA to meet that need. Including Priority Group 8 veterans under a guaranteed funding mechanism is essential to ensuring viability of the system for its core users, preserving VA’s specialized programs, and maintaining cost effectiveness.

Even though over the past two budget cycles Congress has increased discretionary appropriations for veterans health care, the funding levels have simply not kept pace with inflation or the significant increase in demand for services. Additionally, VA began the last two budget cycles without having the benefit of an enacted increased spending level to meet its mission of service to sick and disabled veterans. Although VA requested an increase for veterans health care for fiscal year 2003, it fell far short of what VA’s under secretary for health testified would be necessary—a 13 to 14 percent increase—just to maintain current services. We believe VA has an obligation to provide veterans timely top quality health care and that Congress has an obligation to ensure that VA is provided sufficient funding to carry out that mission. We agree that the real problem, as the PTF aptly states in its report, is that “the Federal Government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions.”

During the 108th Congress, mandatory funding bills have been introduced in both chambers. The Assured Funding for Veterans Health Care Act of 2003 has been introduced in the House of Representatives as H.R. 2318, by House Veterans’ Affairs Committee Ranking Member Lane Evans (D-IL), and in the Senate as S. 50, by Senator Tim Johnson (D-SD). This mandatory health-care funding measure aims to guarantee adequate annual funding for health care for all sick and disabled veterans eligible to receive medical care from VA.

We have often stated that, through their extraordinary sacrifices and contributions, veterans have earned the right to free health care as a continuing cost of national defense. The Health Care Eligibility Reform Act of 1996 authorized eligible veterans access to VA health care and brought us closer to meeting our moral obligation as a nation to care

for veterans and generously provide them the benefits and health care they rightfully deserve.

However, the law, title 38, United States Code, § 1710(a), provides that the secretary “shall” furnish hospital care and medical services, but only to the extent Congress has provided money to cover the costs of the care. Thus, the funding under the federal budget for this program is “discretionary,” meaning it is within the discretion of Congress to determine how much money it will allocate each year for veterans’ medical care. Because the level of funding to cover the costs of treating veterans is not guaranteed, VA is forced to ration medical care. By law, the VA secretary must decide annually whether it can maintain enrollment for all veterans within existing resources. In January 2003, the secretary suspended new enrollments for veterans with the lowest statutory priority, Priority Group 8 veterans, to, in his words, help improve the unacceptably long waiting times for medical care appointments and to meet the increasing demand for services funded by a discretionary account. Secretary Principi stated that the tremendous growth in demand for health-care services, coupled with finite resources, has prevented VA from providing timely access to quality health care to all enrolled veterans.

Making veterans’ health-care funding mandatory would eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment. We believe it is disingenuous for our government to promise health care to veterans and then to make it unattainable because of inadequate funding. Rationed health care is no way to honor America’s obligation to the brave men and women who have so honorably served our nation and continue to carry the physical and mental scars of that service.

We propose to simply shift funding for VA health care from discretionary appropriations to a mandatory funding program so that all eligible veterans enrolled in the VA health-care system have timely access to VA medical programs and services currently provided under title 38, United States Code. We believe this will stop the severe rationing of health care that is typical of today’s veterans’ health-care system.

Mandatory health-care funding would not create an individual entitlement to health care nor change VA’s current mission. We do not propose changing the existing eligibility criteria for Priority Groups 1 through 8 or the medical benefits package defined in current regulations, only the way the funds are provided for VA health care. Having a sufficient number of veterans in the health-care system is critical to maintaining the viability of the system and sustaining it into the future. By including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our nation’s sick and disabled veterans.

Veterans expect this administration to honor its commitment and obligation to those who previously served in the Armed Forces and to those who are currently serving in Iraq and the war on terror. Our nation’s sick and disabled veterans cannot wait any longer for the government to take action. Now is the perfect opportunity for this administration and Congress to move forward on the recommendations of the PTF, charged with improving

health-care delivery for our nation's veterans, and to support a permanent solution to resolve this untenable situation.

**CRITICAL ISSUE #4: Funding for Research**

***Funding for VA medical and prosthetics research is inadequate to support the full costs of the VA research portfolio and fails to provide the resources needed to maintain, upgrade, and replace aging research facilities.***

The Department of Veterans Affairs (VA) medical and prosthetic research is a national asset that helps to attract high-caliber clinicians to practice medicine and conduct research in VA health-care facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

Focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population, VA research is patient oriented. Sixty percent of VA researchers treat veterans. As a result, The Veterans Health Administration (VHA), which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofits, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment to steady and sustainable growth in the annual research and development (R&D), appropriation is necessary for maximum productivity.

The annual appropriation for the Medical and Prosthetics Research Program that makes this leverage and synergy possible relies on an outdated funding system. A thorough review of the VHA research funding methodology is needed to ensure adequate funds for both the direct and indirect costs of this world-class research program. The Office of Research and Development allocates R&D funding for the direct costs of projects, while indirect costs and physician and nurses' salaries are covered by the medical care appropriation, with no centralized means to ensure that each facility research program receives adequate support. As demands on medical center resources increase, physicians have difficulty finding time to fulfill their clinical, administrative, and training responsibilities **and** to conduct research. Also, funds to staff the necessary oversight committees\_ Research and Development Committees, Institutional Review Boards, Animal Safety Committee, Biosafety Committee, etc.\_are scarce.

VA-funded programs are barely one-third (37%) of the total VA research enterprise, yet VA has failed to secure equitable reimbursement for its indirect costs from all of its research partners, particularly other federal agencies. VA investigators are to be applauded for their success in obtaining extramural grants, but the medical care appropriation should not bear the entire cost of the necessary infrastructure.

For decades, VA has failed to request, and Congress has failed to mandate, construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor construction funding amounting to over \$45 million and \$290 million for major construction. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements as well as at least one major research construction project per year until the backlog is addressed.

VA medical and prosthetics research is highly productive and has a direct impact on the quality of care provided to veterans, but Congress must ensure adequate resources for both the direct and indirect costs of advancing medical diagnosis and treatment.

**FY 2005 Recommendations:**

- Steady and sustainable growth in the R&D appropriation
- A separate minor construction funding stream specifically for research facilities and greater consideration of the research mission in the major construction budget
- Equitable sharing of indirect costs among VA and its research partners

**CRITICAL ISSUE #5: VA Rulemaking Authority**

*Today's VA is misusing its rulemaking authority for self-serving purposes and to orchestrate an erosion of veterans' rights.*

From America's beginnings, our citizens recognized that our nation's very existence and future depended on strong armed forces. They appreciated the fundamental necessity and exceptional value of military service. On the principle that those who devote part of their youth and risk their lives and health to defend their country deserve special treatment and advantages over those who do not, we, as a country, have, through Congress, accorded veterans special honors and provided for generous benefits. Consistent with our indebtedness to veterans and our deep appreciation for their contributions and sacrifices, our citizens have charged the Department of Veterans Affairs (VA) with providing veterans seeking benefits with the highest level of personal service and assistance in obtaining those benefits. Every effort is to be made to help veterans apply for and establish entitlement to the benefits they claim, and, within the law, VA must endeavor to grant them the benefits they seek. For VA to create procedural impediments or substantive rules to limit veterans' rights offends the very essence and spirit of benefits for veterans and is antithetical to the intent of our grateful nation as expressed in the laws of Congress.

Congress has repeatedly stated its intent that the ultimate goal of VA's unique process is to ensure that veterans receive every benefit to which they are entitled. That goal overrides agency convenience and expedience, and toward that end, the VA system must afford veterans advantages not afforded to claimants in other agencies. When enacting legislation to improve the process, Congress has frequently sought to preempt any

misinterpretation of its intent that would formalize or make VA claims procedures burdensome for veterans. On these occasions, Congress has gone to great lengths to emphasize and reaffirm its intent to preserve the “pro-claimant bias,” informality, and helpful nature of the process. Congress expressly stated it intends that no changes be made to the existing system except to further the goals of informality, accuracy, and fairness.

The federal courts have reaffirmed on many occasions the principle that laws governing veterans benefits are to be liberally construed in favor of veterans. It is a well-settled rule of statutory construction that ambiguities in such statutes are to be resolved in favor of veterans.

Historically, VA’s regulations were drafted to reflect these benevolent goals and the special treatment and considerations to be accorded veterans seeking benefits. For example, a longstanding VA regulation begins with this declaration: “It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation.” 38 C.F.R. § 3.102 (2002). In another regulation the essence of VA policy is articulated with this statement: “Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government.” 38 C.F.R. § 3.103 (2002).

Regrettably, with its decisions immune to judicial review and VA operating in what has been described as a state of “splendid isolation” for most of the 20th century, VA adjudicators often ignored the liberal provisions of VA regulations. With the advent of judicial review, the courts began enforcing the letter and spirit of the law and these regulations. In reaction, VA began to construe the statutes as narrowly as possible to limit veterans’ entitlements, and it began to rewrite its rules in ways designed to diminish veterans’ rights, to make the process more burdensome and formal, and to serve for VA’s own advantage, convenience, and purposes rather than to serve the interests of veterans.

Now, new regulations written by VA no longer have the traditional pro-veteran tone. They often have a negative, restrictive focus. They appear calculated to give VA the upper hand against claimants and to impair veterans’ due process rights or access to an open claims process and benefits. Today’s VA regulations are too often self-serving; they are designed for VA expedience and to incorporate VA’s resistance to liberalizing legislation. Sometimes their apparent aim is to inhibit what VA cannot prohibit. VA exploits opportunities to reinterpret statutory provisions to remove from its longstanding regulations provisions favorable to veterans. With aloofness, VA pays little real attention to public comments and offers flimsy rationales for brushing them aside. VA’s justifications in response to public comments sometimes suggest pretext; are tenuous, specious, or shallow; or are as arbitrary as the text of the rules themselves. VA vigorously defends narrow or restrictive judicial interpretations of its regulations that are adverse to veterans but actively seeks to overturn judicial constructions that are more favorable to veterans than VA desires.

Outraged veterans organizations have begun to challenge more frequently VA's regulations, but, consistent with courts' tendency to indulge federal agencies, the results have been mixed, despite special canons of statutory construction intended to favor veterans. While veterans organizations have had some successes in getting the most objectionable regulations invalidated, the courts have sometimes strained to defer to VA rules, and veterans organizations have sometimes not prevailed even in exceptionally meritorious challenges. As one court noted, this practice of judicial deference "all too often is taken to mean simply that administrative agencies win any dispute involving statutory construction." *Mid-America Care Foundation v. National Labor Relations Board*, 138 F.3d 638, 642 (6th Cir. 1998). VA's awareness of these circumstances appears to embolden it in its arbitrary rulemaking.

In matters of veterans' rights, this type of agency behavior must not be tolerated. If the secretary of Veterans Affairs is unwilling to rein in those who write his regulations and if the courts continue to permit such behavior, we will turn to Congress to impose special constraints and requirements upon VA's rulemaking to ensure that VA carries out the will of the people to treat veterans as a special class; to ensure that VA does not deal with veterans grudgingly, indifferently, or at arms-length as if they were ordinary litigants or claimants for federal benefits; and certainly to ensure that VA does not treat veterans like adversaries.

As has often been observed, veterans have unique needs, the nation has an extraordinary obligation to meet those needs, **and** the VA system is therefore a unique system with an extraordinary mission. The procedures, rules, and remedies of other forums or agencies are frequently improperly suited or inadequate for the administration of veterans programs. In view of the hardening of VA's regulations and its departure from the benevolent role assigned to it by Congress, specially tailored laws may become necessary to bring VA's rulemaking back in line with its unique mission as the nation's patron and benefactor for veterans. (Despite our continuing deep dissatisfaction with the VA's regular rulemaking, we acknowledge that early experience with VA's Regulations Rewrite Task Force has been much more positive.)

*The Independent Budget* will recommend the following actions: (1) that the secretary of Veterans Affairs act decisively to put an end to VA's self-serving rulemaking; (2) that Congress scrutinize VA's rulemaking more closely as part of its oversight role; (3) that Congress take action or enact legislation to override VA rules that run counter to congressional intent; and (4) that Congress enact special provisions to control VA rulemaking if the secretary of Veterans Affairs fails to bring VA's rulemaking back in line with congressional intent and VA's benevolent mission.

## **CRITICAL ISSUE #6: Benefits Process**

***To reduce the high error rate and avoid a consequent unacceptably large case backlog with protracted processing times in veterans' compensation and pension claims, the Veterans Benefits Administration (VBA) must address the root causes of its quality problems.***

The inability of the Veterans Benefits Administration (VBA), to process and decide veterans' compensation and pension (C&P) claims accurately and timely is widely recognized as one of the most serious and persisting problems affecting the Department of Veterans Affairs (VA) and veterans. This problem has seriously degraded VA's ability to fulfill its mission of assistance to veterans and its corresponding responsibilities to them under the law. It has prevented disabled veterans from receiving within a reasonable time the compensation or pension they often urgently need to relieve the economic effects of disability. Although this problem plagued VA for several years, VA's various initiatives and plans have failed to solve the problem. Rather, while the number of C&P claims decreased substantially over the past decade, the claims backlog continued to grow larger because production declined and because high error rates necessitated rework of large numbers of cases, thereby adding to the workload of an already overburdened system.

The historical dynamics of this intolerable situation include flawed policies and a series of management failures. In a climate of immunity from outside review over several decades, a culture and mind-set developed within VA whereby adjudicators began making decisions based on their own personal beliefs, attitudes, and predilections. Unwritten rules evolved, and arbitrary practices became ingrained. The decisions were based more on these unwritten rules and practices than the law. As a result, angry veterans demanded, and eventually received, the right to have judicial review of VA decisions.

The courts found fundamental departure from the law in numerous areas. For a while VA attempted to resist the precedents of courts. Then VA found that its adjudicators were poorly equipped to interpret and apply case law. Other factors, such as budget reductions and inadequate resources, intervened to compound the burden. Rather than address the problems directly, VA management went through a period of denial and blamed its problems on judicial review.

The claims backlog grew. VA management began to press for increased production. VA further compromised quality for quantity. Alarming claims backlogs, and consequent pressure from Congress and the veterans community, eventually forced VA to devote more meaningful attention to this serious problem. By that time, poor quality pervaded the claims processing system and the backlog was enormous. VA's own internal study revealed poor quality as the major cause of its inefficiency, but the poor quality was rooted in other factors, such as inadequate training and resources. Poor quality was a precipitating cause of the backlog and then, with the focus on production, also became an effect of the backlog.

To break this vicious cycle, VA needed a technically sound strategy and effective implementation. In its business process reengineering (BPR) plan, it had a well-designed and technically sound strategy to address the root causes, but VA management failed to take the decisive action necessary to implement the plan. In addition, while the BPR plan correctly identified the root causes in the sense of the process and set out appropriate remedies, it did not address the paramount need to change the negative institutional culture and strengthen management within VA. These flaws seriously hindered progress in implementing the plan's reforms. Today VA still struggles with the same enormous problem.

Studies by various panels, commissions, and other bodies have failed to produce effective solutions because they have either recommended reducing veterans' rights and benefits to reduce VA's workload and thus accommodate its inefficiency or they have lost focus and strayed away from the root causes to various incidental and contributing factors. Reducing veterans' rights and benefits to allow VA to remain inefficient is indefensible, and any viable and effective solution will necessarily require that VA first address the root causes.

In its October 2001 report the VA Claims Processing Task Force made beneficial recommendations, but implementation of these recommendations has not resulted in the kind of system-wide and sustained improvements necessary to overcome the problem. Although VA has gained ground in reducing its large backlog of pending claims for disability benefits, these gains appear more the result of targeting of resources and stop-gap measures than systematic improvements in quality and accountability for quality. Indeed, in 2001, despite large numbers of inexperienced adjudicators and complex new procedural requirements in the Veterans Claims Assistance Act of 2000, which would be expected to both slow claims dispositions and result in increased errors, VA shifted its emphasis to increased production to meet goals of reducing the claims backlog. Under this emphasis on production, VA regional office directors became accountable for production targets, some were required to develop plans to increase production but not quality, and performance awards were based primarily on production. VA awarded bonuses for production to some regional offices that had not met VA accuracy standards. Quality again took a back seat to quantity. During fiscal year 2002, VA increased its number of claims decisions by two-thirds. Thus, there were three factors, each of which, by itself, would each be expected to have a negative effect on accuracy: increased production with a corresponding de-emphasis on quality, inexperienced staff, and new complex procedural requirements. Together these three factors could be expected to have a compounding effect. According to the United States General Accounting Office (GAO) in its September 2003 report, *Veterans' Benefits: Improvements Needed in the Reporting and Use of Data on the Accuracy of Disability Claims Decisions*, GAO-03-1045, VA's accuracy in compensation and pension claims decisions declined from 89 to 81 percent during fiscal years 2001 to 2002. GAO also found that VA has not made the best use of the accuracy data it collects to evaluate regional office performance, to correct errors, to identify needed training, and to hold regional offices accountable for accuracy.

At the end of fiscal year 2003, VA had reduced its pending caseload to 253,000 claims, coming close to meeting its goal of reducing pending disability claims to 250,000. VA reported that it had increased its monthly claims decisions by more than 70 percent above its 2001 level despite an inexperienced workforce and increased procedural burdens on VA. VA also surprisingly reported that its accuracy improved to 85 percent in fiscal year 2003. With its continued net decline in accuracy over the past three years, the number of claims needing additional work to correct errors is likely to rise. Accordingly, while the unmanageable claims backlog would appear on the surface to have been largely overcome for the present, the true amount of claims work awaiting VA may be greater than indicated by the inventory of currently pending claims. The backlog of pending claims may very well again begin to quickly grow, repeating the familiar vicious cycle in which poor quality necessitates rework and results in increased workloads, increased backlogs, decline in timeliness, and greater pressure to increase production at the expense of quality. Gains on the claims backlog through increased production at the expense of quality are only cosmetic and temporary. The only way to break this vicious cycle is quality first. That requires management discipline and dogged persistence in improving quality even if timeliness and VA's pending claims statistics suffer in the short term. VA must focus primarily on the root cause of this problem to overcome it.

Clearly, VA's adjudicators make erroneous decisions because they are poorly trained in the law, they operate in a culture of indifference to the law, and they are not accountable for their poor proficiency and performance. Accordingly, in conjunction with the deployment of better training, VA must take bold steps to change its institutional culture, and it must make its decisionmakers and managers accountable. With its primary focus on these fundamental defects, VA should intensify its efforts to make other essential process improvements, such as better disability examinations and data exchange between VBA and its health-care facilities. With well-informed, well-reasoned claims decisions will come fairness and efficiency. Stable reductions in claims backlogs and consistent timeliness will eventually follow.

To improve quality in VA claims decisions and stabilize the inventory of pending claims to avoid the return of enormous claims backlog and consequent long delays in the delivery of compensation and pension benefits, *The Independent Budget* will recommend the following steps: (1) that VBA improve the substance, implementation, and measurement of the effectiveness of its training for compensation and pension adjudicators; (2) that VA take decisive and immediate steps to change its negative institutional culture to instill in its decisionmakers and line management more positive attitudes and fidelity to the law; (3) that VA impose from top to bottom real accountability for proficiency and a quality product; and (4) that, in addition to these root causes of inefficiency, VA address as soon as possible other substantial contributing problems, such as the adequacy of VA disability examinations and its technology for information exchange between VBA and its medical facilities.

**CRITICAL ISSUE #7: CARES/Construction**

***The VA National CARES process must not be used as an excuse to defer vital infrastructure maintenance and construction projects.***

VA's Capital Asset Realignment for Enhanced Services (CARES) is a national process to reorganize VA through a data-driven assessment of its infrastructure and programs. Through CARES, VA is evaluating the health services it provides and identifying changes that will help meet veterans current and future health-care needs. The process is identifying both redundancies and gaps in VA health-care services and has resulted in a national plan to rectify deficiencies through realignment of VA medical centers and services. At the present time a CARES Commission (appointed by the secretary of the Department of Veterans Affairs) is evaluating the national plan proposed by VA. Their report is due by January of 2004.

The IBVSOs have been supportive of the CARES process, with primary emphasis on the "ES" (Enhanced Services). We recognized that the location and mission of some VA facilities may need to change to improve veterans access, to allow more resources to be devoted to medical care rather than to the upkeep of inefficient buildings, and to accommodate modern methods of health-service delivery.

While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-term care and small size facilities. These data should include such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; costs associated with contracting for care in the community; the costs related to shutting down and disposing of property to include asbestos removal; the costs to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements. We acknowledge that the VA Office of Facilities Management has assembled construction cost data for various functional building types; however, the inclusion of the aforementioned costs could provide the rationale for reconsidering some decisions. VA must make it clear to all involved parties that the very essence of CARES is planning for a cost-effective system dedicated to direct and efficient delivery of quality health care of veterans in a timely manner.

In addition, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The IBVSOs are concerned that, once CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

VA Facilities Management also has developed facility demolition costs. These costs are divided into two categories, the actual demolition cost to bring down a building and the cost to haul and dispose of the refuse. However, an asbestos-abatement factor has not been included in this computation and could drastically increase both the demolition cost and the disposal costs of eliminating excess buildings from VA's inventory. The IBVSOs believe an asbestos-abatement factor should be included in demolition costs when appropriate.

Currently, most VA medical centers, with an average age of 53 years, are in critical need of repair. Sadly, the prospect of system wide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance and renovations of VA facilities.

**Critical Issue # 8: National Cemetery Administration**

*The National Cemetery Administration faces two major challenges: first, to provide for the passing of the generation of men and women that defended freedom and democracy in World War II; and, second, to ensure the maintenance of current cemeteries and the continued planning, design, and construction of world-class, quality cemeteries to honor veterans.*

America's National Cemetery Administration (NCA) has a long and proud history of service to America's veterans and their families.

The first national cemeteries were developed by act of Congress in July 1862 authorizing the president to purchase "cemetery grounds to be used as national cemeteries for soldiers who shall have died in the service of the country." That year 14 new cemeteries were established.

Presently NCA maintains more than 2.6 million gravesites in approximately 14,000 acres of cemetery land while providing interments to nearly 90,000 individuals annually. NCA responsibilities include 120 cemeteries, 61 open for full service, 25 allow only cremations, and 34 are closed to new interments. A new cemetery in Oklahoma, Fort Sill National Cemetery, is currently under construction and operating a fast-track section that permits interments to begin prior to completion of all construction activities. In addition, continued progress is anticipated on cemetery development in Atlanta, Florida, Pittsburgh, Detroit, and Sacramento.

Legislation is pending to authorize VA to continue developing new cemeteries in areas not currently served by either a national veterans cemetery or a state veterans cemetery. These areas include development of six new national cemeteries located in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida.

Clearly, the rapid aging of the current veteran population has placed great demands on NCA operations and available burial space. At present, most World War II veterans are in their late 70s, with veterans from the Korean War and Vietnam Era close behind. Nearly 655,000 veteran deaths are estimated in 2005 with the death rate peaking at 690,000 in 2009; of these, it is expected that 109,000 will seek burial in a national cemetery. As veteran deaths accelerate, it is obvious the demand for veteran burial benefits will increase.

Workload per full-time employee equivalent will grow, as a result of the increasing demands of interments, gravesite maintenance, and other areas of cemetery operations. The increased burial rate with its resulting demand on cemetery support services necessitates an appropriate budgetary increase for the NCA.

An important element of the NCA national cemeteries is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect and nurture this national treasure, the system has and continues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the nation.

When *The Independent Budget (IB)* for fiscal year 2005 is published later this year, we will recommend approximately \$175 million for the NCA operational budget. This level of funding is consistent with NCA's growing demands and in concert with the respect due every man and woman who has worn the military uniform of the United States of America. It is also consistent with the driving needs reported in the Millennium Act (P.L. 106-117) studies on improvements, upkeep, and repair to veteran cemeteries.

For the State Grants program, the *IB* will recommend approximately \$37 million. For major construction, the *IB* will recommend \$68 million and minor construction of \$50 million for road repaving, one-time repairs, drainage, and related costs of maintenance activity.

In this vein, we call on the administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.